Report of the Collaborative Benefits Committee

February 14, 2012
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Committee Members

Honorable Jamie Benoit  Honorable Dick Ladd
County Council District 4                County Council District 5

Honorable Jerry Walker  Craig Oldershaw
County Council District 7                IAFF 1563 President

Mike Akers  Jean Tinsley
AFSCME 582 President                Non-Represented
Employee Representative

Andrea Fulton  Richard Drain
Personnel Officer                Controller

John Hammond
Budget Officer
Committee Facilitator

February 14, 2012
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The Honorable John R. Leopold  
County Executive  
Arundel Center  
Calvert & Northwest Streets  
Annapolis, Maryland 21401

Members of the Anne Arundel County Council  
Arundel Center  
Calvert & Northwest Streets  
Annapolis, Maryland 21401

Dear Mr. Leopold & Members of the County Council:

I am pleased to forward you a copy of the Report of the Collaborative Benefits Committee which was formed by the adoption of Resolution 50-11 on September 6, 2011. Members of the Committee met weekly starting September 27 through the end of the year and heard a number of presentations on various aspects of County benefits. Considerable focus was placed on the retiree health benefit as it presents significant funding challenges to the County.

The report contains a number of recommendations designed to address the cost of County benefits and bring them more in line with surrounding counties and the private sector. Many of these recommendations will require action on the part of the County Council as changes to the County Code are required to implement some changes. Additionally, other changes will require agreement from various labor groups, as the changes are subjects to collective bargaining.

The discussions of the Committee were at times spirited but never contentious. Unanimity on the Committee's recommendations was not achieved as demonstrated by the Minority Report which is attached to the report. However, overall the report can serve as a blue print to the policymakers as they deal with the issues surrounding County benefits.

I would be remiss if I did not recognize the considerable efforts of Jessica Leys of the Office of the Budget and John Peterson and Judi Lohn of the Office of Personnel, in assisting the Committee in its work. Also I should acknowledge the contributions of Alex Leblanc and Terrence Pringle of AON
Hewitt Consulting, Leon Kaplan of PRM Consulting, Tom Lowman of Bolton Partners, and Charles Mannion from the County Auditor’s Office who were regular attendees of Committee meetings and provided valuable insights into the issues considered by the Committee.

The Committee is available to make a personal presentation to you of the Committee’s work.

Sincerely,

[Signature]

John R. Hammond
Committee Member and Meetings Facilitator
# Report of the Collaborative Benefits Committee

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Executive Summary
Report of the Collaborative Benefits Committee
Executive Summary

The Benefits Collaborative Study Group was created as a result of the passage of Resolution 50-11 (Appendix A), adopted by the County Council on September 6, 2011. The Study Group was created to:

1. review existing employment and post-employment benefits provided by the County;
2. assess the impact of the continued increase in the costs of the benefits on current and projected revenues and expenditures of the County;
3. determine fair and equitable priorities in the reduction of the benefit costs, ensuring that the benefits are fair to employees, retirees, and taxpayers of the County and can be funded on a fiscally sustainable basis; and
4. report to the County Executive and County Council recommendations on fair and equitable reductions of continued benefit costs.

Conforming to the provisions of the resolution, the Committee was composed of the following members:

Jamie Benoit – County Councilman – District 4
Richard Ladd – County Councilman – District 5
Jerry Walker – County councilman – District 7
Craig Oldershaw – Local 1563 IAFF
Mike Akers – Local 582 AFSCME
Jean Tinsley – Non-represented Employees
Andrea Fulton – Personnel Officer
Richard Drain – Controller
John Hammond – Budget Officer

The County provides a considerable list of benefits to its employees,

- including 14 or 15 paid holidays
- two to five weeks annual leave
- 15 days disability leave
- a personal day
- family health insurance at either a 90/10 or 80/20 cost share depending on plan
- retiree health insurance at an 80/20 cost share
- defined benefit pension benefit that provides for 20-and-out retirement for public safety employees and a maximum benefit of 70% of final earnings plus an additional 6% for eligible military service and 30-and-out for non-uniform employees with a maximum benefit of 60% of final earnings plus up to 6% for eligible military service. Employees contribute between 4% and 7.25% of salary depending upon pension plan.
- Term life insurance during employment
- Optional life insurance continuing into retirement
The Committee focused its efforts on three benefit categories: employee health insurance, retiree health insurance, and employee pension benefits. The majority of the Committee’s efforts were placed upon the retiree health benefit because of the significant funding issues associated with this particular benefit. This benefit also required significant review of the employee health insurance benefit since the two benefits are so closely related.

**Health Care Costs**

The past two decades have seen an historic escalation in the cost of healthcare as a number of forces have come together to create a “perfect storm”. These include:

- advances in medical technology that have resulted in more expensive treatments that have extend expected life spans
- discovery of miracle drugs that can successfully treat medical conditions further extending life spans
- demographic trends as the post-war baby boomers in large numbers are now reaching Medicare eligibility, swelling the post-65 population

The County’s health care costs over the recent years are shown in the following graph and reflect the impact of these trends.

These rapidly rising costs have been a significant contributor to the ever increasing expense of County benefits for its employees.

**Other Factors Impacting County Benefit Costs**

- **GASB 45** – A statement from the Government Accounting Standards Board that requires governments to recognize the cost of their post-employment benefits
other than pension benefits (which are governed by another GASB statement requiring disclosure of liabilities). The requirement became effective in 2004 and has been responsible for the focus of governments on the retiree health benefit. For Anne Arundel County, at a favorable 8% discount rate, this liability totals $672.7 million across the County government, the Community College and the Public Library. The annual cost of this benefit, on a fully funded basis, is $69.16 million. Rather than recognizing the full annual cost of this benefit however, the County has been funding just the PayGo portion of the benefit which is $21 million or annually. Thus the county has been under funding this benefit by $48.16 million (the “funding hole”) which gives rise to today’s $672.7 million liability.

- **Patient Protection and Affordable Care Act** - The passage of the Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148) has introduced many new provisos to employers in the provision of health care, including the requirement to cover children up to the age of 26 who do not have health insurance coverage available to them, prospective limits on Flexible Spending Accounts, excise taxes on “Cadillac” insurance plans, and Medicare compensation changes such as bundled payment based on an episode of care. The promise of this legislation is "to bend" the healthcare cost “curve”, but many fear that instead it will increase healthcare costs. Additionally, the Supreme Court has recently agreed to hear an appeal to lower court decisions dealing with the constitutionality of the statute.

- **Medicare Solvency** – Again the impact of the post-war baby boom is being felt here as the number of Medicare (and Social Security) eligible individuals are drawing benefits which are severely straining the available program funds. The insolvency of Medicare or benefit and funding changes adopted to avoid insolvency could place an increased burden on employers, including the County.

**Major Benefit Program Costs**

The two tables below summarize the cost to the County of its major benefit programs:

<table>
<thead>
<tr>
<th>Unit</th>
<th>Salaries</th>
<th>FICA &amp; Medicare Amount</th>
<th>FICA &amp; Medicare %</th>
<th>Health Insurance Amount</th>
<th>Health Insurance %</th>
<th>Pension Contribution Amount</th>
<th>Pension Contribution %</th>
<th>Retiree Health Amount</th>
<th>Retiree Health %</th>
</tr>
</thead>
<tbody>
<tr>
<td>County</td>
<td>206,341,900</td>
<td>12,966,100</td>
<td>6.3%</td>
<td>39,958,300</td>
<td>19.4%</td>
<td>48,165,000</td>
<td>23.3%</td>
<td>17,900,000</td>
<td>8.7%</td>
</tr>
<tr>
<td>BOE</td>
<td>577,894,000</td>
<td>41,665,000</td>
<td>7.2%</td>
<td>126,919,000</td>
<td>22.0%</td>
<td>8,885,000</td>
<td>1.5%</td>
<td>30,000,000</td>
<td>5.2%</td>
</tr>
<tr>
<td>College</td>
<td>52,669,100</td>
<td>4,000,000</td>
<td>7.6%</td>
<td>8,528,000</td>
<td>16.2%</td>
<td>525,000</td>
<td>1.0%</td>
<td>1,006,000</td>
<td>1.9%</td>
</tr>
<tr>
<td>Library</td>
<td>9,939,000</td>
<td>770,000</td>
<td>7.7%</td>
<td>3,129,800</td>
<td>31.5%</td>
<td>226,000</td>
<td>2.3%</td>
<td>500,000</td>
<td>5.0%</td>
</tr>
</tbody>
</table>

1 State pension system picks up majority of pension cost for BOE, College & Library
2 Actual budget amount on a PayGo basis.
Major Benefit Costs by Component Unit

<table>
<thead>
<tr>
<th>Unit</th>
<th>Total Budget</th>
<th>Salaries</th>
<th>Salaries as a % of Budget</th>
<th>Benefits</th>
<th>Benefits as a % of Budget</th>
<th>Total Salaries &amp; Benefits</th>
<th>Total as a % of Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>County</td>
<td>533,017,300</td>
<td>206,341,900</td>
<td>38.71%</td>
<td>118,989,400</td>
<td>22.32%</td>
<td>325,331,300</td>
<td>61.04%</td>
</tr>
<tr>
<td>BOE</td>
<td>911,227,000</td>
<td>557,894,000</td>
<td>63.42%</td>
<td>207,469,000</td>
<td>22.77%</td>
<td>785,363,000</td>
<td>86.2%</td>
</tr>
<tr>
<td>College</td>
<td>102,976,100</td>
<td>52,669,100</td>
<td>48.8%</td>
<td>14,059,000</td>
<td>13.65%</td>
<td>66,728,100</td>
<td>64.8%</td>
</tr>
<tr>
<td>Library</td>
<td>18,417,600</td>
<td>9,939,000</td>
<td>53.96%</td>
<td>4,627,000</td>
<td>25.12%</td>
<td>14,566,000</td>
<td>79.1%</td>
</tr>
</tbody>
</table>

A third perspective on benefit cost to the County is on the basis of an average County employee. The table below provides selected employee amounts (normal cost amounts for pension and retiree health).

<table>
<thead>
<tr>
<th>Employee</th>
<th>Salary</th>
<th>FICA &amp; Medicare</th>
<th>Health Insurance Coverage</th>
<th>Pension</th>
<th>Retiree Health Insurance</th>
<th>Total Benefits</th>
<th>Total as a % of Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintenance Worker I</td>
<td>33,300</td>
<td>2,500</td>
<td>11,200</td>
<td>3,200</td>
<td>4,400</td>
<td>21,300</td>
<td>63.96%</td>
</tr>
<tr>
<td>Management Aide</td>
<td>50,500</td>
<td>3,900</td>
<td>13,600</td>
<td>7,700</td>
<td>4,400</td>
<td>29,600</td>
<td>58.61%</td>
</tr>
<tr>
<td>Accountant III</td>
<td>81,200</td>
<td>6,200</td>
<td>13,500</td>
<td>7,900</td>
<td>4,400</td>
<td>32,000</td>
<td>39.41%</td>
</tr>
<tr>
<td>Fire Fighter III</td>
<td>63,600</td>
<td>4,900</td>
<td>13,500</td>
<td>15,900</td>
<td>6,600</td>
<td>40,900</td>
<td>64.31%</td>
</tr>
<tr>
<td>Police Corporal</td>
<td>69,800</td>
<td>1,000</td>
<td>13,900</td>
<td>16,700</td>
<td>7,700</td>
<td>39,300</td>
<td>56.30%</td>
</tr>
<tr>
<td>Detention Officer</td>
<td>48,500</td>
<td>3,700</td>
<td>10,100</td>
<td>7,400</td>
<td>6,700</td>
<td>27,900</td>
<td>57.53%</td>
</tr>
<tr>
<td>Deputy Sheriff I</td>
<td>46,300</td>
<td>3,500</td>
<td>10,200</td>
<td>7,100</td>
<td>6,700</td>
<td>27,500</td>
<td>59.40%</td>
</tr>
</tbody>
</table>

Committee Principles

During the discussions of the committee a set of principles that should be applied to the Committee’s work evolved. These principles were:

1. The County’s benefits should be “fair”. They should be in the middle of the pack for the County’s peer group that includes Baltimore City, Baltimore County, Howard County, Calvert County, Prince George’s County, Montgomery County and the State of Maryland.
2. The savings to the County from any benefit changes should be utilized to prefund the retiree health insurance benefit. Until a trust is formally established, savings from implemented benefit changes shall be walled off based on a “lockbox” plan from the general fund.

3. The impact of benefit changes should be spread across the spectrum of impacted groups: new employees, current employees, and retirees.

Legal Issues

The Committee considered a number of legal issues involved with the provision of various benefits and the ability of the employer to modify benefits for current employees and retirees. The County Office of Law provided a risk matrix to demonstrate the different legal issues presented by individual benefit changes on different groups of employees and retirees. Generally pension changes to current retirees and employees present more legal issues than modification to employee health care and retiree health care. Additionally, labor contract provisions come into play further impacting the ability to modify benefits.

A further legal issue was the creation of a “lockbox” to wall off savings from the modification of existing benefits so as to provide a funding source for the retiree health insurance benefit. This will involve the need for a Charter Amendment and the creation of an eventual trust to hold the assets of a pre-funded retiree health care fund.

Public & Private Sector Comparisons

The Committee reviewed several presentations comparing County salaries to other counties in the metropolitan region, as well as comparisons of health insurance benefits, retiree health insurance benefits and pension benefits. (Appendix H) These comparisons demonstrate that with respect to salaries Anne Arundel County is generally in the middle of the group for the job classifications of local governments. With respect to health benefits, the County offers a comparably better benefit package; but the overall cost to the employee is slightly better because of a more favorable employer cost share than many other jurisdictions provide and relatively favorable out of pocket limitations.

For the retiree health benefit the County again compares quite favorably to other jurisdictions, particularly with respect to the five year vesting provision for non-public safety employees and with a benefit that provides an 80-20 cost share regardless of years of service.

The pension benefit provided by the County is at least as comparable to other jurisdictions and does offer relatively low employee contribution rates and certainly at least average annual accrual rates, with favorable age and service provisions for drawing the benefit, including a DROP program for police and fire pension plan members.

The County’s benefits far exceed those available in the private sector, particularly with respect to employee health care, pension, and retiree health care. Generally private employers provide a lower cost share to employees for the health care benefit. With respect to a pension benefit, the private sector utilizes a 401k program with limited employer matching contributions,
rather than a defined benefit pension. Lastly, it is the rare private sector employer who is providing a retiree health care benefit for new employees.

**Significant Findings**

- **Employee Heath Insurance**
  The benefit offered by Anne Arundel County is generous when compared to other public sector employers in the region, particularly with respect to the low co-pays and out of pocket requirements. This situation provides little economic incentive for the user to manage his/her own health condition so as to mitigate costs to the consumer. Additionally the cost share provision at 90/10 for the two HMO plans and 80/20 for Triple Choice, as well as 100% for the dental and vision plans, is quite favorable compared to other jurisdictions (with the notable exception of the Anne Arundel County Board of education which provides a 997/3 cost share plan for some of its employees) and the private sector.

- **Retiree Health Benefit**
  The retiree health benefit is of the most concern for the County, as it is a benefit that the County is funding on a PayGo basis. This is an unsound financial practice. Absent a plan to address this liability, it will continue to spiral upwards and eventually strangle the County’s ability to provide for current services. This is a very unpleasant prospect for County taxpayers and would in all likelihood result in County retirees not receiving the promised retiree benefit as a result of a bankruptcy court determination.

  Fortunately the task to reduce the County’s cost of retiree health benefits is facilitated by the number of options available to realize cost savings, and the generosity of the County’s current benefit. Indeed the benefits consultant utilized by some employee groups, Mr. Randy Hart from the firm of CBIZ during his presentation to the Committee on November 15, 2011 (Appendix O), identified the County’s current retiree health benefit as the “gold mine” as far as being able to realize cost savings.

  The present benefit allows non-public safety employees to vest in this benefit after only five years of service; and allows for retirement benefits to start at an early age (20-and-out for public safety and 30-and-out for employees), and provides for an 80/20 cost share.

  Other rich components of the retiree health benefit include:
  - No employee contribution during employment towards the benefit
  - Benefit is not related to years-of-service
  - Transfer of service from the State of Maryland permitted
  - Spousal and dependent coverage provided
  - Terminated vested employees eligible for coverage (5 year vesting)
Pre-65 retiree health benefit is the same health plan as for current employees, it offers the same low co-pays and low deductibles; further adding to the County’s cost of the benefit. Also, the County’s current policies do not take advantage of the possible availability of alternate health care coverage to retirees.

There are lower cost methods to provide supplemental coverage to Medicare eligible retirees than the County’s current wrap program. One alternative is the Connector Plan where the retiree can compare and purchase qualified health and drug plans from the private sector. A Connector Plan provides personalized individual health plans to the retiree, with freedom of choice and the value of the open market. Another advantage is that it incorporates an insurance product, thereby transferring the risk which is currently borne by the County to the insurer.

- **Pension Benefit**

The pension benefit for County employees generally falls above the middle of the pack of surrounding local governments, and is more lucrative than the pension programs of the State of Maryland. The Police Officers and Firefighters plans have individual features (100% Joint & Survivor and DROP) that are quite employee friendly. Employee contributions across-the-board are generally below the median, particularly when the benefit provisions are taken into consideration.

The table below shows the present value of the pension benefit demonstrates how lucrative the County’s pension benefit is.

<table>
<thead>
<tr>
<th>Plan and Retirement Age</th>
<th>Employee Contribution Rate</th>
<th>Initial Annual Pension</th>
<th>Present Value of Benefit</th>
<th>Rate of Return Required*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee – Age 55</td>
<td>4.00%</td>
<td>$24,243</td>
<td>$314,080</td>
<td>16%</td>
</tr>
<tr>
<td>30 Years of Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Police - Age 45</td>
<td>7.25%</td>
<td>$39,690</td>
<td>$634,126</td>
<td>21%</td>
</tr>
<tr>
<td>20 Years of Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fire - Age 50</td>
<td>7.25%</td>
<td>$47,686</td>
<td>$744,476</td>
<td>17%</td>
</tr>
<tr>
<td>25 Years of Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detention - Age 45</td>
<td>6.75%</td>
<td>$32,919</td>
<td>$486,849</td>
<td>21%</td>
</tr>
<tr>
<td>20 Years of Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* The annual rate of return required to be earned on an employee’s contributions in order to realize the present value of the benefit.

There are inconsistent policies in play with the County’s Police and Fire pension plans in that they have a provision to encourage early retirement (20-and-out) and another to encourage continued employment (DROP plan).

Employee contributions to the various public safety plans present an inequity in that the plan benefits are the same for all members of the plan, yet under current conditions, some employees are paying a discount for the same benefit.
Recommendations

The Committee comprehensively reviewed the employee health benefit, retiree health benefit and the pension benefit and analyzed a number of alternatives to each of the benefits. The alternatives are designed to either lower the cost of the retiree health benefit or lower the cost of other benefit programs (current employee health insurance and pension plan) so as to free up existing County funds so that they can be applied to fund the retiree health benefit on a permanent basis. Discussion of these alternatives was spirited, and not all alternatives were unanimously supported by Committee members.

<table>
<thead>
<tr>
<th>#</th>
<th>Alternatives</th>
<th>Action Required</th>
<th>Savings High</th>
<th>Savings Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Plan Design Changes to Employee Health Insurance Plan (Co-pays &amp; Deductibles)</td>
<td>Administrative</td>
<td>$2.90</td>
<td>$2.90</td>
</tr>
<tr>
<td>2</td>
<td>Cost Share – Current Employees HMO Plan only @ 85/15</td>
<td>Negotiate</td>
<td>$6.30</td>
<td>$3.40</td>
</tr>
<tr>
<td>3</td>
<td>Cost Share – Current Employees Dental &amp; Vision Plans at 80/20 split</td>
<td>Negotiate</td>
<td>$0.90</td>
<td>$0.00</td>
</tr>
<tr>
<td>4</td>
<td>Plan Design changes to Retiree Health benefit similar to Employee Plan</td>
<td>Administrative</td>
<td>$1.66</td>
<td>$1.66</td>
</tr>
<tr>
<td>5</td>
<td>Terminated Vested Benefit Adjustment</td>
<td>Legislative</td>
<td>$0.75</td>
<td>$0.75</td>
</tr>
<tr>
<td>6</td>
<td>Eliminate Transferred Service Credit for Retiree Health Benefit</td>
<td>Legislative</td>
<td>$0.10</td>
<td>$0.00</td>
</tr>
<tr>
<td>7</td>
<td>Pre-65 Retirees Graduated Scale Based on an HMO Plan @ 80/20 Max Benefit</td>
<td>Legislative</td>
<td>$3.85</td>
<td>$3.85</td>
</tr>
<tr>
<td>8</td>
<td>10 Year Revised Basic Plan Graduated Scale with Transition Plan (Low – 5 Year Employee Plan)</td>
<td>Legislative</td>
<td>$26.60</td>
<td>$22.40</td>
</tr>
<tr>
<td>9</td>
<td>Eliminate one-time deferral and require utilization of new employer health insurance or available spousal coverage</td>
<td>Legislative</td>
<td>$6.51</td>
<td>$6.51</td>
</tr>
<tr>
<td>10</td>
<td>Pension Plan Consistent Employee Contribution Rates for plan members</td>
<td>Negotiate &amp; Legislative</td>
<td>$0.32</td>
<td>$0.32</td>
</tr>
<tr>
<td>11</td>
<td>Pension Plan 25 Year or Age 55 and 10 years service normal benefit</td>
<td>Negotiate</td>
<td>$1.00</td>
<td>$0.00</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$50.89</strong></td>
<td><strong>$41.79</strong></td>
</tr>
</tbody>
</table>
In addition, the following other recommendations have been made:

1. Establish a trust to insulate health benefit prefunded assets
2. Establish a broad wellness program
3. Create a permanent benefits committee
4. Develop a strategic plan

The $48.16 million “hole” is plugged if all of the “High” recommendations were implemented, while 80% of the “hole” is dealt with if the “Low” recommendations were to be implemented. It is understood that some can be implemented relatively quickly (changes to the retiree health insurance benefit), and others will require more time as they are subject to collective bargaining (employee cost sharing and pension changes).

The full report serves as a blueprint to accomplish the goal of putting the County’s retiree health insurance benefit on a sound fiscal foundation. The reader is encouraged to read the entire report so as to gain a full understanding of the current County benefit provisions, the details of the findings, and the justification for the recommendations.
Committee Report
Report of the Collaborative Benefits Committee

I. Introduction

A. Establishment of Committee

The Benefits Collaborative Study Group was created as a result of the passage of Resolution 50-11 (Appendix A), adopted by the County Council on September 6, 2011. The Study Group was created to:

1. review existing employment and post-employment benefits provided by the County;
2. assess the impact of the continued increase in the costs of the benefits on current and projected revenues and expenditures of the County;
3. determine fair and equitable priorities in the reduction of the benefit costs, ensuring that the benefits are fair to employees, retirees, and taxpayers of the County and can be funded on a fiscally sustainable basis; and
4. report to the County Executive and County Council recommendations on fair and equitable reductions of continued benefit costs.

The resolution also specified that the Study Group be composed of:

1. three members of the County Council, which are filled by Councilman Jamie Benoit, Councilman Jerry Walker and Council Chairman Dick Ladd;
2. three members of the Executive Branch, which are filled by Budget Officer John Hammond, Personnel Officer Ande Fulton, and Controller Richard Drain;
3. three members representing employee groups of the County filled by Craig Oldershaw as a representative of public safety represented employees, Mike Akers as a representative of non-public safety represented employees, and Jean Tinsley as a representative of employees not represented by a bargaining unit.

The resolution finally specified that the Office of the Budget and the Personnel Office will provide technical and staff support to the Study Group, and that an interim report should be completed by October 31, 2011, and a final report and recommendations be completed by December 31, 2011.

The Committee focused its efforts on three benefit categories: employee health insurance, retiree health insurance, and employee pension benefits. The majority of the Committee’s efforts were placed upon the retiree health benefit because of the significant funding issues associated with this particular benefit. This benefit also required significant review of the employee health insurance benefit since the two benefits are so closely related.

The Committee also has focused on the benefits applicable to Anne Arundel County employees. While the County is the primary funder of the Board of Education, Community College and Library, these organizations are governed by independent boards which control the pay and benefit structure for their organizations. Additionally, for the Board of Education and the Community College, the pension benefit is provided primarily by the State of Maryland. It is anticipated that to the extent that the County makes cost saving changes to its benefits, that its component units would take similar action so as to bring all units into general conformity.
B. Background

1. Healthcare Costs

The past two decades have seen an historic escalation in the cost of healthcare as a number of forces have come together to create a “perfect storm”. Medical research has been quite successful in developing new techniques for medical care and diagnosis tools to identify medical problems early in their development so that treatment can be successful. Additionally the drug industry has developed “wonder drugs” that have extended the expected life of Americans. These forces, while increasing the life expectancy of the population have thereby had a consequent impact on the utilization of healthcare services as older members of society are large consumers of healthcare services. Additionally, the aging of the post war baby boomers is adding dramatically to the percentage of the population that is Medicare eligible, and is a trend that will continue to grow for the next two decades, thereby placing an ever increasing demand for health care services. These forces have resulted in increased healthcare costs and are reflected in the recent healthcare costs confronting the County, as seen in the following chart:

Chart 1

These rapidly rising costs have been a significant contributor to the ever increasing expense of County benefits for its employees. Consequently, any examination of County benefits requires a detailed focus on its healthcare benefits, both for current employees as well as retirees.

The Government Finance Officers Association has identified six “Leverage Points” that governments should focus on in order to manage these increasing costs:
1. Change the level of the benefit provided. Modify how many and what type of benefits the plan provides and who they provide them to
2. Manage participants’ choice of providers. Direct or even limit health plan participants’ choices to lower-cost providers.
3. Share cost with employees. Structure the health plan so that employees bear part of the burden of benefit costs.
4. Reduce use of health care services by employees. Address the economic incentives and actual need for health care services.
5. Right-source health benefits services. Use the right combination of outsourced service providers and providers within a network to deliver health benefits.
6. Maximize the value received for the health care dollar. Rather than just minimizing costs, consider the benefit received per dollar spent on health benefits.

(Appendix B -- *Containing Health Care Costs*; Shyne C. Kavanagh, Senior Manager of Research, GFOA Research & Consulting Center, 2011). The findings and recommendations contained in this report are consistent with these “Leverage Points.”

2. GASB 45

As previously mentioned, the retiree health benefit presents a significant funding issue to Anne Arundel County. These funding issues were brought into clear focus with the issuance of Statement Number 45 by the Governmental Accounting Standards Board (GASB) in June of 2004 that addressed the Accounting and Financial Reporting for Employers for Postemployment Benefits Other Than Pensions. This Statement established requirements that standardize the methods used to account for non-pension post employment benefits, commonly referred to as “other post employment benefits” or “OPEB”. In order to implement these changes, governments must quantify and recognize the cost of OPEB attributable to former and current employees.

Attempts to quantify these benefits have revealed sizable liabilities for many governments. Consequently those entities have been forced to evaluate their fiscal ability to afford the current liability.

Governments offer post employment incentives to their employees as a form of deferred compensation. The most common post employment benefits are pensions and retirement savings programs. However, other forms of these post employment benefits, including continuing healthcare and insurance coverage, are also offered.

GASB established the current accounting and reporting standards for pensions in 1994. Since that time, governments have been required to recognize the costs of the pension benefits during the years that the respective employees are working. Governments typically set aside funds during each budget year to fund the pension costs of its current employees. If funds are not set aside for this purpose, governments must record expenses and liabilities on the financial statements for any annual contributions not set aside. Until the issuance of Statement #45 in 2004, GASB had not required the same treatment for OPEB.

Anne Arundel County has funded its pension plan on a pre-funded basis as required by GASB since 1994. The principle involved is that employee benefits should be funded over the employee’s employment years.

While Anne Arundel County has been pre-funding its pension benefits (which is now approximately 85% funded through a pension fund with $1.3 billion of assets), it has not set aside funds for OPEB. Instead, costs of these benefits are being recognized on a PayGo basis. For instance, in this fiscal year Anne Arundel County will recognize health insurance premiums
paid for those retirees currently covered by County health benefits. Therefore, the County is not recording the post retirement health care liability of its former and current employees, but instead is deferring the costs until those premiums are paid. This deferral places the burden of funding the benefits on future government resources and future taxpayers.

GASB Statement 45 requires governments to recognize the value of these incentives as they are earned. The Statement requires that governments actuarially estimate the dollar value of benefits attributable to former vested and current employees, calculate an annual contribution required to pay for these benefits, and either set aside the contribution in a trust, or record the unfunded contribution as a liability on the financial statements. In FY2012, the total liability for the County, Community College and Library System for FY2012 is nearly $1.2 billion at a 4% discount rate. At an 8% discount rate this liability is $672.7 million.

Obviously, the assumed interest rate utilized to value the liability has a significant impact on the reported size of the liability. Which interest rate to utilize may be a function of the purpose of the measurement, which may include:

- Funding: Determining the County’s contribution to prefund the benefit
- Accounting: Determining the County’s accounting expense
- Value to members: Determining the market value of the promise to participants

Each of these purposes may result in a different interest rate to be utilized. Appendix C provides a detailed discussion on this topic. For the balance of this report, an 8% discount rate has been utilized for issues related to funding. For purposes of value of benefits to members, a 4% discount rate has been employed.

3. Patient Protection and Affordable Care Act

The passage of the Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148) has introduced many new provisos to employers and the provision of health care, including the requirement to cover children up to the age of 26 who do not have health insurance coverage available to them, prospective limits on Flexible Spending Accounts, excise taxes on “Cadillac” insurance plans, and Medicare compensation changes such as bundled payment based on an episode of care. Other provisions require the elimination of the consideration of pre-existing conditions in the underwriting of policies and the elimination of the coverage gap (“doughnut hole”) in the Part D (Drug) coverage of Medicare in 2020 (A comprehensive review of the PPACA is contained in Appendix D). The promise of this legislation is "to bend" the healthcare cost “curve”, but many fear that instead it will increase healthcare costs. Additionally, the Supreme Court has recently agreed to hear an appeal to lower court decisions dealing with the constitutionality of the statute.

4. Medicare Solvency

Much has been written lately concerning the solvency of not only Medicare, but the entire Social Security program. With the aging of the post-war baby boomers, the number of Social Security and Medicare eligible recipients is growing rapidly and their expected life span is also growing. These factors are rapidly accelerating the cash drain on the Social Security and Medicare programs and the forecasts are that they will be bankrupt in the next 30 years unless program changes are undertaken. In 1983, some changes were made to the Social Security system such that the full retirement age has gradually been increased to age 67. However the Medicare eligibility age still remains at 65. Given the funding status of these two programs, it is
not unreasonable to assume that changes will be required in order to sustain them. An obvious prospective change is to further increase the Social Security retirement age as well as increase the age for Medicare eligibility. It is indeed inconsistent to have the current situation where Medicare eligibility begins at 65, while the standard Social Security eligibility age is 67. Given the changing demographics of the country, it is not unreasonable to believe that both programs will at some point in the near future arrive at an eligibility age of at least 70.

The Patient Protection and Affordable Care Protection Act as well as the current fiscal status of Medicare (and Social Security) have introduced additional complications and uncertainty to the County’s benefits programs. Ideally the County’s benefits program should be integrated with federal programs so as to be mutually beneficial. However, the uncertainty as to the legal status of the Patient Protection and Affordable Care Protection Act and its consequent impact on health insurance costs have significant cost implications for the County’s retiree health benefit as well as its health insurance program for current employees. Additionally, the fiscal condition of Medicare has further implications on the County’s retiree health benefit, particularly to the extent that the County’s plan is integrated with Medicare. Lastly, the fiscal status of Social Security and its impact upon increasing the Social Security retirement age will undoubtedly have an impact on County pension costs (perhaps a favorable impact if employees work longer).

C. Benefit Cost Overview

The County and its component units currently appropriate significant funds for the provision of benefits to its employees as shown in the table below for FY2012.

<table>
<thead>
<tr>
<th>Table 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>County Funding of Major Employee Benefits</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unit</th>
<th>Salaries</th>
<th>FICA &amp; Medicare Amount</th>
<th>Health Insurance Amount</th>
<th>Pension Contribution Amount</th>
<th>Retiree Health Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>County</td>
<td>206,341,900</td>
<td>12,966,100 6.3%</td>
<td>39,958,300 19.4%</td>
<td>48,165,000 23.3%</td>
<td>17,900,000 8.7%</td>
</tr>
<tr>
<td>BOE</td>
<td>577,894,000</td>
<td>41,665,000 7.2%</td>
<td>126,919,000 22.0%</td>
<td>8,885,000 1.5%</td>
<td>30,000,000 5.2%</td>
</tr>
<tr>
<td>College</td>
<td>52,669,100</td>
<td>4,000,000 7.6%</td>
<td>8,528,000 16.2%</td>
<td>525,000 1.0%</td>
<td>1,006,000 1.9%</td>
</tr>
<tr>
<td>Library</td>
<td>9,939,000</td>
<td>770,000 7.7%</td>
<td>3,129,800 31.5%</td>
<td>226,000 2.3%</td>
<td>500,000 5.0%</td>
</tr>
</tbody>
</table>

\[1\] State pension system picks up majority of pension cost for BOE, College & Library

\[2\] Actual budget amount on a PayGo basis.

Another perspective of the benefit costs is in relation to the overall budgets of the component units.

<table>
<thead>
<tr>
<th>Table 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Benefit Costs by Component Unit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unit</th>
<th>Total Budget</th>
<th>Salaries</th>
<th>Salaries as a % of Budget</th>
<th>Benefits</th>
<th>Benefits as a % of Budget</th>
<th>Total Salaries &amp; Benefits</th>
<th>Total as a % of Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>County</td>
<td>533,017,300</td>
<td>206,341,900</td>
<td>38.71%</td>
<td>118,989,400</td>
<td>22.32%</td>
<td>325,331,300</td>
<td>61.04%</td>
</tr>
<tr>
<td>BOE</td>
<td>911,227,000</td>
<td>557,894,000</td>
<td>63.42%</td>
<td>207,469,000</td>
<td>22.77%</td>
<td>785,363,000</td>
<td>86.2%</td>
</tr>
<tr>
<td>College</td>
<td>102,976,100</td>
<td>52,669,100</td>
<td>48.8%</td>
<td>14,059,000</td>
<td>13.65%</td>
<td>66,728,100</td>
<td>64.8%</td>
</tr>
<tr>
<td>Library</td>
<td>18,417,600</td>
<td>9,939,000</td>
<td>53.96%</td>
<td>4,627,000</td>
<td>25.12%</td>
<td>14,566,000</td>
<td>79.1%</td>
</tr>
</tbody>
</table>
A third perspective on benefit cost to the County is on the basis of an average County employee. The table below provides selected employee amounts (normal cost amounts for pension and retiree health).

Table 3

<table>
<thead>
<tr>
<th>Employee</th>
<th>Salary</th>
<th>FICA &amp; Medicare</th>
<th>Health Insurance Coverage</th>
<th>Pension</th>
<th>Retiree Health Insurance</th>
<th>Total Benefits</th>
<th>Total as a % of Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintenance Worker I</td>
<td>33,300</td>
<td>2,500</td>
<td>11,200</td>
<td>3,200</td>
<td>4,400</td>
<td>21,300</td>
<td>63.96%</td>
</tr>
<tr>
<td>Management Aide</td>
<td>50,500</td>
<td>3,900</td>
<td>13,600</td>
<td>7,700</td>
<td>4,400</td>
<td>29,600</td>
<td>58.61%</td>
</tr>
<tr>
<td>Accountant III</td>
<td>81,200</td>
<td>6,200</td>
<td>13,500</td>
<td>7,900</td>
<td>4,400</td>
<td>32,000</td>
<td>39.41%</td>
</tr>
<tr>
<td>Fire Fighter III</td>
<td>63,600</td>
<td>4,900</td>
<td>13,500</td>
<td>15,900</td>
<td>6,600</td>
<td>40,900</td>
<td>64.31%</td>
</tr>
<tr>
<td>Police Corporal</td>
<td>69,800</td>
<td>1,000</td>
<td>13,900</td>
<td>16,700</td>
<td>7,700</td>
<td>39,300</td>
<td>56.30%</td>
</tr>
<tr>
<td>Detention Officer</td>
<td>48,500</td>
<td>3,700</td>
<td>10,100</td>
<td>7,400</td>
<td>6,700</td>
<td>27,900</td>
<td>57.53%</td>
</tr>
<tr>
<td>Deputy Sheriff I</td>
<td>46,300</td>
<td>3,500</td>
<td>10,200</td>
<td>7,100</td>
<td>6,700</td>
<td>27,500</td>
<td>59.40%</td>
</tr>
</tbody>
</table>

Other benefits available to County employees include:
1a. 14 paid holidays per year (15 every other year for Election Day)
1b. 15 paid holidays per year for public safety employees
2. Annual Leave

<table>
<thead>
<tr>
<th>Years of Service</th>
<th>Leave Per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 3</td>
<td>13 Days</td>
</tr>
<tr>
<td>3 to less than 15</td>
<td>20 Days</td>
</tr>
<tr>
<td>15 or more</td>
<td>26 Days</td>
</tr>
</tbody>
</table>

3. Disability Leave – 15 days per year
4. Personal Leave – 1 day
5. Term life insurance during employment
6. Optional life insurance continuing into retirement

D. Principles Utilized by the Committee

During the discussions of the committee a set of principles that should be applied to the Committee’s work evolved. These principles were:
1. The County’s benefits should be “fair”. They should be in the middle of the pack for the County’s peer group that includes Baltimore City, Baltimore County, Howard County, Calvert County, Prince George’s County, Montgomery County and the State of Maryland.
2. The savings to the County from any benefit changes should be utilized to prefund the retiree health insurance benefit. Until a trust is formally established, savings from implemented benefit changes shall be walled off based on a “lockbox” plan from the general fund.

3. The impact of benefit changes should be spread across the spectrum of impacted groups: new employees, current employees, and retirees.

II. Legal Issues

One of the important considerations of the Committee during its deliberations was the legal implications of making changes to County benefits. The Committee received input from the County’s Office of Law on many legal issues pertaining to health and pension benefits. Generally speaking pension benefits have been interpreted by the courts to be protected under the contract clause of the U.S. Constitution when such benefits are prefunded by contributions made by an employer and employee during an employee’s active period of employment. This has the practical impact of making it difficult to retroactively reduce benefits to current retirees and vested members of a pension plan. Prospective changes can be made, but for those employee groups represented by a collective bargaining unit, any changes must be arrived at through the bargaining process.

Health benefits on the other hand offer more flexibility from a legal standpoint because they are not prefunded in the manner of pension benefits. The cost of health benefits for current employees can be modified; however, for represented employees the benefit is a subject of collective bargaining. The County cannot unilaterally change the cost share of health benefits for those employees who are members of a collective bargaining unit. The components of the group health insurance plan (plan design) can be modified by the County within reason outside of the collective bargaining process.

The cost share of retiree health insurance, on the other hand is not a subject of collective bargaining (with the exception of the FOP). The cost share of retiree health insurance is codified in the Personnel Article of the County Code in Section 6-1-308(b)(3) and it is currently established that an eligible retiree pays 20% of the cost of a group insurance policy and the County pays the remaining 80% (Appendix E contains the County Code provision). As with active employees the components of the group health insurance plan design can be modified by the County within reason outside of the collective bargaining process. It is also interesting to note that the retiree health provision of the County Code is written in terms of “retiree coverage” which means the County’s current practice of allowing retirees to purchase dependent coverage is entirely gratuitous.

Appendix F contains a memo from Deputy County Attorney David A. Plymyer in which a “risk matrix” for making changes to the retiree health insurance benefit is listed.

Another topic that received a great deal of consideration was the concept of creating a mechanism to receive employer contributions to a fund for the pre-funding of the retiree health insurance benefit, similar to the method employed by the County to pre-fund its employee pension obligation. The concept is to create a “lockbox” into which the employer contributions would be placed in order to insure that funds would be available to pay the benefit during an employee’s retirement. The “lockbox” would take the form of a trust arrangement and would be an important component of the County’s long term commitment to meet its retiree health insurance promise and give a high degree of assurance to the employees and retirees that the
funds necessary to meet this commitment are secure. A second memo from Mr. Plymyer is incorporated in Appendix G.

III. Public and Private Sector Comparisons

The Committee reviewed several presentations comparing County salaries to other counties in the metropolitan region, as well as comparisons of health insurance benefits, retiree health insurance benefits and pension benefits. (Appendix H) These comparisons demonstrate that with respect to salaries Anne Arundel County is generally in the middle of the group for the job classifications of local governments. With respect to health benefits, the County offers a comparably better benefit package; but the overall cost to the employee is slightly better because of a more favorable employer cost share than many other jurisdictions provide and relatively favorable out of pocket limitations.

For the retiree health benefit the County again compares quite favorably to other jurisdictions, particularly with respect to the five year vesting provision for non-public safety employees and with a benefit that provides an 80-20 cost share regardless of years of service.

The pension benefit provided by the County is at least as comparable to other jurisdictions and does offer relatively low employee contribution rates and certainly at least average annual accrual rates, with favorable age and service provisions for drawing the benefit, including a DROP program for police and fire pension plan members.

While specific salary comparisons were not made with the private sector, it is believed that County salaries are comparable to the private sector. A more detailed benefits survey of large private sector private employers in the County was undertaken. The results show that the County’s benefits are significantly better and are offered at a lower cost to employees (Appendix I). Nationally, the current benefits situation is a result of a significant movement by the private sector to reduce their benefit package because of increasing cost pressure (Appendix J). The private sector has been moving away from defined benefit pension plans over the past two decades and has replaced these plans with either defined contribution plans or simply made 401k plans available to their employees with no employer subsidy (Appendix K). It should be noted however that Calvert (5% employer contribution) and Montgomery (8% employer contribution) counties utilize a defined contribution plan for their general employees.

With respect to a retiree health program, it is the rare private sector employer that continues to provide this benefit. Only 19% of employers offer medical coverage to Medicare eligible retirees, down 40% in 1993 (Mercer National Survey of Employer-Sponsored Health Plans 2010).
Additionally, Towers Watson reports in a survey that 60% of employers who currently offer retiree medical plans are rethinking their programs for 2012 or 2013.

Large private sector employers generally provide an employee health insurance program, and under the Patient Protection and Affordable Care Act all employers will be required to provide a health insurance plan for employees. The cost share for health insurance coverage in the private sector is generally less for the employer than in the public sector. It is the unusual plan in the private sector that would provide employer cost sharing at the 80% level, particularly with benefits comparable to the County’s. Additionally, many private sector employers provide subsidized health insurance coverage only to the employee, making the dependent coverage a greater responsibility of the employee, indeed up to 100% of the cost.

IV. Anne Arundel County Employee Health Insurance Benefit

A. Benefit Description

Anne Arundel County government offers eligible employees the choice of three medical plans: The CareFirst Blue Choice Triple Option plan, CareFirst BlueChoice HMO plan, and CIGNA Open Access In-Network plan. None of these plans impose a pre-existing condition limitation.

The CareFirst Blue Choice Triple Option plan offers three levels of benefits in one health care plan. The benefit level determines the out-of-pocket expenses.

<table>
<thead>
<tr>
<th>Table 4</th>
<th>Triple Choice Benefit Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Level 2</td>
</tr>
<tr>
<td>Network</td>
<td>Referrals Required</td>
</tr>
<tr>
<td>Co-Pays</td>
<td>$5 PCP/$10 Specialist</td>
</tr>
<tr>
<td>Deductible (Individual/Family)</td>
<td>$100/$200</td>
</tr>
<tr>
<td>Out of Pocket Max (Individual/Family)</td>
<td>$500/$1,000</td>
</tr>
<tr>
<td>Lifetime Max</td>
<td>Unlimited except on fertility services &amp; organ transplant</td>
</tr>
<tr>
<td>Co-Insurance</td>
<td>95%/5% Travel &amp; Lodging</td>
</tr>
</tbody>
</table>

Source: 2012 Open Enrollment & Benefits Reference Guide

The CareFirst BlueChoice HMO plan offers a network of credentialed doctors in which the participant chooses a primary care physician (PCP). The PCP provides medical care or refers the participant to the most appropriate BlueChoice specialist or facility. Office visits for illness or preventive care for both the PCP and specialist require a $5 co-pay. Emergency services and inpatient hospitalizations are covered at 100% of the allowed benefit after the co-pay. Out of pocket expenses are maximized at $800 (single) and $1,600 (family) per calendar year. The yearly deductible is $0.

The CIGNA Open Access In-Network plan provides a single network of more than 50,000 credentialed primary and specialty care physicians, hospitals and facilities. This is a referral free, self-directed choice with no Primary Care Physician selection required. The plan provides coverage for both in-network and out-of-network. Primary care and specialist visits have a $5 co-pay. Emergency services and inpatient hospitalizations are covered at 100% of the
allowed benefit. Out of pocket expenses are maximized at $1,100 (single), $2,200 (double), and $3,600 (family) per calendar year. The yearly deductible is $0.

The employee cost share is 20% for BlueChoice Triple Option, 10% for Blue Choice HMO and 10% for CIGNA Open Access In-Network. This amount is a pre-tax deduction from the employee’s biweekly paycheck.

In addition to medical coverage, the healthcare rates provide a prescription drug plan. Regardless of which medical plan an active employee participates, CVS Caremark administers the prescription drug benefit. Co-pay for up to a 30 day supply of prescriptions are $5 for each generic medication, $15 for each brand name medication on the drug list, and $25 for each brand name medication not on the drug list. Co-pay for up to a 90 day supply of prescriptions are $10 for each generic medication, $30 for each brand name medication on the drug list, and $50 for each brand name medication not on the drug list.

All of the health plans also provide for a dental and vision benefit at no cost to the employee. The dental benefit allows the employee to choose either a CIGNA DHMO plan or a CIGNA PPO plan. The DHMO provides for no annual deductible or annual maximum. It is an in-network program that provides for no cost coverage on preventive and diagnostic services and a schedule of benefits for other dental services (restorative, root canal, orthodontia, etc.). The PPO provides both in-network and out-of-network benefits with a $1,000 annual maximum benefit and an annual deductible of $10 per person for individual coverage and $25 per person for family coverage. In-network coverage is similar to the DHMO although for major restorative (crowns, bridges, etc.) and orthodontia requires co-insurance from 50% to 80% and a $1,000 lifetime maximum orthodontia benefit for dependent children applies. Out-of-network reimbursement is based on 90th percentile of reasonable and customary allowances.

The vision coverage is a VSP WellVision© plan which provides both in-network and out-of-network coverage. The plan provides for annual allowances for various vision services including examinations ($40), lenses & frames ($120) or contact lenses ($75), as well as discounts on PRK and LASIK surgery.

The cost to the County and the employee for the various health insurance plans is shown below:

| Table 5A  |
| County Health Insurance Rates |
| Medical Plans | Monthly Total Rate | Monthly County Contribution | Monthly Employee Contribution | Biweekly Employee Contribution (26 Pay Periods) |
| Blue Choice Triple Option | | | | |
| Individual | $684.86 | $547.89 | $136.97 | $63.22 |
| Parent and Child | $1,222.41 | $977.93 | $244.48 | $112.84 |
| Husband and Wife | $1,458.65 | $1,166.90 | $291.75 | $134.64 |
| Family | $1,888.78 | $1,511.02 | $377.76 | $174.33 |
| Blue Choice HMO | | | | |
| Individual | $509.83 | $455.25 | $50.58 | $23.33 |
| Parent and Child | $903.70 | $813.33 | $90.37 | $41.71 |
| Husband and Wife | $1,077.86 | $970.07 | $107.79 | $49.79 |
| Family | $1,355.33 | $1,255.80 | $159.53 | $64.40 |
| CIGNA Open Access Plus In-Network | | | | |
| Individual | $534.82 | $481.34 | $53.48 | $24.68 |
| Parent and Child | $961.04 | $864.94 | $96.10 | $44.30 |
| Husband and Wife | $1,149.01 | $1,028.71 | $114.90 | $52.75 |
| Family | $1,477.37 | $1,320.63 | $167.74 | $68.19 |
### B. Findings

The benefit offered by Anne Arundel County is generous when compared to other public sector employers in the region, particularly with respect to the low co-pays and out of pocket requirements. This situation provides little economic incentive for the user to manage his/her own health condition so as to mitigate costs to the consumer. Additionally the cost share provision at 90/10 for the two HMO plans and 80/20 for Triple Choice, as well as 100% for the dental and vision plans, is quite favorable compared to other jurisdictions (with the notable exception of the Anne Arundel County Board of Education which provides either a 97/3 or 95/5 cost share HMO plan; or a Triple Option plan with either a 92/8 or a 90/10 cost share for its employees), is quite favorable to other jurisdictions and the private sector, and consequently expensive to the County.

### C. Recommendations

Based on the committee’s discussions, including the belief the users of the service should pay for the service, while healthy individuals should be more favorably treated, and in comparison to other jurisdictions the Committee recommends that the following actions be implemented:

1. **Plan Design Changes**

   These are changes in the current plan design including co-pays, deductibles and cost shares. The associated annual savings has been provided by the County’s healthcare consultants, AON Hewitt.

---

**Table 5B**  
**County Dental & Vision Rates**

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Monthly Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CIGNA Dental DM0</strong></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$17.55</td>
</tr>
<tr>
<td>Parent &amp; Child</td>
<td>$35.09</td>
</tr>
<tr>
<td>Husband &amp; Wife</td>
<td>$44.57</td>
</tr>
<tr>
<td>Family</td>
<td>$50.69</td>
</tr>
<tr>
<td><strong>CIGNA Dental PP0</strong></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$39.07</td>
</tr>
<tr>
<td>Parent &amp; Child</td>
<td>$69.30</td>
</tr>
<tr>
<td>Husband &amp; Wife</td>
<td>$89.87</td>
</tr>
<tr>
<td>Family</td>
<td>$99.89</td>
</tr>
<tr>
<td><strong>VSP Vision</strong></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$2.98</td>
</tr>
<tr>
<td>Parent &amp; Child</td>
<td>$5.95</td>
</tr>
<tr>
<td>Husband &amp; Wife</td>
<td>$7.61</td>
</tr>
<tr>
<td>Family</td>
<td>$8.64</td>
</tr>
</tbody>
</table>

Source: 2012 Open Enrollment & Benefits Reference Guide
Table 6

<table>
<thead>
<tr>
<th>Plan Design</th>
<th>Current Benefit</th>
<th>Proposed Change</th>
<th>Cost Savings (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Co-pay</td>
<td>$5 Primary/$5 Specialist $10 Primary/$20 Specialist</td>
<td>$15 Primary/$35 Specialist</td>
<td>$1.0</td>
</tr>
<tr>
<td>Emergency Co-pay</td>
<td>$35 ER/$35 Urgent Care</td>
<td>$75 ER/$35 Urgent Care</td>
<td>$0.1</td>
</tr>
<tr>
<td>Prescription Co-pay</td>
<td>$5/$15/$25</td>
<td>$5/$25/$35</td>
<td>$0.6</td>
</tr>
<tr>
<td>HMO Deductible</td>
<td>$0</td>
<td>$200</td>
<td>$1.0</td>
</tr>
<tr>
<td>Triple Choice Deductible</td>
<td>$200/$400/$600</td>
<td>$250/$500/$1,000</td>
<td>$0.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>$2.9</strong></td>
</tr>
</tbody>
</table>

These changes can be implemented during the next contract period commencing January 1, 2013 and do not require negotiation with represented employee groups.

2. Cost Share

Increase the employee cost share thereby reducing the County’s annual cost. Current cost share is 90/10 for HMO plans, 80/20 for Triple Choice plan, and 100/0 for Dental and Vision plans.

A. Healthcare

Table 7

<table>
<thead>
<tr>
<th>Healthcare - Savings from Cost Share Alternatives</th>
<th>Cost Share</th>
<th>Cost Savings (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HMO Plan only @ 90/10 HMO Plan only @ 85/15 HMO Plan only @ 80/20 HMO Plan only @ 75/25</td>
<td>$ 3.4 $ 6.3 $ 9.2 $12.1</td>
</tr>
<tr>
<td></td>
<td>Triple Choice at dollar amount of 90% of HMO premium Triple Choice at dollar amount of 85% of HMO premium Triple Choice at dollar amount of 80% of HMO premium Triple Choice at dollar amount of 75% of HMO premium</td>
<td></td>
</tr>
</tbody>
</table>

AND

B. Dental & Vision

Table 8

<table>
<thead>
<tr>
<th>Dental &amp; Vision - Savings from Cost Share Alternatives</th>
<th>Cost Share</th>
<th>Cost Savings (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>80/20</td>
<td>$ 0.9</td>
</tr>
</tbody>
</table>
Cost share changes will have to be negotiated with the various represented groups of employees. As the above tables indicate there is significant cost savings available from making a change to the cost share provision. While representative of the various employee groups were less desirous of making any change to the current cost share arrangement, the consensus of the remaining Committee members is that Dental and Vision cost sharing at 80/20 is reasonable and fair, and that a either an 85/15 or 80/20 cost share for health insurance was acceptable.

V. Anne Arundel County Retiree Health Benefit

A. Benefit Description

The health benefits provided to retirees are tied to the retiree’s pension eligibility and retirement. County employees are eligible for retiree health insurance benefits if they are a retiree that currently receives a monthly County retirement pension and have not waived coverage. Once a retiree waives medical coverage, he/she may not elect coverage in the future. Dependents have administratively been eligible if they are a legal spouse, a child up to age 26, or a dependent grandchild for whom the retiree is the legal guardian.

County retirees who are eligible for Medicare must enroll in both Medicare Parts A & B as soon as they are Medicare eligible to have full claims coverage. Retirees who are eligible for Medicare & County health insurance may elect the CIGNA PPO Medicare Wrap plan currently provided by the County. The CIGNA PPO Medicare Wrap plan is designed for benefit eligible retirees and spouses age 65 and over. This plan provides coverage for a variety of medical services and benefits not fully covered by Medicare Parts A & B alone. The CIGNA PPO Medicare Wrap plan is available nationwide and allows members the freedom to visit any provider throughout the country. In general, CIGNA pays the Medicare deductible plus 80% of the patient’s responsibility after the Medicare awarded amount.

County retirees, who are eligible for medical insurance benefits but not eligible for Medicare, may select from the health plans provided to active employees. These plans include The CareFirst Blue Choice Triple Option plan, CareFirst BlueChoice HMO plan, and CIGNA Open Access In-Network plan.

The Retiree cost share is 20% for health coverage (Anne Arundel County Code 6-1-308(b) (3), 100% for dental coverage and 100% for vision. Below is the Anne Arundel County retiree rate schedule for 1/1/12 - 12/31/12:

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Monthly Total Rate</th>
<th>Monthly County Cost</th>
<th>Monthly Retiree Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BLUE CHOICE TRIPLE OPTION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$ 684.86</td>
<td>$ 547.89</td>
<td>$ 136.97</td>
</tr>
<tr>
<td>Parent &amp; Child</td>
<td>$ 1,222.41</td>
<td>$ 977.93</td>
<td>$ 244.48</td>
</tr>
<tr>
<td>Husband &amp; Wife</td>
<td>$ 1,458.63</td>
<td>$ 1,166.90</td>
<td>$ 291.73</td>
</tr>
<tr>
<td>Family</td>
<td>$ 1,098.78</td>
<td>$ 1,011.82</td>
<td>$ 377.76</td>
</tr>
<tr>
<td><strong>BLUE CHOICE HMO</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$ 595.83</td>
<td>$ 494.66</td>
<td>$ 101.17</td>
</tr>
<tr>
<td>Parent &amp; Child</td>
<td>$ 903.70</td>
<td>$ 722.86</td>
<td>$ 180.74</td>
</tr>
<tr>
<td>Husband &amp; Wife</td>
<td>$ 1,077.86</td>
<td>$ 862.29</td>
<td>$ 215.57</td>
</tr>
<tr>
<td>Family</td>
<td>$ 1,395.33</td>
<td>$ 1,116.26</td>
<td>$ 279.07</td>
</tr>
<tr>
<td><strong>CIGNA Open Access Plus In-Network</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$ 534.82</td>
<td>$ 427.85</td>
<td>$ 106.96</td>
</tr>
<tr>
<td>Parent &amp; Child</td>
<td>$ 961.04</td>
<td>$ 768.84</td>
<td>$ 192.21</td>
</tr>
<tr>
<td>Husband &amp; Wife</td>
<td>$ 1,143.01</td>
<td>$ 914.41</td>
<td>$ 228.60</td>
</tr>
<tr>
<td>Family</td>
<td>$ 1,677.37</td>
<td>$ 1,181.89</td>
<td>$ 295.47</td>
</tr>
<tr>
<td><strong>Medicare Supplemental (For Retiree or Spouse Eligible for Medicare due to Age or Disability)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$ 630.69</td>
<td>$ 594.55</td>
<td>$ 126.14</td>
</tr>
<tr>
<td>Husband &amp; Wife</td>
<td>$ 1,261.38</td>
<td>$ 1,099.10</td>
<td>$ 252.28</td>
</tr>
</tbody>
</table>
Table 9B
Retiree Dental and Vision Rates

| CIGNA Dental Plans And YSP Vision Plan (Retires Pay 100% Of Cost For CIGNA Dental And YSP Vision) |
|-----------------------------------------------------|-----------------|-----------------|-----------------|-----------------|
| Individual                                          | Dental Care     | Dental PPO      | Vision          |
|                                                     | (DHMO-network   | (INDEMNITY)     | (VSP)           |
|                                                     | dentist required)|                |                 |
| Individual                                          | $ 17.21         | $ 38.30         | $ 2.92          |
| Parent & Child                                      | $ 34.40         | $ 67.94         | $ 5.83          |
| Husband & Wife                                      | $ 43.70         | $ 88.11         | $ 7.46          |
| Family                                              | $ 49.70         | $ 97.93         | $ 8.47          |

Source: 2012 Open Enrollment & Benefits Reference Guide

In addition to medical coverage, these rates provide a rich prescription drug plan. Despite what medical plan a retiree participates in, CVS Caremark administers the prescription drug benefit. Below is a chart that outlines the coverage provided by CVS Caremark:

Table 10
CVS Caremark Drug Plan Coverage

<table>
<thead>
<tr>
<th>When to Use Your Benefits</th>
<th>CarePlus Retail Pharmacy 2666 Riva Road, Annapolis, MD</th>
<th>Network Retail</th>
<th>CVS/pharmacy</th>
<th>Mail Service Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For immediate and maintenance medication needs</td>
<td>For immediate and maintenance medication needs</td>
<td>For immediate and maintenance medication needs</td>
<td>For maintenance medication needs</td>
</tr>
</tbody>
</table>

**Where:**
The CVS Caremark Retail Program includes more than 64,000 participating pharmacies nationwide, including independent pharmacies and chain pharmacies. To locate a CVS Caremark participating retail network pharmacy in your area, simply click on "Find a Local Pharmacy" at [www.caremark.com](http://www.caremark.com).

**Copays**

<table>
<thead>
<tr>
<th>Copay** up to a 30-Day Supply</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>* $5 for each generic medication</td>
<td>* $12 for each brand-name medication on the drug list</td>
<td>* $22 for each brand-name medication not on the drug list</td>
<td>* $5 for each generic medication</td>
<td>* $15 for each brand-name medication on the drug list</td>
</tr>
</tbody>
</table>

**Refill Limit:**

<table>
<thead>
<tr>
<th>Refill Limit</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>One initial fill plus one refill on maintenance medications up to a 30-day supply</td>
<td>One initial fill plus one refill on maintenance medications up to a 30-day supply</td>
<td></td>
<td>Up to a 90-day supply</td>
</tr>
</tbody>
</table>

**Copay**

<table>
<thead>
<tr>
<th>Copay** up to a 90-Day Supply</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>* $10 for each generic medication</td>
<td>* $30 for each brand-name medication on the drug list</td>
<td>* $50 for each brand-name medication not on the drug list</td>
<td></td>
<td>* $10 for each generic medication</td>
</tr>
</tbody>
</table>

Source: 2012 Open Enrollment & Benefits Reference Guide

For the post-65 prescription drug coverage, the County currently takes advantage of the retiree drug subsidy (RDS) under Medicare. The program was designed to encourage employers to continue offering prescription drug coverage to retirees eligible for Medicare by providing a federal subsidy. Employers receive a tax-free subsidy of approximately 28% of covered prescription drug costs for their retirees, between threshold and limit amounts which are set by Center for Medical Services (CMS) and annually adjusted for inflation. The County receives approximately $900K in subsidy each year. This program will no longer be available to the County as of CY2013 under the Patient Protection and Affordable Care Act (PPACA). For employers with Medicare-eligible retirees, this change will significantly impact their post-
Many employers are re-evaluating their retiree prescription drug offerings in the short term and migrating to an Employer Group Waiver Plan (EGWP). Under a direct-contract EGWP approach, the pre-tax federal subsidiary is set at the national average less the Part D base beneficiary premium. This plan allows the County to remain self-funded, retain the current plan design and take advantage of the government’s tax free opportunities. Unlike the RDS option, the EGWP direct subsidy is a contract with EGWP that includes subsidization for administrative costs and profit margins based on the national average of commercial plans. The estimated savings is 35% over traditional methods of paying for retiree prescription expenses such as self-funding and applying for the RDS Subsidy (Appendix L). The county is pursuing this option for CY2012.

B. Findings

Background

The retiree health benefit is of the most concern for the County as it is a benefit that the County is funding on a PayGo basis. This is an unsound financial practice; and as previously noted, the Government Accounting Standards Board (GASB), through its issuance of Statement Number 45, requires governments to report the liability associated with this benefit as part its annual financial statement. As a consequence of the County’s PayGo funding this liability has been building on the County’s balance sheet and could jeopardize its bond rating (currently AAA by S&P and AA+ by Moody’s), thereby giving rise to increased cost of borrowing to support the County’s capital budget.

The growth in the County’s net OPEB obligation and that of its component units is shown in the table below based upon a 4% discount rate since the past service liability is not currently being funded:

<table>
<thead>
<tr>
<th>Table 11</th>
<th>Growth In OPEB Obligation at 4% Discount Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>County</td>
</tr>
<tr>
<td></td>
<td>2009</td>
</tr>
<tr>
<td>County</td>
<td>$126,826,000</td>
</tr>
<tr>
<td></td>
<td>$192,396,000</td>
</tr>
<tr>
<td></td>
<td>$261,428,000</td>
</tr>
</tbody>
</table>

An actuarial review of the County’s current retiree health benefit has been performed by the County’s actuarial consulting firm, Bolton Partners, in order to quantify the total magnitude of the liability. The following tables summarize the results of the analysis (Appendix M):

<table>
<thead>
<tr>
<th>Table 12</th>
<th>Annual Required Contribution @ 8% Discount Rate, Millions of Dollars</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Emp.</td>
<td>Police</td>
</tr>
<tr>
<td>20.35</td>
<td>10.43</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 13</th>
<th>Actuarial Accrued Liability @ 8% Discount Rate, Millions of Dollars</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Emp.</td>
<td>Police</td>
</tr>
<tr>
<td>147.53</td>
<td>78.78</td>
</tr>
</tbody>
</table>
The affect of Statement Number 45 is an incentive to advance fund this retiree liability over the employee’s working life (normal cost), similar to the County’s current practice (and GASB incentive) of funding an employee’s retirement benefit. The County’s current accrued actuarial liability for retiree health insurance for its current employees and retirees is $672.7 million at an assumed 8% discount rate (includes the Library System and Community College, but not the Board of Education which is an approximately $600 million additional liability). (GASB allows an 8% discount rate if the liability is being funded over a 30 year amortization period, if not a lower interest rate must be utilized. At a 4% interest rate, this liability is $1.3 billion for the County, Library and Community College; including the Board of Education would add $1.3 billion additional liability, or a total of $2.5 billion.) In order to fund this liability over 30 years (past service cost) and fund the additional benefit earned each year by County employees (normal cost), an annual appropriation of $69.16 million is required, again assuming an 8% discount rate. This $69.16 million annual amount compares to the County’s FY2012 $21 million PayGo appropriation for this liability, or an increase of $48.16 million over the current budget’s PayGo appropriation.

This unfunded actuarial accrued liability needs to be addressed and has served as the catalyst for the formation of this Committee. Absent a plan to address this liability, the liability will continue to spiral upwards and eventually strangle the County’s ability to provide for current services. This is a very unpleasant prospect for County taxpayers and would in all likelihood result in County retirees not receiving the promised retiree benefit as a result of a bankruptcy court determination.

Several local governments across the United States (including Vallejo, California, Central Falls, Rhode Island) are currently confronting bankruptcy as a result of benefit promises that now cannot be kept, while several states including New York and California are considering changes in worker’s benefits because of the escalating costs (Appendix N). Closer to home, the State of Maryland has recently implemented a revised pension plan and is considering passing some or all of the responsibility of teacher pensions down to the counties because of dwindling state revenue and the size of the teacher pension liability. Maryland also changed its retiree health benefit by requiring Medicare eligible retirees starting in 2020 (when the “doughnut hole” is closed under the PPACA) to utilize Medicare Part D coverage instead of the state’s drug plan.

In order to address this significant problem, the Committee has spent considerable time researching and considering alternatives described below that will place this benefit on a sound financial foundation. As previously alluded to, the ability to do so is complicated by the dynamic nature of the healthcare environment, which includes rapidly increasing costs and recent federal government action that is currently under review by the Supreme Court.

Fortunately the task to reduce the County’s cost of retiree health benefits is facilitated by the number of options available to realize cost savings, and the generosity of the County’s current benefit. Indeed the benefits consultant utilized by some employee groups, Mr. Randy Hart from the firm of CBIZ during his presentation to the Committee on November 15, 2011 (Appendix O), identified the County’s current retiree health benefit as the “gold mine” as far as being able to realize cost savings.
1. Universal Alternatives

Years of Service

The County’s current retiree benefit is a very rich benefit as demonstrated by the following statistics related to the present value of the benefit (assuming a 4% discount rate) for a retiree with a spouse of the same age under different circumstances:

<table>
<thead>
<tr>
<th>Age</th>
<th>Present Value of Retiree Health Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>45</td>
<td>$398,227 $398,227 $398,227 $621,927 $621,927 N.A.</td>
</tr>
<tr>
<td>55</td>
<td>$356,214 $356,214 $356,214 $439,453 $439,453 $439,453</td>
</tr>
</tbody>
</table>

Shaded area discounted from the benefit at age 60 since benefit cannot be received until age 60 with less than 20 years service

These amounts are substantial, and are a result of the present benefit which allows non-public safety employees to vest in this benefit after only five years of service and allows for retirement benefits to start at an early age (20-and-out for public safety and 30-and-out for employees). Also, there is no employee contribution towards the cost of this benefit, and everyone receives the same cost share (80/20) for the same benefit benefit, regardless of the years of service.

Graduated Scale

The “all-or-nothing” feature of the current County benefit is unusual and very lucrative for those who work for the County for a relatively short time. Most of the plans of other jurisdictions utilize a type of graduated scale for the benefit, tying the amount of the benefit to years of service, and also requiring a considerable long-term commitment to the employer before the employee vests in the benefit. Indeed two of the County’s component units, the Board of Education and the Community College utilize a graduated scale and have a longer vesting period (10 years), as well as capping the benefit at a maximum of a 75/25 cost share (Appendix P). Both of these plans also do not provide for a terminated vested benefit (allow an employee who has vested but not yet eligible for a retirement benefit because of not having achieved retirement age), which the County’s current plan does allow.

Transfer of Credit

A similar issue (perhaps best characterized as a mirror image) involves the transfer of service with the State of Maryland by a new employee to Anne Arundel County. For purposes of a pension benefit, the County gives full credit for time with the State of Maryland in calculating the years of service, as long as the employee works at least five years for the County. The former State employee is required to transfer their contributions to the State’s pension system to the County’s pension system in order to receive credit for their State time in the County system. (It should be noted that the State’s contribution on behalf of the transferred employee does not
come to the County’s pension system, thereby resulting in a windfall gain to the State’s pension system.)

For purposes of the retiree healthcare benefit, the issue becomes whether transferred State time should be utilized in the determination of the graduated scale benefit? Some contend that the State time should count towards determining the County healthcare benefit since it serves as a recruiting tool. This may be true, but no one has done any kind of fiscal analysis to validate the assertion.

The other side of the issue is that the time should not count towards the determination of the benefit. The arguments for this position include:

1. By counting it towards the benefit, it values experience with the State of Maryland as being worth more to the County than with an employee’s experience elsewhere, including the private sector, a concept that most objective views would consider farcical.
2. To do so for the retiree healthcare benefit, because time is transferable for pension purposes, ignores the important fact that for pension purposes, at least the County is receiving the transferee’s own contributions to the pension benefit, which is not the case for the retiree healthcare benefit, since there is no equivalent employee contribution for retiree healthcare in the State of Maryland’s retiree healthcare plan.
3. The retiree healthcare benefit is a very valuable benefit and should be available to County employees who have demonstrated a long term commitment to the County’s citizens, which is the reason for increasing the County’s currently short (5 year) vesting provision.

While some may contend that the impact of this item is small when related to the overall cost of the County’s retiree healthcare benefit, it begs the strong arguments listed above, and violates an important management rule that is too often ignored – “There is no right way to do the wrong thing”.

**Dependent Coverage**

With respect to dependent coverage, several plans of other governmental units provide a lesser cost share for dependent coverage than for the retiree coverage. If the County were to simply change the health benefit for an employee’s spouse from the present 80/20 cost share to a 60/40 spousal cost share for future retirees, the savings would be $4.4 million in the County’s Annual Required Contribution. A reduction to 75/25 spousal cost share would result in a $1.1 million savings in the Annual Required Contribution of the County.

**Terminated Vested Employee Coverage**

The retiree health benefit for terminated vested employees is another area of potential savings in a restructured retiree health program. Terminated vested employees are employees who have left County employment prior to being eligible to receive an immediate pension benefit. As the retiree health benefit is tied to the County’s pension benefit, most, if not all, terminated vested employees would fall into the non-public safety employee category. The following alternative options to the present 80/20 cost share for this category of former employees should be considered:
1. The benefit would only be available to those terminated vested employees that have 20 years of County service and the benefit would be determined as to where they fall in the transition matrix to be discussed later;
2. Regardless of the years of service a 50/50 cost share benefit would apply; or
3. Regardless of the years of service a 50/50 cost share benefit would apply and no spousal or dependent coverage would be provided.

As previously mentioned in the above legal issues section, there may be some legal considerations to these various alternatives (Appendix F).

These universal alternatives above have been considered for modifying the current retiree health benefit and the resultant savings are summarized in the below table (Appendix M):

### Table 15

<table>
<thead>
<tr>
<th>Option</th>
<th>Cost</th>
<th>Savings from Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>69.16</td>
<td>----</td>
</tr>
<tr>
<td>No Retiree Health Benefit Until Age 55 or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actuarial Equivalent Reduction for Benefit Prior to Age 55</td>
<td>58.74</td>
<td>10.42</td>
</tr>
<tr>
<td>Suspend Benefit If Coverage is Available from Spouse or</td>
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<td></td>
</tr>
<tr>
<td>New Employer</td>
<td>62.65</td>
<td>6.51</td>
</tr>
<tr>
<td>Cost Share 75/25 Rather than 80/20</td>
<td>66.71</td>
<td>2.45</td>
</tr>
<tr>
<td>Spousal Cost Share 75/25</td>
<td>68.10</td>
<td>1.06</td>
</tr>
<tr>
<td>Spousal Cost Share 60/40</td>
<td>64.78</td>
<td>4.38</td>
</tr>
<tr>
<td>Eliminate Terminated Vested Employees</td>
<td>68.18</td>
<td>0.98</td>
</tr>
</tbody>
</table>

### Table 16

<table>
<thead>
<tr>
<th>Option</th>
<th>Cost</th>
<th>Savings from Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>672.69</td>
<td>----</td>
</tr>
<tr>
<td>No Retiree Health Benefit Until Age 55 or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actuarial Equivalent Reduction for Benefit Prior to Age 55</td>
<td>593.98</td>
<td>78.71</td>
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<tr>
<td>Suspend Benefit If Coverage is Available from Spouse or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Employer</td>
<td>622.69</td>
<td>50.00</td>
</tr>
<tr>
<td>Cost Share 75/25 Rather than 80/20</td>
<td>654.20</td>
<td>18.49</td>
</tr>
<tr>
<td>Spousal Cost Share 75/25</td>
<td>664.60</td>
<td>8.09</td>
</tr>
<tr>
<td>Spousal Cost Share 60/40</td>
<td>639.12</td>
<td>33.57</td>
</tr>
<tr>
<td>Eliminate Terminated Vested Employees</td>
<td>661.95</td>
<td>10.74</td>
</tr>
</tbody>
</table>

### 2. Pre-65 Alternatives

**Plan Design**

Because the pre-65 retiree health benefit is the same health plan as for current employees, it offers the same low co-pays and low deductibles; further adding to the County’s cost of the benefit. Accordingly, it would be logical to implement the same plan design changes for the pre-65 retiree health plan as are suggested for the active employee health plan’s benefit.
Below are changes in the current plan design including co-pays, deductibles and cost shares for the under 65 retirees that participate in the County’s health care plans. These are the same changes that were discussed in the section of this report dealing with the health insurance benefit for current employees. The associated savings has been provided by the County’s healthcare consultants, AON Hewitt.

Table 17

<table>
<thead>
<tr>
<th>Plan Design</th>
<th>Current Benefit</th>
<th>Proposed Change</th>
<th>Cost Savings (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Co-pay</td>
<td>$5 Primary/$5 Specialist</td>
<td>$15 Primary/$35 Specialist</td>
<td>$0.5</td>
</tr>
<tr>
<td></td>
<td>$10 Primary/$20 Specialist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Co-pay</td>
<td>$35 ER/$35 Urgent Care</td>
<td>$75 ER/$35 Urgent Care</td>
<td>$0.06</td>
</tr>
<tr>
<td>Prescription Co-pay</td>
<td>$5/$15/$25</td>
<td>$5/$25/$35</td>
<td>$0.5</td>
</tr>
<tr>
<td>HMO Deductible</td>
<td>$0</td>
<td>$200</td>
<td>$0.5</td>
</tr>
<tr>
<td>Triple Choice Deductible</td>
<td>$200/$400/$600</td>
<td>$250/$500/$1,000</td>
<td>$0.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>$1.66</strong></td>
</tr>
</tbody>
</table>

Cost Share

Similarly, because pre-65 retirees choose from the same healthcare plans available to active employees, a generous benefit in relation to other public sector employers in the region results. Another possible alternative is to simply change the existing 80/20 cost share to a different cost/share Consideration should be given to reducing costs in this sector of the County’s benefit by providing a dollar cost share for the Triple Choice option to the cost share dollar amount that results from the HMO cost share percentage. This is similar to the proposal for active employees.

Table 18

<table>
<thead>
<tr>
<th>Pre-65 Retiree Healthcare - Savings from Cost Share Alternatives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cost Share</strong></td>
</tr>
<tr>
<td>HMO Plan only @ 90/10</td>
</tr>
<tr>
<td>Triple Choice at dollar amount of 90% of HMO premium</td>
</tr>
<tr>
<td>HMO Plan only @ 85/15</td>
</tr>
<tr>
<td>Triple Choice at dollar amount of 85% of HMO premium</td>
</tr>
<tr>
<td>HMO Plan only @ 80/20</td>
</tr>
<tr>
<td>Triple Choice at dollar amount of 80% of HMO premium</td>
</tr>
<tr>
<td>HMO Plan only @ 75/25</td>
</tr>
<tr>
<td>Triple Choice at dollar amount of 75% of HMO premium</td>
</tr>
</tbody>
</table>
Coverage Deferral

Another cost saving option is to change the current policy of allowing the deferral of the retiree benefit one-time. It is advantageous to the County if a retiree were to defer the subscription to the retiree health benefit during retirement. Many retirees have access to health coverage through their spouse or through a subsequent employer if they choose to remain in the workforce after retiring from the County. The current policy of a one-time deferral puts the retiree in the position of rarely deferring the County’s retiree benefit, thus denying the County the savings that could be available had the employee utilized an alternative available coverage. The savings to the County could be substantial, particularly from the pre-65 retirees. As an incentive for pre-65 retirees to defer the utilization of the retiree health benefit and instead utilize alternative coverage to which they have access, a credit could be given to the graduated scale benefit such that the County’s cost share would increase if the employee deferred coverage for a sufficient period of time.

<table>
<thead>
<tr>
<th>Option</th>
<th>Cost</th>
<th>Savings from Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>$69.16</td>
<td>----</td>
</tr>
<tr>
<td>Suspend Benefit If Coverage is Available from Spouse or New Employer</td>
<td>$62.65</td>
<td>$6.51</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Option</th>
<th>Cost</th>
<th>Savings from Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>$672.69</td>
<td>----</td>
</tr>
<tr>
<td>Suspend Benefit If Coverage is Available from Spouse or New Employer</td>
<td>$622.69</td>
<td>$50.00</td>
</tr>
</tbody>
</table>

3. Post-65 Alternatives

A simplistic approach to this category of the retiree health benefit would be to simply alter the cost share form the present 80/20 for the CIGNA Wrap plan to a 75/25/ split which would produce $588,000 of annual savings to the County or a 70/30 cost share which would result in $1,176,000 of annual county savings. There is a different approach to the CIGNA wrap plan however, that can result in significant savings to both the County and the retiree. This alternative is outlined next.

Connector Plan

The Committee also explored concepts relating to the evolving market of private Medicare Connector or Exchange coupled with Health Reimbursement Accounts (HRA). These exchanges offer both Medicare Supplement plans (also referred to as Medigap policies) and Medicare Advantage plans. Medicare Supplement plans provide coverage for services that Medicare does not cover. These plans operate very similarly to the County’s current CIGNA PPO Medicare Wrap plan. Under a supplemental policy, Medicare will pay its share of the Medicare-approved amount for covered health care costs and then the supplemental policy pays its share. The retiree has to pay a premium for the supplemental policy. Every Medigap policy must follow federal and state laws and are identified by letters A-N. All policies offer the same options for covered health care services.
basic benefits, but some of the policy variations offered provide additional benefits, which the retiree can choose to best fit its individual needs. In order to gain knowledge on this topic the Committee heard a presentation from United Health Care that outlined coverage and costs associated with the AARP Medicare Supplement plans (Appendix Q). A Medicare Advantage Plan (like an HMO or PPO) is an alternative way to receive Medicare benefits. Unlike “Original Medicare,” in which the government pays for Medicare benefits when you receive them, Medicare Advantage Plans (MA Plans) are offered by private companies approved by Medicare, and Medicare pays these companies to cover your Medicare benefits. If you join a Medicare Advantage Plan, the plan will provide all of your Medicare Part A and B coverage. This is different than a Medicare Supplement plan, which just pays for costs that Medicare does not cover. All MA plans cover emergency and urgent care.

A Medicare Connector or Exchange is a centralized service whereby the retiree can compare and purchase qualified health and drug plans. These health exchanges have existed for more than five years. Employers can provide the retiree access to this service with financial assistance to meet the employer’s coverage responsibility and help make post-retirement benefits affordable to the employer and provide a generous supplemental Medicare benefit to the retiree. The retiree will depend on the health exchange for personalized individual health plans. This provides the retiree with freedom of choice and the value of the open market. All of the above Medicare plans are available under an exchange or connector model. The exchange or connector model provides a structure to assist the employer in the transition from a group (the current Cigna PPO Medicare Wrap plan) to individual coverage with decision support tools and personalized service features that empower the retiree. Another advantage is that it incorporates an insurance product, thereby transferring the risk which is currently borne by the County to the insurer. (Appendix R)

Medicare is an ideal benefit upon which to build an insurance exchange. It allows for huge risk pools that continue to grow since there are over 40 million retirees enrolled in Medicare, and the post-war baby boomers will swell the numbers over the next two decades. The market is a guaranteed issue market so adverse selection is not an issue. Everyone has to join Medicare at age 65 regardless of health condition. Exchanges are very competitive as carriers compete on prices that are filed annually for standardized plans and the retiree selects the best performing plan from the best performing carrier that fits the retiree’s individual needs (Appendix S).

It should also be noted that once insurance exchanges are up and running under the provisions of PPACA (assuming the statute is held to be Constitutional), there is the prospect that a cost saving insurance mechanism would be available for the pre-65 retirees.

The Committee reviewed presentations from a vendor, Extend Health Inc, which outlined an example of a Medicare Connector model. Extend Health’s private Medicare exchange enables individuals to shop for enhanced Medicare coverage through an integrated website and call center. Their health exchange has over 70 national and regional health insurance carriers, with 3,500 different available plans. This connector model provides all Medicare plan types (Medicare Advantage, Medigap/Medicare Supplement plans), Prescription Drug plans, vision and dental plans. Plans were compared side-by-side with the existing CIGNA PPO Medicare Wrap plan (which includes the CVS-Caremark Drug Plan), both from the coverage and cost perspectives.
The committee reviewed a fiscal comparison (Table below) of the current CIGNA Wrap plan to a Connector model (market exchange) plan that includes a County subsidy of $3,000 per year, and concluded that the County could save up to 50% and the retiree could save approximately 74% of costs by utilizing a Connector model.

### Table 20

**Cost Comparison**

CIGNA Wrap vs. Market Exchange  
(Includes CVS-Caremark Drug Plan)  
Number of Participants: 1120

#### Current Plan: CIGNA Wrap (80/20)

<table>
<thead>
<tr>
<th>Retiree Pays</th>
<th>Catastrophic</th>
<th>Healthy</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIGNA Premium</td>
<td>$1,514</td>
<td>$1,514</td>
</tr>
<tr>
<td>Medical OOP</td>
<td>$1,354</td>
<td>$104</td>
</tr>
<tr>
<td>Drug OOP</td>
<td>$1,206</td>
<td>$147</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$4,074</strong></td>
<td><strong>$1,765</strong></td>
</tr>
</tbody>
</table>

| County Pays  | CIGNA Premium | $6,055 |

#### Individual Medicare Market Exchange¹

<table>
<thead>
<tr>
<th>Retiree Pays</th>
<th>Catastrophic</th>
<th>Healthy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium</td>
<td>$3,169</td>
<td>$3,169</td>
</tr>
<tr>
<td>Medical OOP</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Drug OOP²</td>
<td>$886</td>
<td>$281</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$4,055</strong></td>
<td><strong>$3,450</strong></td>
</tr>
<tr>
<td>County HRA</td>
<td>($3,000)</td>
<td>($3,000)</td>
</tr>
<tr>
<td><strong>Net</strong></td>
<td>$1,055</td>
<td>$450</td>
</tr>
</tbody>
</table>

| Savings to Retiree | $3,019  | $1,315 |
| Percentage Savings | 74%     | 74%    |
| Savings to County  | $3,067  | $3,067 |
| Percentage Savings | 51%     | 51%    |
| **Total Savings to County** | $3,434,592 | $3,434,592 |

**Notes:**

(1) Does not include ExtendHealth admin costs  
(2) Catastrophic Drug OOP costs include approximately $2,400 in anticipated donut hole funding for the top 10% of seniors

To meet the affordability of retiree health insurance and provide flexibility to the retiree, the County could provide financial support through a tax-advantaged savings account, such as a health reimbursement account (HRA). As the employer, the County can provide a specific
amount of funds into a retiree’s account to be used only for federal qualified health related expenses. This account could purchase a retiree’s health and drug plan, as well as pay for co-pays and deductibles. Any unused funds can be used for other qualified expenses. As mentioned, the above table includes a $3,000 annual County subsidy provided through an HRA.

The Connector model offers a win-win situation for the County and the retiree. From the County’s perspective it offers the promise of substantial cost savings from its current retiree health benefit costs, as well as bringing some predictability to cost. It also eliminates carrier negotiations as all carriers will be competing on price for the individual retiree, and will reduce the County’s administrative burden. From the retiree’s perspective, it offers increased personalization and choice, while at the same time providing equal or better benefits at a substantial savings to the retiree, thereby enhancing the retiree’s peace of mind.

The Committee also examined the elimination of its Part D Coverage in the year 2020, an alternative the State of Maryland recently adopted in order to reduce its actuarial accrued liability. This option is predicated on a provision in the Patient Protection and Affordable Care Act that closes the “donut hole” in the year 2020. While this option may have been attractive to the State of Maryland, since it results in an approximate 45% reduction in its unfunded actuarial accrued liability because of the demographics of its retiree population (fewer pre-65 retirees than the County because of the County’s predominance of public safety retirees); it is based upon the assumption that the Patient Protection and Affordable Care Act will be found constitutional by the Supreme Court and that Medicare will be able to afford this increased cost responsibility. If the County were to follow the State of Maryland’s lead, the reduction in the annual required contribution (ARC) would be $14.3 million or 21% and the unfunded accrued liability would be reduced by $133.8 million or 20%.

Based on the committee’s discussions and presentations from outside groups, the following proposals for reductions in retiree medical benefits (both pre & post 65) were reviewed:

4. **Basic Benefit Plan Alternatives**

   **20 year Basic Benefit Plan** – This is a graduated scale retiree health benefit with Medicare Connector coverage. The basic benefit is based on a 20 year vesting requirement. It provides a percentage cost share for retirees under the age of 65 and a fixed dollar amount (indexed to a medical cost inflation factor of 4% annually) for retirees over the age of 65 to apply to a Connector Model plan. The dollar amount for the 65 and over benefit are for the individual, therefore a husband and wife would receive twice the amount.

<table>
<thead>
<tr>
<th>Service</th>
<th>&lt;65 Cost Share</th>
<th>65 &amp; Over Dollar Subsidy</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>50/50</td>
<td>$ 200</td>
</tr>
<tr>
<td>25-29</td>
<td>65/35</td>
<td>$ 225</td>
</tr>
<tr>
<td>30+</td>
<td>75/25</td>
<td>$ 250</td>
</tr>
</tbody>
</table>

Table 21A
Table 21B

<table>
<thead>
<tr>
<th>Current Years of Service at Retirement</th>
<th>Transition Schedule Under Age 65 Benefit</th>
<th>Transition Schedule 65 and Over Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Service</td>
<td>20/24 25/29 30</td>
<td>If  Then</td>
</tr>
<tr>
<td>6</td>
<td>60/40 65/35 75/25</td>
<td>60/40 $ 200</td>
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<td>7</td>
<td>60/40 65/35 75/25</td>
<td>65/35 $ 225</td>
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<td>8</td>
<td>60/40 65/35 75/25</td>
<td>70/30 $ 225</td>
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<td>9</td>
<td>60/40 65/35 75/25</td>
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<td>70/30 70/30 75/25</td>
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<tr>
<td>20-24</td>
<td>70/30* 70/30* 75/25</td>
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<tr>
<td>25-29</td>
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<td></td>
</tr>
<tr>
<td>30</td>
<td>X X 75/25</td>
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</tr>
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</table>

* If already in DROP, then 75/25

Under this proposal, retirees who delay receipt of their benefits could receive a greater subsidy (but no greater than the benefit provided to retirees with 30 years of service). If the under 65 benefit is not utilized, then the retiree’s cost share is decreased by 2% for each year not utilized after retirement & post 65 benefit is increased to corresponding amount. For example, an employee who retired at age 57 with 25 years of service, who delayed receipt of their benefit to age 62 (5 years) would receive an extra 10 percent subsidy.

This plan also includes a transition schedule for all current employees that pro-rates the cost share percentage or fixed dollar amount based on the current years of service an active employee currently has and years of service at the time of retirement. The benefit does not become available to current employees until they have 20 years of service at retirement.

10 year Revised Basic Plan – This plan is a revision of the 20 year basic plan that provides the same basic benefit structure for future employees and requires 20 year vesting. It provides a percentage cost share for retirees under the age of 65 and a fixed dollar amount (indexed to a medical cost inflation factor of 4% annually) for retirees over the age of 65 to apply.
to a Connector Model plan. The dollar amount for the 65 and over benefit are for the individual, therefore a husband and wife would receive twice the amount.

### Table 22

<table>
<thead>
<tr>
<th>Service</th>
<th>&lt;65 Cost Share</th>
<th>65 &amp; Over Dollar Subsidy</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>50/50</td>
<td>$200</td>
</tr>
<tr>
<td>25-29</td>
<td>65/35</td>
<td>$225</td>
</tr>
<tr>
<td>30+</td>
<td>75/25</td>
<td>$250</td>
</tr>
</tbody>
</table>

**10 Year Revised Basic Plan**  
**Future Employees**

<table>
<thead>
<tr>
<th>Service</th>
<th>Under Age 65 Benefit</th>
<th>65 and Over Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Current Employees</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transition Schedule</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Under Age 65 Benefit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Service</td>
<td>10/14</td>
</tr>
<tr>
<td>0.1-9</td>
<td>25/75</td>
<td>50/50</td>
</tr>
<tr>
<td>10</td>
<td>25/75</td>
<td>60/40</td>
</tr>
<tr>
<td>11</td>
<td>35/65</td>
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</tr>
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<td>X</td>
</tr>
<tr>
<td>25-29</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>30</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

* If already in DROP, then 75/25

Current retiree assumes the maximum benefit of 75/25 or $250.

The transition schedule differs from the 20 year in that 10 year vesting rather than 20 year vesting applies.

5 year Employee Plan – This is a graduated scale retiree health benefit with Medicare Connector coverage. The basic benefit is based on the years of service starting at 10 years (10 year vesting). It provides a percentage cost share for retirees under the age of 65 and a fixed dollar amount for retirees over the age of 65 to apply to a Connector Model plan. The dollar amount for the 65 and over benefit are for the individual, therefore a husband and wife would receive twice the amount. Future hires would get a 50% subsidy after 10 years, a 60% subsidy
with 15-19 years and a 70% subsidy for 20 or more years of service. The dollar subsidiary for the Connector model would be $175 after 10 years, $200 with 15-19 years, and a $225 for 20 or more years of service at retirement. As with the previous alternatives the fixed dollar post 65 benefit is indexed to a medical cost inflation factor of 4% annually.

<table>
<thead>
<tr>
<th>Service</th>
<th>&lt;65 Cost Share</th>
<th>65 &amp; Over Dollar Subsidy</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-14</td>
<td>50/50</td>
<td>$175</td>
</tr>
<tr>
<td>15-19</td>
<td>60/40</td>
<td>$200</td>
</tr>
<tr>
<td>20</td>
<td>70/30</td>
<td>$225</td>
</tr>
</tbody>
</table>

Current retiree assumes the maximum benefit of 85/15 or $275

This plan includes a transition schedule for all current employees that pro-rates the cost share percentage or fixed dollar amount based on the years of service the retiree has. The benefit becomes available at 5 years (5 year vesting).

The cost savings of the three above proposal were calculated by the County’s actuarial consultants, Bolton Partners, Inc. as follows:

<table>
<thead>
<tr>
<th></th>
<th>Cost $</th>
<th>Savings $</th>
<th>Savings %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Future &amp; Current Retirees</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 Yr Basic Plan - Connector</td>
<td>36.9</td>
<td>32.3</td>
<td>46.6%</td>
</tr>
<tr>
<td>10 Yr Revised Basic Plan - Connector</td>
<td>42.5</td>
<td>26.6</td>
<td>38.5%</td>
</tr>
<tr>
<td>5 Yr Employee Plan - Connector</td>
<td>46.7</td>
<td>22.4</td>
<td>32.4%</td>
</tr>
</tbody>
</table>
### Table 25

**Funded Expense Impact (AAL)**

**8% Discount Rate**

(in millions)

<table>
<thead>
<tr>
<th>Current Plan</th>
<th>$672.7</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Future &amp; Current Retirees</strong></td>
<td></td>
</tr>
<tr>
<td>Cost $</td>
<td>Savings $</td>
</tr>
<tr>
<td>-------</td>
<td>-----------</td>
</tr>
<tr>
<td>20 Yr Basic Plan - Connector</td>
<td>405.4</td>
</tr>
<tr>
<td>10 Yr Revised Basic Plan - Connector</td>
<td>441.1</td>
</tr>
<tr>
<td>5 Yr Employee Plan - Connector</td>
<td>470.1</td>
</tr>
</tbody>
</table>

### C. Recommendations

1. **Plan Design Changes** - Based on the committee’s discussions, including the belief the users of the service should pay for the service, while healthy individuals should be more favorably treated, and in comparison to other jurisdictions the Committee recommends the above plan design changes be adopted. The cost savings from these changes as indicated above total $1.66 million.

2. **Graduated Scale** – Given the value of this benefit and its cost, a graduated scale similar to that employed for the County’s pension benefit should be implemented. There is inherent fairness in the concept that longer service to the County warrants a greater benefit to the employee.

3. **Vesting** – a longer vesting requirement is called for, again due to the significant value and cost of the benefit. The current five year vesting for non-public safety employees is untenable. A twenty year vesting requirement is equitable and is consistent with the current defacto vesting requirement for the public safety units. Given that current employees were hired on the basis of five year vesting, a change to ten year vesting for current employees in a transition plan seems equitable. Some Committee members continue to believe that a ten year vesting plan for new employees is preferable.

4. **Connector Model** – Offers the prospect of savings to both the County and the post-65 retiree. The ability to utilize consumer driven healthcare whereby individuals are empowered to select the best healthcare plan for their individual circumstances is a significant improvement to the benefit and should be incorporated in the County’s retiree healthcare benefit. It provides a retiree friendly solution that is sustainable and cost effective.

5. The Ten Year Revised Basic Plan and Connector should be adopted by the County as it incorporates a graduated scale, results in 20 year vesting for new employees, and provides for a fair transition schedule for current employees.
This recommendation incorporates the Graduated Scale, 20 Year Vesting for new employees, and the utilization of a Connector Model, resulting in a total reduction in the County’s annual required contribution (ARC) of $26.6 million and a reduction in the accrued actuarial liability (AAL) of $231.6 million (both at an 8% discount rate). Similar to recommendation #3 above, some Committee members prefer the Employee 5 Year plan alternative that preserves five year vesting for current employees, while still moving to a graduated scale benefit and utilization of a Connector model. This alternative results in a reduction in the County’s annual required contribution (ARC) of $22.4 million and a reduction in the accrued actuarial liability (AAL) of $202.6 million (both at an 8% discount rate).

6. The one-time deferral of the retiree health benefit should be eliminated so as to allow greater utilization of non-County healthcare options that may be available to retirees through either subsequent employers of available spousal coverage. A credit schedule to the retiree’s benefit for the non-utilization of the retiree benefit should also be adopted. The savings from this recommendation would be approximately $6.51 million.

7. The pre-65 retiree benefit, in addition to being based on a graduated scale, should include a provision that ties the dollar amount of the Triple Choice benefit plan to the dollar amount that results from the cost share provision of the HMO plan.

8. Terminated Vested Employees – Given that current employees will experience a reduction in their current benefit, it is equitable that terminated vested employees experience a benefit adjustment. Accordingly, a 50/50 cost share benefit, regardless of years of service, would apply and no spousal or dependent coverage would be provided.

9. Transfer of service credit for the retiree health plan benefit should be eliminated for new employees. A transition plan for current employees who have prior State service could be utilized, such as allowing one year credit for each two years of State service or requiring a minimum of 10 or 15 years County service before credit is given for State service.

VI. Anne Arundel County Pension Benefit

A. Benefit Description

The County has established four separate pension plans for various groups of employees, General Employees, Police Officers, Firefighters, and Detention Center Officers and Deputy Sheriffs. All plans require an employee contribution. Plan provisions are subject to collective bargaining for represented employees. The basic terms of the individual plans are presented in the following table:
<table>
<thead>
<tr>
<th>Plan Provision</th>
<th>General Employees</th>
<th>Police Officers</th>
<th>Firefighters</th>
<th>Detention Center Officers &amp; Deputy Sheriffs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Formula</td>
<td>2% of final earnings per year of service</td>
<td>2.5% of final earnings per year of service up to 20 years plus 2% for each successive year of service</td>
<td>2.5% of final earnings per year of service up to 20 years plus 2% for each successive year of service</td>
<td>2.5% of final earnings per year of service up to 20 years plus 2% for each successive year of service</td>
</tr>
<tr>
<td>Military Service Credit</td>
<td>Up to 3 Years</td>
<td>Up to 3 Years</td>
<td>Up to 3 Years</td>
<td>Up to 3 Years</td>
</tr>
<tr>
<td>Credit for Unused Disability Leave</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Maximum Benefit</td>
<td>60% plus credit for military service and unused disability leave</td>
<td>70% plus credit for military service and unused disability leave</td>
<td>70% plus credit for military service and unused disability leave</td>
<td>70% plus credit for military service and unused disability leave</td>
</tr>
<tr>
<td>Normal Retirement</td>
<td>Age 60 or 30 years 5 year vesting</td>
<td>20 years or age 50 and 5 years of service</td>
<td>20 years or age 50 and 5 years of service</td>
<td>20 years or age 50 and 5 years of service</td>
</tr>
<tr>
<td>Final Earnings</td>
<td>Highest 3 years of last 5 years basic pay</td>
<td>Highest 3 years of last 5 years basic pay</td>
<td>Highest 3 years of last 5 years basic pay</td>
<td>Highest 3 years of last 5 years basic pay</td>
</tr>
<tr>
<td>Joint &amp; Survivor</td>
<td>Actuarial Reduction</td>
<td>100%</td>
<td>100%</td>
<td>Actuarial Reduction</td>
</tr>
<tr>
<td>COLA</td>
<td>Lesser of 2.5% or 60% of CPI</td>
<td>Lesser of 2.5% or 60% of CPI</td>
<td>Lesser of 2.5% or 60% of CPI</td>
<td>Lesser of 2.5% or 60% of CPI</td>
</tr>
<tr>
<td>Disability</td>
<td>Line of Duty – &gt; of accrued benefit or 66.7% Non-Line of Duty – &gt; accrued benefit or 25% of final earnings</td>
<td>Line of Duty – &gt; of accrued benefit or 66.7% Non-Line of Duty – &gt; accrued benefit or 20% of final earnings</td>
<td>Line of Duty – &gt; of accrued benefit or 66.7% Non-Line of Duty – &gt; accrued benefit or 20% of final earnings</td>
<td>Line of Duty – &gt; of accrued benefit or 66.7% Non-Line of Duty – &gt; accrued benefit or 20% of final earnings</td>
</tr>
<tr>
<td>DROP</td>
<td>No</td>
<td>20 years service, 3 to 5 year term</td>
<td>20 years service, 3 to 5 year term</td>
<td>No</td>
</tr>
<tr>
<td>Employee Contribution</td>
<td>4%</td>
<td>7.25% Sergeant and below 5% Lieutenant and above</td>
<td>7.25% Captain and below 5% Battalion Chief and above</td>
<td>6.75% Detention Center Sergeant and below 5% Detention Center Lieutenant and above and all Deputy Sheriffs</td>
</tr>
</tbody>
</table>
B. Findings

The pension benefit for County employees generally falls above the middle of the pack of surrounding local governments, and is more lucrative than the pension programs of the State of Maryland. The Police Officers and Firefights plans have individual features (100% Joint & Survivor and DROP) that are quite employee friendly. Employee contributions across-the-board are generally below the median, particularly when the benefit provisions are taken into consideration.

The table below shows the present value of the pension benefit demonstrates how lucrative the County’s pension benefit is.

<table>
<thead>
<tr>
<th>Plan and Retirement Age</th>
<th>Employee Contribution Rate</th>
<th>Initial Annual Pension</th>
<th>Present Value of Benefit</th>
<th>Rate of Return Required*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee – Age 55</td>
<td>4.00%</td>
<td>$24,243</td>
<td>$314,080</td>
<td>16%</td>
</tr>
<tr>
<td>30 Years of Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Police - Age 45</td>
<td>7.25%</td>
<td>$39,690</td>
<td>$634,126</td>
<td>21%</td>
</tr>
<tr>
<td>20 Years of Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fire - Age 50</td>
<td>7.25%</td>
<td>$47,686</td>
<td>$744,476</td>
<td>17%</td>
</tr>
<tr>
<td>25 Years of Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detention - Age 45</td>
<td>6.75%</td>
<td>$32,919</td>
<td>$486,849</td>
<td>21%</td>
</tr>
<tr>
<td>20 Years of Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Bolton Partners

* The effective annual rate of return required to be earned on an employee’s contributions in order to realize the present value of the benefit.

The County’s pension system is well funded when compared to governmental units in general, with a funded ratio of approximately 85%. This level of funding, which represents nearly 9% of the General Fund’s general county funding, comes at a price to the taxpayer as the following table shows the calendar year 2010 pension contributions in dollars and as a percent of plan payroll.

<table>
<thead>
<tr>
<th>General Employees</th>
<th>Police Officers</th>
<th>Firefighters</th>
<th>Detention Officers &amp; Deputy Sheriffs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer Contributions</td>
<td>$17,284,080</td>
<td>$14,055,660</td>
<td>$14,648,580</td>
<td>$4,907,130</td>
</tr>
<tr>
<td>Employer Contributions as a % of Payroll</td>
<td>14.0%</td>
<td>33.1%</td>
<td>30.6%</td>
<td>25.4%</td>
</tr>
<tr>
<td>Employee Contributions</td>
<td>$4,556,815</td>
<td>$2,297,386</td>
<td>$2,494,043</td>
<td>$1,084,820</td>
</tr>
<tr>
<td>Employee Contributions as a % of Payroll</td>
<td>3.7%</td>
<td>5.4%</td>
<td>5.2%</td>
<td>5.6%</td>
</tr>
</tbody>
</table>

Source: 2010 CAFR of Retirement & Pension system – pages 85-88
It should be noted however, that these contribution amounts are not driven by poor investment performance. Indeed the County’s investment performance has been quite good, having achieved the 8% actuarially assumed rate of return over the past twenty years.

The above pension contributions for the County are composed of two parts. The first part is the “normal cost”, which is the cost of the benefit for another year of service. The second part of the cost is the “past service cost” which is the amortization of the previously unfunded component of the benefit. For fiscal year 2012 the breakdown of these costs and other cost adjustments is shown in the table below:

<table>
<thead>
<tr>
<th>Cost Components of Actuarial Contribution</th>
<th>General Employees</th>
<th>Police Officers</th>
<th>Firefighters</th>
<th>Detention Officers &amp; Deputy Sheriffs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal Cost</td>
<td>$10,645,732</td>
<td>$8,994,810</td>
<td>$10,688,840</td>
<td>$2,655,651</td>
<td>$32,985,033</td>
</tr>
<tr>
<td>Past Service Cost</td>
<td>$6,356,231</td>
<td>$4,035,801</td>
<td>$2,434,655</td>
<td>$1,979,435</td>
<td>$14,806,122</td>
</tr>
<tr>
<td>Expenses</td>
<td>$482,000</td>
<td>$398,000</td>
<td>$377,000</td>
<td>$77,000</td>
<td>$1,334,000</td>
</tr>
<tr>
<td>Total</td>
<td>$17,483,963</td>
<td>$13,428,611</td>
<td>$13,500,495</td>
<td>$4,712,086</td>
<td>$49,125,155</td>
</tr>
<tr>
<td>8% Interest Cost</td>
<td>$1,398,717</td>
<td>$1,074,289</td>
<td>$1,080,040</td>
<td>$376,967</td>
<td>$3,930,012</td>
</tr>
<tr>
<td>Total Recommended Contribution</td>
<td>$18,882,680</td>
<td>$14,502,900</td>
<td>$14,580,535</td>
<td>$5,089,053</td>
<td>$53,055,167</td>
</tr>
</tbody>
</table>

Source: January 1, 2011 Actuarial Reports

The above pension funding data demonstrates the difference between the County’s funding of its pension obligation and its retiree health obligation. As the above table demonstrates, for the pension obligation the County is annually funding the year’s annual accrual of the benefit for employees (the normal cost) and is funding the past service liability of employees over a thirty year time-frame (past service cost). This situation is significantly different from the retiree health insurance obligation, where the funding is not even meeting the normal cost responsibility (the annual cost of the benefit for the current year), much less making a payment on the unfunded liability (the past service liability). Consequently the overall liability continues to increase annually. On the other hand, because of the County’s pension funding program, the normal cost is funded every year and a payment towards the past service liability is also made, thereby steadily reducing the total past service liability (the Pension System liability is 85% funded). Once the past service liability is funded, the County’s annual funding cost will be able to be reduced as the only cost will be the normal cost component. (See table on next page)
### Table 30

Pension & Retiree Health Funding

<table>
<thead>
<tr>
<th></th>
<th>Budgeted – To Be Funded in FY2012</th>
<th>FY2012 Actuarial Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal Cost</td>
<td>32,985,033</td>
<td>32,985,033</td>
</tr>
<tr>
<td>Past Service Cost</td>
<td>14,806,122</td>
<td>14,806,122</td>
</tr>
<tr>
<td>Expenses &amp; Interest</td>
<td>5,264,012</td>
<td>5,264,012</td>
</tr>
<tr>
<td>Total</td>
<td>53,055,167</td>
<td>53,055,167</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Budgeted – To Be Funded in FY2012</th>
<th>FY2012 Actuarial Requirement*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retiree Health</td>
<td></td>
<td>County</td>
</tr>
<tr>
<td>Normal Cost</td>
<td>23,384,000</td>
<td>963,000</td>
</tr>
<tr>
<td>Past Service Cost</td>
<td>39,962,000</td>
<td>1,402,000</td>
</tr>
<tr>
<td>Total</td>
<td>27,469,000</td>
<td>63,346,000</td>
</tr>
<tr>
<td>PayGo Cost</td>
<td>24,793,000</td>
<td>1,187,000</td>
</tr>
</tbody>
</table>

*Determined using 8% discount rate, CAFR Uses 4% rate

Some of the current provisions of the County’s pension plan present inconsistent policy objectives. On the one hand, the public safety plans all offer a generous option for the employee to retire after 20 years of service and immediately begin to collect a 50% retirement benefit. The justification for this policy is that these positions require a great deal of physical effort and mental stress. On the other hand, the County offers police officers and firefighters the option of a Deferred Retirement Option Plan (DROP), whereby an individual can “retire” (the retirement benefit is frozen at the current amount) and continue to work for up to five additional years. While the employee continues to work, their retirement benefit is paid into an account that currently earns a guaranteed 4.25% interest. Consequently, an employee who stays in the DROP program can accumulate a substantial nest egg (often times in excess of $250,000) when he/she finally leave active service. The justification for the DROP program is that it provides an incentive for experienced employees to remain with the County. From an overall cost standpoint to the County, it is advantageous for an employee to work longer rather than retire, as the incremental pension and retiree health benefits earned cost less than the payment of the retiree pension and health benefit.

In recognition of this inconsistency, the Committee examined the cost savings from increasing the normal retirement provision for the Police and Fire pension plans from 20 years to 25 years or age 55 with ten years service. The cost savings, totaling nearly $3.5 million, are displayed below:
Table 31

<table>
<thead>
<tr>
<th></th>
<th>20 Years Service</th>
<th>25 Years Service</th>
<th>Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>January 2011 Valuation</td>
<td>Cost</td>
<td>% Pay</td>
</tr>
<tr>
<td>Police Plan</td>
<td>$ 14,502,900</td>
<td>34.2%</td>
<td>$ 12,817,978</td>
</tr>
<tr>
<td>Fire Plan</td>
<td>$ 14,580,535</td>
<td>30.5%</td>
<td>$ 13,162,141</td>
</tr>
<tr>
<td>Detention/Sheriff</td>
<td>$ 5,089,053</td>
<td>26.4%</td>
<td>$ 4,746,130</td>
</tr>
<tr>
<td>Total</td>
<td>$ 34,172,488</td>
<td></td>
<td>$ 30,726,249</td>
</tr>
</tbody>
</table>

Additionally, an unusual and expensive provision of the Police and Fire plans is the 100% Joint and Survivor benefit. The cost savings, $5 million, from modifying this provision to an actuarially reduced benefit for the spousal survivor benefit is shown below:

Table 32

<table>
<thead>
<tr>
<th></th>
<th>January 2011 Valuation</th>
<th>J&amp;S Elimination</th>
<th>Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cost</td>
<td>% Pay</td>
<td>Cost</td>
</tr>
<tr>
<td>Police Plan</td>
<td>$ 14,502,900</td>
<td>34.2%</td>
<td>$ 12,289,666</td>
</tr>
<tr>
<td>Fire Plan</td>
<td>$ 14,580,535</td>
<td>30.5%</td>
<td>$ 11,762,046</td>
</tr>
<tr>
<td>Total</td>
<td>$ 29,083,435</td>
<td></td>
<td>$ 24,051,712</td>
</tr>
</tbody>
</table>

As previously mentioned any change in retirement benefits presents legal issues and must be negotiated with the respective bargaining units.

Finally, the provision dealing with the employee contribution to the various public safety plans presents an inequity in that the plan benefits are the same for all members of the plan, yet under current conditions, some employees are paying a discount for the same benefit. This situation was created by the requirement to negotiate pension contributions with each bargaining unit and the number of different bargaining units that participate in the public safety pension plans.

C. Recommendations

1. **Consistency in employee contributions** – Given that the benefit for participants in individual pension plans is the same for all participants, it would be logical that all participants in a plan pay the same percentage of pay. The cost savings from bringing all members to the higher level or contributions of the plans in question are shown below:

Table 33

<table>
<thead>
<tr>
<th></th>
<th>Applicable</th>
<th>Rate</th>
<th>Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police Plan</td>
<td></td>
<td>7.25%</td>
<td>$ 124,851</td>
</tr>
<tr>
<td>Fire Plan</td>
<td></td>
<td>7.25%</td>
<td>$ 108,831</td>
</tr>
<tr>
<td>Detention/Deputy Sheriff Plan</td>
<td></td>
<td>6.75%</td>
<td>$ 84,983</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>$ 318,665</td>
</tr>
</tbody>
</table>
2. **Increase normal retirement to 25 years or 10 years and age 55** – This would be consistent with the philosophy behind the DROP benefit which is to encourage increased length of service of employees, thereby retaining experienced workers. Savings to the County’s pension contribution would amount to $3,446,239 if done all at once. A more equitable approach would be to utilize a transition schedule such as outlined in the table below. This would produce a savings of approximately one million dollars in the annual pension contribution.

<table>
<thead>
<tr>
<th>Table 34 Increase Normal Retirement from 20 Years to 25 Years Transition Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Years of Service</td>
</tr>
<tr>
<td>--------------------------</td>
</tr>
<tr>
<td>20</td>
</tr>
<tr>
<td>19</td>
</tr>
<tr>
<td>18</td>
</tr>
<tr>
<td>17</td>
</tr>
<tr>
<td>16</td>
</tr>
<tr>
<td>15</td>
</tr>
<tr>
<td>14</td>
</tr>
</tbody>
</table>

**VII. Other Recommendations**

**A. Establish a trust to insulate health benefit prefunded assets**

In order to give assurance to employees that the funding of the retire health benefit is secure, a trust fund should be established once a secure funding stream is established to fund the benefit over the long term. The trust would be similar, if not identical to the arrangement that currently exists for the County’s pension system. In order to accomplish the creation of a trust an enabling Charter Amendment needs to first be adopted. Subsequently, an ordinance can be adopted to actually create the trust and outline the trust’s provisions of governance and activities.

**B. Establish a broad wellness program**

Wellness plans have proven to be cost effective tools to lower the cost of active employee healthcare programs as well as retiree healthcare benefits. The old adage of “an ounce of prevention is worth a pound of cure” is applicable in this arena. Many forward looking private sector firms have adopted wellness programs to provide an incentive for employees to live a healthy lifestyle, thereby realizing savings in their health insurance claims. Anne Arundel County has utilized some rudimentary wellness activities, but these efforts can be greatly expanded and enhanced (Appendix T). Also, the Anne Arundel County Fire Department has adopted a successful physical fitness program that has resulted in identified savings to the County’s self insurance program.
C. Create a permanent benefits committee

Because of the importance of benefits in the personnel equation and the significance of their cost in the County’s operating budget, continuous attention should be focused on this area. A cross-functional committee should be established to formally monitor and review the County’s benefit structure, funding, and performance. The Committee should include membership from the County’s component units (Board of Education, Community college and the Library system) as well.

D. Develop a Strategic Plan

In order to continue the momentum of dealing with County benefits a strategic plan should be developed to include immediate, intermediate and long range milestones so as to keep a focus on this important aspect of County compensation and cost. Such a plan would consist of the following components:

Immediate Actions (Present to One Year)

1. Formalize a permanent Benefits Committee
2. Implement plan design changes
3. Commence education program for Connecter Plan for post-65 retirees (Appendix U)
4. Develop RFP for Connection Plan
5. Establish mechanism for the formation of a Trust for managing pre-funding assets (Charter Amendment)
6. Initiate discussions with component units to result in collaboration over entire benefit spectrum to result in comparative benefits and cost savings from economies of scale

Intermediate Actions (One to Three Years)

1. Initiate Connector Plan
2. Monitor and evaluate public and private sector benefit developments
3. Negotiate changes to current health care cost shares with employee organizations
4. County Council to provide a written policy statement with details including the degree of merging or commonality of benefits between component units
5. Implement component unit cost savings from collaborative efforts
6. Undertake a new hire pension benefit study
7. Monitor PPACA developments, evaluate changes and make adjustments in County benefits accordingly
8. Evaluate utilization of an insurance exchange for pre-65 retirees with 2014 implementation of exchanges under PPACA
9. Develop an enhanced Wellness Program, to include possibility of establishing a third party clinic for County employees and retirees
10. Commence funding of retiree health benefit trust
Long Term Actions (Three Years and Beyond)

1. Assure funding of the retiree benefit trust such that annual contributions will fully fund obligation by 2045
2. Consider ways to provide for self adjusting programs to provide a balance between protecting benefits and controlling cost
3. Evaluate and adjust health benefits and wellness program as environment changes

VIII. Conclusion

The primary focus of the Committee is to develop a retiree health benefit and funding mechanism in order to insure that the County can deliver on its promise to employees. As detailed in this report the current benefit, at an 8% discount rate has a cost of $69.16 million annually. Currently the County is funding its retiree health insurance obligation on a PayGo basis which requires $21 million for FY2012. Thus there is a $48.16 million “hole” in the County’s funding program for this benefit, which is resulting in an ever increasing overall liability, which annually increases the annual funding requirement.

The recommendations in this report are designed to either lower the cost of the retiree health benefit or lower the cost of other benefit programs (current employee health insurance and pension plan) so as to free up existing County funds so that they can be applied to fund the retiree health benefit on a permanent basis. The alternatives are summarized on the Table 35 on the next page.

The $48.16 million “hole” in the County’s funding of retiree health benefit is plugged if all of the “High” recommendations were to be implemented, while 80% of the “hole” is dealt with if the “Low” recommendations were to be implemented. It is understood that some can be implemented relatively quickly (changes to the retiree health insurance benefit), and others will require more time as they are subject to collective bargaining (employee cost sharing and pension changes). **However, this report serves as a blueprint to accomplish the goal of putting the County’s retiree health insurance benefit on a sound fiscal foundation.**
### Table 35

**Summary of Recommendations**

<table>
<thead>
<tr>
<th>#</th>
<th>Alternatives</th>
<th>Action Required</th>
<th>Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>High</td>
</tr>
<tr>
<td>1</td>
<td>Plan Design Changes to Employee Health Insurance Plan (Co-pays &amp; Deductibles)</td>
<td>Administrative</td>
<td>$2.90</td>
</tr>
<tr>
<td>2</td>
<td>Cost Share – Current Employees HMO Plan only @ 85/15</td>
<td>Negotiate</td>
<td>$6.30</td>
</tr>
<tr>
<td></td>
<td>Triple Choice at dollar amount of 85% of HMO premium (Low – 90/10 and 90%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Cost Share – Current Employees Dental &amp; Vision Plans at 80/20 split</td>
<td>Negotiate</td>
<td>$0.90</td>
</tr>
<tr>
<td>4</td>
<td>Plan Design changes to Retiree Health benefit similar to Employee Plan</td>
<td>Administrative</td>
<td>$1.66</td>
</tr>
<tr>
<td>5</td>
<td>Terminated Vested Benefit Adjustment</td>
<td>Legislative</td>
<td>$0.75</td>
</tr>
<tr>
<td>6</td>
<td>Eliminate Transferred Service Credit for Retiree Health Benefit</td>
<td>Legislative</td>
<td>$0.10</td>
</tr>
<tr>
<td>7</td>
<td>Pre-65 Retirees Graduated Scale Based on an HMO Plan @ 80/20 Max Benefit</td>
<td>Legislative</td>
<td>$3.85</td>
</tr>
<tr>
<td></td>
<td>Triple Choice at dollar amount of 80% of HMO premium</td>
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<td></td>
</tr>
<tr>
<td>8</td>
<td>10 Year Revised Basic Plan Graduated Scale with Transition Plan (Low – 5 Year Employee Plan)</td>
<td>Legislative</td>
<td>$26.60</td>
</tr>
<tr>
<td>9</td>
<td>Eliminate one-time deferral and require utilization of new employer health insurance or available spousal coverage</td>
<td>Legislative</td>
<td>$6.51</td>
</tr>
<tr>
<td>10</td>
<td>Pension Plan Consistent Employee Contribution Rates for plan members</td>
<td>Negotiate &amp; Legislative</td>
<td>$0.32</td>
</tr>
<tr>
<td>11</td>
<td>Pension Plan 25 Year or Age 55 and 10 years service normal benefit</td>
<td>Negotiate</td>
<td>$1.00</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$50.89</strong></td>
</tr>
</tbody>
</table>

In addition, the following other recommendations have been made:

1. Establish a trust to insulate health benefit prefunded assets
2. Establish a broad wellness program
3. Create a permanent benefits committee
4. Develop a strategic plan
Minority Report
Collaborative Benefits Committee

Minority Report

February 7, 2012

Some members of the Collaborative Benefits Committee are not supportive of the scope of change recommended in the committee’s final report as it conflicts with the fairness principal included in the September 16, 2011 County Council resolution establishing this study group.

The committee members objecting to the pace of change outlined in this report include Public Safety, AFSCME and Hourly Non-Represented leaders (“employee stakeholders”). The need to examine the cost of active and retiree benefits is fully understood and supported by the employee stakeholder groups. Many concepts and changes in this report are acceptable to employee stakeholders and in fact have been originally proposed by the dissenting employee stakeholder members. Specifically, the employee stakeholder members of this committee agree with the following recommendations put forth by the committee at large:

### Table 35

<table>
<thead>
<tr>
<th>#</th>
<th>Alternatives</th>
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<th>Savings Low</th>
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<td>$0.90</td>
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The employee stakeholder groups remain an open and interested party to this important discussion. However, the employee stakeholders desire a balanced approach to a sustainable level of benefits for both active and retired County employees that is fair to all current employees and affordable for the County. The magnitude of change proposed in this report is not acceptable to employee stakeholders without additional thoughtful discussion and analysis. Recommended action item #8 below is the best example of the need for more discussion and review as it does not provide for any grandfather provisions for current long term employees.
Specifically, the employee stakeholders represented on this committee cannot give endorsement at this time to the following recommendations put forth by the committee at large:

### Table 35

<table>
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<td></td>
<td>Total</td>
<td>$50.89</td>
<td>$41.79</td>
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The employee stakeholder groups have participated in past committees (2002, 2005 and 2008 Health Insurance Fund Committee) created to examine the cost of health benefits and/or GASB obligations for our County. As a major participant in the County’s benefit plans, the employee stakeholders are a willing participant in these workgroups and seek value for the County and its employees regarding the funding for benefits. However, the spirit of past employee benefit committees as well as this 2011 Collaborative Benefits Committee is to solve the fiscal issues presented by the cost of benefit plans with simple cost shifting to the County’s employees, and not by the utilization of progressive employee benefit management techniques. The past and proposed benefit reductions via cost shifting are damaging to the County’s long term employees and are often deployed with little consideration for the impact that such changes have on an employee’s total compensation position.
A full and complete total compensation study has not been part of this committee’s work. Such a study would place values on the salary, paid time off, health (active and retiree) and pension benefits for County employees versus other local counties. Some basic salary and benefit comparisons have been constructed but they are each either limited, incomplete or inaccurate. Some counties are included as peers such as Harford County and Calvert County when they are clearly not peers of our county at all. An example of the benchmarking inaccuracy is the comparison to Baltimore County’s health benefits. The plans included in the comparison are for post 7/1/2007 employees only. The more generous benefits for the grandfathered pre 7/1/2007 employees are omitted entirely from the comparison. The Federal Employees’ plans are utilized in the health benefits comparison but only 2 out of 21 federal health options for Marylanders are included in the analysis. Employee contributions for each county are shown as a percentage of premiums but not as dollar amounts. Without values assigned to each current benefit (salary, active health, retiree health and pension) for the peer group the comparisons are of limited value and lead to inaccurate conclusions about our total compensation relativity. It is highly doubtful that County employees today are middle of the pack on total compensation. With the implementation of each recommended change, Anne Arundel County employees (but not BOE) will fall further and further below the peer group in total compensation. This outcome would clearly violate the Collaborative Benefits Committee’s stated principle to position our benefit plans in the middle of the pack of the peer group.

Isolated comparative references in the final report to private sector benefits are of little value when private sector salaries and bonuses are not also included. We suggest the private sector is not a fair total compensation comparison at all since unique County jobs like public safety do not exist in the private sector.

Some background on cost shifting to County employees is required as we consider the next set of benefit changes. Prior to 2003, the County’s rich PPN health plan was available at a 97/3% split and HMO’s were 100% County funded for public safety employees. Reductions and changes to the County subsidy and available plans for health insurance in 2003, 2004, 2005 and 2006 diminished the previous 97/3% contribution split to 80/20% for the less rich PPO style plan (Triple Choice) and 90/10% for HMO options. These reductions in the County’s subsidy and benefit levels for health insurance had a dramatic impact on an employee’s take home pay and out of pocket expenses. Further proposed reductions in the contribution split would be in direct conflict with the County Council’s September 16, 2011 resolution from the fairness concept it espoused. It would be inappropriate to shift additional payroll contribution costs for health care on the heels of County employee furloughs and/or -5% on average pay cuts that saved the County (and cost the employees) about $21M over the past two years.

Employee stakeholders understand the rapid rise in the cost of healthcare over the past decade. They understand how that drove the need to find solutions to the long term fiscal problem of healthcare, but they are dismayed that the solution is always rooted in shifting a greater percentage of the cost from the County to its employees. The dramatic increase in employee contributions noted above came about without a strategic employee benefits plan being developed by the County. How can the County continue to ask its employees to consistently pay more for their benefits without any formal strategic benefits plan in place? If benefits are roughly 21% of the County’s budget, why hasn’t a short term and long term benefits strategy
been developed by the County? Why have savings from a decade of cost shifting from the County to its employees not been utilized to begin formal funding of the GASB 45 OPEB obligation that was identified in 2004 (see Labor Coalition memos from 2006 & 2007)? The employee stakeholder members of this Collaborative Benefits Committee respectfully request that the pattern of cost shifting from the County to the employees ends while the committee’s recommended strategic approach to employee benefits is adopted by the County. We support this committee’s recommendation to develop a strategic plan moving forward but ask that major benefit changes to our current benefits configuration be put on hold until we reach consensus on a strategic plan and better understand the impact of the Federal PPACA law.

This committee has steadfastly refused to discuss grandfathering retiree health provisions for long term County employees. We understand that the County may have to offer a different set of benefits to newly hired employees due to the cost of post retirement benefits. This approach over time will address the GASB issue. But current employees, who have worked for the county for 5, 10 and 15 years or more with the understanding that they had a certain compensation package, should not lose the benefits they have earned. It is unfair to now radically change this approach midway through an employee’s career of government service. The committee members supporting this minority report feels strongly that the absence of any grandfathering provisions fails the fairness principle espoused by the overall committee. Many local government entities in Maryland like Baltimore County (peer group) and the Anne Arundel County Board of Education have used grandfathering concepts when making dramatic benefits changes affecting long term employees. This is particularly true regarding post retirement benefits.

The County’s employee benefit plans are an important investment in the County’s Human Capital. All stakeholders in these benefit plans need to feel confident that the County is getting a fair value for the considerable sum it spends on benefits and a return on the investment in its Human Capital. We should maximize the value received for our benefits dollars, not just look to minimize costs. For example, a well designed wellness program funded with incentives for employee participation will yield a positive return for the County in future years. Other progressive employers begin sophisticated wellness programs over a decade ago because of the positive impact on future health costs and productivity. A healthy, productive employee work force is a value to the citizens of our county. A prudent and well managed benefits program for our entire workforce, including the Board of Education, can put the County on the right long term financial path.

The employee stakeholders have retained a national benefits consulting firm (CBIZ) to evaluate the health benefits program and to offer input regarding the structure of the County’s health plans. CBIZ was permitted to present its ideas and concepts to the Collaborative Benefits Committee in November 2011. The basic premise of the high level CBIZ input on the County’s benefits is closely aligned with a 2011 report on public sector health care costs from Colonial Life sponsored by the Government Finance Officers Association (GFOA). Essentially, CBIZ and the Colonial Life report highlight that Anne Arundel County has historically not utilized proven strategies to control the rise of health care costs except for merely cost shifting to employees.
The CBIZ and the Colonial Life/ GFOA Report itemized leverage points available to the County that would provide a more superior approach to managing the benefit plans than exists today. Briefly, the seven ROI All-Stars in the report are:

- Utilize on-site health clinics
- Review variable premium contributions
- Add high deductible health plans with H.S.A. accounts
- Add/expand wellness programs
- Use self insurance
- Use Cooperative Purchasing
- Add value based plan design concepts

These leverage points have been widely available for at least 5 years or more yet the County has only utilized two of the seven recommendations. The employee stakeholders ask that the ongoing benefits committee suggested in the final committee report evaluate and analyze these important and cost effective leverage points before the Collaborative Benefits Committee recommends major changes to our current benefit plans.

The Cooperative Purchasing point above likely represents a solid near term cost control opportunity for the County. Historically, the County’s record on managing the fees and performance of the employee benefit vendors has been mediocre at best. Requests for Proposals have not been routinely conducted every 3-5 years and generally do not include the Board of Education’s (BOE) plans. Yet, due to the advantage of larger volumes and economies of scale, the Anne Arundel Community College has been part of the County plans. When RFP’s have been conducted for the government and college plans, they have produced positive financial results for the County (Pharmacy RFP 2008). With the additional volume of the BOE plans, the County could have gained substantial financial results over the past decade without shifting costs to the employees. There could have also been substantial administrative and communications savings realized by cooperative purchasing without shifting costs to the employees. Since the premise behind the County Council’s resolution is the unsustainable trend of future health care costs for the County, we ask for the development of a strategic plan that over time brings the BOE plans into alignment with the County government plans. It is inherently unfair to ask a teacher to contribute 4% of a health plan’s cost and a public safety employee to pay 20% of a similar health plan. The County’s fiscal concerns cannot be addressed without consideration of the BOE benefit plans as the BOE funding makes up 51% of the County’s FY2012 budget.

One of the points made by CBIZ during their presentation focused on opportunities for the County to save health care dollars in the post retiree health program. Progressive employers over the past decade have moved away from +65 retiree medical supplement plans such as the one in place at the County today. Other employers, including governments, have made use of Group Medicare Advantage plans to deeply reduce the cost of retiree health care while giving retirees better benefits. Part D pharmacy plans (PDP plans) and EGWPs have also been successful used to reduce the cost of retiree health plans. None of these successful retiree plan management changes have been utilized by the County during our era of cost shifting and GASB obligations. Nor have they been fully vetted by this committee.
CBIZ also noted, with the stakeholders support, that a Medicare Connector plan for post 65 retirees could be a win for all parties associated with retiree health care. In fact, the savings in item 8 from the list of recommended changes generates over $22M in savings related in part to the use of the connector concept for current and future retirees. The dissenting members of the Collaborative Benefits Committee remain open to this concept after it is more fully studied and compared to the other post 65 retirement options that could replace the current plan and the County’s 80% funding.

The three employee stakeholder members to the Collaborative Benefits Committee are in agreement with short term changes to the active and retiree plan designs as noted above and to the potential introduction of the connector approach for post 65 retiree benefits. These plan changes will generate deep savings for the County in 2013 and beyond while also reducing the GASB obligation over $200M. Future benefit changes that may further reduce the rate of growth in health care costs are also likely to come out of the new benefits committee and the development of a long term strategic benefits plan for Anne Arundel County. It is a thoughtful long term strategy that considers total employee compensation that we favor over the simple and damaging employee cost shifting of the past eight years. It is our premise that we move forward with diligence on these important benefit issues and with an appreciation of all that the long time County employees have done to make this County a great place to live and work.
Appendix A

Resolution 50-11
RESOLUTION establishing a Collaborative Study Group to review existing employment and
post-employment benefits provided by Anne Arundel County and assess the impact of and make
recommendations on the continued increase in the costs of such benefits

WHEREAS, the costs to Anne Arundel County of providing employment and post-
employment benefits are increasing at rates that exceed projected rates of increase in
County revenues on both a short-term and long-term basis; and

WHEREAS, the continuing national, regional, and local economic recession has
dramatically reduced the amount of County tax revenues generally and thus limited the
amount of revenue that can be appropriated to the current costs as well as future liabilities
for such benefits; and

WHEREAS, such limitations have resulted in a structural deficit in the Anne Arundel
County budget that has adversely affected the ability of the County to make the Annual
Required Contribution under Government Accounting Standards Board Statement No.
45; and

WHEREAS, the implementation of changes in Federal health care law will significantly
affect the cost of health care services and the manner in which those services are
administered, paid for and delivered; and

WHEREAS, there is an immediate necessity for representatives of the Executive and
Legislative Branches of County government to work collaboratively with representatives
of bargaining units of County employees as well as non-represented County employees to
develop short-term and long-term priorities and recommendations to address the costs to
the taxpayers of Anne Arundel County and to the employees of Anne Arundel County of
providing employment and post-employment benefits; and

WHEREAS, such a collaborative effort should include a factual comparison of Anne
Arundel County employment and post-employment benefits with those benefits provided
by the State of Maryland and other local governments and governmental units as well as
the utilization of such comparison in the development of options, plans, and
modifications that can control costs and fairly allocate risk over time; and
WHEREAS, utilization of such a comparison in the formulation of options, plans, and
recommendations can help ensure that Anne Arundel County will remain competitive in
its efforts to hire and retain competent employees, while funding such benefits on a
structurally sound basis in current and future budgets; now, therefore be it

Resolved by the County Council of Anne Arundel County, Maryland, That it endorses the
creation of a Collaborative Study Group (the “Group”) to review existing employment and post-
employment benefits provided by Anne Arundel County and assess the impact of and make
recommendations on the continued increase in the costs of such benefits; and be it further

Resolved, that the Group shall be charged to:

1. review existing employment and post-employment benefits provided by Anne Arundel
County;

2. assess the impact of the continued increase in the costs of the benefits on current and
projected revenues and expenditures in the Anne Arundel County Budget;

3. determine fair and equitable priorities in the reduction of the benefit costs, ensuring
that such benefits are fair to employees, retirees, and taxpayers of Anne Arundel County and can
be funded on a fiscally sustainable basis; and

4. report to the County Executive and County Council their recommendations on fair and
equitable reduction of continued benefit costs and;

and be it further

Resolved, that the Group shall consist of:

1. three members of the County Council, not more than two of whom shall be of the
majority party, selected by the Chairman of the County Council;

2. three representatives of the Executive Branch of County government, one of whom
shall be the Budget Officer, and one of whom shall be the Personnel Officer and the other of
whom shall be selected by the County Executive; and

3. three representatives of the employees of Anne Arundel County, one of whom shall be
a representative of public safety employees selected by the bargaining units representing public
safety employees, one of whom shall be a representative of non-public safety employees who are
represented by a bargaining unit selected by the bargaining units representing non-public safety
employees, and one of whom shall be a representative of employees who are not members of a
bargaining unit selected by the current Representative of the non-represented employees;

and be it further

Resolved, that the Group shall be provided with technical and staff support from the Budget
Office and the Personnel Office; and be it further
Resolved, that the Group shall hold its initial meeting as soon as practicable after passage of this Resolution, submit an interim report to the County Council and County Executive no later than October 31, 2011, and submit a final report and recommendations no later than December 31, 2011.

READ AND PASSED this 6th day of September, 2011

By Order:

Elizabeth E. Jones
Administrative Officer

I HEREBY CERTIFY THAT RESOLUTION NO. 50-11 IS TRUE AND CORRECT AND DULY ADOPTED BY THE COUNTY COUNCIL OF ANNE ARUNDEL COUNTY.

Richard B. Ladd
Chairman
Appendix B

GFOA White Paper – Containing Health Care Costs
Containing Health Care Costs

Proven strategies for success in the public sector
The cost of employee health-care benefits has increased rapidly over recent years, contributing to the budgetary stress that governments are already facing as a result of declining or stagnant revenues and escalating costs in other areas. While public employers are under pressure to contain employee benefit costs, they are also motivated to provide benefits that help them maintain a healthy and productive workforce and attract the best employees to public service.

The GFOA, with a grant from Colonial Life, conducted independent research to identify the most innovative and effective strategies local governments can employ to meet the dual goals of containing costs and managing the quality of employee health-care benefits. Our study included a survey of GFOA members, case studies, and secondary sources. The findings and resulting publication were reviewed and approved by an independent panel of GFOA members who are experienced in employee benefit management.

We found that public employers have a range of potential strategies available, each of which relies on different underlying approaches to containing costs and preserving benefit quality. For example, wellness programs reduce employees’ need for costly medical interventions and increase quality of life by focusing on preventative strategies like nutrition and fitness. Onsite clinics direct public employees toward a low-cost provider while increasing accessibility to care. High deductible health plans have the potential to significantly reduce employer premiums by introducing a consumer approach into employees’ decisions about how they use their health benefit, while putting more money in the pockets of employees through a health savings account.

Of course, a change to health benefits can be an emotional and potentially controversial topic because it can affect the well-being of employees and their families. This report also provides advice for considering which strategies to pursue. It also suggests ways of building support for the selected strategies among elected and appointed officials and public employees.

It is our hope that public officials are able to use this report as they consider ways to manage costs and maintain effective benefit programs for their employees.

Anne Spray Kinney
Director, Research and Consulting Center
Government Finance Officers Association

Patrick McCullough
Assistant Vice President, Public Sector Practice Leader
Colonial Life
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INTRODUCTION

The escalating cost of employee health care benefits has been an intractable problem for employers, both public and private, across the United States. Health insurance premiums have grown a cumulative 138% between 1999 and 2010. This compares to cumulative wage growth of 42% over the same period.1 Unfortunately, this trend is not expected to abate in the near future – employer health care cost trends are projected to increase by an average of 8.5% in 2011, up from 8% in 2010.²

What is behind this budget-busting trend? A number of factors are thought to be at work. The leading ones include increasingly sophisticated (and expensive) medical technology and an aging population.³ Other reasons might include provider consolidation (decreasing competition) and cost-shifting from Medicare and Medicaid to private insurance plans as reimbursements from these federal programs fails to keep up with rising costs and providers look to make up the difference elsewhere.⁴

Public employers might not be able to do a lot to counteract these kinds of forces, but GFOA’s research has found that there are still important leverage points for public employers to manage and contain the cost of employee health care benefits, while still promoting a healthy workforce. This paper describes these leverage points and includes specific cost management strategies within each point. The discussion focuses on the strategies that have been found to have the most profound effects and that have proven successful in the public sector.

The paper focuses on more innovative strategies, though the tried-and-true are discussed too. Wherever possible, the we cite concrete return-on-investment estimates. Of course, strategies with profound impacts will often require multiple years to yield their full benefit, so the paper also highlights “fiscal first aid” tactics that can be used to help control costs in the short term.

The paper concludes with a discussion on how to move from strategy to action, including selecting specific strategies to implement and build support for changes to the benefit plan.

About our Sources
GFOA and Colonial Life surveyed a sample of GFOA members, conducted case study interviews of public managers who reported successful use of innovative cost management strategies, and reviewed secondary research. The survey has a margin of error of +/- about 6%.⁵
THE LEVERAGE POINTS OF HEALTH BENEFIT COST MANAGEMENT

GFOA research identified six primary leverage points governments can use to manage employee health care benefits costs. These are:

1. **Change the level of the benefit provided.** Modify how many and what type of benefits the plan provides and who they provide them to.
2. **Manage participants’ choice of providers.** Direct or even limit health plan participants’ choices to lower-cost providers.
3. **Share cost with employees.** Structure the health plan so that employees bear part of the burden of benefit costs.
4. **Reduce use of health care services by employees.** Address the economic incentives and actual need for health care services.
5. **Right-source health benefit services.** Use the right combination of outsourced service providers and providers within a network to deliver health benefits.
6. **Maximize the value received for the health care dollar.** Rather than just minimizing costs, consider the benefit received per dollar spent on health benefits.

### 1. Change Level of Benefit Provided

Employers can control how many and what type of benefits the plan provides and who they are provided to. Of course, the more benefits a plan provides and the greater the number of participants in the plan, the greater the total cost of the plan will be.

As such, a public employer can consider reducing the benefit level provided to contain costs. This could include, for example, making dental, vision or other non-core coverage a voluntary option for which the employee would bear the full cost. This strategy was sparsely used by GFOA survey respondents (33%), but 86% of those respondents would recommend it, and 70% would recommend it highly — mainly because it allows employees access to expanded benefits without increasing the cost to the employer.

Certain types of services could also be dropped from the plan. For instance, one city in GFOA’s research dropped bariatric surgery. However, eliminating core benefits is a rarely used strategy, according to GFOA’s survey: Fewer than 5% have eliminated benefits for active employees. Indeed, eliminating benefits is a blunt instrument for cost containment, as it can decrease the quality of the benefits offered. Benefits have often been considered an important part of the attraction to public sector work, so this is not an insignificant consideration. In fact, about a quarter of the survey respondents cited the negative impact on employees as a reason for not eliminating benefits, while another 30% cited the lack of familiarity with the impacts as a reason for avoiding the technique.

### The ROI All-Stars

Within the six leverage points, GFOA’s research found that these strategies had the best return on investment potential. These strategies will be discussed in detail in the paper:

- **Onsite clinics.** Direct employees toward a low-cost provider while increasing satisfaction with care.
- **Variable premium contributions.** Structure employee premium contributions as a percentage of the total premium or a flat employer contribution where employees must cover the balance.
- **High-deductible health plan and health savings account.** Introduce a consumer-driven mentality to employee health care in order to reduce excess usage.
- **Wellness program.** Take a structured approach to improving employee health and, therefore, reduce need for more costly health care interventions.
- **Self-insurance.** Retain the risk associated with health insurance, as well as the profit.
- **Cooperative purchasing.** Pool with other employers to augment purchasing power.
- **Value-based insurance design disease management.** Use cost differentials to direct limited medical resources to their best effect.
Another option is to encourage employees to waive benefit coverage. For example, some governments offer cash incentives to employees to drop coverage, especially if they have coverage from other sources (e.g., a spouse), or to at least drop spousal coverage if the spouse has their own insurance. The Village of Romeoville, Illinois, for example, offered employees cash payments ranging from $2,000 to $4,000 per year to waive coverage. However, this sort of strategy was not often used by GFOA’s survey respondents (only 35% used it), but 76% of those that did would recommend it to others. Reservations about this strategy centered around the potentially small number of employees who would take the incentive and the possibility of the most healthy employees opting to drop coverage, thus leading to an increase in premiums.

Fiscal First Aid: Health Benefit Eligibility Audit

An audit of the health benefit plan could reveal that a number of participants aren’t technically eligible to participate. This could include, for example, dependents who are over age or who aren’t blood relatives or a spouse. Also, former employees may not have been removed from the plan. For example, the City of Montgomery, Alabama (population 205,764), found a potential annual savings of over $1.3 million when it discovered that 288 dependents, or 8.9%, were ineligible for benefits coverage. Smaller governments can also realize savings. Upon an initial audit, a town of 20,000 people found $20,000 in potential savings on an annual $1.2 million budget for employee health benefits.

Federal health care reform might reduce the yield available from eligibility audits because it expands coverage requirements for dependents, but audits will still remain an important cost management technique.

2. Manage Participants’ Choice of Providers

Employers can take steps to direct or even limit health plan participants’ choices to lower cost providers. Most public managers are familiar with the trade-offs between plan cost and degree of insurance provider control in health care delivery. A health maintenance organization (HMO) will typically cost less than a preferred provider organization (PPO) because it manages care more tightly. A “narrow network HMO” will reduce costs more by further restricting choice in available providers. However, less choice typically translates into less perceived benefit on the part of employees.

One strategy to manage choice of providers while improving the quality of the health benefit for employees is on-site health centers, also known as on-site clinics. An on-site clinic is essentially a doctor’s office that is provided by the public employer, on or near the employer’s premises. Staffing varies with expected use of the clinic, from only nurse practitioners and physician assistants to a full medical staff. The services offered range from just immunizations and limited acute care to physicals, lab work, behavioral health services, and even pharmacy services. A variety of management models is available for clinics, but GFOA’s case study research suggests that most governments favor relying on a third-party vendor to manage the clinic on their behalf. That’s because doing so, if contracted properly, reduces the government’s responsibility for regulatory compliance and liability concerns that would otherwise come with operating a clinic.

An on-site clinic provides savings to the employer through the following advantages:

- **On-site clinics can provide services more cheaply than commercial providers.** To provide one example, Elkhart County, Indiana (903 employees and 756 plan participants), performs a full panel blood draw at its clinic as part of its wellness program. Elkhart pays about $10 for each test, while a private provider might charge up to $100 to a patient for a comparable service.
- **Because an on-site clinic is more accessible to employees than commercial providers (i.e., closer and cheaper),** employees seek treatment for minor conditions before they become major conditions that are more costly to treat.
Employees take less time off from work both because they don’t need to travel to get medical attention and because scheduling is usually better integrated with the employer’s needs.

Research has found that on-site clinics offer a substantial return on investment (ROI): figures range from $1.60 to $4 saved for every dollar invested. The experience of GFOA’s cases study research confirms substantial benefits are available. For example, Cabarrus County, North Carolina, offers a full-service clinic to 1,300 employees and dependents and realized a net cost savings of $624,000 over a four-year period.

Of course, an on-site clinic does not have guaranteed returns. First, to be effective, a clinic must have a certain number of potential patients — about 800 to 1000. This does not mean that on-site clinics are an impossibility for smaller employers — multiple employers can share a clinic. In Texas, the City of Mesquite is on the border of what is required to run a cost-effective clinic (1,148 employees), so it joined with the Mesquite School District (4,700 employees) to offer a full-service clinic. Corpus Christi Regional Transit Authority (213 employees) contracted with a local physician group to provide preferential rates at their clinics (see sidebar below).

Once in place, employees must have an incentive to visit the clinic instead of a commercial provider. GFOA’s case studies used a number of enticements to make the clinics less expensive and more convenient than other alternatives:

- Waive or substantially reduce co-pays when visiting the clinic.
- Provide convenient scheduling options such as web-based appointment setting. Employers can also negotiate wait time standards with the managers of the clinic to ensure visits are expeditious.
- Develop advantageous time-off policies for using the clinic, such as not requiring the use of sick time to visit clinic or allowing flexible work scheduling.
- Make sure the clinic staff is professional and friendly.
- Provide services that are focused but cover major employee needs. Clinics that provide only the most basic services will not see high utilization, and services that are too specialized will not enjoy economies of scale.

Research has found that on-site clinics offer a substantial return on investment: figures range from $1.60 to $4 saved for every dollar invested.

Fiscal First Aid: Urgent Care Clinics
The Corpus Christi Regional Transportation Authority used urgent care clinics to rapidly access some of the benefits of on-site clinics. Essentially, the CCRTA contracted with a commercial provider to give the Authority highly preferential rates for the urgent care needs of CCRTA health plan participants in exchange for directing plan participants to the clinic. The clinics are neither exclusive to CCRTA employees nor on CCRTA premises. Rather, the contracted physician group has three separate clinics in different parts of the community, so is still convenient for employees. CCRTA found that the clinic showed a positive return in the first year because there were no start-up costs to speak of – the CCRTA just had to encourage employees to use the clinics.

3. Share Cost with Employees
Health care costs have escalated at a rate that far exceeds inflation. Sharing costs with employees is a way to share this burden. In addition to reducing the employer’s cost, cost sharing should help make the case with employees for strategies that reduce the total costs of the health plan because employees become more cognizant of the trade-offs between increasing health care costs and other uses of resources (e.g., their take home pay). To
illustrate, restricting the plan participants’ choices of providers decreases the quality of the benefit to employees, but research shows that employees typically prefer less choice to higher premium costs. Hence, structuring employee contributions to premiums such that their contribution depends on the total cost of the plan they select gives employees an incentive to choose a less costly plan (e.g., an HMO over a PPO).

Increasing premiums, co-pays, or deductible are all forms of cost sharing. These methods were used by 47% of GFOA’s survey respondents. Increasing deductible was slightly more popular, with 56% of respondents indicating they had used it. Among those that haven’t used these strategies, the most important barrier was usually the negative impact on employees.

While increasing an employee’s cost-sharing might be a strategy, employers should also be aware that doing so could cause a loss of "grandfathered" status under the Patient Protection and Affordable Care Act of 2010 (PPACA). Under PPACA, an employer group health plan that was in existence on March 23, 2010, can retain grandfathered status and avoid several of PPACA’s new coverage mandates that are applicable to group health plans (e.g., providing no-cost preventive care benefits and providing greatly expanded claims and appeals rights, including a right to an external appeal to an independent review organization). A group health plan can lose grandfathered status if it raises employees' coinsurance rates, raises fixed-dollar cost sharing (such as deductible, co-pays, or out-of-pocket maximums) by more than the increase in medical inflation plus 15%, or reduces the percentage of the plan's premium paid by the employer by more than 5% (all as measured from March 23, 2010). Many employer group health plans have already lost grandfathered status and have become subject to PPACA’s full range of coverage mandates. However, plans that have not yet lost grandfathered status and want to retain it should carefully review the limits imposed by PPACA on increasing employee cost-sharing mechanisms.

For plans that intend to increase employee cost-sharing, one way to mitigate some of this negative impact on employees is to implement a health reimbursement account (HRA). An HRA is an account the employer funds for each employee, and it can be used to give the employee tax-free reimbursement for qualified medical expenses. An HRA can be used to complement a traditional type of plan, like an HMO or PPO. If any employer is able to realize significant savings from the cost-sharing strategies described above, it can use part of the savings to fund HRAs. Because the money provided to employees through the HRA is tax-free, it can go a long way toward offsetting the increased out-of-pocket expenses they incur with the health plan. It should be noted that this strategy is, in some ways, similar to a health savings account (HSA) and high-deductible health plan (HDHP). However, the HRA strategy described here can be used when the deductible faced by employees are not high enough to qualify for an HSA, under IRS rules. HDHPs and HSAs are explained further in the next section of this paper.

Another option to help alleviate some of the potential for employees to experience higher out-of-pocket costs associated with cost sharing strategies (and higher deductible and co-insurance requirements in particular) is supplemental insurance. This supplement applies to higher cost, less common uses of medical services, like hospital confinement or outpatient surgery. The concept is that it will cost less to provide this more limited insurance than more comprehensive coverage, but employees still have some measure of protection. Hence,
employees have the supplemental insurance to guard against exorbitant out-of-pocket expenses owing to uncommon use of services, while the employer saves money through the more advantageous employee cost-sharing arrangements for more mundane services.

4. Reduce Use of Health Care Services by Employees
The extent to which plan participants use benefits is a key driver of the cost to the employer. There are two main factors underlying participants’ use of care. First is participants’ economic incentive to use health care. The typical health insurance model provides an incentive to overuse health care services because there is not a very direct connection between participants’ out-of-pocket costs and the actual cost of services. For example, if participants’ only cost is a $30 co-pay, there is no incentive to choose a physician who charges $100 for an office visit over one who charges $150. In fact, total overuse of service in the health care system has been estimated at between 30% and 50%. The second factor underlying participants’ use of health services is their need for service owing to their health conditions. Chronic health conditions and employees’ poor health habits are major contributors to the cost of an employer’s health plan.

Hence, employers can seek to: 1) create incentives for employees to make economically efficient choices when they need care; and 2) help employees become healthier so they need less medical care. The consumer-directed health care movement has evolved to address the first point, and employer wellness programs address the second.

Consumer-Directed Health Care
The basic premise behind consumer-directed health care is to make plan participants discerning consumers of health care services, including improved information on cost-effective choices and incentives to reduce spending. The overarching goal is to give participants a stake in containing costs. The practical incarnation of this philosophy with the greatest potential impact for an employer’s bottom line is a high-deductible health plan (HDHP) paired with health savings account (HSA) or health reimbursement account (HRA).

Fiscal First Aid: Multi-Tiered Drug Benefit
Providing a drug benefit that includes a smaller employee co-pay for generic drugs, a larger co-pay for brand name drugs, and perhaps an even larger co-pay for lifestyle drugs is consistent with consumer directed health care principles.

The most prominent feature of an HDHP is a very high deductible. To qualify as an HDHP, a plan must have deductible of a certain minimum size. The standards are set by the IRS each year and in 2011 are a bit more than $1,100 per year for individuals and $2,300 for families. However, in practice, HDHPs often have higher deductible than the IRS minimum – GFOA’s case studies commonly reported deductible of between $2,000 and $5,000, but deductible as high as $10,000 are not unheard of in the private sector. Once a plan participant meets the deductible, the health insurance benefit is activated. At this point, the participant will have a coinsurance obligation, usually paying from 10% to 20% of the claims. This obligation continues until the participant reaches an out-of-pocket maximum, at which point the insurer becomes totally responsible for all covered claims. HDHPs can be designed to limit or expand the choice of providers, much like an HMO or PPO — a design feature that becomes most germane once the deductible is met.

An HDHP is usually accompanied by an HSA or HRA. An HSA can be used only with HDHPs; it is a tax-advantaged savings account that can be used to put aside money to pay for qualified medical expenses. Employees can make tax-free contributions to an HSA, and employers can contribute as well. A key difference between an
HRA and an HSA is that the employee has “ownership” of the money in the HSA upon separation from the employer. With an HRA, the employer is the “owner” and can design the plan to provide a former employee and qualified dependents access to the funds or to require the employee to forfeit the funds upon separation from service. GFOA’s case studies demonstrated a strong preference for using HSAs over HRAs for supplementing an HDHP (though it is possible to use both16). This is because they believe that employee ownership of the HSA contributes to the “consumer driven” nature of the plan and to employee acceptance of HDHP.17

Because employees are completely responsible for health service costs up to relatively large amount with an HDHP, compared to a traditional plan, they will presumably will be more discerning about which health providers to use or whether to use services at all, and they might even scrutinize provider invoices more closely. This should translate into a lower claims experience for the employer and, hence, lower overall costs for the health plan.

It is, however, difficult to obtain a good estimate of total return on investment for an HDHP. One reason is that HDHPs have gained popularity only in the last few years, so there is limited data on which to base an evaluation. Second, because HDHPs have an important financial impact on employees as well as employers, a serious evaluation of ROI must encompass both parties. One study that attempts to overcome these two problems ran 24 simulated scenarios of HDHP/HSA against a more traditional plan and found that the total financial benefit (for both employee and employer) was greater under HDHP/HSA in 21 cases, with a total average differential of $2,019 in favor of HDHP/HSA over the entire simulated 40-year time period.18 Furthermore, at the end of the simulated period, the employee had built up an average HSA balance of $35,147. This indicates that an HDHP/HSA shouldn’t have a negative effect on employees and should even provide a net benefit.

With respect to just the employer’s costs, other research indicates savings of between 12% and 30% of premiums.19 Anecdotal evidence from GFOA’s case studies seems to support the proposition that HDHPs can provide significant savings in at least some cases: 20

- The City of Ludington, Michigan (population, 8,300, 53 full-time employees in the health plan), saved $100,000 in the first year.
- Chautauqua County, New York (population 135,000, 83 employees enrolled in HDHP), saved about $2,000 per participant.
- Columbia Public Schools, Missouri (2,550 full-time equivalent), reduced the total annual cost increases for its benefit plan to 5%, down from 9%, with only half of eligible employees choosing the HDHP option, (The rest remained in a traditional plan.)
- The City of Havre de Grace, Maryland (population 13,000, 130 employees), reduced premiums by more than $250,000 per year.

However, HDHPs have been subjected to three important criticisms. These concerns, along with the common responses of HDHP advocates, are presented below.

**Cash flow challenges for plan participants.** Some plan participants can experience cash flow problems if they don’t have enough money available to meet the deductible for their medical expenses. The essential starting point for dealing with this problem is to pair the HDHP with an HSA and/or HRA so employees will have resources available to offset the higher out-of-pocket costs. For reasons explained earlier, HSAs were more preferred by GFOA’s case studies.
Even with an HSA in place, the employee may not be able to put aside enough cash to make payments on deductible. To alleviate this concern, it was very common for the case study governments to "seed" the HSA for the employee each year. This contribution was often equal to the entire amount of the deductible, but was in all cases a substantial percentage of the deductible. This was seen as necessary to both alleviate cash flow concerns and, in cases where employees had choices between HDHP and traditional plans, to attract employees to HDHP. However, it should be noted that all of the case study governments were relatively new to HDHPs, so it was unclear if annual seeding will remain an ongoing trend or a limited-term tactic to build a cushion in employees' HSAs.

A last tool to help with cash flow concerns is a short-term loan program. Such a program is much like overdraft protection at a bank. Chautauqua County set up a small loan fund to help employees with problems meeting the deductible. Any loans made have to be paid back by the end of the year at a nominal interest rate.

Underutilization of preventative care. Given the incentive to minimize medical costs, plan participants may underutilize preventative services because they are often not perceived as an immediate, pressing need. This would, of course, lead to worse long-term health outcomes and higher costs for the employer. The commonly accepted solution is to provide for "first dollar coverage" for preventative services, which means coverage is provided for certain services regardless of whether the HDHP deductible is met. This means that preventative coverage under an HDHP is comparable to that of traditional plans. Among the most common covered services are immunizations, well-baby and well-child care, mammography, pap tests, and annual physical exams and screenings.

**Health Care Reform and Preventative Care**

It is worth noting that health care reform promotes preventative care by requiring non-grandfathered plans to provide specified preventive care services to plan participants without any employee cost-sharing. The preventive care services required by PPACA range from immunizations to screenings for various types of cancer to annual physicals and mammograms. The goal of the legislation is to encourage employees to seek preventive care by eliminating the employees' out-of-pocket costs for doing so.

Adverse selection. HDHPs are thought to hold the greatest attraction for younger and healthier individuals because they have less need for medical care and will therefore benefit from lower premiums and/or building up funds in an HSA. The other side of this coin is that less healthy individuals will gravitate toward traditional plans, thereby driving up the claims experience for these types of plans, making them even more expensive. Perhaps due to the relative novelty of HDHPs and HSAs (having only gained popularity in recent years) and the long time period over which adverse selection problems would manifest, GFOA could not find any definitive secondary research on whether adverse selection does in fact occur in employer plans or the impact of adverse selection on employer costs. GFOA's case study governments that offer traditional plans in addition to an HDHP have reported that adverse selection has not yet proven to be a problem, though they remain aware of the possibility.

Regardless of the potential gains for employees, HDHP can be a tough sell. Here are some suggestions from GFOA's case studies for making an HDHP a positive experience:

- **Do not reduce the overall scope of coverage under the HDHP compared to the traditional plan.** For example, if certain services are excluded from the HDHP, employees might associate the change with the very concept of HDHP (rather than just recognizing it as change in coverage levels that could have occurred under any plan type).
- **If possible, offer the HDHP as an option with traditional plans.** This will allow a smoother transition. Be patient, though; for employers that offer multiple plans, reaching participation goals might take some time. Persistence and planning can pay off, however. Columbia Public Schools reached 55% HDHP participation in the first couple of years, though they were hoping for just 50%.
• **Complement the HDHP with an HSA and seed it.** Employees like having an individual account to which they can make tax-free contributions that earn them interest, and an account that they control and get to keep. An HRA does not offer these advantages to the employee. Once established, it is wise for the employer to make contributions to the HSA for the employee. This will build goodwill and shouldn’t prevent the employer from realizing bottom-line savings.

• **Educate employees on what HDHP is and what its implications are.** Studies show that most people don’t really understand HDHPs. In-person meetings, printed materials, and online tools to help employees understand the individual financial impact an HDHP are all important. Our case studies advise not to assume too much when working with different employee groups. For example, the conventional wisdom is that low-wage employees would be least receptive to HDHP because of cash flow concerns. Columbia Public Schools, however, found that its lower-wage employees were among some of the most interested in the plan because of the opportunity to put more money in their own pockets through lower premium costs and an HSA.

• **Find good HDHP and good HSA vendors.** Some vendors specialize in HDHPs, so offering an HDHP may not be as simple as asking the current health insurance provider for an HDHP option. Selectivity is also important for the financial institution that acts as the custodian for the HSA. Our case studies reported that HSA administration can be a significant irritant to the employee, if not handled well. In particular, look for custodians that have low fee structures and high interest rates, easy access to funds (though a debit card option, for example), and customer service systems that are tailored to HSAs.

• **Make the cost of providing health benefits transparent.** Many of GFOA’s case studies used employee benefit committees to keep employees informed of the cost of health care. This can make the rationale for going to an HDHP much more compelling, especially if the public employer already has a system for variable sharing of premium costs. In fact, in Ludington, Michigan, employees welcomed the HDHP as a way to escape the continuing concern about health benefits becoming totally unaffordable for the City and its employees.

**Wellness Programs**

Wellness programs are initiatives employers offer in an attempt to affect the overall health of employees (and sometimes dependents), decreasing health care costs and increasing productivity. Wellness programs can take a number of forms, including a health risk assessment (e.g., lifestyle questionnaire, biometric evaluation), self-help educational materials, individual counseling, educational classes and seminars, or behavioral modification programs such as coaching. Wellness programs can have a specific focus of intervention such as weight loss, fitness, or smoking cessation, or address multiple risk factors.

Wellness programs have generated a great deal of enthusiasm among public and private employers. Almost 80% of GFOA’s survey respondents have undertaken at least some form of wellness initiative. Of those respondents, 90% would be willing to recommend it to others, and 65% would recommend it enthusiastically. These attitudes are consistent with those of private firms. This enthusiasm is not misplaced. A number of rigorous studies have shown the significant ROI potential of wellness. One meta-study of ROI for large employers (defined as more than 1,000 employees) showed that for every dollar spent, the return was $3.27 over an average three-year period. Other studies have found higher and lower ROIs, but it does seem clear that wellness programs have significant potential financial benefits, and not just for larger employers:

**Spend Money to Save Money**

Wellness programs might actually result in increased utilization of preventative services. However, this should lead to lower utilization of more costly interventions over time.
• The City of Arden Hills, Minnesota (pop 9,550, 25 employees participating in the health plan), improved its experience, leading to a $24,000 refund from their carrier and a 13% decrease in premiums.

• Since the City of Lewiston, Maine (pop 41,500, employees 443), implemented a wellness program in 2006, its health care premiums have decreased by $736,757 (through 2008). From 2007 through 2010, premiums have increased an average of 3.3%, less than the national averages of about 4.5% to 5% during that same period.26

Wellness programs sometimes have an additional ROI benefit for public employers that offer health care to retirees. The City of Irving, Texas (population 216,000, 1,800 employees), was able to reduce its GASB 45 unfunded actuarial accrued liability by 50% (from $52 million to $26 million) within two years of implementing a new retiree health insurance strategy that includes a comprehensive wellness program as a key component. The City of Irving’s approach shows that wellness programs do not have to end when active employees retire.

Given that wellness programs are fairly well established in the public sector, this paper will not address the basics of such programs but will examine the best practices of wellness programs revealed by GFOA research:

Assess the population. ROI can be best achieved by focusing wellness activities on the areas of greatest need. Biometric evaluations, claims analysis, and employee surveys are all helpful sources of data. Seek to determine the most common types of claims, the most common predictive factors, and the highest cost diseases. This will enable the employer to develop a focused, limited program. For instance, Olmsted County, Minnesota (population 141,000, enrolled employees 930), found that weight loss was its most pressing need, so the City started there. It was then able to demonstrate clear positive results to the County Board (the initiative paid for itself in the first year, and employees who benefited testified in front of the Board), thereby paving the way for additional wellness activities.

Individualize the intervention. Wellness programs that rely solely on one-size-fits all interventions are less successful than programs that recognize and address participants at multiple risk levels and provide special support for those at greatest risk. For example, Olmsted County has two levels of weight loss support:

• Intermediate: This program is open to plan participants with a body mass index (BMI) of more than 25. The 12-week program takes place in a support group setting and features advice from personal trainers, dieticians, and health coaches. Also, the County’s wellness coordinator reviews participants’ weekly food journals and provides weigh-in opportunities.

• Intensive: The intensive weight loss program is open to plan participants with a BMI of more than 35, or more than 30 with one co-morbid condition.27 The program can last up to 48 weeks, and it consists of individual sessions with a personal trainer and dietician, weekly food and physical activity accounting and weigh-ins, and consultations with a certified health coach.

As the Olmsted example illustrates, different intervention methods, like support groups, individualized counseling, and feedback, all have a role. Some research suggests that telephone counseling can be a particularly effective intervention because it is a low-cost way to provide individualized expert attention for plan participants.28

Incentives. Incentives are becoming an increasingly regular feature of wellness programs29 and were in common use among the governments participating in GFOA’s case studies. GFOA found several types of financial incentives in use:
Some research suggests that $100 for a single instance of behavior (i.e., completing a health risk assessment) is the point at which an incentive becomes meaningful to employees. Further, the reward should be paid soon after the activity is completed in order to maximize positive reinforcement. Finally, rewards are often more effective if they are not included in the regular paycheck (e.g., a gift card). However, an incentive program can work even if it does not follow these standards. In Lewiston, 86% of eligible plan participants take part in the wellness program, and a little more than 50% participate in Irving. In Manatee, 93% of employees completed the wellness actions necessary to qualify for the most advantageous plan. Incentives need not necessarily be monetary. For example, the City of Arden Hills found that a relevant gift — a pedometer — was effective for increasing employees’ interest in the wellness program. Many of GFOA’s case studies found that inter-departmental challenges were also useful. For example, departments can compete with each other to see which group of employees can lose the most weight, walk the most miles, or complete the greatest number of wellness activities.

Finally, more employers might begin considering disincentives for unhealthy behaviors more seriously. For example, Elkhart, Indiana, assesses an “up charge” equal to 10% of the employee’s monthly premium share if the employee fails to complete biometric screening. Other employers have started assessing tobacco users a surcharge on top of their existing contributions to the health benefit.

**Design a program for the whole person.** The wellness program should integrate various approaches to improving employee health. For example, Olmsted County found that it was necessary to address the psychological issues behind overeating to reach weight loss objectives. Another illustration is that a smoking cessation initiative should be accompanied by a weight management program.

Leading wellness programs are recognizing the importance of stress in employee health. Programs address the drivers of stress and increase employee coping capabilities. Specific interventions can include stress management coaching, worksite exercise programs, discounted gym memberships, or massage therapy.

**Track results.** Employers should track the results of the wellness program over time and adjust the program accordingly. This includes both employee health results and financial impacts. The same sources of data used to originally assess the workforce can be used to gauge progress. Are claims decreasing? Are biometric results improving? Also, more timely data can be gathered, such as participation in wellness events. Wireless technology has the potential to greatly improve result tracking by monitoring employee exercise regimens and submitting information like calories burned or steps taken.
Engage participants. Of course, for the wellness program to achieve the best results, plan participants have to participate and, ideally, participate enthusiastically. This starts with communication. An insight revealed by GFOA’s case studies was that the human resources office needs to be seen as credible and trustworthy. If employees have little confidence that information from biometric scans, lifestyle questionnaires, etc. will be used properly, then they will be less likely to join the wellness program. Also, GFOA’s case studies related that it can be helpful to have “wellness champions” throughout the organization to help communicate the program. It is usually not especially difficult to find a handful of employees who would be enthusiastic about the program and spread that enthusiasm to others.

Perhaps the greatest challenge the case studies encountered with their programs was engaging dependents. Not only do dependents generate a significant portion of the claims in virtually any plan, but they can sabotage the employee’s efforts to achieve personal wellness goals (imagine trying to lose weight when the rest of the family is not supportive). None of the GFOA case studies are completely satisfied with their solution to this problem, but many are trying. King County, Washington, provides an example of one approach.\(^\text{35}\) Much like Manatee County, King County presents employees with three tiers of plans, ranging from the least cost-beneficial for the employee to the most. King County requires both the employee and the spouse to meet certain wellness objectives to qualify for the best plan.

Remain aware of legal restrictions. Wellness programs must comply with a number of legal issues, so public employers need to be careful about how programs are designed. Some of the most important legal concerns include:\(^\text{36}\)

- **Make the program voluntary.** The program must be voluntary in name and in fact. For example, employers can’t set the rewards for participating so high as to be a significant part of compensation, or predicate participation in the health care benefit on participation in the wellness program.
- **Provide everyone with an opportunity for reward.** If a wellness program provides rewards based on health status factors, then the program must comply with requirements under the Public Health Service Act that are intended to make awards available to a broad range of participants, not just the healthiest.
- **Keep data secure.** Employers often collect a lot of health data through wellness programs, so privacy laws must be respected. This includes developing appropriate privacy policies and procedures as well as being mindful of using aggregate data, rather than individual data, to operate the wellness program.
- **Tax issues with incentives.** Some incentives, like gift cards, create a tax liability, while others, like reduced premiums, do not.

5. **Right-Source Health Benefit Services**

As with many services, third-party organizations can often provide health benefits more cost-effectively than in-house resources. However, this is not always the case. Governments have important opportunities to retain some parts of the work of providing benefits while still lowering their overall costs. Hence, a public employer needs to consider the opportunities and settle on the right mix of outsourced and in-sourced services, taking into account factors such as internal capacity, risk tolerance, and economies of scale. The largest such opportunity is self-insurance, so it will be the first point of discussion in this section, including considerations about moving to self insurance and what employers that are already self-insured can do to maximize the benefits of this strategy. Cooperative purchasing of health care benefits will be explored next, and finally, a number other right-sourcing strategies.
Self-Insurance
The largest potential gain from right-sourcing, for many employers, will come from self-insuring or self-funding the health plan. Self-insured employers assume the risk for providing health care benefits, rather than transferring it to a third-party insurer. Under this system, the employer pays for each claim as it is incurred, rather than paying a fixed premium to the health insurance provider. The financial benefits to self-insurance can be substantial — a reduction of approximately 10% in health care costs. These savings arise from eliminating the profit margin of commercial insurers, being able to design the benefit plan to the employer’s exact specifications, and avoiding legislative mandates that apply to commercial insurers, the costs of which are passed on to customers.

However, it should be noted that self-insurance has generally been regarded as the province of larger employers — generally those with more than 200 employees. This is confirmed by research that shows only 16% of private firms with fewer than 200 employees are self-insured, compared to 59% when all firms are considered. Smaller employers usually aren’t able to spread the risk or realize administrative economies of scale for processing claims and dealing with legal compliance requirements. However, smaller employers could gain the benefits of self-funding if they have the financial wherewithal (cash reserves) to withstand the variable expenses associated with paying actual claims as they are incurred or if they join a multi-employer benefit pool that is self-funded.

Public employers that wish to pursue self-funding need to decide how to best use third-party (e.g., private contractor) assistance. As a first step, the employer should find a consultant experienced in self-funded plans to help with: evaluating how much risk the public employer is willing and able to retain versus transferring it to a third-party insurer; negotiating terms with other service providers; and assessing the need for stop-loss insurance.

Stop-loss insurance reduces the risks associated with self-insurance by reimbursing the employer for claims that exceed a specified level. Stop-loss coverage can be especially important for risk-adverse employers. Public agencies are generally thought to be risk adverse, and GFOA’s survey bears this out, showing that only about 40% of respondents are self-insured. When looking at only respondents that have budgets of more than $50 million, the percentage of self-insured employers is still just 46% — making it appear that public agencies make significantly less use of self-insurance than private firms. Hence, a good stop-loss strategy might be essential to gaining acceptance of self-insurance among decision makers. Also, factors such as an aging workforce and increasingly sophisticated treatments are making high-cost claims more commonplace, which makes an even stronger case for stop-loss coverage.

Stop-loss coverage can apply to individuals whose claims exceed a given ceiling in a single year, in order to protect against infrequent but severe cases. Stop-loss coverage can also apply to the employer’s total costs for health care. The former is probably the more important of the two because it protects against impossible-to-predict events. The latter may be of interest to more risk adverse or smaller employers, but on average will be less beneficial because insurers typically set stop loss limits at a level of aggregate spending that is rather unlikely to be reached in any given year.

A self-insured employer should consider the role of a third-party administrator. Self-insured employers can administer claims in-house or contract out to a third-party administrator.

Finally, a self-insured employer should consider the role of a third-party administrator. Self-insured employers can administer claims in-house or contract out to a third-party administrator. The tasks of an administrator could include enrolling employees, providing customer service, processing claims, reviewing and validating invoices, provid-
ing wellness programming, and analyzing claims data. Further, a third-party administrator handles many regulatory compliance issues, although employers should never forget that they — not their third-party administrators — are ultimately responsible for the legal compliance of a self-funded plan. As a result, it is critical that employers carefully review their contracts with their third-party administrators and ensure that they have legal protections if the third-party administrator fails to perform its duties properly. An administrator should be more than just an outsourced transaction processor, though; third-party administrators can save significant costs by providing additional analysis of invoices, spending trends, and claims patterns.

Beyond these fundamentals, there are a number of other ways that employers can optimize their self-insurance strategies:

- **Carve out high-cost claims.** Claims that are rare but extremely costly can be covered by conventional insurance, thereby proving protection against low-frequency, high-cost claims. Examples include organ transplants and specialty pharmaceuticals.
- **Carefully manage high-cost areas.** Because a self-insured employer has more control over plan design, it can more rigorously manage high-cost areas. While the specific areas of greatest cost will vary for each employer, managing chronic diseases and conducting billing audits offer benefit for all employers.
- **Use data to drive wellness programs.** The previous section on wellness advocated analyzing claim data to focus wellness activity. Self-insured employers typically have much greater access to claims data. In fact, GFOA's case studies with the greatest returns from wellness programs cited self-insurance as one of the keys to their success.

**Cooperative Purchasing**

Cooperative arrangements are a staple of government purchasing, and the same idea can be applied to health benefits. According to GFOA's survey, only about a third of governments use cooperative purchasing for health care, but of those that do, most (70%) recommend it enthusiastically. This suggests untapped potential. Cooperative arrangements can take a variety of forms, from pooling purchasing power, to negotiating with vendors, to implementing a self-insurance strategy for employers that are too small to do it on their own, to designing benefit packages, to providing specialized analysis and administration services.

Cooperative purchasing can have important benefits. The Texas Municipal League’s Intergovernmental Employee Benefits Pool (with more than 150,000 covered lives in two separate pools) estimates that new members can save 5% to 20% on their premiums. Further, the Pool has the resources to design a plan to fit available budgets, so new members can reduce costs as much as they need. In another example, Marathon County, Wisconsin, gains access to benchmarking information and predictive cost modeling technology through its cooperative — resources it would not otherwise have.

Cooperative purchasing is not without its limits, foremost among which is the fact that public employers must be willing to sacrifice some flexibility when joining a pool. For example, if the cooperative decides to switch vendors for a given service, all members need to be ready to make the switch, even if they liked the old vendor. In addition, cooperative purchasing arrangements will not necessarily provide a benefit to all employers. Large employers might be better off self-insuring on their own. Also, depending on how the cooperative’s rates are structured, employers with particularly good claims experience might find they can get lower rates outside of the cooperative. Finally, traditional insurers might object to the cooperative and raise their concerns with members of the government’s governing board. Cooperatives obviously pose a threat to insurers’ business model, so they might take steps to poison the idea.
Other Right-Sourcing Strategies
Moving to self-insurance or cooperative purchasing is a fairly significant change. Here are some other strategies to make sure a public agency is getting the most from third-party providers.

Re-bidding or renegotiating. It is no secret that government budgets are shrinking. Third-party providers can be asked to share the pain via re-bidding or renegotiating. Among GFOA’s survey respondents, this was a common and well-regarded technique — 64% have used it, and 85% would recommend it. The benefits can be substantial. For example, Lackawanna County, Pennsylvania (pop. 214,000, 1,110 employees), regularly re-bids its insurance and recently saved $400,000 on its prescription drug plan over three years. However, this strategy can be used only so often (generally, every three to five years for medical benefits), and the organization must be committed to changing vendors, if necessary, lest the procurement process lose credibility.

Shift benefits education and communication expense to suppliers. Employers can transfer the cost of benefit plan communication (e.g., annual benefits booklet printing, employee benefit statement software, and educational websites) to the benefits suppliers. More than half of GFOA’s survey respondents use this technique and about 83% would recommend it, while 70% would recommend it enthusiastically. Respondents cited the economies of scale and specialization the vendor brings as well as the opportunity to reduce the government’s administrative costs. However, some governments found that this strategy wasn’t cost effective. For example, larger governments that administer much of their plans in-house may already have the requisite scale and expertise.

Use an external service provider for benefits enrollment. Employers can use an outside party to supply an enrollment system and manage open enrollment on behalf of the employer, rather than maintaining and managing a system and processing fully in-house. The rationale for this strategy is much the same as for the strategy discussed above: economies of scale and specialized expertise can be accessed through a third party. The results of GFOA’s survey were also somewhat similar. In this instance, just less than half use this strategy, of which 77% would recommend it, and 63% would recommend it enthusiastically. The survey again found that large, self-insured employers might already have in-house capabilities in this area, but it also showed that small governments might have less use for this strategy, given the small number of people who make any changes to their benefits each year.

6. Maximize the Value Received for the Health Care Dollar
Rather than just minimizing costs, the employer should also consider the value received from health care: the benefit received per dollar spent. A value-based approach seeks to maximize use of treatments that are of high value to patients and minimize the use of unnecessary or ineffective treatments. This should lead to a better long-term cost experience because the medical services used have the greatest impact both now and in the long term.

When applied to employer-provided health plans, a value-based approach to health care is known specifically as value-based insurance design (VBID). The premise of VBID is that high-cost and chronic cases account for the bulk of an employer’s overall costs. These kinds of patients usually agree to follow the course of treatment recommended by the provider. Therefore, containing costs requires that providers recommend cost-effective treatments and that the patient then follow through on their agreement with the provider. For example, studies have shown that higher co-payments will reduce usage of drugs, even if the drugs are of high value and would lead to better long-term outcomes. Hence, eliminating or lowering co-payments for high-value treatments eliminates an important barrier to patients’ maintaining their treatment regimen. To illustrate, it is far better to subsidize an employee’s $2-a-day drug cost for a high-value drug for a heart condition and potentially avoid a heart bypass surgery at more than $100,000 later on.
In the most basic approach to VBID, the employer simply lowers or eliminates co-payments for drugs or treatments that are proven to have high value relative to other treatment regimens. An elaboration on this basic model is to have more individualized cost-sharing arrangements, depending on a plan participant’s specific condition. For example, a plan participant with heart problems may have no co-payments for a drug with proven value for heart conditions, while another participant, who doesn’t have a heart problem, would have to make co-payments if they sought to use the drug for another condition, where value hasn’t been demonstrated. The crux of the idea is to adjust the out-of-pocket costs for health services based on how clinically beneficial a service is to a particular patient. This concept can also be extended to providers — employees can be given a financial incentive for using the most cost-effective providers. For example, a hospital with a lower rate of hospital-acquired infections would have lower co-pays than one with a higher rate.

VBID is still an emerging best practice in both the public and private sector. However, one notable long-term success is the City of Asheville, North Carolina (population 83,000, 1,130 employees). Since 1996, the City has run a highly successful disease management program that conforms to VBID principles. Asheville currently has five programs covering diabetes, asthma, depression, hypertension, and cholesterol. The program works as follows:

• A plan participant is identified as eligible and enrolls. Eligibility can be determined by a referral from a doctor, the City’s on-site clinic, or self-referral. Once enrolled, the patient receives co-pay waivers for medications that are of proven value to treating the disease.

• Patients are assigned to pharmacist care manager and enrolled in an educational program. The program focuses on the importance of complying with the treatment regimen.

• The patient meets with the pharmacist care manager on regular basis and gets lab tests. This information is coordinated with the patient’s doctor. All labs, drug co-pays, and pharmacist visits are 100% covered so long as the patient complies with the education classes, care manager visits, and lab draws. If patients fail to comply, they are removed from the program and must resume full co-payments.

The Asheville model is especially interesting because it has been widely studied and replicated. The City has seen positive results from each of its five programs within one year and has received an ROI of about $4 for every $1 invested. The program results in fewer trips to the emergency room for participants, less time off from work, and, of course, lower costs for the City. To illustrate the hard-dollar cost savings, the city’s program for hypertension resulted in a 46.5% reduction in cardiovascular-related medical costs during the period of one study. It is notable that cardiovascular medication use increased three-fold during this same period, thereby illustrating the premise of value-based insurance design.
FROM IDEAS TO ACTION
This part of the paper addresses how public employers can implement the cost management ideas described earlier. The first section provides guidance about which strategies to pursue, and the second addresses how to build support for the required changes.

Considering Strategies
Employers have a number of leverage points available for managing the cost of employee benefits and an even greater number of specific strategies within those leverage points. The employer must choose which strategies to go with based on factors such as the organization’s size, political environment, cost management goals, and impact on employee health and access to care. Below is a summary of the strategies with the most potential, based on GFOA’s research, along with points germane to the consideration of each strategy.

Onsite clinic. Direct employees toward a low-cost provider while simultaneously increasing their satisfaction with the care they receive.
- ROI ranges from $1.60 to $4 saved for every dollar invested, including soft-dollar saving such as increased productivity.
- Must have approximately 800 to 1,000 potential patients to be cost-effective.
- Employees must be encouraged to choose the clinic over alternatives.
- Clinic can provide more accessible and cheaper services to employees.

Premium contributions that are variable with total premium. Structure employee premium contributions as a percentage of the total premium or a flat employer contribution where employees must cover the balance.
- Contributions rise with increases in premiums so the employer does not bear full burden of increases.
- Gives employees a stake in other strategies that will reduce premium costs.
- Could conflict with collective bargaining agreements.

High-deductible health plan and health savings accounts. Introduce a consumer-driven mindset to employee health care to reduce excess usage.
- Saves between 12% and 30% of total premium costs.
- Might save employees money, especially if variable premium contributions are in place.
- Can produce unintended negative consequences if not designed properly.
- Higher deductible could conflict with collective bargaining agreements.

Wellness program. Take a structured approach to improving employee health and, therefore, reduce the need for more costly health care interventions.
- ROI for large employers averages $3.27 over a three-year period (includes soft dollar savings). Smaller employers can see a return on investment as well.
- The program can start with a limited scope of interventions or delivery mechanisms, but more comprehensive programs will have the greatest effect.
- Steps must be taken to encourage employees to participate.
- Wellness programs have clear health benefits for employees.

Self-insurance. Retain the risk associated with health insurance, as well as the profit.
- Can result in about a 10% reduction in health care costs.
- Self-insurance is generally effective only for cost-beneficial for larger employers (with at least 200 employees)
- Requires active management of risk (e.g., stop-loss insurance)
- Gives employer great flexibility to design the benefit. This provides the opportunity to design benefits that best meet employee and employer needs.

To reduce excess usage, introduce a consumer-driven mindset to employee health care.
Cooperative purchasing. Pool with other employers to augment purchasing power.
• Can help reduce costs by approximately 5% to 20%
• Provides economies of scale and access to best practices that might not otherwise be available.
• Members of the pool must give up some flexibility for the pool to work.
• Some governments (e.g., larger jurisdictions and/or those with very good claims experience) might be better off outside of the pool.

VBID disease management. Use cost differentials to direct limited medical resources to their best effect.
• ROI of about $4 for every $1 invested, over a multi-year period (including soft-dollar savings).
• Can start with a focus on one or two diseases and expand from there.
• Improves health outcomes for targeted employee groups.
• VBID is perhaps the least common of the strategies presented here, but the Asheville Project provides a solid model.

Besides considering the individual strategies, employers should consider the potential for interactions among strategies, both positive and negative. Examples include the following:
• GFOA’s most successful users of wellness and disease management cited their self-insurance programs as crucial to their success. This is because self-insurance typically grants access to a greater amount of claims detail than would be available from many commercial insurers. The data can be used to tailor the program to the greatest needs and to track progress. Also, a self-insured arrangement means that the employer will capture the full monetary benefit of a wellness or disease management program.
• An on-site clinic can boost participation in a wellness program because it makes it much more convenient for employees to get blood screens, visit a medical professional, etc.
• A cooperative purchasing arrangement can provide the economies of scale necessary for strategies that are normally limited to larger employers, such as an on-site clinic or self-insurance.
• An on-site clinic that charges less than “market value” for services in order to entice employees to use it could run afoul of IRS rules for the types of health plans that HDHP employees are allowed to participate in. This would prevent employees or employers from making contributions to an HSA, for example.

Building Support
Changes to the benefit plan can be a controversial subject. Employees could see a change in the level of benefits as a change in their compensation, and a change in the benefit plan might reduce their total take-home pay. Decision makers (i.e., elected officials, executive management) are concerned with the job satisfaction of the government’s workforce, the ROI of changes to the plan, and public perceptions. Below are strategies for working with employees and decision makers to build support for changes to the health care benefit.

Employees
A first strategy to consider for building support with employees is an employee benefit committee. A committee should include members drawn from collective bargaining groups, employees who aren’t represented by collective bargaining, and management. The committee should be given substantive responsibility over the design of the benefit plan. For example, in Clackamas County, Oregon (population 375,000, 1,800 employees in benefit-eligible positions), the committee decides the level, scope, and design of benefit plans offered to employees for medical and vision coverage, dental coverage, and for disability and life insurance. However, the committee must also take responsibility for designing a plan that is affordable, including examining claims data to account
for high cost areas and respecting financial constraints the government is subject to. Further, committee members serve as ambassadors to the employee group they were drawn from by soliciting feedback on plan changes and helping to explain cost drivers and decisions. GFOA’s case studies have found that benefit committees can go a long way toward building acceptance of benefit changes; however, the success of the committee depends on a collaborative spirit and transparency of information (e.g., claims, costs, available resources).

Another strategy is to educate employees about the value of their benefit so that they better appreciate the costs involved and the need for the benefit to be managed carefully. One popular tool is a benefit value statement. Benefits are significant piece of employee compensation, yet most employees don’t understand the value of what they are receiving. A benefit value statement lists out the benefits that are available to the employee, along with the monetary value of those benefits. However, it is important that the benefit statement not just enumerate the employer’s costs, but that it also helps the employee understand what benefits are available and how to get the best use of them. This makes it more likely that employees will read the information and even share it with their spouses. In addition, group and individual meetings around enrollment time can supplement the written statement, giving employers the opportunity to explain benefits in person and make sure employees understand what is available.

Many of the strategies discussed in this paper have potential value for employees. While the primary objective of these strategies is to control employer costs, GFOA’s case studies have highlighted some examples of positive effects on employees:

- On-site clinics are convenient for employees and can reduce their out-of-pocket costs for medical care.
- If employees share a variable of the premium cost (e.g., a percentage of total), any strategy that reduces premium costs can put more money in their pockets.
- A health savings account and high deductible health plan could provide a means for some employees to start saving money, tax free, for the future.
- A wellness program or a disease management program can lead to better long-term health outcomes.
- Self-insurance allows the employer more freedom to design a plan that most precisely meets the needs of the workforce.

**Decision Makers**

Decision makers have multiple concerns when it comes to changes to the benefit plan. By following the guidelines above for gaining employee support, decision makers’ concerns about workforce satisfaction can be alleviated. However, that still leaves concerns about public perceptions as well as return on investment.

Public employee compensation has been a hot topic in the news, so decision makers will naturally be cognizant of public perceptions. A first step is to do a total compensation study that compares the total value of compensation packages with those of comparable governments. Appendix 1 provides a table of employer costs per hour.
Containing Health-Care Costs: Proven Strategies for Success in the Public Sector

worked for total employee compensation and costs as a percent of total compensation for state and local government workers, including by employer size and bargaining unit status. The table was provided to GFOA by the Bureau of Labor Statistics using unpublished data from the Bureau’s National Compensation Survey. Appendix 1 also provides advice from the Bureau on using its National Compensation Survey data for comparative purposes.

In today’s political climate, decision makers might also wish to compare compensation costs with regional averages for all employers of a similar size (public or private) to get better sense of the compensation of public servants compared to those they serve. While this is certainly a valid question, the Bureau of Labor Statistics cautions against using National Compensation Survey data for cross-sector comparisons, given differences in compensation structures and occupations. As such, public managers will have to undertake a more customized and nuanced analysis if they wish to address this question.

The final concern decision makers have is the ROI from pursuing health benefit cost containment strategies. The first step to achieving a positive ROI is to take a long-term approach. GFOA’s best practice, Strategic Health-Care Plan Design, recommends that governments develop and adopt a formal multi-year plan to manage health care costs. This helps emphasize to all decision makers that the economics of many cost management strategies can take a while to fully develop, so a long-term commitment is required.

A long-term plan also makes it easier to take smaller steps toward a larger ultimate goal. An incremental approach limits the upfront investment and allows managers to assess the impacts of relatively small changes, and then make adjustments before proceeding further. It also limits the amount of change that employees will have to adjust to at one time. Many cost management strategies are compatible with an incremental approach. Here are some examples from GFOA’s case studies:

• A wellness or disease management program can start off by focusing on just one or two particular types of intervention (e.g., weight loss, diabetes). Use an employee health risk assessment and/or claims analysis to suggest which intervention would offer the best ROI.
• A high deductible health plan could start off with a deductible at the IRS minimum and move up over time. Employers can seed the employees’ health savings accounts, at least temporarily, to help them make the transition.
• An employer could self-insure the dental plan as a low-risk way to get experience with self-insurance. If it proves successful, self-insurance of other benefits could be explored.

CONCLUSION

Public employers face relentless upward pressures on health care costs. This paper has identified six leverage points employers have available for managing costs, as well as specific strategies for each. The optimal strategies for any given employer will vary with size, political environment, and the needs of the employees. However, the positive experiences many governments across the United States have had with health care cost containment illustrates that success is possible. By selecting and sticking to focused strategies, public employers can begin to change their approach to employee health care, both saving money and preserving the value of the benefit for employees.
Appendix 1

State and Local Government Employer Costs per Hour Worked for Employee Compensation and Costs as a Percent of Total Compensation

The information in the appendix (see chart on the following page) was provided to GFOA by the Bureau of Labor Statistics, using unpublished data from the Bureau’s National Compensation Survey.

What is the National Compensation Survey (NCS)?
- Comprehensive employer-based survey of approximately 36,000 establishments
- Represents almost all industries in the private sector and state and local government (note: the table in this appendix uses only state and local government data)
- Includes all employee size classes

Employer Costs for Employee Compensation
- NCS provides estimates of employer costs for wages and salaries and individual benefits
- Includes all major benefits but does not include low-cost benefits, items that are a cost of doing business, training, or payments in kind
- Estimates are expressed as a cost per hour worked (CPHW)
- Produced four times a year

Making Comparisons
- You can compare any grouping of employees to NCS data that makes sense for your purposes.
- Wages and salaries are calculated by:
  - Wages = Hourly wage rate
  - Salary = Pay divided by the hours worked for that specific time period
- Benefits are calculated according to cost per hour worked (CPHW)
  - CPHW = Annual cost divided by annual hours worked
  - Annual hours worked = Scheduled hours - leave hours (paid and unpaid) + overtime hours
- Avoid double counting and excluding costs
- Make apples-to-apples comparisons:
  - Government versus government
  - Occupation versus occupation
Exhibit 1: Employer Costs per Hour Worked for Employee Compensation and Costs as a Percent of Total Compensation: State and Local Government Workers, by Establishment Employment Size and Bargaining Unit Status, June 2011

<table>
<thead>
<tr>
<th>Compensation Component</th>
<th>Cost</th>
<th>1-99 Workers</th>
<th>1-49 Workers</th>
<th>50-99 Workers</th>
<th>100 Workers or More</th>
<th>100-499 Workers</th>
<th>500 Workers or More</th>
<th>Union</th>
<th>Non-union</th>
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<tbody>
<tr>
<td>Total Compensation</td>
<td>$29.92</td>
<td>100.0%</td>
<td>$27.86</td>
<td>100.0%</td>
<td>$33.28</td>
<td>100.0%</td>
<td>$42.01</td>
<td>100.0%</td>
<td>$37.11</td>
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<tr>
<td>Wages and Salaries</td>
<td>$19.75</td>
<td>66.0%</td>
<td>$18.61</td>
<td>66.8%</td>
<td>$21.62</td>
<td>65.0%</td>
<td>$27.43</td>
<td>65.3%</td>
<td>$24.32</td>
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<tr>
<td>Total Benefits</td>
<td>$10.17</td>
<td>34.0%</td>
<td>$9.26</td>
<td>33.2%</td>
<td>$11.66</td>
<td>35.0%</td>
<td>$14.58</td>
<td>34.7%</td>
<td>$12.79</td>
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<tr>
<td>Paid Leave</td>
<td>$2.13</td>
<td>7.1%</td>
<td>$1.95</td>
<td>7.0%</td>
<td>$2.43</td>
<td>7.3%</td>
<td>$3.16</td>
<td>7.5%</td>
<td>$2.61</td>
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<tr>
<td>Vacation</td>
<td>$0.93</td>
<td>3.1%</td>
<td>$0.89</td>
<td>3.2%</td>
<td>$0.99</td>
<td>3.0%</td>
<td>$1.18</td>
<td>2.8%</td>
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<td>Holiday</td>
<td>$0.66</td>
<td>2.2%</td>
<td>$0.63</td>
<td>2.2%</td>
<td>$0.71</td>
<td>2.1%</td>
<td>$0.91</td>
<td>2.2%</td>
<td>$0.72</td>
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<td>Sick</td>
<td>$0.44</td>
<td>1.5%</td>
<td>$0.37</td>
<td>1.3%</td>
<td>$0.56</td>
<td>1.7%</td>
<td>$0.84</td>
<td>2.0%</td>
<td>$0.68</td>
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<td>Personal</td>
<td>$0.11</td>
<td>0.4%</td>
<td>$0.07</td>
<td>0.3%</td>
<td>$0.17</td>
<td>0.5%</td>
<td>$0.23</td>
<td>0.6%</td>
<td>$0.22</td>
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<td>Supplemental Pay</td>
<td>$0.24</td>
<td>0.8%</td>
<td>$0.25</td>
<td>0.9%</td>
<td>$0.22</td>
<td>0.7%</td>
<td>$0.35</td>
<td>0.8%</td>
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<td>Overtime and Premium(1)</td>
<td>$0.12</td>
<td>0.4%</td>
<td>$0.13</td>
<td>0.5%</td>
<td>$0.11</td>
<td>0.3%</td>
<td>$0.18</td>
<td>0.4%</td>
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<td>Shift Differentials</td>
<td>$0.02</td>
<td>0.1%</td>
<td>$0.02</td>
<td>0.1%</td>
<td>$0.02</td>
<td>(2)%</td>
<td>$0.06</td>
<td>0.1%</td>
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<td>Non-production Bonuses</td>
<td>$0.10</td>
<td>0.3%</td>
<td>$0.10</td>
<td>0.4%</td>
<td>$0.09</td>
<td>0.3%</td>
<td>$0.12</td>
<td>0.3%</td>
<td>$0.09</td>
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<td>Insurance</td>
<td>$3.43</td>
<td>11.5%</td>
<td>$2.94</td>
<td>10.6%</td>
<td>$4.23</td>
<td>12.7%</td>
<td>$5.05</td>
<td>12.0%</td>
<td>$4.67</td>
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<tr>
<td>Life</td>
<td>$0.04</td>
<td>0.1%</td>
<td>$0.04</td>
<td>0.2%</td>
<td>$0.04</td>
<td>0.1%</td>
<td>$0.09</td>
<td>0.2%</td>
<td>$0.05</td>
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<tr>
<td>Health</td>
<td>$3.34</td>
<td>11.2%</td>
<td>$2.86</td>
<td>10.3%</td>
<td>$4.12</td>
<td>12.4%</td>
<td>$4.89</td>
<td>11.6%</td>
<td>$4.55</td>
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<td>Short-term Disability</td>
<td>$0.02</td>
<td>0.1%</td>
<td>$0.02</td>
<td>0.1%</td>
<td>$0.03</td>
<td>0.1%</td>
<td>$0.03</td>
<td>0.1%</td>
<td>$0.02</td>
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<tr>
<td>Long-term Disability</td>
<td>$0.03</td>
<td>0.1%</td>
<td>$0.02</td>
<td>0.1%</td>
<td>$0.04</td>
<td>0.1%</td>
<td>$0.04</td>
<td>0.1%</td>
<td>$0.04</td>
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<tr>
<td>Retirement and Savings</td>
<td>$1.98</td>
<td>6.6%</td>
<td>$1.68</td>
<td>6.0%</td>
<td>$2.47</td>
<td>7.4%</td>
<td>$3.52</td>
<td>8.4%</td>
<td>$2.90</td>
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<td>Defined Benefit</td>
<td>$1.71</td>
<td>5.7%</td>
<td>$1.37</td>
<td>4.9%</td>
<td>$2.25</td>
<td>6.8%</td>
<td>$3.20</td>
<td>7.6%</td>
<td>$2.64</td>
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<tr>
<td>Defined Contribution</td>
<td>$0.28</td>
<td>0.9%</td>
<td>$0.31</td>
<td>1.1%</td>
<td>$0.22</td>
<td>0.7%</td>
<td>$0.32</td>
<td>0.8%</td>
<td>$0.26</td>
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<tr>
<td>Legally Required Benefits</td>
<td>$2.38</td>
<td>8.0%</td>
<td>$2.42</td>
<td>8.7%</td>
<td>$2.32</td>
<td>7.0%</td>
<td>$2.49</td>
<td>5.9%</td>
<td>$2.32</td>
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<tr>
<td>Social Security and Medicare</td>
<td>$1.50</td>
<td>5.0%</td>
<td>$1.44</td>
<td>5.2%</td>
<td>$1.60</td>
<td>4.8%</td>
<td>$1.92</td>
<td>4.6%</td>
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<tr>
<td>Medicare</td>
<td>$0.31</td>
<td>1.0%</td>
<td>$0.29</td>
<td>1.1%</td>
<td>$0.34</td>
<td>1.0%</td>
<td>$0.44</td>
<td>1.0%</td>
<td>$0.39</td>
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<tr>
<td>Federal Unemployment Insurance</td>
<td>(4)</td>
<td>(4)</td>
<td>(4)</td>
<td>(4)</td>
<td>(4)</td>
<td>(4)</td>
<td>(4)</td>
<td>(4)</td>
<td>(4)</td>
</tr>
<tr>
<td>State Unemployment Insurance</td>
<td>$0.12</td>
<td>0.4%</td>
<td>$0.13</td>
<td>0.5%</td>
<td>$0.11</td>
<td>0.3%</td>
<td>$0.11</td>
<td>0.3%</td>
<td>$0.16</td>
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<tr>
<td>Workers’ Compensation</td>
<td>$0.76</td>
<td>2.5%</td>
<td>$0.85</td>
<td>3.1%</td>
<td>$0.61</td>
<td>1.8%</td>
<td>$0.45</td>
<td>1.1%</td>
<td>$0.45</td>
</tr>
</tbody>
</table>

1 Includes premium pay for work in addition to the regular work schedule (such as overtime, weekends, and holidays.)
2 Less than .05%
3 Comprises the old-age, survivors, and disability insurance (OASDI) program
4 Cost per hour worked is $0.01 or less.

Note: The sum of individual items may not equal totals due to rounding.

Source: Bureau of Labor Statistics
National Compensation Survey

UNPUBLISHED DATA
Notes


5 The margin of error represents a 90% confidence level, which is to say that GFOA is 90% certain the true population statistic falls within the margin of error range.


7 A 2003 survey by the International City/County Managers Association showed about a 15% cost advantage for HMOs versus PPOs.

8 Xuguang Tao, MD, PhD; David Chenoweth, PhD, FAWHP; Amy S. Alfriend, RN, MPH, COHN-S/CM; David M. Baron, MBA, CISSP; Tracie W. Kirkland, MS, APRN/PNP; Jill Scherb, PAC; Edward J. Bernacki, MD, MPH. “Monitoring Worksite Clinic Performance Using a Cost-Benefit Tool.” Journal of Occupational and Environmental Medicine. Volume 51, Number 10, October 2009.

9 A full panel blood draw provides a variety of measures for cholesterol, glucose, liver function, etc.

10 See Xuguang Tao, et al. for a discussion of ROI. ROI figures often include soft-dollar savings like less sick time used and higher productivity. Xuguang and colleagues cite the most modest ROI figures; consulting groups and industry advocates cite higher figures. Differences likely stem from differences in how ROI is calculated (e.g., which benefits of clinics are included in calculation and how they are monetized) and the structure of the clinics being evaluated.


13 The rules for HRAs are set by the IRS. See, for example, IRS publication 969.


15 One author estimates that 80% of an employer’s costs are caused by 10% of plan participants, due to chronic disease. Adapted from Samuel H. Fleet. “Self-Funding: Taking Control of an Employer’s Health Benefits Destiny Under the Patient Protection and Affordable Care Act.” Compensation & Benefits Review. 43: 30. 2011.

16 While it is possible to use both an HRA and HSA, doing so creates many complications under IRS rules, so is uncommon in practice.
17 This belief is supported by research that showed a greater level of savings and participant engagement with HSAs than HRAs. See Joanne Sammer and Stephen Miller. “Consumer-Driven Decision: Weighing HSAs vs. HRAs.” Society for Human Resource Management. May 2011.


19 Paul Brucker, in a white paper by Alliant Benefit Solutions titled “Is an HDHP/HSA the right prescription for your company?” quotes benefit consultants who estimate typical savings of about 30%, and as high as 40%. Other studies by United Health Group and Council for Affordable Health Insurance show savings of closer to 12%.

20 All figures are net of seed contributions made to employees’ HSAs.


23 In a study by Alliant, only 32% of survey respondents had heard of an HDHP if their company did not offer one. Another study by Guardian Life Insurance showed, for example, that 60% of workers do not realize they would own an HSA, and 55% aren’t aware that spending for qualified expenses from HSAs is tax free.

24 Results from the Kaiser Family Foundation Survey of Employer-Sponsored Health Benefits, 2010, show that 81% of firms with more than 200 employees see wellness programs as effective in improving employee health, and 69% see them as effective in controlling costs.

25 ROI figures include soft-dollar savings like productivity gains and reduced absenteeism. See Katherine Baicker, David Cutler, and Zirui Song. “Workplace Wellness Programs Can Generate Savings.” Health Affairs. February 2010.

26 National averages are based on information from The Kaiser Family Foundation and the Health Research & Educational Trust Employee Health Benefits Survey 2010.

27 A co-morbid condition is an illness that occurs along with obesity at greater rates than would be found in the normal population. An example is diabetes.

28 Such programs have been shown to have an ROI of 1.00 to 1.70 after three years. George Thomas DeVries III. “Innovations in Workplace Wellness: Six New Tools to Enhance Programs and Maximize Employee Health and Productivity.” Compensation & Benefits Review. 2010 42: 46.

29 A 2008 survey of large employers by Watson Wyatt showed that 74% expected to be using incentives in 2009, up from 50% in 2008. See the 13th Annual National Business Group on Health/Watson Wyatt study “The One Percent Strategy: Lessons Learned From Best Performers.”

Notes


34 Ibid.

35 King County was not investigated directly by GFOA, but its experience is described in: Ha T. Tu and Ralph C. Mayrell. “Employer Wellness Initiatives Grow, but Effectiveness Varies Widely.” Research Brief. National Institute for Health Care Reform. July 2010.

36 For more information, see Christopher S. Sears and Shalina A. Schaefer. “Legal Implications of Employee Wellness Programs for Governmental Employers.” Ice Miller, LLP. 2011.


39 Fleet.

40 Ibid.

41 Adapted from Fleet, op cit.

42 One author estimates that 80% of an employers costs are caused by 10% of plan participants. Adapted from Fleet, op cit.


46 These programs are collectively known as “The Asheville Project” and were extensively studied and written about in the Journal of the American Pharmacists Association. ROI figures include soft-dollar savings (e.g., productivity enhancements, less time off work, etc.).

Appendix C

Bolton Partners Memo – The Discount Rate for OPEB Calculations
Memorandum

To: John Hammond
From: Tom Lowman
Date: January 13, 2012
Re: The discount rate for OPEB calculations

The following are some of my thoughts and opinions on the question of whether 4% or 8% is the right assumption\(^1\) to measure the value of the County's OPEB promises. The answer is largely based on the "purpose" of the measurement. For example, here are three different purposes for this assumption:

- Funding: Determine the County's contribution to prefund the benefit
- Accounting: Determining the County's accounting expense
- Value to members: Determining the market value of the promise to participants

Each of these purposes likely has a different answer. There may also be differences due to whether we are (1) following existing rules, (2) creating our own theoretical basis for choosing a rate or (3) considering political realities within certain ranges of reasonableness.

Why 4%? Under current accounting rules the County must use a short term interest rate. In the past the County has used 4% for this purpose. We could argue that the 4% rate is too high in the current market but in the long term might be appropriate. A 4% rate is lower than the rate expected to be earned on money invested like the pension fund (which would be closer to 8%). If the County moved from the pay-as-you-go funding approach to prefunding like with the pension fund, the discount rate could be increased to 8% under existing GASB accounting rules. When we usually discuss 4% or 8% it is tied the impact under current accounting rules and the choice between pay-as-you-go vs. prefunding.

Accounting rules are not static. However, the 2011 proposed changes in the GASB pension accounting rules would change the basis from short term rates to a long term government bonds index but for unfunded plan but the result in the current market environment would be about the same. (There are many other types of proposed changes).

\(^1\) For the purpose of this memo we will not distinguish between the expect return on investments and the discount rate. However, generally we are taking about the correct discount rate.
Why 8%? We expect about an 8% return on pension fund investing. Some pension plans assume less than 8% but few are lowering expectations below 7%. 8% remains a common assumption for pension plans and is used for funding and accounting purposes. This 7% to 8% range is not a risk free return expectation, meaning that future taxpayers will bear investment risk (the larger the fund the larger the risk) and we have seen over the last decade how expensive the investment risk can be.

If we were to determine the value of the benefit to a member, the right discount rate is probably closer to 4%. Employees could not "buy" this benefit on their own in the market place based on an 8% discount rate. Setting a proper discount rate to measure employee value also is complicated since it is difficult to determine the risk premium associated with the likelihood that the payment of the benefit continues.

The commission's goals seem to include reducing OPEB benefits to a level the County can afford to fund fully on a prefunding basis (thus reducing the benefit but adding security by creating a dedicated trust fund). At one extreme this could mean to fund at a conservative discount rate (e.g. 4%) and fund any unfunded liability immediately (not over 30 years). Politically this is not going to happen and this would be more conservative than even the pension plan is managed. Anything less conservative leaves a cost (or risk) to future taxpayers or requires virtual elimination of benefits. Therefore, for practical reasons we would expect many on the commission to select the highest reasonable discount rate and push out the amortization period as far as they deem reasonable. For this reason, we would expect that many on the Commission would support using an 8% return assumption (to match the pension plan) and a 30-year amortization period (the current allowable maximum GASB 45 period). Will some look back later and complain that this choice was not conservative enough? Yes, but that is why we created this memo. Because this benefit has not been funded in the past, to ask the current generation of taxpayers to pay for both current and past promises on a more conservative basis is perhaps too much to ask. Also, the more conservative the assumptions, the deeper the needed cuts. Political will and fairness often limit what can be done.
# Today’s Discussion

<table>
<thead>
<tr>
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<th>Overview and Current Environment</th>
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<tbody>
<tr>
<td>1</td>
<td>Latest Regulatory Guidance</td>
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<tr>
<td>2</td>
<td>Key Action Steps for Plan Sponsors</td>
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<tr>
<td>3</td>
<td>Case Studies and Impact Analysis</td>
</tr>
<tr>
<td>4</td>
<td>Considerations for Dropping Group Coverage</td>
</tr>
<tr>
<td>5</td>
<td>Select Health Reform Provisions</td>
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</tbody>
</table>
Health Reform Overview

- Health reform is a journey; not an event
  - Legislation spans 2010 – 2018 and beyond
- The legislation is complex and lacks clarity
  - Employers will need professional advice and services to achieve compliance, assess cost implications, redesign benefit structure, and establish long term strategy
  - Employers should review all legal issues with their counsel
- Legislation drives coverage expansion and insurance market reform
  - Minimal near-term assistance for employers to help control costs

Healthcare Reform – Impact on Stakeholders

- Increase in Customers
- Fees/Taxes
- Min Loss Ratio Requirements
- Consumer Protections
- Increase in Demand
- Changes in Medicare Reimbursements
- Reform builds on Employer-Sponsored System
- Play-or-Pay Starting 2014
- Short-term Trend Increase

Reform focus is on Access, not on Cost Control
Health Reform Overview—Coverage v. Cost

Expanding/Improving Coverage
- Health Insurance Exchanges with Reformed Rules
- Expansion of Medicaid
- Individual Mandate
- Employer Mandate

Paying for Expanded Coverage
- Federal Coverage/Subsidies
- Medicare/Medicaid Payment Changes
- Taxation of High Income Individuals
- Increase Other Taxes
- High-Cost Employer Coverage Taxation

Impact:
- = Direct impact to employers
- = Indirect impact to employers
- = Direct and indirect impact to employers

The Price Tag

CBO Estimate—New Savings, New Revenue Will Offset Higher Costs

System Savings: $517 billion
New Revenue: $564 billion

Total Cost of Expanded Coverage: $938 Billion
Impact: $143 Billion reduction to the federal deficit (without “doc fix”)
If Past is Prologue, Expect More Health Care Legislation

Federal health care legislation enacted into law (1985-2010)
- COBRA (1985)*
- Section 89 (1986)* and repeal of section 89 (1990)*
- The Medicare catastrophic coverage program and repeal (1990)*
- HIPAA (1996)*
- Medicare + Choice (1996)*
- The Patients’ Bill of Rights (1996-2001)*
- The Women's Health and Cancer Rights Act (1998)*

* White House and Congress controlled by different political parties

If Past is Prologue, Expect More Health Care Legislation

- Mental Health Parity (2008)*
- Michelle's Law and GINA (2008)*
- COBRA subsidies (2009 and 2010)
- Patient Protection and Affordable Care Act (2010)

* White House and Congress controlled by different political parties
The Agencies—Moving Forward . . .

Implementation of PPACA continues
- Claims and appeals process, including IROs, effective this year for non-grandfathered plans
- Guidance due by March on new communication rules (4 page summary) for group health plans
- Employers still awaiting guidance on “essential health benefits”
  - TMJ syndrome
  - Chiropractic benefits
  - Infertility treatments
- Effective date of automatic enrollment postponed until guidance is issued (likely 2014)

. . . But Not in All Areas

- Nondiscrimination testing rules for fully insured group health plans will not go into effect until after the issuance of regulations
  - Were originally scheduled to become effective January 1, 2011 for calendar year, non-grandfathered insured plans
  - Now will become effective 2012, at the earliest
- Guidance postpones imminent implementation of testing rules that were expected to result in the termination or restructuring of many executive-only medical plans
  - These plans get a reprieve until at least 2012, and possibly later
  - W-2 reporting of value of group benefits delayed until 2012 (reportable in 2013)
Potential Market Impact of MLR (Medical Loss Ratio) Requirements

- New MLR requirements are as follows:
  - 85% minimum MLR for large market (100+ EEs)
  - 80% minimum MLR for individual and small group markets
- States still reviewing new regulations on MLRs and carriers continue to adopt a low profile on how MLR rules will impact renewals and new business.
- Carriers must determine potential rebate exposure from new MLR calculations
- Carrier must begin paying rebates to policyholders beginning in 2012

Some smaller carriers/health plans may downsize their product offerings and/or exit insured business in response to potential MLR exposure

Carriers (and consultants) may look to convert insured business to ASO funding

Carrier may re-assess administrative costs of internal programs based on MLR impact

Big question is the impact of MLR regulations on individual products offered in the state Insurance Exchanges given the high probability of adverse selection of Exchange enrollees

MLRs (combined with excise tax on insured plans) will impact carrier profitability and may affect ASO fees for self funded plans
The States—Planning for Exchange Implementation in 2014

- No Exchanges regulations issued yet
- Options for states are to form regional Exchange or default to federal set-up
- Key Issues/Work stream for state based Exchange Development
  - Governance/Administrative structure
    - State government, quasi government, or non-profit entity
    - Market organizer or selective purchasers
    - Funding source after January 1, 2015
    - Sustainability for participants and carriers

The States—Planning for Exchange Implementation in 2014

- Eligibility/Enrollment
  - Definition of small market 50EE or 100EE
  - Large employer participation in 2017
  - Employee enrollment period
  - Workflow for subsidy calculation
  - Restricting Exchange usage to US citizens and legal immigrants
  - Premium billing and collection
  - Free choice vouchers
  - Non-electronic enrollment process

- Education and marketing
  - Role of brokers and navigators
  - Creating a “civic obligation” to buy coverage
The States—Planning for Exchange Implementation in 2014

Information Technology
- Calculation of costs and benefit levels and what is visible to the applicant
- Linkage to other state and federal databases
- Paperless system accessible by consumer, brokers, and navigators
- Web site development and maintenance

Carrier and Plan Selection
- Innovation of new plan options
- Quality ratings and member decision support
- Definition of small markets and non-Exchange market
- Risk adjustment mechanism to deal with risk selection
- How many carriers will play?

Financial Management
- Should individual & small markets be merged
- Cost control
- Funding sources in 2015
- Rate review of Exchange plans
- Dealing with potential selection bias from weak penalties for individual mandate
The States—Adult Child Rule and State Income Tax Laws

- Employers that adopted adult child coverage during 2010 might have to report imputed income for state income tax purposes on coverage of employees' adult children.
- In 2010, IRS ruled that adult child coverage would not be taxable to employees for federal income tax purposes.
- Some state income tax laws (e.g., Connecticut, New York) automatically mirror the Federal definition of adjusted gross income when defining adjusted gross income for state income tax purposes.
  - Additional state legislative action not necessary to incorporate new enactments of Federal law.
The States—Adult Child Rule and State Income Tax Laws

- Many state income tax laws do not automatically mirror Federal definition
  - Definitions in the state income tax codes are tied to Federal definitions as of a particular date
  - State legislation is necessary to incorporate newly enacted Federal provisions
- According to the American Payroll Association, as of November 2010, several states had not yet amended their income tax laws to exclude the value of health insurance coverage for adult children who do not otherwise qualify as Federal income tax dependents

A New Compliance Era Began March 23, 2010

- Patient Protection and Affordable Care Act ("PPACA") now governs all health care plans
- There are three types of employer health care plans:
  - "Grandfathered Health Plans" as of March 23, 2010;
  - "Grandfathered Health Plans" that lose their "grandfather" status; and
  - "New" health care plans established after March 23, 2010
- Each type also can be collectively or non-collectively bargained
Advantages of a Grandfathered Health Plan

Grandfathered health plans do not have to comply with these PPACA group market rules:

- **2011:** 100% coverage of preventive health services
- **2011:** Nondiscrimination rules (fully insured plans)
- **2011:** Changes to appeals process (external review)
- **2011:** Various patient protections, including coverage of emergency services, access to pediatric care, and obstetrical and gynecological care
- **2011:** File financial data reports with HHS and state insurance departments
- **2012:** File quality of care reports with HHS
- **2014:** Coverage for individuals participating in approved clinical trials
- **2014:** Cost-sharing limits not exceeding HSA maximums—currently $5950 (individual) and $11,900 (family)
- **2014:** No discrimination against licensed health care providers
- **2014:** Health status nondiscrimination rules (wellness reward threshold increased to 30%)
Prevalence Data on Plans Losing Grandfather Status

About 85% of employers anticipate losing grandfather status for one or more medical plans by 2014

Employers’ Estimate of Year in Which Grandfathering Will Be Lost

<table>
<thead>
<tr>
<th>Year</th>
<th>Self-Insured Plans</th>
<th>Fully-Insured Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>51%</td>
<td>46%</td>
</tr>
<tr>
<td>2012</td>
<td>21%</td>
<td>18%</td>
</tr>
<tr>
<td>2013</td>
<td>8%</td>
<td>7%</td>
</tr>
<tr>
<td>2014</td>
<td>8%</td>
<td>10%</td>
</tr>
</tbody>
</table>

(\(n = 466\))

Anticipated Cause of Lost Grandfathering

- Design Changes: 72%
- Subsidy Changes: 39%
- Plan Consolidation: 16%
- Changing Carriers: 16%
- Union Negotiations: 15%

(\(n = 466\); participants could select multiple responses)

Source: 2010 Hewitt survey of employers’ reaction to grandfathered plan rules and guidance surrounding preventive care and other group market insurance reforms.

Adult Child Dependent Coverage to Age 26

- Interim Final Regulations Issued May 10, 2010 – Addresses coverage extension
  - Effective for plan years beginning on or after September 23, 2010 regardless of plan’s grandfathered status
  - Requires plans that provide dependent coverage to children to make coverage available to all “children” under the age of 26
    - Student status, marital status, residency, financial support, dependent status for tax purposes, or other criteria not applicable
  - Exception for grandfathered plans until January 1, 2014 if coverage under nonparent eligible employer sponsored plan available
    - Mandates special enrollment opportunity for certain adult children
      - Timing: No later than 1st day of plan year; must last 30 days
      - Must provide written notice to eligible adult children
  - IRS Notice 2010-38 issued April 27 – Addresses taxation of coverage
    - Health coverage or reimbursement of medical expenses for a child who has not attained age 27 by the end of the taxable year will not be taxable to the employee
      - Tax exclusion applies even if the child is not a tax dependent
      - Effective on or after March 30, 2010
      - Special rule for cafeteria plans permitting retroactive amendments in 2010
Annual/Lifetime Dollar Limits

- Interim Final Regulations Issued June 28, 2010
  - Plans cannot impose annual or lifetime dollar limits on essential health benefits for plan years beginning on or after September 23, 2010 except as noted below (regardless of grandfathered status)
- Restricted Annual Limit Exception
  - For plan years beginning before January 1, 2014, a group health plan or group health insurance policy may impose the following restricted annual limits on essential health benefits:

<table>
<thead>
<tr>
<th>Plan Year Beginning</th>
<th>Plan Year Ending</th>
<th>Annual Limit Must Proceed</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 23, 2010</td>
<td>September 23, 2011</td>
<td>$7,800,000</td>
</tr>
<tr>
<td>September 23, 2011</td>
<td>September 23, 2012</td>
<td>$1,250,000</td>
</tr>
<tr>
<td>September 23, 2012</td>
<td>September 23, 2013</td>
<td>$2,000,000</td>
</tr>
</tbody>
</table>

- “Mini-Med” or Limited Benefit Plans Annual Limit Exception
  - A process will be established by which such plans may seek a waiver until 2014 to permit lower restricted annual limits, if compliance with the higher limits would result in a significant decrease in access to benefits or a significant increase in premiums
- Grandfathered Plan Status Implications
  - A change in annual limits, even if permissible, can result in the loss of grandfathered plan status

Patient Protections

Primary Care Providers
- Interim Final Regulations Issued
  - Require plans that offer a network of providers to permit any practitioner in the network to be designated as an individual’s primary care provider, pediatrician, or gynecologist
  - Notice must be provided informing each participant of his/her right to make such a designation
  - Do not apply to grandfathered plans

Emergency Services
- Interim Final Regulations Issued
  - Require plans to cover emergency services without the need for pre-authorization and without regard to whether the provider is in its network
  - Group health plan or group health insurance coverage that offers a network of providers, covers emergency services, and subjects such services to a co-payment or to co-insurance, must ensure that the rate imposed for out-of-network emergency providers does not exceed the cost-sharing requirements that would be imposed if the services were rendered by a network provider [balance billing is permissible subject to minimum reimbursement requirements]
  - Do not apply to grandfathered plans
Patient Protections (Cont’d)

<table>
<thead>
<tr>
<th>Pre-Existing Conditions</th>
<th>Rescissions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interim Final Regulations Issued</strong></td>
<td><strong>Interim Final Regulations Issued</strong></td>
</tr>
<tr>
<td>• Prohibit the exclusion of coverage of specific benefits associated with a pre-existing condition</td>
<td>• Prohibit the retroactive rescission of health coverage except in the case of fraud or intentional misrepresentation of a material fact</td>
</tr>
<tr>
<td>• Prohibit a complete exclusion from the plan if based on a pre-existing condition</td>
<td>• Apply to insured plans in the group and individual markets, as well as self-insured plans</td>
</tr>
<tr>
<td>• Leave unchanged the existing rule under HIPAA that permits an exclusion of benefits for a condition if the exclusion applies regardless of when the condition arose relative to the effective date of coverage</td>
<td>• Do not prohibit coverage from being cancelled on a prospective basis</td>
</tr>
<tr>
<td>• Apply to plan years beginning on or after January 1, 2014, except for individuals under age 19, applies for plan years beginning on or after September 23, 2010</td>
<td>• Do not prohibit coverage from being cancelled retroactively if the cancellation is attributable to a failure to pay required premiums or contributions</td>
</tr>
<tr>
<td>• <strong>Apply to grandfathered plans</strong></td>
<td>• Require 30 days advance notice of a rescission, when still permitted</td>
</tr>
<tr>
<td></td>
<td>• <strong>Apply to grandfathered plans</strong></td>
</tr>
</tbody>
</table>

**Preventive Care Services**

• **Interim Final Regulations Issued July 19, 2010**
  • Require non-grandfathered group health plans and health insurers to:
    • Cover “recommended” preventive health services, and
    • Eliminate cost-sharing requirements for required preventive health services (cost-sharing permitted for out-of-network services)
  • Effective for plan years beginning on or after September 23, 2010
  • Permit the use of reasonable medical management techniques for determining the frequency, method, treatment, or setting for the provision of preventive services, if not otherwise specified in guidelines
  • Grant a one year delay following the release of a new or modified recommendation or guideline for implementation
  • If a preventive service is no longer “recommended”, plans are not required to cover or waive cost-sharing
Required Preventive Services

- The following preventive services must be covered without cost sharing:
  - For all plan participants, United States Preventive Services Task Force (USPSTF) recommendations that have a current rating of A or B
  - For children, adolescents, and adults, Centers for Disease Control and Prevention (CDC)-approved immunizations recommended for routine use by its Advisory Committee on Immunization Practices
  - For infants, children, and adolescents, Health Resources and Services Administration (HRSA) guidelines for preventive care and screenings
  - For women, HRSA guidelines for preventive care and screening not otherwise addressed by the recommendations of the USPSTF, which are expected to be released by August 1, 2011

- Special Rule for Breast Cancer Screening:
  - The most recent recommendations issued in November 2009 (begin screening at age 50) will be disregarded and the prior recommendations issued in 2002 (begin screening at age 40) will be considered current until new recommendations are issued.

For a complete list of required preventive services, visit: http://www.healthcare.gov/center/regulations/prevention/recommendations.html

Physician Office Visits and Cost Sharing

- The rules clarify that:
  - If physicians provide recommended preventive services during office visits, and bill or track separately for the services, plans may still require copayments or other cost-sharing for the office visits but not the preventive services.
  - If physicians don’t bill or track separately for recommended preventive services, and the primary purpose for the office visits is to deliver the preventive services, plans may not require copayments or other cost-sharing for the office visits.
  - If physicians don’t bill or track separately for recommended preventive services, and the primary purpose of the office visits is not to deliver the preventive services, plans may still require copayments or other cost-sharing for the office visits.
Internal & External Appeals Regulations

- Interim Final Regulations Issued July 23, 2010
  - Require nongrandfathered individual and group health plans to:
    - Make changes to internal claims and appeals processes, and
    - Institute a new mandatory, external review under either a State or Federal process
  - Effective for plan years beginning on or after September 23, 2010
  - Transition period until July 1, 2011 for establishment of compliant State external review processes
  - For plan years beginning before July 1, 2011, existing State external review processes apply

Internal Claims & Appeals Process

- Regulations build upon existing DOL claims procedures and require the following changes:
  - Adverse Benefit Determinations – Rescissions of coverage are now included in the definition
  - Expedited Notice for Urgent Care – Plans must notify claimants of benefit determination of urgent care claims within 24 instead of 72 hours
  - Full and Fair Review – Before an adverse benefit determination is issued, a plan must now also provide the claimant, free of charge, any new or additional evidence considered and the rationale for a decision as soon as possible and sufficiently in advance of the final internal adverse benefit determination to give the claimant an opportunity to respond
  - Conflict of Interest – Plans must ensure that all claims determinations and appeals are designed to ensure impartiality and independence of the persons making the decisions
- Denial Notices – Notices of adverse benefit determinations must be “culturally and linguistically appropriate,” and include:
  - Sufficient information necessary to identify the claim involved (date of service, provider, claim amount, diagnosis and treatment codes and meanings)
  - The reason(s) for the adverse determination (including the denial code and its meaning and a discussion of the decision)
  - A description of available internal and external appeal processes; and
  - Contact information for office of health insurance consumer assistance or ombudsman
Internal Claims & Appeals Process (Cont’d)

• Exhaustion of Internal Appeal – If plans fail to adhere to the new requirements, the internal claims review process is deemed exhausted and the claimant can proceed to external claims review and/or applicable judicial remedies

• Continued Coverage – Plans must provide continued coverage pending the outcome of the appeal

External Claims & Appeals Process

• Nongrandfathered plans must comply with either a State external review process (if applicable) or a new Federal external review process
  – Insured and non-ERISA self-funded plans (church and governmental plans) need to comply with existing or future State external review process
  – Self-insured group health plans will need to comply with Federal external review process standards which are described in temporary regulatory guidance

• Regulations provide minimum requirements for qualifying State external review processes, including the consumer protections of the National Association of Insurance Commissioners (NAIC) Model Act requirements
  – Provides transition period for State external review processes until the plan year beginning on or after July 1, 2011; before then, existing processes will be deemed compliant
  – If no applicable State process, then will need to comply with Federal process

• Interim rules regarding federal external review process standards are contained in recent regulatory guidance

• HHS Secretary can deem external review processes in effect as of March 23, 2010, as compliant
Break Time for Nursing Mothers – DOL Fact Sheet

• DOL Wage and Hour Division Fact Sheet #73 Issued July 15, 2010
  – Requires employers to grant break time to an employee to express breast milk for her nursing child for one year after child’s birth
  – PPACA amended Section 7 of the Fair Labor Standards Act (FLSA); the FLSA amendment took effect when PPACA was signed into law on March 23, 2010
• Break Timing
  – “Reasonable” amount of time “as frequently as needed”
• Break Location
  – A place other than a bathroom
  – Functional as a space for expressing breast milk
  – Shielded from view, and
  – Free from any intrusion by co-workers or the public
• Coverage
  – Only employees not exempt from FLSA’s overtime pay requirements are eligible
  – State law may impose similar requirements for exempt employees
  – Employers with less than 50 employees are exempt if compliance would pose an undue hardship
• Compensation
  – Employers are not required to compensate employees for these breaks; however:
    • An employer allowing paid breaks must compensate a nursing employee in the same way it does others if she uses such a break to express breast milk; and
    • The lactation break must be treated as time worked if the employee is not “completely relieved from duty” during the break

Early Retiree Reinsurance Program

• Interim Final Regulations Issued
  – Program began June 1, 2010
  – Applications must be submitted and approved before claim submission
  – Plan must have programs/provisions in place designed to reduce costs for members with chronic and high-cost conditions
  – Plan sponsors must have programs and policies in place to detect fraud, waste and abuse
  – Payments used to “reduce plan’s costs” or reduce retiree contributions or cost sharing

“First Come First Serve” – One time application opened June 2010:
$5 billion limit for the entire period program offered
Ceases 12/31/2013 in anticipation of Exchanges in 2014
Grandfathered Plan Regulations

- Interim Final Regulations Issued June 17, 2010
  - Grandfathered Health Plan Definition:
    - A plan in which individuals were enrolled on March 23, 2010 and continuously covers at least one individual since then (need not be the same individual)
    - Exempt from certain health reform provisions
    - Permitted to add family members and new enrollees
    - Grandfather status applies separately to each "benefit package" (e.g., option)
    - If no impermissible changes are made, plan can retain grandfather status indefinitely

Changes Resulting in Loss of Grandfathered Plan Status

- Issuance of new policy, certificate or contract of insurance (exception for certain bargained plans)
- Elimination of all or substantially all benefits to diagnose or treat a particular condition
- Increase in percentage coinsurance requirements
- Increase in copays by more than the greater of $5 (adjusted for medical inflation) or medical inflation since March 23, 2010 plus 15 percentage points
- Increase deductibles or OOP maximum by more than medical inflation since March 23, 2010 plus 15 percentage points
- Decrease in employer contribution rate toward cost of any coverage tier for similarly situated individuals by more than 5 percentage points (if the rate is based on cost of coverage) or by more than 5% (if the rate is based on a formula such as hours worked)
- Decrease or add a new annual limit on the dollar value of benefits (exception for plans that had a lifetime, but no annual, limit on March 23, 2010)
- Transfer of employees into another grandfathered plan to avoid new consumer protections
- Merger, acquisition or similar business restructuring primarily to cover new individuals under a grandfathered health plan

Plans that lose grandfather status become subject to all health reform law provisions
Changes Permitted Without Loss of Grandfathered Plan Status

- Change amount of premiums (as long as employer contribution rates towards cost of any coverage tier for similarly situated individuals do not decrease by more than 5 percentage points since March 23, 2010)
- Increase benefits
- Changes to third party administrator (for self-insured plans)
- Changes to comply with federal/state laws
- Voluntary health reform plan changes
- Renewal of policy, certificate, or contract of insurance
- Changes to fixed amount copayments (within specified limits)
- Changes to employer contribution rates (within specified limits)
- Increase deductibles or OOP maximum (within specified limits)
- Addition of annual limits (within specified limits)
- Special transition rules
  - Changes made to comply with contracts, plan amendments, or State insurance department filings entered into prior to March 23, 2010
  - Good faith changes prior to the issuance of regulations
  - Revocation/modification of any impermissible changes

Collectively Bargained Plans

- No delayed effective date for self-funded collectively bargained plans in effect on March 23, 2010 (need to comply with health reform law provisions at the same time as other grandfathered plans)
- Fully-insured collectively bargained plans may make changes and still retain grandfather status until the end of the last collectively bargained agreement in effect on March 23, 2010
  - At that time, collectively bargained plan either retains or immediately loses grandfather status, depending on changes made
  - A change in insurers until that time does not, by itself, cause loss of grandfather status
Grandfathered Plan Disclosure & Record-Keeping Requirements

• Participant Disclosure Requirements
  – Plan materials (e.g., open enrollment materials, SPDs, SMMs, etc.) must include a statement indicating that the plan is considered to be grandfathered, and must provide contact information for questions or complaints
  – Model language provided

• Maintenance of Records
  – Plans must maintain records that document the benefit terms that were in effect on March 23, 2010, and that verify grandfathered status
  – Must make records available upon request to any participant, beneficiary, policy subscriber, or state or Federal agency official

Changes That May Result in Loss of Grandfathered Plan Status

• Changes the agencies are considering adding to the list of impermissible changes:
  – Changes to plan structure (i.e., switching from Health Reimbursement Arrangement to major medical coverage)
  – Changes in a network plan’s provider network
  – Changes to a prescription drug formulary
  – Any other substantial changes to the overall benefit design

• Any new standards that are more restrictive than the interim final regulations would only apply prospectively to changes to plans or health insurance coverage after issuance of the final rules
### Health Reform Provisions Applicable to Grandfathered Plans

<table>
<thead>
<tr>
<th>Health Reform Provision</th>
<th>Effective Date (calendar year plans)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• No lifetime or annual dollar limits on essential health benefits (restricted annual limits allowed 2011-2014; “mini-med” plans may apply for a waiver of those limits)</td>
<td>2011</td>
</tr>
<tr>
<td>• Extension of dependent coverage until age 26 (grandfathered plan exception until 2014 if coverage is available under nonparent plan)</td>
<td>2011</td>
</tr>
<tr>
<td>• Prohibition on rescissions (retroactive) of coverage</td>
<td>2011</td>
</tr>
<tr>
<td>• Uniform explanation of coverage</td>
<td>2012</td>
</tr>
<tr>
<td>• Auto-enrollment for large plans (200+ FTEs)</td>
<td>Unclear (subject to issuance of regulatory guidance)</td>
</tr>
<tr>
<td>• Prohibition on waiting periods &gt;90 days</td>
<td>2014</td>
</tr>
</tbody>
</table>

### Health Reform Provisions Not Applicable to Grandfathered Plans (i.e., What Plans That Lose Grandfather Status Need to Comply With)

- Coverage of preventive health services without any cost-sharing (2011)
- Nondiscrimination by insured plans in favor of highly compensated individuals (2011)
- No prior authorizations to select doctors for obstetrical/gynecological care or for emergency services (2011)
- Claims and appeals procedures (2011)
- Uniform rating rules (2011)
- Quality of care reporting requirements (2011)
- Transparency in coverage disclosures (2011)
- Coverage of adult children to age 26 who have other nonparent eligible employer-sponsored health plan coverage (until 2014 when grandfathered plans must cover all adult children to age 26)
- Coverage for individuals participating in approved clinical trials (2014)
- Insurance premiums rating restrictions (2014)
- Guaranteed availability of health insurance coverage (2014)
- Guaranteed renewability of insurance coverage (2014)
- Nondiscrimination based on health status (2014)
- Nondiscrimination with respect to health providers (2014)
- Essential health benefits package requirements [for insured small group market plans] (2014)
- Annual cost-sharing limits (2014)
Today’s Discussion

0 Overview and Current Environment
1 Latest Regulatory Guidance
2 Key Action Steps for Plan Sponsors
3 Case Studies and Impact Analysis
4 Considerations for Dropping Group Coverage
5 Select Health Reform Provisions
6 Health Reform Self-Service Tools
7 Appendix: Legislative Details and Model Notices
8 Reference: Health Reform Chronology

Implementation of Health Reform

<table>
<thead>
<tr>
<th>Regulatory Challenges</th>
<th>Plan Sponsor Near-Term Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Complex and challenging new law to implement</td>
<td>• Limited or delayed guidance from agencies</td>
</tr>
<tr>
<td>• 2,400 pages plus 153 page reconciliation bill plus managers’ amendments</td>
<td>• Some market reform changes must be implemented for plan years beginning on or after September 23, 2010, e.g.,</td>
</tr>
<tr>
<td>• Date of enactment was March 23, 2010 and amended on March 30, 2010</td>
<td>– Coverage of dependents up to 26</td>
</tr>
<tr>
<td>• HHS (Health and Human Services), DOL and IRS on point for implementation</td>
<td>– Elimination of lifetime/annual maximums</td>
</tr>
<tr>
<td>• Many regulations are already issued, and many more are to come</td>
<td>• Medical plan impact</td>
</tr>
<tr>
<td></td>
<td>– Accounting changes related to Medicare retiree drug subsidy tax</td>
</tr>
<tr>
<td></td>
<td>– Early retiree reinsurance program</td>
</tr>
</tbody>
</table>
### Key Action Steps for Plan Sponsors

<table>
<thead>
<tr>
<th>Year – Provision</th>
<th>Action Steps</th>
</tr>
</thead>
</table>
| 2010 – Temporary Reinsurance for Pre-65 Retirees | • Determine if eligible per May 3 guidelines  
• Apply for claim reimbursement  
• File quickly |
| 2010 – Insurance Market Reforms | • Conduct actuarial impact modeling  
• Update plan documents, HIPAA certificates, & SPDs  
• Communicate plan design changes |
| 2011 – Comply with Class Act | • If participating, prepare enrollment and payroll systems  
• Communicate value of enrollment for long term care & disability |
| 2011 – OTC Drugs (except insulin) Paid through Accounts Need Prescription | • Update administrative process with vendors  
• Communicate new guidelines prior to and during annual enrollment |
| 2011 – Model the cost impact of the health reform law | • Conduct cost modeling over a 3-5 year period  
• Model the cost to the organization to drop sponsorship of group health coverage beginning in 2014 when the Exchanges are operational  
• Model the cost impact of remaining “grandfathered” versus moving to a new plan with modified plan design  
• If the employer has retiree medical coverage, model the cost impact of insurance market reforms and other provisions of the new law |
| 2013 – Implement federal requirement to auto enroll new hires and continue enrollment of existing enrollees (subject to regulatory guidance yet to be issued) | • Comply with federal requirements to provide enrollment to new hires  
– Determine medical plan in which to enroll new hires  
– Create opt-out procedures  
• Update SPDs and plan documents  
• Work with employee benefit outsourcing partner to update systems |
### Key Action Steps for Plan Sponsors (Cont’d)

<table>
<thead>
<tr>
<th>Year – Provision</th>
<th>Action Steps</th>
</tr>
</thead>
</table>
| 2012 – Disclosure of Cost of Group Coverage on Forms W-2 (2012 W-2 statements distributed to employees in 2013) | • Calculate plan costs once regulatory guidance is issued  
 • Develop employee communications to explain new cost reporting |
| 2012 – Develop Uniform Summary of Benefits | • Await HHS guidelines on model summary  
 • Develop and distribute to workforce  
 • Ensure that 60-day advance notice of any changes to that Summary is provided to participants |
| 2012 – Fee for Comparative Effectiveness Program | • Budget for fee of $1/participant in Year 1 and $2/participant up to 2019 |
| 2013 – FSA salary reduction contributions limited to $2,500 (indexed to CPI) | • Update plan documents, HIPAA certificates, and SPDs  
 • Communicate new guidelines to workforce prior to annual enrollment |
| 2013 – Employee Communications about Insurance Exchanges | • Create and distribute notices to workforce |
| 2014 – Effective Date for Key Employer Responsibilities | • Eliminate > 90 day waiting period  
 • Update SPDs and plan documents  
 • Eliminate any annual dollar limits on essential health benefits (restricted annual limits no longer permitted)  
 • Determine compliance with minimum 60% of actuarial value  
 • Determine number of employees at risk for both the free rider penalty and employee vouchers  
 • Comply with federal requirements to inform new hires about Insurance Exchanges and their potential eligibility for subsidized coverage |
Other Key Provisions

<table>
<thead>
<tr>
<th>Year</th>
<th>Provisions</th>
</tr>
</thead>
</table>
| 2013 | • Tax credits for middle income Americans up to 400% of FPL (Federal Poverty Level)  
      • Fee for Comparative Effectiveness Research of $2 for each covered individual |
| 2014 | • Individual Mandate begins with penalties in 2015  
      • Medicaid expansion to 133% of FPL  
      • State-based Insurance Exchanges are operational for individuals and small groups; may be expended by states in 2017 to larger employer groups |
| 2020 | • Medicare Part D “donut hole” closed |

Key Health Reform Notice Requirements

<table>
<thead>
<tr>
<th>Provision</th>
<th>Action Steps</th>
</tr>
</thead>
</table>
| Extension of Dependent Coverage to Age 26 | • Notice of Opportunity to Enroll  
  - Offer and communicate 30-day special enrollment opportunity for those previously ineligible; can coincide with open enrollment if notice is prominent  
  - Model notice provided  
  - No later than first day of the first plan year on or after 9/23/10 |
| Lifetime limit removal | • Notice that Lifetime Limit No Longer Applies and Opportunity to Re-Enroll  
  - Provide individuals who reached limit with notice that lifetime limit no longer applies and provide those no longer enrolled with opportunity to re-enroll  
  - Model notice provided  
  - No later than first plan year on or after 9/23/10 |
| Patient Protections (PCP & OB/GYN) | • Update Plan Documents (non-grandfathered plans only)  
  - For plans that require PCP designation, communicate that members may select any participating PCP or pediatrician and no referral needed for OB/GYN care. Primary care physician designation and OB/GYN self referral change  
  - Model notice provided  
  - No later than first plan year on or after 9/23/10 |
| Rescissions | • Notice of Rescission or Cancellation of Coverage  
  - Provide 30 day prior notice and include an appeal notice  
  - Upon rescission or cancellation of coverage |
Key Health Reform Notice Requirements

<table>
<thead>
<tr>
<th>Provision</th>
<th>Action Steps</th>
</tr>
</thead>
</table>
| Grandfather Status               | • Notice of Grandfathered Plan Status (grandfathered plans only)  
  - Plan materials (e.g., open enrollment materials, SPDs, SMMs, etc.) must include a statement indicating that the plan is considered to be grandfathered, and must provide contact information for questions or complaints  
  - Model notice provided  
  - No later than first plan year on or after 3/23/10 |
| Health Account Changes           | • Update Plan Documents  
  - Health accounts (FSAs, MSAs and HSAs) can no longer be used to pay for OTC medications without a prescription (except insulin)  
  - Penalty for using HSA for non-qualified medical expense doubles from 10% to 20%  
  - Effective 1/1/2011 |
| W-2 Reporting                    | • W-2 Reporting of value of health benefits  
  - W-2 Forms provided to each employee must include “value” of health benefit coverage (value defined as COBRA cost)  
  - Effective 1/1/2012 (2012 Forms W-2 delivered to employees in 2013) |
| CHIP Notice                      | • CHIP Notice  
  - Describe the availability of premium assistance for certain employees/dependents residing in participating states  
  - Model notice provided  
  - No later than the latter of (1) the first day of the first plan year beginning after 2/4/2010 or (2) 5/1/2010 |

Employer Call to Action

An employer’s long-term strategy should consider all potential factors that impact costs:

<table>
<thead>
<tr>
<th>Potential Factor</th>
<th>How to Determine Cost Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct impact of health reform legislation</td>
<td>• Aon’s actuarial cost modeling</td>
</tr>
<tr>
<td>Expected cost increases by insurers from significantly increased tax and regulatory burden</td>
<td>• Cost impact to become clearer upon renewal</td>
</tr>
<tr>
<td>Cost - shifting from reduced Medicare payments over the next 10 years</td>
<td>• Difficulty to quantify employer impact by location; partially offset by less cost shifting from coverage expansion</td>
</tr>
</tbody>
</table>
Employer Call to Action

• National health reform law addresses coverage for the uninsured and insurance market reforms; little help for plan sponsors to lower long term medical trend
• Health reform could add an additional 2% to 5% health care costs for plan sponsors. Engaging in cost modeling offered by Aon actuaries can determine 3-5 year cost impact
• Congress is likely to raise the $2,000/EE free rider penalty by 2014 for employers who do not offer group coverage or that provide unaffordable coverage. The penalty is not tax deductible
• Employers will get little help from Washington to lower EE health costs, resulting in the need for new health care strategy

Next Steps for Plan Sponsors

• Focus on near-term compliance with insurance market reforms
• Model the long term impact of national health reform on costs of group coverage.
• Consider new strategies to lower long-term medical trend.
• Decide on communication approach for employees on impact of new national health reform law
• Focus on participation in temporary re-insurance program for pre-65 retirees (if applicable)
• Monitor development of HHS regulations providing guidance on implementation of new health reform law
Impact of Health Reform

<table>
<thead>
<tr>
<th>Change</th>
<th>Effective for Calendar Year Plans</th>
<th>Estimated Cost to Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Adult children up to age 26, regardless of marital or full-time student status, can be covered under our grandfathered plans unless they are eligible for coverage under a nonparent employer-sponsored health plan (beginning 2014, can be covered under parent plans even if coverage available elsewhere)</td>
<td>2011</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>• Elimination of lifetime plan benefit maximum</td>
<td>2011</td>
<td>&lt;0.5%</td>
</tr>
<tr>
<td>• Pre-existing exclusions are waived for children age 19 and under</td>
<td>2011</td>
<td>&lt;0.5%</td>
</tr>
<tr>
<td>• Over-The-Counter (OTC) drugs, except insulin, are not reimbursable under the healthcare FSA without a prescription</td>
<td>2011</td>
<td>None</td>
</tr>
<tr>
<td>• Forms W-2 must disclose value of health benefits</td>
<td>2012</td>
<td>Administrative cost only</td>
</tr>
<tr>
<td>• CLASS Act – national voluntary Long Term Care (LTC) insurance – auto-enrollment with payroll deductions (unless employee opts-out)</td>
<td>2011</td>
<td>Administrative cost only</td>
</tr>
<tr>
<td>• Auto-enrollment in health coverage (unless employee opts-out)</td>
<td>2013</td>
<td>Administrative cost only</td>
</tr>
</tbody>
</table>
### Impact of Health Reform

<table>
<thead>
<tr>
<th>Change</th>
<th>Year of Enactment</th>
<th>Estimated Cost to Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Comparative Effectiveness Fee of $1 per participant in year 1, $2 per participant thereafter. Ends on 1/1/2020</td>
<td>2013</td>
<td>&lt;0.1%</td>
</tr>
<tr>
<td>• Cap salary deferral contributions to Healthcare Flexible Spending Account (HCFSA) at $2,500</td>
<td>2013</td>
<td>None</td>
</tr>
<tr>
<td>• Increase Medicare tax by .9% for individuals earning over $200,000 for an individual</td>
<td>2013</td>
<td>None</td>
</tr>
<tr>
<td>• Free Rider Penalty invoked if plan has less than a 60% actuarial value, is considered “unaffordable” or if employer does not offer health coverage at all</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 60% actuarial value (i.e., plan must pay at least 60% of covered expenses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• “Unaffordable” defined as employee premiums (medical and Rx) in excess of 9.5% of AGI</td>
<td>2014</td>
<td>• Lesser of $3,000 for each EE receiving subsidy or $2,000 for each full-time EE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Low risk of EEs meeting eligibility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Penalty is cost savings as our subsidy is greater than the current penalty</td>
</tr>
<tr>
<td>• Employer must offer free choice vouchers to qualified employees</td>
<td>2014</td>
<td>Administrative cost only – voucher is equal to employer subsidy amount</td>
</tr>
<tr>
<td>• Employees eligible if income &lt;400% FPL and employer plan contributions are 8%-9.8% of AGI</td>
<td></td>
<td>~1%</td>
</tr>
<tr>
<td>• Pre-existing exclusions are waived for all</td>
<td>2014</td>
<td></td>
</tr>
<tr>
<td>• Excise Tax on High Cost Plans (also known as “Cadillac Tax”)</td>
<td>2018</td>
<td>Varies by plan</td>
</tr>
</tbody>
</table>
Considerations for Dropping Group Coverage

- Exchange costs for employers may significantly increase by the time Exchanges are available in 2014
  - The $2,000 annual employer assessment (free ride penalty) for not providing coverage, or for providing unaffordable coverage, will probably increase over time due to medical inflation, adverse claims experience, new benefits being added to Exchange programs as a result of lobbying efforts and public demand, etc., and become a more significant percentage of payroll
- Employers likely will be pressured to provide additional compensation to employees who participate in an Exchange
  - Some employees may need greater compensation initially to afford coverage through an Exchange if they are ineligible for subsidy
  - If government subsidies to individuals for Exchange coverage are reduced or eliminated, employers may need to provide employees with additional compensation so they can afford coverage
  - State Exchanges could emerge as insurers of last resort, becoming even more expensive for employees
- Any additional compensation to cover Exchange costs may increase payroll (FICA/FUTA) taxes for the employer, and income and payroll (FICA) taxes for the employee
Considerations for Dropping Group Coverage (cont’d)

- Some employees (e.g., higher compensated employees making more than 4 times the federal poverty limit, which is now approximately $88,000 for a family of 4) will have to pay premiums in the Exchanges that may be higher than for group coverage.
- Paying for coverage of younger employees through an Exchange will result in a cost “subsidy” for higher compensated Exchange participants.
- Employers with employees in multiple states may have different Exchange benefit structures according to the employee’s state of residence.
- Employers may lose control over health and wellness initiatives, which may impact absenteeism or productivity.
- If most other employers continue to provide health insurance and you do not, you may no longer be considered an “employer of choice.”

The Drivers of Employee Attraction, Retention and Engagement

Encompass Total Rewards

<table>
<thead>
<tr>
<th>Top Attraction Drivers</th>
<th>Top Retention Drivers</th>
<th>Top Engagement Drivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Competitive base pay</td>
<td>Necessary tools</td>
<td>Clear career path</td>
</tr>
<tr>
<td>2 Competitive healthcare benefits</td>
<td>Necessary resources</td>
<td>Involved in decisions that affect my work</td>
</tr>
<tr>
<td>3 Financial stability of company</td>
<td>Career development</td>
<td>Career development</td>
</tr>
<tr>
<td>4 Flexible work schedule</td>
<td>Reliable workgroup</td>
<td>Necessary resources</td>
</tr>
<tr>
<td>5 Competitive retirement benefits</td>
<td>Senior leadership making right decisions for the future</td>
<td>Teamwork</td>
</tr>
<tr>
<td>6 Competitive vacation/time-off</td>
<td>Competitive healthcare benefits</td>
<td>Co-workers make personal sacrifices to drive success</td>
</tr>
<tr>
<td>7 Reputation as a great place to work</td>
<td>Clear career path</td>
<td>Co-workers make personal efforts to improve their skills needed to contribute</td>
</tr>
<tr>
<td>8 Opportunity for advancement</td>
<td>Manager understands what motivates me</td>
<td>Manager understands what motivates me</td>
</tr>
<tr>
<td>9 Challenging work</td>
<td>People-oriented culture</td>
<td>Appropriate decision-making authority</td>
</tr>
<tr>
<td>10 Company culture</td>
<td>Stress management</td>
<td>Good understanding of how healthcare benefits work</td>
</tr>
</tbody>
</table>

Total Rewards

Note: Attraction, retention and engagement drivers vary by age, tenure, job group, level, etc.
Source: 2009 Aon Consulting Engagement 2.0 Employee Survey
Total Rewards Design Trade-offs and the Impact on Employee Engagement

Engagement by Perceived Value of Total Rewards Mix

<table>
<thead>
<tr>
<th>ENGAGEMENT</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Pay</td>
<td>Below Avg</td>
<td>Below Avg</td>
<td>Average</td>
<td>Below Avg</td>
<td>Average</td>
<td>Below Avg</td>
<td>Above Avg</td>
</tr>
<tr>
<td>Stock Options</td>
<td>Below Avg</td>
<td>Below Avg</td>
<td>Average</td>
<td>Below Avg</td>
<td>Average</td>
<td>Below Avg</td>
<td>Above Avg</td>
</tr>
<tr>
<td>Pay fairness</td>
<td>Below Avg</td>
<td>Below Avg</td>
<td>Average</td>
<td>Below Avg</td>
<td>Average</td>
<td>Below Avg</td>
<td>Above Avg</td>
</tr>
<tr>
<td>Perf Management</td>
<td>Below Avg</td>
<td>Below Avg</td>
<td>Average</td>
<td>Below Avg</td>
<td>Average</td>
<td>Below Avg</td>
<td>Above Avg</td>
</tr>
<tr>
<td>H&amp;W benefits</td>
<td>Below Avg</td>
<td>Below Avg</td>
<td>Average</td>
<td>Below Avg</td>
<td>Average</td>
<td>Below Avg</td>
<td>Above Avg</td>
</tr>
<tr>
<td>Retirement Benefits</td>
<td>Below Avg</td>
<td>Below Avg</td>
<td>Average</td>
<td>Below Avg</td>
<td>Average</td>
<td>Below Avg</td>
<td>Above Avg</td>
</tr>
<tr>
<td>Career Development</td>
<td>Below Avg</td>
<td>Below Avg</td>
<td>Average</td>
<td>Below Avg</td>
<td>Average</td>
<td>Below Avg</td>
<td>Above Avg</td>
</tr>
<tr>
<td>Immediate Manager</td>
<td>Below Avg</td>
<td>Below Avg</td>
<td>Average</td>
<td>Below Avg</td>
<td>Average</td>
<td>Below Avg</td>
<td>Above Avg</td>
</tr>
</tbody>
</table>

Source: 2009 Aon Consulting Engagement 2.0 Employee Survey

Today’s Discussion

0  Overview and Current Environment
1  Latest Regulatory Guidance
2  Key Action Steps for Plan Sponsors
3  Case Studies and Impact Analysis
4  Considerations for Dropping Group Coverage
5  Select Health Reform Provisions
6  Health Reform Self-Service Tools
7  Appendix: Legislative Details and Model Notices
8  Reference: Health Reform Chronology
### Today’s Discussion

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<thead>
<tr>
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<th>Overview and Current Environment</th>
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<td>Latest Regulatory Guidance</td>
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<td>Considerations for Dropping Group Coverage</td>
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<tr>
<td>5</td>
<td>Select Health Reform Provisions – Early Retiree Reinsurance Program</td>
</tr>
<tr>
<td>6</td>
<td>Health Reform Self-Service Tools</td>
</tr>
<tr>
<td>7</td>
<td>Appendix: Legislative Details and Model Notices</td>
</tr>
<tr>
<td>8</td>
<td>Reference: Health Reform Chronology</td>
</tr>
</tbody>
</table>

#### Early Retiree Reinsurance Program – Overview

- **Interim Final Regulations Issued**
  - Intended to provide relief for plan sponsors providing early retirement (pre-Medicare) health benefits
  - Provides federal reimbursement for 80% of individual claims between $15,000 and $90,000 incurred during the plan year
  - Legislation funded $5 billion for reimbursement through HHS
  - Reimbursement provisions are effective June 21, 2010
  - Program ends no later than January 1, 2014, (may end sooner if funds are exhausted)
What Do Employers/Plan Sponsors Need to Do Now?

- Prepare to apply for certification to participate in the program
  - Applications are now available
  - Plan sponsors reimbursed on a first-come, first-serve basis
  - Unlikely that $5 billion funding will be adequate to pay all claims – Therefore early certification is critical
  - Must demonstrate that retiree health plan meets all applicable requirements
- Certification application must meet all requirements
  - Applications failing requirements will be denied
  - Plan sponsor may have to reapply, losing original “place in line”

What are the Participation Rules for the Program?

- Plan Sponsor submits application for participation
  - Use same definition of plan sponsor as RDS
  - Plan Sponsor will receive the reimbursement payments
- Plan must be “employment based” plan
  - Use same definition as “group health plan” for RDS
- Plan must have programs to generate cost savings for “chronic and high cost conditions”
  - Health conditions likely to generate claims above $15,000 in a year for one participant
  - Program must be in place as of the start of the plan year beginning in 2010
  - Sponsor must be able to demonstrate (if audited) that program has generated, or had potential to generate, savings through audit
Which Retirees are Eligible for Reimbursement?

- Early Retirees
  - Age 55 or older, but not eligible for Medicare coverage
  - Cannot be active employee of any employer providing health benefits
  - Retiree includes spouses, surviving spouses, and dependents of retirees
  - Reimbursement can be made for costs of eligible spouses, surviving spouses, and dependents of early retirees even if they are under age 55 and/or are eligible for Medicare

How are Health Claims Determined for Reimbursement?

- Eligible costs based on the individual retiree claim payments
  - Costs are determined by individual covered participant
- 80% of health benefit cost between $15,000 and $90,000
  - Dollar limits will be indexed to CPI-Med for plan years after 10/1/2011
- Health benefit cost:
  - Includes medical, surgical, prescription drug expenses
  - Cost is net of any discounts or rebates of any type
  - Cost includes out of pocket amounts paid by retiree
    - Plan sponsor must provide evidence that the out of pocket portion of the claims were actually paid by the early retiree
How are Health Claims Determined for Reimbursement?

- **Transition rule for 2010**
  - Plan Sponsors may apply for reimbursement for plan year starting prior to June 1, 2010 and ending during 2010
  - Claims incurred prior to June 1 are counted toward reimbursement but only to a maximum of $15,000

- **Example:**
  - An early retiree incurs $23,000 of claims between January and June 1, 2010
  - After June 1, the early retiree incurs an additional $32,000 of claims

<table>
<thead>
<tr>
<th>Incurred amount</th>
<th>Used in determination of the reimbursement amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>$23,000</td>
<td>$15,000</td>
</tr>
<tr>
<td>$32,000</td>
<td>$32,000</td>
</tr>
</tbody>
</table>

Reimbursement would be 80% of $32,000 (the allowed claims above $15,000)

Other Plan Sponsor Requirements

- **Application of reinsurance reimbursements**
  - Must reduce the benefit costs (or premiums) to the Plan Sponsor or the plan participants
  - May not be used as general revenue for the Plan Sponsor
  - Tax treatment of reimbursement amounts not yet clarified

- **Claims documentation for reimbursement**
  - List of early retirees with individual claim costs documented
  - HHS will provide guidance on format for claim submission

- **Plan Sponsor must maintain required records**
Today’s Discussion

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Insurance Exchanges

Features

- State-based marketplace for buyers and sellers of health insurance
- Operational in 2014 for uninsured individuals and ERs with <50EE
- Family of 4 earning less than $88,000 is eligible for subsidized coverage when purchasing in the Exchange
- Federal funding to states to design Exchange but must be self-sufficient by 2016

Key Challenges

- Reforms such as guarantee issue, guaranteed renewal, 3:1 age banding, & insurance market reforms will drive premiums higher
- Weak individual mandate with modest penalties for not purchasing health insurance
- Use of traditional health plans such as PPOs and HMOs will not result in lower costs under the Exchange
- Only insured medical products – self-funding not permitted
Insurance Exchanges-Implications for Plan Sponsors

• Exchange health plans options will vary from state to state and carriers will selectively participate state by state
  – May increase administrative burden on employers with multi state locations
• Carriers must develop new health products (replacing traditional plans) to be successful in demanding Exchange environment
  – Premium trends may increase above current levels
• Some employers will consider dropping their group coverage in 2014
  – Negative implications for recruitment and retention of employees
  – Employees using the Exchange who earn <$88,000 for a family of 4 will see higher premiums offset by federal subsidies resulting lower EE contributions
  – Employees using the Exchange who earn >$88,000 for a family of 4 will see higher premiums given the absence of federal subsidies
• Modest $2,000 free rider penalty in 2014 for ERs that do not sponsor group health coverage, or provide affordable coverage, penalty likely to increase before 2014
Impact of HCR on Prescription Drugs

<table>
<thead>
<tr>
<th>Enhancements</th>
<th>Restrictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increased Rx volume</td>
<td>Retiree Drug Subsidy no longer tax-deductible income</td>
</tr>
<tr>
<td>– PBMss are the biggest winners</td>
<td></td>
</tr>
<tr>
<td>• New FDA authorized process for generic availability of biologics</td>
<td>Annual Fees for Pharma</td>
</tr>
<tr>
<td>• Grants for reimbursements for MTM services</td>
<td>Health FSA cap and reimbursement restrictions on OTC drugs</td>
</tr>
<tr>
<td>• Federal Upper Limit (FUL) pricing calculated by new Average Manufacturer Price (AMP)</td>
<td>Excise taxes on medical device manufacturers and importers</td>
</tr>
<tr>
<td>• Contracts with Long Term Care (LTC) facilities for waste reduction</td>
<td>Increase in Medicaid drug rebate percentage</td>
</tr>
<tr>
<td>• Closing of coverage gap from 100 – 25%</td>
<td>Payments cuts to Medicare Advantage Plans</td>
</tr>
<tr>
<td>• $250 rebate to Part D enrollees in coverage</td>
<td>Decreased bargaining power for pharmacy benefit managers due to transparency requirements?</td>
</tr>
</tbody>
</table>

Today’s Discussion

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Where Can I Find Out More?

- Aon’s Health Care Reform Microsite is a great resource:
  - Weekly briefings
  - Webinar recordings
  - FAQs
  - Side-by-side comparison of the Senate and Reconciliation Bills
  - Survey findings

www.aon.com/healthcarereform

Employer Shared Responsibility Provisions

Free Rider Provision
- Applies to large ERs with 50 or more full-time equivalent employees (FTEs)
  - FTE = 30+ hours/week
- Employers not offering health coverage to all FTEs pay $2,000 per FTE if any FTE enrolls in Exchange
- Employer offering coverage pay $3,000 for each FTE who receives Exchange subsidy/credit (subject to a certain maximum penalty) if:
  - Coverage <60% of allowed costs
  - EE pays >9.5% of their household income for health coverage
- First 30 employees not included in calculation of assessment
- Effective 1/1/2014

Employee Voucher
- Applies to ERs who offer minimum essential coverage
- Employers would convert health coverage subsidy to cash for any employees who:
  - Pay between 8% and 9.8% of their household income for health coverage
  - Whose household income is less than 400% of poverty line
  - Opt out of employer sponsored coverage for coverage in an Exchange based plan
- No penalties imposed for EEs who receive vouchers
- Effective 1/1/2014
### Administrative Requirements

#### Auto Enrollment
- Applies to new hires and existing enrollees
- Employees can opt out
- Employer can choose plan for auto enrollment
- Effective date unclear; may be 3/23/2010 upon enactment or until regulatory guidance issued

#### W-2 Reporting
- Employers required to report the “value” of health benefits provided to each employee
  - Value defined as COBRA cost
- Effective 1/1/2012 (Forms W-2 delivered in 2013)

#### Appeals Process
- Employer plans must have HHS-approved external review process
- Effective for plan years beginning on or after September 23, 2010 (6 months after enactment)  (1/1/2011 for CY plans)

### Administrative Requirements (cont’d)

#### Uniform Explanation of Coverage
- Annual distribution of summary of benefits and coverage
  - Not to exceed 4 pages; 12 point font
  - Culturally and linguistically appropriate
- Uniform Explanation is in addition to the SPD required by ERISA
- HHS to issue standards
- Effective 2012 (first summary due within 24 months of enactment)
- 60 days advance notice to participants required if any information in Uniform Explanation changes

#### Exchange Notification
- Employers must notify employees at time of hire of the availability of Exchanges and their potential eligibility for a subsidy
  - No requirement to offer same coverage as Exchange based plans
- Effective 1/1/2013

#### Transparency Requirements
- Same transparency requirements as Exchange based plans
- Claims payment policies and data
- Information on rating policies, cost sharing and payment for OON
**Administrative Requirements (cont’d)**

<table>
<thead>
<tr>
<th>CLASS Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Voluntary federal LTC insurance program</td>
</tr>
<tr>
<td>• No underwriting restrictions</td>
</tr>
<tr>
<td>• 5-year waiting period</td>
</tr>
<tr>
<td>• Eligible for benefit if at least 2 ADLs for 90 days</td>
</tr>
<tr>
<td>• Lifetime benefit payments</td>
</tr>
<tr>
<td>• ERs may auto-enroll EEs and offer access via payroll deductions</td>
</tr>
<tr>
<td>- EEs may opt-out</td>
</tr>
<tr>
<td>- Must be actively employed to enroll</td>
</tr>
<tr>
<td>• Effective 1/1/2011</td>
</tr>
</tbody>
</table>

**Tax Provisions**

<table>
<thead>
<tr>
<th>Medicare Payroll Surtax</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Adjusted gross income &gt;$200K for individuals and &gt;$250K for couples</td>
</tr>
<tr>
<td>• Additional surtax on wages of 0.9%</td>
</tr>
<tr>
<td>• Additional surtax on investment income of 3.8%</td>
</tr>
<tr>
<td>• Additional taxes on higher income individuals replaces lost revenue from delayed enactment of high cost excise tax (estimated $210 billion)</td>
</tr>
<tr>
<td>• Effective 1/1/2013</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>High Cost Plan Excise Tax</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 40% excise tax on health plans whose annual cost exceeds:</td>
</tr>
<tr>
<td>- $10,200 single/$27,500 family</td>
</tr>
<tr>
<td>• Cost includes all health plans, including FSAs or HRAs, ER HSA contributions</td>
</tr>
<tr>
<td>• Higher thresholds for retirees and high risk professions; age/gender differences</td>
</tr>
<tr>
<td>• Indexed to CPI-U (+1% in 2019)</td>
</tr>
<tr>
<td>• Effective 2018; no delayed effective date for collectively bargained plans</td>
</tr>
</tbody>
</table>
Tax Provisions (cont’d)

Comparative Effectiveness Research Fee

- Fee to fund federal comparative clinical effectiveness research
- Applies to insurers and plan sponsors
- Applies to all plans, regardless of grandfather status
- $2 for each covered individual annually ($1 for plan years ending in 2013), indexed to CPI
- Effective for plan years ending after 9/30/2012 (1/1/2013 for CY plans)
- Fee sunsets after 2019

CLASS Act (Title VIII of the Patient Protection and Affordable Care Act)

<table>
<thead>
<tr>
<th>Provision</th>
<th>Objective</th>
<th>Employer Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLASS Program nominally effective January 1, 2011, but still subject to:</td>
<td>Creates a voluntary, government-administered Long Term Care Insurance plan</td>
<td>Benefits unlikely to fully cover costs in most cases. CLASS does not eliminate the need for private Long Term Care insurance</td>
</tr>
<tr>
<td>- HHS finalizing operating details and structure during 2011</td>
<td>To enable those in need to remain at home or in their community. Pays for home care and related services</td>
<td>No penalty for employers who do not offer CLASS. Individual enrollment alternative will be available</td>
</tr>
<tr>
<td>- HHS finalizing benefit design and premium structure by October 1, 2012</td>
<td>To guarantee access to basic coverage for all working, taxable wage earners over age 18</td>
<td>Employer Option: offer CLASS coverage and payroll deductions. All employees are automatically enrolled unless they opt-out. Employer may contribute but not required</td>
</tr>
<tr>
<td>- Benefits expected to be $50-$75 per day, graded based on level of impairment. No benefit duration limit</td>
<td>Current average monthly premium estimates vary widely:</td>
<td></td>
</tr>
<tr>
<td>- Eligibility for benefits requires</td>
<td>- Congressional Budget Office: $123</td>
<td></td>
</tr>
<tr>
<td>- 5 years prior enrollment and premium payment (“Vesting Period”)</td>
<td>- Centers for Medicare and Medicaid Services: $240</td>
<td></td>
</tr>
<tr>
<td>- Loss of 2 or 3 (TBD) of 6 Activities of Daily Living or substantial cognitive impairment</td>
<td>- American Academy of Actuaries: $160</td>
<td></td>
</tr>
</tbody>
</table>
**Model Language Notice - Lifetime Limit No Longer Applies and Enrollment Opportunity**

Plans and issuers are required to give written notice that the lifetime limit on the dollar value of all benefits no longer applies and that an individual, if covered, is once again eligible for benefits under the plan. Additionally, if the individual is not enrolled in the plan or health insurance coverage, or if an enrolled individual is eligible for but not enrolled in any benefit package under the plan or health insurance coverage, then the plan or issuer must also give such an individual an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll). The notices and enrollment opportunity must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010. For individuals who enroll under this opportunity, coverage must take effect not later than the first day of the first plan year beginning on or after September 23, 2010.

These notices may be provided to an employee on behalf of the employee’s dependent. In addition, the notices may be included with other enrollment materials that a plan distributes to employees, provided the statement is prominent. For either notice, if a notice satisfying the requirements is provided to an individual, the obligation to provide the notice with respect to that individual is satisfied for both the plan and the issuer.

The following model language can be used to satisfy the notice requirement:

```
The lifetime limit on the dollar value of benefits under [Insert name of group health plan or health insurance issuer] no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact the [insert plan administrator or issuer] at [insert contact information].
```

**Model Language Notice – Grandfathered Plans**

To maintain status as a grandfathered health plan, a plan or health insurance coverage must include a statement, in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan or health insurance coverage, that the plan or coverage believes it is a grandfathered health plan within the meaning of section 1251 of the Patient Protection and Affordable Care Act and must provide contact information for questions and complaints.

The following model language can be used to satisfy this disclosure requirement:

```
This [group health plan or health insurance issuer] believes this [plan or coverage] is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information]. [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.]
```
Model Language Notice - Opportunity to Enroll
in connection with Extension of Dependent Coverage to Age 26

The interim final regulations extending dependent coverage to age 26 provide transitional relief for a child whose
coverage ended, or who was denied coverage (or was not eligible for coverage) under a group health plan or health
insurance coverage because, under the terms of the plan or coverage, the availability of dependent coverage of children
ended before the attainment of age 26. The regulations require a plan or issuer to give such a child an opportunity to
enroll that continues for at least 30 days (including written notice of the opportunity to enroll), regardless of whether the
plan or coverage offers an open enrollment period and regardless of when any open enrollment period might otherwise
occur. This enrollment opportunity (including the written notice) must be provided not later than the first day of the first
plan year beginning on or after September 23, 2010. The notice may be included with other enrollment materials that a
plan distributes, provided the statement is prominent. Enrollment must be effective as of the first day of the first plan year
beginning on or after September 23, 2010.

The following model language can be used to satisfy the notice requirement:

Individuals whose coverage ended, or who were denied coverage (or were not eligible for
coverage), because the availability of dependent coverage of children ended before
attainment of age 26 are eligible to enroll in [Insert name of group health plan or health
insurance coverage]. Individuals may request enrollment for such children for 30 days from
the date of notice. Enrollment will be effective retroactively to [insert date that is the first day
of the first plan year beginning on or after September 23, 2010.] For more information
contact the [insert plan administrator or issuer] at [insert contact information].

Patient Protection Model Disclosure

When applicable, it is important that individuals enrolled in a plan or health insurance coverage know of their
rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires designation of a primary care
physician; or (2) obtain obstetrical or gynecological care without prior authorization. Accordingly, the interim final
regulations regarding patient protections under section 2719A of the Affordable Care Act require plans and issuers to
provide notice to participants of these rights when applicable. The notice must be provided whenever the plan or issuer
provides a participant with a summary plan description or other similar description of benefits under the plan or health
insurance coverage. This notice must be provided no later than the first day of the first plan year beginning on or after
September 23, 2010.

The following model language can be used to satisfy the notice requirement:

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:
[Name of group health plan or health insurance issuer] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [plan administrator or issuer] at [insert contact information].

For plans and issuers that require or allow for the designation of a primary care provider for a child, add:
For children, you may designate a pediatrician as the primary care provider.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:
You do not need prior authorization from [name of group health plan or issuer] or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the [plan administrator or issuer] at [insert contact information].
Medicaid and the Children’s Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

Contact Information for State CHIP and Medicaid Programs

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of September 1, 2010. You should contact your State for further information on eligibility.

<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid Website</th>
<th>Medicaid Phone</th>
<th>CHIP Website</th>
<th>CHIP Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td><a href="http://www.medicaid.alabama.gov">Website</a></td>
<td>1-800-362-1504</td>
<td><a href="http://www.CHIPplus.org">Website</a></td>
<td>303-866-3243</td>
</tr>
<tr>
<td>Colorado</td>
<td><a href="http://www.colorado.gov/">Website</a></td>
<td>1-800-866-3513</td>
<td><a href="http://www.CHPplus.org">Website</a></td>
<td>303-866-3243</td>
</tr>
<tr>
<td>Alaska</td>
<td><a href="http://health.hss.state.ak.us/dpa/programs/medicaid/">Website</a></td>
<td>1-888-316-8800</td>
<td><a href="http://www.arkidsfirst.com/">Website</a></td>
<td>1-888-474-8275</td>
</tr>
<tr>
<td>Arizona</td>
<td><a href="http://www.azahcccs.gov/applicants/default.aspx">Website</a></td>
<td>1-877-764-5437</td>
<td><a href="http://www.in.gov/fssa/2408.htm">Website</a></td>
<td>1-877-438-4479</td>
</tr>
<tr>
<td>Arkansas</td>
<td><a href="http://health.hss.state.ak.us/dpa/programs/medicaid/">Website</a></td>
<td>1-888-316-8800</td>
<td><a href="http://www.fdhc.state.fl.us/Medicaid/index.shtml">Website</a></td>
<td>1-866-762-2237</td>
</tr>
<tr>
<td>California</td>
<td><a href="http://www.dhcs.ca.gov/services/Pages/TPLRS.CALI_cont.aspx">Website</a></td>
<td>1-866-298-8443</td>
<td><a href="http://www.in.gov/fssa/2408.htm">Website</a></td>
<td>1-877-438-4479</td>
</tr>
</tbody>
</table>
### Contact Information for State CHIP and Medicaid Programs (cont.)

<table>
<thead>
<tr>
<th>State</th>
<th>Program</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>IOWA</td>
<td>Medicaid</td>
<td><a href="http://www.dhs.state.ia.us/hipp">www.dhs.state.ia.us/hipp</a></td>
<td>1-888-346-9562</td>
</tr>
<tr>
<td>KANSAS</td>
<td>Medicaid</td>
<td><a href="http://medicaidprovider.hlsi.state.ka.us/ClientWebsite/ClientSearch">website</a></td>
<td>1-800-444-6014</td>
</tr>
<tr>
<td>KENTUCKY</td>
<td>Medicaid</td>
<td><a href="http://chfs.ky.gov/dms/default.htm">website</a></td>
<td>1-800-635-2570</td>
</tr>
<tr>
<td>KANSAS</td>
<td>Medicaid</td>
<td><a href="http://www.khpa.ks.gov">website</a></td>
<td>800-766-9012</td>
</tr>
<tr>
<td>NEBRASKA</td>
<td>Medicaid</td>
<td><a href="http://www.dhhs.ne.gov/med/medindex.htm">website</a></td>
<td>1-877-255-3092</td>
</tr>
<tr>
<td>KENTUCKY</td>
<td>Medicaid</td>
<td><a href="http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm">website</a></td>
<td>1-800-356-1561</td>
</tr>
<tr>
<td>MASSACHUSETTS</td>
<td>Medicaid and CHIP</td>
<td><a href="http://www.mass.gov/MassHealth">website</a></td>
<td>1-800-462-1120</td>
</tr>
<tr>
<td>NEVADA</td>
<td>Medicaid and CHIP</td>
<td><a href="http://www.nevadacheckup.nv.org/">website</a></td>
<td>1-877-543-7669</td>
</tr>
<tr>
<td>LOUISIANA</td>
<td>Medicaid</td>
<td><a href="http://www.lahipp.dhh.louisiana.gov">website</a></td>
<td>1-888-342-6207</td>
</tr>
<tr>
<td>MAINE</td>
<td>Medicaid</td>
<td><a href="http://www.dhs.state.mn.us/">website</a></td>
<td>800-657-3739</td>
</tr>
<tr>
<td>MASSACHUSETTS</td>
<td>Medicaid and CHIP</td>
<td><a href="http://www.mass.gov/MassHealth">website</a></td>
<td>1-888-997-2583</td>
</tr>
<tr>
<td>MINNESOTA</td>
<td>Medicaid</td>
<td><a href="http://health.utah.gov/medicaid/">website</a></td>
<td>1-866-435-7414</td>
</tr>
<tr>
<td>MISSOURI</td>
<td>Medicaid</td>
<td><a href="http://www.dhp.state.mn.us">website</a></td>
<td>800-444-7730</td>
</tr>
<tr>
<td>OREGON</td>
<td>Medicaid and CHIP</td>
<td><a href="http://www.oregonhealthykids.gov">website</a></td>
<td>1-877-314-5678</td>
</tr>
<tr>
<td>PENNSYLVANIA</td>
<td>Medicaid</td>
<td><a href="http://www.dhp.state.mn.us">website</a></td>
<td>1-866-435-7414</td>
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<tr>
<td>RHODE ISLAND</td>
<td>Medicaid</td>
<td><a href="http://www.rhodeislandhealth.gov">website</a></td>
<td>1-800-362-3002</td>
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<tr>
<td>SOUTH CAROLINA</td>
<td>Medicaid</td>
<td><a href="http://www.dhl.state.mn.us">website</a></td>
<td>800-362-3002</td>
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<tr>
<td>TEXAS</td>
<td>Medicaid</td>
<td><a href="http://www.homehealthny.com">website</a></td>
<td>1-800-432-5092</td>
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<td>UTAH</td>
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<td>VIRGINIA</td>
<td>Medicaid and CHIP</td>
<td><a href="http://www.insureoklahoma.org">website</a></td>
<td>1-888-255-3092</td>
</tr>
<tr>
<td>WEST VIRGINIA</td>
<td>Medicaid</td>
<td><a href="http://www.dhl.state.mn.us">website</a></td>
<td>800-362-3002</td>
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Today’s Discussion

0 Overview and Current Environment
1 Latest Regulatory Guidance
2 Key Action Steps for Plan Sponsors
3 Case Studies and Impact Analysis
4 Considerations for Dropping Group Coverage
5 Select Health Reform Provisions
6 Health Reform Self-Service Tools
7 Appendix: Legislative Details and Model Notices
8 Reference: Health Reform Chronology

Health Care Reform – Chronology

<table>
<thead>
<tr>
<th>March (date of enactment)</th>
<th>June (90 days after enactment)</th>
<th>September (plan years beginning 6 months after enactment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senate Bill (H.R. 3590)</td>
<td>Small business under 25 full-time equivalent employees and average annual wages under $50,000 eligible for tax credit (retroactive to 1/1/2010)</td>
<td>Bans pre-existing conditions exclusions for dependents under age 19</td>
</tr>
<tr>
<td>enactment March 23, 2010</td>
<td>Temporary reinsurance program for employers who provide coverage for early retirees</td>
<td>- Prohibits lifetime/restrictive annual dollar maximums</td>
</tr>
<tr>
<td></td>
<td>Provides immediate access to high risk pools for uninsured (pre-existing conditions)</td>
<td>- Mandates dependent coverage to age 26 for those not eligible for other group coverage</td>
</tr>
<tr>
<td></td>
<td>Seniors will receive a $250 rebate to help fill the Medicare “donut hole”</td>
<td>- Prohibits rescissions except for fraud</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Preventive care covered without cost sharing (new plans)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Group plans must cover ER services without prior authorizations and in- or out-of-network (new plans)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Group plans must allow designation of OB/GYN or pediatrician as PCP (new plans)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Employer plans must have HHS approved external appeal process (new plans)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Insured group health plans subject to nondiscrimination rules re: highly compensated individuals (new plans)</td>
</tr>
</tbody>
</table>
### Health Care Reform – Chronology (cont’d)

<table>
<thead>
<tr>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>- OTC drugs (except insulin) without prescription no longer eligible under FSA, HRA, or HSA</td>
<td>- Employers required to provide employees with Uniform Summary of Coverage (24 months post-enactment)</td>
<td>- Caps FSA salary reduction contributions to $2,500/year</td>
</tr>
<tr>
<td>- Higher penalty on withdrawal of HSA funds for non-medical expenses</td>
<td>- Plans must report annually to HHS and participants regarding improving quality of care (24 months post-enactment)</td>
<td>- Imposes an additional hospital insurance tax of 9 percent on high income individuals ($200,000 individual, $250,000 joint)</td>
</tr>
<tr>
<td>- Employers with less than 100 employees are eligible for wellness grants (up to 5 years)</td>
<td>- Employers must satisfy expanded Forms 1099 reporting requirements for payments to corporate service providers</td>
<td>- Imposes an additional 3.9% Medicare payroll tax on unearned income for high income individuals ($200,000 individual, $250,000 joint)</td>
</tr>
<tr>
<td>- New federal voluntary LTC program established (CLASS Act)</td>
<td>- Employers required to disclose value of health benefits on Forms W-2</td>
<td>- Imposes a comparative effectiveness fee of $2 per participant for insurers</td>
</tr>
<tr>
<td>- Requires insurers to annually report percent of premiums spent on medical services; if less than 80%, must provide rebate to enrollees (large group plans must spend 85%)</td>
<td></td>
<td>- Employers required to provide written notice to employees about Exchange and subsidies</td>
</tr>
<tr>
<td>- Auto-enrollment of new hires for employers with more than 200 employees* (likely effective when HHS regulations issued)</td>
<td></td>
<td>- Tax exclusion of Medicare Part D drug subsidy eliminated</td>
</tr>
</tbody>
</table>

*auto-enrollment effective date is still unclear
Appendix E

County Code Section 6-1-308 – Group Health Insurance – Cost Share
§ 6-1-308. Group health insurance.

(a) Generally. The County shall provide a group health plan for employees who are members of the group health plan; employees permanently and totally disabled from performing an occupation who have been retired from County service as a consequence of the disability; and, in accordance with criteria established by the Personnel Officer, employees who retire from County service.

(b) Cost. The cost of each employee's benefits under the group health plan shall be shared by the County and the employee:

(1) for employees represented by an exclusive representative, as provided in a memorandum of agreement negotiated and signed under Title 4 between the County and the exclusive representative;

(2) for employees who are not represented by an exclusive representative, as determined by the Personnel Officer;

(3) for employees who retire from County service, the County shall pay 80% of the cost and the employee shall pay 20% of the cost; and

(4) for part-time employees who work at least 50% of the normal work week, the County shall pay a prorated portion of the cost paid for full-time employees.

(c) Health care accounts. The County may establish health care accounts approved by the Internal Revenue Service to permit the accumulation of monies to pay for the health care expenses of employees and retirees.

(1985 Code, Art. 8, § 1-307) (Bill No. 33-89; Bill No. 34-93; Bill No. 23-04; Bill No. 86-04)
Appendix F

Office of Law Memo –
David Plymyer – Risk Matrix
To: Members, Collaborative Study Group

From: David A. Plymyer, Deputy County Attorney /s/

Date: October 3, 2011

Subject: Risk “Matrix” - Options for Making Changes to Post-Employment Health Care Insurance Benefits; Legal Risks

Dear Members:

At the suggestion of Councilman Benoit and in my role as “staff counsel” to the Group, I am providing a summary of the legal risks attendant to making various changes to the post-employment health care insurance benefits offered to County employees and their spouses and other dependents. This is in part a distillation of the information that I provided to members of the County Council by memorandum dated September 7, 2011.

I have limited this summary to post-employment benefits, primarily because that is the basis of the so-called GASB Statement 45 liability, which may be summarized as the obligation of the County to pay post-employment benefits that have been incurred as the result of services already rendered to the County, whether by former employees or by current employees. The health care insurance benefits offered to County employees and their spouses and other dependents during their employment with the County has no direct effect on the County's unfunded liability as reported under GASB Statement 45.1

Because this summary addresses only post-employment health care insurance benefits, there is another point relevant to the discussion: The health care insurance benefits offered to County employees represented by a union during their employment are subject to collective bargaining under current law; post-employment health care insurance benefits offered to County employees (past or present) are not.

For purposes of comparison, I will use a Likert scale, with “1” being No or Minimal Risk of successful legal challenge, “3” being Moderate Risk, and “5” being Prohibitive Risk. Needless to say, this risk assessment represents my best legal judgment, and there will be disagreements as to its accuracy. The level of precision attempted by any lawyer in making this type of assessment is going to be affected by the absence of legal precedent in Maryland on the extent to which statutory descriptions of post-employment benefits that are not funded during the

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1 GASB Statement 45 assumes that post-employment benefits will be paid as those benefits currently are described by the governmental entity. If those benefits are reduced, the assumptions then change, and any unfunded liability also will be reduced.
active service of an employee create contractual obligations enforceable against a local government.

The adjective "modest" is used to describe certain changes to benefits. Suffice it to say at this point that, in general, the more "modest" the change, the lower the risk of successful legal challenge.

A. Benefits of employees who already have retired.

<table>
<thead>
<tr>
<th>BENEFIT CHANGE</th>
<th>RISK LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>A modest increase in the percentage of the costs paid for coverage other than</td>
<td>3</td>
</tr>
<tr>
<td>the Medicare Supplement, currently established by ordinance at 20%. (E.g., increase to 30%.)</td>
<td></td>
</tr>
<tr>
<td>Elimination of Medicare Supplement coverage entirely, or a significant increase in the retiree’s percentage of the costs from 20%.</td>
<td>2</td>
</tr>
<tr>
<td>Elimination of Prescription Drug Coverage for Medicare-eligible retirees by “transition” to Medicare Part D.</td>
<td>2</td>
</tr>
<tr>
<td>Modest changes to the structure of the Group Health Plan offered to retirees, including increases to deductibles and co-pays.</td>
<td>1</td>
</tr>
</tbody>
</table>

B. Benefits of spouses and dependents of employees who already have retired. (Also applies to surviving spouses.)

<table>
<thead>
<tr>
<th>BENEFIT CHANGE</th>
<th>RISK LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elimination of all coverage, including Medicare Supplement and Prescription Drug Coverage.</td>
<td>1</td>
</tr>
<tr>
<td>A significant increase in the percentage of costs paid for all coverages.</td>
<td>1</td>
</tr>
<tr>
<td>Significant changes to the structure of the Group Health Plan offered to spouses and dependents of retirees, including increases to deductibles and co-pays.</td>
<td>1</td>
</tr>
</tbody>
</table>

C. Future benefits of active employees who have “vested” in the benefits of their pension plans either by becoming eligible for normal retirement or by accruing the number of years of “credited service” required to vest in plan benefits. (Also applies to “terminated vested” former employees.)

<table>
<thead>
<tr>
<th>BENEFIT CHANGE</th>
<th>RISK LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>A modest increase in the percentage of the costs paid for coverage other than</td>
<td>2</td>
</tr>
<tr>
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<td>1</td>
</tr>
</tbody>
</table>
retirees, including increases to deductibles and co-pays.

D. Future benefits of spouses and dependents of active employees who have “vested” in the benefits of their pension plans either by becoming eligible for normal retirement or by accruing the number of years of “credited service” required to vest in plan benefits.

<table>
<thead>
<tr>
<th>BENEFIT CHANGE</th>
<th>RISK LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
<tr>
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<td>1</td>
</tr>
<tr>
<td>Significant changes to the structure of the Group Health Plan offered to spouses and dependents of retirees, including increases to deductibles and co-pays.</td>
<td>1</td>
</tr>
</tbody>
</table>

E. Future benefits of active employees who have not “vested” in the benefits of their pension plans either by becoming eligible for normal retirement or by accruing the number of years of “credited service” required to vest in plan benefits.

<table>
<thead>
<tr>
<th>BENEFIT CHANGE</th>
<th>RISK LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elimination of all coverage, including Medicare Supplement and Prescription Drug Coverage.</td>
<td>1</td>
</tr>
<tr>
<td>A significant increase in the percentage of costs paid for all coverages.</td>
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</tr>
<tr>
<td>Significant changes to the structure of the Group Health Plan offered to retirees, including increases to deductibles and co-pays.</td>
<td>1</td>
</tr>
</tbody>
</table>

F. Future benefits of spouses and dependents of active employees who have not “vested” in the benefits of their pension plans either by becoming eligible for normal retirement or by accruing the number of years of “credited service” required to vest in plan benefits.

<table>
<thead>
<tr>
<th>BENEFIT CHANGE</th>
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</tr>
<tr>
<td>A significant increase in the percentage of costs paid for all coverages.</td>
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</tr>
<tr>
<td>Significant changes to the structure of the Group Health Plan offered to spouses and dependents of retirees, including increases to deductibles and co-pays.</td>
<td>1</td>
</tr>
</tbody>
</table>

One final caveat is that specific changes will have to be reviewed for compliance with the federal Patient Protection and Affordable Care Act of 2010, the requirements of which are phased in over a period of time.
Appendix G

Office of Law Memo
David Plymyer
Recommendation for Issues to Be Considered
MEMORANDUM

To: Members, Collaborative Study Group

From: David A. Plymyer, Deputy County Attorney /s/

Date: October 3, 2011

Subject: Recommendations for Issues to Be Considered

Dear Members:

There are three actions that I recommend that the Group consider. These actions do not involve specific health care insurance benefit changes, and address the legal structure within which such benefits are established and funded.

1. **A charter amendment authorizing the County Council to establish an Other Post-Employment Benefits (OPED) Trust.**

   Under County law, a charter amendment is required in order to set up a continuing, non-lapsing fund as a means of setting aside money for funding “other post-employment benefits” (i.e., other than pension benefits). A charter amendment also is required in order to give the entity chosen to administer such a "trust fund" any degree of autonomy from the other operations of County government, such as purchasing requirements.

   My recommendation has been to propose an amendment to the County Charter that **authorizes** the County Council to pass an ordinance establishing such a trust fund, designating an entity responsible for the trust, and conferring on that entity the autonomy that the County Council believes is appropriate. There is a certain element of timing that has to do with the Charter Revision Commission, which meets once every ten years and is meeting now.

   I am aware that there are policy considerations that go into the timing of creating such a trust, not the least of which is the availability of money to put into it. Consequently, my recommendation is limited to giving the County Council the authority to act if and when it deems such action appropriate. For what it is worth, the "conventional wisdom" is that eventually state and local governments will have to establish OPED trusts as vehicles for funding a sustainable program of health insurance benefits.

2. **An ordinance that adequately sets forth the County’s "program" for providing health insurance benefits to employees, retirees, and their spouses and other dependents.**
The current law, found in § 6-1-308 of the County Code, is inadequate to the task. Section 6-1-308 includes no mention of coverage for anyone other than employees or retirees, including spouses and other dependents, and surviving spouses. There is no mention of the types of coverages that may be offered within the County's "group health plan," including such expensive coverages such as Prescription Drug Coverage and the Medicare Supplement. Finally, there is no express delegation of authority to the Personnel Officer other than the duty to establish “criteria” governing the manner in which County's group health plan is provided to employees who retire from County service, and to determine the allocation of the costs of coverage for nonrepresented employees.

Without going into further detail at this point, I believe that the County Council at a minimum should set forth by law the basic parameters of the County’s program for providing health insurance benefits, and to make explicit those powers and duties that it wishes to be exercised by the Office of Personnel or any other administrative official. Fundamental issues regarding the nature of and eligibility for County benefits should be decided by the County Council, although certainly the responsibility for detail must be delegated.

3. **As part of the ordinance referenced in the previous section, language clarifying that the allocation of costs for participation in the County's group health plan by retirees "may be changed from time to time as deemed necessary by the County Council."**

Section 6-1-308(b)(3) of the County Code now states that the County shall pay 80% of the cost, and the "employee" shall pay 20% of the cost. Considerable research, analysis, and discussion has gone into the subject of whether, by the current language of § 6-1-308(b)(3) of the County Code, the County Council has created a “contractual” obligation on behalf of the County that may be enforced in a court of law by retirees, in the manner of accrued pension benefits.

Unless the County Council believes that the current allocation is a "promise" that must be kept going forward (and that a way can be found to fund that promise), it should give itself and future County Councils the clear option to make reasonable adjustments in the allocation, at least until such benefits are funded in the same manner as pension benefits. While such action would not resolve the legal effect of the current law, it would certainly resolve the issue going forward.
Appendix H

Wage comparisons – Area Counties
Sheriff Sergeants Wage Comparisons

- Effective 6/30/2011

<table>
<thead>
<tr>
<th>Entry (Sheriff Sergeants)</th>
<th>Entry Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prince George's County</td>
<td>$55,926</td>
</tr>
<tr>
<td>Montgomery County</td>
<td>$54,963</td>
</tr>
<tr>
<td><strong>Anne Arundel County</strong></td>
<td><strong>$47,895</strong></td>
</tr>
<tr>
<td>Baltimore County</td>
<td>$43,642</td>
</tr>
<tr>
<td>Howard County</td>
<td>$42,890</td>
</tr>
<tr>
<td>Baltimore City</td>
<td>$41,074</td>
</tr>
<tr>
<td>Median</td>
<td>$43,642</td>
</tr>
<tr>
<td>Anne Arundel Variance</td>
<td>9.7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Top Step - Base + Longevity (Sheriff Sergeants)</th>
<th>Top Step Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prince George's County</td>
<td>$93,239</td>
</tr>
<tr>
<td>Montgomery County</td>
<td>$88,545</td>
</tr>
<tr>
<td><strong>Anne Arundel County</strong></td>
<td><strong>$75,332</strong></td>
</tr>
<tr>
<td>Howard County</td>
<td>$69,306</td>
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<tr>
<td>Baltimore County</td>
<td>$68,548</td>
</tr>
<tr>
<td>Baltimore City</td>
<td>$65,568</td>
</tr>
<tr>
<td>Median</td>
<td>$69,306</td>
</tr>
<tr>
<td>Anne Arundel Variance</td>
<td>8.7%</td>
</tr>
</tbody>
</table>
Deputy Sheriff Wage Comparisons

- Effective 6/30/2011

<table>
<thead>
<tr>
<th>Entry (Deputy Sheriffs)</th>
<th>Montgomery County</th>
<th>Prince George's County</th>
<th>Anne Arundel County</th>
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</thead>
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<tr>
<td>Montgomery County</td>
<td>$43,642</td>
<td>$42,807</td>
<td>$39,140</td>
</tr>
<tr>
<td>Prince George's County</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Anne Arundel County</td>
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<td></td>
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<tr>
<td>Howard County</td>
<td>$38,730</td>
<td></td>
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<tr>
<td>Baltimore County</td>
<td>$37,747</td>
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<tr>
<td>Baltimore City</td>
<td>$36,280</td>
<td></td>
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</tr>
<tr>
<td>Median</td>
<td>$38,730</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anne Arundel Variance</td>
<td>1.1%</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Top Step - Base + Longevity (Deputy Sheriffs Series)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Montgomery County</td>
</tr>
<tr>
<td>Prince George's County</td>
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<tr>
<td>Howard County</td>
</tr>
<tr>
<td>Baltimore County</td>
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<tr>
<td>Anne Arundel County</td>
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<tr>
<td>Baltimore City</td>
</tr>
<tr>
<td>Median</td>
</tr>
<tr>
<td>Anne Arundel Variance</td>
</tr>
</tbody>
</table>
Police Officer Wage Comparisons

- Effective 6/30/2011

<table>
<thead>
<tr>
<th>Entry (FOP)</th>
<th>Top Step - Base + Longevity (FOP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Montgomery County</td>
<td>Baltimore County</td>
</tr>
<tr>
<td></td>
<td>Montgomery County</td>
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<tr>
<td></td>
<td>Prince George's County</td>
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<td></td>
<td>Prince George's County</td>
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<td>Howard County</td>
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<td>Howard County</td>
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<td></td>
<td>Harford County</td>
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<tr>
<td></td>
<td>Harford County</td>
</tr>
<tr>
<td><strong>Anne Arundel County</strong></td>
<td><strong>Anne Arundel County</strong></td>
</tr>
<tr>
<td></td>
<td>Anne Arundel County</td>
</tr>
<tr>
<td></td>
<td>Baltimore City</td>
</tr>
<tr>
<td></td>
<td>MD State Police</td>
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<tr>
<td></td>
<td>Median</td>
</tr>
<tr>
<td></td>
<td>Median</td>
</tr>
<tr>
<td></td>
<td>Anne Arundel Variance</td>
</tr>
<tr>
<td></td>
<td>Anne Arundel Variance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Montgomery County</td>
<td>$46,972</td>
<td>$96,143</td>
</tr>
<tr>
<td>Baltimore County</td>
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<td>$86,774</td>
</tr>
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<td>Prince George's County</td>
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<td>Howard County</td>
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<td>Harford County</td>
<td>$42,973</td>
<td></td>
</tr>
<tr>
<td><strong>Anne Arundel County</strong></td>
<td><strong>$41,620</strong></td>
<td><strong>$85,848</strong></td>
</tr>
<tr>
<td>Baltimore City</td>
<td>$41,465</td>
<td></td>
</tr>
<tr>
<td>MD State Police</td>
<td>$40,207</td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>$45,947</td>
<td>$81,161</td>
</tr>
<tr>
<td>Anne Arundel Variance</td>
<td>-9.8%</td>
<td>5.2%</td>
</tr>
</tbody>
</table>
Police Sergeant Wage Comparisons

- Effective 6/30/2011

<table>
<thead>
<tr>
<th>Entry (Police Sergeants)</th>
<th>Top Step - Base + Longevity (Police Sergeants)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prince George's County</td>
<td>Baltimore County</td>
</tr>
<tr>
<td>Howard County</td>
<td>Montgomery County</td>
</tr>
<tr>
<td>Harford County</td>
<td>Howard County</td>
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<tr>
<td>Montgomery County</td>
<td>Anne Arundel County</td>
</tr>
<tr>
<td>Baltimore City</td>
<td>Prince George's County</td>
</tr>
<tr>
<td>Baltimore County</td>
<td>Harford County</td>
</tr>
<tr>
<td>Anne Arundel County</td>
<td>Maryland State Police</td>
</tr>
<tr>
<td>Median</td>
<td>Baltimore City</td>
</tr>
<tr>
<td>Anne Arundel Variance</td>
<td>Median</td>
</tr>
<tr>
<td></td>
<td>Anne Arundel Variance</td>
</tr>
</tbody>
</table>

|                             | $72,710                        | $116,464                        |
| Howard County               | $64,709                        | $100,221                        |
| Harford County              | $60,861                        | $96,782                         |
| Montgomery County           | $59,816                        | Anne Arundel County             |
| Baltimore City              | $59,200                        | $95,854                         |
| Baltimore County            | $58,680                        | Prince George's County          |
| Anne Arundel County         | $57,006                        | $94,904                         |
| Maryland State Police       | $49,377                        | Harford County                  |
| Median                      | $59,816                        | $92,061                         |
| Anne Arundel Variance       | -4.7%                          | Maryland State Police           |
|                             |                                | Baltimore City                  |
|                             |                                | Median                          |
|                             |                                | Anne Arundel Variance           |
|                             |                                | 1.0%                            |
Police Lieutenant Wage Comparisons

- Effective 6/30/2011

<table>
<thead>
<tr>
<th>Entry (Police Lieutenant)</th>
<th>Prince George's County</th>
<th>Howard County</th>
<th>Montgomery County</th>
<th>Harford County</th>
<th>Baltimore City</th>
<th>Baltimore County</th>
<th>Anne Arundel County</th>
<th>Maryland State Police</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$82,380</td>
<td>$79,482</td>
<td>$74,352</td>
<td>$70,200</td>
<td>$67,292</td>
<td>$66,135</td>
<td>$62,708</td>
<td>$62,146</td>
</tr>
<tr>
<td>Median</td>
<td>$70,200</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Anne Arundel Variance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-10.7%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Top Step - Base + Longevity (Police Lieutenant)</th>
<th>Baltimore County</th>
<th>Montgomery County</th>
<th>Anne Arundel County</th>
<th>Howard County</th>
<th>Harford County</th>
<th>Prince George's County</th>
<th>Maryland State Police</th>
<th>Baltimore City</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$134,821</td>
<td>$115,912</td>
<td>$111,359</td>
<td>$108,339</td>
<td>$103,106</td>
<td>$104,395</td>
<td>$100,960</td>
<td>$88,603</td>
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<tr>
<td>Median</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$104,395</td>
</tr>
<tr>
<td>Anne Arundel Variance</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>6.7%</td>
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</table>
Firefighter Wage Comparisons

- Effective 6/30/2011

<table>
<thead>
<tr>
<th>Entry Level Firefighter</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Howard County</td>
<td>$45,078</td>
</tr>
<tr>
<td>Montgomery County</td>
<td>$41,613</td>
</tr>
<tr>
<td>Prince George's County</td>
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<tr>
<td><strong>Anne Arundel County</strong></td>
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<tr>
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<td>Baltimore City</td>
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</tr>
<tr>
<td>Median</td>
<td>$40,848</td>
</tr>
<tr>
<td>Anne Arundel Variance</td>
<td>-11.7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Top Step - Base + Longevity (Journey Level Firefighter)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prince George's County</td>
<td>$90,731</td>
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<tr>
<td>Baltimore County</td>
<td>$81,504</td>
</tr>
<tr>
<td>Montgomery County</td>
<td>$79,472</td>
</tr>
<tr>
<td><strong>Anne Arundel County</strong></td>
<td><strong>$78,504</strong></td>
</tr>
<tr>
<td>Howard County</td>
<td>$76,777</td>
</tr>
<tr>
<td>Baltimore City</td>
<td>$60,846</td>
</tr>
<tr>
<td>Median</td>
<td>$79,472</td>
</tr>
<tr>
<td>Anne Arundel Variance</td>
<td>-1.2%</td>
</tr>
</tbody>
</table>
Detention Officer Wage Comparisons

- Effective 6/30/2011

<table>
<thead>
<tr>
<th>Entry (Detention Officers)</th>
<th>Top Step - Base + Longevity (Detention Officers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Montgomery County</td>
<td>Montgomery County $72,881</td>
</tr>
<tr>
<td>Baltimore County</td>
<td>Prince George's County $70,685</td>
</tr>
<tr>
<td>Harford County</td>
<td>Harford County $68,869</td>
</tr>
<tr>
<td>Anne Arundel County</td>
<td>Anne Arundel County $68,719</td>
</tr>
<tr>
<td>Howard County</td>
<td>Baltimore County $62,216</td>
</tr>
<tr>
<td>Prince George's County</td>
<td>Howard County $59,030</td>
</tr>
<tr>
<td>State of Maryland</td>
<td>State of Maryland $52,915</td>
</tr>
<tr>
<td>Median</td>
<td>Median $65,543</td>
</tr>
<tr>
<td>Anne Arundel Variance</td>
<td>Anne Arundel Variance 4.8%</td>
</tr>
</tbody>
</table>

|                           | Montgomery County $40,538                         |
|                           | Baltimore County $39,667                           |
|                           | Harford County $39,166                             |
|                           | Anne Arundel County $38,051                        |
|                           | Howard County $37,086                              |
|                           | Prince George's County $36,647                     |
|                           | State of Maryland $31,724                          |
| Median                    | $38,126                                           |
| Anne Arundel Variance     | -0.2%                                             |
Detention Officer Sergeant Wage Comparisons

- Effective 6/30/2011

<table>
<thead>
<tr>
<th>Entry (Detention Officer Sergeant)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Harford County</td>
<td>$52,458</td>
</tr>
<tr>
<td>Montgomery County</td>
<td>$51,739</td>
</tr>
<tr>
<td>Howard County</td>
<td>$49,733</td>
</tr>
<tr>
<td>Baltimore County</td>
<td>$45,630</td>
</tr>
<tr>
<td>Prince George's County</td>
<td>$44,436</td>
</tr>
<tr>
<td><strong>Anne Arundel County</strong></td>
<td>$43,631</td>
</tr>
<tr>
<td>State of Maryland</td>
<td>$34,865</td>
</tr>
<tr>
<td>Median</td>
<td>$47,682</td>
</tr>
<tr>
<td>Anne Arundel Variance</td>
<td>-8.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Top Step - Base + Longevity (Detention Officer Sergeant)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Montgomery County</td>
<td>$86,272</td>
</tr>
<tr>
<td><strong>Anne Arundel County</strong></td>
<td>$81,661</td>
</tr>
<tr>
<td>Harford County</td>
<td>$79,373</td>
</tr>
<tr>
<td>Prince George's County</td>
<td>$77,875</td>
</tr>
<tr>
<td>Howard County</td>
<td>$77,771</td>
</tr>
<tr>
<td>Baltimore County</td>
<td>$71,938</td>
</tr>
<tr>
<td>State of Maryland</td>
<td>$56,469</td>
</tr>
<tr>
<td>Median</td>
<td>$77,823</td>
</tr>
<tr>
<td>Anne Arundel Variance</td>
<td>4.9%</td>
</tr>
</tbody>
</table>
Automotive Mechanic
AFSCME 582

- The Automotive Mechanic job series has three titles – Automotive Mechanic I, II, and III
- At maximum base + longevity for Automotive Mechanic III, Anne Arundel County ranks 5 of 7, within 4.9% of the survey group median of $64,296

Automotive Mechanic III – Max Base + Longevity*

* - Harford County reports no comparable job match
Equipment Operator
AFSCME 582

- The Equipment Operator job series has four titles – Equipment Operator I, II, III and Senior Equipment Operator

- At maximum base + longevity for Equipment Operator III – the most senior, non-specialized title within the Equipment Operator job series – Anne Arundel County ranks 3 of 8 and exceeds the survey median of $53,548 by 3.4%

### Equipment Operator III – Max Base + Longevity

<table>
<thead>
<tr>
<th>County</th>
<th>Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>State of Maryland</td>
<td>$36,506</td>
</tr>
<tr>
<td>Baltimore City</td>
<td>$38,635</td>
</tr>
<tr>
<td>Howard County</td>
<td>$47,050</td>
</tr>
<tr>
<td>Prince George's County</td>
<td>$53,548</td>
</tr>
<tr>
<td>Baltimore County</td>
<td>$55,182</td>
</tr>
<tr>
<td>Anne Arundel County</td>
<td>$55,351</td>
</tr>
<tr>
<td>Montgomery County</td>
<td>$63,343</td>
</tr>
<tr>
<td>Harford County</td>
<td>$71,178</td>
</tr>
</tbody>
</table>
Maintenance Worker
AFSCME 582

- The Maintenance Worker job series has two titles – Maintenance Worker I and II (full-performance)
- At maximum base + longevity, Anne Arundel County represents the median value among the jurisdictions surveyed

Maintenance Worker II – Max Base + Longevity*

<table>
<thead>
<tr>
<th></th>
<th>Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>State of Maryland</td>
<td>$38,838</td>
</tr>
<tr>
<td>Prince George's County</td>
<td>$42,299</td>
</tr>
<tr>
<td>Howard County</td>
<td>$43,930</td>
</tr>
<tr>
<td>Anne Arundel County</td>
<td>$45,424</td>
</tr>
<tr>
<td>Baltimore County</td>
<td>$47,861</td>
</tr>
<tr>
<td>Montgomery County</td>
<td>$52,594</td>
</tr>
<tr>
<td>Harford County</td>
<td>$62,608</td>
</tr>
</tbody>
</table>

* - Baltimore City reports no comparable job match
Police Communications Operator
AFSCME 582

- The Police Communications Operator series has two titles – Police Communications Operator I and II (full-performance)
- At maximum base + longevity, Anne Arundel County represents the median value among the jurisdictions surveyed

Police Communications Operator – Max Base + Longevity*

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baltimore City</td>
<td>$45,661</td>
</tr>
<tr>
<td>State of Maryland</td>
<td>$46,516</td>
</tr>
<tr>
<td>Baltimore County</td>
<td>$56,836</td>
</tr>
<tr>
<td>Anne Arundel County</td>
<td>$58,174</td>
</tr>
<tr>
<td>Howard County</td>
<td>$60,778</td>
</tr>
<tr>
<td>Montgomery County</td>
<td>$66,375</td>
</tr>
<tr>
<td>Prince George's County</td>
<td>$78,595</td>
</tr>
</tbody>
</table>

* - Harford County reports no comparable job match
## Booking Officer

**AFSCME 2563**

- The Booking Officer job series has one job tile – Booking Officer I. Employees progress through the pay range by receiving merit increments.

- Among the seven (7) jurisdictions surveyed, only three reported a job match for Booking Officer I, and in one jurisdiction (Harford County) deputy sheriffs perform the duties of booking officers. The pay ranges for each jurisdiction that reported a job match for Booking Officer I are reflected below:

### Booking Officer Pay Ranges (Min – Max Base + Longevity)

<table>
<thead>
<tr>
<th>County</th>
<th>Pay Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anne Arundel</td>
<td>$28,910 - $51,499</td>
</tr>
<tr>
<td>State of Maryland</td>
<td>$31,724 - $49,599</td>
</tr>
<tr>
<td>Howard County</td>
<td>$32,968 - $53,248</td>
</tr>
<tr>
<td>Harford County</td>
<td>$42,910 to $68,869</td>
</tr>
</tbody>
</table>

---
Crime Scene Technician
AFSCME 2563

- The Crime Scene Technician job series has two titles – Crime Scene Technician I and II (full performance)

- Anne Arundel County’s Crime Scene Technician job series has material differences in educational requirements and job duties from three comparison jurisdictions
  - In Harford County, Deputy Sheriffs perform the duties of Anne Arundel’s Crime Scene Technician
  - In Baltimore and Montgomery County, Crime Scene Technicians require a bachelor’s degree, while Anne Arundel Crime Scene Technicians require an associate’s degree

- Among the five jurisdictions with comparable education requirements and job duties, Anne Arundel County represents the median value at maximum base + longevity
Financial Clerk I
AFSCME 2563

- The Financial Clerk job series has one job tile – Financial Clerk I. Employees progress through the pay range by receiving merit increments.

- At maximum base + longevity, Anne Arundel County ranks 4 of 8 and exceeds the survey median of $48,737 by 4.9%
Office Support Assistant
AFSCME 2563

- The Office Support Assistant series has three titles – Office Support Assistant I and II, as well as Office Support Specialist.

- Anne Arundel County's Office Support Specialist requires a high school degree, while matching job titles in Harford, Howard, and Prince George's County require a bachelor's degree.

- Among the four jurisdictions with comparable education requirements, Anne Arundel County ranks 3 of 4 at maximum base + longevity.

Office Support Specialist*
Max Base + Longevity

- Baltimore City reports no comparable job match.
Correctional Program Specialist
AFSCME 2563

- The Correctional Program Specialist job series has two titles – Correctional Program Specialist I and II

- At maximum base + longevity for Correctional Program Specialist II, Anne Arundel County ranks 3 of 7, approximately 18% above the survey group median of $69,639
### Accountant - Journey Level

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Comparable Title</th>
<th>Min Salary</th>
<th>Rank</th>
<th>% Diff</th>
<th>Max Sal (1)</th>
<th>Rank</th>
<th>% Diff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anne Arundel County Gov’t</td>
<td>Accountant II</td>
<td>$49,932</td>
<td>1</td>
<td></td>
<td>$82,900</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Baltimore City</td>
<td>Accountant II</td>
<td>$40,000</td>
<td>5</td>
<td>19.89%</td>
<td>$56,800</td>
<td>6</td>
<td>31.48%</td>
</tr>
<tr>
<td>Baltimore County</td>
<td>Accountant II (35 hr)</td>
<td>$45,630</td>
<td>4</td>
<td>8.62%</td>
<td>$71,938</td>
<td>4</td>
<td>13.22%</td>
</tr>
<tr>
<td>Harford County</td>
<td>Accountant II</td>
<td>$47,400</td>
<td>3</td>
<td>5.07%</td>
<td>$90,230</td>
<td>1</td>
<td>-8.84%</td>
</tr>
<tr>
<td>Howard County</td>
<td>Fiscal Specialist I</td>
<td>$49,733</td>
<td>2</td>
<td>0.49%</td>
<td>$80,163</td>
<td>3</td>
<td>3.30%</td>
</tr>
<tr>
<td>Maryland State</td>
<td>Accountant II</td>
<td>$38,594</td>
<td>6</td>
<td>22.71%</td>
<td>$61,427</td>
<td>5</td>
<td>25.90%</td>
</tr>
<tr>
<td><strong>Median - Other Jurisdictions</strong></td>
<td></td>
<td>$45,630</td>
<td></td>
<td>8.62%</td>
<td>$71,938</td>
<td></td>
<td>13.22%</td>
</tr>
</tbody>
</table>

### Accountant II

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Comparable Title</th>
<th>Min Salary</th>
<th>Rank</th>
<th>% Diff</th>
<th>Max Sal (1)</th>
<th>Rank</th>
<th>% Diff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anne Arundel County Gov’t</td>
<td>Accountant II</td>
<td>$49,932</td>
<td>2</td>
<td></td>
<td>$82,900</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Baltimore City</td>
<td>Accountant II</td>
<td>$40,000</td>
<td>7</td>
<td>19.89%</td>
<td>$56,800</td>
<td>8</td>
<td>31.48%</td>
</tr>
<tr>
<td>Baltimore County</td>
<td>Accountant II</td>
<td>$45,630</td>
<td>5</td>
<td>8.62%</td>
<td>$71,938</td>
<td>6</td>
<td>13.22%</td>
</tr>
<tr>
<td>Harford County</td>
<td>Accountant II</td>
<td>$47,400</td>
<td>4</td>
<td>5.07%</td>
<td>$90,230</td>
<td>1</td>
<td>-8.84%</td>
</tr>
<tr>
<td>Howard County</td>
<td>Fiscal Specialist I</td>
<td>$49,733</td>
<td>3</td>
<td>0.49%</td>
<td>$80,163</td>
<td>5</td>
<td>3.30%</td>
</tr>
<tr>
<td>Maryland State</td>
<td>Accountant II</td>
<td>$38,594</td>
<td>8</td>
<td>22.71%</td>
<td>$61,427</td>
<td>7</td>
<td>25.90%</td>
</tr>
<tr>
<td>Montgomery County</td>
<td>Accountant/Auditor III</td>
<td>$51,598</td>
<td>1</td>
<td>-3.34%</td>
<td>$87,173</td>
<td>2</td>
<td>-5.15%</td>
</tr>
<tr>
<td>Prince Georges County</td>
<td>Accountant II</td>
<td>$43,142</td>
<td>6</td>
<td>13.60%</td>
<td>$83,937</td>
<td>3</td>
<td>-1.25%</td>
</tr>
<tr>
<td><strong>Median - Other Jurisdictions</strong></td>
<td></td>
<td>$45,630</td>
<td></td>
<td>8.62%</td>
<td>$80,163</td>
<td></td>
<td>3.30%</td>
</tr>
</tbody>
</table>
## Attorney - Journey Level

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Comparable Title</th>
<th>Min Salary</th>
<th>Rank</th>
<th>% Diff</th>
<th>Max Sal (1)</th>
<th>Rank</th>
<th>% Diff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anne Arundel County Gov't</td>
<td>Attorney III</td>
<td>$67,159</td>
<td>2</td>
<td></td>
<td>$111,498</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Baltimore City</td>
<td>Assistant Solicitor</td>
<td>$44,200</td>
<td>6</td>
<td>34.19%</td>
<td>$84,600</td>
<td>6</td>
<td>24.12%</td>
</tr>
<tr>
<td>Baltimore County (1)</td>
<td>Assistant County Attorney</td>
<td>$46,532</td>
<td>5</td>
<td>30.71%</td>
<td>$118,272</td>
<td>2</td>
<td>-6.08%</td>
</tr>
<tr>
<td>Harford County</td>
<td>Assistant County Attorney II</td>
<td>$64,300</td>
<td>3</td>
<td>4.26%</td>
<td>$114,629</td>
<td>3</td>
<td>-2.81%</td>
</tr>
<tr>
<td>Howard County</td>
<td>Senior Attorney</td>
<td>$74,901</td>
<td>1</td>
<td>-11.53%</td>
<td>$120,827</td>
<td>1</td>
<td>-8.37%</td>
</tr>
<tr>
<td>Maryland State</td>
<td>Assistant Attorney General VI</td>
<td>$60,290</td>
<td>4</td>
<td>10.23%</td>
<td>$98,808</td>
<td>5</td>
<td>11.38%</td>
</tr>
</tbody>
</table>

**Median - Other Jurisdictions**

$60,290 10.23% $114,629 -2.81%

### NOTES:

(1) Exempt from classified service and salaries negotiated with County Attorney

---

## Attorney - Journey Level

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Comparable Title</th>
<th>Min Salary</th>
<th>Rank</th>
<th>% Diff</th>
<th>Max Sal (1)</th>
<th>Rank</th>
<th>% Diff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anne Arundel County Gov't</td>
<td>Attorney III</td>
<td>$67,159</td>
<td>3</td>
<td></td>
<td>$111,498</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Baltimore City</td>
<td>Assistant Solicitor</td>
<td>$44,200</td>
<td>8</td>
<td>34.19%</td>
<td>$84,600</td>
<td>8</td>
<td>24.12%</td>
</tr>
<tr>
<td>Baltimore County (1)</td>
<td>Assistant County Attorney</td>
<td>$46,532</td>
<td>7</td>
<td>30.71%</td>
<td>$118,272</td>
<td>3</td>
<td>-6.08%</td>
</tr>
<tr>
<td>Harford County</td>
<td>Assistant County Attorney II</td>
<td>$64,300</td>
<td>4</td>
<td>4.26%</td>
<td>$114,629</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Howard County</td>
<td>Senior Attorney</td>
<td>$74,901</td>
<td>2</td>
<td>-11.53%</td>
<td>$120,827</td>
<td>2</td>
<td>-8.37%</td>
</tr>
<tr>
<td>Maryland State</td>
<td>Assistant Attorney General VI</td>
<td>$60,290</td>
<td>5</td>
<td>10.23%</td>
<td>$98,808</td>
<td>6</td>
<td>11.38%</td>
</tr>
<tr>
<td>Montgomery County</td>
<td>Assistant County Attorney III</td>
<td>$77,596</td>
<td>1</td>
<td>-15.54%</td>
<td>$131,413</td>
<td>1</td>
<td>-17.86%</td>
</tr>
<tr>
<td>Prince Georges County</td>
<td>Attorney II</td>
<td>$49,943</td>
<td>6</td>
<td>25.63%</td>
<td>$97,168</td>
<td>7</td>
<td>12.85%</td>
</tr>
</tbody>
</table>

**Median - Other Jurisdictions**

$60,290 10.23% $114,629 -2.81%

### NOTES:

(1) Exempt from classified service and salaries negotiated with County Attorney

16/02/2013 09:00 PM
## ANNE ARUNDEL COUNTY
### CLASSIFICATION/COMPENSATION SURVEY

### Buyer - Journey Level

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Comparable Title</th>
<th>Min Salary</th>
<th>Rank</th>
<th>% Diff</th>
<th>Max Sal (1)</th>
<th>Rank</th>
<th>% Diff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anne Arundel County Gov't</td>
<td>Buyer III</td>
<td>$46,369</td>
<td>2</td>
<td>4.93%</td>
<td>$76,983</td>
<td>2</td>
<td>19.87%</td>
</tr>
<tr>
<td>Baltimore City (1)</td>
<td>Procurement Specialist I</td>
<td>$44,084</td>
<td>5</td>
<td>1.59%</td>
<td>$61,683</td>
<td>5</td>
<td>19.87%</td>
</tr>
<tr>
<td>Baltimore County</td>
<td>Staff Buyer</td>
<td>$45,630</td>
<td>3</td>
<td>1.59%</td>
<td>$71,938</td>
<td>4</td>
<td>6.55%</td>
</tr>
<tr>
<td>Harford County</td>
<td>Procurement Agent II</td>
<td>$47,400</td>
<td>1</td>
<td>-2.22%</td>
<td>$90,230</td>
<td>1</td>
<td>-17.21%</td>
</tr>
<tr>
<td>Howard County</td>
<td>Admin Analyst I</td>
<td>$44,845</td>
<td>4</td>
<td>3.29%</td>
<td>$72,384</td>
<td>3</td>
<td>5.97%</td>
</tr>
<tr>
<td>Maryland State</td>
<td>Agency Procurement Specialist II</td>
<td>$38,594</td>
<td>6</td>
<td>16.77%</td>
<td>$61,427</td>
<td>6</td>
<td>20.21%</td>
</tr>
<tr>
<td><strong>Median - Other Jurisdictions</strong></td>
<td></td>
<td>$44,845</td>
<td>3</td>
<td>3.29%</td>
<td>$71,938</td>
<td>6</td>
<td>6.55%</td>
</tr>
</tbody>
</table>

### NOTES:
1. Requires pass certification test for Certified Public Purchasing Buyer within 2 years of hiring, failure to pass is grounds for dismissal

---

### Mediation - Other Jurisdictions

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Comparable Title</th>
<th>Min Salary</th>
<th>Rank</th>
<th>% Diff</th>
<th>Max Sal (1)</th>
<th>Rank</th>
<th>% Diff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anne Arundel County Gov't</td>
<td>Buyer III</td>
<td>$46,369</td>
<td>3</td>
<td>1.59%</td>
<td>$76,983</td>
<td>3</td>
<td>19.87%</td>
</tr>
<tr>
<td>Baltimore City (1)</td>
<td>Procurement Specialist I</td>
<td>$44,084</td>
<td>6</td>
<td>4.93%</td>
<td>$61,683</td>
<td>7</td>
<td>19.87%</td>
</tr>
<tr>
<td>Baltimore County</td>
<td>Staff Buyer</td>
<td>$45,630</td>
<td>4</td>
<td>1.59%</td>
<td>$71,938</td>
<td>5</td>
<td>6.55%</td>
</tr>
<tr>
<td>Harford County</td>
<td>Procurement Agent II</td>
<td>$47,400</td>
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### NOTES:
1. Requires pass certification test for Certified Public Purchasing Buyer within 2 years of hiring, failure to pass is grounds for dismissal
## ANNE ARUNDEL COUNTY
### CLASSIFICATION/COMPENSATION SURVEY

### Information Systems Help Desk

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ANNE ARUNDEL COUNTY
CLASSIFICATION/COMPENSATION SURVEY

Paralegal

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<tr>
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<td>-0.69%</td>
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## ANNE ARUNDEL COUNTY
### CLASSIFICATION/COMPENSATION SURVEY

**Personnel Analyst - Journey Level**

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1/6/20123:09 PM
## Planner - Journey Level

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<td>$88,795</td>
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<tr>
<td>Maryland State</td>
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<td>$43,725</td>
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<td>15.56%</td>
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<td>Montgomery County</td>
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<tr>
<td>Prince Georges County</td>
<td>Programmer Systems Analyst II</td>
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<td>7</td>
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<td><strong>Median - Other Jurisdictions</strong></td>
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<td>$52,116</td>
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<td>-4.37%</td>
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<td>-7.11%</td>
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## ANNE ARUNDEL COUNTY
### CLASSIFICATION/COMPENSATION SURVEY

### Recreation Specialist

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Comparable Title</th>
<th>Min Salary</th>
<th>Rank</th>
<th>% Diff</th>
<th>Max Sal (1)</th>
<th>Rank</th>
<th>% Diff</th>
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<tbody>
<tr>
<td>Anne Arundel County Gov’t</td>
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<td>$49,932</td>
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<td>$82,900</td>
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<tr>
<td>Baltimore City</td>
<td>Recreation Programmer</td>
<td>$42,267</td>
<td>3</td>
<td>15.35%</td>
<td>$59,076</td>
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<tr>
<td>Baltimore County</td>
<td>Recreation Comm Supervisor II</td>
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<tr>
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<tr>
<td>Howard County</td>
<td>Recreation Services Coordinator II</td>
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<td>$65,395</td>
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<td>21.12%</td>
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<tr>
<td>Maryland State</td>
<td>NCC</td>
<td></td>
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<tr>
<td><strong>Median - Other Jurisdictions</strong></td>
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<td>$41,372</td>
<td>17.14%</td>
<td>$68,667</td>
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### NOTES:
Anne Arundel County position has supervisory responsibilities

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Comparable Title</th>
<th>Min Salary</th>
<th>Rank</th>
<th>% Diff</th>
<th>Max Sal (1)</th>
<th>Rank</th>
<th>% Diff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anne Arundel County Gov’t</td>
<td>Recreation Supervisor</td>
<td>$49,932</td>
<td>1</td>
<td></td>
<td>$82,900</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Baltimore City</td>
<td>Recreation Programmer</td>
<td>$42,267</td>
<td>5</td>
<td>15.35%</td>
<td>$59,076</td>
<td>7</td>
<td>28.74%</td>
</tr>
<tr>
<td>Baltimore County</td>
<td>Recreation Comm Supervisor II</td>
<td>$45,630</td>
<td>3</td>
<td>8.62%</td>
<td>$71,938</td>
<td>5</td>
<td>13.22%</td>
</tr>
<tr>
<td>Harford County</td>
<td>Recreation Specialist II</td>
<td>$39,900</td>
<td>7</td>
<td>20.09%</td>
<td>$76,190</td>
<td>4</td>
<td>8.09%</td>
</tr>
<tr>
<td>Howard County</td>
<td>Recreation Services Coordinator II</td>
<td>$40,477</td>
<td>6</td>
<td>18.94%</td>
<td>$65,395</td>
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<td>21.12%</td>
</tr>
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<tr>
<td>Montgomery County</td>
<td>Recreation Specialist</td>
<td>$47,028</td>
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<td>5.82%</td>
<td>$79,312</td>
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<td>Prince Georges County</td>
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<tr>
<td><strong>Median - Other Jurisdictions</strong></td>
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<td>14.82%</td>
<td>$74,064</td>
<td>10.66%</td>
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### NOTES:
Anne Arundel County position has supervisory responsibilities

1/6/20123:09 PM
### Anne Arundel County Classification/Compensation Survey

#### Systems Analyst

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Comparable Title</th>
<th>Min Salary</th>
<th>Rank</th>
<th>% Diff</th>
<th>Max Sal (1)</th>
<th>Rank</th>
<th>% Diff</th>
</tr>
</thead>
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<tr>
<td>Anne Arundel County Gov't</td>
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<td>$62,365</td>
<td>1</td>
<td></td>
<td>$103,536</td>
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<td>23.31%</td>
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<td>1.50%</td>
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<td>7.48%</td>
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<td></td>
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<td></td>
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<tr>
<td>Maryland State</td>
<td>IT Programmer Analyst Lead/Adv</td>
<td>$46,563</td>
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<td>$74,725</td>
<td>5</td>
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<tr>
<td><strong>Median - Other Jurisdictions</strong></td>
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<td></td>
<td>$87,551</td>
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</table>
Appendix I

Private Sector Benefit Comparisons
<table>
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<tr>
<th>Coverage</th>
<th>Prescription Coverage</th>
<th>Dental - Employee Share</th>
<th>Vision - Employee Share</th>
<th>Retiree Health</th>
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<tbody>
<tr>
<td><strong>Private Salaried</strong></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td><strong>Rx glasses</strong>: Separate</td>
<td>Copay $10</td>
<td>Co-Pay: $5</td>
<td>10%</td>
<td>$5</td>
</tr>
<tr>
<td>Individual</td>
<td>$500/$800</td>
<td>$800/$800</td>
<td>$0/$0</td>
<td>Generic</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Private Hourly Union</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Rx glasses</strong>: Separate</td>
<td>Copay $10</td>
<td>Co-Pay: $5</td>
<td>10%</td>
<td>$5</td>
</tr>
<tr>
<td>Individual</td>
<td>$500/$800</td>
<td>$800/$800</td>
<td>$0/$0</td>
<td>Generic</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Savings Plan</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prescription</strong></td>
<td></td>
<td>Co-Pay: $5</td>
<td>10%</td>
<td>$5</td>
</tr>
<tr>
<td>Individual</td>
<td>$2,000/$3,000</td>
<td>$3,000/$5,000</td>
<td>$0/$0</td>
<td>Generic</td>
</tr>
<tr>
<td>Family</td>
<td>$4,000/6,000</td>
<td>$6,000/10,000</td>
<td>$0/$0</td>
<td>Generic</td>
</tr>
<tr>
<td><strong>General</strong></td>
<td>Co-Pay: $250/$625</td>
<td>$250/$625</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$1,000/$1,500</td>
<td>$1,500/$3,000</td>
<td>$0/$0</td>
<td>Generic</td>
</tr>
<tr>
<td>Family</td>
<td>$2,000/$3,000</td>
<td>$3,000/$6,000</td>
<td>$0/$0</td>
<td>Generic</td>
</tr>
</tbody>
</table>

**Note**: Percentages apply after deductables have been met.

---

**Private Salaried**

- **Monthly Employee Contribution**: Non
- **Deductible**: $200 Single/$400 Family
- **In-Network**: $10 co-pay, Plan pays balance
- **Formulary**: 30% ($60 max)

**Private Hourly Union**

- **Monthly Employee Contribution**: Non
- **Deductible**: $250/$625
- **In-Network**: 100% plan; $1k/no family OOP
- **Formulary**: 30% ($80 max)

**Savings Plan**

- **Employee Contribution**: 1% to 75%
- **Employer Matching Contribution**: 1% to 4.5%
- **Retirement Account contribution of 3% to 5% (Based on Age)**
- **Employee responsible for investment of funds**
- **Co-Pays**:
  - Primary Dr.: $20/50%
  - Specialist: $20/75%

**OOP**

- **In/Out Co-Pays**:
  - $0/$0
  - $250/$625

**Max**

- **Individual**: $3,000/$5,000
- **Family**: $6,000/$10,000

**Emerg. Room**

- 10%/10% 0% after

**Note**: Percentages apply after deductables have been met.

**Max**

- **Individual**: $2,000
- **Family**: $4,000
- **10% after**

**Note**: Percentages apply after deductables have been met.

---

**Savings Plan**

- **Employee Contribution**: 1% to 75%
- **Employer Basic Contribution**: 1% to 9.5%
- **Employer Matching Contribution**: 1% to 4.5%
- **Retirement Account contribution of 3% to 5% (Based on Age)**

**Max**

- **Individual**: $3,000
- **Family**: $6,000

**Emerg. Room**

- 10%/10% 0% after

**Note**: Percentages apply after deductables have been met.

---

**Savings Plan**

- **Employee Contribution**: 1% to 75%
- **Employer Matching Contribution**: 1% to 4.5%
- **Retirement Account contribution of 3% to 5% (Based on Age)**
- **Employee responsible for investment of funds**

**Max**

- **Individual**: $3,000
- **Family**: $6,000

**Emerg. Room**

- 10%/10% 0% after

**Note**: Percentages apply after deductables have been met.

---

**Max**

- **If employee contributes**
- **Must contribute 4%**
- **Employer matches at 50% for first 12 years, then matches at 75% after 12 years**

**Savings Plan**

- **Employee Contribution**: 1% to 75%
- **Employer Matching Contribution**: 1% to 4.5%
- **Retirement Account contribution of 3% to 5% (Based on Age)**

**Max**

- **Individual**: $3,000
- **Family**: $6,000

**Emerg. Room**

- 10%/10% 0% after

**Note**: Percentages apply after deductables have been met.
Appendix J

National Business Group on Health Article – Large Employer Survey
Majority of Large Employers Revamping Health Benefit Programs for 2012, National Business Group on Health Survey Finds

August 18, 2011

For more information contact:
Ed Emerman
eemerman@eaglepr.com
609-275-5162

For Immediate Release

Employers Projecting Costs to Increase 7.2% Next Year; Nearly Two-Thirds Expect to Increase Employee Share of Premiums

WASHINGTON, DC, August 18, 2011 -- With the cost of employee health care benefits expected to increase next year at more than twice the rate of inflation, large U.S. employers are planning to have workers share more of the cost next year, according to a new survey by the National Business Group on Health, a non-profit association of 329, mostly large employers. The survey also found that more employers are adopting consumer-directed health plans and making other changes to their benefit programs as various components of the health care reform law take effect.

According to the survey, employers estimate their health care benefit costs will increase an average of 7.2% in 2012. That is slightly lower than this year's 7.4% average increase, but it is on a higher base and it still sharply outpaces the economy's anemic growth and business conditions. To help control those increases and begin driving down costs to avoid the Cadillac tax, employers are planning to use a wider variety of cost-sharing strategies. More than half of respondents (53%) plan to increase the percentage that employees contribute to the premiums, while 39% plan to increase in-network deductibles. Additionally, about one in four employers plans to increase out-of-network deductibles (23%) and out-of-pocket maximums (22%) next year. The survey, based on responses from 83 of the nation's largest corporations, was conducted in June 2011.

"Employers are facing a multitude of challenges posed by rising health care costs, the weak economy and the financial and administrative impact of complying with the new health reform law," said Helen Darling, President and CEO of the National Business Group on Health. "As a result, employers are being much more aggressive in their use of cost-sharing techniques and cost control programs, and are making certain that employees have more reasons to be cost-sensitive health care consumers."

Indeed, according to the survey, nearly three in four employers (73%) will offer employees at least one consumer-directed health plan (CDHP) in 2012, a sharp increase from 61% that offer a plan this year. In addition, about two in ten employers (17%) will have or move to a total replacement consumer-directed health plan in 2012. The most common type of CDHP plan is a high-deductible health plan with a health savings account (75%).

The survey also found that more than half (57%) provide employees' spouses and domestic partners access to telephonic or online weight management coaches while 54% provide access to online weight management tools. Approximately one-third of employees also make these programs available to employees' children.

Changes as a Result of Health Care Reform

Respondents were asked what changes they made or are planning to make as regulations from the Patient Protection and Affordable Care Act continue to come into effect. The survey found the following:

-- Annual Benefit Limits: The majority of employers (59%) are not making any changes for 2012, (full restrictions on benefit limits will be banned in 2014). However, more than one-fourth (27%) are making changes to annual limits for preventive and wellness services. Another 14% are making changes to annual limits for mental health and substance abuse services.

-- Grandfather Status: Nearly one fourth (23%) will have at least one benefit option that keeps its grandfather status in 2012 while 19% will drop its grandfather status. About one half (49%) did not have any benefit option in grandfather status this year.

-- Default Plan for New Hires: More than one fourth (27%) plan to use their least costly health plan for employees as their default plan for new full-time hires as required. Slightly fewer (19%) plan to use the least costly plan for employers as
the default plan.

"Employers understand that affordability is tied to employees’ premium costs and household incomes so they have two strong arguments for aggressively driving down costs -- both theirs and employees. That said, the federal government has to start helping reduce costs too. Like the national debt crisis that we are struggling to solve, we have to solve the health care cost crisis, which is seriously undermining our economy, businesses’ abilities to create jobs, working families, our global competitiveness and our standard of living. This is our other national crisis, and they are so intertwined that if we don’t reduce costs and medical trend, we will continue to barrel toward insolvency,” said Darling.

**About the National Business Group on Health**

The National Business Group on Health is the nation’s only non-profit organization devoted exclusively to representing large employers’ perspective on national health policy issues and providing practical solutions to its members’ most important health care problems. The Business Group helps drive today’s health agenda while promoting ideas for controlling health care costs, improving patient safety and quality of care and sharing best practices in health benefits management with senior benefits, HR professionals, and medical directors from leading corporations. Business Group members, which include 66 Fortune 100 companies, provide health coverage for more than 55 million U.S. workers, retirees and their families. For more information, visit [www.businessgrouphealth.org](http://www.businessgrouphealth.org).
Appendix K

Why Public Pensions Are So Rich

Shifting government workers to 401(k)-style plans would offer greater transparency and keep benefits in line with the private economy.

By ANDREW G. BIGGS And JASON RICHWINE

According to government union leaders, their employee retirement benefits are "not lavish by any means." So says Art Pulaski of the California Labor Federation. According to the American Federation of Teachers, public-employee pensions "typically are modest." And the Service Employees International Union asserts that "After decades of full-time work for the state, the sad truth is that far too many retired state employees receive yearly amounts that force them to live in poverty."

These claims are misleading, but reformers have a hard time conveying to taxpayers precisely how generous public-sector retirement benefits can be. That's because government employees typically have "defined benefit" pensions that pay a guaranteed benefit regardless of how the plan's investments may fare. Most private-sector workers hold "defined contribution" 401(k)-type savings accounts that guarantee no specific pension. Complex formulas obscure the fact that public pensions typically are much more generous than 401(k) plans, making the situation ripe for misleading claims.

A case in point is the Illinois Teachers Retirement System (TRS), which insists that, because Illinois teachers don't participate in Social Security, the average teacher's pension of almost $43,000 "cannot qualify as 'too generous.'" One might assume from such a statement that the typical Illinois teacher who retires this year after a full career will collect $43,000 per year. Not so. That average figure reflects the pensions of employees who retired years or decades ago, as well as individuals who worked only part of their careers in public schools.

The 2010 annual report for the TRS actually shows that the average teacher who retires today after 30 to 34 years of service had final earnings of $84,466 and collects a pension of $60,756 a year, plus annual cost-of-living adjustments, providing an income higher than 95% of retirees in Illinois. That's a lifetime value of almost $1.6 million if collected at age 62, and more if the employee retires in his 50s, as many do. In addition, Illinois employees—like many public employees around the country—are eligible for retiree health care that can be worth thousands of dollars per year.

Compared to this, how would a private-sector worker's retirement plan stack up? Private-sector workers typically rely on a combination of Social Security and a 401(k). If the private employee had the same $84,466 final earnings as that veteran teacher, Social Security would pay around $17,750 per year. The remaining $43,000 has to come from elsewhere.

The private worker wouldn't get far to that goal through his employer's contribution to a 401(k). An employer contribution of 6% of pay every year—an amount that only one out of 10 employers exceeds—would generate a
guaranteed income of around $3,850 per year in retirement. Benefit levels are low in part because, to replicate the government-guaranteed benefits a public employee receives, a worker with a 401(k) would have to have invested in ultrasafe (but low-yielding) assets such as Treasury securities.

To make up the rest, a private worker would need to save an almost implausible 45% of his salary for retirement. Compare that to the 9.4% of salary that Illinois teachers must contribute toward their pension plan. Many Illinois teachers pay even less because their school districts "pick up" all or part of the 9.4%, a practice that reforms in Wisconsin and Ohio have targeted.

Public employees who don’t work full careers fare less well under defined-benefit pension plans, and those with very short careers would do better with a 401(k). But for the average public employee, retirement benefits typically are several times more generous than what they would receive in the private economy.

This comparison illustrates the generosity of retirement benefits for Illinois teachers, but we could generate similar examples for public employees in California, Ohio, Wisconsin or practically any other state where public-sector pay has been a major issue.

As long as the public sector uses defined-benefit pension plans, fair comparisons of benefits will require the kind of detailed calculations presented here. But shifting public employees to 401(k)-style retirement plans would offer greater transparency for taxpayers.

The generosity of defined contribution pensions can’t be obscured by complicated accounting rules and benefit formulas. The benefit is simply what the employer puts into the account each year, and that’s it. Such pensions also allow for much greater portability, attracting mobile employees who fare poorly under defined-benefit plans and eliminating the "job lock" that keeps burned-out public employees who wish to quit from doing so.

There is no good reason why public employees should receive retirement benefits so much more generous than those of other Americans. If government workers were moved to defined-contribution pensions, it would be much easier to ensure fair market compensation in government.

*Mr. Biggs is a resident scholar at the American Enterprise Institute. Mr. Richwine is a senior policy analyst at the Heritage Foundation.*
Appendix L

Milliman White Paper – EGWP/Wrap: Why Now?
EGWP/wrap: Why now?

Questions and answers about the employer group waiver plan with wraparound benefits

Steven P. May
David M. Liner, FSA

For health plans that offer their retired employees prescription drug benefits, new rules from the Centers for Medicare and Medicaid Services (CMS) make the option of an Employer Group Waiver Plan with a wraparound supplemental plan (EGWP/wrap) attractive as a way to achieve significant plan savings.

Many employers have heard about this opportunity, but there is some confusion about exactly how advantageous the EGWP/wrap option may be and how to change to it from current plans such as those involving the retiree drug subsidy (RDS). This article aims to clarify some frequently asked questions about EGWP/wrap.

What is EGWP/wrap?
EGWP/wrap is an official Medicare Part D program containing a wraparound provision that ensures that retired employees will receive benefits at least equal to those of the plan that the employer currently offers. Employers who are now getting the RDS on behalf of their programs are likely to find that they can save money above and beyond their RDS by switching to an EGWP/wrap. Much of the savings will occur in the donut hole of drug expenses not currently covered by Medicare. Other employers who provide prescription drug coverage that does not currently qualify for RDS may also be able to take advantage of an EGWP/wrap.

What makes such savings possible?
Published and confirmed CMS guidance leads us to these projected savings, driven largely by the fact that, under the Patient Protection and Affordable Care Act (PPACA), pharmaceutical companies (pharma) will be covering 50% of the beneficiary’s share of the cost of brand-name drugs occurring in the donut hole coverage gap. This is known as the Coverage Gap Discount Program and was a provision introduced in the PPACA. Employer plans that receive RDS cannot access this Discount Program; it is only through the EGWP/wrap program that members and plan sponsors can benefit.

CMS guidance also states that the 50% pharma reimbursement will count as member cost sharing. This will have the effect of accelerating plan members through the coverage gap and into the catastrophic layer of drug expenses, where federal reinsurance payments cover most of the cost.

What is the difference between EGWP/wrap and standard EGWP?
Pharma reimbursement under the Coverage Gap Discount Program is calculated as 50% of the beneficiary cost share. In a standard EGWP there is typically plan coverage for brand-name drugs above the initial coverage limit (ICL), which reduces the pharma payments. In an EGWP/wrap, all of the brand drug coverage is moved to the wraparound plan in order to maximize the payments by pharma.

Does the EGWP/wrap plan require a change in benefits?
In general, you will be providing the same benefit level that your retirees are currently receiving. There are certain CMS requirements that must be met, and you will want to discuss those with your pharmacy benefits manager. For example, Medicare Part D formularies need to be approved by CMS, so if you have modified your prescription drug formulary to exclude certain categories of drugs that CMS requires, you may be required to include them; there are programs required by CMS such as those dealing with fraud and abuse, grievance, and medication therapy; and the benefit plan designs must meet certain CMS requirements.

How much can a plan sponsor save by switching to EGWP/wrap?
Plan sponsors currently filing for the RDS enjoy savings that typically range from $600 to $700 per beneficiary per year. The EGWP/wrap option typically increases the financial savings by 40% to 120% (compared with RDS) depending on a variety of factors. Detailed analysis can accurately project the amount of savings likely to be generated by the EGWP/wrap approach.

Will the PBM coordinate the benefits with Medicare?
In general, yes. The idea is for third-party pharmacy benefit managers (PBMs) to coordinate with Medicare so that there will be one card and the transactions regarding the pharma discounts and the Medicare payments take place in the background. The largest PBMs already have plans in place for transitioning to the requirements and procedures of EGWP/wrap. Many of the smaller to mid-size PBMs are also working to make the adjustment. Some, however, are struggling with how to coordinate the benefits with Medicare.

Employers who decide to make the switch should discuss the issue with their PBM to make sure all is in order, and consider putting performance guarantees in place to ensure that participants receive benefits seamlessly.

How will EGWP/wrap work for retirees who are plan members?
Retirees should experience no complications from the switch to EGWP/wrap. Plan sponsors will need to enroll their members in the Medicare Part D plan through the government as a group plan.
The PBM will build a formulary and plan design that mirrors the employer’s current plan. To retirees, the new plan should look just like the old plan.

What does it mean to enroll retirees in Medicare Part D?
An employer can build a group plan that duplicates the benefits retirees now have so that they will have no reason to leave the employer plan and join the government plan individually. Retirees will roll into the EGWP/wrap seamlessly. There will be no action required by the retirees and the EGWP/wrap plan administrator will handle all necessary paperwork.

Will retirees need both a Medicare drug card and their third-party PBM card?
In principle, the answer is no. Many third-party PBMs are prepared to coordinate their activities so that plan members will need only one card. But this is a question a plan sponsor should discuss with its PBM.

Will retirees have to pay any costs out of pocket and wait to be reimbursed?
An EGWP/wrap can be set up to mirror an employer’s current plan, so if there is a copayment structure, that same structure should serve the new plan. In a consumer-driven health plan, members’ payments at the pharmacy should take place just as they do now.

Will the federal Medicare formulary exclude any drugs that are now available to retirees?
There are some drugs that Medicare will not cover, but you should discuss how these drugs may be covered by the wraparound plan.

There are also some protected drug classes that CMS requires as a part of its formulary for an EGWP or any other kind of a Part D plan—drugs for the treatment of particular medical conditions. You should request that your PBM run a formulary match for your review during your discussions about a change to an EGWP/wrap plan. Plans that have narrow formularies need to take the potential expansion of covered drugs into account when analyzing the change to an EGWP/wrap.

Is it possible to modify the Medicare formulary to maintain current benefits?
CMS’s formulary is often different from the formulary a given plan has in place. The PBM can customize its formulary to build upon the Medicare list so as to match a plan’s benefits. This might involve an increase in PBM charges, but such an increase is not likely to affect plan savings greatly. It is not likely that the EGWP/wrap formulary can exclude Medicare-required drugs.

Suppose that some individual retirees join the EGWP/wrap and then leave that plan. Will they be penalized if, at a future date, they decide to re-enroll in it?
Generally, no—as long as an individual has continuous coverage through his or her employer. The employer’s plan will look like a group plan, and employees should be able to move between it and the EGWP/wrap. However, you should review current and proposed plan documents to make sure these limitations are addressed.

Can a plan sponsor switch back to its previous plan if the EGWP/wrap doesn’t work out as well as anticipated?
Basically, the answer is yes, but if collective bargaining is in play, this question will probably need to be handled through an employer/employee discussion.

Can a plan sponsor implement an EGWP/wrap now so as to take immediate advantage of the savings?
EGWP/wrap plans became available with CMS rules that went into effect as of the 2011 plan year as a result of federal healthcare reform. An employer can make the change as soon as it designs and creates the new plan, in cooperation with the PBM.

How should an employer communicate the changeover to an EGWP/wrap?
Employers will need to mount a concerted communication campaign. Retirees are always nervous about changes in their benefits, so it is important to make sure they understand the changeover and are comfortable with their benefits and the way they will receive them. The changeover takes place between the employer and the PBM; it’s important to reassure retirees that it’s primarily an administrative issue and that retirees’ benefits are not changing.

Must the employer still submit information to CMS and attest to the richness of the plan?
No. If an employer has been receiving an RDS payment, the actuarial work for the RDS will no longer be required. Gone also will be the employer’s administrative burden of submitting eligibility and tracking plan designs. The PBM contracts directly with CMS. The PBM is responsible for completing the applications, reconciliation, and actuarial certification regarding the adequacy of the plan.

How long will the savings accruing from an EGWP/wrap be available?
That’s impossible to say, because CMS rules are always subject to change. The current rules and pricing structure, including the discounts from pharmaceutical companies, are as we have described them for the time being. All we can say with certainty is that there is an opportunity now to realize very significant savings by switching to EGWP/wrap, and plan sponsors are well advised to consider doing so.

Conclusion
The availability of EGWP/wrap plans presents an opportunity for many employers to realize substantial savings by switching their current Medicare Plan D drug benefits from the RDS scenario. The current rules are clear, and the time to take advantage of this opportunity is now.

Steven May is a senior health benefits consultant with the Hartford, Connecticut, office of Milliman. Contact him at steve.may@milliman.com.

David Liner, FSA, is a consulting actuary with the Hartford, Connecticut, office of Milliman. Contact him at dave.liner@milliman.com.
Appendix M

Bolton Partners Letter – OPEB – Possible Plan Changes
October 28, 2011

Ms. Judi Lohn, Assistant Personnel Officer
Anne Arundel County Government
Office of Personnel
2660 Riva Road
Annapolis, MD 21401

Re: OPEB- Possible Plan Changes

Dear Judi,

This letter is in response to your request for the expense impact for 10 proposed plan changes provided to us in an October 19th e-mail. They are:

1) Eliminate post age 65 coverage (A - both for current and future retirees, and B - future retirees only)
2) Eliminate post age 65 prescription drug Coverage after 2019 (A - both for current and future retirees and B for future retirees only)
3) Institute service based subsidies (future retirees only)
   A. For general employees (60% after 10-14 Years, 70% 15-19 Year, 80% 20-24 years, 85% 25-29 Years, 90% 30+ years.
   B. Public safety and corrections: 60% with 20 years of service, increasing 1.5% per year of service to a 75% maximum with 30 or more years of service.
   C. All Employees: 50% with 15 years of service, increasing 2% per year per year of service to an 80% maximum with 30 or more years of service.
   D. All Employees: 3.0% per year to a 75% maximum, 20 year service requirement.
4) No retiree health benefits Until Age 55 (future retirees only)
5) Actuarial equivalent reduction of health benefits for retirement commencement before age 55 (future retirees only)
6) Suspend health coverage if retired employee can obtain health insurance through a new employer or spouse. Benefit recommences at full retirement (future retirees only).
7) Change existing plan from an 80 percent subsidy to a 75 percent subsidy (future retirees only).
8) Change existing plan from an 80 percent subsidy to a 75 percent subsidy for spouse only (future retirees only).
9) Change Existing Plan from and 80 percent subsidy to a 60 percent subsidy for spouse only (future retirees only).
10) Eliminate coverage for term vested individuals (future retirees only)

We did not separately price option 4 and 5 because if the reduction is truly actuarially equivalent the cost should be the same.

Bolton Partners, Inc.
100 Light Street • 9th Floor • Baltimore, Maryland 21202 • (410) 547-0500 • (800) 394-0263 • Fax (410) 685-1924
Actuarial, Benefit and Investment Consultants
The following tables summarize the results for the ARC and the Accrued Liability.

### Anne Arundel County
**Impact on FY2012 – Funded 8 Percent ARC**

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<th>Option</th>
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<th>Library</th>
<th>Police</th>
<th>Fire</th>
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<th>College</th>
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### Anne Arundel County
**Impact on FY2012 – Funded 8 Percent Accrued Liability**

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<th>Option</th>
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Assumptions and Method

The assumptions and methods are based on revised valuation report sent to Anne Arundel County on October 25, 2011. However we have used an 8 percent discount rate, which is the funded discount rate used for the pension plan. Under the GASB45 standard a funded discount rate assumption can be used if an irrevocable trust is established and the County contributes at least the funded ARC to the trust. Anne Arundel County has not yet established a trust.

There could be some cost impacts due to employees who are eligible to retire, electing to retire before the plan change came into effect, which would lower the savings. We have not factored behavioral changes into our analysis.

Under Option 5 Actuarially equivalent factors would have to be developed. The actuarial equivalent factors would depend on the discount rate used for the calculation. If a higher discount rate (e.g. 8 percent) is used to calculate the factors, then there will be larger reduction for early commencement than would result if you assume a lower interest rate more like the current GASB45 discount rate of 4 percent to calculate the actuarial equivalence factors. So if actuarial equivalence factors were developed at an 8 percent discount rate and a lower discount rate was used to determine the expense there could be some additional reductions in cost.

To estimate the cost of Option 6 an assumption as to the percentage of retiring employees who are employed by a new employer with available health insurance or who have spouses with health insurance is required. We also must make an assumption as to when they might ultimately retiree and rejoin the plan.
The following table provides our assumptions for Option 6.

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<th>Age at Retirement from Anne Arundel County</th>
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</table>

Recently the Actuarial Standards of Practice were revised to require that the actuary consider mortality improvements. This new standard is effective for valuations after July 1, 2011. We have not yet determined how the new standard might impact Anne Arundel County actuarial valuation but it could increase liabilities significantly. We did not include a provision for mortality improvement in these estimates.

Including a service requirement to be eligible for benefits may change employee behavior. Retirement may be delayed until eligibility for the OPEB plan is met. We have not factored this possible behavioral change into our analysis.
Actuarial Certification

This letter has been prepared for the Anne Arundel County Government for the purposes of estimating the impact on the funded ARC under the proposed plan changes. It is neither intended nor necessarily suitable for other purposes. Bolton Partners is not responsible for the consequences of any other use.

In general Post Retirement medical valuations are based on an assumption for post-retirement medical increases. If medical costs increase at a rate greater than our assumption there could be a dramatic increase in the cost. Future actuarial measurements may differ significantly from the current measurements presented in this letter, due to such factors as the following: plan experience differing from that anticipated by the economic or demographic assumptions; changes in economic or demographic assumptions; increases or decreases expected as part of the natural operation of the methodology used for these measurements (such as the end of an amortization period or additional cost or contribution requirements based on the plan’s funded status); and changes in plan provisions, applicable law or accounting rules.

The actuarial methods and assumptions used in this letter comply with GASB 45 and the actuarial standards of practice promulgated by the American Academy of Actuaries.

Bolton Partners is completely independent of Anne Arundel County, its programs, activities, or any of its officers of key personnel. We and anyone closely associated with us does not have any relationship which would impair our independence on this assignment.

Kevin Binder is a Member of the American Academy of Actuaries and meets the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained in this letter.

Please let us know if you have any questions concerning this letter,

Sincerely,

BOLTON PARTNERS, INC.

Kevin Binder, FSA, EA
(443) 573-3906
kbinder@boltonpartners.com
Appendix N

News Articles on Municipal Bankruptcies
California Proposes to Curtail Workers' Benefits

By VAUHINI VARA

California Gov. Jerry Brown on Thursday unveiled what would be one of the nation's widest-reaching pension overhauls, a proposal that would raise the retirement age and shift more investing responsibilities to public workers.

The 12-point plan includes meshing a 401(k)-style component into newly hired workers' retirement plans, raising the age at which some future employees retire to 67 from 55 now and boosting pension contributions for current workers. Labor groups immediately expressed disapproval.

"We're disappointed that the governor is proposing pension changes that will undermine retirement security for public employees," said Dave Low, chairman of Californians for Retirement Security, a group representing dozens of unions in the state. Unions and their mostly Democratic allies in the legislature are likely to oppose the most far-reaching parts of the plan, raising questions even at the outset about whether they stand a chance of passage.

"My goal is to provide a fair but sustainable income-security plan," Mr. Brown said at a news conference. So far, the governor's most high-profile policy proposals have failed, including a bid to extend earlier tax increases and an effort to change how corporations are taxed.

Mr. Brown's proposal comes as states nationwide increasingly target public pensions for cost-cutting, driven by recession-battered pension funds, budget shortfalls and a backlash against public employees' compensation. So far in 2011, 27 state legislatures have enacted significant retirement-system changes, following 21 states in 2010, according to the National Conference of State Legislatures. In New York, Democratic Gov. Andrew Cuomo has...
also suggested he would pursue pension changes. The activity is "far in excess of what has happened in any previous year," said Ron Snell of the conference, which is a clearinghouse of information on state politics.

Mr. Brown's proposal goes further than what most states have enacted. A retirement age of 67 and a "hybrid" benefits plan for new workers are uncommon, Mr. Snell said. The hybrid plan would pair a reduced defined-benefit component with a 401(k)-style defined-contribution component that would be managed professionally.

The proposed overhaul requires a combination of legislative approval and a vote by Californians, and some of the most far-reaching changes could well be eliminated—or the plan could break down entirely without enough support. The plan would save the state $4 billion to $11 billion over the next 30 years, and $21 billion to $56 billion over the next 60 years, in its general fund and elsewhere, according to the state Finance Department. The state spent $135.9 billion in the fiscal year that ended in June, from its general, special and bond funds.

Mike Genest of California Pension Reform, a group pushing for changes to the pension system, said, "The governor's proposal is more substantial than I expected, particularly with regards to new employees, but it doesn't go nearly far enough" because the biggest changes wouldn't apply to current employees. Mr. Genest was a state director of finance under former Republican Gov. Arnold Schwarzenegger.

Write to Vauhini Vara at vauhini.vara@wsj.com
In Vallejo, A Municipal Bankruptcy Means Big Sacrifices For Ordinary Workers

First Posted: 01/31/11 08:14 AM ET Updated: 05/25/11 07:30 PM ET

The American real estate boom turned Vallejo, California -- previously known for little more than the freeway that runs through it -- into a hot property market in the San Francisco Bay Area. But when the home-building stopped, so did the flow of money into municipal coffers, sending the city into bankruptcy nearly three years ago.

That was merely the beginning of sustained pain for Vallejo's municipal employees. As the community adjusts to a wrenching new budgetary reality, one no longer propelled by exploding property revenues, the burden has fallen on ordinary city workers.

David de Alba, a 45-year-old mechanic who has worked for the city for eight years, typifies this process. Vallejo has slashed its budget to get its books in order, reducing its general fund payroll by more than 100 workers, or about 30 percent, since 2007. De Alba has seen his monthly pay drop by about $1,000.

Last summer, after missing mortgage payments, he went into default. In November, he filed for personal bankruptcy. Financial troubles strained his marriage, and his wife left him, taking their teenage children with her. This month, the bank foreclosed on his house. He moved out last Friday, relinquishing his home of nearly two decades. He now plans to move to a trailer park.

De Alba puts the blame for this descent squarely on the city.

"They pretty much destroyed my life," de Alba says. "They put the whole burden on the working class guy."

Like cities across the country, Vallejo has seen its revenues wither in the wake of the recession, prompting pay cuts for municipal employees. In one regard, Vallejo's experience is unusual -- municipal bankruptcy remains rare, as it brings negotiations with employees into court proceedings. But the negotiations themselves are now commonplace: As cities like Vallejo struggle to get their fiscal houses in order, they are often doing so at the expense of their middle-class workers.
Vallejo's latest plan to emerge from bankruptcy, filed this month, illustrates a stark fact about municipal finance. If bondholders -- including banks and other financial institutions -- were to take a significant hit, that could send tremors through the bond market, raising borrowing costs for cities nationwide. This is why Vallejo and other municipal governments find themselves leaning most directly on their "unsecured creditors," those with no direct claims on assets pledged against debts. In plainest talk: They are zeroing in on ordinary workers and retirees, putting wages and benefits on the line.

De Alba and hundreds of other current and former Vallejo employees say the city owes them for the pay they were denied, when two labor contracts were rejected in court. But under the latest plan, Vallejo would compensate these workers and retirees for only a fraction of their claims. The people who make the city run -- firefighters, maintenance workers, engineers and others -- would be forced to help prop up the city's finances.

It's a bitter plan, as the city readily acknowledges. But, for now, it amounts to Vallejo's only hope to get back on its feet. The city of 120,000 has been in bankruptcy proceedings since May 2008. The legal battles, which have allowed Vallejo to restructure its obligations, have cost the city nearly $10 million and have angered the unions, as workers contend that Vallejo forced concessions they otherwise wouldn't have accepted.

"It's not a happy time," says Marc Levinson, the lead bankruptcy lawyer for the city. "What do you do? The money just doesn't appear."

A onetime Navy town tucked into a northern corner of California's Bay Area, Vallejo is most often traversed at high speed, on the drive from San Francisco to Sacramento along Interstate 80. In the 1990s and early 2000s, the local economy soared on the back of the real estate boom. From 1997 to 2000, building permits for new single-family homes increased over 10-fold, according to the city's financial statements. From 2002 to 2008, property tax assessments doubled.

But after the spectacular boom came a devastating bust. Since peaking in May 2006, home prices in Vallejo have plummeted 63.3 percent, according to data provider Zillow.com. The carnage there almost makes the national crash seem tame, as home prices nationwide have fallen 31 percent since their peak, according to the Case-Shiller 20-city index.

Vallejo's coffers buckled. Property taxes -- the city's largest source of revenue -- have dropped 33 percent since their peak, as sliding home values meant Vallejo couldn't collect as much from homeowners.

"In early 2008 the city confronted the reality that it would soon be unable to pay its bills as they became due," reads Vallejo's recent legal statement, in a passage whose straightforward language draws a striking contrast to the surrounding jargon.

Salaries froze when the bankruptcy began in mid-2008, and many city workers say they've missed two raises they otherwise would have gotten. Employees in the electrical and maintenance workers' union saw two wage cuts last year, together inflicting a 10 percent drop in pay.

"I've told my membership, don't go out and buy a new car," says Frank Caballero, 56, a senior maintenance worker who's president of the local division of the International Brotherhood of Electrical Workers. "There are things we're used to that we can't do anymore. You can't go out to dinner, you can't buy a new shirt if you want it. Everything is so tight right now."

Wages were cut further still. Previously, the city covered employees' health care. But as new labor contracts were drawn, maintenance workers and firefighters -- and retirees -- suddenly shoulder ed a fourth of those costs.
Workers near retirement who have accrued payouts from not taking allotted sick days claim that that money, too, has been withheld.

One bad year can affect a worker for life. Pension benefits are calculated based on a worker's highest pay level, so a pay cut -- or even a missed raise -- ripples forward in time.

"If you're 26, and you're working for the city, it's not an issue, because at some point your compensation will exceed what it would have been back in 2010," says Dean Gloster, the lawyer representing the electrical workers' and firefighters' unions. "But if you're at retirement age, and you have a bad back, and you can't carry fire hoses up stairs anymore, and this is it for you, well, it's pretty tough."

Workers, retirees and other "unsecured creditors" claim the city owes them about $262 million. Under the new plan, these people could make as little as five cents on every dollar.

For de Alba, the mechanic, his annual pay has dropped from just over $70,000 to about $60,000, he says. The city owes him about $18,000 for the compensation he's missed since the bankruptcy began, he says, but he predicts he'll get less than $1,800. Caballero, the union president, is similarly pessimistic.

"They owe us this, but to tell you the truth, I don't see us collecting any of this from the city," Caballero says. "We're just trying to scramble to see what else we can do."

Vallejo's budget squeeze made de Alba fall behind on his mortgage. Monthly, his pay dropped from $5,800 to about $4,800. His mortgage, he says, was $2,300. He stopped paying the mortgage bills early last year. By summer, he was in default.

Characteristic of the real estate slump, the value of de Alba's home has fallen below the value of the loan. The house is now worth $130,000, he estimates. His mortgage, he says, was $380,000. As home prices continue to fall nationally -- and as foreclosures push prices down still further, in a punishing feedback loop -- more homeowners like de Alba are falling underwater.

After a series of missed payments, the bank sent de Alba a default notice last summer. He was granted a temporary mortgage modification, but the payments failed to stay at a manageable level. Facing growing obligations he couldn't meet, de Alba filed for personal bankruptcy in November. The foreclosure process, already underway, was delayed.

Financial stress, meanwhile, had soured his relationship with his wife. As the couple confronted the prospect of losing the home where they had raised five children and had lived for 18 years -- and which had once belonged to de Alba's mother-in-law -- their marriage fell apart.

"The financial strain just gave us more to argue about," de Alba says. "We already had issues going on, but it never helps when you have money problems."

Last week, with the bank repossession imminent, de Alba prepared to leave his home. He packed up what belongings he would take with him, put a few things in storage, gave some to his brother and threw the rest in the trash.

Throughout the house, possessions were in boxes. In the bedroom he once shared with his wife, pictures of his kids in sports uniforms -- baseball, softball, football -- once hung on the walls. Now, the walls were bare.

"It's a sad thing," de Alba says. "Rooms are empty where there used to be so much of our stuff."

At this point, de Alba is hoping to land a different job at the nearby city of Napa, doing the same work he does now. The new job would pay him more, about what he was previously making in Vallejo, he says. He's optimistic about his chances of getting hired.
Still, the Vallejo bankruptcy has filled him with a resentment that seems unlikely to go away soon.

"I heard so many times through this bankruptcy, 'You guys are lucky to have jobs right now,'" he says. "And you know, I'm not lucky to have a job. I tested for this job, I beat 80 other people out to get this job. I'm not lucky. I prepared myself to have a good job. But they didn't care about that."

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"The Moment I Knew" Divorce Meetup
Meetup in Linthicum Heights to discuss the moment you knew your marriage was over →
Cuts for the Already Retired

By MARY WILLIAMS WALSH

Retired police and firefighters from Central Falls, R.I., have agreed to sharp pension cuts, a step thought to be unprecedented in municipal bankruptcy and one that could prompt similar attempts by other distressed governments.

If approved by the bankruptcy court, the agreement could be groundbreaking, said Matthew J. McGowan, the lawyer representing the retirees.

“This is the first time there’s been an agreement of the police and firefighters of any city or town to take the cut,” he said, referring to those already retired, who are typically spared when union contracts change. “I’ve told these guys they’re like the canary in the coal mine. I know that there are other places watching this.”

As cities, towns and counties struggle with fiscal pain, there has been speculation that they could shed their pension obligations in bankruptcy. Some have said it might, in fact, be easier for local governments to drop those obligations than it is for companies, which use a different chapter of the bankruptcy code. Large steel companies, airlines and auto suppliers like Delphi have terminated pension plans in bankruptcy.

“But it’s a fight that municipalities haven’t been willing to fight,” said David Skeel, a law professor at the University of Pennsylvania who writes frequently on bankruptcy.

Municipalities have been reluctant because public pensions are protected by statutes and constitutional provisions meant to make them nearly airtight. And even if the rules could be broken in bankruptcy, that would present a different problem. Local officials who want to cut pensions do not, as a rule, want to shortchange their bondholders for fear of not being able to borrow in the future — yet bankruptcy law requires that both types of creditors be treated equitably.

Rhode Island sought to sidestep the issue with a law that gave bondholders more protections than retirees. Central Falls’s retirees used that issue to gain some bargaining power, extracting a commitment from the state to seek extra money for the next five years. The extra money is not a sure thing, though, and would not cover all the cuts to the retirees over those years.

The last American city to work its way through Chapter 9 bankruptcy was Vallejo, Calif., which finished the process this year. It had to navigate similar stumbling blocks. Initially, it planned to cut its workers’ and retirees’ pensions, but it changed course when California’s giant state pension system, which administered Vallejo’s plan, threatened a costly and debilitating court battle.

Vallejo instead cut pay, health care and other benefits, as well as city services and payments to its bondholders, and left the pensions intact. Even though the bondholders faced a loss, all parties eventually agreed they had been treated equitably, and the state passed a law making it easier for Vallejo to continue borrowing.

The episode strengthened the perception that public retirement plans were unalterable, even in bankruptcy.

“Central Falls is undermining that,” said Mr. Skeel, who wrote about Vallejo’s bankruptcy for a coming issue of The University of Chicago Law Review.

Central Falls had little choice. For years, its government failed to contribute enough to its police and firefighters’ pension fund, and the fund effectively ran out of money this fall. The city, which had also promised the retirees comprehensive health benefits, could not cover the pension and health payments out of its general revenue.

The police and firefighters have known for months that drastic cuts were looming. Last month, the unions representing active workers negotiated new contracts, which called for workers to complete at least 25 years to receive pensions, instead of 20. Workers will also have to meet much more rigorous standards to qualify for disability pensions.

Until now, 60 percent of Central Falls police officers and firefighters have retired on full disability pensions, drawing the inflation-protected and tax-free payments even when they embarked on new careers. One of them, at 43, has become a prominent personal-injury lawyer and can be seen in television ads shooting baskets and pretending to fall down a manhole. That retiree, Robert Levine, a former police officer, said his disability was the result of an on-duty car crash where he was not at fault, and that his pension had been granted lawfully after his condition was certified by three different doctors.

The retirees, who are not represented by the unions, voted in favor of their pension reductions last week. The cuts would be up to 55 percent of each retiree’s benefits, which now vary widely, from about $4,000 to $46,000 a year, depending on final salary, years of service and other factors. A few retirees would give up more than $25,000 a year. Central Falls’s police and firefighters do not participate in Social Security.
The new agreement also reduces the annual cost-of-living adjustments and requires retirees to start contributing toward the cost of their health benefits. But it does not take disability pensions away from retirees — something that could become a sticking point.

In the negotiations, the state’s revenue director promised to seek money from the state — enough to pay most retirees a supplement of several thousand dollars a year for five years.

Having recently enacted a big and painful package of pension cuts for state workers and teachers, Rhode Island legislators say they are in no mood to help a city’s retirees who stripped their own pension fund, often collecting disability pensions when they were well enough to work.

The retirees’ lawyer, Mr. McGowan, won support for the state money by threatening to challenge a state law enacted just before Central Falls declared bankruptcy last summer. The law protects holders of general-obligation bonds issued by Rhode Island and its municipalities by giving them priority in bankruptcy. Without the law, investors could find themselves subject to the same losses as the retirees.

The state law was intended to prevent a contagion effect, in which Central Falls’s bankruptcy would frighten investors away from other cities’ bonds, driving up borrowing costs across the state.

The idea of shielding municipal bondholders during bankruptcy is controversial, however.

“It’s not clear to me that you ought to be protecting bondholders,” said Mr. Skeel. “It seems unfair to me that you’re singling out one type of creditor to bear the burden, and another type not to.”

Mr. McGowan, the retirees’ lawyer, said he had threatened to sue Central Falls’s bondholders on the argument that the state law had given them a “voidable fraudulent transfer”— an abusive deal that could be undone by a bankruptcy court. He said the state did not want such a challenge, so it agreed to push for pension supplements.

Theodore Orson, who represents Central Falls’s state-appointed receiver in the bankruptcy, said negotiations would have been impossible without the law. He said he thought Chapter 9 should be amended to give cities the ability to shield their bondholders if they could show a compelling need to do so. But that would take an act of Congress, and federal lawmakers, at odds over their own debt and deficit, show no interest in taking on the cities’ fiscal woes.

“One thing I think we’ve demonstrated in Rhode Island is, we really have a functional state government,” Mr. Orson said. “We are pulling together and making what we believe to be difficult decisions that you don’t see Congress making right now.”
Cuomo calls for new, cheaper public pension plan

Associated Press

ALBANY, N.Y. — Gov. Andrew Cuomo has revived his proposal for a new, cheaper tier of public pension eligibility to spare state and local governments and their taxpayers from skyrocketing costs.

The new pension tier comes just a year after the last revision that also aimed to cut down on the cost of lucrative public pensions for a bulge of baby boomer retirees.

But most of those savings are still more than a decade away.

The new plan in his State of the State speech Wednesday is aimed at greater savings sooner.

The cost of public pensions is a crisis for local governments and, in some other states, has pushed cities toward bankruptcy.

Governments in New York pay for pensions and health care at levels mostly eliminated as unaffordable in the private sector.

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Cuomo calls for new, cheaper public pension plan

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Those Who Root for the Bull

Bricks, Mortar Lead Cuomo Agenda
Appendix O

Cbiz Health Benefits Presentation – November 15, 2011
Current Issues

- Health Plan Costs
  - Employee cost sharing
- OPEB and GASB 45
  - Retiree Cost-Sharing
  - Retiree Eligibility Provisions
- Health Reform Legislation – PPACA
- Health Benefits Strategy
Preliminary Observations

- Anne Arundel County’s plans and cost sharing are similar to other local jurisdictions.
- The drivers of health care utilization by county employees have not been fully identified.
- Many of the tactics known to bend trend have not been utilized by Anne Arundel County:
  - Wellness
  - Data Management
- Short Term and Long Term benefits strategy needed.
## Plan Management Concepts

<table>
<thead>
<tr>
<th>Category</th>
<th>Initiatives</th>
<th>Current Situation</th>
<th>Recommended / Consideration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vendor Management</strong></td>
<td>Conduct RFP for Medical/Rx Plans</td>
<td>Last marketed in 2008 and 2009</td>
<td>Market every five years</td>
</tr>
<tr>
<td></td>
<td>Vendor Consolidation</td>
<td>Medical plans split between Cigna and Carefirst. Carve out pharmacy - Caremark</td>
<td>Explore consolidation strategies and carve in pharmacy</td>
</tr>
<tr>
<td></td>
<td>Implement and manage performance guarantees</td>
<td>Performance Guarantees in place? Trend guarantee? DM ROI guarantee?</td>
<td>Monitor results against guaranteed metrics; continue to negotiate improved, meaningful metrics and guarantees</td>
</tr>
<tr>
<td></td>
<td>Vendor Audits</td>
<td>Last medical claim audit? Rx audit? Dependent eligibility audit?</td>
<td>Audit plans every 3-5 years</td>
</tr>
<tr>
<td></td>
<td>Hold regular vendor meetings</td>
<td>Meet with vendors 2 - 4 times / year</td>
<td>Hold annual vendor summit regarding strategy, integration, and service expectations</td>
</tr>
</tbody>
</table>
## Plan Management Concepts

<table>
<thead>
<tr>
<th>Category</th>
<th>Initiatives</th>
<th>Current Situation</th>
<th>Recommended / Consideration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actives: modify plan designs</td>
<td>Three similar medical options today. Copays and deductibles are low.</td>
<td>Consider value based plan designs, over time drive participant behavior change</td>
<td></td>
</tr>
<tr>
<td>Pre 65 retirees</td>
<td>PPO and HMO option</td>
<td>Consider unique plan design for early retirees. Post 2014; consider health exchanges and county subsidy (define contribution). Special requirements needed for public safety employees.</td>
<td></td>
</tr>
<tr>
<td>Post 65 retirees</td>
<td>Medicare wrap approach</td>
<td>Review Medicare Advantage plans and Medicare connector model. Deep savings for plan sponsors and retirees over the past 5 years. EGWP or other unique pharmacy strategies for retirees should be considered to capture Part D donut hole subsidy to 2020. RFP needed. Review eligibility.</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Low copays.</td>
<td>Value based approach. Develop specialty strategy.</td>
<td></td>
</tr>
<tr>
<td>Benchmark against peer group</td>
<td>Benchmarked plans to other local subdivisions; AA Co is currently near the mean in health benefits.</td>
<td>Maintain competitive position. Need a total compensation analysis.</td>
<td></td>
</tr>
<tr>
<td>Implement high performance network</td>
<td>Not currently offered</td>
<td>Evaluate carrier options. Cost and quality implications</td>
<td></td>
</tr>
<tr>
<td>Participate in PCMH or ACO program</td>
<td>Not currently offered</td>
<td>Evaluate carrier options. Potential to drive more primary care. Global payments with ACO (future).</td>
<td></td>
</tr>
<tr>
<td>Implement an onsite clinic</td>
<td>Pharmacy in place. Not currently offered for medical or WC.</td>
<td>Evaluate cost / benefit of onsite clinic. Integration opportunities.</td>
<td></td>
</tr>
</tbody>
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## Plan Management Concepts

### Health & Productivity

<table>
<thead>
<tr>
<th>Category</th>
<th>Initiatives</th>
<th>Current Situation</th>
<th>Recommendation/Consideration</th>
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</thead>
<tbody>
<tr>
<td>Wellness &amp; DM RFP</td>
<td>Lunch and learns, on-site classes, screenings</td>
<td></td>
<td>Expand wellness program. Add incentives, measure ROI</td>
</tr>
<tr>
<td></td>
<td>Conduct health risk appraisals</td>
<td></td>
<td>Add to the wellness program</td>
</tr>
<tr>
<td></td>
<td>Conduct biometric exams</td>
<td>Employees encouraged to obtain from PCP</td>
<td>Consider onsite vendor</td>
</tr>
<tr>
<td></td>
<td>Offer chronic condition coaching</td>
<td>Available from carriers</td>
<td></td>
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<tr>
<td></td>
<td>Provide employee wellness incentive</td>
<td></td>
<td>Monitor participation and obtain feedback</td>
</tr>
<tr>
<td></td>
<td>Provide spousal wellness incentive</td>
<td></td>
<td>Monitor participation and obtain feedback</td>
</tr>
<tr>
<td></td>
<td>Implement tobacco surcharge</td>
<td></td>
<td>Monitor % of tobacco users each year</td>
</tr>
<tr>
<td></td>
<td>Reward/penalize based on health</td>
<td></td>
<td>Create long-term incentive strategy with the goal of rewarding health outcomes within 3-5 years</td>
</tr>
<tr>
<td></td>
<td>outcome</td>
<td></td>
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<tr>
<td></td>
<td>Obtain senior leaders and managers'</td>
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</tr>
<tr>
<td></td>
<td>support</td>
<td></td>
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<tr>
<td></td>
<td>Designate department health champions</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identify health plan budget</td>
<td>Results tracked monthly</td>
<td>Share results with stakeholders</td>
</tr>
<tr>
<td></td>
<td>Establish employee cost share goals</td>
<td>Under review</td>
<td>Identify cost share from contributions as well as plan design</td>
</tr>
<tr>
<td></td>
<td>Identify wellness incentive budget</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consider stop loss coverage</td>
<td>No stop loss policy is in place</td>
<td>Track participation and cost of incentives in 2013</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>As catastrophic claims increase, re-evaluate need for this annually; review captive options</td>
</tr>
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# Plan Management Concepts

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<thead>
<tr>
<th>Category</th>
<th>Initiatives</th>
<th>Current Situation</th>
<th>Recommendation/Consideration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PPACA</strong></td>
<td>Evaluate impact of exchanges - actives</td>
<td>Penalties could apply if actives obtain coverage thru exchange</td>
<td>Conduct cost-benefit analysis of providing health benefits</td>
</tr>
<tr>
<td></td>
<td>Evaluate impact of exchanges - retirees</td>
<td>Exchanges might be less costly for retirees</td>
<td>Consider directing pre-65 retirees to exchanges in 2014 with possible stipend from the county</td>
</tr>
<tr>
<td></td>
<td>Part-time medical plan</td>
<td></td>
<td>Reconsider need for part-time plan / find alternative plan</td>
</tr>
<tr>
<td></td>
<td>Excise tax</td>
<td>Not applicable until 2018</td>
<td>Forecast health plan costs to 2018 and mitigate future increases</td>
</tr>
<tr>
<td></td>
<td>Re-evaluate eligibility criteria and cost share</td>
<td>PPACA will change eligibility rules and waiting periods in 2014</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Benchmark against peer group</td>
<td></td>
<td>Monitor peer group reaction to PPACA</td>
</tr>
<tr>
<td></td>
<td>Retiree Medical (Medicare Eligible)</td>
<td></td>
<td>PPACA may drive reduction in MA reimbursements; explore other retiree options</td>
</tr>
<tr>
<td><strong>Data Analysis</strong></td>
<td>Integrate health and absence data</td>
<td>Unknown</td>
<td>Measure direct and indirect costs of health and disability</td>
</tr>
<tr>
<td></td>
<td>Establish scorecard for stakeholders</td>
<td></td>
<td>Quarterly distribution</td>
</tr>
<tr>
<td></td>
<td>Health and productivity measures</td>
<td></td>
<td>Establish key metrics (engagement, ROI, gaps in care, etc)</td>
</tr>
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</table>
Appendix P

Office of Budget Presentation – Retiree Heath Insurance County Comparisons – October 4, 2011
Retiree Health Insurance
(OPEB – GASB 45)

County Comparisons

Office of the Budget
October 4, 2011
Principles

- Reduce County cost; be fair to the Taxpayer
- Be fair to each employee group; “share the pain”
- Benefit should be in the “middle of the pack”
# Existing Benefit by Unit

<table>
<thead>
<tr>
<th>Eligibility (vesting)</th>
<th>County</th>
<th>BOE</th>
<th>College</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employees – 5 years</td>
<td></td>
<td>10 Years</td>
<td>10 Years</td>
</tr>
<tr>
<td>Public Safety – 20</td>
<td></td>
<td>10-14</td>
<td>2.5% Per Year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>15-19</td>
<td>75% Max</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20+</td>
<td></td>
</tr>
<tr>
<td>Employer Cost Share</td>
<td>80%</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>Spousal</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Dependent</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Term Vesting</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
# County Benefit Comparisons

<table>
<thead>
<tr>
<th>County</th>
<th>Eligibility</th>
<th>Employer Cost Share</th>
<th>Spousal/Dependent</th>
</tr>
</thead>
</table>
| Anne Arundel | Employees – 5 yrs  
Public Safety – 20 yrs                                                        | 80%                                                      | Yes/Yes                                                |
| Howard       | All Employees – 15 yrs                                                        | 15-19 years 50%  
20-24 years 75%  
25+ years 90%                                             | Yes (25%)/No (access)                                    |
| Baltimore    | All Employees – 10 yrs                                                        | Graduated Scale  
25% to 92%                                                | Yes/Yes  
Non Medicare Dependents  
62.5%-75%                                                 |
| Harford      | Employees – 20 yrs  
Public Safety – 12 yrs                                                          | Hired Before July 2010  
20 yrs - 85%  
25 yrs – 90%  
Hired after July 2010  
12-14 yrs 75  
15–19 yrs 80%  
20-24 yrs 85%  
25+ yrs 90%                                             | Yes/Yes                                                |
| P.G.         | Employees – 10 yrs  
Public safety – 5 yrs                                                            | HM0 78%  
POS 73%  
Vision & Rx 88%                                           | Yes/Yes                                                |
| Montgomery   | By Retirement Group & Age                                                       | Hired Before Jan 1, 1987  
80% for equal yrs worked, then 0%  
Hired after December 31, 1986  
5 yrs 50%  
10 yrs 60%  
15+ yrs 70%                                              | Yes/Yes                                                |
| Maryland     | Employees - 5 Yrs  
Hired after June 30, 2011 – 10 yrs                                           | Retired before July 1, 1984  
Maximum 80%  
Hired after 6/30/11 Graduated up to 25 yrs  
Medicare Part D by 2020                                   | Yes/Yes                                                |
Appendix Q

United Healthcare Presentation – Anne Arundel Retiree Options – November 15, 2012
Anne Arundel Retiree Options

November 15, 2011
A National Medicare Leader

Time-tested and proven expertise to work with employers to design, deliver and maintain a variety of cost-effective retiree solutions

Largest provider of Medicare plans – provider of choice for more than 9 million Medicare eligible adults for over 25 years

A broad portfolio of all available market products that gives retirees meaningful choice in an overwhelming marketplace

Retiree health care specialists that focus exclusively on delivering the personalized service your retirees deserve
United Healthcare’s Employer Group Retiree Experience

- More than 3,000 employers utilize our employer group retiree products and services
- Over the past 10 years, UnitedHealthcare has transitioned hundreds of thousands of Medicare retirees from employer group plans to individual health insurance plans through our retiree solutions
- We administer more than 100,000+ Retiree Reimbursement Accounts that deliver defined contribution employer financial support towards individual insurance plans
Strategic Considerations

Current Plan Designs
Reform Impact
Plan Options
Anne Arundel County Objectives

Key Objectives for Retiree benefits plan

• Reduce Anne Arundel’s overall retiree plan costs

• Offer choice and flexibility to retirees with multiple plan options available

• Minimize disruption to retirees: make transition as simple as possible

• Provide ongoing support to retirees through outstanding customer service pre and post transition

• Shift benefits questions and administration away from HR Dept.
Current Post-65 Plan Offerings

**Medical:** Cigna Medicare Supplement Plan

- Annual deductible: Not Applicable
- Coinsurance: 80%/20%
- Out of pocket max: $2,000 per indv; $4,000 per family
- Lifetime max: $1,000,000

**Prescription Drug:**

- CVS Caremark
- $5 Generic
- $15 Preferred
- $25 Non Preferred

Average Monthly Premium For Anne Arundel Retirees: $630.69

Medicare Coordination

RDS

Average age of your retirees is 77
PPACA: A Game-Changer for RDS vs. Part D

<table>
<thead>
<tr>
<th>Retiree Drug Subsidy (RDS)</th>
<th>Part D Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Payments are taxable income beginning in 2013</td>
<td>• 50% brand name coverage gap discount program (2011)*</td>
</tr>
<tr>
<td>• Future expected payments have never been allowable as an offset to GASB 45 liabilities</td>
<td>• Closing of the coverage gap for generics and brand name drugs (2011-2020)</td>
</tr>
</tbody>
</table>

Compared with typical RDS eligible plans:
• Group PDPs (EGWP) = same level of benefits at a lower net cost
• Individual PDPs = slightly less rich benefits at a much lower cost

Which is the best solution for you and your retirees?

*Discount dollars are applied toward True-Out-of-Pocket annual limit further reducing retiree’s costs
Phased elimination of the Part D Coverage Gap

**Brand-name drugs**

**Generic drugs**

**Exhibit 3**
Cost Sharing for Brand-Name Drugs in the Medicare Part D Coverage Gap, 2010-2020

**Exhibit 4**
Cost Sharing for Generic Drugs in the Medicare Part D Coverage Gap, 2010-2020

Between now and 2020, the Coverage Gap closes, eliminating any need for Employer sponsored supplemental benefits.

Beginning in 2011, Pharmaceutical manufacturers will discount the price of brand-name drugs by 50% for non-LICS members in the coverage gap. Member coinsurance for brand-name drugs shown above is net of this discount.
Individual and group Part D plans deserve consideration by employers

Note 1: 50% brand name coverage gap discount program (2011).

Note 2: Phased elimination of Part D coverage gap (full 2020 impact shown. Initial impact will be minimal)

A survey by a leading industry consulting firm predicts that 75% of large employers will move to Part D by 2013.
Who is UnitedHealthcare Medicare Pharmacy Solutions?

The largest Part D plan, with experience successfully managing and communicating pharmacy benefits to the Medicare population

We serve over 6.8 Million Part D members (the largest market share by far, including retirees of over 600 employers) and have developed systems and processes leading to:

- Better experience and support for a retiree population
- Greater value for clients based on breadth and scale of industry partnerships
- Improved communication due to the use of plain language material

---

**Employer Value**

- **Retiree Satisfaction**
  Access, communication, support
- **Flexible Benefit Design**
  Value, innovation, choice
- **Formulary Management**
  Options that cover up to 100% of Part D Eligible Drugs
- **Experienced Team**
  Extensive knowledge and leadership in Part D

**Operational and Member Excellence**

<table>
<thead>
<tr>
<th>Benefit Compilation:</th>
<th>100% accuracy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member retention:</td>
<td>&gt; 96% retention rate^</td>
</tr>
<tr>
<td>Leading mail order:</td>
<td>97% satisfaction</td>
</tr>
</tbody>
</table>

Our mail order pharmacy ranked highest in customer satisfaction and cost competitiveness factors in J.D. Power and Associates’ 2010 National Pharmacy Study℠

UnitedHealthcare service data, Dec 2009.
^AARP Preferred Plan 2008-2010
EGWP Part D Options – Leveraging 50% Discounts

This example assumes that the claim occurs in the Part D Coverage Gap, on a brand-name retail drug that costs $200 with a $15 Copayment

Current Plan

Pharma pays $0

Plan Pays Remainder Of $185

Member Pays $15

EGWP Plan

Pharma pays $100

Plan Pays Remainder of $85

Member pays $15

Employer realizes the $100 savings in this claim example, by leveraging the Pharma discounts, while the member continues with the same OOP expense!

* in a retail setting, not via home delivery
## 2012 UnitedHealthcare Individual Medicare Part D Product Portfolio Summary

<table>
<thead>
<tr>
<th><strong>Phase I</strong> (Deductible)</th>
<th><strong>Plan Type</strong></th>
<th><strong>AARP MedicareRx Preferred / United MedicareRx</strong></th>
<th><strong>AARP MedicareRx Enhanced</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td></td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Phase II</strong> Initial Coverage Limit (2012 $2,930)</th>
<th><strong>Target Segment</strong></th>
<th><strong>Formulary</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Copays for a 30-day preferred retail supply</strong></td>
<td>Open Market</td>
<td>Formulary C12</td>
</tr>
<tr>
<td>Tier 1: $4-8</td>
<td></td>
<td>74%</td>
</tr>
<tr>
<td>Tier 2: $8-12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 3: $35-45</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 4: $89-95</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 5: 33%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Copays for 90-day Preferred Mail Service supply</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 1: $0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 2: $8-12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 3: $90-120</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 4: $252-270</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 5: 33%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Phase III</strong> Coverage Gap</th>
<th><strong>Formulary</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>50% discount on brands (non-LICS)</td>
<td></td>
</tr>
<tr>
<td>86% coinsurance on generics (non-LICS)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Phase IV</strong> Catastrophic Coverage (2012 TrOOP $4,700)</th>
<th><strong>Formulary</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater of 5% of drug cost, or $2.60 for generics and $6.50 for brands.</td>
<td></td>
</tr>
<tr>
<td>Greater of 5% of drug cost, or $2.60 for generics and $6.50 for brands.</td>
<td></td>
</tr>
</tbody>
</table>

### Membership (June 2011)
- 2012 UnitedHealthcare Individual Medicare Part D Product Portfolio Summary  
- 2012 Monthly Premium: $82.00 - $98.90  
- Formulary:  
  - Drugs covered: Formulary C12  
  - 74%  
- Formulary: Formulary A12  
  - 96%  

### 2012 Monthly Premium
- Tier 1: $4  
- Tier 2: $7  
- Tier 3: $40  
- Tier 4: $76  
- Tier 5: 33%  
- Tier 1: $4-8  
- Tier 2: $8-12  
- Tier 3: $35-45  
- Tier 4: $89-95  
- Tier 5: 33%  
- 50% discount on brands (non-LICS)  
- 86% generic coinsurance (non-LICS)
Medical Product Offering Considerations

When retirees were given a stipend to choose a UHC plan (MAPD or Med Supp) for 1/1/11, 87% of retirees chose Medicare Supplement and Part D; 13% chose Medicare Advantage*

<table>
<thead>
<tr>
<th>Group Name</th>
<th>Total # Eligible Retirees</th>
<th>Medicare Advantage</th>
<th>Part D</th>
<th>Medicare Supplement</th>
<th>Total UHC plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer 1</td>
<td>1,102</td>
<td>53</td>
<td>333</td>
<td>573</td>
<td>959</td>
</tr>
<tr>
<td>Employer 2</td>
<td>7,997</td>
<td>773</td>
<td>5,821</td>
<td>6,008</td>
<td>12,602</td>
</tr>
<tr>
<td>Employer 3</td>
<td>3,117</td>
<td>431</td>
<td>1,100</td>
<td>1,331</td>
<td>2,862</td>
</tr>
<tr>
<td>Employer 4</td>
<td>1,093</td>
<td>14</td>
<td>384</td>
<td>350</td>
<td>748</td>
</tr>
</tbody>
</table>

Because your population has an extremely high average age and the current plan structure is very similar to a Medicare Supplement plan, we believe that the vast majority of your retirees would prefer and choose a Medicare Supplement and rich Part D plan over a Medicare Advantage plan.

* Based on UHC Connector Model data
Group Portfolio Solution

• UHG offers the Group Portfolio Solution in response to market interest in offering an array of choice across group Medicare plans to a retiree.

• “Group Portfolio” refers to offering a retiree a choice of different Group coverage offerings. Not to be confused with “Connector Model” which refers to services that are available to help an employer move its retirees from a Group Coverage environment to an Individual Coverage environment.

• Group Portfolio allows an employer to take the first step in allowing retiree choice without moving the retirees to the individual market.

• Multiple products with multiple plans can be offered to retirees using a defined dollar contribution approach and supported by either split billing or RRA. The unique financial and health needs of each member will determine the appropriate plan for your retiree and will be discovered by our retiree specialists after doing a full needs assessment.
### 2012 Group Portfolio Retiree Standard Senior Supplement Plans A-N

<table>
<thead>
<tr>
<th>PLAN</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>Part A Deductible</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Part A Coinsurance (plus coverage for 365 add'l days after Medicare benefits end)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Blood: First three pints of blood each</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Skilled Nursing Co-insurance</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Hospice</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Part B Deductible</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Medical Expenses: Part B coinsurance</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Part B Preventive Care Coinsurance</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Part B Excess Charges</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Foreign Travel Emergency</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

\[1\] $4,640 maximum out of pocket, indexed to Medicare costs  
\[2\] $2,320 maximum out of pocket, indexed to Medicare costs  

\(X = \text{Covered up to plan limits}\)
Advantages – Insured AARP Medicare Supplement Plans

Choice
- Freedom to choose doctors and hospitals anywhere in U.S.
- Choice of Plans – up to 7 Plans with varying coverage and price points

Access
- Guaranteed-issue, guaranteed-renewable
- No pre-existing condition exclusions – virtually no claim forms

Trust
- Medical underwriting (for rate class placement) is waived, most favorable rate class is granted for most subsidized groups
- Endorsed by AARP, a name trusted by seniors

Financial Security
- 3.0 million insured members protected by rate stabilization reserve
- No minimum employer subsidy for endorsing or sponsoring employer

Ease of Administration
- Turn Key – all administrative services (enrollment, eligibility, and split billing and direct bill)
- Turn Key – all member calls, claims and correspondence

You may recognize our Medicare Supplement Insurance plans in the market as:

[Image: AARP Health Medicare Supplement Insurance]

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**Fully-Insured AARP Medicare Supplement Insurance Plans**

**Why AARP Medicare Supplement Insurance Plans?**

- **Competitive, cost-effective rates** – Rates for AARP Medicare Supplement Plans have increased an average of only 4.6% each year nationally in the past ten years.**

- We also cover over 3.0 million members nationwide, so we can keep costs lower nationally.

- **96% member satisfaction rate with AARP Medicare Supplement Insurance Plans**
- **98% customer representative satisfaction rate with most problems resolved on the first call**
**AARP Medicare Supplement Plans**

Fully insured individual Medicare supplement insurance; Group Administered

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Part A Coinsurance and Hospital Benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>50%</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>Part A Deductible</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part B Coinsurance or Copayment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>50%</td>
<td>75%</td>
<td>$20 / $50</td>
</tr>
<tr>
<td>Part B Deductible</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part B Excess Charges*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>50%</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>Blood – First 3 Pints</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>50%</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>Foreign Travel Emergency</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice Care Coinsurance or Copayment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>50%</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>Preventive Care Coinsurance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility Care Coinsurance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>50%</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>Average Monthly Premiums**</td>
<td>$125</td>
<td>$165</td>
<td>$196</td>
<td>$197</td>
<td>$80</td>
<td>$117</td>
<td>$134</td>
</tr>
<tr>
<td>Membership - Percentage of Total Enrolled</td>
<td>2.5%</td>
<td>2.7%</td>
<td>7.4%</td>
<td>75.2%</td>
<td>1.8%</td>
<td>1.2%</td>
<td>9.2%</td>
</tr>
</tbody>
</table>

- If a provider does not accept Medicare assignment they may charge up to 115% of Medicare allowable charges.

**The above monthly premium amounts are the 2011 national weighted averages. Actual premium rates vary by state, plan, discount availability, age, area, and underwriting application. Average rates are net of discounts. Not available on a group basis to pre-65 disableds. Excludes Medicare Select and High Deductible Plans.

Illustrative Rates

**Proposed Benefits**

- AARP Plan F $216.76
- AARP Plan L $137.28
- AARP Plan N $151.85
- AARP Preferred $ 37.92
- AARP Enhanced $ 89.31

Combining the two richest plans (F and Enhanced, individual Part D) will cost approximately $306.07
AARP Medicare supplement insurance plans

No networks, no referrals
Your retirees’ coverage goes with them anywhere in the United States. Includes access to specialists. Convenient for travelers

Coverage anywhere in the United States
Retirees who live part time in different states can see doctors for their medical needs, not just for emergency care like other Medicare plans

Flexibility
Retirees can change plans with just a phone call*
No medical underwriting

What makes AARP Medicare supplement plans stand out?*
• 96% member satisfaction
• 98% customer representative satisfaction rate, with most problems resolved on the first call
• 9 out of 10 members would recommend the plan

*change is made the 1st of the month, following the member’s request. Members can change plans up to 12 times a year

*http://www.uhcpmedsupstats.com or call to request a copy of the full report.
AARP Medicare Supplement – Additional Benefits

- UnitedHealth Group will **pay for** the first year membership fee for all non-AARP members to join the AARP Program - a value of $16.00 per household (except for residents in the state of New York who are responsible to pay their AARP membership dues)

- Membership in AARP provides all retirees with value added services, such as discounts on travel services, as well as subscriptions to “AARP The Magazine” and the “AARP Bulletin”

---

**BRAIN AEROBICS**

**Play Sudoku**

Test your logic and patience. In Sudoku a player fills in the grid so the numbers 1 through 9 appear only once in every horizontal row, every vertical column and every 3x3 mini-box. There is only one solution.

1 8 3 4 5
2 1 5 3 1
3 6 8 2 1
4 7 6 8
5 2 1 4

---

**Is It Time to Talk About Social Security?**

**Wake-up call:** America’s largest social program is spending more on benefits than it’s collecting in taxes. Blame the recession.
Medicare Supplement plans are standardized*. Consideration points: stability, price, flexibility to change plans without medical underwriting and portability.

<table>
<thead>
<tr>
<th>AARP Medicare Supplement plans are available nationwide, to 100% of your retirees. Top 3 states based on 2009 census</th>
<th>Number of your members living in the state</th>
<th>AARP Medicare Supplement State Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maryland</td>
<td>975</td>
<td>2</td>
</tr>
<tr>
<td>Florida</td>
<td>81</td>
<td>1</td>
</tr>
<tr>
<td>Delaware</td>
<td>31</td>
<td>1</td>
</tr>
</tbody>
</table>

*with the exception of MA, MN & WI

Source: Mark Farrah & Associates
Open Market Concerns…

United States Senate
WASHINGTON, DC 20510

October 6, 2010

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health Human Services
200 Independence Ave. SW
Washington, D.C. 20201

Dear Secretary Sebelius:

We share your commitment to delivering high quality health care coverage to our nation’s Medicare beneficiaries at the best possible price. This commitment is exemplified by the announcement that beneficiaries enrolled in Medicare Advantage plans will see their premiums decrease by 45 cents a month, on average, next year.

While Medicare Advantage premiums are declining, we are hearing disturbing stories from beneficiaries across the country about excessive premium increases for Medigap supplemental insurance policies. For example, some beneficiaries enrolled in the United of Omaha Life Insurance Company will see their Medigap premiums increase by approximately 40 percent between 2010 and 2011. An increase of this magnitude raises serious concerns about premium-setting practices and rate review procedures in place for Medigap policies.

As you know, the Affordable Care Act establishes an annual review process for premium increase for health insurance coverage and provides $250 million in funding to States so they can engage in meaningful rate review. While this rate review does not apply to Medigap plans, we request that you work with Governors and State Insurance Commissioners to help them gain this authority where it does not exist today.

In addition, you can help State officials assess the accuracy of Medigap rate increases. We request that you conduct a study of Medigap trends and costs to provide a benchmark against which proposed rates can be measured.

We look forward to working with you to ensure that Medigap enrollees are protected from unnecessary rate hikes by insurance companies and that State regulators have the necessary tools to make this happen. Seniors, like all Americans, deserve to get the most health care for their premium dollars.

Thank you for your consideration of this request.

Sincerely,

Harry Reid
Max Baucus
John F. Kerry

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Internal performance guarantees exist between UnitedHealthcare and AARP Services to ensure the highest levels of customer satisfaction.

Strict quality expectations are set by AARP Services for all aspects of the operation. There are internal quality programs in enrollment, billing, member communications, claims and customer service.

Service metrics are consistently met and often times exceeded.

<table>
<thead>
<tr>
<th>Service Metric</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Callers reach a live voice within 30 seconds</td>
<td>85%</td>
</tr>
<tr>
<td>Call Abandonment Rate</td>
<td>&lt;2%</td>
</tr>
<tr>
<td>Same day initial call resolution</td>
<td>95%</td>
</tr>
<tr>
<td>Enrollment materials received within 4 calendar days</td>
<td>95%</td>
</tr>
<tr>
<td>Claim turnaround within 10 business days</td>
<td>95%</td>
</tr>
<tr>
<td>Claim financial accuracy</td>
<td>98.5%</td>
</tr>
<tr>
<td>Billing turnaround time within 3 business days</td>
<td>95%</td>
</tr>
<tr>
<td>ID card issued or replaced within 4 calendar days</td>
<td>95%</td>
</tr>
<tr>
<td>Customer Satisfaction – Very Satisfied</td>
<td>90%</td>
</tr>
</tbody>
</table>
AARP Medicare Supplement – Enrollment

Customized enrollment kits are developed from the employer roster and mailed to each retiree and spouse

- Toll-free customer service call centers for help with applications
- Paper applications are mailed to processing center and outbound contacts are made for missing information.
- 97.8% of members receive their enrollment materials in 4 calendar days
- Web access through www.aarphealthcare.com for enrollment and general education
- 100% of members receive their ID cards and welcome packages in 4 calendar days
- 97.4% of members receive replacement cards within 4 calendar days
AARP Medicare Supplement –
Monthly Billing Options

**Employer**

- Bill produced 5th of month for following month (e.g. March bill on Feb. 5) and sent to Employer
- Bill can also be accessed on Employer secured Website
- Can also be paid via check, wire, or ACH
- Payment due 25th of month (e.g. March bill on Feb. 25)
- Split billing capability if needed

**Retiree**

- Coupon for first month’s premium included in Welcome package
- Coupon booklet and envelopes for the remainder of the year are mailed to retirees’ home address in the next few weeks
- Payment due first day of each month (e.g. March bill due on March 1)
- EFT payments due on the first day of each month although withdrawn on the 5th day of the month
- As long as premiums are paid, coverage cannot be discontinued; even if employer no longer sponsored a retiree plan
Anne Arundel Considerations

- Design and plan flexibility to offer group or individual options
- National market leader, as well as your top 3 states
- Lowest cost Medicare Supplement provider in the majority of the U.S.
- Offers a 10-year proven record of rate stability
- Demonstrates 96% member satisfaction with the plans
- Allows retirees to change plans as their needs change with no medical questions or pre-existing conditions
- Minimizes disruption to all retirees
- Offers retirees meaningful choice of up to 7 Medicare Supp. options
Questions?
Appendix R

Milliman White Paper – Health Insurance Exchanges Explained
Health Insurance Exchanges Explained

1 The content of this paper should not be used as a substitute for legal advice from your legal advisor or as a substitute for tax advice from your tax professional.
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Executive Summary ......................................................... 3
Introduction .................................................................. 3
Impact on Employers .................................................... 4
Exchange Functions and Operations ............................... 5
Insurance Carrier Integration ......................................... 6
Governance of Health Insurance Exchanges ................. 6
Private Exchange Example: Extend Health, Inc. .......... 7
Active Purchaser Exchange Example: Massachusetts .... 7
Market Facilitator Exchange Example: Utah ............... 8
Conclusion .................................................................... 8
Executive Summary

Health insurance exchanges are a centralized service whereby individuals can compare and purchase qualified health plans, as well as access eligibility determinations. Employers can send employees to an exchange with financial assistance to meet their coverage responsibility and help make insurance affordable for employees. Successful enrollment in health plans and effective exchange communication hinges on the exchange’s ability to provide an exceptional user experience, driven by powerful and interoperable website and call center technology. The exchange website will facilitate standardized plan information comparison, provide decision support tools, and offer personalized account services; integration with an exchange call center will allow advisors on the telephone to view the caller’s plan application, enrollment history and personal information that is saved in an individual account.

Both employers and employees have the opportunity to benefit from exchanges, taking advantage of the flexibility, value, decision support and freedom that purchasing insurance through an exchange will provide.

Introduction

The Patient Protection and Affordable Care Act of 2010 (the “ACA”) reforms the health insurance market by, among other things:

- Requiring health insurance companies to cover all applicants
- Requiring individuals to obtain insurance and employers to offer coverage
- Providing Federal financial assistance to help make health insurance affordable.

For individuals without affordable employer-sponsored coverage, health insurance exchanges will help make coverage accessible and affordable.

Exchanges will also serve an important role for employers, who can use exchanges to give employees a meaningful choice of health plans outside of legacy group plans, and to moderate the ballooning costs of providing health insurance. Many employers already rely on private exchanges for their Medicare-eligible retiree populations, and provisions in the ACA—including guaranteed issue (requiring insurers to extend coverage to everyone regardless of pre-existing conditions), a mandate to purchase insurance and financial assistance to make it affordable—make certain that exchange enrollment will continue to grow.
Purpose of Health Insurance Exchanges

Health insurance exchanges are a centralized service whereby individuals can compare and purchase qualified health plans. Exchanges will certify health plans based on standards for covered benefits and provider networks, and assign quality ratings to promote transparency and accountability. Plans offered through exchanges will cover essential health benefits, as defined by the Federal government in the ACA and in regulations.

An Exchange is a mechanism for organizing the health insurance marketplace to help individuals and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality. By pooling people together, reducing transaction costs, and increasing transparency, Exchanges create more efficient and competitive markets for individuals and small employers.

– Healthcare.gov

In addition to shopping and applying for health plans, individuals without employer coverage will rely on exchanges for eligibility determinations for Federal financial assistance and other public health programs. Individuals with incomes below 133% of the Federal poverty limit (FPL) will be eligible for their state Medicaid program; premium tax credits and cost sharing reductions will be available for individuals with incomes between 133-400% FPL.

Employers can send employees to an exchange with financial assistance to meet their coverage responsibility and to make insurance affordable for employees. Exchange eligibility rules for employers and exchange options that employers may make available for employees are discussed in the section “Impact on Employers.”

While the concept of purchasing health insurance through an exchange is relatively straightforward—similar in certain ways to purchasing airplane tickets on travel websites that aggregate flight information—the creation and operation of a successful exchange depends on dynamic functionalities that are standardized, scalable, and designed for the user experience.

Impact on Employers

The ACA establishes a requirement for most employers to offer affordable health insurance to employees, and emphasizes exchanges as a mechanism for employers to provide coverage. Employers with 50 or more full-time employees must offer health insurance that meets a minimum standard by 2014. If an employer does not offer insurance, or the insurance offered is not affordable for employees, the employer pays a penalty. Small employers with fewer than 50 employees are exempt from this employer responsibility requirement, though over half already offer health insurance today.

Beginning in 2014, employers with up to 100 employees may purchase health insurance for their employees through an exchange, though states have the option of limiting initial exchange eligibility to employers with fewer than 50 employees. Starting in 2017, states may expand exchange availability to larger employers as a means of offering affordable health insurance to employees.

To meet the affordability requirement for health insurance, large employers who send their employees to the exchange will need to do so with financial support. The majority of small employers that currently offer health insurance may also choose to continue supporting employees by subsidizing coverage. This may take the form of a tax-advantaged savings account, such as a health reimbursement arrangement, that employees use to reduce premiums and cost-sharing amounts.
Employers who send employees to exchanges for coverage will be able to limit employee plan selection to one plan, plans within one coverage level (e.g. bronze or silver), plans from multiple coverage levels, or allow employees to enroll in any available exchange plan. Employees who access employer-sponsored coverage through the exchange will benefit from the personalization of individual health plans, freedom of choice, and the value of an open market. Exchanges will help manage the employee's transition from group to individual coverage with decision support tools and personalized website features that empower their users.

In addition to the benefits for employees, employers can significantly reduce the internal resources required to administer a group health plan. To facilitate this reduction, exchanges will have to develop two-way data transfer capabilities with employers to administer the financial assistance or plan availability requirements, and keep employers apprised of changes in employees' enrollment status. Another benefit for employers who send employees to an exchange is the security of knowing that the exchange health plans are certified to offer minimum coverage levels and adhere to insurance reform rules in the ACA.

**Exchange Functions and Operations**

Successful enrollment in health plans and effective exchange communication hinges on the exchange's ability to create functions designed for an exceptional user experience. The primary customers of exchanges will be individuals and employees enrolling in a health plan with the support of robust and interoperable online and call center technology. Employers using the exchange will be critical customers as well, exchanging enrollment and financial data with the exchange. Underlying the exchange's Internet website and call center will be electronic integration with participating insurance carriers, to ensure a smooth process for updating rates and benefits, applications, and enrollment.

**Website**

The ACA requires that exchanges maintain a website where individuals can see and compare standardized information about available health plans. Individuals should be able to compare features easily among plans at four different levels of coverage, designated as bronze, silver, gold and platinum. For many individuals, especially those accustomed to limited plan choice through an employer, the variety of plan options could seem overwhelming without easy-to-use tools that help them through the decision-making process.

To guide individuals through the eligibility, plan selection and application process, exchange websites should give individuals a secure account where they can store their personal information. This information fuels decision support tools that filter plans based on individual preferences and medical needs, such as prescribed drugs, existing health care providers, or requirement for out-of-network coverage. The ACA also requires that exchange websites provide an electronic calculator for individuals to determine out-of-pocket costs based on their plan coverage. This suite of standardized comparison and decision support tools will give exchange enrollees a supportive environment to find the health plan that best meets their needs.
Telephone
A toll-free telephone line will be available for individuals who prefer to talk to an advisor about their choices, or for those who need extra support as they navigate the website. Interoperability of the website and call center is critical to a successful customer experience.

Advisors working at the call center should be able to view an individual’s personal information, including eligibility, plan selection and application information. Individuals accessing the call center should automatically be routed to benefit advisors who are licensed and appointed to handle enrollment requests, based on the callers’ geographic location and plan selection or eligibility. Tight integration between the website and call center allows individuals to alternate between accessing the exchange online and telephonically, minimizing paperwork and administrative hassles.

Insurance Carrier Integration
In addition to automatic connectivity between website and call center technology, a successful exchange will establish electronic integration with insurance carriers. An individual’s application will be automatically transmitted to the insurance carrier, which then sends electronic updates on the application or enrollment status back to the individual through the exchange. Electronic integration with insurance carriers also allows exchange software to display health plan summaries and disclaimers. These are automatically generated and updated based on data submitted by participating insurance carriers, ensuring that plan information is accurate.

Insurance carrier integration ensures that the plan selection, eligibility determination, application and enrollment process is streamlined and reduces time-consuming errors.

Governance of Health Insurance Exchanges
Each state will make decisions about the creation, governance and operational philosophy for running its exchange. States implementing an exchange by 2014 are currently making critical decisions to determine the geographic scope of the exchange and how the exchange will be governed. States may elect to run one statewide exchange, regional exchanges within the state, or participate in a multi-state exchange. The exchange can be governed by a state agency (new or existing), a quasi-governmental agency, or a non-profit entity. If a state does not choose to operate an exchange, the Federal government will provide a fallback option to ensure individuals and employees have access to affordable, qualified health plans.

States running an exchange will operate according to one of the following models, or with a model that blends features of each:

1. Active purchaser: Exchange uses the market leverage of enrollees to evaluate plan bids and selectively offer plans, and/or negotiate to restrict cost growth of plan offerings.

2. Market facilitator or open marketplace: Exchange relies solely on qualified health plans meeting minimum standards for entrance into the exchange, and allows market forces to set plan premiums.

Exchange governance duties also include awarding grants to Navigators. Navigators will conduct public education activities, distribute impartial information about financial assistance and plan availability, facilitate plan enrollment, and refer enrollees with complaints or questions to an appropriate agency.

The following sections examine currently-existing insurance exchanges (two state exchanges and the Extend Health private Medicare exchange) to illustrate some of the key governance differences and their impact on exchange functionality. The Massachusetts exchange is an example of an active purchaser governance model, while the Utah exchange is much closer to the open marketplace.
model. The Extend Health exchange exemplifies the functions and operations that exchange implementers will need to create successful exchanges within their own states.

**Private Exchange Example: Extend Health, Inc.**

Extend Health is the nation's first and largest private Medicare exchange. Medicare exchanges have existed for the past five years, allowing employers to continue financial support of retiree health benefits by transitioning them from "one size fits all" legacy group plans to individual Medicare supplemental plans. Traditionally, employers provide tax-free dollars to allow retirees to buy private Medicare insurance plans that pay for medical, hospital and pharmacy costs not covered by original Medicare.

Extend Health's private Medicare exchange enables individuals to shop for Medicare supplemental plans through an integrated website and call center, and it provides powerful decision support tools. Individuals can choose private Medicare insurance options from thousands of plans offered by over 70 national and regional health insurance carriers. The Extend Health exchange offers personalization of individual health plans, a wide range of choice among a standardized set of plans, and the value of a competitive, open market.

Extend Health has invested heavily in its proprietary, scalable e-commerce platform that enables it to provide users with extensive health insurance information across plans and carriers in a user-friendly format. The company's robust insurance exchange platform helps individuals educate themselves about health insurance and Medicare and evaluate and enroll in the Medicare plans that best meet their needs. The platform also allows Extend Health to communicate electronically with its carrier partners to process health insurance applications quickly and efficiently.

Extend Health estimates that it has saved its clients up to 50% on retiree health care costs, while also increasing retiree choice of Medicare coverage. Trained benefit advisors, using the robust proprietary technology platform, have matched hundreds of thousands of retirees to supplemental Medicare plans.

**Active Purchaser Exchange Example: Massachusetts**

Passed in 2006, Massachusetts' health reform law required individuals to purchase health insurance and employers to contribute to employee health insurance; made public financial assistance available to ensure affordability; and created an exchange where individuals and employers can purchase insurance. Plans participating in the exchange are approved by a Board, and are required to meet certain coverage and cost standards.

A primary point of access to Massachusetts' exchange is through its web portal. Website planning, building, and maintenance were managed by a team with expertise in relevant policy, programs and technology, and the project was led by a staff fluent in information technology. The state hired a vendor with prior experience operating an online insurance marketplace for small businesses to build and administer the website and operate a customer service call center. Massachusetts wanted users to be able to access expert advice at any point in the shopping and enrollment process, so it created interoperability with the call center such that advisors can access an individual's personalized online account information. Drawing from Massachusetts' experience, clearly defining business needs for the website—for example, the ability to directly import data from exchange-participating plans, and enrollment and premium billing services—will help ensure a common vision for the website and effective implementation.

Massachusetts now has the highest rate of insured residents in the nation (as of April 2011, over 96%), and has over 200,000 enrollees as of the same date. The exchange offers choices among seven different insurance carriers, representing about 90% of the commercial health insurance market in the state.
Market Facilitator Exchange Example: Utah

Created in 2009, Utah’s Health Exchange is a one-stop shop for purchasing health insurance through an internet-based information portal. Utah employed a health insurance exchange to encourage private competition and personal responsibility. As of July 2011, Utah’s exchange had 157 small employer groups enrolled for a total of 4,059 covered lives. The exchange acts as a market organizer, allowing any willing carrier to participate.

Currently, Utah’s exchange is geared toward small employers in the state. While Utah’s health insurance market outside of the exchange requires small employers to contribute at least 50% of the employees’ premium, the exchange market does not require any contribution. Instead, employers can contribute nothing, a percentage of the premium, or make a defined contribution—a fixed dollar amount—for employees to purchase coverage. According to a Utah state official, Utah’s exchange likely gives small employers and employees access to a wider range of health plans with respect to carriers, plan networks, benefits and cost sharing than was previously available to them outside of the exchange. However, a survey of employers who considered, but ultimately decided not to enroll in the exchange, found that over half did not find choosing a plan to be an easy process.

Conclusion

The presence of robust exchanges, a responsibility to provide affordable coverage, and guaranteed issue of health insurance presents an opportunity for employers to evaluate their current offering. For employers, offering employees a choice to purchase health insurance through an exchange may provide significant value over current group coverage for both the employer and employees. In particular, an exchange can offer:

- **Flexibility**: Employers can access more personalized, and in some cases more affordable, health insurance outside of group coverage. Employers no longer have to worry about offering health plans that meet every employee’s needs.

- **Value**: Efficiencies from a centralized marketplace, regulation and oversight of health plans, as well as the standardization of plan benefits and information reporting, could help to constrain annual premium growth, thereby giving employees and employers better value and more predictable costs.

- **Decision Support**: Employers will need decision support tools to find the best health plan as their choices expand. A vital component of the exchange will be a robust website and interoperable call center with tools that help employees make decisions about cost and coverage.

- **Freedom**: Employers can exit the health insurance business, but still offer access to coverage to attract high-caliber employees and take advantage of defined contribution tax-advantaged accounts, such as health reimbursement accounts.

---

1. Employer-sponsored coverage must have at least a 60% actuarial value.
2. Affordable is defined as the employee contribution to health insurance not exceeding 9.5% of the employee’s income.
3. DHHS “Establishment of Exchanges and Qualified Health Plans” proposed rule.
4. DHHS “Establishment of Exchanges and Qualified Health Plans” proposed rule.
Appendix S

Extend Health Presentation – Take Control of Retiree Heath Care Costs!
January 11, 2012
Take Control of Retiree Health Care Costs!

1/11/2012

Richard K. Wheeler, SVP Extend Health, Inc.
Judy Locatis, Benefits Manager, Whirlpool Corporation

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Agenda

- Employer Challenges with Retiree Health Benefits
- Medicare Market Dynamics
- Why Medicare works in an Exchange Model
- Extend Health Overview
- Whirlpool Corporation – Case Study
The Challenge: Sustainable Retiree Health Care Benefits
Employers Grapple with Retiree Benefits
Growing cost and complexity

Employer

SPDs
ERISA
FAS 106
HIPAA
Price increases
Open enrollment
Formulary development
Cost shifting
RDS
Carriers
negotiations
subsidy application
5500s
Price increases
Open enrollment
Formulary development
Cost shifting
RDS
Carriers
negotiations
subsidy application
5500s
Health Care Costs Rising
Faster than corporate profits - even in a down economy

Sources: Kaiser/HRET Survey of Employer Sponsored Health Benefits, 2011; U.S. Economic Watch, BBVA Research, August 2011
Retiree Health Benefit Trends

- 2010: Only 19% of employers offer medical coverage to Medicare-eligible retirees, down from 40% in 1993*

- Towers Watson survey: 60% of employers who currently offer retiree medical plans are rethinking their programs for 2012 or 2013

**Employers Offering Medical Plans for Medicare-Eligible Retirees 1993 - 2010**

*Source: Mercer National Survey of Employer-Sponsored Health Plans 2010*
Defined Benefit vs. Defined Contribution

- “We used to get pensions, now we get 401K plans and IRAs”
  - Participation in defined contribution plans has increased from 36% of private sector employees in 1999 to 43% in 2008
  - Participation in defined benefit plans hovered around 20% throughout the same period
- Today: defined contribution for Medicare-eligible retirees
- 2014: Health care reform opens up defined contribution for active employees
Why Medicare is Ideal for an Exchange

1. Huge risk pools.....and growing
   • Large individual market ~ 40mm retirees enrolled in Medicare

2. Guaranteed issue.....no adverse selection issue
   • Everyone joins at 65: Healthy, episodic, chronic and catastrophic

3. Best-in-Market plans
   • Retiree picks the best performing plan from best performing carrier

4. Carriers compete on price
   • File rates every year
   • Standardized plans

5. Federal subsidies

6. PPACA
   • 2011+ Donut hole closing
   • 2013 RDS subsidy tax
   • 2014 Affordable Care for pre-65
Medicare Market Stability

- Medicare Advantage enrollees in 2012 will pay an avg. monthly premium of $38.31, a 3.4% increase over 2011 avg. premium of $37.52*

- Part D enrollees in 2012 will pay an avg. monthly premium of $39.62, a 3.7% increase over 2011 avg. premium of $38.22*

- In 2012, nearly 88% of Medicare beneficiaries will have access to an MA plan with $0 premium*

- MediGap plans continue to be affordable, plentiful and stable on a national scale – avg. monthly Plan F premium is $175

Legislative Market Accelerators
PPACA speeding inevitable transition

2010
Part D rebate

2011
Doughnut hole begins to close

2013
RDS tax subsidy eliminated

2014
Guaranteed issue + state exchanges
Inefficiency of the Group Model

Geographic dispersion = loss of group buying power
Inefficiency of the Group Model

Geographic dispersion = loss of group buying power
Impact on Retirees

Paying more for less with no control or choice
Extend Health runs the country’s largest private Medicare exchange

More than 30 Fortune 500 companies

More than 75 health insurance carriers

More than 4,000 plans offered

Hundreds of thousands served!
Employers

Deliver retirement benefits through a defined contribution solution

The Solution

- Provide subsidy
- Engage retiree health exchange coordinator

Employer
How Our Exchange Works
Technology + human advocacy + carrier relationships

Retiree
Benefit Advisor
Extend Health Exchange
Individual Carriers
## Benefits for Both Employers and Retirees

<table>
<thead>
<tr>
<th>Employers</th>
<th>Retirees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substantial retiree benefits saving</td>
<td>Increase personalization and choice</td>
</tr>
<tr>
<td>Make costs sustainable &amp; predictable</td>
<td>Provide equal or better benefits</td>
</tr>
<tr>
<td>Eliminate carrier negotiations</td>
<td>Substantial retiree savings</td>
</tr>
<tr>
<td>Reduce administrative burden</td>
<td>Enhance peace of mind</td>
</tr>
</tbody>
</table>
Market-Leading Private Sector Clients
Fortune 1000, including 31 Fortune 500 companies

[Logos of various companies]
Labor and Public Sector Experience
Introducing: Judy Locatis, Benefits Manager, Whirlpool Corporation
About Whirlpool Corporation

World’s top home appliance maker with more than $18 billion in annual sales

Whirlpool is the world’s #1 global appliance brand

Celebrating 100 years 11/11/11!

Ranked #143 on the Fortune 500 list

71,000 employees and 66 manufacturing and tech centers around the globe

Vision:
Every Home...Everywhere...with Pride, Passion and Performance
Whirlpool Corporation Retirees

- 24,000 retirees across the U.S.
- 20,000 are enrolled in benefits

Our retirees:

- Pre and post Medicare
- Hourly and salaried
- Union and non-union
- Many retirees are associated with legacy organizations acquired by Whirlpool Corporation
Previous Medicare-eligible retiree offering

<table>
<thead>
<tr>
<th>Retirees had no plan choice</th>
<th>Simple 80/20 Plans</th>
<th>Simple 70/30 Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>– one size needed to “fit” all within subgroups</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Whirlpool had over 90 individual plans due to acquisitions & legacy plans
What drove the change

Need for predictability and limit Whirlpool Corporation’s exposure trend

To reduce administrative costs and burden

Desire to provide retirees with plan choice

Wanted to provide a sustainable, cost effective, retiree friendly solution
Desired Outcomes

- Provide competitive benefits
- Offer flexibility and choice to retirees
- Manage benefit costs
- Comply with laws and regulations
- Reduced FAS 106 (OPEB) liabilities and RDS subsidy
Approval & buy-in process

- Laid foundation to obtain leadership buy-in
- RFP process – toll gates with leadership
- Towers Watson provided actuarial modeling
- Anticipated and managed internal and external pushback; built anticipated pushback into the communication plan
About Whirlpool Corporations' HRA design criteria

Desire for competitive level of benefits tailored to retiree’s needs
- Considered all legacy plans
- Understood the buying power of the Medicare market and how far HRA funds can go

Consider long-term funding obligations
- Annual review of HRA funding

Establish enrollment rules
- Retiree must call Extend Health at conversion or when retiree becomes Medicare eligible
How Whirlpool Corporation's HRA works

<table>
<thead>
<tr>
<th>Subsidy of $1,020 to each retiree and eligible spouse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocated monthly ($85)</td>
</tr>
</tbody>
</table>

Use funds in HRA to reimburse qualified healthcare expenses

Subsidy provided each year, however, Whirlpool reserves the right to change or terminate at anytime

Most reimbursements occur automatically – via electronic feeds from the carrier, to Extend Health, to HSB
Communication strategy

Keys to success:

- Held weekly implementation calls with Extend Health and HSB. Calls focused on rollout communication and retiree eligibility.
- Leveraged communication materials developed by Extend Health.
- Onsite meetings were key! 35 meetings were conducted in preparation for the 2011 transition. 6100 retirees attended these meetings.
- Conference calls were conducted for those who were not able to attend on-site meetings.
- Enrollment reporting was sent to Whirlpool along with an issue log. The issue log was worked until a resolution was reached.
Results: No retiree left behind

- **70%** of those eligible enrolled in 401 plans sold by 48 carriers
- **77%** enrolled in Medigap plans & **23%** enrolled in Medicare Advantage plans
- Annual FAS 106 and 112 liabilities were significantly reduced in the past 5 years
- Members are happy with having an affordable choice

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## Lessons learned

<table>
<thead>
<tr>
<th>What worked:</th>
<th>What we’d change:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Our communication plan strategy. We communicated early and often!</td>
<td>• Whirlpool and Extend Health met to conduct a post audit after year 1 (2009).</td>
</tr>
<tr>
<td>• Live meetings were well received!</td>
<td>- Added appointment setting</td>
</tr>
<tr>
<td>• Retirees loved the personal attention they received from Extend Health!</td>
<td>- Were better prepared for the influx of calls</td>
</tr>
<tr>
<td>They were able to call as often as they wanted, for as long as they</td>
<td>• Better understanding of auto reimbursement process on the front end</td>
</tr>
<tr>
<td>wanted. They could even have neighbors, relatives, etc. call with them</td>
<td></td>
</tr>
<tr>
<td>so that there was another person listening to the conversation!</td>
<td></td>
</tr>
<tr>
<td>• Phased approach of eligibility</td>
<td></td>
</tr>
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</table>
Advice to other companies:

- It takes work and open communication to make your transition a success
- Initial messaging from Whirlpool was critical; build time in the process to set the stage
- Help retirees understand that this is not a take away, but rather an opportunity to get a plan that is right for their needs and budget
- Once members use Extend Health’s services, they are satisfied
- Extend Health provides the experts; follow their lead!
For more information
Visit: extendhealthnow.com
Email: sales@extendhealth.com
or inquiries@extendhealth.com
Call: 1-888-232-3034
Appendix T

Anne Arundel County Wellness Presentation
Mission Statement

• Anne Arundel County Government cares about the health and wellness of County employees.

• The Wellness Program will provide information and inspiration to encourage each employee to lead healthier lifestyles.
Participants

- Anne Arundel County Government
- Anne Arundel County Public Schools
- Anne Arundel County Library
- Anne Arundel Community College
- Aetna
- CareFirst BC/BS
- CIGNA
- Health Department
- Anne Arundel Medical Center
Our First Year 2009-2010

Wellness Consortium
Logo
Mission Statement
Wellness Survey
Five Year Plan
Wellness Fair
Sunscreen Mailing
Nutrition Classes
Open Enrollment
Our Second Year 2011

- Negotiated Money From the Vendors
- Member of the Mid-Atlantic Wellness Council
- Walking Program
- My Plate
- Biometric Screening
- Yoga
- Holiday Survival
Open Enrollment

- Education, Education, Education
- What's New
- Reaching Out, Presentations at sites
- Flu Shots
- Guide Book Photos

*Challenge
  Limited Reach
  Retirees
  Communication/Visibility
  Contracts

*Success
  More participation, more educations because we had none!
  Flu Shots keeping our employees healthier, staying at work?
  More employees reading the book
  Feedback
Appendix U

Extend Health Article – How Long Does A Retiree Transition Take: Implementation Milestones
January 2012
How Long Does a Retiree Transition Take: Implementation milestones

If you’re evaluating a Medicare exchange solution for your retirees, you may be wondering how much time the transition will take so you can figure out when to get started. After five years of experience at Extend Health, we have developed a process and a recommended timeline that works. If you are planning to move your retirees to coincide with the change to the RDS taxable status, this article will help you understand what you need to do to make the transition before the change takes place on January 1, 2013.

The actual start date for the process is determined by the start date for new insurance benefits. Employers can choose any start date they wish. In an ideal world the process would take place over a five to six month period, divided into four phases as follows, with key milestones in place during each phase:

**Planning:** Starts four to five months before enrollment begins (seven to nine months before new coverage start date) and lasts six-eight weeks

**Retiree Education:** Starts 45 days before enrollment begins and lasts six to seven weeks

**Enrollment:** Starts 90 days before start of new coverage. Employers have the option of designating the dates or length of time during which they want enrollment to take place; we recommend allowing four to six weeks.

**Post Enrollment:** The employer’s responsibilities during this phase are minimal. Extend Health takes over all administrative tasks for the newly-enrolled retirees.

**Phase One: Planning**

Ideally, this phase takes place four or five months before enrollment begins. Once the decision to move forward has been made, there are a number of key elements that need to be put in place before announcing the change, including:

- Employer and Extend Health team meet to plan transition
- Do data analysis to determine retiree HRA funding amounts
- Write and distribute employer announcement of benefits change

**Phase Two: Retiree Education**

This phase, which starts 45 days prior to enrollment, is focused on making sure retirees understand the changes to their benefits and the process for enrolling new coverage. During this phase:

- Getting Started Guide, first Extend Health mailing, delivered to retirees. Includes welcome letter, FAQ, and workbook to assist in creating profile
- Retirees create profile either on-line or on the phone with a benefit advisor
- Retirees schedule enrollment appointments
- Retiree on-site meetings take place

**Phase Three: Enrollment**
The start date of the enrollment phase is calculated by looking at the start date for new coverage and counting back 90 days. The employer can choose any start date it likes. For example, if an employer wants new coverage to start on June 1, then enrollment should begin on March 1. This allows time for insurance carriers to process the new applications and mail insurance cards to retirees in time for the start of coverage. During this phase:

Retirees receive the Extend Health Enrollment Guide, including Medicare basics plan education, what to expect on the enrollment call, and appointment confirmation. Enrollment calls take place. Extend Health delivers reminder post cards and (if necessary) certified mail to those retirees who do not respond in a timely manner.

**Phase Four: Post-Enrollment**

The employer's role is minimal during the post-enrollment phase. Retirees often have questions during this phase but Extend Health has a team of benefit advisors and customer service representatives who will help them with carrier or HRA issues, or any future changes to their medical and prescription drug requirements. During this phase:

Extend Health delivers plan selection confirmation letter
Insurance carriers send out welcome guides and new insurance cards
Extend Health delivers a welcome letter and the HRA packet

**Example timeline**

If an employer wants new retiree benefits to start on September 1st, the timeline for a smooth transition would look something like this:

Phase 1 planning begins between February 15 and February 28
Phase 2 retiree education begins April 15
Phase 3 enrollment begins June 1
Phase 4 post-enrollment begins with the start of new coverage on September 1

Appendix V

Minutes of Committee Meetings
Collaborative Study Group
Minutes of September 27, 2011


Members Excused: Andrea Fulton, Richard Drain

Staff Present: Jessica Leys, Judi Lohn, Charlie Mannion, David Plymyer, John Peterson, Helen Shomberg

The meeting of the Collaborative Study Group was called to order at 1:15 p.m. by John Hammond.

Minutes
Mr. Hammond introduced the group members and staff followed by an opportunity for the members to express their expectations and concerns. Mr. Benoit asked questions about the ground rules for the meetings. The group meetings are subject to the open meetings rules and as such will require public notice and meeting minutes. The Office of Personnel will coordinate the meeting notices, recordings and minutes.

Mr. Hammond gave an overview of the County’s revenue. FY 12 revenue projections are $1,186 million dollars. Approximately 47% of revenue comes from property taxes, 31% comes from income tax and the rest comes from recordation and transfer fees, state shared revenue, licenses and permits and local sales taxes. The County has a structural deficit. There are two ways to close the deficit, raise revenue or reduce expenditures. The revenue assumptions going forward include ending furloughs to County workers and some assumptions of cost of living adjustments and merit pay. Revenue projections include 15 million in slots revenue in FY13 rising to a max of 25 million. The expenditure projections include rising health care and pension costs as well as starting to fund the Other Post Employment Benefits (OPEB) liability at a rate of 10 million dollars a year. Taking over Board of Education pension costs are not included in the assumptions for future expenditures. The goal is to eliminate the OPEB liability for the County employees, library employees and community college employees. The 2006 OPEB liability was $1.3 billion. The OPEB liability is based on an 8% discount rate. There was discussion about the assumptions that make up the OPEB liability and the need to make some efforts to start to address the unfunded liability. There was discussion on the significant components of the revenue projections. Property tax revenue is assumed to be 4%. Actual CPI and the tax cap are components of the actual tax revenue. Income tax projections assume a 4% increase. In reality income tax revenues have been flat. Recordation and transfer taxes have dropped significantly. Revenue of 65 million is estimated for FY12. YTD actual revenue is falling short of that projection. Shared State revenue has seen an $18 million decrease from the elimination of the shared highway user revenue. The revenue projections assume some slot revenue in 2012. There was discussion on how slot revenue can actually be spent as a part of the County budget.
Mr. Hammond discussed retiree health insurance. GASB 45 is a requirement that entities recognize the retiree health liability over an employee’s working life. The actuarial accrued liability is the estimate total present value for all future retiree health benefits that the county will have to pay. The unfunded liability is the difference between the actuarial liability and existing assets set aside for those payments. We currently have no money set aside for the OPEB liability. The actuarial required contribution (ARC) is the amount that we should set aside each year to fund the liability. The ARC is composed of a normal cost (current year benefit accruals) and the amortization of the unfunded liability over 30 years. The County had put aside a total of $25 million in the Health Fund for OPEB, however, these funds were removed to help balance the budget. There was discussion of a retiree health trust fund. Such a fund would require a charter amendment to authorize the County Council to set up such a trust. Mr. Plymyer suggested making a recommendation to the Charter Revision Commission to add this amendment. The current ARC is projected at $117.6 million. The County currently contributes only paygo to the retiree health fund. This year’s paygo is $42 million of which $15 million is attributable to County employees. There is a $75 million gap between the ARC and the County contribution (paygo).

Mr. Hammond discussed the status of the County Pension system. The County makes a $53 million annual contribution to the pension fund. It is expected that the County pension contribution will continue to rise in the coming years. The combined plans are around 85% funded. Mr. Hammond showed a summary of personnel costs by employee group.

Mr. Peterson discussed the eligibility rules and vesting requirements for the four County pension plans, a summary of the retirees in each plan and a projection of the future vested participants who will be eligible for benefits.

Ms. Lohn discussed the County health plans including the available plans and prescription drug coverage. Ms. Lohn provided information on who participates in the County health plan, who is eligible for benefits as well as a snapshot of current participants and the fees and claims costs for the year to date.

There was discussion on the scope of the study group. The scope is more than OPEB but OPEB is the vast majority of the issue. We currently have $53 million in annual active health care costs and $23.6 million in annual retiree health care costs. There was discussion around wellness programs and incentives/discounts for participation in wellness programs. There was discussion about the retiree Medicare supplement (Wrap plan) as well as health savings accounts (HSA).

The Group asked the Office of Personnel staff to provide a matrix of plan design changes as a framework for discussion at the next meeting. The Group asked for a break out of health claim by employees and dependents. The Group asked the Office of Law to provide a matrix of legal concerns regarding plan changes. The Group will meet again on Tuesday October 4, 2011 at 1:00 at the Office of Personnel.

The meeting was adjourned at 3:55.

Respectfully submitted,

[Signature]

John K. Peterson
Assistant Personnel Officer
Collaborative Study Group
Minutes of October 4, 2011


Staff Present: Jessica Leys, Judi Lohn, Charlie Mannion, David Plymyer, John Peterson

Guests: Alex LeBlanc, AON Hewitt, Terrence Pringle, AON Hewitt, Jamie Roberts, AON Hewitt

The meeting of the Collaborative Study Group was called to order at 1:00 p.m. by John Hammond.

Minutes
A packet of handouts was distributed to the group members including: minutes from the previous meeting, a letter from the State Public Employees’ and Retirees’ Benefit Sustainability Commission, a Kaiser Foundation survey, a Washington Post article regarding the survey, Pension plan comparisons, health benefit plan comparisons, a breakdown of claims by employee, retiree and dependants, and a matrix of benefit plan factors and savings.

Alex LeBlanc from AON Hewitt presented information comparing the County’s health plans to various surrounding jurisdictions. Overall, the County plans are on the higher side of the middle of the pack. Mr. LeBlanc stated that there has been a lot of discussing amongst governmental plans around the State regarding shifting costs to participants. There was discussion on the comparisons of how the County’s variables compare to other jurisdictions. The out-of-pocket maximum is pretty low compared to other jurisdictions as are the co-pays for doctor’s office and emergency room visits. The prescription co-pays are middle of the pack. There was discussion on which items/variables have the biggest effect on the County’s cost. Increasing prescription drug co-pays by $5 would result in a $1.5 million dollar savings, increasing office visit co-pays would have a $.5 million savings, increasing the ER co-pay from $35 to $100 would result in a $250,000 savings, increasing out of pocket maximums by $500 would result in $1 million savings. There was discussion on what types of changes would be preferred from the perspective of employee satisfaction. There are two theories on cost sharing. In the first, people would rather pay a little more across the board and share the costs evenly. In the second, increasing the co-pays is most fair because the person utilizing the services the most is the one paying a little more. There was discussion around changes to how the services are delivered, wellness plans and design features aimed at reducing costs. Most of these features are best suited for active employees. Retirees are much more challenging when it comes to wellness programs. Mr. LeBlanc stated that the health care services for those over 65 are going to change significantly under health reform.

There was discussion on why a participant would choose a PPO vs. an HMO at a significantly reduced cost. AON has done studies on coverage choice and the overwhelming drivers are price and access.
Employees have the perception that an HMO provides a lower quality of care and restricts an employee’s choices. This is not necessarily true and it can be a matter of educating employees. A question was raised if people are generally sophisticated enough about health care to look at the total cost of health care. Most people just look at the cost of premiums.

A question was raised about Health Savings Accounts and if they are currently being utilized by any public sector plans. AON was not aware of any public sector plans but they are active in private sector plans. The formula for these types of consumer driven plans include a high deductible and then a health care account to use to pay for medical bills. Any unused amount in the health account can roll over into the next year.

AON discussed the comparison of the County’s health care benefits for over-age 65 retirees to other jurisdictions. The County has a Medicare wrap around plan for over-age 65 retirees. The County’s prescription drug plan is a fairly rich plan compared to other areas. The total medical benefits are middle of the road compared to other jurisdictions. There was discussion on the federal subsidy that the County receives for its prescription plan and the elimination of the subsidy and the closing of the Medicare “doughnut hole”. The State is transitioning retirees from a prescription drug plan to Medicare D resulting in significant savings to the State’s OPEB liability. A majority of the cost for over-age 65 retirees is prescription drug coverage.

All major municipalities are having the same discussion regarding retiree health care costs. The State has recently taken action to reduce the OPEB liability. A question was raised when some of the other jurisdictions made service based changes to their plans. The group would like to be able to contact some of these plan administrators and find out what issues they faced, what savings they realized and to learn from what other jurisdictions may have done. AON is hoping to share a comprehensive survey in the near future.

There was discussion regarding vesting and the differences between public safety and other employees. The group should be looking at all issues regarding vesting and retirement age for health benefits including a graduated scale with better benefits or cost sharing with more years of service.

AON discussed the comparison of dental and vision plans with other jurisdictions. The County’s plans are not as “rich” as other jurisdictions, but they are 100% funded by the County for active employees. Retirees pay the premium for dental and vision.

There was discussion about municipalities holding back waiting to see what will happen with health reform. Municipalities are meeting and looking at options. AON anticipates some jurisdictions to make changes by the end of the year. The group discussed having a short term four to five year plan primarily around retiree medical plans. By 2014 the State will have health care exchanges. It is a complicated issue as to who will participate in the exchanges and how the will be priced. AON will be back to discuss the Health Reform Act.

There was a short discussion about the comparison of the four County retirement plans and the comparison of the County’s plans to other jurisdictions. There was discussion around the employer cost for these plans and the variables that make up the costs of these plans.

Andrea Fulte presented a packet of salary comparisons for a variety of public safety and general employee positions. The County is generally in the middle of the pack for these positions. There was discussion on which jurisdictions the County should be compared to and who we compete with for employees. The group asked to see some additional comparisons for some of the County’s non-represented positions. The union members shared their opinions of how competitive the County was with salary and benefits. Employees are well aware of what is going on in surrounding jurisdictions.
There was discussion that County must address retiree health and the legacy costs associated with retiree health care. If the County does not address retiree health care, less and less money is going to be available to pay active employees. There was discussion around revenue, income and property tax and future liabilities.

There was discussion of the underlying principles that the group should follow: 1) Reduce County cost; be fair to taxpayers 2) Be fair to each employee group; “share the pain” 3) Benefits should be in the “middle of the pack”

There was discussion on what was a reasonable target to address in terms of OPEB liability in order to feel like the group has been successful. As an example, the Taylor Commission ended up making recommendations that addressed 44% of the annual required contribution (ARC). The County’s current ARC is $118 million. The current pay go contribution is $42 million. There was a discussion regarding the Board of Education. Should the group address the BOE OPEB or let the Board deal with that separately. There was discussion concerning the bond rating organizations and their expectations.

Dave Plymyer summarized some of the legal risks to plan changes. John Hammond presented a draft of retiree health cost factors and what the savings would be to potential changes by “high”, “medium”, and “low” savings. The group asked if it was possible to combine the charts of potential savings and legal risk factors into one chart.

There was discussion of the principles and what constituted “fair” to the employee groups and what are the specific options. The topic of a charter amendment to authorize the creation of a health care trust fund was discussed. It was discussed that there should be some concrete measures coming out of the group that reduce health care costs. The group agreed that at the meeting on Tuesday October 18, members should be prepared to put some ideas on the table and discuss real options. As part of the discussion regarding the principles it was discussed that any savings resulting from changes to the health plan should be directed to any future health care trust fund. No changes can be made to the health plan until January 2013. It was discussed that the County should visit returning to a fiscal year for health benefits instead of the current calendar year model. There was discussion of legal issues around changes. If the group takes changes off the table for current retirees there will not be a big enough dent in the OPEB. The group needs to make modest changes and share the risk with retirees, employees and the County.

The Group will meet again on Tuesday October 11, 2011 at 1:00 at the Office of Personnel.

The meeting was adjourned at 4:20.

Respectfully submitted,

John K. Peterson
Assistant Personnel Officer
Collaborative Study Group
Minutes of October 11, 2011


Staff Present: Jessica Leys, Judi Lohn, Charlie Mannion, David Plymyer, John Peterson

Guests: Deborah Sosnoski, IAFF, Alex LeBlanc, AON Hewitt, Terrence Pringle, AON Hewitt, Anne Timmons, State of Maryland

The meeting of the Collaborative Study Group was called to order at 1:05 p.m. by John Hammond.

Minutes
The minutes of the previous meeting were reviewed and adopted.

Andrea Fulton, Personnel Officer distributed salary comparisons for non-represented employees and discussed a number of job classifications. For most of the classifications, Anne Arundel County salaries are right in the middle of the road. In general, Prince George’s County and Montgomery County lead the rankings and the State of Maryland lags behind.

Alex LeBlanc from AON Hewitt gave a presentation on the recent federal health care reform legislation. The initial legislation was 2,500 pages with approximately 200 new pages coming out each month. The expectation is that the final version will be over 10,000 pages of regulations. The legislation is changing on almost a weekly basis.

By 2014, every state is mandated to have a health care exchange or participate in the federal government’s exchange. Health plan designs will be mandated and will include a lot of wellness benefits. There are two ways plans can impact the future cost of health care: get at the root cause of health issues (wellness, risk management, etc.); and cost sharing or cost shifting. Under the health care exchanges, employees may be able to opt out of the County plan and join and exchange. The County would be required to pay the exchange a minimum amount of money. Employers will be required to ensure that all employees have coverage. There was discussion around who would be included in the state exchanges. Most likely the Medicaid population would be included in the exchange. The State of Maryland is pushing ahead to be one of the first states ready with an exchange. Many employers are looking at potentially moving the under 65 year old retiree population into the exchanges if they are available. The federal government set up the Early Retiree Reinsurance Program (ERRP) to fund $5 billion in subsidies for employers provide insurance to retirees under age 65. Anne Arundel County has been approved to participate in this program and has been approved for $900K in subsidies (the money has not yet been received). The $5 billion in subsidies is going to run out fairly quickly.
As part of health reform, there are going to be substantial cuts to the reimbursements that Medicare makes to providers. There is a fear that with these cuts, doctors are going to stop seeing Medicare patients.

There are going to be big changes to the way prescriptions drugs will be paid for through Medicare Part D. The County has continued our retiree prescription drug plan with a subsidy from the federal department of Health and Human Services. The County receives $2 million per year in subsidies to continue our retiree prescription drug program. The current subsidies will be gradually phased out. There may be ways to continue to offer the plan and get subsidies in the future. The Medicare D “doughnut hole” is being eliminated by 2020. Adopting the Medicare D plan for all retirees after 2020 will have a big impact on the County’s OPEB liability.

There was discussion surrounding Medicare cuts and the effect of cuts on the availability of doctors as well as the effect on Medicare wrap plans. There was discussion regarding employers tying health care subsidies to age and service and the likelihood of moving those that do not qualify into the health care exchanges. There was discussion about giving employees a set amount of money and allowing them to purchase insurance through AARP or an exchange.

Alex LeBlanc discussed the County’s status as a “grandfathered” plan for health reform legislation and the effect of losing that status. Eventually, all plans will lose this status. There was discussion of the timing of events for changes in plan design and windows of opportunity for making changes. The County needs to find ways to get control of costs, reduce the Annual Required Contribution (ARC) to OPEB, and then find ways to fund the future liability costs. There was discussion on the complexities of regulation and administration of health care reform. Alex suggested some handouts, viewing the AON website and will look into providing some materials that help explain health care reform legislation.

Anne Timmons from the State of Maryland discussed some of the changes that the State has made and changes that they may be considering regarding health insurance. The state has a $1.2 billion budget covering 230,000 lives. The Public Employees’ and Retirees’ Benefit Sustainability Commission looked at all areas of health care and pension benefits for State employees. For the plan year beginning July 1, 2011, the State made changes to prescription drug plans only. The State bifurcated retirees and active employees for prescription drug coverage. Prescription co-pays increased for both active and retirees, out-of-pocket expenses increase for retirees and the cost sharing split increased for retirees from an 80/20 split to 75/25. The State also plans to move eligible retirees into Medicare D starting in 2020. For new hires, the pension vesting time is now 10 years and the service for full retiree subsidy increased from 16 years to 25 years. The State is currently in negotiations with their Unions through an economic opener to achieve a 5% reduction in health care costs. There are a number of proposals on the table to reach the 5% savings. There was discussion regarding consumer driven plans and health care savings plans (HSAs). The State is not currently considering HSAs. There was discussion of the State’s OPEB liability and the status of the State’s trust fund. The State has not funded any of their OPEB liability. The State chose not to maintain “grandfathered” status for any of their health plans. Ms. Timmons discussed the impact of losing this status including the need to set up an outside claims appeal process. There was discussion of the friction to change and the retirees response to the changes made. Overall, there was less pushback than expected from the retirees.

Ms. Timmons discussed the progress of the State health care exchange. A request for proposal has been completed to select a vendor to run the exchange. The exchange is expecting to start taking applications in 2014. The idea was to start with smaller employers and then offer the exchange to other employers. Ms. Timmons did not know of any movement to enroll the Medicaid population in the State Exchange.

There was discussion on patient centered care. The State participated in a pilot program that allows doctors to work closer with patients in an effort to curtail expenses. The State also participates with CareFirst’s who offers the Patient Care Medical Home. The State revisits health care issues every year. The Sustainability Commission is in effect until July 2012 but it is unknown if they are going to reconvene.
There has been no discussion of enacting employee contributions to a GASB trust fund. Ms. Timmons mentioned that there are some counties that have made significant changes to their plans including Montgomery County and Harford County.

There was discussion on the use of generic and brand name drugs and requiring generics. There was discussion on pooling with the State for prescription drug coverage. The State does have a program for municipalities to pool with the State but as of yet no one is participating. The County may lose some of its ability to control the plan if it pools with the State. There was some discussion of economies of scale and if the savings that the State has realized would translate in the same level if the County made similar changes.

The Group will meet again on Tuesday October 18, 2011 at 1:00 at the Office of Personnel.

The meeting was adjourned at 4:05.

Respectfully submitted,

[Signature]

John K. Peterson
Assistant Personnel Officer
Collaborative Study Group
Minutes of October 18, 2011


Staff Present: Jessica Leys, Judi Lohn, Charlie Mannion, David Plymier, John Peterson

Guests: Deborah Sosnoski, IAFF, Alex LeBlanc, AON Hewitt, Tom Lowman, Bolton Partners

The meeting of the Collaborative Study Group was called to order at 1:10 p.m. by John Hammond.

Mr. Hammond introduced Tom Lowman, Bolton partners. Mr. Lowman and Alex LeBlanc are on hand to help the group with suggestions and costing of modifications to benefits.

There was discussion on starting with what might be an appropriate level of benefits rather than getting bogged down in the costs. The cost is absolutely a factor but it might be better to deal with the costs once the group determines a level of benefits that it can agree to.

There was discussion on stop/loss coverage for the County to reduce exposure to large claims. The County has looked into an aggregate stop/loss policy but it was not reasonable. Under the new health reform law there is no lifetime cap on medical expenses per employee. The County could purchase stop/loss coverage per individual. The County reviews historical experience against the cost of a stop/loss coverage every year. The County’s health care population is large enough that the claims risk is spread out sufficiently to not require stop/loss coverage at this time.

The discussion returned to the goals for this group and where success may lie in the range of goals. It may be more meaningful to determine the goals and then balance the fairness issues against those goals to determine any recommended changes to benefits. Fairness includes what is a reasonable fair benefit for the employees and what is fair to the taxpayers. Should the group look at what is a fair/reasonable benefit and then back into the costs? It is hard to determine a starting point without a goal. One of the results has to be an amortization schedule on how these benefits are going to be funded. One suggested goal is to fully fund the OPEB liability over a 30 year period. There are two ways to shrink the liability: reduce the cost and fund the liability. It is
hard to predict what the real costs will be twenty to thirty years from now so we will have to review the liability each year and adjust the costs. A method of auto-correction should be built into the plan that allows adjustments. This should be part of the trust fund governance. A period of transition from what exists now to a future benefit should also be part of the planning.

Tom Lowman was questioned as to the impact of plan changes to savings and the overall plan liability. Tom shared a chart from 2005 that is very similar to a chart that was distributed last week with Low/Med/high savings. Tom’s chart is part of the 2006 GASB45 Taskforce Report that was distributed to the Group on September 27, 2011, specifically pages 30-33. Tom replied that the prior chart was generally accurate regarding changes to vesting, co-pays, etc.

There was discussion regarding how to deal with the OPEB liability for the Board of Education. Does the County prefund a separate trust fund for the board or allow them to resolve their own OPEB liability issues? With no direct control over the BOE, should this group try and create goals for them.

Goals were restated as forming a health care trust as a funding vehicle and funding the benefit over 30 years with regular reviews of progress.

There was discussion on what constitutes a long term employee and is it reasonable to ask employees to work longer for the same benefit. The idea of a graduated scale for benefit cost sharing tied to service was raised. There was discussion on what would be the minimum required service to be eligible for County subsidized health insurance. There was discussion over vesting and those employees who left as vested employees as well as those active employees who have already vested in their retirement plans. There was discussion regarding de-linking retirement eligibility with health care eligibility. There was discussion around the average age and average years of service of retirees across the various plans. There was discussion around codifying language and giving the Personnel Officer guidance as to who is covered for health insurance including spouse and dependants. There was more discussion on various graduated scales for health care eligibility and possibly having different scales for public safety. There was discussion around requiring retirees who are reemployed somewhere to obtain health insurance from their current employer. The retiree could return to the County’s health care when they are no longer working.

There was a discussion around prescription drug coverage and the savings recognized by the State when they made changes to prescription co-pays.

It was mentioned that some of the Council met with the Howard County Executive, Ken Ulman who indicated that Howard County was recognizing some savings by doing something with their health plan that Anne Arundel County was not doing. It was unclear what Howard County was doing, but Ms. Fulton will contact Howard County to determine what this may be.

There was discussion about recognizing savings to our administrative costs if we could couple with the Board of Education. The Board has been unwilling to coordinate with the County. The Council will begin discussions with the Board to find areas where we can work together to achieve savings.

There was discussion on bidding our contracts and potential savings from going out to bid.
Bolton and AON will get a list of areas of benefit changes and will cost them out within the next two weeks. The list will include changes to co-pays, deductibles, cost sharing, moving retirees to Medicare D in 2020, etc. There was discussion of what is palatable and what is fair, increasing deductibles or co-pays versus increasing out pocket maximums and similar comparisons.

There was discussion about having an active employee contribution to retiree health and would this be part of the health trust fund. There was discussion on the make up and characteristics of a health trust fund. Any realized savings from benefit changes should go into the trust fund.

There was a discussion of making changes to active employees’ co-pays, deductibles, etc.

There was discussion around changes to the retiree prescription plan and taking advantage of law changes and administrative changes. There was discussion of what constitutes retiree health care and if the County should eliminate the Medicare Wrap coverage.

The central point is that the group is trying to take some costs out of the system because the County can not continue to afford it. The group is trying to find ways to best shift the costs and share some of the burden.

Staff will try and have a draft report prepared to circulate to the group ahead of the next meeting.

The Group will meet again on Tuesday October 25, 2011 at 1:00 at the Office of Personnel.

The meeting was adjourned at 4:05.

Respectfully submitted,

John K. Peterson
Assistant Personnel Officer
Collaborative Study Group  
Minutes of October 25, 2011


Staff Present: Jessica Leys, Judi Lohn, Charlie Mannion, David Plymyer, John Peterson

Guests: Alex LeBlanc, AON Hewitt, Terrence Pringle, AON Hewitt, Leon Kaplan, PRM Consulting

The meeting of the Collaborative Study Group was called to order at 1:10 p.m. by John Hammond.

Mr. Hammond passed out copies of the previous minutes, a report of changes to health benefits made by Howard County, and a draft copy of the interim study group report.

Council Chairman Ladd announced that he had tentatively set November 14th at 9:00 am as a work session to present the interim report to the full Council and to talk through what the group has done so far.

Mr. Hammond mentioned that a variety of cost savings measures have been sent to Bolton Partners for pricing and that the group should have some answers by the next meeting.

The group has agreed to continue meeting every Tuesday at 1:00 through December 2011.

The group reviewed the draft interim report. There was discussion about adding additional information to the report giving additional background information on retiree health care cost issues. Mr. Hammond will add a section for background highlighting the need to address the OPEB liability. The group went over the various alternatives to changes in benefits. Bolton and Aon are going to provide cost savings for the various alternatives. There was discussion over the various assumptions used in the costing.

There was discussion about addressing the Board of Education’s OPEB liability. The report should include a statement to try and get the BOE to work closer with the County. The bigger issue as discussed is the BOE’s retiree health care liability. The report can spotlight the BOE’s liability and can serve as a vehicle for the Council to make suggestions to the BOE to address
their liability and to report back to the Council on steps they have taken. The reduction goals that the County realizes can become the goals for the BOE. The Council could pass a follow on resolution asking the BOE to review their OPEB liability. The Group discussed adding an epilogue to the final report describing the issues with the BOE and the need to address their OPEB liability.

There was discussion around the draft alternative requiring retirees to take other health care offered by a new employer or a spouse’s employer. Discussion on how this would be administered and if we would require a retiree to take a lesser health care benefit.

There was discussion on a funding plan and how and what would be proposed for funding the long term liability. This is part of the “next steps”

Aon is going to provide some information and revised numbers regarding changes to co-pays etc. for active employees. The focus of the interim report is on retiree health but the group will have to discuss existing employee coverage as well. This information will be included in the final report.

Mr. Hammond will make the recommended changes to the draft document and try and circulate a new draft prior to the end of the week.

There was discussion on the administration of the report, whether it should be signed, if the group is going to vote on specific issues and how to present the final report.

Alex LeBlanc from Aon/Hewitt presented a report on health care cost savings including moving to an 80/20 split on all health plans, increasing prescription co-pays, and increased deductibles for both active and retiree groups. Making changes to the wrap plan was not included in the costing but would have similar savings.

There was discussion of offering retirees the ability to choose Medicare supplement plans from a vendor similar to AARP. The County wrap plan is currently a self insured plan. The County may be able to recognize substantial saving by moving to a different type of Medicare Wrap vendor.

Prescription drug costs are currently 50% of the over age 65 health care costs. There was discussion on the current health care rates for over age 65 retirees and how these rates are calculated. There was discussion on the various rebates and subsidies and the continuing nature of any government subsidies.

There was discussion on the Early Retirement Insurance Program and how the funds are being allocated among the states, union groups and municipalities. The County has seen some benefits from this program.

Mr. Hammond passed out a basic overview of the Medicare program including the various program parts and costs to participate.

Staff will try and have a draft report prepared to circulate to the group ahead of the next meeting. At the next meeting the group will finish up the interim report, Bolton will give a presentation on costs savings and the group will continue the discussion of possible recommendations for plan changes.
The Group will meet again on Tuesday November 1 at 1:00 at the Office of Personnel.

The meeting was adjourned at 3:15.

Respectfully submitted,

John K. Peterson
Assistant Personnel Officer
Collaborative Study Group
Minutes of November 1, 2011


Staff Present: Jessica Leys, Judi Lohn, Charlie Mannion, David Plymyer, John Peterson

Guests: Alex LeBlanc, AON Hewitt, Terrence Pringle, AON Hewitt, Tom Lowman, Bolton Partners, Teresa Sutherland, County Auditor

The meeting of the Collaborative Study Group was called to order at 1:10 p.m. by John Hammond.

Mr. Hammond passed out copies of Interim Report and asked if anyone had any changes or additions to the report before it was sent to the Council. No changes were suggested.

Mr. Hammond reintroduced Tom Lowman from Bolton Partners. The Group had provided Bolton with 10 possible plan changes and Bolton developed the associated cost savings to the Annual Required Contribution (ARC) and the OPEB liability. Bolton based the cost estimates on the assumption that the County would create a trust fund and work to fund it. This would allow the County to use an 8% discount rate in determining the future liability. Per Mr. Lowman, the current health care pay go costs are around $27 million. The ARC (based on the 8% assumption) is $69 million. The OPEB liability including the library and community college is $672 million. Mr. Lowman provided a handout showing the cost savings by plan change broken out by savings to the library, college and by County employee groups (Employees, Police, Fire, Detention).

There was a question about cost savings for plan design changes, co-pays, etc. AON presented the cost savings associated with these types of changes at the previous meeting.

There was discussion around the risk factors associated with changes to term vested participants and to vested employees and/or spouses in general.

There was a discussion on how our participants’ demographics differ from the State’s plan. The County has a higher percentage of public safety retirees than the State plan. Employee costs (benefit costs) are generally higher for public safety employees.
There was discussion around plan changes which would eliminate retiree health coverage before age 55 as well as changes requiring retirees to take other coverage (new employer, spouse's employer) if available.

There was discussion of coverage rates based on graduated scales and whether or not there should be one universal scale or different scales for public safety and non-public safety.

There was discussion on County employment vesting eligibility for health care benefits.

Mr. Lowman was asked what other jurisdictions have done. Mr. Lowman stated that all other jurisdictions are having the same discussions and that Bolton has prepared very similar studies for other employers.

There was discussion on active employee contributions to the retiree health fund. Mr. Lowman spoke about the experience that the City of San Jose is having with employee contributions and the potential issues that may arise.

There was discussion on the impact of having different benefits for existing employees and new hires and what the scale of the difference may be. There was discussion about what is an appropriate level of benefits and what can the County afford.

There was discussion of funding the retiree health liability and of setting benchmarks. Part of any final plan should include a funding plan with long term and short term goals. There was a discussion of goals and of what dollar amount of reduction of the liability would be an acceptable goal. The current ARC is $69 million and the current pay go contribution is $27 million. This leaves an additional $42 million in cost reductions or additional contributions necessary in order to meet the ARC. The BOE has a similar liability bringing the County's total ARC liability to around $80 million. This Group can only really affect the County's liability but the BOE is part of the total framework.

There was discussion on the percentage of revenue spent on health care and how that percentage compares to other jurisdictions. The Group would like to get a “normal” cost for health care benefits across counties. Bolton will try and put together some numbers for the Group.

There was discussion on increasing the employer contributions to the ARC as future revenues increased. In the past, all incremental revenue increases have been absorbed by normal budget inflation costs. Increases in employer contributions to the ARC will have to come at the expense of other cuts or increases to revenue. There was discussion that all of the cuts can not come at the expense of the employees. There was further discussion on the appropriate benefit levels and how we can transition over time to those levels. There was discussion on the benefit plan change alternatives and what might be most palatable to the employee groups.

There was discussion on the post 65 health benefits and changes to the Medicare Wrap plan. The County could bring in a vendor that offered a variety of Wrap or supplemental plans and allow retirees to choose the plan that is best for them. There was discussion of the County setting a fixed amount to contribute and capping any increases to that amount by a fixed percentage. Increase each year. The Personnel Officer will put together a short description of post age 65 retiree health benefit coverage. Aon will provide information on private vendor Medicare supplemental plans. This information will be available for the employee groups to share with
their members. Bolton will do a cost study on the savings to the ARC and the OPEB liability that would be potentially realized by moving to alternative Medicare supplemental vendors and capping the County’s expenses to a set percentage increase each year.

The next meeting will be at 1:00 p.m. on Tuesday November 8, 2011 at the Office of Personnel.

The meeting was adjourned at 4:15 p.m..

Respectfully submitted,

[Signature]

John K. Peterson
Assistant Personnel Officer
Collaborative Study Group
Minutes of November 8, 2011


Members Absent: Councilman G. James Benoit

Staff Present: Jessica Leys, Judi Lohn, Charlie Mannion, David Plymyer, John Peterson

Guests: Alex LeBlanc, AON Hewitt, Terrence Pringle, AON Hewitt, Leon Kaplan, PRM Consulting

The meeting of the Collaborative Study Group was called to order at 1:10 p.m. by John Hammond. Mr. Hammond passed out a revision to the pricing chart created by Bolton Partners showing a revised calculation under option 3 (Institute service based subsidies). Mr. Hammond also passed out a Wall Street Journal article on retiree health care costs.

The County Council work session will be held on November 14, 2011 at 9:00 to discuss the interim report.

Alex LeBlanc, AON Hewitt, distributed a handout on Medicare and discussed the various aspects of Medicare coverage (Parts A, B, D and supplemental plans) as well as a comparison of standard Medicare supplemental programs to the County’s Medicare wrap plan coverage.

Currently the County provides the same prescription drug plan for active employees, retirees and post age 65 retirees. Because of this, the County receives some reimbursements from the federal government for having a post age 65 program. The subsidy is being reduced each year and may eventually be phased out. There are other options for getting subsidies. The County could join an Employer Group Waiver Program. Under this program the County may be entitled to subsidies from both the federal government and the drug manufacturers. There was a discussion of the Medicare D (prescription drug coverage), the doughnut hole provision and Medicare D supplemental plans. Per Alex, supplemental plans prices range from $37.50/month to $89.70/month. The current cost to the County for over age 65 retiree prescription drug coverage is $379.53/month. The cost to the County for active employees and under age 65 retirees is $280-$300/month. In 2020, the State will no longer provide a prescription drug plan for post age 65 retirees and they will only have Medicare D coverage.
There was discussion of Medicare supplemental programs as compared to the County wrap plan. Similar plans cost retirees $100-$110/month. With "Medigap" coverage, retirees can use any doctor that accepts Medicare. Currently around 90% of doctors do accept Medicare. Medigap coverage plans are fully insured plans as opposed to the County’s self-insured wrap plan. Switching to a fully insured plan could reduce the risk to the County for large claims.

There were questions on the legal issues surrounding the idea of moving over age 65 retirees to medigap or supplemental plan coverage.

John Hammond passed out information from an insurance company that works with employers and retirees to match retirees to a Medicare supplemental plan that is best for them. The County could provide the retiree with a set dollar amount in a Health Reimbursement Account (HRA) which the retiree could use to purchase medigap coverage. There was discussion about HRAs for active employees.

There was discussion of timing and steps necessary to affect a change to providing outside supplemental coverage rather than a County self insured wrap plan. There was discussion of including a suggested timeline in any final report to the Council.

Alex LeBlanc will coordinate with AARP to attend the next group meeting to speak about medigap coverage and supplemental plans. The employee representatives would like to have their health care consultant (CBIZ) present to the group at the next meeting.

There was discussion of the pre-age 65 retiree group and the costs associated with retiree health care coverage. There was discussion about the County providing one tier of benefit coverage with an 80/20 split and allowing retirees to choose other options but only with the same dollar subsidy provided in the initial 80/20 plan. If the total cost of the main option is $505.83, the 80/20 split would be $404.66 (employer cost)/$101.17 (retiree cost). The County would apply the $404.66 employer share to any plan that the retiree may choose. If the retiree chose a plan that cost $534.82 the split would turn out to be more like 75/25. There was discussion of applying this same concept to active employees, offering one plan with a 90/10 cost split and allowing employees to choose other plans but only at the same dollar match as the 90/10 split.

There was discussion of setting money aside that is walled off from other uses short of setting up a formal trust. There was discussion of setting up a funding plan to put additional monies aside for the OPEB liability. There was discussion about the Board of Education and what responsibility the County has or what the County can do to make sure that the Board is addressing the liability.

The next meeting will be at 1:00 p.m. on Tuesday November 15, 2011 at the Office of Personnel.

The meeting was adjourned at 4:10 p.m..

Respectfully submitted,

John K. Peterson
Assistant Personnel Officer
Collaborative Study Group
Minutes of November 15, 2011


Members Absent: Councilman G. James Benoit

Staff Present: Jessica Leys, Judi Lohn, Charlie Mannion, David Plymyer, John Peterson

Guests: Alex LeBlanc, AON Hewitt, Terrence Pringle, AON Hewitt, Leon Kaplan, PRM Consulting, Randy Hart, CBIZ, Lori Vavrinec, United Health Care, Denise Lindeen, United Health Care

The meeting of the Collaborative Study Group was called to order at 1:05 p.m. by John Hammond.

Mr. Hammond passed out the minutes of the previous meeting.

There was discussion about a time line for going forward after the groups final report has been issued. The final report could contain an optimized sequence of events necessary to implement the recommendations of the group.

Mr. Hammond introduced Randy Hart of CBIZ. CBIZ is a health care consultant for the public safety unions. The union had asked CBIZ to look over the groups materials and see if they had any thoughts on what the group had been doing or anything to add to the conversation. Mr. Hart distributed a hand out on health benefits and discussed how the County’s plans are similar to other jurisdictions. Mr. Hart stressed the need to get at the drivers of health care costs and to “bend the trend”. There are two main ways to lower the expected 9% trend increase in health care costs: Plan management and Wellness initiatives. Mr. Hart discussed areas of plan management including regular RFPs, audits and data management. There are two types of claims audits, random audits which the County currently performs and an audits of the entire claims population. Better data management can help understand the issues and drivers of health care costs and help make decisions on plan design. Per Mr. Hart, 70% of health care costs are related to lifestyle decisions. Mr. Hart discussed wellness initiatives and the effectiveness of wellness programs. Per Mr. Hart, plan designs should reward people for good behavior.

Judi Lohn will provide the Group with a short description of the County’s wellness program.
There was a discussion of Health Savings Accounts. Mr. Hart recommended that due to the complexity of such consumer driven plans this is something the County could address further down the road. There was discussion about plan designs for Pre-age 65 retirees, health exchanges and defined contributions plans. Mr. Hart suggested that over 65 retiree health care is the "Gold Mine" for County savings and the connector model is one method of providing large savings while providing similar or even better benefits to retirees. There was discussion around the benefit of participating in EGWP plans as well as value based plan designed, patient centered medical homes, on site medical clinics and high performance networks. Per Mr. Hart, any strategy has to include any understanding of PPACA (health reform) and data analysis, the constant and steady monitoring of health care costs with key metrics and scorecards distributed to all stakeholders.

There was discussion on the education necessary and the difficulty of moving older retirees to the connector model.

Mr. Hammond introduced Lori Vavrinec and Denise Lindeen from United Health Care who came to speak about Medicare supplement plans. United Health Care distributed a booklet. There was discussion of decreasing drug subsidies and the closing of the Part D coverage gap (doughnut hole). EGWP plans provide an alternative way of getting the subsidies. The subsidies would come from the federal government and the pharmaceutical manufacturers. The booklet included a comparison of Medicare D gap coverage plans. There was discussion of Medicare Advantage and Medicare supplement plans. The combination of the two “richest” plans for Medicare supplement and enhanced Part D coverage would be approximately $306 per month as compared the $630 total monthly cost for the County’s Medicare wrap plan. There was discussion of retiree reimbursement accounts and the County providing a set dollar amount for Medicare supplement plans. There was discussion about managing the transition to Medicare supplement plans and education material and customer support necessary to make the transition. There was discussion about drug co-pays and what drugs fall under each tier of coverage. United Health Care can provide a drug formulary showing what drugs are covered under each tier. There is no cost to the County to administer the connector model but there is a cost to the County for administering the health reimbursement accounts. The County could go with split billing with United Health Care billing the County for the set amount and the retiree for anything over the fixed dollar amount.

Mr. Hammond distributed a proposed schedule for the remainder of the meetings.

The next meeting will be at 1:00 p.m. on Tuesday November 22, 2011 at the Office of Personnel.

The meeting was adjourned at 4:20 p.m..

Respectfully submitted,

John R. Peterson
Assistant Personnel Officer
Collaborative Study Group
Minutes of November 22, 2011


Staff Present: Jessica Leys, Judi Lohn, Charlie Mannion, David Plymyer, John Peterson

Guests: Leon Kaplan, PRM Consulting,

The meeting of the Collaborative Study Group was called to order at 1:10 p.m. by Mr. Hammond.

The minutes of the past two meetings were adopted by consent.

Ms. Lohn distributed information on the County’s wellness program. The County has entered into a wellness consortium with the Anne Arundel County Board of Education, the County Public Library system, Anne Arundel Community College, Aetna, Care First BC/BS, Cigna, the County Health Department and the Anne Arundel Medical Center. Ms. Lohn outlined the consortium’s timetable of events and five year plan. Ms. Lohn discussed the wellness survey and what items the survey showed that employees would like the group to focus on. Ms. Lohn discussed the programs that have been offered so far as well as what programs are coming up in the future. Ms. Lohn discussed communication efforts and using open enrollment to communicate and educate employees around wellness efforts. Ms. Lohn discussed the challenges and successes of the program. There was discussion of flu shots and measures of success.

There was a discussion of the Fire Department’s wellness program and how to measure success around that program. Mr. Oldershaw offered that the program has reduced line of duty injuries and the use of line of duty disability leave. There was a discussion of where savings are identified through wellness programs and the need to track data. There was a discussion of expanding the Fire Departmnet’s wellness program and opening it up to other County employees. There was discussion of motivations and incentives for participation in wellness programs.

Mr. Hammond distributed a handout on benefit plan change options. Per Mr. Plymyer, plan design items for active employees such as co-pays, deductibles, etc. are not subject to the labor negotiations process. The cost share of the plan (90/10 or 80/20 split) may be subject to negotiations but not the plan design. Any changes are fair game for future employees. The unions do not negotiate for future employees or retirees, only active employees. There was
discussion on what items are subject to negotiations and what groups of participants are covered by negotiations. There was discussion around what changes are legally possible and defensible. There was discussion of the cost sharing split (80/20) for retirees and if this can or should be changed.

There was discussion of having a health care board similar to the pension board of trustees that would monitor health care costs and benefits on a regular basis. There was discussion that any savings generated from plan changes should go toward a health care savings fund or trust fund.

There was discussion around the current benefits for active employees and what are reasonable co-pays and deductibles. There was discussion around what is an appropriate target for savings from plan changes. The consensus target was $30 million in annual savings from plan changes.

There was discussion around only having one vendor providing health care benefits. This may reduce the administrative cost for operation the health care plans. It is more important to get at the claims cost and identify a provider that manages the claims. There was discussion of providing one HMO style plan at the 90/10 cost share split and then providing the same actual dollar subsidy amount to employees if they preferred a different plan. The effect would be that the employees who chose a “richer” plan would not get the same cost share (90/10) but would get the same dollar subsidy and could choose to pay more for other plans. There was discussion of bundling the prescription drug coverage with the health plan rather than having separate vendors.

There was discussion around providing coverage for employees only, limiting coverage if a spouse has coverage through another employer and providing coverage to spouses and dependants but at a higher rate.

There was discussion around a defined contribution amount and/or providing a flat dollar amount of health care coverage. There was discussion around changing the cost share ration from 90/10 or 80/20 to 85/15 or 75/25. There was discussion around adding cost sharing to dental and vision coverage.

There was discussion of changes for future employees and whether or not they should have a different level of benefits from existing employees.

There was discussion of items to discuss at the next meeting as well as discussion around getting pricing options around some of the suggested changes. Future items for discussion include possible funding sources to come up with monies for the OPEB liability as well as potential changes to pension benefits.

The next meeting will be at 1:00 p.m. on Tuesday November 29, 2011 at the Office of Personnel.

The meeting was adjourned at 4:15 p.m.

Respectfully submitted,

John K. Peterson
Assistant Personnel Officer
Collaborative Study Group  
Minutes of December 6, 2011


Staff Present:  Jessica Leys, Charlie Mannion, David Plymyer, Judi Lohn, John Peterson

Guests:  Alex LeBlanc, AON Hewitt, Terrence Pringle, AON Hewitt, Leon Kaplan, PRM Consulting

The meeting of the Collaborative Study Group was called to order at 1:10 p.m. by Mr. Hammond.

Per Mr. Hammond, Bolton Partners is working on cost projections for savings associated with the changes discussed last week. The projections should be available in time for next weeks meeting.

Mr. Hammond mentioned that today’s discussion is scheduled to be on the funding of future liabilities. The first step is to set up a mechanism to set money aside. Mr. Plymyer from the Office of Law discussed his memorandum to the committee of November 14, 2011. Mr. Plymyer discussed the fact that the County Charter does not allow the County to “fence off” funds outside of State law or a Charter amendment expressly providing that authority. Any monies left in a budgeted fund lapse at the end of the fiscal year and would need to be re-appropriated. Mr. Plymyer discussed submitting a Charter amendment that would set up a reserve fund for retiree health benefits that could only be used for retiree health. The same amendment would also allow the Council to ultimately set up a retiree health benefits trust fund. This two part sequence can be accomplished with a single Charter amendment as proposed in Mr. Plymyer’s memo and would give the County the ability to start protecting these funds while taking time to establish a qualified trust fund.

There was discussion around the make up of the trust fund and the role of the trustees of the fund. There was discussion around ensuring the adequate funding of the reserve fund or trust fund was appropriated each year and a mechanism to ensure proper funding.

There was discussion on where the funding for the reserve fund or trust fund would come from. The group previously discussed targeting an annual required contribution (ARC) of $30 million. If we are able to achieve $5 million in savings from plan changes and if we are currently putting...
in $20 million through annual pay go we need to come up with approximately $5 million in additional funds. There was discussion on the County’s ability to come up with an additional $5 million. The county could “ladder” in to the additional $5 million over several years starting with an additional $1 million contribution and increasing by $1 million each year until the $5 million target has been reached. There was discussion around the fact that for the purposes of GASB liability, the reserve fund would not allow the County to use an 8% discount rate but rather a 4% rate. Once an actual trust fund was established, the County could begin using an 8% rate.

There was more discussion around growing into the funding requirements and what requirements would be set around the appropriation of monies to go into the trust fund to reduce the liability. One concern is that future councils or administrations could choose not to appropriate an adequate amount of funds and what controls could be put in place to ensure that changes made by the current council and administration could not be undone.

There was a discussion on capping the increases in required contributions each year in order to put some parameters on the growth of any retiree health obligation. As opposed to pension benefits, future health care increases cannot be easily controlled. There was discussion on putting a cap on the health care obligation in either the trust agreement or the County Code.

There was more discussion on the role of the health fund trustees and whether or not they should manage the administration of health benefits as well as the investments in the trust. There was discussion that the study of health benefits needs to be a continual review process.

There was discussion on the details of a trust agreement. Bolton Partners had forwarded a copy of an example of a draft trust agreement. The council members asked if they could get a copy of the example draft agreement.

There was a brief discussion about not offering any health benefits to retirees and instead enhancing the pension benefit to compensate for the retirees needing to procure their own health insurance. Concerns were raised that the future of mandated health care is uncertain and if the federal government moves to a single payer plan or mandated employer contributions to a health care plan we may be obligated to pay the enhanced pension benefit and still contribute to health care in some fashion.

There was discussion on including information in the final report regarding the continuation of the Study Group for the purpose of overseeing the progress being made to address the OPEB liability.

The next meeting will be at 1:00 p.m. on Tuesday December 13, 2011 at the Office of Personnel.

The meeting was adjourned at 2:30 p.m.

Respectfully submitted,

John K. Peterson
Assistant Personnel Officer
Collaborative Study Group  
Minutes of December 13, 2011


Staff Present: Jessica Leys, Charlie Mannion, David Plymyer, Judi Lohn, John Peterson

Guests: Alex LeBlanc, AON Hewitt, Terrence Pringle, AON Hewitt, Leon Kaplan, PRM Consulting

The meeting of the Collaborative Study Group was called to order at 1:05 p.m. by Mr. Hammond.

Mr. Hammond distributed a chart showing a new graduated scale for health benefit coverage based on years of service with the County and a chart for transitioning current employees to the new scale. The new cost share for under retiree health under age 65 would range from a 50/50 cost share split at 20 years of service up to a 75/25 split with 30 or more years of service. At age 65, the County would provide a fixed dollar amount towards the retiree’s purchase of health care through a Medicare connector model.

Mr. Hammond distributed a handout showing the expense impact of the above changes on the unfunded actuarial accrued liability and the annual required contribution (ARC). The current ARC for the general County government, library and community college is $69.1 million. Depending on which changes were adopted, changing the cost sharing scale for under age 65 retirees and providing a fixed dollar amount for over age 65 retirees could reduce the ARC between $10 million and $34 million.

Mr. Hammond distributed a letter from Bolton Partners explaining their assumptions and cost savings by employee group for the above changes.

There was discussion around the graduated scale and its impact on employees.

Mr. Hammond distributed a handout on cost savings associated with plan design changes including changes to co-pays, cost sharing on dental and vision coverage, and providing a base HMO plan at an 80/20 split for active employees and a 75/25 split for under age 65 retirees. The County would provide other health plans but would only subsidize them at the same dollar amount as the subsidy to the HMO plans.
The County currently budgets $65 million per year for active employees and under age 65 retirees. The plan design changes as proposed could reduce the budget by as much as $18 million per year. These savings could then put used as part of the payment to the ARC.

There was discussion around the cost sharing split for retirees and what is a workable plan. There was discussion around keeping the HMO split for active employees at 90/10 and what savings may still be realized by capping the subsidy to other plans at the same dollar amount.

There was discussion around incorporating and active wellness program and the impact it could have on “bending the trend” of rising health care costs. There was discussion on providing incentives to employees to participate in a wellness program and or having higher premiums or co-pays for those employees who do not participate. The final report should include a statement on including a comprehensive wellness program.

There was discussion on plan design changes and the savings to the ARC and the OPEB liability. There was discussion on the various cost savings elements and what would be palatable to the employee groups including a discussion on what the right level of benefits may be and whether or not the proposed benefits are still good benefit for employees.

Mr. Hammond distributed a chart comparing retiree health care eligibility for the general County, the board of education and the community college.

The next meeting will be the final group meeting prior to completing the report. There was discussion on what items may still need to have costs savings calculated. There was discussion around costing different levels of service requirements for health care eligibility and cost sharing, keeping the split for active employees at 90/10 for the HMO and providing the same dollar subsidy to any other health plan the employee may choose, the cost savings to the OPEB liability by increasing the public safety plans to a “25 and out”, decreasing subsidies for spouses and/or dependants and requiring retirees who have access to other health care through either a new employer or spouse to use that coverage first.

Mr. Hammond will also get costs around the Medicare connector model and what level of coverage certain dollar amounts will purchase.

The next meeting will be at 1:00 p.m. on Tuesday December 20, 2011 at the Office of Personnel.

The meeting was adjourned at 3:55 p.m.

Respectfully submitted,

[Signature]

John K. Peterson
Assistant Personnel Officer
Collaborative Study Group
Minutes of December 20, 2011


Staff Present: Jessica Leys, Craig Glendenning, David Plymyer, Judi Lohn, John Peterson, Teresa Sutherland

Guests: Alex LeBlanc, AON Hewitt, Terrence Pringle, AON Hewitt, Leon Kaplan, PRM Consulting, Tom Lowman, Bolton Partners

The meeting of the Collaborative Study Group was called to order at 1:15 p.m. by Mr. Hammond.

Mr. Hammond introduced Tom Lowman, Bolton Partners who will be able to speak to the detail behind the pricing studies to be discussed today.

Mr. Hammond thanked both Bolton Partners and AON Hewitt for such quick turn around on providing cost studies and pricing information.

Mr. Hammond distributed a cost comparison showing the differences between the County’s current Medicare Wrap plan and a market exchange Medicare plan. The savings to the individual retirees ranged from $1,300 to $3,000 and the savings to the County would be approximately $3,067 per retiree or around $3.4 million annually. These savings assume that the County would provide each over age 65 retiree with $250 per month in a Health Savings Account (HSA) to purchase a Medicare plan. There was discussion on indexing the HSA to inflation capped at a specific percentage. There was discussion around the future of the Medicare program and the Medicare prescription program and how these programs may change over the coming years.

Mr. Hammond distributed a handout showing the impact of the above changes to the Annual Required Contribution (ARC) and the Actuarially Assumed Unfunded Liability (AAUL). The handout included a copy of a transition schedule with a graduated scale for the County subsidy for retiree health starting with 20 years of County service. There was discussion regarding how the transition schedule would impact current retirees and current employees.

There was discussion around the variety of Medicare exchange plans and the different levels of coverage. The Medicare plan F is the most similar to the current Medicare wrap plan that the
County offers. There was discussion on the different types of Medicare connector models or exchanges.

There was discussion of different methods of tying the retiree health care eligibility and subsidy to years of service including a plan requiring 20 years of service to get health insurance, a plan requiring 10 years and a plan that would allow existing employee with at least five years of service to be eligible for retiree health benefits.

Mr. Hammond distributed a handout showing the present value in dollars of the County retiree health benefit for current employees as the benefit exists today and under a variety of proposed scenarios.

Mr. Hammond distributed a calculation worksheet showing the cost savings associated with a variety of plan changes. Members and staff calculated the total savings and remaining unfunded contribution by starting with the current estimated ARC of $69.1 million, subtracting the current pay go retiree health contribution of $21 million and then subtracting the savings associated with a variety of plan design changes and benefit restructuring changes. Any dollar amount left over after the savings were applied would constitute an underpayment of the ARC. There was discussion around what plan design changes or benefit restructuring had some group consensus.

There was discussion around an increased County contribution to retiree health care coming from either increased revenues or from cost savings from other parts of the current budget. There was discussion around including a recommendation in the final report to suggest an increase in the County’s contribution fund the OPEB liability.

Mr. Hammond will work on a draft of the final report to be circulated to the committee prior to the next meeting.

There will be no meeting on Tuesday December 27, 2011. The next meeting will be at 1:00 p.m. on Tuesday January 2, 2011 at the Office of Personnel.

The meeting was adjourned at 3:35 p.m.

Respectfully submitted,

John K. Peterson
Assistant Personnel Officer
Collaborative Study Group
Minutes of January 10, 2012


Staff Present: Jessica Leys, David Plymyer, Judi Lohn, John Peterson, Charlie Mannion

Guests: Alex LeBlanc, AON Hewitt, Terrence Pringle, AON Hewitt, Tom Lowman, Bolton Partners, Randy Hart, CBIZ

The meeting of the Collaborative Study Group was called to order at 1:10 p.m. by Mr. Hammond.

Mr. Hammond had sent out a draft of the final report by email to the study group members prior to the meeting. Mr. Hammond asked for a general sense of the committee’s response to the draft.

There was discussion around different areas of savings and changes to the benefit structure. There was discussion around the initial effort to find $30 million in savings and that the savings were to be fair to both the taxpayers and the employees. There was discussion around the concept of keeping the benefits in the “middle of the pack” relative to other jurisdictions. Benefit changes should be taken in to consideration as part of total compensation to employees.

There was discussion about having an ongoing plan for addressing health care costs and wellness issues and to keep the committee in place to continually review the plans. There was discussion regarding implementing some benefit plan changes now and reviewing the results in 18 months to see how the changes have impacted the OPEB liability.

There was discussion around the Board of Educations willingness to address their OPEB liability. There was discussion about having one medical plan for both the BOE and the general County employees and what savings there may be based on economies of scale. There was discussion about a Council resolution requesting the BOE to report on their OPEB liability and what steps they are taking to address this issue. There was discussion around requiring the BOE to include in their annual report to the Council their OPEB liability and the steps they have taken to address the liability.
There was discussion around how quickly we need to resolve the liability and whether or not we need to solve the funding issue immediately or if we can make some strides today and revisit in 18 months to see what next steps may need to be taken.

There was discussion on setting long term goals and determining a sustainable benefit for future employees and retirees and determining what is a reasonable amount that the County can afford to pay for benefit costs. There was discussion on staying competitive for hiring new employees and providing competitive benefits while maintaining affordable costs for the County.

There was discussion around the unknowns surrounding health care reform and what changes may be coming in the next several years. Any long term plans should be flexible enough to change depending on new legislation or new health care regulations.

There was discussion on what recommendations within the report were agreeable to all members of the committee. There was general agreement around a number of the recommendations. Some of the recommendations will need to go through the collective bargaining process.

There was a request to add a minority opinion report to the final report. There was discussion of notable exceptions missing from the report. Randy Hart of CBiz offered recommendations including better use of data mining and analytics to determine where the health care dollars are being spent. Mr. Hart recommended moving in a systematic structured planed way and developing both a mid-term and long term strategy.

There was discussion around the development of a strong wellness program which could result in future cost savings.

There was discussion on how to structure the final report in order to reflect those areas of agreement as well as those areas of disagreement. There was discussion as to what constitutes “service” for meeting health care vesting and graduated scale eligibility, only actual County service or transferred service as well. The report will include the various options.

There was discussion as to what recommendations would require legislation and what can be done without legislation as well as a time frame for implementing any changes.

Mr. Hammond will work on revising the draft of the final report to incorporate elements of today’s discussion and will send out electronic versions on which all the members can make track changes and resubmit.

There will be no meeting on Tuesday January 17, 2012. The next meeting will be at 1:00 p.m. on Tuesday January 24, 2012 at the Office of Personnel.

The meeting was adjourned at 3:20p.m.

Respectfully submitted,

John K. Peterson
Assistant Personnel Officer
Collaborative Study Group
Minutes of January 24, 2012


Staff Present: Jessica Leys, David Plymyer, Judi Lohn, John Peterson, Charlie Mannion

Guests: Terrence Pringle, AON Hewitt, Leon Kaplan, PRM Consulting

The meeting was called to order at 1:10 by Mr. Hammond.

Mr. Hammond mentioned that he had circulated the final draft report by email to all of the group members. The employee groups have submitted a “minority report” that they would like included with the final report. The “minority report” shows areas of agreement with the final report as well as areas where there is some disagreement.

Mr. Hammond went over the changes made to the final draft from previous versions of the report.

There was discussion over the Board of Education and working with the Board to gain economies of scale when bidding out health care. There was discussion on the “maintenance of effort” and the difficulties in realizing savings from any changes to the Board of Education’s costs as well as the consequences for not meeting maintenance of effort. There was discussion around the Board’s willingness to work with the County government and the lack of incentive for the Board to save money on expenses.

There was discussion on Section B.3 Patient Protection and Affordable Care Act and Section B.4 Medicare Solvency.

There was a discussion on the public and private sector comparisons. There were no salary comparisons for private sector companies. Mr. Hammond will try and get some salary comparisons for the final report.

There was discussion on areas where the employee groups disagreed with the final draft report including the impact of any health care changes on the lower paid employees. There was
discussion around staying in the “middle of the pack” with regards to total compensation in comparison to surrounding jurisdictions. There was discussion around the ability to retain and recruit quality employees in order to provide the citizens of Anne Arundel County with excellent service.

There was discussion on creating a strategic plan and of extending the committee to continue to review and address changes in health care benefits. There was a suggestion to look at the changes in 12-18 months and determine if we moved too fast or not fast enough.

There was discussion around creating a health care lock box followed by a health care trust fund to secure monies associated with the savings realized as a result of the changes to the health care benefits.

There was a discussion around whether or not the County has a contractual obligation for retiree health care.

There was a discussion on strengthening the language in Section D Principles Utilized by the Committee, to include the terms “GASB” and “lock box”.

There was discussion on the timing of changes and how these changes will be implemented, legislation, negotiation, etc. There was discussion on providing the Council with the results of the negotiation process as soon as there is agreement or the various parties go to arbitration or fact finding. There was discussion of a timetable for implementing any necessary legislation including discussion of adding a calendar or projected timeline to the final report.

There was discussion on the effects of a grandfathering component for existing employees or those employees who are already vested for retirement purposes.

Mr. Hammond will make changes to the draft report incorporating the discussion and suggestions from today’s meeting and will reissue the draft final report within two weeks.

There was discussion on how the final report will be presented to the County Council. The committee will present the report to the County Council at a March work session.

There will be no meeting next week. The next meeting will be at 1:00 p.m. on Tuesday February 7, 2012 at the Office of Personnel.

The meeting adjourned at 3:40 p.m.

Respectfully submitted,

John K. Peterson
Assistant Personnel Officer
Collaborative Study Group
Minutes of February 7, 2012

Members Present: Council Chairman Richard Ladd, Councilman Jerry Walker, John Hammond, Andrea Fulton, Craig Oldershaw, R. Michael Akers, E. Jean Tinsley

Staff Present: Jessica Leys, John Peterson, Charlie Mannion

Guests: Alex LeBlanc, AON Hewitt, Terrence Pringle, AON Hewitt, Leon Kaplan, PRM Consulting

The meeting of the Collaborative Study Group was called to order at 1:15 p.m. by Mr. Hammond.

Mr. Hammond distributed the final draft report and went over changes from the previous versions. Mr. Hammond will still need to make some final edits to the document based on suggestions and corrections. Mr. Hammond will put together a final transmittal to go to the County Executive and County Council.

The “minority report” as submitted by the employee groups will be appended to the final report and included in the transmittal.

There was discussion on how the minority report differs from the final group report.

There were concerns by the employee groups about the pace and scope of changes being made. There was discussion about making some initial changes now and revisiting other changes in the future. Mr. Oldershaw introduced a couple of letters referencing previous health study groups that he asked be included as appendixes to the final report.

There was some discussion on grandfathering existing employees and how that impacts the cost savings.

There was discussion on the connector plan model and the cost of living indexing tied to the fixed dollar amounts paid by the County for over age 65 retirees. There was discussion on how we can move forward planning for the connector model while still making changes and “tweaking” the design around the model.
Mr. Hammond distributed a suggested timetable for implementation of the various recommendations in the report.

There was discussion around issuing a statement to the press regarding the work of the committee and the timing of such a statement.

There was discussion on legislating a continuing health committee to report back to the Council on a regular basis. This committee should focus strictly on health benefit issues. There was some discussion over the membership of the committee.

Mr. Hammond thanked the group for their efforts and for their open and honest discussion, he thanked AON for all of their support throughout the process and he thanked the staff support for all of their hard work.

The meeting was adjourned at 1:55 p.m.

This was the last meeting of the Collaborative Study Group.

Respectfully submitted,

[Signature]

John K. Peterson
Assistant Personnel Officer
August 9, 2006

Mark Atkisson, Personnel Officer  
Anne Arundel County Maryland  
Post Office Box 6675  
Annapolis, MD 21401

RE: 2007 Health Insurance Program

Dear Mr. Atkisson,

The Anne Arundel County Labor Coalition would like to thank the Office of Personnel for hosting the ongoing series of Health Insurance Committee meetings concerning the future direction of the Anne Arundel County Government’s health insurance program.

As you are aware, Labor has historically been a responsive partner to the County Government in helping to control the cost increase of health care. For example, the introduction of the Triple Choice health plan and mandatory mail order for prescription drugs have helped to limit cost increases for health care over the last three years. During the same time period, increases to the employee share of premiums for the Triple Choice health plan have risen from 3% to 20% of total premium for some employees. In total, we estimate that the County has saved almost $3 million dollars from increases to the employees’ share of health care premiums for the entire program over the last three years.

At this point in time, it is the Labor Coalition’s position that there should be no changes to the current employee cost sharing (percentage splits) for health insurance premiums and that no changes to the benefit plan designs be made for the plan year beginning 1/1/2007.

The ongoing Health Insurance Committee meetings have brought to the surface questions concerning the overall management of the health insurance program. It is the Labor Coalition’s belief that more attention needs to be focused on vendor management to ensure that the program is operating in a highly efficient and cost effective manner before any further changes are implemented.

A few examples of our concerns surrounding the health insurance program are as follows:

- The fact that the County’s health insurance benefits program has not undertaken a formal RFP (excluding Piggybacking) evaluation since 1994 is troubling to us. A well conducted RFP process would reveal the most capable and cost effective vendors for the County to partner with in accordance with the Five Principles surrounding the health insurance program.

- Further investigation into and a more thorough accounting of the potential savings to be gained by combining the respective County Government and Board of Education health insurance benefit programs should be pursued.
• The elimination of the CareFirst MPOS provider network in favor of the CareFirst BlueChoice provider network may be premature without a compete study of this proposed change. We are still awaiting the results of a disruption analysis comparing the two networks. In addition, we question the cost savings cited by CareFirst for this proposed change and recommend that the County get assurances of these savings from CareFirst in the form of a guarantee.

• We are intrigued by the potential benefits of consumerism based plan designs in health care. However, such a change in course from the benefit plan designs offered today would obviously require a significant investment in communication and education that could not possibly be completed between now and the Open Enrollment period. Additionally, any consideration of consumerism based plan designs should include a review of the marketplace to identify best in class vendors.

• FutureHealth’s potential for effectively managing those with chronic diseases needs to be more fully supported by the County. Greater incentives and more effective communication of this program is sorely needed to improve upon the poor participation rate today in this program.

• Caremark’s running of the pharmacy benefit plan has been hampered by poor customer service, especially surrounding the mail service program, and nebulous claims of cost savings. Their current contract with the County expires and the end of 2007 and we recommend that pharmacy management be put out for competitive bidding, including consideration of a fully transparent contract.

• We just recently began receiving reporting data for the health care program from the County. A process for us to receive monthly enrollment and claims data by health plan on an ongoing basis still needs to be put into place. The receipt of this data is critical for us to conduct a comprehensive analytical study of the health care program.

With precious little time between now and the scheduled Open Enrollment, we do not see how any new plans could be fully evaluated and implemented for a 1/1/2007 start date.

We look forward to continuing our efforts with the County in working towards the goal of the high quality, cost effective health insurance benefits program.

Sincerely,

O’Brien Atkinson, Chairman
Anne Arundel County Labor Coalition

cc: John P. O’Connor, Assistant Personnel Officer
Anne Arundel County Council
Appendix X

February 21, 2007

Ms. Andrea Fulton, Personnel Officer
Anne Arundel County Maryland
Post Office Box 6675
Annapolis, MD 21401

RE: 2007 Health Insurance Program

Dear Ms. Fulton,

I am writing you this correspondence on behalf of the Anne Arundel County Labor Coalition, which represents each of the eleven bargaining groups that are currently involved in contract negotiations with the County. It is imperative that we have a meeting as soon as possible to address a very serious concern that will in all likelihood result in stalled negotiations with all represented employee groups.

As you may know, early last year, the Office of Personnel under Mark Atkisson called for a committee on Health Insurance Benefits to identify potential cost saving ideas including alternative healthcare plans. Mr. Atkisson encouraged the committee to research and consult on best practices. Knowing very little about the healthcare industry or practices of the Office of Personnel with regard to healthcare, we formed a Labor Coalition outside of this committee consisting of the leadership of the bargaining units that the County deals with. We retained a professional healthcare consulting firm (CBIZ) to assist us and ultimately assist the County in reaching its goal of more affordable healthcare.

The attached correspondence was presented to the Office of Personnel regarding our position following numerous meetings with our prospective groups. This was rapidly becoming a collaborative effort to reduce the County's exposure to further healthcare costs and reduce the effect that these costs were having on County employees.

It was our understanding that we had come to agreement on these issues. Shifting cost shares once again is not the solution to our healthcare crisis. In spite of our agreement, your representatives are introducing further cost share-shifting proposals to our individual groups in negotiations and we have to, at very least, meet to clarify our relationship with regard to healthcare concerns.

Please call me at your earliest convenience to set up a meeting.

Sincerely,

O'Brien Atkinson, IV
Chairman, AACo Labor Coalition