

**Administration and County Services Committee**

*David Heeres*

*Ed Boettcher, Chairman*

*Laura Stanek*

**Special Meeting Minutes  
September 19, 2016**

Members: Ed Boettcher, Dave Heeres, Laura Stanek  
Members absent: None  
Others: Pete Garwood, Janet Koch, Debra Ho'on, Sherry Comben, Tina Schrader, Sheryl Guy, Laura Evans, Scott Boni, Ed Smith, Jim Janisse, Teresa Ankney, Danell Doucette, Sandy Davids

**1. The meeting was called to order at 1:00 p.m. by Chair Ed Boettcher.**

**2. Public Comment**

None.

**3. Dewey Insurance Presentation**

Pat Dewey and Darci Fitch of Dewey Insurance distributed hard copies of their presentation (see attached pgs. 3-27). Current rates for the County's two plans were reviewed, along with the proposed Health Savings Account (HSA) plan, all with Priority Health. Mr. Dewey and Ms. Fitch then discussed proposed Blue Cross Blue Shield (BCBS) health insurance rates for "high" plans and "low" plans. Out of network costs were not provided in order to make a shorter presentation.

Ms. Fitch provided a brief overview of HSAs, saying that funds deposited into an HSA stay with the employee even if the employee leaves the employ of the County. (She said the Community Blue plans (CB) were more benefit rich, that anything the provider provides was under the copay.) Also, under the CB plans all referrals were treated as if they were in-network and that emergency room visits were covered if the patient was admitted.

In Simply Blue plans, Ms. Fitch said, more costs hit the deductible amount. In addition to the office visit copay, any office procedures would be coded as a diagnostic procedure and would be billed to the plan-holder and apply to their deductible. Out of network referrals would be considered out of network costs and emergency room fees would hit the deductible even if the patient was admitted. The Blue Care Network (BCN) is an HMO.

Regarding the self-funded proposal, Mr. Dewey said the underwriter didn't recommend that the County self-fund on a standalone basis. Though it might work to the County's benefit, his recommendation was to wait a year and see if the County's claims stabilized.

Mr. Dewey said Priority Health had declined to quote a self-funded plan, as they had felt it would be more expensive than the existing rates. Pete Garwood, County Administrator, noted that Priority Health was in the position to have the most accurate information about the County's health insurance claims. Mr. Dewey said Priority felt they had the group priced correctly.

**DRAFT**

Mr. Dewey said the County had been with Dewey Insurance for 10 years. He added that he offered to reduce his agency's commission and had asked Priority Health to match that reduction. Mr. Dewey hadn't received a response from Priority Health about a reduction, but expected to hear soon.

Mr. Dewey said at the previous Administration Committee meeting, references had been made to PA 106 of 2007, the Public Employees Health Benefit Act. He pointed out Sections 124.75(a), 124.79(a) and 124.79(b).

Mr. Boettcher asked about bidding the County's health insurance. Mr. Dewey said base prices from insurance agents were the same and added that agent commissions were typically between 3-4% of the premiums; his was 2.75%.

Mr. Boettcher mentioned the Etna insurance network. Mr. Dewey said another insurance provider was United Health Care, but it wasn't used widely in the region. He expressed concern about the physician network of both companies.

Ms. Fitch spoke about the difference between referrals and authorizations; referrals typically involve an office visit, authorizations were more often a phone call. Referrals and authorizations help coordinate care.

Mr. Boettcher said there are two questions; what insurance plans to choose and at what level should the employer hard caps be set. Ms. Fitch said the 2017 hard caps from the State of Michigan were not available as of that morning. She added that both Priority and BCBS were fine to work with, but she had found that Priority was easier to work with on claim issues.

Mr. Boettcher asked the employee representatives their opinions; Mr. Janisse said he would like to directly compare numbers from the various plans.

It was the consensus of the Committee to review the materials provided by the different insurance agencies and make a recommendation at the October 6 Administration Committee meeting. Mr. Garwood said his office would provide a compiled spreadsheet to the employee representatives and the Committee by September 26. It was agreed that the cost of the health care premiums will drive the recommendations for Antrim County employee hard caps.

**4. Various Matters as Appropriate**

None.

**5. Public Comment**

None.

The meeting was adjourned at 2:10 p.m.

# Antrim County

*Renewal Packet*

**Presented By**

**Dewey Insurance**

**Phone: (231) 258-2301**

2017 - 2018

*Dewey Insurance Agency, Inc*

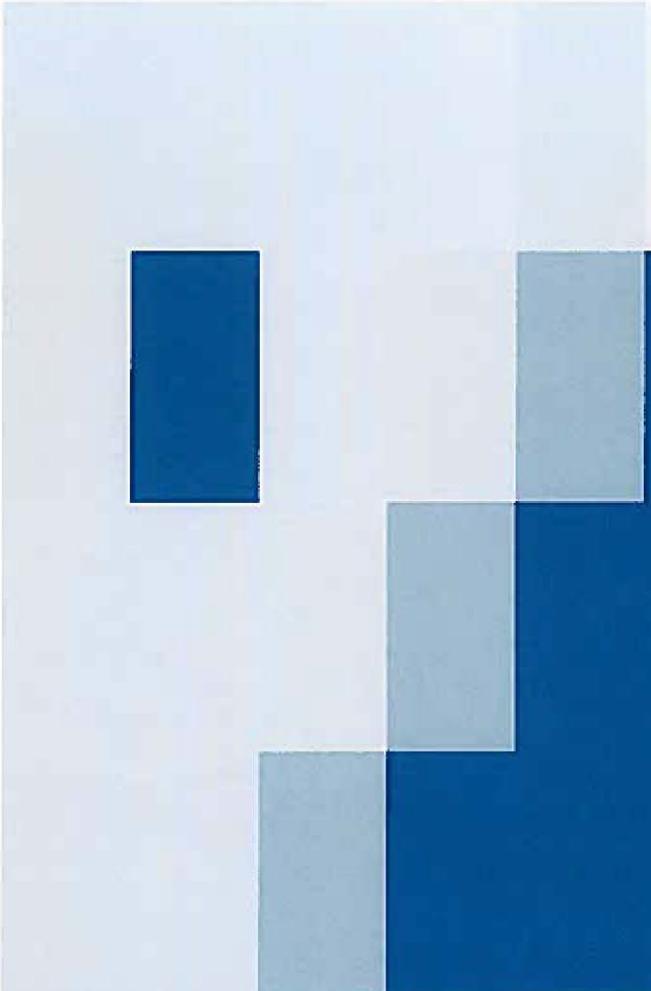
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# Priority Health High Plan

Antrim County HIGH PLAN \$0 Deductible	Current Priority Health HMO 10/01/2015— 10/01/2016			Renewal Priority Health HMO 10/01/2016— 10/01/2017			Renewal Priority Health HMO 1/01/2017— 1/01/2018		
Benefits	In-Network			In-Network			In-Network		
Annual Deductible Individual / Family	\$0 / \$0			\$0 / \$0			\$0 / \$0		
Member Co-Insurance AD	0% Most Services			0% Most Services			0% Most Services		
Co-Insurance Maximum	\$0			\$0			\$0		
Annual Out of Pocket Maximum Individual / Family	\$6,350 / \$12,700			\$6,850 / \$13,700			\$6,850 / \$13,700		
Preventive Care (Certain Codes)	Covered 100%			Covered 100%			Covered 100%		
Primary/Specialist/Urgent Care	\$25 / \$25 / \$25			\$25 / \$25 / \$25			\$25 / \$25 / \$25		
Emergency Room	\$50			\$50			\$50		
Prescription Drugs 1-30 Day	\$10 / \$40			\$10 / \$40			\$10 / \$40		
Census	Single (10)	Double (7)	Family (9)	Single (10)	Double (7)	Family (9)	Single (10)	Double (7)	Family (9)
Estimated Rate W/Tax & Fees	\$675.13	\$1,518.30	\$1,823.38	\$772.83	\$1,738.71	\$2,086.41	\$772.31	\$1,737.55	\$2,085.01
Estimated Premium W/Tax & Fees	\$33,789.82/Mo		\$405,477.84/Yr	\$38,676.96/Mo		\$464,123.52Yr	\$38,651.04/Mo		\$463,812.48/Yr
% Change Over 2015				14.46%			14.39%		



# Priority Health

## Low 80/20

Antrim County LOW PLAN 80/20		Current Priority Health HMO 10/01/2015— 10/01/2016			Renewal Priority Health HMO 10/01/2016— 10/01/2017			Renewal Priority Health HMO <del>10/01/2017— 10/01/2018</del>		
Benefits		In-Network			In-Network			In-Network		
Annual Deductible Individual / Family		\$750 / \$1,500			\$750 / \$1,500			\$750 / \$1,500		
Member Co-Insurance AD		20% Most Services			20% Most Services			20% Most Services		
Co-Insurance Maximum		\$1,500 / \$3,000			\$1,500 / \$3,000			\$1,500 / \$3,000		
Annual Out of Pocket Maximum Individual / Family		\$6,350 / \$12,700			\$6,850 / \$13,700			\$6,850 / \$13,700		
Preventive Care (Certain Codes)		Covered 100%			Covered 100%			Covered 100%		
Primary / Specialist / Urgent Care Visits		\$30 / \$45 / \$75			\$30 / \$45 / \$75			\$30 / \$45 / \$75		
Emergency Room		\$150 (Deductible Applies)			\$150 (Deductible Applies)			\$150 (Deductible Applies)		
Prescription Drugs 1-30 Day		\$10 / \$50			\$10 / \$50			\$10 / \$50		
Census		Single (15)	Double (17)	Family (47)	Single (15)	Double (17)	Family (47)	Single (15)	Double (17)	Family (47)
Estimated Rate W/Tax & Fees		\$518.24	\$1,165.33	\$1,427.01	\$599.43	\$1,348.60	\$1,647.06	\$599.55	\$1,348.86	\$1,647.39
Estimated Premium W/Tax & Fees		\$94,653.68/Mo \$1,135,844.16/Yr			\$109,329.47/Mo \$1,311,953.64/Yr			\$109,351.20/Mo \$1,312,214.40/Yr		
% Change over 2015					15.50%			15.53%		

Antrim County		Proposed HMO Low - 10 H.S.A.		
BENEFITS	IN-NETWORK			
Annual Deductible Individual / Family	\$2,000 / \$4,000			
Member Co-Insurance After Deductible	20%			
Member Co-Insurance Maximum	N/A			
Member Annual Out-of-Pocket Maximum Individual / Family (Includes Deductible, Coinsurance, Copays)	\$4,000 / \$8,000			
FREQUENTLY USED SERVICES				
Preventive Care (Certain payable codes)	Covered 100%			
Primary Care / Specialist / Urgent Care	20% After Deductible			
Emergency Room	20% After Deductible			
Prescription Drugs 1-30 Day Supply	\$15 / \$50 / \$80 After Deductible (Certain preventive drugs covered with copay prior to deductible.)			
Census: Single (15) Double (17) Family (47)				
Estimated Rates W/Taxes & Fees	\$437.89	\$985.17	\$1,203.19	
Estimated Premium W/Taxes & Fees	\$79,866.17/Mo		\$958,394.04/Yr	
% Change Over 2015	-15.62%			

## HSA Basics

A health savings account (HSA) can be used to help pay for qualified medical expenses, including your deductible, copayments and coinsurance. Any unused money automatically rolls over from year to year.

Important Information	How it works
What is an HSA?	An HSA is a special kind of bank account that helps you pay for your medical expenses. It is paired with a high deductible health plan (HDHP).
Are there tax advantages with an HSA?	<p>No taxes are paid on the money deposited into your HSA.</p> <ul style="list-style-type: none"> <li>• Employer contributions to the HSA is not taxable income.</li> <li>• If you contribute money you've already paid taxes on, you can get a tax deduction.</li> <li>• You don't have to pay taxes on interest that your HSA earns.</li> <li>• You don't have to pay taxes on money withdrawn from your HSA used to pay for qualified medical expenses.</li> </ul>
What can my HSA funds be used for?	<p>HSA funds can only be used to pay for qualify health expenses determined by the IRS. Examples include:</p> <ul style="list-style-type: none"> <li>• Doctor and hospital expenses.</li> <li>• Anything requiring a prescription.</li> <li>• Eyeglasses, dental care, etc.</li> </ul>
Who does the HSA belong to?	Your HSA stays with you if you change jobs or retire, just like your retirement IRA or 401(k), even if your employer makes all the deposits. You can use the money in your HSA to pay for qualified health and medical expenses. Or you can let it build, tax free, to use later.
What is the contribution limit to an HSA?	<p>2017:</p> <p>Single Contract: \$3,400</p> <p>Family Contract: \$6,750</p> <p>Age 55+: \$1,000 Additional</p>
Where can I find more information?	For more detailed information on HSA plans and taxes, visit the U.S. Department of Treasury website at <a href="http://www.ustreas.gov">www.ustreas.gov</a> or talk with your tax adviser.



# BCBS / BCN High Plan Options

<b>Antrim County</b>	<b>Proposed BCN - 4 (Similar to PH High Plan)</b>			<b>Proposed BCN - 1</b>			<b>Proposed BCBS CB 1</b>			<b>Proposed BCBS Simply Blue 250</b>		
<b>BENEFITS</b>	<b>IN-NETWORK</b>			<b>IN-NETWORK</b>			<b>IN-NETWORK</b>			<b>IN-NETWORK</b>		
Annual Deductible Individual / Family	\$0 / \$0	*	.	\$0 / \$0	.	.	\$0 / \$0	.	.	\$250 / \$500	*	.
Member Co-Insurance After Deductible	0% - Most Services			10% - Most Services			0% - Most Services			20% - Most Services		
Member Co-Insurance Maximum	N/A			\$1,000 / \$2,000			N/A			\$1,500 / \$3,000		
Member Annual Out-of-Pocket Max Individual / Family (Includes Deductible, Coinsurance, Copays)	\$6,600 / \$13,200			\$5,000 / \$10,000			\$6,350 / \$12,700			\$6,350 / \$12,700		
<b>FREQUENTLY USED SERVICES</b>												
Preventive Care (Certain payable codes)	Covered 100%			Covered 100%			Covered 100%			Covered 100%		
Primary Care / Specialist / Urgent Care	\$25 / \$25 / \$25			\$20 / \$30 / \$35			\$30 / \$30 / \$30			\$20 / \$20 / \$20		
Emergency Room	\$50			\$150			\$50			\$150		
Prescription Drugs 1-30 Day Supply	\$10/\$40/\$80			\$4/\$15 / \$40 / \$80 / 20% / 20%			\$10/\$40/ \$80			\$10/\$40/\$80		
Census: Single (10) Double (7) Family (9)												
Estimated Rates <b>W/Taxes &amp; Fees</b>	\$602.60	\$1,446.23	\$1,807.79	\$568.40	\$1,364.15	\$1,705.19	\$780.17	\$1,872.41	\$2,340.51	\$625.13	\$1,500.31	\$1,875.38
Estimated Premium	\$32,419.72/Mo		389,063.64/Yr	\$30,579.76 /Mo		\$366,957.12/Yr	\$41,973.16/Mo		\$503,677.92/Yr	\$33,631.89/Mo		\$403,582.68/Yr
% Change Over 2015	-4.05%			-9.50%			24.22%			-0.47%		

# BCBS / BCN Low Plan Options

<b>Antrim County</b>	<b>Proposed BCN - 5 (Similar to PH 80/20 Plan)</b>			<b>Proposed BCBS CB 12</b>			<b>Proposed BCBS Simply Blue 1000</b>			<b>Proposed BCN - 3</b>		
<b>BENEFITS</b>	<b>IN-NETWORK</b>			<b>IN-NETWORK</b>			<b>IN-NETWORK</b>			<b>IN-NETWORK</b>		
Annual Deductible Individual / Family	\$750 / \$1,500		*	\$1,000 / \$2,000			\$1,000 / \$2,000		*	\$1,000 / \$2,000		
Member Co-Insurance After Deductible	20% - Select Services			20% - Most Services			20% - Most Services			20% - Select Services		
Member Co-Insurance Maximum	\$1,500 / \$3,000			\$2,500 / \$5,000			\$2,500 / \$5,000			\$2,500 / \$5,000		
Member Annual Out-of-Pocket Max Individual / Family (Includes Deductible, Coinsurance, Copays)	\$6,600 / \$13,200			\$6,350 / \$12,700			\$6,350 / \$12,700			\$6,600 / \$13,200		
<b>FREQUENTLY USED SERVICES</b>												
Preventive Care (Certain payable codes)	Covered 100%			Covered 100%			Covered 100%			Covered 100%		
Primary Care / Specialist / Urgent Care	\$30 / \$45 / \$65			\$30 / \$30 / \$30			\$30 / \$50 / \$60			\$20 / \$40 / \$50		
Emergency Room	0% After Deductible			\$150			\$150			\$150 After Deductible		
Prescription Drugs 1-30 Day Supply	\$15/ \$50 / 50%			\$15/\$50/50%			\$15/\$50/50%			\$4/\$15 / \$40 / \$80 / 20% / 20%		
Census: Single (15) Double (17) Family (47)												
Estimated Rates W/Taxes & Fees	\$493.60	\$1,184.63	\$1,480.79	\$584.54	\$1,402.90	\$1,753.62	\$519.56	\$1,246.95	\$1,558.69	\$487.59	\$1,170.21	\$1,462.77
Estimated Premium	\$97,139.84/Mo	\$1,165,678.08/Yr		\$115,037.54/Mo	\$1,380,450.48/Yr		\$102,249.98/Mo	\$1,226,999.76/Yr		\$95,957.61/Mo	\$1,151,491.32/Yr	
% Change Over 2015	2.63%			21.54%			8.03%			1.38%		

<b>Antrim County</b>		<b>Proposed BCN - 2 H.S.A.</b>		
<b>BENEFITS</b>		<b>IN-NETWORK</b>		
Annual Deductible Individual / Family		\$1,350 / \$2,700		
Member Co-Insurance After Deductible		0% - Select Services		
Member Co-Insurance Maximum		N/A		
Member Annual Out-of-Pocket Max Individual / Family (Includes Deductible, Coinsurance, Copays)		\$2,350 / \$4,700		
<b>FREQUENTLY USED SERVICES</b>				
Preventive Care (Certain payable codes)		Covered 100%		
Primary Care / Specialist / Urgent Care		0% After Deductible		
Emergency Room		0% After Deductible		
Prescription Drugs 1-30 Day Supply		\$10/\$30 / \$60/\$80/20% /20% After Deductible		
Census: Single (15) Double (17) Family (47)				
Estimated Rates W/Taxes & Fees		\$444.35	\$1,066.45	\$1,333.06
Estimated Premium		\$87,448.72/Mo \$1,049,384.64/Yr		
% Change Over 2015		-7.61%		

# BCBS / BCN Self Funded Proposal



Blue Cross Blue Shield of Michigan

County of Antrim  
 Self Funded Proposal: Weekly Call-In (ASC)  
 Effective date: October 1, 2016  
 Enrolled Employees: 107

Medical, Prescription Drugs

Benefit Plans

\*Contract plan designs may be subject to additional charges both within the new business process and potentially with future changes.

Medical & Rx

• Community Blue 1 - In Network \$0 Ded/0%, \$6,350 OOPM, Out Network \$250 Ded/20%, \$12,700 OOPM, ER \$50, \$30 OV / \$30 MT, XVA-ASC, Pref Rx Cert / PD-TTC \$10/\$40/\$80 RXCM LG, • CONTRACTS: 27

• Simply Blue SB \$1,000 / 20% ECM - In Network \$1,000 Ded/20%, \$2,500/\$6,350 OOPM, Out Network \$2,000 Ded/40%, \$5,000/\$12,700 OOPM, ER \$150, TCP \$30,\$50,\$60,\$150 OV / \$30 MT XVA-ASC, Pref Rx Cert / PD-TTC \$15/\$50/50%/\$70/\$100-RXCM LG, • CONTRACTS: 80

	Annual	PCPM
<b>Estimated Claims Cost</b>		
Medical Claims	\$712,000	\$554.52
Prescription Drug Claims	\$363,000	\$282.71
<b>Total Estimated Claims</b>	<b>\$1,075,000</b>	<b>\$837.23</b>
<i>Claims are reflective of BCBSM Overall Discount of 42% (including a 42.1% In-Network Discount).</i>		
Hospital Prospective Funding Deposit (30/365 x \$509,900):	\$42,000	
<b>Fixed Costs</b>		
Medical Administrative Fee	\$80,000	\$62.24
Prescription Drug Administrative Fee	\$3,000	\$2.29
Specific Stop-Loss: \$35,000	\$373,000	\$290.18
Aggregate Stop-Loss: 125%	\$14,000	\$10.74
<b>Total Fixed Costs</b>	<b>\$470,000</b>	<b>\$365.45</b>

Amounts are estimates based on historical data and actual results may be substantially different. Therefore, the figures shown are not guaranteed.

**Total First Year Estimated Cost with Hospital Prospective Funding Deposit** \$1,587,000  
 (excluding any applicable tax assessments)

**Total Annual Estimated Michigan Claims Tax** \$9,007  
 This amount is Blue Cross and BCN's estimate and is subject to change

<b>Maximum Estimated Liability @ 125% Aggregate Stop-Loss Coverage</b>	
Maximum Estimated Claim Cost	\$1,343,800
Hospital Prospective Funding Deposit	\$42,000
Total Fixed Costs	\$470,000
<b>Estimated Liability</b>	<b>\$1,855,800</b>

Amounts are estimates based on historical data and actual results may be substantially different. Therefore, the figures shown are not guaranteed.

Stop-Loss Pricing Options

Specific Attachment Point	Specific Monthly Rate	Aggregate Monthly Rate	Total Stop-loss Premium	Aggregate 125% Immature Attachment Point (Annual)	Maximum Stop-Loss Claim Liability
\$35,000	\$290.18	\$10.74	\$300.92	\$12,562	\$1,344,184
\$40,000	\$266.34	\$12.09	\$278.43	\$12,777	\$1,367,177
\$45,000	\$246.46	\$13.19	\$259.65	\$12,961	\$1,386,792

Specific stop-loss protection applies to medical and prescription drug claims. Aggregate stop-loss applies only to medical and prescription drug claims.  
 • BCBSM will pay 3.5% of stop-loss fees listed above for agent fees.  
 • The 3.5% is not negotiable, there is no availability to add or subtract fee percentage from stop-loss. It is a set 3.5%.

BCBSM requires the BCBSM/Blue Care Network Service Company disclosure form be completed and submitted prior to the effective date of coverage. Coverage will not start until receipt and approval by Underwriting. Updated claims information, including a Top-25 Prescription Drug Utilization Report, may be required to bind coverage.

The Stop-Loss Pricing Options shown do NOT include BCBSM's/BCN's estimates of applicable Federal and state taxes, fees and assessments which will be added in your future bills.

As required by US Treasury Regulations, we also inform you that any tax information contained in this communication is not intended to be used and cannot be used by any taxpayer to avoid penalties under the Internal Revenue Code.

\*If the group purchases a HSA, HRA, or FSA program, an additional charge, no more than \$4.45 per contract per month will be charged for each contract enrolled in the program.



## County of Antrim

Effective October 1, 2016

**The illustrative rates below represent a self-funded program.  
These rates are not available for a fully-insured product.**

### Plan 1

- Community Blue 1 - In Network \$0 Ded/0%, \$6,350 OOPM, Out Network \$250 Ded/20%, \$12,700 OOPM, ER \$50, \$30 OV / \$30 MT, XVA-ASC,
- Pref Rx Cert / PD-TTC \$10/\$40/\$80 RXCM LG, • CONTRACTS: 27

Contract	Medical & Drugs		
One Person	\$704.78		
Two Person	\$1,691.48		
Family	\$2,114.35		
Complementary	\$736.57		

### Plan 2

- Simply Blue SB \$1,000 / 20% ECM - In Network \$1,000 Ded/20%, \$2,500/\$6,350 OOPM, Out Network \$2,000 Ded/40%, \$5,000/\$12,700 OOPM, ER \$150, TCP \$30,\$50,\$60,\$150 OV / \$30 MT XVA-ASC,
- Pref Rx Cert / PD-TTC \$15/\$50/\$100/\$200/\$700/\$1000-RXCM LG, • CONTRACTS: 80

Contract	Medical & Drugs		
One Person	\$469.32		
Two Person	\$1,126.37		
Family	\$1,407.96		
Complementary	\$677.21		

*Illustrative rates represent mature claims cost for October 1, 2016 to September 30, 2017 and include administrative fees with \$35,000 Specific Stop-Loss pooling cost and 125% Aggregate stop-loss coverage.*

ASC Relative Rate Levels:	Cross	Shield	Rx
	2.8874	1.9971	11.4811

*Please use the above RRLs to obtain additional benefit pricing. It is not guaranteed that a request through Rate Control will provide pricing based on the above RRLs.*

#### Proposal Assumptions/Disclaimer:

SIC Code	9111	MI Contracts	107	Single	25
Average Age	50	Non-MI Contracts	0	2 Person	24
				Family	58
				Comp's	0
				Out Out's	0

◊BCBSM has included the member cost out of pocket maximum accumulator in the 2014 benefit designs. Your BCBSM benefits may be richer than a competitor not using an accumulator.

#### Total Annual Estimated Michigan Claims Tax

The Total Annual Estimated Michigan Claims Tax of \$13,914 for the October 1, 2016 through September 30, 2017 contract period and is subject to change.

Estimated Annual Taxes, Fees and Assessments are for quoting purposes only and are subject to change. You will be invoiced actual taxes, fees and assessments.



## Blue Care Network Service Company

County of Antrim  
 Self Funded Proposal: Weekly Call-In (ASC)  
 Effective date: October 1, 2016  
 Enrolled Employees: 107

### Medical, Prescription Drugs

#### Benefit Plans

- BCN Classic HMO LG - , , , \$6,600 OOPM, \$25 OV, , \$25 UC, \$50 ER, Rx - \$10 / \$40 / \$80 (Contraceptives, Open Formulary), \$6,600 OOPM, Mail Order 2X copay • CONTRACTS: 27
- BCN Classic HMO LG - 20%, \$750 Ded, \$1,500 ECM, \$6,600 OOPM, \$30 OV, \$45 SP, \$65 UC, , Rx - \$15 / \$50 / 50% (Contraceptives, Open Formulary), \$6,600 OOPM, Mail Order 2X copay • CONTRACTS: 80

*\*Complex plan designs may be subject to additional charges both within the new business process and potentially with future changes.*

Michigan Contracts	107
Out of State Contracts	0
	107

#### Estimated Claims Costs

#### Blue Care Network Service Company

Immature Medical Claims (without Capitation)	\$575,000
Capitation	\$74,000
Prescription Drug Claims	\$240,000
<b>Total Estimated Claims</b>	<b>\$889,000</b>
Hospital Prospective Funding Deposit	\$33,000

*Amounts are estimates based on historical data and actual results may be substantially different. Therefore, the figures shown are not guaranteed.*

#### Fixed Costs

#### PCPM Fee

Medical Administrative Fee	\$62.24	
Managed Care Fee	\$3.50	\$80,000
Prescription Drug Administrative Fee	\$2.29	\$4,000
Specific Stop-Loss: \$35,000	\$290.18	\$3,000
Aggregate Stop-Loss: 125%	\$10.74	\$373,000
		\$14,000
<b>Total Fixed Costs</b>		<b>\$474,000</b>

#### Maximum Estimated Liability with 125% Aggregate Stop-Loss Coverage

Maximum Estimated Claim Cost	\$1,018,750
Hospital Prospective Funding Deposit	\$33,000
Total Fixed Costs	\$474,000
<b>Estimated Liability</b>	<b>\$1,525,750</b>

*Amounts are estimates based on historical data and actual results may be substantially different. Therefore, the figures shown are not guaranteed.*

**Total First Year Estimated Cost with Hospital Prospective Funding Deposit** (excluding any applicable tax assessments)

**\$1,396,000**

**Total Annual Estimated Michigan Claims Tax** <sup>1</sup>

**\$9,007**

#### Stop-Loss Pricing Options

Specific Attachment Point	Specific Monthly Rate	125% Aggregate Monthly Rate	Total Stop-loss Premium	Blue Care Aggregate Immature Attachment Point
\$25,000	\$354.93	\$7.77	\$362.70	\$9,080
\$30,000	\$319.19	\$9.38	\$328.57	\$9,323
<b>\$35,000</b>	<b>\$290.18</b>	<b>\$10.74</b>	<b>\$300.92</b>	<b>\$9,521</b>
\$40,000	\$266.34	\$12.09	\$278.43	\$9,684
\$45,000	\$246.46	\$13.19	\$259.65	\$9,823

*Specific stop-loss protection applies to medical and prescription drug claims. Aggregate stop-loss applies only to medical and prescription drug claims.*

*<sup>1</sup> Blue Care Network will pay 3.5% of stop-loss fees listed above for agent fees.*

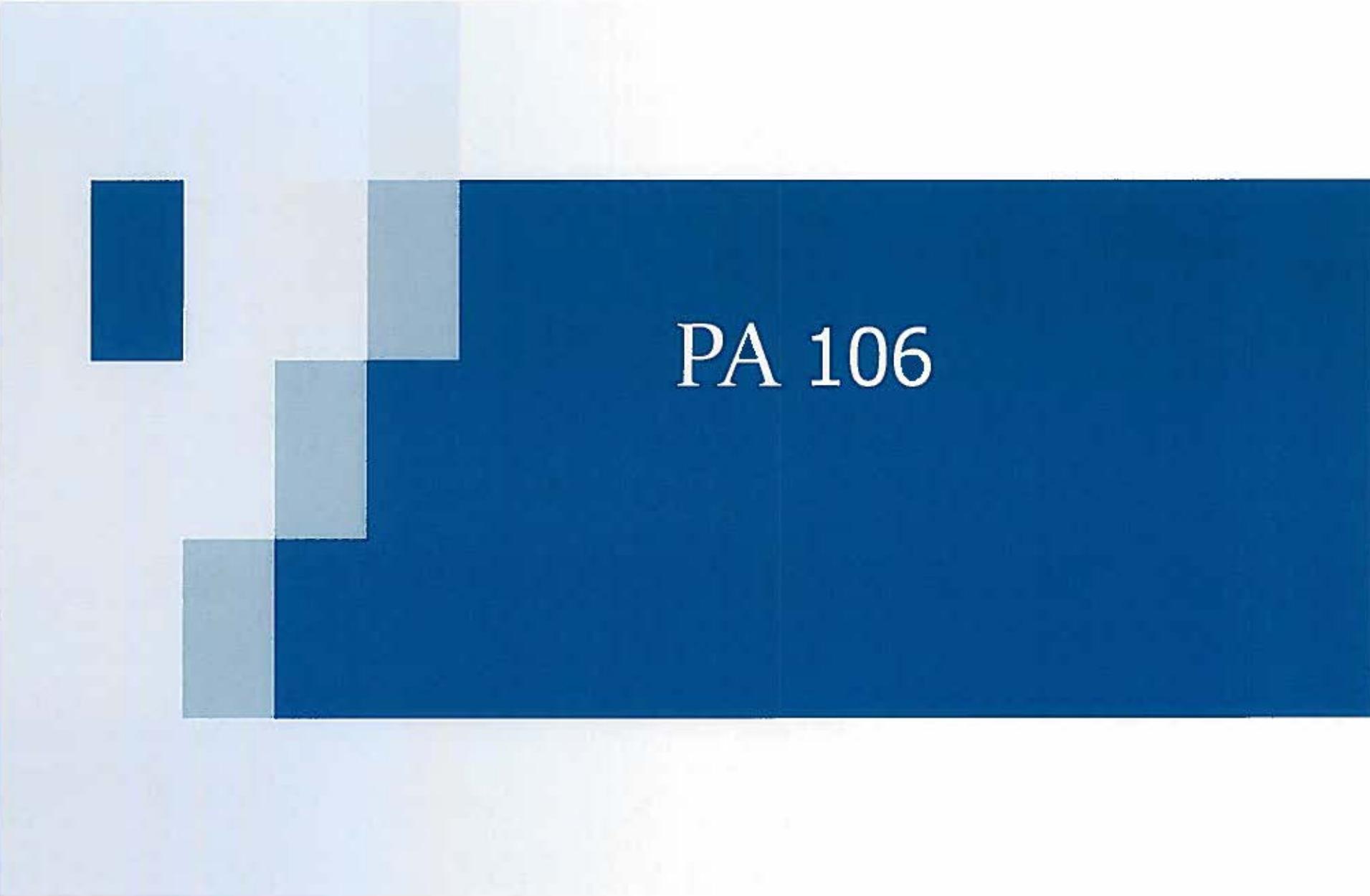
*<sup>2</sup> The 3.5% is not negotiable, there is no availability to add or subtract fee percentage from stop-loss. It is a set 3.5%.*

BCBSM requires the BCBSM disclosure form be completed and submitted prior to the effective date of coverage. Coverage will not start until receipt and approval by Underwriting. Updated claims information, including a Top-25 Prescription Drug Utilization Report, may be required to bind coverage.

<sup>1</sup>The Total Annual Estimated Michigan Claims Tax above is BCBSM and Blue Care Network Service Company's estimate and is subject to change.

*As required by US Treasury Regulations, we also inform you that any tax information contained in this communication is not intended to be used and cannot be used by any taxpayer to avoid penalties under the Internal Revenue Code.*

*\*If the group purchases a HSA, HRA, or FSA program, an additional charge, no more than \$4.45 per contract per month will be charged for each contract enrolled in the program.*



PA 106

**PUBLIC EMPLOYEES HEALTH BENEFIT ACT**  
**Act 106 of 2007**

AN ACT to prescribe the conditions upon which public employers may provide certain benefits; to require the compilation and release of certain information and data; to provide certain powers and duties to certain state officials, departments, agencies, and authorities; and to provide for appropriations.

History: 2007, Act 106, Imd. Eff. Oct. 1, 2007.

*The People of the State of Michigan enact:*

**124.71 Short title.**

Sec. 1. This act shall be known and may be cited as the "public employees health benefit act".

History: 2007, Act 106, Imd. Eff. Oct. 1, 2007.

**124.73 Definitions.**

Sec. 3. As used in this act:

(a) "Carrier" means a health, dental, or vision insurance company authorized to do business in this state under, and a health maintenance organization or multiple employer welfare arrangement operating under, the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302; a system of health care delivery and financing operating under section 3573 of the insurance code of 1956, 1956 PA 218, MCL 500.3573; a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373; a nonprofit health care corporation operating under the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704; a voluntary employees' beneficiary association described in section 501(c)(9) of the internal revenue code, 26 USC 501(c)(9); a pharmacy benefits manager; and any other person providing a plan of health benefits, coverage, or insurance in this state.

(b) "Commissioner" means the commissioner of the office of financial and insurance services.

(c) "Medical benefit plan" means a plan, established and maintained by a carrier or 1 or more public employers, that provides for the payment of medical, optical, or dental benefits, including, but not limited to, hospital and physician services, prescription drugs, and related benefits, to public employees.

(d) "Public employee" means an employee of a public employer.

(e) "Public employer" means a city, village, township, county, or other political subdivision of this state; any intergovernmental, metropolitan, or local department, agency, or authority, or other local political subdivision; a school district, a public school academy, or an intermediate school district, as those terms are defined in the revised school code, 1976 PA 451, MCL 380.1 to 380.1852; or a community college or junior college described in section 7 of article VIII of the state constitution of 1963. Public employer includes a public university that elects to come under the provisions of this act.

(f) "Public employer pooled plan" or "pooled plan" means a public employer pooled plan established pursuant to section 5(1)(b).

(g) "Public university" means a public university described in section 4, 5, or 6 of article VIII of the state constitution of 1963.

History: 2007, Act 106, Imd. Eff. Oct. 1, 2007.

**124.75 Medical, optical, or dental benefits provided to public employees; methods; solicitation of bids; number; frequency; participation of public employer in purchasing pool or coalition.**

Sec. 5. (1) Subject to collective bargaining requirements, a public employer may provide medical, optical, or dental benefits to public employees and their dependents by any of the following methods:

(a) By establishing and maintaining a plan on a self-insured basis. A plan under this subdivision does not constitute doing the business of insurance in this state and is not subject to the insurance laws of this state.

(b) By joining with other public employers and establishing and maintaining a public employer pooled plan to provide medical, optical, or dental benefits to not fewer than 250 public employees on a self-insured basis as provided in this act. A pooled plan shall accept any public employer that applies to become a member of the pooled plan, agrees to make the required payments, agrees to remain in the pool for a 3-year period, and satisfies the other reasonable provisions of the pooled plan. A public employer that leaves a pooled plan may not rejoin the pooled plan for 2 years after leaving the plan. A pooled plan under this subdivision does not constitute doing the business of insurance in this state and, except as provided in this act, is not subject to the insurance laws of this state. A pooled plan under this subdivision may enter into contracts and sue or be sued in its own name.

(c) By procuring coverage or benefits from 1 or more carriers, either on an individual basis or with 1 or more other public employers.

(2) A public employer or pooled plan procuring coverage or benefits from 1 or more carriers shall solicit from different carriers 4 or more bids when establishing a medical benefit plan, including at least 1 bid from a voluntary employees' beneficiary association described in section 501(c)(9) of the internal revenue code, 26 USC 501(c)(9). A public employer or pooled plan procuring coverage or benefits from 1 or more carriers shall solicit from different carriers 4 or more bids every 3 years when renewing or continuing a medical benefit plan, including at least 1 bid from a voluntary employees' beneficiary association described in section 501(c)(9) of the internal revenue code, 26 USC 501(c)(9). A public employer or pooled plan that provides for administration of a medical benefit plan using an authorized third party administrator, an insurer, a nonprofit health care corporation, or other entity authorized to provide services in connection with a noninsured medical benefit plan shall solicit from different carriers 4 or more bids for those administrative services when establishing a medical benefit plan. A public employer or pooled plan that provides for administration of a medical benefit plan using an authorized third party administrator, an insurer, a nonprofit health care corporation, or other entity authorized to provide services in connection with a noninsured medical benefit plan shall solicit from different carriers 4 or more bids for those administrative services every 3 years when renewing or continuing a medical benefit plan.

(3) This act does not prohibit a public employer from participating, for the payment of medical benefits and claims, in a purchasing pool or coalition to procure insurance, benefits, or coverage, or health care plan services or administrative services.

(4) A public university may establish a medical benefit plan to provide medical, dental, or optical benefits to its employees and their dependents by any of the methods set forth in this section.

(5) A medical benefit plan that provides medical benefits shall provide to covered individuals case management services that meet the case management accreditation standards established by the national committee on quality assurance, the joint commission on health care organizations, or the utilization review accreditation commission.

**History:** 2007, Act 106, Imd. Eff. Oct. 1, 2007;—Am. 2011, Act 93, Eff. Oct. 1, 2011.

**124.77 Public employer pooled plan; certificate of registration; application; form; notice of additional information needed; investigation; issuance or denial of certificate of registration; notice of denial; request for hearing; books open to commissioner.**

Sec. 7. (1) A person shall not establish or maintain a public employer pooled plan in this state unless the pooled plan obtains and maintains a certificate of registration pursuant to this act.

(2) A person wishing to establish a pooled plan shall apply for a certificate of registration on a form prescribed by the commissioner. The application shall be completed and submitted to the commissioner along with all of the following:

(a) Copies of all articles, bylaws, agreements, or other documents or instruments describing the rights and obligations of employers, employees, and beneficiaries with respect to the pooled plan and the expected number of public employees to be covered for medical, optical, or dental benefits under the pooled plan.

(b) Current financial statements of the pooled plan or, for a newly established pooled plan, 3 years of financial projections.

(c) A statement showing in full detail the plan upon which the pooled plan proposes to transact business and a copy of all contracts or other instruments that it proposes to make with or sell to its members, together with a copy of its plan description.

(3) The commissioner shall examine the application and documents submitted by the applicant for completeness and shall notify the applicant not later than 30 days after receipt of the application of any additional information needed. The commissioner may conduct any investigation that the commissioner considers necessary and examine under oath any person interested in or connected with the pooled plan.

(4) The commissioner shall issue or deny a certificate of registration within 90 days of receipt of the applicant's substantially completed application. The commissioner shall not issue a certificate of registration to the pooled plan unless the commissioner is satisfied that the pooled plan is in a stable and unimpaired financial condition, that the pooled plan is qualified to maintain a medical benefit plan in compliance with this act, and that the pooled plan meets the requirements in section 9(1)(a), (e), (f), (g), and (h). The commissioner shall deny a certificate of registration to an applicant who fails to meet the requirements of this act. Notice of denial shall be in writing and shall set forth the basis for the denial. If the applicant submits a written request within 60 days after mailing of the notice of denial, the commissioner shall promptly conduct a hearing pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, in which the applicant shall be given an opportunity to show compliance with the requirements of this act.

Rendered Friday, August 12, 2016

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(5) The pooled plan, upon receipt of its initial certificate of registration, which shall be a temporary certificate, shall proceed to the completion of organization of the proposed pooled plan.

(6) A pooled plan shall open its books to the commissioner, and a final certificate of registration shall not be issued by the commissioner to a pooled plan until the pooled plan has collected cash reserves as provided in section 9.

**History:** 2007, Act 106, Imd. Eff. Oct. 1, 2007.

**124.79 Public employer pooled plan; requirements; effect of insufficient reserves; collection of cash reserves.**

Sec. 9. (1) In addition to other requirements as provided in this act, a public employer pooled plan established on or after the effective date of this act shall do all of the following:

(a) Establish and maintain minimum cash reserves of not less than 25% of the aggregate contributions in the current fiscal year or in the case of new applicants, 25% of the aggregate contributions projected to be collected during its first 12 months of operation, as applicable; or not less than 35% of the claims paid in the preceding fiscal year, whichever is greater. Reserves established pursuant to this section shall be maintained in a separate, identifiable account and shall not be commingled with other funds of the pooled plan. The pooled plan shall invest the required reserve in the types of investments allowed under section 910, 912, or 914 of the insurance code of 1956, 1956 PA 218, MCL 500.910, 500.912, and 500.914. The pooled plan may satisfy up to 100% of the reserve requirement in the first year of operation, up to 75% of the reserve requirement in the second year of operation, and up to 50% of the reserve requirement in the third and subsequent years of operation, through an irrevocable and unconditional letter of credit. As used in this subdivision, "letter of credit" means a letter of credit that meets all of the following requirements:

(i) Is issued by a federally insured financial institution.

(ii) Is issued upon such terms and in a form as approved by the commissioner.

(iii) Is subject to draw by the commissioner, upon giving 5 business days' written notice to the pooled plan, or by the pooled plan for the member's benefit if the pooled plan is unable to pay claims as they come due.

(b) Within 90 days after the end of each fiscal year, file with the commissioner financial statements audited by a certified public accountant. An actuarial opinion regarding reserves for known claims and associated expenses and incurred but not reported claims and associated expenses, in accordance with subdivision (d), shall be included in the audited financial statement. The opinion shall be rendered by an actuary approved by the commissioner or who has 5 or more years of experience in this field.

(c) Within 60 days after the end of each fiscal quarter, file with the commissioner unaudited financial statements, affirmed by an appropriate officer or agent of the pooled plan.

(d) Within 60 days after the end of each fiscal quarter, file with the commissioner a report certifying that the pooled plan maintains reserves that are sufficient to meet its contractual obligations, and that it maintains coverage for excess loss as required in this act.

(e) File with the commissioner a schedule of premium contributions, rates, and renewal projections.

(f) Possess a written commitment, binder, or policy for excess loss insurance issued by an insurer authorized to do business in this state in an amount approved by the commissioner. The binder or policy shall provide not less than 30 days' notice of cancellation to the commissioner.

(g) Establish a procedure, to the satisfaction of the commissioner, for handling claims for benefits in the event of dissolution of the pooled plan.

(h) Provide for administration of the plan using personnel of the pooled plan, provided that the pooled plan has within its own organization adequate facilities and competent personnel to service the medical benefit plan, or by awarding a competitively bid contract, to an authorized third party administrator, an insurer, a nonprofit health care corporation, or other entity authorized to provide services in connection with a noninsured medical benefit plan.

(2) If the commissioner finds that a pooled plan's reserves are not sufficient to meet the requirements of subsection (1)(a), the commissioner shall order the pooled plan to immediately collect from any public employer that is or has been a member of the pooled plan appropriately proportionate contributions sufficient to restore reserves to the required level. The commissioner may take such action as he or she considers necessary, including, but not limited to, ordering the suspension or dissolution of a pooled plan, if the pooled plan is consistently failing to maintain reserves as required in this section, is using methods and practices that render further transaction of business hazardous or injurious to its members, employees, beneficiaries, or to the public, has failed, after written request by the commissioner, to remove or discharge an officer, director, trustee, or employee who has been convicted of any crime involving fraud, dishonesty, or moral turpitude, has failed or refused to furnish any report or statement required under this act, or if the commissioner, upon investigation, determines that it is conducting business fraudulently or is not meeting its contractual

obligations in good faith. Any proceedings by the commissioner under this subsection shall be governed by the requirements and procedures of sections 7074 to 7078 of the insurance code of 1956, 1956 PA 218, MCL 500.7074 and 500.7078.

History: 2007, Act 106, Imd. Eff. Oct. 1, 2007.

**124.81 Access to books, records, and documents; payment of annual assessment.**

Sec. 11. The commissioner, or any person appointed by the commissioner, may examine the affairs of any pooled plan, and for such purposes shall have free access to all the books, records, and documents that relate to the business of the plan, and may examine under oath its trustees, officers, agents, and employees in relation to the affairs, transactions, and condition of the pooled plan. Each authorized pooled plan shall pay an assessment annually to the commissioner to be deposited into the insurance bureau fund created in section 225 of the insurance code of 1956, 1956 PA 218, MCL 500.225, in an amount equal to 1/4 of 1% of the annual self-funded contributions made to the pooled plan for that year. The assessments paid under this section shall be appropriated to the office of financial and insurance services to cover the additional costs incurred by the office of financial and insurance services in the examination and regulation of pooled plans under this act.

History: 2007, Act 106, Imd. Eff. Oct. 1, 2007.

**124.83 Articles, bylaws, and trust agreement; filing; notice of meetings; powers of board of trustees.**

Sec. 13. (1) The articles, bylaws, and trust agreement of the pooled plan and all amendments thereto shall be filed with and presumed approved by the commissioner before becoming operative. The trust agreement shall be filed on a form prescribed by the commissioner.

(2) Each member employer of a pooled plan shall be given notice of every meeting of the members and shall be entitled to an equal vote, either in person or by proxy in writing by such member.

(3) The powers of a pooled plan, except as otherwise provided, shall be exercised by the board of trustees chosen to carry out the purposes of the trust agreement. Not less than 50% of the trustees shall be persons who are covered under the pooled plan or the collective bargaining representatives of those persons. No trustee shall be an owner, officer, or employee of a third party administrator providing services to the pooled plan.

History: 2007, Act 106, Imd. Eff. Oct. 1, 2007.

**124.85 Public employer with 100 or more employees; claims utilization and cost information; compilation; "relevant period" defined; disclosure; availability; protected health information not included; date of compilation.**

Sec. 15. (1) Notwithstanding subsection (2), a public employer that has 100 or more employees in a medical benefit plan shall be provided with claims utilization and cost information as provided in subsection (3).

(2) A public employer that is in an arrangement with 1 or more other public employers, and together have 100 or more employees in a medical benefit plan or have signed a letter of intent to enter together 100 or more public employees into a medical benefit plan, shall be provided with claims utilization and cost information as provided in subsection (3) that is aggregated for all the public employees together of those public employers, and, except as otherwise permitted under subsection (1), shall not be separated out for any of those public employers.

(3) All medical benefit plans in this state shall compile, and shall make available electronically as provided in subsections (1) and (2), complete and accurate claims utilization and cost information for the medical benefit plan in the aggregate and for each public employer as follows:

(a) A census of all covered employees, including all of the following:

(i) Year of birth.

(ii) Gender.

(iii) Zip code.

(iv) The contract coverage type for the employee, such as single, dependent, or family, and number of individuals covered by contract.

(b) Claims data for the employee group covered by the medical benefit plan, including at least all of the following:

(i) For a plan that provides health benefits, information concerning hospital and medical claims under the plan, presented in a manner that clearly shows all of the following for each of the 3 most recent experience years:

(A) Number and total expenditures for hospital claims.

- (B) Number and total expenditures for medical claims.
- (C) Number of hospital claims exceeding \$50,000.00.
- (D) Number of medical claims exceeding \$50,000.00.
- (E) Total expenditures for claims exceeding \$50,000.00.
- (ii) For a plan that provides prescription drug benefits, information concerning prescription drugs claims under the plan, presented in a manner that clearly shows all of the following:
  - (A) Amount charged and amount paid for prescription drugs claims for each of the 3 most recent experience years.
  - (B) Total amount charged and amount paid for brand prescription drugs claims for each of the 3 most recent experience years.
  - (C) Total amount charged and amount paid for generic prescription drugs claims for each of the 3 most recent experience years.
  - (D) The 50 most frequently prescribed brand prescription drugs for which claims were made for the most recent experience period.
  - (E) The 50 most frequently prescribed generic prescription drugs for which claims were made for the most recent experience period.
- (iii) For a plan that provides dental benefits, information concerning dental claims and total expenditures for these claims under the plan, presented in a manner that clearly shows at least all of the following for each of the 3 most recent experience years:
  - (A) Number of claims submitted and total charged.
  - (B) Number of and total expenditures for claims paid.
  - (C) Total expenditures for claims submitted to network providers.
- (iv) For a plan that provides optical benefits, information concerning optical claims and total expenditures for these claims under the plan, presented in a manner that clearly shows at least all of the following for each of the 3 most recent experience years:
  - (A) Number of claims submitted and total charged.
  - (B) Number of and total expenditures for claims paid.
  - (C) Total expenditures for claims submitted to network providers.
  - (c) Fees and administrative expenses for the most recent experience year, reported separately for health, dental, and optical plans, and presented in a manner that clearly shows at least all of the following:
    - (i) The dollar amounts paid for specific and aggregate stop-loss insurance.
    - (ii) The dollar amount of administrative expenses incurred or paid, reported separately for medical, pharmacy, dental, and vision.
    - (iii) The total dollar amount of retentions and other expenses.
    - (iv) The dollar amount for all service fees paid.
    - (v) The dollar amount of any fees or commissions paid to agents, consultants, third party administrators, or brokers by the medical benefit plan or by any public employer or carrier participating in or providing services to the medical benefit plan, reported separately for medical, pharmacy, stop-loss, dental, and vision.
    - (vi) Other information as may be required by the commissioner.
  - (d) For health, dental, and optical plans, a benefit summary for the current year's plan and, if benefits have changed during any of the 3 most recent experience years, a brief benefit summary for each of those experience years for which the benefits were different.
- (4) Except as otherwise provided in subsection (3), claims utilization and cost information required to be compiled under this section shall be compiled on an annual basis and shall cover a relevant period. For purposes of this subsection, the term "relevant period" means the 36-month period ending no more than 120 days prior to the effective date or renewal date of the medical benefit plan under consideration. However, if the medical benefit plan has been in effect for a period of less than 36 months, the relevant period shall be that shorter period.
- (5) A public employer or combination of public employers shall disclose the claims utilization and cost information required to be provided under subsections (1) and (2) to any carrier or administrator it solicits to provide benefits or administrative services for its medical benefit plan, and to the employee representative of employees covered under the medical benefit plan, and upon request to any carrier or administrator who requests the opportunity to submit a proposal to provide benefits or administrative services for the medical benefit plan at the time of the request for bids. The public employer shall make the claims utilization and cost information required under this section available at cost and within a reasonable period of time.
- (6) The claims utilization and cost information required under this section shall include only de-identified health information as permitted under the health insurance portability and accountability act of 1996, Public Law 104-191, or regulations promulgated under that act, 45 CFR parts 160 and 164, and shall not include any

protected health information as defined in the health insurance portability and accountability act of 1996, Public Law 104-191, or regulations promulgated under that act, 45 CFR parts 160 and 164.

(7) All claims utilization and cost information described in this section is required to be compiled beginning 60 days after the effective date of this act. However, claims utilization and cost information already being compiled on the effective date of this act is subject to this section on the effective date of this act.

**History:** 2007, Act 106, Imd. Eff. Oct. 1, 2007;—Am. 2011, Act 93, Eff. Oct. 1, 2011.