City Of Northfield Minnesota

Employee Benefits Committee

September 24, 2019

Gallagher

Insurance | Risk Management | Consulting

Agenda

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- PEIP Renewal
- BCBS Offer Review
- Considerations
- Next Steps

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PEIP Renewal

PEIP Renewal

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Overall 5.61%

	CURRENT			RENEWAL		
Plan Design Features	Advantage Health Plan High Option	Advantage Health Plan Value Option	Advantage Health Plan HSA Compatible	Advantage Health Plan High Option	Advantage Health Plan Value Option	Advantage Health Plan HSA Compatible
Enrollment (per 7/23/19 census)						
Employee	12	5	38	12	5	38
Family	10	2	22	10	2	22
Rates						
Employee	$885.78	$795.40	$605.10	$922.82	$829.50	$645.26
Family	$2,364.88	$2,123.64	$1,615.52	$2,463.72	$2,214.68	$1,722.70
Estimated Total Annual Premium	**$1,212,452**			**$1,280,486**		
Change over Current (%)				**5.61%**		
Change over Current ($)				**$68,034**		
Change over Current (%)	**N/A**	**N/A**	**N/A**	**4.2%**	**4.3%**	**6.6%**
Change over Current ($)	**N/A**	**N/A**	**N/A**	**$17,195**	**$4,231**	**$46,608**

- Higher (6.6%) increase to HDHP HSA plan
- Benefit plan changes to all plans, see following pages

City of Northfield

PEIP Summary of Plan Benefits for 2019

The information contained herein is subject to the disclosures and disclaimers on the final page of this illustration

2019 Benefits Schedules	Advantage Health Plan - High Option	Advantage Health Plan - Value Option	Advantage Health Plan - HSA Compatible
In-Network	You Pay	You Pay	You Pay
A. Preventive Care - Routine medical exams, cancer screening - Child health preventive services, routine immunizations - Prenatal and postnatal care and exams - Adult immunizations - Routine eye and hearing exams	Cost Level 1 / 2 / 3 / 4 Nothing	Cost Level 1 / 2 / 3 / 4 Nothing	Cost Level 1 / 2 / 3 / 4 Nothing
B. Annual First Dollar Deductible	Cost Level 1 / 2 / 3 / 4 Single: $150 / $250 / $550 / $1,250 Family: $300 / $500 / $1,100 / $2,500	Cost Level 1 / 2 / 3 / 4 Single: $500 / $700 / $1,100 / $1,800 Family: $1,000 / $1,400 / $2,200 / $3,600	Cost Level 1 / 2 / 3 / 4 COMBINED MEDICAL/PHARMACY Single Coverage: $1500 / $2000 / $3000 / $4000 *Family Coverage (per family member): $2,600 / $3,200 / $4,800 / $6,400 *Family Coverage (per family): $3,000 / $4,000 / $6,000 / $8,000
C. Office visits for Illness/Injury, for Outpatient Physical, Occupational or Speech Therapy, and Urgent Care - Outpatient visits in a physician's office - Chiropractic services - OP mental health & chemical dependency - Urgent Care clinic visits (in or out of network)	Cost Level 1 / 2 / 3 / 4 $25 / $30 / $60 / $80 copay per visit (annual deductible applies)	Cost Level 1 / 2 / 3 / 4 $30 / $35 / $95 / $120 copay per visit (annual deductible applies)	Cost Level 1 / 2 / 3 / 4 $40 / $50 / $100 / $120 copay per visit (annual deductible applies)
D. Network Convenience Clinics and online care	Cost Level 1 / 2 / 3 / 4: $0 copay	Cost Level 1 / 2 / 3 / 4: $0 copay	Cost Level 1 / 2 / 3 / 4: $0 copay (annual deductible applies)
E. Emergency Care - Emergency care received in a hospital ER	Cost Level 1 / 2 / 3 / 4 $100/$100/$100/25% (annual deductible applies)	Cost Level 1 / 2 / 3 / 4 $125 / $125 / $125 / 30% (annual deductible applies)	Cost Level 1 / 2 / 3 / 4 $150 / $150 / $150 / 50% (annual deductible applies)
F. Inpatient Hospital Copay	Cost Level 1/2/3/4 $100/$200/$500/25% (annual deductible applies)	Cost Level 1 / 2 / 3 / 4 $150 / $325 / $750 / 30% (annual deductible applies)	Cost Level 1 / 2 / 3 / 4 $400 / $650 / $1,500 / 50% (annual deductible applies)
G. Outpatient Surgery Copay	Cost Level 1/2/3/4 $60/$120/$250/25% (annual deductible applies)	Cost Level 1 / 2 / 3 / 4 $100 / $175 / $350 / 35% (annual deductible applies)	Cost Level 1 / 2 / 3 / 4 $250 / $400 / $800 / 50% (annual deductible applies)
H. Hospice and Skilled Nursing Facility	Cost Level 1 / 2 / 3 / 4: Nothing	Cost Level 1 / 2 / 3 / 4: Nothing	Cost Level 1 / 2 / 3 / 4: Nothing after annual deductible
I. Prosthetics and Durable Medical Equipment	Cost Level 1 / 2 / 3: 20%/20%/20% Cost Level 4: 25% coinsurance (annual deductible applies)	Cost Level 1 / 2 / 3: 20% / 20% / 25% Cost Level 4: 35% coinsurance (annual deductible applies)	Cost Level 1 / 2 / 3 / 4 20% / 25% / 30% / 50% coinsurance (annual deductible applies)
J. Lab (including allergy shots), **Pathology and X-ray** (not included as part of preventive care and not subject to office visit or facility copayments)	Cost Level 1 / 2 / 3 / 4 5% / 5% / 20% / 25% coinsurance (annual deductible applies)	Cost Level 1 / 2 / 3 / 4 10% / 10% / 20% / 35% coinsurance (annual deductible applies)	Cost Level 1 / 2 / 3 / 4 20% / 25% / 30% / 50% coinsurance (annual deductible applies)
K. MRI/CT Scans	Cost Level 1 / 2 / 3 / 4 5% / 10% / 20% / 25% coinsurance (annual deductible applies)	Cost Level 1 / 2 / 3 / 4 10% / 10% / 20% / 35% coinsurance (annual deductible applies)	Cost Level 1 / 2 / 3 / 4 20% / 25% / 30% / 50% coinsurance (annual deductible applies)
L. Other expenses not covered in A – K above, including by not limited to: • Ambulance and Home Health Care • Outpatient Hospital Services (non-surgical), including - Radiation/chemotherapy, Dialysis, Day treatment for mental health and chemical dependency and Other diagnostic or treatment-related OP services	Cost Level 1 / 2 / 3 / 4 5% / 5% / 20% / 25% coinsurance (annual deductible applies)	Cost Level 1 / 2 / 3 / 4 10% / 10% / 20% / 35% coinsurance (annual deductible applies)	Cost Level 1 / 2 / 3 / 4 20% / 25% / 30% / 50% coinsurance (annual deductible applies)
M. Prescription Drugs (30-day supply of Tier 1, Tier 2, or Tier 3 prescription drugs, including insulin; or a 3-cycle supply of oral contraceptives)	Cost Level 1 / 2 / 3 / 4 $14 tier one; $25 tier two; $50 tier three	Cost Level 1 / 2 / 3 / 4 $20 tier one; $40 tier two; $65 tier three	Cost Level 1 / 2 / 3 / 4 $25 tier one; $40 tier two; $65 tier three (annual deductible applies)
N. Plan Maximum Out-of-Pocket Expense for Prescription Drugs (excludes Infertility) (single/family)	Cost Level 1 / 2 / 3 / 4 Single: $800; Family: $1,600	Cost Level 1 / 2 / 3 / 4 Single: $1,000; Family: $2,000	** Cost Level 1 / 2 / 3 / 4 COMBINED MEDICAL/PHARMACY Single Coverage: $3,000 / $3,000 / $4,000 / $5,000 Family Coverage (per family member): $5,000 / $5,000 / $6,850 / $6,850 Family Coverage (per family): $6,000 / $6,000 / $8,000 / $10,000
O. Plan Maximum Out-of-Pocket Expense (excluding prescription drugs) (single/family)	Cost Level 1 / 2 / 3 / 4 Single: $1,200 / $1,200 / $1,600 / $2,600 Family: $2,400 / $2,400 / $3,200 / $5,200	Cost Level 1 / 2 / 3 / 4 Single: $2,200 / $2,200 / $3,200 / $4,200 Family: $4,400 / $4,400 / $6,400 / $8,400	See Section N above

Emergency care or urgent care at a hospital emergency room or urgent care center out of the plan's service area or out of network is covered as described in sections C and E above.

This chart applies only to in-network coverage. Point of Service coverage is available only for members whose permanent residence is outside the State of Minnesota and outside the service areas of the health plans participating in Advantage. This category includes employees temporarily residing outside Minnesota on temporary assignment or paid leave [including sabbatical leaves] and college students. It is also available to all dependent children and spouses permanently residing outside the service area.

***Under the High Option and Value Option**: These members pay a $350 single or $700 family deductible (separate and distinct from the deductibles listed in section B above) and 30% coinsurance to the out-of-pocket maximums described in section O above. Members pay the drug copayment described at section M above to the out-of-pocket maximum described at section N.*

***Under the HSA Compatible Option**: These members pay a $1,500 single or $3,000 family deductible (separate and distinct from the deductibles listed in section B above) and 30% coinsurance to the out-of-pocket maximums described in section N above. Members pay the drug copayment described at section M above to the out-of-pocket maximum described at section N.*

A standard set of benefits is offered in all PEIP Advantage Plans. There are still some differences from plan to plan in the way that benefits, including the transplant benefits, are administered, in the referral and diagnosis coding patterns of primary care clinics (and in the definition of Allowed Amount under the High and Value Option Plans).

***Under the High Option and Value Option**: These Plans use an **embedded deductible**. If a family member reaches the individual deductible then the deductible is satisfied for that family member. If any combination of famly members reaches the family deductible, then the deductible is satisfied for the entire family.*

***Under the HSA Compatible Option**: *The family Deductible is the **maximum amount** that a family has to pay in deductible expenses in any one calendar year. The family Deductible is **not** the amount of expenses a family must incur before any family member can receive benefits. Individual family members only need to satisfy their individual deductible once to be eligible for benefits. Once the family Deductible has been met, deductible expenses for the family are waived for the balance of the year.*

***The family Out-of-Pocket Maximum is the **maximum amount** that a family has to pay in any one calendar year. The per-family member embedded Out-of-Pocket Maximum is the maximum amount that a family has to pay in any one calendar year on behalf of any individual family member.*

City of Northfield

PEIP Summary of Plan Benefits effective January 2020

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2020 Benefits Schedules (changes over prior year are identified by red font)	Advantage Health Plan - High Option	Advantage Health Plan - Value Option	Advantage Health Plan - HSA Compatible
In-Network	**You Pay**	**You Pay**	**You Pay**
A. Preventive Care - Routine medical exams, cancer screening - Child health preventive services, routine immunizations - Prenatal and postnatal care and exams - Adult immunizations - Routine eye and hearing exams	Cost Level 1 / 2 / 3 / 4 Nothing	Cost Level 1 / 2 / 3 / 4 Nothing	Cost Level 1 / 2 / 3 / 4 Nothing
B. Annual First Dollar Deductible	Cost Level 1 / 2 / 3 / 4 Single: $250 / $400 / $750 / $1,500 Family: $500 / $800 / $1,500 / $3,000	Cost Level 1 / 2 / 3 / 4 Single: $600 / $850 / $1,300 / $2,100 Family: $1,200 / $1,700 / $2,600 / $4,200	Cost Level 1 / 2 / 3 / 4 COMBINED MEDICAL/PHARMACY Single Coverage: $1,500 / $2,000 / $3,000 / $4,000 *Family Coverage (per family member): $2,800 / $3,200 / $4,800 / $6,400 *Family Coverage (per family): $3,000 / $4,000 / $6,000 / $8,000
C. Office visits for Illness/Injury, for Outpatient Physical, Occupational or Speech Therapy, and Urgent Care - Outpatient visits in a physician's office - Chiropractic services - OP mental health & chemical dependency - Urgent Care clinic visits (in or out of network)	Cost Level 1 / 2 / 3 / 4 $30 / $35 / $65 / $85 copay per visit (annual deductible applies)	Cost Level 1 / 2 / 3 / 4 $35 / $40 / $100 / $125 copay per visit (annual deductible applies)	Cost Level 1 / 2 / 3 / 4 $45 / $55 / $105 / $130 copay per visit (annual deductible applies)
D. Network Convenience Clinics and online care	Cost Level 1 / 2 / 3 / 4: Nothing	Cost Level 1 / 2 / 3 / 4: Nothing	Cost Level 1 / 2 / 3 / 4: $0 copay (annual deductible applies)
E. Emergency Care (in or out of network) - Emergency care received in a hospital ER	Cost Level 1 / 2 / 3 / 4 $100 / $100 / $100 / 25% (annual deductible applies)	Cost Level 1 / 2 / 3 / 4 $125 / $125 / $125 / 30% (annual deductible applies)	Cost Level 1 / 2 / 3 / 4 $150 / $150 / $150 / 50% (annual deductible applies)
F. Inpatient Hospital Copay	Cost Level 1 / 2 / 3 / 4 $100 / $200 / $500 / 25% (annual deductible applies)	Cost Level 1 / 2 / 3 / 4 $150 / $325 / $750 / 30% (annual deductible applies)	Cost Level 1 / 2 / 3 / 4 $400 / $650 / $1,500 / 50% (annual deductible applies)
G. Outpatient Surgery Copay	Cost Level 1 / 2 / 3 / 4 $60 / $120 / $250 / 25% (annual deductible applies)	Cost Level 1 / 2 / 3 / 4 $100 / $175 / $350 / 35% (annual deductible applies)	Cost Level 1 / 2 / 3 / 4 $250 / $400 / $800 / 50% (annual deductible applies)
H. Hospice and Skilled Nursing Facility	Cost Level 1 / 2 / 3 / 4: Nothing	Cost Level 1 / 2 / 3 / 4: Nothing	Cost Level 1 / 2 / 3 / 4: Nothing after annual deductible
I. Prosthetics and Durable Medical Equipment	Cost Level 1 / 2 / 3: 20% / 20% / 20% Cost Level 4: 25% coinsurance (annual deductible applies)	Cost Level 1 / 2 / 3: 20% / 20% / 25% Cost Level 4: 35% coinsurance (annual deductible applies)	Cost Level 1 / 2 / 3 / 4 20% / 25% / 30% / 50% coinsurance (annual deductible applies)
J. Lab (including allergy shots), **Pathology and X-ray** (not included as part of preventive care and not subject to office visit or facility copayments)	Cost Level 1 / 2 / 3 / 4 10% / 10% / 20% / 25% coinsurance (annual deductible applies)	Cost Level 1 / 2 / 3 / 4 10% / 15% / 25% / 35% coinsurance (annual deductible applies)	Cost Level 1 / 2 / 3 / 4 20% / 25% / 30% / 50% coinsurance (annual deductible applies)
K. MRI/CT Scans	Cost Level 1 / 2 / 3 / 4 10% / 15% / 25% / 30% coinsurance (annual deductible applies)	Cost Level 1 / 2 / 3 / 4 10% / 15% / 25% / 35% coinsurance (annual deductible applies)	Cost Level 1 / 2 / 3 / 4 20% / 25% / 30% / 50% coinsurance (annual deductible applies)
L. Other expenses not covered in A – K above, including by not limited to: • Ambulance and Home Health Care • Outpatient Hospital Services (non-surgical), including: - Radiation/chemotherapy, Dialysis, Day treatment for mental health and chemical dependency and Other diagnostic or treatment-related OP services	Cost Level 1 / 2 / 3 / 4 5% / 5% / 20% / 25% coinsurance (annual deductible applies)	Cost Level 1 / 2 / 3 / 4 10% / 10% / 20% / 35% coinsurance (annual deductible applies)	Cost Level 1 / 2 / 3 / 4 20% / 25% / 30% / 50% coinsurance (annual deductible applies)
M. Prescription Drugs (30-day supply of Tier 1, Tier 2, or Tier 3 prescription drugs, including insulin; or a 3-cycle supply of oral contraceptives)	Cost Level 1 / 2 / 3 / 4 $18 tier one; $30 tier two; $55 tier three	Cost Level 1 / 2 / 3 / 4 $25 tier one; $45 tier two; $70 tier three	Cost Level 1 / 2 / 3 / 4 $30 tier one; $50 tier two; $75 tier three (annual deductible applies)
N. Plan Maximum Out-of-Pocket Expense for Prescription Drugs (excludes PKU & Infertility) (single/family)	Cost Level 1 / 2 / 3 / 4 Single: $1,050; Family: $2,100	Cost Level 1 / 2 / 3 / 4 Single: $1,250; Family: $2,500	** Cost Level 1 / 2 / 3 / 4 COMBINED MEDICAL/PHARMACY Single Coverage: $3,000 / $3,000 / $4,000 / $5,000 Family Coverage (per family member): $5,000 / $5,000 / $6,900 / $6,900 Family Coverage (per family): $6,000 / $6,000 / $8,000 / $10,000
O. Plan Maximum Out-of-Pocket Expense (excludes prescription drugs) (single/family)	Cost Level 1 / 2 / 3 / 4 Single: $1,700 / $1,700 / $2,400 / $3,600 Family: $3,400 / $3,400 / $4,800 / $7,200	Cost Level 1 / 2 / 3 / 4 Single: $2,600 / $2,600 / $3,800 / $4,800 Family: $5,200 / $5,200 / $7,600 / $9,600	See Section N above

Emergency care or urgent care at a hospital emergency room or urgent care center out of the plan's service area or out of network is covered as described in sections C and E above.

This chart applies only to in-network coverage. Point of Service coverage is available only to members whose permanent residence is outside both the State of Minnesota and the Advantage Plan's service area. This category includes employees temporarily residing outside Minnesota on temporary assignment or paid leave [including sabbatical leaves] and college students. It is also available to dependent children and spouses permanently residing outside the service area.

***Under the HSA Compatible Option**: These members pay a $1,500 single or $3,000 family deductible (separate and distinct from the deductibles listed in section B above) and 30% coinsurance to the out-of-pocket maximums described in section N above. Members pay the drug copayment described at section M above to the out-of-pocket maximum described at section N. This benefit must be requested.*

***Under the Value Option and the High Option**: These members pay a $350 single or $700 family deductible (separate and distinct from the deductibles listed in section B above) and 30% coinsurance to the out-of-pocket maximums described in section O above. Members pay the drug copayment described at section M above to the out-of-pocket maximum described at section N. This benefit must be requested.*

A standard set of benefits is offered in all PEIP Advantage Plans. There are still some differences from plan to plan in the way that benefits, including the transplant benefits, are administered, in the referral and diagnosis coding patterns of primary care clinics (and in the definition of Allowed Amount under the High and Value Option Plans).

***Under the Value Option and the High Option**: These Plans use an **embedded deductible**. If a family member reaches the individual deductible then the deductible is satisfied for that family member. If any combination of family members reaches the family deductible, then the deductible is satisfied for the entire family.*

***Under the HSA Compatible Option**: *The family Deductible is the **maximum amount** that a family has to pay in deductible expenses in any one calendar year. The family Deductible is **not** the amount of expenses a family must incur before any family member can receive benefits. Individual family members only need to satisfy their individual deductible once to be eligible for benefits. Once the family Deductible has been met, deductible expenses for the family are waived for the balance of the year.*

***The family Out-of-Pocket Maximum is the **maximum amount** that a family has to pay in any one calendar year. The per-family member embedded Out-of-Pocket Maximum is the maximum amount that a family has to pay in any one calendar year on behalf of any individual family member.*

PEIP Renewal

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Employee Cost Analysis – Single Coverage

2019	Monthly					Best Case		Worst Case
Single Coverage - PEIP Cost Level 2	Premium	City Contribution	City HSA Contribution	Employee Premium Cost	Annual HSA Contribution	Annual Employee Premium Cost	Annual In-network Out-Of-Pocket Max*	Annual Employee Potential Risk
Advantage Health Plan High Option	$885.78	$717.89	N/A	$167.89	$0	$2,015	$2,000	$4,015
Advantage Health Plan Value Option	$75.40	$672.70	N/A	$122.70	$0	$1,472	$3,200	$4,672
Advantage Health Plan HSA Compatible	$605.10	$577.55	$145.83	$27.55	$1,750	$331	$3,000	$1,581

2020	Monthly					Best Case		Worst Case
Single Coverage - PEIP Cost Level 2	Premium	City Contribution	City HSA Contribution	Employee Premium	Annual HSA Contribution	Annual Employee Premium	Annual In-network Out-Of-Pocket Max*	Annual Employee Potential Risk
Advantage Health Plan High Option	$922.82	$736.41	N/A	$186.41	$0	$2,237	$2,750	$4,987
Advantage Health Plan Value Option	$829.50	$689.75	N/A	$139.75	$0	$1,677	$3,850	$5,527
Advantage Health Plan HSA Compatible	$645.26	$597.63	$145.83	$47.63	$1,750	$572	$3,000	$1,822

PEIP Renewal

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Employee Cost Analysis – Family Coverage

2019	Monthly					Best Case		Worst Case
Family - PEIP Cost Level 2	Premium	City Contribution	City HSA Contribution	Employee Premium	Annual HSA Contribution	Annual Employee Premium	Annual In-network Out-Of-Pocket Max*	Annual Employee Potential Risk
Advantage Health Plan High Option	$2,364.88	$1,457.44	N/A	$907.44	$0	$10,889	$4,000	$14,889
Advantage Health Plan Value Option	$2,123.64	$1,336.82	N/A	$786.82	$0	$9,442	$6,400	$15,842
Advantage Health Plan HSA Compatible	$1,615.52	$1,082.76	$291.67	$532.76	$3,500	$6,393	$6,000	$8,893

2020	Monthly					Best Case		Worst Case
Family Coverage - PEIP Cost Level 2	Premium	City Contribution	City HSA Contribution	Employee Premium	Annual HSA Contribution	Annual Employee Premium	Annual In-network Out-Of-Pocket Max*	Annual Employee Potential Risk
Advantage Health Plan High Option	$2,463.72	$1,506.86	N/A	$956.86	$0	$11,482	$5,500	$16,982
Advantage Health Plan Value Option	$2,214.68	$1,382.34	N/A	$832.34	$0	$9,988	$7,700	$17,688
Advantage Health Plan HSA Compatible	$1,722.70	$1,136.35	$291.67	$586.35	$3,500	$7,036	$6,000	$9,536

BCBS MN Offer

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- Aware Network – largest network, no referrals
- Plan Design Match
  - PEIP Advantage High = $500 / $1500 - $25 copay
  - PEIP Advantage Value = $1000 / $3000 - $40 copay
  - PEIP HSA Compatible = $3000 / $6000 HDHP

	BCBSMN PROPOSAL		
Plan Design Features	$500/$1500 - $25 Copay Deductible Copay Plan T20032	$1000/$3000 - $40 Copay Deductible Copay Plan T20111	$3000/$6000 HDHP.HSA HSA Compatible Plan T20075
Enrollment (per 7/23/19 census)			
Employee	12	5	38
Family	10	2	22
Rates			
Employee	$757.70	$658.79	$609.48
Family	$2,022.94	$1,758.88	$1,627.21
Estimated Total Annual Premium	**$1,141,108**		
Change over Current (%)	**-5.9%**		
Change over Current ($)	**($71,344)**		
Change over Current (%)	**-14.5%**	**-17.2%**	**0.7%**
Change over Current ($)	**($59,476)**	**($16,951)**	**$5,083**

This is a summary only of estimated costs and is not a binding contract or a guarantee of rates. For additional details, please refer to carrier proposals, assumptions & conditions.

- Offer includes 13% rate cap for 2021

BCBS MN Offer

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Plan Design Features	BCBSMN PROPOSAL $500/$1500 - $25 Copay Deductible Copay Plan T20032	$1000/$3000 - $40 Copay Deductible Copay Plan T20111	$3000/$6000 HDHP.HSA HSA Compatible Plan T20075
In-Network	Aware	Aware	Aware
Calendar Year Deductible (Single/Family)	$500 / $1,500	$1,000 / $3,000	$3,000 / $6,000
Embedded or Non-Embedded	Embedded	Embedded	Embedded
Coinsurance Level	80 / 20%	70 / 30%	100 / 0%
Medical & Rx Out-of-Pocket Maximum	$2,000 / $4,000	$5,000 / $10,000	$3,000 / $6,000
Preventive Care	100 / 0% (no deducible)	100 / 0% (no deducible)	100 / 0% (no deducible)
Office Visit/Urgent Care	$25 copay	$40 copay	100 / 0% after ded
Convenience Care/e-visit	$20 copay	$20 copay	100 / 0% after ded
Diagnostic test (blood work)	80 / 20% after ded	70 / 30% after ded	100 / 0% after ded
Diagnostic text (x-ray)	80 / 20% after ded	70 / 30% after ded	100 / 0% after ded
Imaging (CT/PET scans/MRIs)	80 / 20% after ded	70 / 30% after ded	100 / 0% after ded
IP & OP Hospitalization	80 / 20% after ded	70 / 30% after ded	100 / 0% after ded
Emergency Room	80 / 20% after ded	70 / 30% after ded	100 / 0% after ded
Prescription Drugs (Rx)	Classic Pharmacy Network - Does not include CVS & Target Pharmacy's		
Rx Out-of-Pocket Maximum			
Retail	$15 / $50 / $100	$15 / $50 / $100	100 / 0% after ded
Mail Order	3 x Retail	3 x Retail	100 / 0% after ded
Preventive Rx			100 / 0% after ded
Specialty Drugs	80 / 20% (no ded) $350 max copay per script	70 / 30% (no ded) $350 max copay per script	100 / 0% after ded
Out-of-Network			
Deductible	$10,000 / $20,000	$10,000 / $20,000	$10,000 / $20,000
Coinsurance Level	50 / 50%	50 / 50%	50 / 50%
Out-of-Pocket Maximum	$20,000 / $40,000	$20,000 / $40,000	$20,000 / $40,000

Benefits outlined above are a summary of key benefits coverage only. Refer to the plan's policy documents for a full listing of plan benefits.

2020 Options

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Employee Cost Analysis – Single Coverage

2020	Monthly					Best Case		Worst Case
Single Coverage - PEIP Cost Level 2	Premium	City Contribution	City HSA Contribution	Employee Premium	Annual HSA Contribution	Annual Employee Premium	Annual In-network Out-Of-Pocket Max*	Annual Employee Potential Risk
Advantage Health Plan High Option	$922.82	$736.41	N/A	$186.41	$0	$2,237	$2,750	$4,987
Advantage Health Plan Value Option	$829.50	$689.75	N/A	$139.75	$0	$1,677	$3,850	$5,527
Advantage Health Plan HSA Compatible	$645.26	$597.63	$145.83	$47.63	$1,750	$572	$3,000	$1,822

2020	Monthly					Best Case		Worst Case
Single Coverage - Blue Cross Blue Shield	Premium	City Contribution	City HSA Contribution	Employee Premium	Annual HSA Contribution	Annual Employee Premium	Annual In-network Out-Of-Pocket Max*	Annual Employee Potential Risk
$500/$1500 - $25 Copay Deductible Copay Plan T20032	$757.70	$653.85	N/A	$103.85	$0	$1,246	$2,000	$3,246
$1000/$3000 - $40 Copay Deductible Copay Plan T20111	$658.79	$604.40	N/A	$54.40	$0	$653	$5,000	$5,653
$3000/$6000 HDHP.HSA HSA Compatible Plan T20075	$609.48	$579.74	$145.83	$29.74	$1,750	$357	$3,000	$1,607

2020 Options

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Employee Cost Analysis – Family Coverage

2020	Monthly					Best Case		Worst Case
Family Coverage - PEIP Cost Level 2	Premium	City Contribution	City HSA Contribution	Employee Premium	Annual HSA Contribution	Annual Employee Premium	Annual In-network Out-Of-Pocket Max*	Annual Employee Potential Risk
Advantage Health Plan High Option	$2,463.72	$1,506.86	N/A	$956.86	$0	$11,482	$5,500	$16,982
Advantage Health Plan Value Option	$2,214.68	$1,382.34	N/A	$832.34	$0	$9,988	$7,700	$17,688
Advantage Health Plan HSA Compatible	$1,722.70	$1,136.35	$291.67	$586.35	$3,500	$7,036	$6,000	$9,536

2020	Monthly					Best Case		Worst Case
Family - Blue Cross Blue Shield Blue Cross Blue Shield	Premium	City Contribution	City HSA Contribution	Employee Premium	Annual HSA Contribution	Annual Employee Premium	Annual In-network Out-Of-Pocket Max*	Annual Employee Potential Risk
$500/$1500 - $25 Copay Deductible Copay Plan T20032	$2,022.94	$1,286.47	N/A	$736.47	$0	$8,838	$4,000	$12,838
$1000/$3000 - $40 Copay Deductible Copay Plan T20111	$1,758.88	$1,154.44	N/A	$604.44	$0	$7,253	$10,000	$17,253
$3000/$6000 HDHP.HSA HSA Compatible Plan T20075	$1,627.21	$1,088.61	$291.67	$538.61	$3,500	$6,463	$6,000	$8,963

2021 Cost Illustration

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2021	PEIP*			BCBS MN**		
Plan Design Features	High Option	Value Option	HSA Compatible	$500/$1500 - $25 Copay	$1000/$3000 - $40 Copay	$3000/$6000 – HDHP HSA
Enrollment (per 7/23/19 census)						
Employee	12	5	38	12	5	38
Family	10	2	22	10	2	22
Rates						
Employee	$941.28	$846.09	$671.07	$856.20	$744.43	$688.71
Family	$2,512.99	$2,258.97	$1,791.61	$2,285.92	$1,987.53	$1,838.75
Estimated Total Annual Premium	**$1,321,077**			**$1,289,453**		
Change over 2020 (%)	**3.17%**			**13.0%**		
Change over 2020 ($)	**$40,590**			**$148,344**		
Change over 2020 (%)	**2.0%**	**2.0%**	**4.0%**	**13%**	**13%**	**13%**
Employer Contribution (A)						
Employee	$745.64	$698.05	$610.54	$703.10	$647.22	$619.36
Family	$1,531.50	$1,404.49	$1,170.80	$1,417.96	$1,268.77	$1,194.37
Employee Contribution						
Employee	$195.64	$148.05	$60.54	$153.10	$97.22	$69.36
Family	$981.50	$854.49	$620.80	$867.96	$718.77	$644.37

*PEIP 2021 renewal is unknown. Average across all plans/tiers 2016-2020 = 3.22%.

** BCBS MN 2020 rate cap = 13.0%. Northfield is currently running 20% below BCBS book of business.

HSA Plan Premiums

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Single Premiums - HSA	PEIP*	BCBS**
2019	$605.10	N/A
2020	$645.26	$609.48
2021*	$671.07	$688.71

Family Premiums - HSA	PEIP*	BCBS**
2019	$1,615.52	N/A
2020	$1,722.70	$1,627.21
2021*	$1,791.61	$1,838.75

*2021 PEIP Illustration of 4% increase
**2021 BCBS illustration of 13.0% rate cap

Total Spend

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Total Plan Spend	PEIP	BCBS
2020	$1,280,486	$1,141,108
2021*	$1,321,077	$1,311,134
2 year total	$2,601,563	$2,452,242

Total Employer Spend	PEIP	BCBS
2020	$1,077,443	$1,007,754
2021*	$1,097,738	$1,081,926
2 Year Difference	$2,175,181	$2,089,680
2 Year Difference		-$85,501

*Assumptions: July 2019 plan enrollment
PEIP illustrating a 2% increase to High & Value plans and a 4% increase to HSA plan
BCBS with the 13% cap for 2021

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Considerations

Considerations

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PEIP	Category	BCBS
More stable. But a pool, may be higher or lower than warranted.	Premium	Limited stability – community rating will supplement
Limited – only total claims and premiums available upon request	Transparency	Full – ability to see claims and what's driving costs
None – plan design and cost levels determined by PEIP	Control	Full – City can choose between market plans
Members must choose a primary care clinic and go where directed	Access	Open Access – no referrals necessary

Given the unknown with future PEIP renewals, what's most important?

Medical Rate Tiers:

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Considerations

- Moving to 2 tier to 3 tier increases family premium

Plan - 2020	Employee Only	Family	Family Ratio		Employee Only	Employee + One	Family	Family Ratio
PEIP High Option	$922.82	$2,463.72	2.7		$922.82	$1,937.94	$2,820,78	3.1
PEIP Value Option	$829.50	$2,214.68	2.7		$829.50	$1,741.96	$2,535.54	3.1
PEIP HDHP.HSA	$645.26	$1,722.70	2.7		$645.26	$1,355.06	$1,972.38	3.1
BCBSMN $500 Ded 80/20% - $25 copay	$757.70	$2,022.94	2.7		$740.96	$1,556.01	$2,371.07	3.2
BCBSMN $1000 Ded 70/30$ - $40 copay	$658.79	$1,758.88	2.7		$644.24	$1,352.90	$2,061.56	3.2
BCBSMN $3000/$6000 HDHP.HSA Compatible Plan	$609.48	$1,627.21	2.7		$596.01	$1,251.63	$1,907.24	3.2

- Current census has 80 active employees and 9 retirees enrolled in the medical plan
- Of those enrollments 10 active employees are presently covering 2 members and 3 retirees are covering 2 members (most commonly Employee + Spouse)

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Next Steps

Next Steps

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- Council Employment Policy Committee Meeting 9/24/19
- Employee Benefits Committee 10/8/19 2:30pm
- Tentative Council approval of decision 10/15
- Open Enrollment meetings tentatively 10/28/19

Disclosures

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RENEWAL-FINANCIAL NOTICE: This analysis is for illustrative purposes only, and is not a guarantee of future expenses, claims costs, managed care savings, etc. There are many variables that can affect future health care costs including utilization patterns, catastrophic claims, changes in plan design, health care trend increases, etc. This analysis does not amend, extend, or alter the coverage provided by the actual insurance policies and contracts. Please see your policy or contact us for specific information or further details in this regard.

LEGAL NOTICE: The intent of this report is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

COVERAGE NOTICE: This analysis is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

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Thank You!

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