# Report of the McHenry County Council of Governments Ad Hoc Committee on Health Insurance:

## Feasibility and Cost-Benefit Study of a Self-funded Health Insurance Cooperative

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## Executive Summary

Thirteen municipalities and McHenry County participated in the study of a self-funded health insurance cooperative. The findings of the study include:

- Health insurance premiums continue to increase at an alarming pace and fluctuations in premiums from year to year make budgeting for health insurance costs difficult and threaten the sustainability of health benefit programs. This problem is more acute for small and medium sized employers.
- Local governments in N. Illinois have used self-funded health insurance cooperatives to provide health insurance benefits to their employees over the past twenty years and are a viable alternative to individual fully-funded health plans.
- Consultants analyzing the demographic and premium history for the study group concluded that it would be feasible and beneficial for these organizations to join together to create a large self-funded health insurance cooperative.
- Self-funded health insurance cooperatives pool the resources of many organizations to cover all claims up to a specific amount, reinsurance pays for claims above the specific amount and a reserve fund is in place to cover higher than expected claims in a given year or run-out claims if the cooperative is disbanded. Premiums for each organization are determined based on the community rate, individual organization's risk level and types of plans offered to employees.
- The cooperative is formalized through bylaws. The bylaws outline the policies of the cooperative including length of commitment for each organization (a three year minimum is recommended) and reserve policy (20% to 25% of premiums is recommended).
- Expected Benefits of a Self-Insured Health Insurance Cooperative Include:
  - Stabilized premium costs and smaller increases as claims and risk are spread among a large population;
  - Shared fixed expenses (such as administrative and broker fees) among the group, thus minimizing these costs to individual organizations;
  - Access to services and benefits for small communities usually only provided to large organizations;
  - Incentives to keep employees healthy, which lead to enhanced services such as wellness and preventative care programs;
  - Increased leverage in negotiating prices and services; and
  - Greater control over how premium dollars are spent.
- The study group would pay less for premiums in 2007 than they did in 2005 if they were to participate in a self-funded insurance cooperative. The Horton Group provided cost estimates for the group based on 1,700 employees for 2007. The overall savings is 7.81% ($1,429,845.71 less than organizations paid in premiums in 2005 as a whole).
- Potential obstacles to creating a cooperative include the fact that Blue Cross / Blue Shield will not provide access to their network to any cooperative that includes organizations with fewer than 151 employees. Several organizations participating in the study have fewer than 151 employees. In addition, self-funded health insurance cooperatives are a new concept for many McHenry County municipalities and they may be hesitant to change the way they purchase health insurance benefits.

## Study of a Self-Funded Health Insurance Cooperative

In September 2005, the McHenry County Council of Governments formed the Ad Hoc Committee on Health Insurance. Seeking solutions to escalating health insurance costs for local governments in McHenry County, the committee's aim was to research alternatives beyond the typical short-term approaches of switching carriers, changing plan designs or shifting costs to employees. Thirteen municipalities and McHenry County participated in the health insurance study. They provided data on their current health insurance plans and the demographics of their covered employees and dependants. The total number of employee lives included in the study was approximately 1,700. In conducting their research, the committee met with representatives from the Intergovernmental Personnel Benefits Cooperative (IPBC), GCG Financial and the Horton Group. These consultants were chosen to assist with the study because of their experience providing health insurance services to public sector organizations and their work with self-funded health insurance cooperatives. All consultants provided their services free of charge and without obligation. GCG Financial and the Horton Group provided most of the guidance during the study by analyzing demographic information, educating the committee on self-funded insurance cooperatives and providing cost estimates for such a cooperative.

This report provides the result of the study performed by the Ad Hoc Committee, its findings and next steps for creating a self-funded health insurance cooperative.

## The Problem: Small Group Premium Increases and Cost Instability

According to the National Coalition on Health Care, a non-profit, non-partisan coalition that researches health care in the US, health care spending continues to rise at the fastest rate in our history. In 2005, employer health insurance premiums increased an average of 9.2%, nearly three times the rate of inflation.[1] Employee benefit costs continue to rise at an alarming pace. Like the rest of the nation, local governments have seen continued increases in premium costs. In addition, these increases fluctuate from year to year making budgeting for health insurance costs difficult. To offset increases in premiums, organizations are forced to cut back on benefits or shift costs to their employees. These increases and price fluctuations threaten the sustainability of health insurance benefit programs.

Small organizations face larger increases and their employees pay higher deductibles than large organizations. According to the American College of Physicians, small organizations are especially sensitive to rising health care costs, primarily due to their size. Small organizations do not have the considerable pool of employees through which to spread risk and thus find it difficult to afford to cover employees. Administrative costs, in particular, are higher for small organizations, since they lack the economies of scale present in larger organizations.[2]

[1] National Coalition on Healthcare website: www.nchc.org

[2] American College of Physicians. Small Business Pooling Arrangements and Association Health Plans. Philadelphia: American College of Physicians; 2003; Position Paper

Furthermore, many local governments that provide health insurance benefits to their employees are fully-insured and purchase health insurance directly from a health plan such as Blue Cross / Blue Shield. While being fully insured provides convenience and predictability, there is a growing sense that the current system is no longer cost effective or sustainable. Increases in premiums are determined by the health insurance provider with little explanation or input from the organization beyond shopping around for a new provider or reducing benefits. The organization has little knowledge of the claims to premiums ratio and what percentage of their premiums go toward covering claims or company profits. Wellness or preventative care programs are provided at extra cost and there are few incentives to keep employees healthy and claims costs down.

## Is There an Alternative?

A self-funded health insurance cooperative that pools the resources and spreads the risk of many small and medium sized organizations may provide the advantages that larger organizations have in purchasing health benefits for employees. Such cooperative arrangements are not new- they have been used successfully by many local governments in northern Illinois for the past twenty years. Two examples are the Intergovernmental Personnel Benefits Cooperative (IPBC), which includes over 40 local governments, many of which have unions, and the North Suburban Employee Benefit Cooperative, which consists of nine local governments including Wilmette, Lincolnshire and Mundelein. Both cooperatives have been in place for over a decade, illustrating the longevity and utility of cooperatives. Local government health insurance cooperatives are authorized under the 1970 Constitution of the State of Illinois and the Illinois Intergovernmental Cooperation Act. Finally, the consultants assisting with this study determined that a self-funded health insurance cooperative would be beneficial and provide benefits to the organizations participating in this study.

## How Do Self-Funded Health Insurance Cooperatives Work and What are the Potential Benefits?

In a self-funded insurance cooperative, organizations' premiums are pooled to pay all claims up to a specific amount (ie $100,000 per individual and $1,000,000 aggregate). Any claims above these amounts are covered by stop loss re-insurance. The cooperative chooses a health plan that provides access to their network of doctors and hospitals and processes claims. All decisions regarding health plans, the types of PPOs and HMOs offered, reserve policies and incentives are made by the cooperative. All accrued reserves in the cooperative are owned by the participating organizations and invested in an interest-bearing reserve fund. As opposed to the individual fully-insured health insurance plans, wherein organizations pay monthly premiums to a private corporation and never see their premiums again, in a self-funded cooperative, any premium not paid to cover a claim is put into a reserve fund that remains the property of the organizations in the cooperative.

Organizations pay monthly premiums to the cooperative based on three factors: 1) Community rate; 2) Individual organization's risk level; and 3) Types of plans offered to employees. In the case of the estimates provided in this report, the rates were determined by the Horton Group. The method used to determine each participant's premium considers

three criteria: 1) Overall plan savings for the combined risk (ie a large group can leverage a more competitive rate than an individual organization); 2) Demographic risk (the current premium levels with their respective carriers are a determinant of demographic risk); and 3) Plan design (ie how each organization's current plan varies with the three plans offered in the estimate.) In other words, each organization has their appropriate set of premium rates, but their rates are the affected by leverage (being part of a larger group), demographic differences and plan design choice.

The cooperative is formalized through bylaws, which are approved by representatives from each participating organization. The bylaws outline the policies of the cooperative including the length of commitment for participation. According to the consultants, participants should agree to commit to the cooperative for at least three years in order to keep stop loss reinsurance rates down and to attract more health plans to the cooperative. Health plans tend to avoid cooperatives that appear unstable and will charge higher rates if they perceive increased risk in covering the cooperative. The bylaws also contain the reserve policy of the cooperative. According to the consultants, a prudent reserve policy is 20% to 25% of premiums. The reserve is in place to cover higher than expected claims and to cover runout claims in the event the cooperative is disbanded.

Self-funded health insurance cooperatives have been used by local governments because of the benefits they provide. These benefits include: 1.) Stabilized costs; 2) Shared administrative expenses that minimize administrative costs to individual organizations; 3) Greater access for smaller communities to services and plans otherwise not available to them; 4) Built-in incentives that lead to enhanced services such as wellness and preventative care programs; 5) Increased leverage in negotiating prices and services; and 6) Greater control over how premium dollars are spent and any increases or decreases in premiums.

Cooperatives have the ability to stabilize rates, especially when compared to health rates for employers with less than 100 employees. Two main reasons for this are the fact that larger groups have a larger population to spread the risk and larger groups have greater leverage in negotiating fixed costs such as administration and reinsurance expenses. Thus the insurance market has incentive to provide a more competitive offer to large groups than to smaller, individual organizations. Larger employers have historically had lower increases when compared to small group plans.

All participants share in fixed costs such as administrative fees, network access fees and stop loss insurance. A major advantage of participating in an insurance cooperative is the savings achieved by sharing administrative costs. According to the Horton Group, 22% to 32% of premiums in fully insured health plans are fixed costs ( ie administrative fees, access fees, and reinsurance premiums) brokers also charge fees for their services. In the case of Blue Cross/ Blue Shield, brokers charge a minimum of 3% depending on the premium volume (as listed in Attachment E of this report). To illustrate the amount paid in administrative and broker fees, consider the following example. Municipality A (an actual municipality participating in the study) has 116 employees covered by their insurance plan and a premium volume of $1,080,000 per year. At a minimum, Municipality A pays approximately 22% of premiums in fixed costs and 3% of premiums in broker fees per year. This results in $270,000 per year or $22,500 per month in administrative and broker fees. Per employee, Municipality A pays $194 per month for these fees. Horton's cost estimates provided in this report amount to $154,406 per month. This includes re-insurance premiums, Cigna's

administrative fees and Horton's broker fees. $154,406 divided by 1,700 lives in the cooperative results in $90 in administrative and broker fees per capita per month. Under this scenario, Municipality A would save $104 per employee per month or $144,768 per year in administrative fees.

Smaller communities benefit from participating in cooperatives by gaining access to products and services otherwise not available to them through a fully-insured arrangement. Health plans often do not provide comprehensive reporting, discounts and other services to small groups. By participating in a cooperative consisting of thousands of lives, small organizations gain leverage and access to such services.

As mentioned previously, premiums are determined by the cooperative and any premium not used to pay for claims is put into a reserve fund. Organizations in the cooperative own their share of the reserves. Because the pool determines premiums based on historical and estimated claims, there is a lot of incentive to keep claims down by keeping employees healthy. Wellness and preventative care programs become essential cost-containment measures and additional benefits to employees.

Another advantage to participating in a cooperative versus purchasing health insurance individually is the leverage and buying power that a large group brings to the health insurance market. Greater discounts can be negotiated with hospitals and doctors through economies of scale.

Finally, participating in a cooperative allows organizations to decide how premium dollars are allocated. Organizations know that their premiums are paying directly for claims and not corporate profits. In addition, budgeting for health insurance expenses becomes much easier because the organization knows early on from year to year what expected premiums will be.

## Estimated Costs for Each Participating Organization in the Cooperative

The Ad Hoc Committee asked the consultants to provide estimated premiums on three plans; two PPO plans and an HMO plan. Attachment B outlines a summary of each plan. The first PPO plan (PPO Plan A) is nearly identical to the PPO offered by the Village of Lakewood. This is a mid-level plan not dissimilar from the plan offered by many municipalities in the study. The second PPO plan (PPO Plan B) is based on the plan offered by McHenry County. This is a richer plan than that of the Village of Lakewood, with lower deductibles and greater coverage. Finally the HMO plan reflected in the estimated premiums is the HMO plan offered by the Village of Lake in the Hills. The committee requested pricing for three plans in order to provide comparisons on what municipalities would pay in the cooperative versus what they are currently paying for similar plans. The three plans are also included to illustrate the fact that more than one plan design would be available for municipalities to select and choose from in the cooperative.

The Horton Group provided the premium cost estimates presented in Attachment A. Premiums were determined using the three factors mentioned previously in this report. These include 1) the community rate; 2) the individual organization's risk level (as determined through an analysis of premiums paid in 2005); and 3) the type of plan. The

estimated premiums are for a benefit year starting January 1, 2007 and are good for all of 2007. The premiums are inclusive of all administrative fees, consultant fees and reserves. As mentioned previously, these estimated premiums are based on a participation rate of roughly 1,700 lives in the cooperative. Any significant reduction in lives may increase rates and conversely, a significant increase in lives may decrease rates. Attachment C provides an overview of costs for the entire cooperative including administrative fees charged by the health plan (in this case Cigna) and broker fees (in this case Horton). As shown in the pie chart and table in Attachment D, 74% of premiums would cover claims, 11% would be applied to administrative costs and 15% would be used to build up reserves in the pool.

As shown in the premium cost estimate in Attachment C, the 13 participating municipalities and McHenry County paid approximately $18,317,104 in premiums in 2005. The estimated total cooperative cost based on 1,700 lives would be approximately $16,887,259. This amount includes estimated claims, administrative fees and reserves. The total is a reduction of overall costs of approximately 7.81% from 2005. Furthermore, the $16,887,259 in premiums paid by the municipalities and McHenry County to the cooperative includes a 20% reserve or $2,505,730, which would be owned by the cooperative, thus resulting in even further savings or dollars retained by participating organizations.

As shown in the cost estimates, there is an overall savings in premiums for 2007 over what organizations paid in premiums as a whole in 2005. Nevertheless, this may or may not be true for the future. Participating in a self-insured health insurance cooperative will not guarantee decreases or zero increases in premiums from year to year. Depending on claims, there will likely be increases in premiums over time. If some organizations have a bad year in which there are several high claims, their premiums will increase. Nevertheless, the group will determine increases and will know exactly where their premium dollars are allocated.

## Potential Obstacles

The creation of a self-funded health insurance cooperative is a large undertaking and as with any major project, obstacles may be expected. A potential obstacle identified early on by the committee was the fact that Blue Cross / Blue Shield, a common health insurance provider for many organizations in McHenry County, will not participate in a cooperative that includes organizations with fewer than 150 employees. There are several organizations participating in this study that have fewer than 150 employees. Blue Cross / Blue Shield has not provided a rationale for this policy but one can surmise that they would not encourage purchasing methods that would create a larger purchaser with more bargaining clout out of smaller, weaker employer groups. In general, health plans, such as Blue Cross / Blue Shield, can better control their own enrollment and are in a better position to realize higher profits by dealing directly with smaller employers if the plan is already well established in the market.[3] To our knowledge, no other insurance carrier has this policy. In fact, Cigna, another major health insurance provider, has already expressed an interest in participating in this cooperative. Cigna also provides a large network of hospitals and doctors and is recognized nationally as one of the largest health insurance companies in the US.

[3] Issue brief, November 2005 California Healthcare Foundation

Another potential obstacle is fear or hesitancy to change. Although health insurance cooperatives are not new to many local governments in Illinois, this concept is new for many of the organizations participating in the study. Understandably, organizations need to be assured that benefits offered as part of a cooperative will be at least as good as those provided for by their current health plans. Organizations also need to be assured that the financial resources invested in the cooperative are secure. There is every reason to believe, based on the research conducted by the committee, that both of these needs would be met through a self-insured health insurance cooperative. Organizations participating in the cooperative would have full control over the benefits offered by the cooperative as well as selecting health plans that include the doctors and hospitals currently used by their employees. In addition, through the bylaws, the cooperative can put into place policies that provide greater assurance of the cooperative's longevity and fiscal health. Some of these policies, such as requiring a minimum of a three year commitment and determining premium rates partially on an individual organization's risk so that low risk organizations are not penalized through higher premiums for another organization's high risk profile, have been discussed. Ultimately, each organization must weigh the potential benefits of joining a cooperative versus the benefits of staying with their current health insurance program.

## Next Steps

Organizations interested in creating and participating in the health insurance cooperative will engage in the following next steps to create the cooperative:

First, membership in the cooperative must be determined. Organizations interested in pursuing this concept further are invited to attend a meeting at the Village of Fox River Grove Village Hall at 305 Illinois Street in Fox River Grove on March 21, 2007 at 10 am. The focus of the meeting will be to begin preparations to create the cooperative. This includes gathering demographic information from all interested municipalities, determining types of coverage and an estimated start date in order to prepare a cooperative cost package for each municipality. We will also discuss the selection of consultants and health plans to work with the cooperative. After the cooperative cost package has been completed, municipalities will have firm cost information and can then make the final decision as to whether or not they will participate. Once municipalities confirm their participation in the cooperative, intergovernmental agreements, contracts and by-laws will be drafted. From there, the process will progress according to the timeline developed by the municipalities participating in the cooperative.

# Proposed Rates For Cooperative

Attachment A

| Municipality | MEDICAL PROGRAM | RX | EE Only | EE + Spouse | EE + Child(ren) | Family |
|---|---|---|---|---|---|---|
| Village A 79 employees | HMO ($20 OV/ $75 ER/ $100 Hosp - 5 days) | $10/25/40 | $240.36 | $508.21 | $484.28 | $762.01 |
| | PPO ($500/80/60) | $10/25/40 | $282.78 | $597.90 | $569.74 | $896.48 |
| | PPO ($150/90/80) | $6/12 | $328.82 | $695.23 | $662.49 | $1,042.42 |
| Village B 25 Employees | HMO ($20 OV/ $75 ER/ $100 Hosp - 5 days) | $10/25/40 | $211.11 | $449.45 | $410.81 | $649.27 |
| | PPO ($500/80/60) | $10/25/40 | $301.58 | $642.07 | $586.87 | $927.53 |
| | PPO ($150/90/80) | $6/12 | $350.68 | $746.59 | $682.40 | $1,078.52 |
| Village C 160 Employees | HMO ($20 OV/ $75 ER/ $100 Hosp - 5 days) | $10/25/40 | $330.14 | $681.06 | | $865.87 |
| | PPO ($500/80/60) | $10/25/40 | $388.40 | $801.25 | | $1,018.67 |
| | PPO ($150/90/80) | $6/12 | $451.63 | $931.68 | | $1,184.50 |
| Village D 73 Employees | HMO ($20 OV/ $75 ER/ $100 Hosp - 5 days) | $10/25/40 | $216.78 | $467.89 | $481.50 | $708.54 |
| | PPO ($500/80/60) | $10/25/40 | $255.03 | $550.45 | $566.47 | $833.57 |
| | PPO ($150/90/80) | $6/12 | $307.27 | $663.20 | $682.49 | $1,004.30 |
| Village E 124 Employees | HMO ($20 OV/ $75 ER/ $100 Hosp - 5 days) | $10/25/40 | $202.60 | $443.66 | $436.55 | $677.61 |
| | PPO ($500/80/60) | $10/25/40 | $259.74 | $568.80 | $559.67 | $868.73 |
| | PPO ($150/90/80) | $6/12 | $302.02 | $661.39 | $650.78 | $1,010.16 |
| Village F 18 Employees | HMO ($20 OV/ $75 ER/ $100 Hosp - 5 days) | $10/25/40 | $290.54 | $623.55 | $602.02 | $935.02 |
| | PPO ($500/80/60) | $10/25/40 | $341.81 | $733.59 | $708.26 | $1,100.02 |
| | PPO ($150/90/80) | $6/12 | $411.82 | $883.84 | $853.33 | $1,325.33 |
| Village G 16 Employees | HMO ($20 OV/ $75 ER/ $100 Hosp - 5 days) | $10/25/40 | $195.12 | $405.20 | $432.51 | $642.59 |
| | PPO ($500/80/60) | $10/25/40 | $229.56 | $476.70 | $508.84 | $755.99 |
| | PPO ($150/90/80) | $6/12 | $266.93 | $554.31 | $591.67 | $879.05 |

# Proposed Rates For Cooperative

Attachment A

| Municipality | MEDICAL PROGRAM | RX | EE Only | EE + Spouse | EE + Child(ren) | Family |
|---|---|---|---|---|---|---|
| Village H 18 Employees | HMO ($20 OV/ $75 ER/ $100 Hosp - 5 days) | $10/25/40 | $224.09 | $465.35 | $496.72 | $737.98 |
| | PPO ($500/80/60) | $10/25/40 | $263.63 | $547.47 | $584.38 | $868.22 |
| | PPO ($150/90/80) | $6/12 | $306.55 | $636.60 | $679.51 | $1,009.55 |
| Village I 32 Employees | HMO ($20 OV/ $75 ER/ $100 Hosp - 5 days) | $10/25/40 | $223.37 | $513.75 | $469.07 | $598.20 |
| | PPO ($500/80/60) | $10/25/40 | $262.79 | $604.41 | $551.85 | $703.77 |
| | PPO ($150/90/80) | $6/12 | $305.56 | $702.80 | $641.69 | $818.33 |
| Village J 58 Employees | HMO ($20 OV/ $75 ER/ $100 Hosp - 5 days) | $10/25/40 | $331.72 | $686.30 | $627.33 | $981.92 |
| | PPO ($500/80/60) | $10/25/40 | $390.26 | $807.42 | $738.04 | $1,155.19 |
| | PPO ($150/90/80) | $6/12 | $453.79 | $938.86 | $858.18 | $1,343.25 |
| Village K 16 Employees | HMO ($20 OV/ $75 ER/ $100 Hosp - 5 days) | $10/25/40 | $381.48 | $789.25 | $721.43 | $1,129.20 |
| | PPO ($500/80/60) | $10/25/40 | $448.80 | $928.53 | $848.74 | $1,328.47 |
| | PPO ($150/90/80) | $6/12 | $521.86 | $1,079.69 | $986.91 | $1,544.74 |
| Village L 43 Employees | HMO ($20 OV/ $75 ER/ $100 Hosp - 5 days) | $10/25/40 | $246.40 | $512.70 | $477.07 | $743.38 |
| | PPO ($500/80/60) | $10/25/40 | $337.54 | $702.33 | $653.51 | $1,018.32 |
| | PPO ($150/90/80) | $6/12 | $392.49 | $816.66 | $759.90 | $1,184.10 |
| Village M 152 Employees | HMO ($20 OV/ $75 ER/ $100 Hosp - 5 days) | $10/25/40 | $387.27 | $743.91 | | $960.83 |
| | PPO ($500/80/60) | $10/25/40 | $526.13 | $1,011.01 | | $1,304.45 |
| | PPO ($150/90/80) | $6/12 | $611.78 | $1,175.59 | | $1,516.81 |
| Village N 900 Employees | HMO ($20 OV/ $75 ER/ $100 Hosp - 5 days) | $10/25/40 | $340.35 | $702.12 | | $892.65 |
| | PPO ($500/80/60) | $10/25/40 | $400.41 | $826.03 | | $1,050.18 |
| | PPO ($150/90/80) | $6/12 | $465.59 | $960.50 | | $1,221.14 |

## Example Plan Designs for Cooperative Premium Estimates

Attachment B

### HMO

| | |
|---|---|
| Lifetime Benefit Maximum | Unlimited |
| Individual Deductible | |
| Family Deductible | |
| Individual Out of Pocket Expense Limit | |
| Family Out of Pocket Expense Limit | |
| Physician Office Visits | $20 copay then 100% |
| Well Care | $20 copay then 100% |
| Inpatient Hospital Services | $100 copay per day for 1st five days then 100% |
| Outpatient Hospital Services | $20 copay then 100% |

# PPO Plan A

### PPO (in network)

| | |
|---|---|
| Lifetime Benefit Maximum | $5,000,000 |
| Individual Deductible | $500 |
| Family Deductible | $1,500 |
| Individual Out of Pocket Expense Limit | $2,000 |
| Family Out of Pocket Expense Limit | $6,000 |
| Physician Office Visits | $20 co-payment then 100% |
| Well Care | $20 co-payment then 100% |
| Inpatient Hospital Services | 80% |
| Outpatient Hospital Services | 80% |

### PPO (out of network)

| | |
|---|---|
| Lifetime Benefit Maximum | $5,000,000 |
| Individual Deductible | $1,000 |
| Family Deductible | $3,000 |
| Individual Out of Pocket Expense Limit | $4,000 |
| Family Out of Pocket Expense Limit | $12,000 |
| Physician Office Visits | 60% |
| Well Care | 60% |
| Inpatient Hospital Services | 60% |
| Outpatient Hospital Services | 60% |

## Example Plan Designs for Cooperative Premium Estimates

Attachment B

## PPO Plan B

| PPO (in network) | |
|---|---|
| Lifetime Benefit Maximum | $5,000,000 |
| Individual Deductible | $150 (Employee) $150 (Ret) $100 (Dep) |
| Family Deductible | |
| Individual Out of Pocket Expense Limit | $800 |
| Family Out of Pocket Expense Limit | $2,000 |
| Physician Office Visits | 90% |
| Well Care | 90% |
| Inpatient Hospital Services | 90% |
| Outpatient Hospital Services | 90% |

| PPO (out of network) | |
|---|---|
| Lifetime Benefit Maximum | $5,000,000 |
| Individual Deductible | $150 (Ee) $150 (Ret) $100 (Dep) |
| Family Deductible | |
| Individual Out of Pocket Expense Limit | $3,000 |
| Family Out of Pocket Expense Limit | $7,000 |
| Physician Office Visits | 80% |
| Well Care | 80% |
| Inpatient Hospital Services | 65%-80%<br>$100 Deductible per Admission |
| Outpatient Hospital Services | 65%-80% |

Attachment C

McHenry County Council of Governments
Health Review (Including McHenry County)
January 1, 2007
***CIGNA MATURE---ILLUSTRATIVE ONLY****
**Estimated Numbers in magenta text.**

| Reinsurance Data | Current Plans | Mature<br>Cigna |
|---|---|---|
| Reinsurance Carrier | | **Cigna** |
| Specific Deductible | | $100,000 |
| Specific Contract | | 12/12 |
| Specific Coverage | | Medical, Rx |
| Aggregate Contract | | 12/12 |
| Aggregate Coverage | | Medical, Rx |
| Run In Limit | | NA |

| Employee Census | | |
|---|---|---|
| Single Employees | 679 | 679 |
| Family Employees | 1041 | 1041 |
| ***Total Employees:*** | **1720** | **1720** |

| Fixed Costs | | | | |
|---|---|---|---|---|
| **Monthly Fixed Costs** | | (Per Capita) | | |
| Administration Fee | | | | $11.54 |
| Reverse Discount Guarantee | | | | $8.00 |
| Government Compliance Fee | | | | |
| Managed Care Access Fee | | | | |
| OAPlus In Network Access | 341 | | 341 | $12.00 |
| OAPlus Access | 1379 | | 1379 | $10.50 |
| Single Specific Premium | | Stop Loss Reinsurance | | $53.18 |
| Family Specific Premium | | Stop Loss Reinsurance | | $53.18 |
| Aggregate Premium | | | | |
| **Additional Fixed Costs** | | | | |
| Consulting Fee | | | | $6.25 |
| Annual Administration Fee | | | | |
| ***Total Monthly Fixed Costs:*** | | **NA** | | **$154,406.78** |
| ***Total Annual Costs:*** | | **NA** | | **$1,852,881.36** |

| Projected Annual Claims | | ***Estimated Mature Annual Claims*** |
|---|---|---|
| Single | | |
| Family | | |
| Total | **NA** | **$15,034,378** |

| | | |
|---|---|---|
| **Expected Plan Exposure** | **$18,317,104.92** | **$16,887,259.21** |
| **Expected Plan Exposure PMPM (Target Premium)** | | **$371.90** |
| **Expected Dollar Savings** | | **($1,429,845.71)** |
| **Expected Percentage Savings** | | **-7.81%** |

***See important contigencies and caveats in proposal.***

Attachment D

# McHenry County Council of Governments
## Policy Year 2007
## Estimated Asset Flow - First 12 months

| | (A) | (B) | (C) | (D) = A - B - C |
|---|---|---|---|---|
| Mo/Yr | Remitted Premium | Expected Claims | Fixed Cost Expenses | Contribution to Reserves |
| Jan-07 | $1,407,271.60 | $0.00 | $154,406.78 | $1,252,864.82 |
| Feb-07 | $1,407,271.60 | $0.00 | $154,406.78 | $1,252,864.82 |
| Mar-07 | $1,407,271.60 | $1,252,864.82 | $154,406.78 | $0.00 |
| Apr-07 | $1,407,271.60 | $1,252,864.82 | $154,406.78 | $0.00 |
| May-07 | $1,407,271.60 | $1,252,864.82 | $154,406.78 | $0.00 |
| Jun-07 | $1,407,271.60 | $1,252,864.82 | $154,406.78 | $0.00 |
| Jul-07 | $1,407,271.60 | $1,252,864.82 | $154,406.78 | $0.00 |
| Aug-07 | $1,407,271.60 | $1,252,864.82 | $154,406.78 | $0.00 |
| Sep-07 | $1,407,271.60 | $1,252,864.82 | $154,406.78 | $0.00 |
| Oct-07 | $1,407,271.60 | $1,252,864.82 | $154,406.78 | $0.00 |
| Nov-07 | $1,407,271.60 | $1,252,864.82 | $154,406.78 | $0.00 |
| Dec-07 | $1,407,271.60 | $1,252,864.82 | $154,406.78 | $0.00 |
| TOTAL | $16,887,259.21 | $12,528,648.21 | $1,852,881.36 | $2,505,729.64 |
| Percentage Allocations | 100% | 74% | 11% | 15% |

| | |
|---|---|
| TOTAL RESERVES (Expected Accumulation) | $2,505,730 |
| TOTAL CLAIMS 1st Year | $12,528,648 |
| Reserves (as a % of claims) | 20% |

Attachment D

McHenry County Council of Governments
Policy Year 2007
Estimated Asset Flow - First 12 months (Chart View)