Benefit Basics for New Business Managers

Session 150g

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Presenters:

Stephanie Weese, Assistant Superintendent for Administrative Services, Livingston ESA

Mike Hagerty, Area Vice President, Gallagher Benefit Services, Inc.

Chadd Hodkinson, Area Senior Vice President, Gallagher Benefit Services, Inc.

Your Presenters

Let us introduce ourselves

Chadd Hodkinson
Area Senior Vice President
Gallagher Benefit Services, Inc.

Mike Hagerty
Area Vice President
Gallagher Benefit Services, Inc.

Stephanie Weese
Assistant Superintendent for
Administrative Services
Livingston Educational Service
Agency

Discussion Overview

1. Brief feedback from the room on current benefit situation in your districts
2. Discussion around key terms and concepts
3. Review of common causes of cost inefficiencies
4. Evaluation of the impact of union and non-union workforce on the program
5. Overview of emerging trends in Michigan K-12 benefits

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Brief feedback from the room on current benefit situation in your districts

Key Terms and Concepts

Key Elements

- What is covered?
- How much a participant has to pay when accessing services?

- List of facilities and providers where services can be accessed.
- Ability for participant to choose where and when to access services.

- What comes out of the employee's check to be enrolled in the plan
- PA 152

Coverage Level

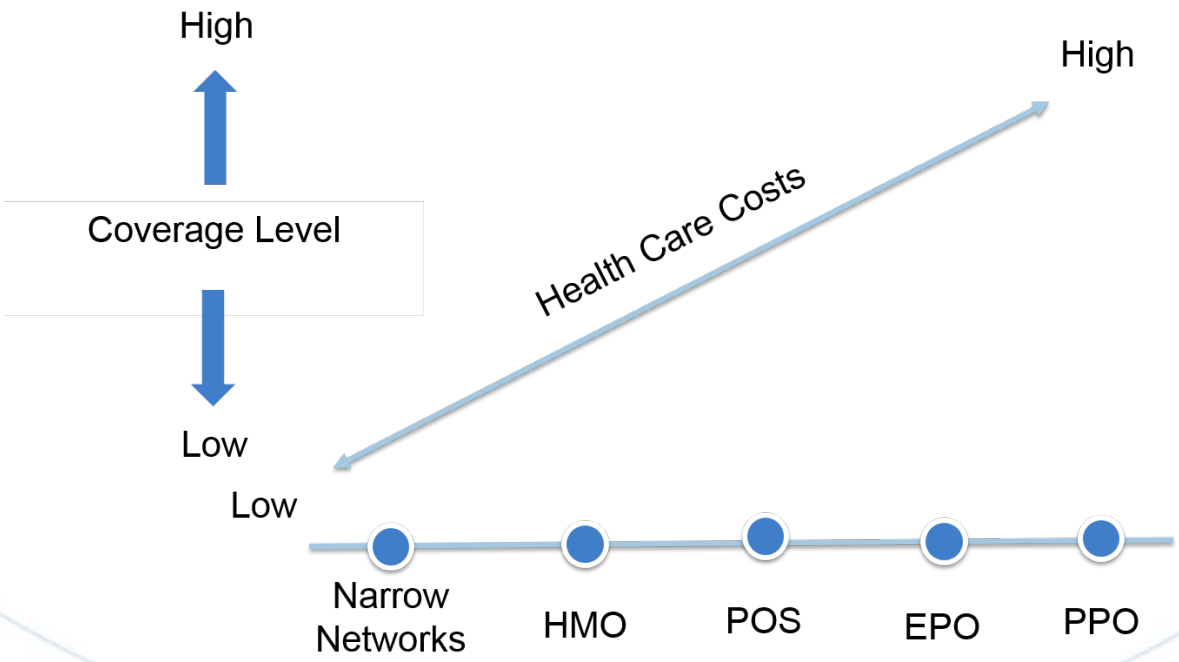
Deductible	Amount of expenses a person pays each benefit year from his/her own pocket before the health plan makes payments for benefits. Services subject to deductible vary by plan type.
Coinsurance	Typically a percentage cost share amount the covered person must pay after the deductible is met for certain services each benefit year. Coupled with a coinsurance maximum which caps the amount a covered person pays after the deductible is met. Services subject to coinsurance vary by plan type.
Copayment or Copay	A flat dollar amount paid for particular services. Services subject to copays and when copays apply (before deductible/coinsurance max is met or after deductible/coinsurance max is met) vary by plan type.
Out of Pocket Maximum	Maximum amount the covered person must spend out of pocket during each benefit year. Amounts spent on deductibles, coinsurance and copayments all go toward the out of pocket maximum.
Traditional Plan	May or may not have deductibles/coinsurance. Copayments typically apply from day one.
High Deductible Health Plan (HDHP)	A plan with a high deductible (at least $1,400 single or $2,800 for a couple or family). Member is responsible for 100% of the cost of all services ***including prescription costs*** until the deductible is met each benefit year. Services considered by the plan to be preventive are covered at 100% and are not subject to the deductible. The IRS allows the use of a Health Savings Account (HSA) to pay for out of pocket expenses.

Flexibility [Network Model]

PPO	A preferred provider organization with a lower out of pocket cost in-network and higher out of pocket cost out-of-network. In-network means the physician or hospital has contracted with the insurance company to accept a reduced fee as payment in full.
EPO	Uses the same in-network list of providers as a PPO, but does not provide access to out-of-network services except in case of emergency.
HMO	A health maintenance organization that requires a member to seek care through a primary care physician or PCP. The PCP then refers members to specialist as allowed by the network. HMOs do not provide access to out-of- network services except in case of emergency.
POS	Uses the same in-network list of providers as an HMO, but provides opportunity to go out-of-network at a reduced benefit.
Narrow Network	Creates steerage toward a set of hospitals/providers with which more affordable reimbursement rates have been negotiated. Access to other hospitals/providers is available at a higher cost and/or at higher out of pocket cost.

Cost

Employee Cost Share/Contribution	The cost to simply be enrolled in the plan. Can typically be deducted from your paycheck on a pre-tax basis.



The Anatomy of a Public School Benefit Program

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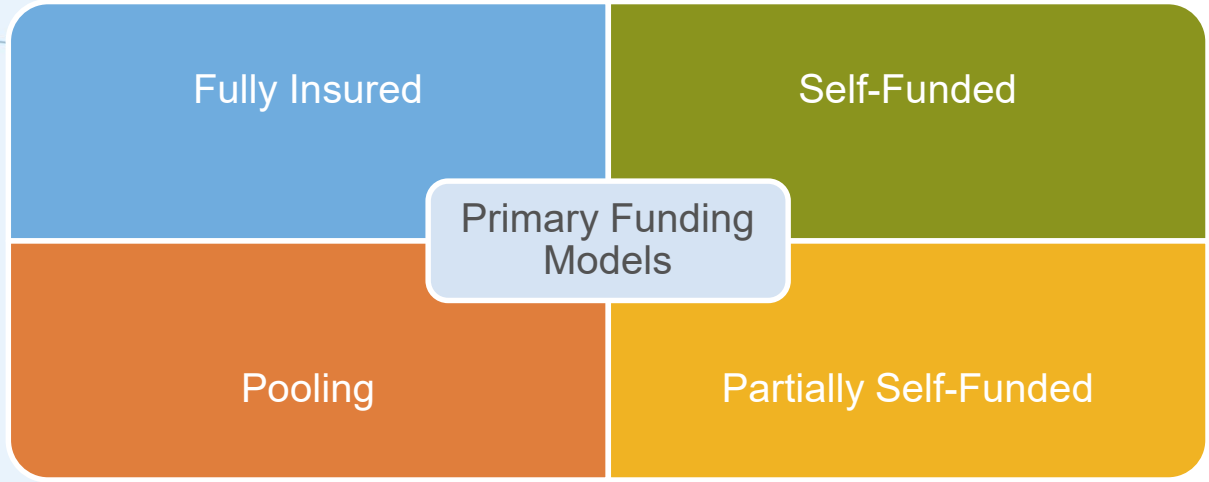
Agent/consultant - - - - - - District

Strategic considerations might include things like funding models, data transparency, employee disruption, potential for cost volatility, compliance, etc.

Medical	Rx	Stop Loss	Dental	Vision	FSA/HRA	Life/LTD
• "Carrier" or "TPA" • Plan design • Provider network • Net cost of medical services accessed	• "Pharmacy Benefit Manager" or "PBM" • Pharmacy contract • Net cost of • prescriptions filled	• "Carrier" or "Captive" • Large claim reimbursements	• "Carrier" or "TPA" • Dental plan design • Dental provider network • Net cost of dental services accessed	• "Carrier" or "TPA" • Vision plan design • Vision provider network • Net cost of vision services accessed	• "Vendor" • Claim reimbursements	• "Carrier" or "TPA" • Life/LTD plan design • Underwriting terms and rate guarantee

Other program elements might include voluntary/worksite benefits, COBRA, etc.

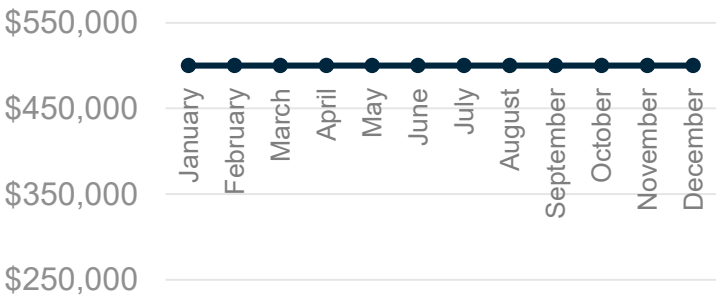
Funding Overview



Funding Overview

Enrollment Type	Monthly Rate	Enrollment	Total Monthly Premium
Single	$600	100	$60,000
Two Person	$1,200	75	$90,000
Family	$1,750	200	$350,000
TOTAL MONTHLY PREMIUM			$500,000

Monthly Premium Illustration

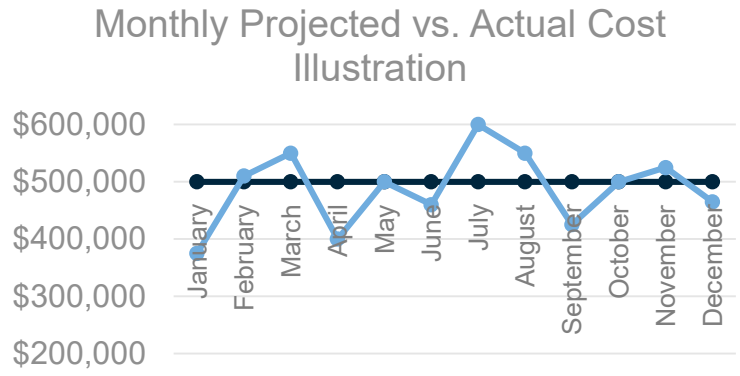


Fully insured

- Established single, two person and family rate for each plan offered
- Rates generally guaranteed for 12 months
- District pays the same rates for 12 months whether enrollees use more care than expected or less

Funding Overview

Cost Components	Monthly Rate	Enrollment	Total Monthly Projected Cost
Administrative Fee	$75.00	375	$28,125
Stoploss Insurance	$125.00	375	$46,875
Projected Claims	$1,133.33	375	$425,000
TOTAL			$500,000



Self-funded

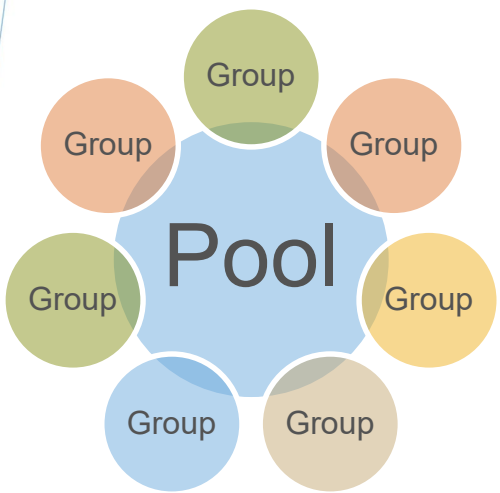
- District pays for the cost of products and services as they are used by enrollees
- Rates are established based on projected costs expected for the 12 month plan year and are not guaranteed
- District pays more if enrollees use more care than expected and pays less if enrollees use less care than expected
- Insurance retained by district to protect against catastrophic losses called stop loss insurance

Funding Overview

Pooling

(example arrangement based on the Western Michigan Health Insurance Pool to be discussed later)

- Sharing claim risk with other employers and taking advantage of collective buying power
- Established single, two person and family rate for each plan offered
- Rates guaranteed for 12 months
- District pays the same rates for 12 months whether enrollees use more care than expected or less
- Pool members make program decisions with a view toward providing high quality coverage at a reasonable and stable cost



Public Act 106 (PA 106)

Among other things, requires public employers procuring coverage or benefits to solicit proposals from a minimum of three insurance carriers and one VEBA every three years or whenever a plan change is made.

Considerations

- The partner selected for this process matters
- Use as a tool to educate
- Carefully review potential alternatives for risk exposure to district and employees, long term stability, fit with district's culture and potential for employee disruption (e.g. provider network, drug formulary change, coverage levels, service).

Michigan Public Act 152

- Public Funded Health Insurance Contribution Act.
- Act requires to comply by either implementing hard cap (default), 20% employee contributions or (requires vote of governing body prior to the start of your plan year)
- Employer hard caps established by PA152 are noted below

1.3% increase for 2023

Election	2022 Annual Cap	2022 Monthly Cap	2023 Annual Cap	2023 Monthly Cap
Single	$7,304.51	$608.71	$7,399.47	$616.62
2-Person	$15,276.01	$1,273.00	$15,474.60	$1,289.55
Family	$19,921.45	$1,660.12	$20,180.43	$1,681.70

Note: Hard caps are released in the month of April each year by the Michigan Dept. of Treasury

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Common Causes of Cost Inefficiencies

Common Causes of Cost Inefficiencies

- Bad advice
- Failure to select optimal carrier/vendor partners based on your district's situation
- Poor relationship and communication with carrier/vendor partners
- Lack of rapport with union and non-union leadership and membership
- Lack of transparency into program elements
- Inefficient contracts and/or arrangements
- Ineffective implementation of program additions or alternatives

Impact of Union & Non-union Participation on the Program

The Plan Cost

Who and How?

Underwriters look at how much we've used our insurance plan as a group in the past to predict how we are likely to use in the future

Premium rates are set to collect enough money over the benefit year to:

- Pay for medical and prescription services received by the group
- Pay for operating expenses
- Other underwriting components include: administrative costs, trend and credibility factors

Data Review

Typical data request submitted to carriers (all data is de-identified):

- Census file summarizing plan participants including information such as date of birth, gender, zip code and current plan elections
- Paid premiums
- 24-36 months of paid claims and enrollment by plan and as a group
- Excess claims reports with diagnosis, typically claims over $50,000 or $75,000
- List of providers used during the previous 12 months
- Benefit summaries

Emerging Trends in Michigan K-12 Benefits

Best Practices & Emerging Trends

Michigan K-12 Benefits

1. Pooling
2. HMOs
3. Pharmacy program evaluation
4. Strategies for addressing cost pressures related to rate increases and minimal hard cap increase
5. Proactively approach annual renewal
6. Benefit committees
7. Retain experienced employee benefits counsel
8. Digital health
9. Considerations around employee experience along with organizational and employee wellbeing
   - Supervisor/employee relationship
   - Financial wellbeing
   - Mental/emotional wellbeing
10. Ancillary program savings opportunities (dental, vision, life and disability coverage)
    - Self-funding
    - Cooperative purchasing
11. Strategic considerations related to voluntary/worksite benefit programs

Thank You!

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