LUMPKIN COUNTY
Board of Commissioners
Special Called Meeting Agenda
Commissioners Boardroom
99 Courthouse Hill
Dahlonega, GA 30533

May 7, 2024
4:30 PM

- **CALL TO ORDER**
- **CONSIDERATION OF AGENDA**
- **CONTRACTS**

  2024-030 Consideration of Renewal of Medical Self-Insurance and Move to New Ancillary Insurances *(Community & Employee Services Director Alicia Davis)*

- **ADJOURNMENT**

Lumpkin County, Georgia

Human Resources

Date: May 7, 2024

Agenda Item: 2024-030 Consideration of Renewal of Medical Self-Insurance and Move to New Ancillary Insurances *(Community & Employee Services Director Alicia Davis)*

Item Description: Lumpkin County Board of Commissioners provides Medical, Dental, Long-Term Disability and Basic term life insurance for eligible full-time employees and certain other designated individuals as allowed. Additionally, other ancillary insurances such as Short-Term Disability, vision insurance, additional life insurance, accident and critical illness, and cancer policies are offered to the same group of employees and elected officials, but premiums are not supported by the county.

Facts & Historical Information:

Medical Insurance

Turner, Wood and Smith (TWS) serves as the employee benefits consultant for Lumpkin County Board of Commissioners. TWS continues to recommend utilizing Healthgram as our third-party administrator for self-insured health coverage. While there is an increase to plan deductibles this year, it is an increase required by the IRS, not by Lumpkin County or Healthgram.

Each year the IRS announces inflation-adjusted limits for Health Savings Accounts (HSAs) and High Deductible Health Plans (HDHPs). To remain an HSA qualified plan, the IRS increased the minimum annual HDHP deductible to $1,600/individual and $3,200 for family. For embedded deductibles, which Lumpkin has, the individual deductible cannot be lower than the minimum family deductible of $3,200.

For the 2024 – 2025 plan year, there is a fixed cost increase of 8.1% or $56,606. This is in addition to the funding needed to continue with self-insurance. Total expected annual cost funding of $2,604,903 plus $220,000 for the reserve fund is recommended.

Ancillary Insurances

TWS markets ancillary insurances periodically based on performance and cost. TWS is recommending all ancillary insurances be moved from current providers to Guardian for dental and vision and to The Hartford for basic life, voluntary life, short term disability, long term disability, accident, and critical illness. Moving to

these companies will be a $10,373 annual savings to the county as well as either being cost neutral or providing cost savings to employees. Additionally, some benefits such as dental coverage will be improved, and the voluntary life insurance will offer a true open enrollment, which is beneficial to employees who may have been previously turned down for life insurance coverage.

Potential Courses Of Action:

A. Choose to continue with self-insurance through Healthgram. Approve all plan amendments (summary attached.) Fund at same level as 2023-2024 which includes absorbing the increased fixed costs of $56,606, adding $220,000 to the reserve fund, and contributing $77,167 more than expected claims for 2024-2025. Approve moving to Guardian for dental and vision coverage and The Hartford for basic life, voluntary life, short term disability, long term disability, accident, and critical illness.
B. Choose to continue with self-insurance through Healthgram. Approve all plan amendments (summary attached.) Fund at a different level directed by the Board. Approve moving to Guardian for dental and vision coverage and The Hartford for basic life, voluntary life, short term disability, long term disability, accident, and critical illness.
C. Choose to continue with self-insurance through Healthgram. Approve all plan amendments (summary attached.) Fund at a different level directed by the Board. Choose to stay with current providers for ancillary coverages.
D. Fund at any of the above levels, but choose not to fund the $220,000 for the reserve fund.

Budget Impact:

Since the health insurance plan year starts in July, all cost changes will be split between the last six months of this fiscal year and the first six months of fiscal year 2025. Budget numbers are based on current enrollment and may change if enrollment numbers increase or decrease.

- With the 2024 - 2025 renewal, expected costs have decreased by more than the fixed cost increase, so Course of Action A will have no budget impact for the remainder of 2024 and we will budget for 2025 at the same level as 2024.
- Course of Action B's impact would be dependent on the funding directed by the Board, but would provide for plan and/or cost improvements to ancillary insurances.
- Course of Action C's impact would be dependent on the funding directed by the Board, but would keep ancillary insurances the same.
- Course of Action D would reduce the cost by $220,000.

Staff Recommendation:

Course of Action A.

AMENDMENT TO SUMMARY PLAN DESCRIPTION
AND MASTER PLAN DOCUMENT
FOR
LUMPKIN COUNTY BOARD OF COMMISSIONERS

Effective: 07/01/24 **Amendment #1-24**

Item *1a - The chart in the Deductible section in the Base Plan is hereinafter amended as highlighted below:

Deductibles	In-Network	Out-of-Network
Individual Deductible	$3,200	$5,000
Family Deductible	$6,400	$10,000

Item *1b - The chart in the Deductible section in the Buy-Up Plan is hereinafter amended as highlighted below:

Deductibles	In-Network	Out-of-Network
Individual Deductible	$3,200	$6,000
Family Deductible	$6,400	$12,000

Item *1c – The various examples of the time to file a civil action shall hereinafter read as follows:

a. Post-Service Claims

For example, if a **Member** received services on January 1, 2023, they must file a civil action against the **Plan** on or before December 31, 2025. If a **Member** received services on December 1, 2023, they must also file a civil action against the **Plan** on or before December 31, 2025. Nothing herein shall extend the time to file a suit.

b. Questions regarding Claims Determinations

For example, if a **Member** received services on January 1, 2023, they must file a civil action against the **Plan** on or before December 31, 2025. If a **Member** received services on December 1, 2023, they must also file a civil action against the **Plan** on or before December 31, 2025. Legal action may be taken only after exhausting the **Plan's** administrative procedures including, but not limited to, completing the appeals process. *See*, Appeals. Nothing herein shall extend the time to file a suit.

c. Determinations on a Level One Appeal

For example, if a **Member** received services on January 1, 2023, they must file a civil action against the **Plan** on or before December 31, 2025. If a **Member** received services on December 1, 2023, they must also file a civil action against the **Plan** on or before December 31, 2025. Nothing herein shall extend the time to file a suit.

d. Determinations on a Level Two Appeal

For example, if a **Member** received services on January 1, 2023, they must file a civil action against the **Plan** on or before December 31, 2025. If a **Member** received services on December 1, 2023, they must also file a civil action against the **Plan** on or before December 31, 2025. Nothing herein shall extend the time to file a suit.

Item *2a-1: The Autism Services portion of the Other Covered Services section in the Base Plan is hereinafter amended as highlighted below to read as follows:

Covered Medical Expense	Payable by Member	
	In-Network	Out-of-Network (Plan Allowance May Apply)
Applied Behavioral Therapy (ABA)	0% after **Deductible**	30% after **Deductible**

Item *2a-2: The Autism Services portion of the Other Covered Services section in the Buy-Up Plan is hereinafter amended as highlighted below to read as follows:

Covered Medical Expense	Payable by Member	
	In-Network	Out-of-Network (Plan Allowance May Apply)
Applied Behavioral Therapy (ABA)	20% after **Deductible**	40% after **Deductible**

Item *2b-1: The Physical, Speech, and Occupational Therapy portion of the Other Covered Services section in the Base Plan is hereinafter amended as highlighted below to read as follows:

Covered Medical Expense	Payable by Member	
	In-Network	Out-of-Network (Plan Allowance May Apply)
Physical, Speech, and Occupational Therapy[1] *Autism / Non-Autism: Limited to 37 combined visits per year*[2]	0% after **Deductible**	30% after **Deductible**

Item *2b-2: The Physical, Speech, and Occupational Therapy portion of the Other Covered Services section in the Buy-Up Plan is hereinafter amended as highlighted below to read as follows:

Covered Medical Expense	Payable by Member	
	In-Network	Out-of-Network (Plan Allowance May Apply)
Physical, Speech, and Occupational Therapy[1] *Autism / Non-Autism: Limited to 37 combined visits per year*[2]	$25 **Copay** per visit	40% after **Deductible**
	Note: The first three visits for any combination of Physical Therapy and Vertebral Manipulation will pay as follows: 0% no **Deductible** (In-Network Only)	

Item *3 – The Claim Filing Procedure section is hereinafter amended as highlighted below:

CLAIM FILING PROCEDURE.

It is the responsibility of the **Member** to see that doctor bills, medical bills, and **Hospital** charges are submitted to the **Plan Supervisor**. **Claim** forms may be obtained from the Human Resources office, or they can be found online at https://members.healthgram.com/other_forms.cfm. **Claim** forms must be filled out completely. **Claims** must be submitted to the **Plan Supervisor** at the address listed on the back of the ID Card.

Item *4 – The Primary Care Physician definition in the Definition section is hereinafter amended to read as follows:

A **Primary Care Physician** or **PCP** is a **Physician** specializing in internal medicine, general practice, family practice, pediatrics, obstetrics or gynecology, and internal medicine when performing primary care chosen by the **Member** to manage the continuity of his or her medical care. Certified Physician's Assistants (PAC's) and Certified Nurse Practitioners (CNP's) supervised by the **Primary Care Physician** may also be considered **PCP's** under the **Plan** as long as they practice in the same location as the **PCP**.

Item *5a –The room and board portion of the Covered Medical Expenses section is hereinafter amended to read as follows:

- **Hospital** room and board charges.
  For more information, *see* Room and Board Charges in Special Provisions.

Item *5b – The room and board portion of the Special Provisions sections in all Plans are hereinafter amended as reflected below to read as follows:

ROOM AND BOARD CHARGES.
Charges by an institution for room and board and other necessary services and supplies must be regularly made at a daily or weekly rate. ~~The semi-private rate is the charge that an institution applies to the beds in a semi-private room with two (2) or more beds. If a Facility has private rooms only, it will be paid the same as the semi-private room charge.~~ Daily room and board charges in a **Hospital** will be paid at either an ICU rate or a regular room rate.

Item *5c – The Substance Use Disorders portion of the Special Provisions sections in all Plans are hereinafter amended as reflected below to read as follows:

SUBSTANCE USE DISORDERS.
Charges for the treatment of **Substance Use Disorders** are **Covered Healthcare Expenses** if all of the following requirements are met:

1. The treatment must be prescribed and supervised by a **Physician**; and,
2. The treatment must have a follow-up therapy program directed by a **Physician** on at least a monthly basis or include meetings at least twice a month with approved organizations devoted to the treatment of **Substance Use Disorders** such as Alcoholics Anonymous or Narcotics Anonymous.

If a **Member** is confined as an **Inpatient** in a **Hospital**, the covered charges include treatment of the medical complications of **Substance Use Disorders**. ~~Room and board charges in excess of the semi-private room rate are not covered.~~

~~If a Member is confined as an Inpatient in a non-Hospital treatment Facility, the covered charges include room and board charges equal to the semiprivate room rate.~~ Charges are covered only for **Facilities** that are recognized by the Joint Commission on Accreditation of Hospitals and licensed by the state. ~~Room and board charges in excess of the semi-private room rate are not covered.~~

Precertification and **Utilization Review** are required for **Inpatient** treatment.

Item *6a – The header in the chart in the Prescription Drug Benefits sections of the Base Plan and Buy-Up Plan are hereinafter amended as reflected below to read as follows:

Prescription Drug Card		
Prescription Drug Type	**Payable by Member**	**Payable by Member** (**Non-Preferred Pharmacies** include: CVS, Walgreen's,

		Rite-Aid, and Target~~, Sam's Club, and Walmart~~)

Item *6b – The Prescription Drug Schedule of Benefits section is hereinafter amended as reflected below to read as follows:

The following Pharmacies are considered a non-Preferred Retail Pharmacy under this Plan: CVS, Rite Aid, ~~Sam's Club,~~ Target, and Walgreens~~, and Walmart~~. All other pharmacies are considered Preferred Retail Pharmacies.

Item *6c – The Prescription Drug Benefits section is hereinafter amended as reflected below to read as follows:

Target, ~~Walmart,~~ CVS, Rite Aid, ~~Sam's Club,~~ and Walgreens are considered **non-preferred Pharmacies** under this Plan. Prescription drugs purchased through these Pharmacies are limited to a 34-day supply only and will be payable subject to the non-preferred Pharmacy copayment amount as stated in the Prescription Drug Schedule of Benefits. All other pharmacies are considered Preferred Retail Pharmacies.

*By signature below, I acknowledge the amendment has been reviewed by **Lumpkin County Board of Commissioners or an authorized representative.** The plan amendment is accepted as final and is ready to be adopted into the Summary Plan Description and Plan Document. Any changes to this plan language will require additional plan amendments or plan document changes. Printing costs are the responsibility of the Plan Sponsor.*

This Amendment is accepted as stated above.

BY: _____ _____
Name Date

_____
Title

Si necesita ayuda en espanol para entender este documento, puede solicitarla sin costo adicional, llamando al numero de servicio (980) 201-3020.

ACCEPTANCE OF SUMMARY OF BENEFIT COVERAGE (SBC)
Lumpkin County Board of Commissioners

I have reviewed the Uniformed Summary of Benefit Coverage Document for **Lumpkin County Board of Commissioners** effective 07/01/2024 and find each document acceptable.

I understand revisions at my request or any copies of summary of benefit coverage are at the expense of employer.

Please print _____ copies of the benefit summary. Healthgram will be passing along all cost associated with printing the summaries to the employer. Printing costs and distribution are the responsibility of the employer.

Lumpkin County Board of Commissioners

_____ _____
Signature Date

Please print clearly to ensure accurate processing

Guardian

Your Insurance Broker is :
Robert Fowler
100 Brenau Avenue
Gainesville
GA 30503
(770) 536-0161

Your Guardian Representative is :
Daniel Navarro
1125 Sanctuary Parkway
Suite 175
Alpharetta
GA 30009
(800) 677-0296

The Guardian Life Insurance Company Of America | 10 Hudson Yards, New York, NY 10001

APPLICATION FOR A PLAN OF GROUP INSURANCE

REQUESTED COVERAGE

Applicant:	Coverage(s):
Lumpkin County Board of Commissioners 99 Courthouse Hill Suite A DAHLONEGA , GA 30533 SIC Code: 9111	**Dental** **Vision**

If information is incorrect, ask your insurance broker for an updated application.

BUSINESS INFORMATION

Types of Organization:
☐ Corporation ☐ Partnership ☐ Proprietorship
☐ S Corp ☑ Other: Government

Nature of Business:
Municipality

Tax ID Number	Date Established
*******57	MM/DD/1832

☐ Yes ☑ No Has your company ever filed, or is it now in the process of filing, for bankruptcy (Chapter 7 or 11) ?

Complete below if your company or any of its affiliates has ever applied for group insurance with Guardian.

Company or Affiliate Name (If different from Section 1)	Plan Number	Cancellation Date
		MM/DD/YYYY

Complete below if there are any COBRA or state continuation cases.

Employee/Dependent	Type	Reason	Continuation Dates

For additional names, please attach a separate sheet

AGREEMENT

Conditions Of Agreement
It is understood that only full-time employees and dependents of such shall be eligible.

Full-time employee means one who regularly works the number of hours in the normal work week established by this applicant (but not less than 30 hours per week) at the applicant's normal place of business.

Acceptance of Plan
It is further understood that no insurance will be effective until the plan is accepted in writing by the Insurance Company(-ies). No contract of insurance is to be implied in any way on the basis of the completion and submission of the application.
Upon acceptance, this application will be attached to and made part of the Group Insurance Policy.

Fraud Warning:
Any person, who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

AGREEMENT Continued	
Insurance Broker Representation: It is further understood that no broker has power on behalf of The Guardian Life Insurance Company of America to make or modify any request or application for insurance, or to bind said Insurance Company by making any promise or representation or by giving and receiving any information.	The undersigned applicant certifies that to the best of his/her knowledge and belief, all of the responses given are true, correct and complete. The applicant understands that a false statement or misrepresentation in the application may result in loss of coverage in the policy, the rescission of the policy, or a revision of the rates quoted.

SIGNATURES

I have reviewed the statements made by me on this application, and they are true and complete to the best of my knowledge and belief. By my signature below, I acknowledge that Lumpkin County Board of Commissioners endorses the Guardian plan of insurance.

Officer, Partner or Proprietor Signature		Witness Signature	
X	Date	X	Date
Title		Title	
Insurance Broker Signature		Additional Insurance Broker Signature	
X	Date	X	Date
Print Name		Print Name	
CMA2007			

Group Plan Number 00065672

Requested Effective Date 07/01/2024

Guardian

Guardian Anytime Website
AAA Pre-Registration Form

Company Name ("Company") Lumpkin County Board of Commissioners

Group Number ("Plan") 00065672 Effective Date 07 / 01 / 2024

Guardian requires at least one person to be designated as the **AUTHORIZED APPROVER OF ACCESS (AAA).** This individual will be responsible for managing and granting access to the group's information on the Guardian Anytime website. The AAA must be an internal company employee. A broker or Third-Party Administrator cannot be the AUTHORIZED APPROVER OF ACCESS".

List AAA(s) who will control administration access to Guardian Anytime for your group plan.

Authorized Approver of Access Name(s)	Phone Number(s)	Email Address(es) *~Please print clearly~*	*Existing User ID*	Divisions *Leave blank if all*
Alicia Davis	706-482-2573	alicia.davis@lumpkincounty.gov		

In addition to the Authorized Approver of Access user(s) identified, please list any additional individuals that should have access as administrators of the group authorized to add, view or change information via Guardian Anytime. The below users will not control the access to the group.

This is for individuals at your company and Third-Party Administrators, your broker will receive access under their Portal.

List additional plan administrator(s) authorized to add, view or change information via Guardian Anytime.

Additional Administrator Name(s)	Phone Number(s)	Email Address(es) *~Please print clearly~*	*Existing User ID*	Divisions *Leave blank if all*

Guardian will pre-register all individuals listed on this form. This form must be signed by an owner or officer of your company. Individuals added or changed in the future will be managed exclusively by your designated AAA.

Each individual pre-registered by Guardian will receive an e-mail with instructions on how to complete the registration.

SIGNATURE AND ATTESTATION

Company understands that it may change this election by providing Guardian thirty (30) days prior written notice. By signing below, you agree: (1) you have authority to act on behalf of the entity applying for insurance ("entity") and (2) you are responsible for approving access and ensuring that only authorized persons within the entity are able to access the sensitive information maintained by Guardian that is protected by certain state and federal privacy laws. You agree that you will manage your employees and/or agents access to Guardian administrative systems ("the Administrative Systems") to enable them to receive information through to perform enrollment, disenrollment and other coverage and billing related functions. As such you agree to: (1) notify Guardian of changes to authorized users; (2) periodically audit your user accounts who have access to the Administrative Systems to validate that all access is still required; and (3) indemnify Guardian for any liability to Guardian caused by your plan's access to the Administrative Systems or your failure to provide updated user information to Guardian, including but not limited to the failure to terminate a user's access to the Administrative Systems once access is no longer required. Further, by signing below you also agree to receive electronic versions of Guardian plan materials and related documents, and Guardian's initial and annual Customer Privacy Notices in lieu of paper copies You understand that you may change this election by providing Guardian thirty (30) days prior written notice.

By: _____ _____
Signature, Company Representative Date

_____
Printed Name and Title, Company Representative

GG-017945

Lumpkin County Board of Commissioners

Firm Cost Summary

July 1, 2024

		HM Current	HM Renewal	HM Option 1
Administration				
Healthgram				
Medical, Rx Claims Administration	169	$27.60	$28.75	$28.75
COBRA Administration	169	$1.50	$1.50	$1.50
Utilization Management	169	$3.75	$3.75	$3.75
Healthgram Connect	169	$7.50	$7.50	$7.50
Tobacco Cessation	hourly	$60.00	$70.00	$70.00
PBM Interface Fee	169	$2.50	$3.00	$3.00
Other				
Health Partners Network Access Fee	169	$2.50	$2.50	$2.50
Veracity Service Fee	169	$12.00	$12.00	$12.00
Stop Loss				
Specific Contract				
Deductible		$75,000	$75,000	$75,000
Contract Type		36/12	48/12	48/12
Covered Benefits		Med/Rx	Med/Rx	Med/Rx
Additional Laser Liability		$175,000	$0	$0
Premium: Single	111	$181.17	$200.39	$210.41
Family	58	$466.07	$505.81	$531.10
Change from Current			**9.4%**	**14.9%**
Aggregate Contract				
Contract Type		36/12	48/12	48/12
Covered Benefits		Med/Rx	Med/Rx	Med/Rx
Premium	169	$8.80	$8.80	$8.80
Attachment Factors: Single	111	$842.61	$769.57	$769.57
Family	58	$2,022.26	$1,846.96	$1,846.96
Annual Attachment Point		$2,529,849	$2,310,551	$2,310,551
Change from Current			**-9%**	**-9%**
No-New-Laser at Renewal/ Rate Cap		Yes; 50%	Yes; 50%	Yes; 50%
Experience Refund		Not Included	Not Included	Included
Retiree Coverage		Not Included	Not Included	Not Included
Stop Loss Commission		0.00%	0.00%	0.00%
Expected Annual Exposure				
Healthgram Administration		$86,900	$90,246	$90,246
Other Administration		$29,406	$29,406	$29,406
Stop Loss Premiums		$583,550	$636,810	$667,758
Expected Annual Claim Cost		$2,023,880	$1,848,441	$1,848,441
Additional Liability		$175,000	$0	$0
Total Expected Annual Cost		**$2,898,735**	**$2,604,903**	**$2,635,851**
Total Maximum Annual Exposure		$3,404,705	$3,067,013	$3,097,962

Notes and Contingencies:

1. If a non-preferred or third-party vendor is selected, additional administrative fees and applicable agreements may apply.
2. ProCare is the assumed PBM.
3. No percentage of savings or per claim fees for out-of-network claim processing.
4. No claim audit or edit fees.
5. Healthgram may receive contingent compensation (override ranging from 0-4%) as a result of stop loss carrier volume and/or performance. This compensation, if received, does not impact premium rates in current nor future policy periods.
6. Subrogation provided for 25% of recovery.
7. Case Management and Maternity Management will increase to a rate of $165.00 per hour.
8. Condition Management will increase to a rate of $70.00 per hour.
9. Required Notices Annual fee = $500.00
10. NY Pool Annual fee = $500.00
11. MHPAEA analysis = $2,000.00
12. **Firm through 5/13.**