



Health and Welfare Benefits Review

City of Memphis

June 10, 2015

 Segal Consulting

Executive Summary

Background

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Comments and Considerations

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Executive Summary

Project Objectives and Scope

- Segal Consulting was retained by the City of Memphis City Council in March 2015 to provide advice and guidance as the City evaluates its health and OPEB plans.
- Specifically, Segal was tasked with the following:
 - Conducting a review, or high-level audit, of income/expenditures of the City's Health Care Plan and Internal Service Fund ("Health Care Plan") for the last five fiscal years, including: comparing income/expenditures to projections (or budget), comparing contribution rates to projections (or budget) and identifying inconsistencies/discrepancies between budget and actual income/expenses.
 - Conducting a review, or high-level audit, of income/expenditures of the City's Other Postemployment Benefit Trust Fund ("OPEB Fund") for the last five fiscal years, including: comparing income/expenditures to projections (or budget), comparing contribution rates to projections (or budget) and identifying inconsistencies/discrepancies between budget and actual income/expenses.
 - Assisting the city in selecting 5 local public, or private, employers as part of peer group for benchmarking study.
 - Benchmarking the City's Health Care plan against the peer group, including comparing key plan features such as copays, deductibles, cost sharing, tiers, plan design and identify outliers.
 - Benchmarking the City's OPEB plan against the peer group, including comparing key plan features such as copays, deductibles, cost sharing, tiers, plan design and identify outliers.
 - Recommending plan changes or modifications to the City's Health Care and OPEB plan for consideration
 - Estimating the impact on the City's Health Care and OPEB plan of recommended plan changes or modifications.
- **Please note Segal was tasked with reviewing the Health and OPEB funds and not auditing the results. Thus, we relied on information provided by the Administration and Mercer.**

Executive Summary

Background

- Mercer presents potential cost reduction opportunities in 2012
 - Short and long-term options estimating \$15M - \$20M in annual savings
- **Virtually none of these opportunities were implemented by the City**
- If implemented, the City would likely have been in a better budget situation when the State passed Senate Bill 2079 in 2014, requiring local governments to fund the pension ARC at 100%
- As a result, in 2014, the City approved dramatic changes to its benefits program for FY 2015
 - Premiums for all current employees and retirees increased 24%, effective October 1, 2014
 - Medicare and pre-Medicare retirees (those not yet 65, but that will be Medicare eligible at 65) offered access-only coverage effective January 1, 2015
 - All employees/retirees who are eligible for Medicare Parts A&B, but fail to enroll or allow coverage to lapse, will be treated as if Parts A&B are available
 - Spouses who have health coverage offered by their employer, prior employer, or Medicare, will not be covered by the City effective January 1, 2015 (Actives delayed, effective January 1, 2016)
 - Tobacco surcharge increased from \$50/month to \$120/month per family effective January 1, 2015
- Changes to-date have focused on cost-shifting at the premium level
- **Less dramatic changes may have resulted had the City acted in 2012. However, hindsight is 20/20**

Executive Summary

Comments and Considerations

- Overall, Medical and Rx benefit levels are competitive with local peers
 - Adjusting design to align with benchmarks may reduce costs by \$5M - \$12M (\$12M would put the City at the low end of the range compared to local peers)
- Total costs (funding rates) are high compared to local peers and similar-value plans on the State Exchange
- Premiums for active employees are competitive, but are significantly higher for retirees (access-only)
- Significant Excise Tax exposure may exist
 - Current Medical/Rx funding rates are close to thresholds
 - Additional costs for FSA, clinic, etc.
 - Cannot manage exposure with premium cost shifts – access-only retiree coverage will likely still result in tax
- There are opportunities to design a more cost efficient program and reduce costs with minimal cost shifting to members

Executive Summary

Comments and Considerations (Active)

- Current premiums are higher than those for similar plans provided by local peers as well as on the State Exchange, suggesting a more cost efficient program could be designed
- Currently, the City program does not include any Consumer-Directed Healthcare (CDH) components, nor does it incent/require members to utilize wellness and health management services
 - For active and pre-Medicare Retirees
 - Implementing a CDH-based design with an accompanying account-based plan providing richer benefits to members that engage in required healthy activities, may result in savings of \$5M-\$10M annually without significant cost shifting to members who complete those activities
 - Explore longer-term opportunities with CIGNA and CVS/Caremark to utilize value-based initiatives with provider payments

Financial Impact: \$5M-\$10M in annual savings

Executive Summary

Comments and Considerations (OPEB)

- Require all retirees to purchase Part B
 - Monthly savings of \$300+ pmpm
 - Part B eligibility not tied to Part A eligibility or status
 - Not eligible for Part D (RDS, EGWP, PDP, etc)
 - City can pay premium and/or late enrollment penalty directly to CMS

- Implement Medicare Advantage-PPO option (MA-PPO) (same provider access as current MA)
 - Requires RFP since CIGNA does not support MA-PPOs
 - Offer two options on par with active plans
 - Set City subsidy at 50% of lower cost option
 - Anticipated premiums of \$175-\$225/month
 - May continue to offer MA-HMO and MedSupp options, but not critical to strategy
 - Offer “Part B only” MA options
 - Can price separately for these retirees or blend premiums with full Medicare MAs

- Introduce service-based subsidy (tops out at 50% of lower cost MA)
 - Consider GF/go forward approach

Financial Impact: \$10M-\$12M in annual savings

Executive Summary

Comments and Considerations

- Streamline dental to two options and introduce more price competitive DHMO option (remains voluntary)
- Streamline vision to single option (remains voluntary)
- Conduct detailed assessment of Excise Tax exposure
- Develop and implement formal reserving policy, such as
 - Define target range of 10%-15% of annual claims and adjust funding rates accordingly if outside of range
 - Funds the IBNR liability while providing solvency protection and cash flow flexibility
- Review eligibility data to reduce inconsistencies
 - Multiple instances where rates don't match current published rates
- Explore centralized data warehousing and reporting
 - Measure and track risk using single methodology
 - Data mining to monitor utilization and assess trends



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Background

- Mercer presents potential cost reduction opportunities in 2012
 - Virtually no response from the City
- City provides savings targets to Mercer in 2013 (maintain 2014 costs)
- April 2014, State passed Senate Bill 2079 requiring local government pension plans to fund 100% of the actuarially determined contribution (ADC - formerly known as the ARC)
 - No contribution requirement for retiree health/OPEB, but puts pressure on allocation of total retirement costs
- City decides that significant benefit cost reductions are necessary
- City approves dramatic changes to benefits program
 - 24% increase in active and retiree premiums
 - Reduction in City's subsidy towards retiree coverage
 - Tobacco and spouse surcharges increased
 - Retiree spouses carved-out

Background

Our Approach

- Request and review information from City
 - Claims
 - Budgets, funding, and projections
 - Benefit changes considered and approved by Council
 - Including supporting analyses
- Collect benchmark data and compare with City benefits
 - Local peers: Shelby County, State of Tennessee, Shelby County Schools, MATA
 - FedEx declined to participate
 - National comparators: South, Public Sector, Employers with 5,000-9,999 employees
- Review Mercer projections and estimated impact of changes
- Provide comments and observations
 - Based on information received – additional information may change comments
- Suggestions and considerations for 2016 and beyond



Background

Mercer's 2012 Considerations

In May 2012, Mercer presents cost savings opportunities for potential combined annual savings of approximately \$15M - \$20M:

Option	Possible Start Date	Potential Annual Savings
2013		
Require eligible retirees to enroll in Medicare	1/1/2013	\$2.0-\$3.2M
Medicare Employer Group Waiver Plan (EGWP)	1/1/2013	\$0.6-\$1.0M
Pharmacy Benefit Considerations	1/1/2013	\$150,000
Dependent Eligibility Audit	1/1/2013	\$1.0M
Medical/Rx Audit	1/1/2013	\$0-\$0.5M
2014		
70%/30% cost share for City/members	1/1/2014	\$5.3M
Advanced program strategies (Consumerism, Value-based benefits, etc)	1/1/2014	\$6.6M

Virtually none of these options were acted upon

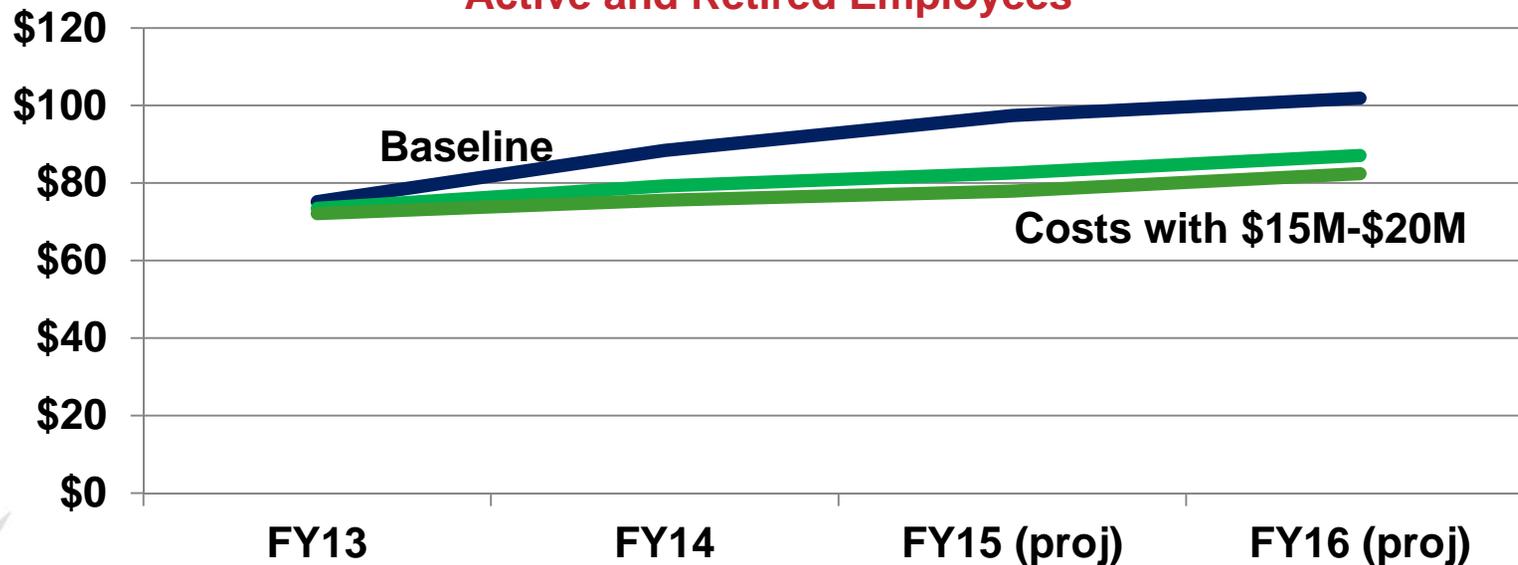
Background

Mercer's 2012 Considerations

The following shows the potential, but unrealized, impact of Mercer's 2012 considerations:

- The City's FY16 active and retired medical cost would have been about \$80M - \$85M (compared to ~\$100M currently) if the 2012 options were acted upon
- The changes proposed would have lowered the medical trend from FY13 to about 3.0% per annum compared to the current ~9.0% trend

ANNUAL NET CITY BENEFIT COSTS **Active and Retired Employees**



Baseline is projection of costs if 2012 program design was still in effect.

Sources: FY13 and FY14 Healthcare Fund Financials and Mercer projections and analysis

Background

2013 Savings Targets

- Opportunities identified by Mercer were (largely) not acted upon
 - In the Fall of 2013, Mercer was asked for additional ideas. Specific savings targets of \$6M in FY15, growing to \$9M in FY20 were provided to Mercer

Option	Potential Annual Savings
Medicare retirees pay full cost (phase in by 2020)	Grows to \$30M+
Tobacco Surcharge	\$1.6M
Spousal Carve-out	\$6.5M
Adjust Plan Design to match Benchmark PPO	\$6.6M
Full Replacement Consumer Directed Health Plan(s)	\$17.6M
Increase contributions for actives and pre-Medicare Retirees	Varies
Employer Group Waiver Plan	\$0.6-\$1.0M
Change Medicare COB to Carve-out approach	Varies
Utilize State Exchange for pre-Medicare Retirees	Varies
Change to July 1 Plan Year	More immediate impact

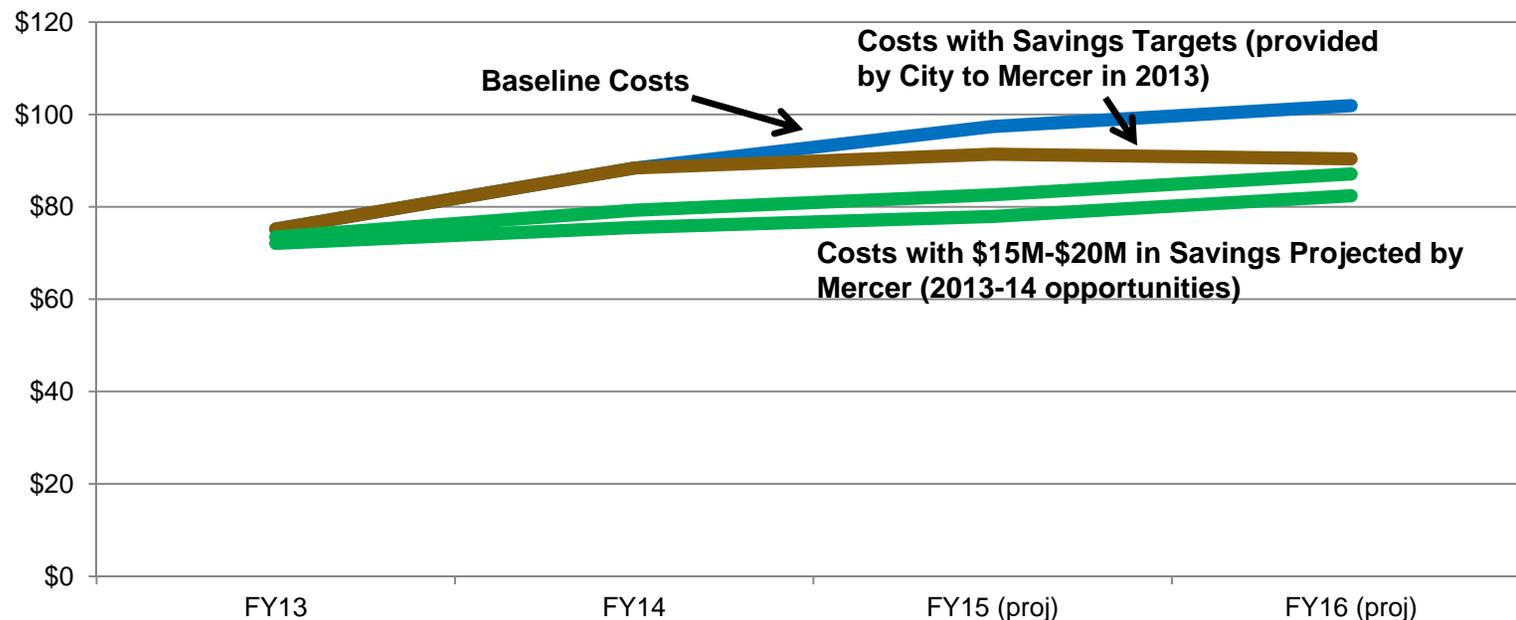
Background

2013 Savings Targets

- The following shows the impact of Mercer's 2013 considerations:
- The 2013 considerations provided savings that approach Mercer's 2012 considerations
- However, the 2013 considerations were more draconian than those proposed in 2012 even though the FY16 savings are about the same

ANNUAL NET CITY BENEFIT COSTS - ACTIVE AND RETIRED EMPLOYEES

\$ millions



Baseline is projection of costs if 2012 program design was still in effect.

Sources: FY13 and FY14 Healthcare Fund Financials and Mercer projections and analysis

Background

Initial Changes for FY15 Budget

- The City adopts the following changes as part of the FY15 budget, on June 17, 2014 (projected to exceed savings target):
- Insurance premiums for all current employees and retirees increased 24%, effective October 1, 2014
- Medicare and pre-Medicare retirees (those not yet 65, but that will be Medicare eligible at 65) offered access-only coverage, effective January 1, 2015
 - \$23M in savings put towards the pension obligation
- 1,100 post-65 retirees without Medicare A&B remain on the City's plan
 - 13 (pre-65) surviving spouses and children of employees killed in the line of duty will also remain on the City's plan
- Spouses who have health coverage offered by their employer, prior employer, or Medicare, will not be covered by the City, effective January 1, 2015
- Tobacco surcharge increased from \$50/month to \$120/month per family, effective January 1, 2015

Background

Changes for 2015

- Benefits and contributions as shown in Open Enrollment materials are slightly different:
- Working spouses of active employees are charged \$100 monthly surcharge (not carved-out)
 - Spouses of retirees with other coverage available are carved out
- Tobacco surcharge is \$120/month, but is referred to as “nicotine surcharge”
- Retiree coverage:
 - Pre-Medicare:
 - 70% City subsidy for Basic and Premier plans - available only to those who have no other coverage options via retiree’s or spouse’s employer
 - Access-only (100% retiree paid), for those who have other coverage options available, but choose to enroll in the City plans (Basic & Premier)
 - Age 65+ with Parts A/B:
 - City pays 25% of Medicare Advantage and Medicare Supplement options – includes pharmacy benefits (insured EGWP)
 - Access-only (100% retiree paid), for those who choose to enroll in the City plans
 - Age 65+ without Parts A/B:
 - 70% City subsidy for Basic and Premier plans

Background

Proposed Changes for FY16 Budget

Changes included in proposed FY16 budget (May 12, 2015):

- No increase to healthcare premiums in FY16
- Spousal carve-out extended to actives (\$100 surcharge currently)
 - Retirees currently have carve-out
- Pre65 Non-Medicare retirees: phase-out 70% City subsidy and convert to access-only coverage on January 1, 2016
- Post65 Medicare Retirees:
 - Continue 25% City subsidy, if participating in Medicare Advantage, Medicare Supplement, and/or Part D Rx plans
 - Access-only (pay 100% premium), if participating in the City plans
- Post65 Non-Medicare Retirees: continue 70% City subsidy
 - Includes certain grandfathered members and surviving spouses/children

City projects \$10.7M financial impact Jan 1- Jun 30, 2016

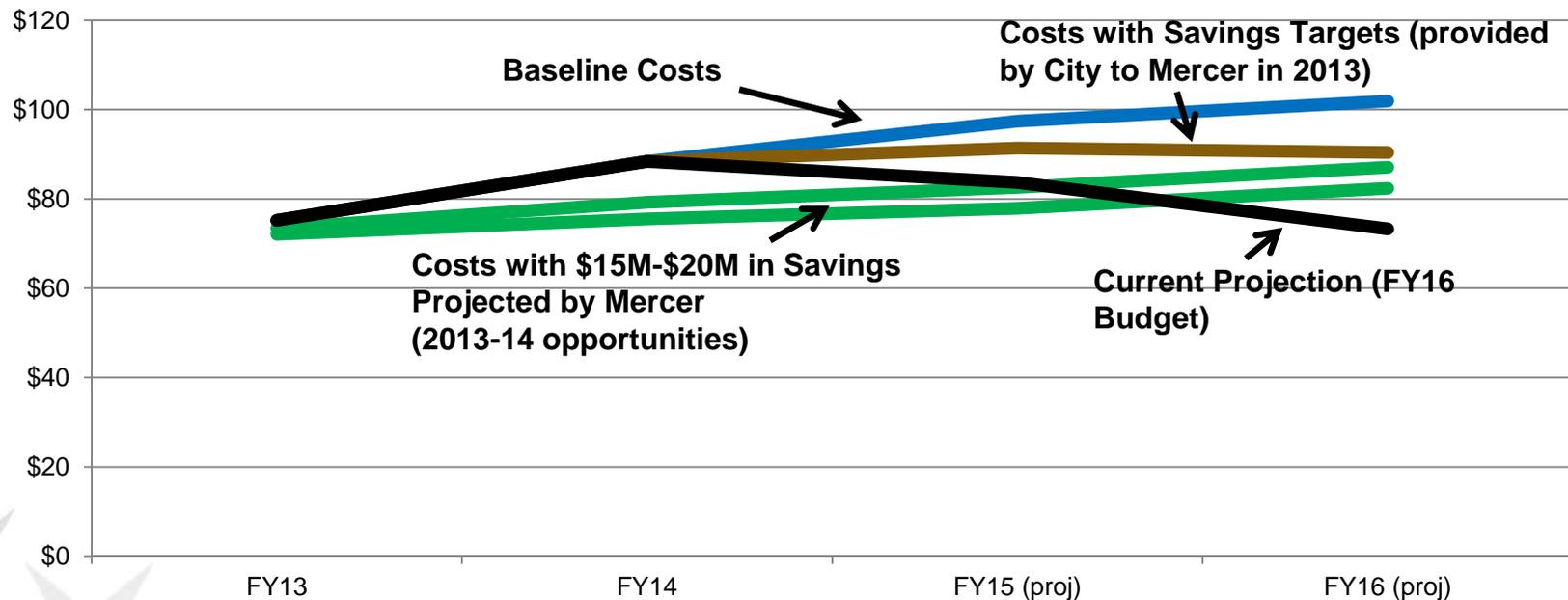
Background

Where We Are Today

For FY16, the City has proposed changes more far reaching than offered for consideration by Mercer, as shown below:

- The FY16 proposed changes actually decrease the cost significantly below the options proposed in 2012 and 2013
- The primary driver of the savings, above the 2012 and 2013 considerations, is the elimination of OPEB coverage which is projected to save \$8M - \$10M in FY16

ANNUAL NET CITY BENEFIT COSTS - ACTIVE AND RETIRED EMPLOYEES \$ millions



Baseline is projection of costs if 2012 program design was still in effect.



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Financial Review

- Segal reviewed a wealth of financial information: budget materials, rate sheets, eligibility data, claims and enrollment data, projections from Mercer, etc
 - Developed our own projections and reviewed cost impact of suggested changes
 - No significant issues to report
- Separate funds for active and retiree benefits
- OPEB Funded on a Pay As You Go (PAYG) basis
 - Separate OPEB Fund, but not anticipated to accumulate significant assets
- Employer and Employee actual funding consistent with full funding rates/premiums
- Transfers to OPEB trust as needed from active trust
- No formal reserving policy is evident
 - City provides additional funding to both Funds as needed – to be expected with a self-insured program
 - City contributed additional \$4.2M in FY14

Financial Review

- City does not purchase Stop-Loss insurance to protect against potentially catastrophic events
 - Many groups of similar size purchase Stop-Loss
 - 24 claimants exceeding \$250,000 in 2014 (22 in 2013)
 - Sharp recent Rx trends and continued rise in costs of specialty care
- City provides 70% subsidy for active employees on average:
 - Subsidy varies by coverage tier and plan option

	Employee Rate	Funding Rate	EE %
Basic Plan			
Single	\$200.90	\$570.00	35%
Family	\$426.50	\$1,155.00	37%
Premier Plan			
Single	\$217.96	\$642.00	34%
Family	\$440.26	\$1,476.00	30%
Value Plan			
Single	\$92.00	\$506.00	18%
Family	\$365.80	\$1,163.00	31%

- Majority of employees (3,200 of 5,700) are in Premier Plan with Family coverage, driving the overall cost share to 70%/30%

Financial Review

- Dental and Vision premiums are 3-tier
 - Single, Subscriber + 1, Family
- Medical/Rx are 2-tier
 - Single, Family
- Four-tier is not uncommon
 - Single
 - Subscriber + Spouse
 - Subscriber + Child(ren)
 - Family
- Significant losses in 2014:
 - Higher Rx costs and trend (industry wide issue)
 - “Run-on-bank” at end of year in retiree plans due to announced 2015 changes
- Eligibility file includes inconsistencies (mainly minor)
 - Retirees with spousal surcharge
 - Premiums and rates not found on rate sheets





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Benchmarking

Local Practices

- Compared Actuarial Value of City plans with local peers.
- Actuarial Value is the portion of total cost of coverage covered on average by the plan.
 - A plan with a 90% actuarial value results in the average member paying 10% of total costs via deductibles, copays, etc
- Plans on the Federal and State Health Care Marketplaces (or exchanges) use a metal level system:
 - Platinum Plans provide 90% Actuarial Value
 - Gold Plans provide 80% Actuarial Value
 - Silver Plan provide 70% Actuarial Value
- This analysis utilizes the same convention for purposes of comparison and discussion

Benchmarking

Detailed Comparison

➤ Active Plans

- The Value HMO option was designed as the “affordable” benefit option; however, the total cost of this plan is greater than other Gold-level Exchange plans
 - Higher deductible than most of the comparator group, but provides comparable out-of-pocket, office visit, and inpatient hospital benefits
 - Rx benefits are richer than comparator group – lower copays
- Basic and Premier PPO options are richer than the local and regional/national comparators
 - Greater benefits/lower out-of-pocket costs generate higher plan utilization
 - These plans have higher total costs than the local comparator groups, as well as Exchange plans of comparable value

➤ Retiree Plans

- Memphis offers more choice/plan options to retirees than any other entity in the comparator group – same PPO plans as the active population, 2 Medicare Advantage plans, 3 MedSupp plans and 4 Part D Rx plans.
- City retirees pay more for their benefits than retirees of the local comparators, largely due to the ‘access only’ offering to those employees who are eligible for benefits elsewhere
 - 2 of the 4 comparator groups, who have a service-based contribution strategy, offer ‘access only’ to those retirees in the lowest service years category
- Higher overall retiree costs bolstered by allowing post-65 retirees who do not have Medicare Part A or B, to participate in the City’s Basic and Premier PPO plans – same plans offered to active employees

➤ Savings opportunity to move to benchmark plans:

- \$5M to move to average/typical plans
- \$12M to move to plan designs at the low end of the range

Benchmarking

Local Practices

- All local peers offer wellness and health management programs
- The State utilizes advanced strategies:
 - Value-based: Lower member costs for completion of healthy activities (ParTNers for Health)
 - Access to better benefits for lower premiums
 - Introducing CDH in 2016
 - Operates on-site clinic in Nashville
- Shelby County
 - Provides incentives for wellness program participation
 - Offers CDH option
- Shelby County Public Schools
 - Offers a gym, fitness classes, and access to nutritionists
 - 2 'Family Care Center' (employee minor care clinic) locations
- MATA
 - Single high value plan offered
 - Relatively low EE/REE contributions

Benchmarking

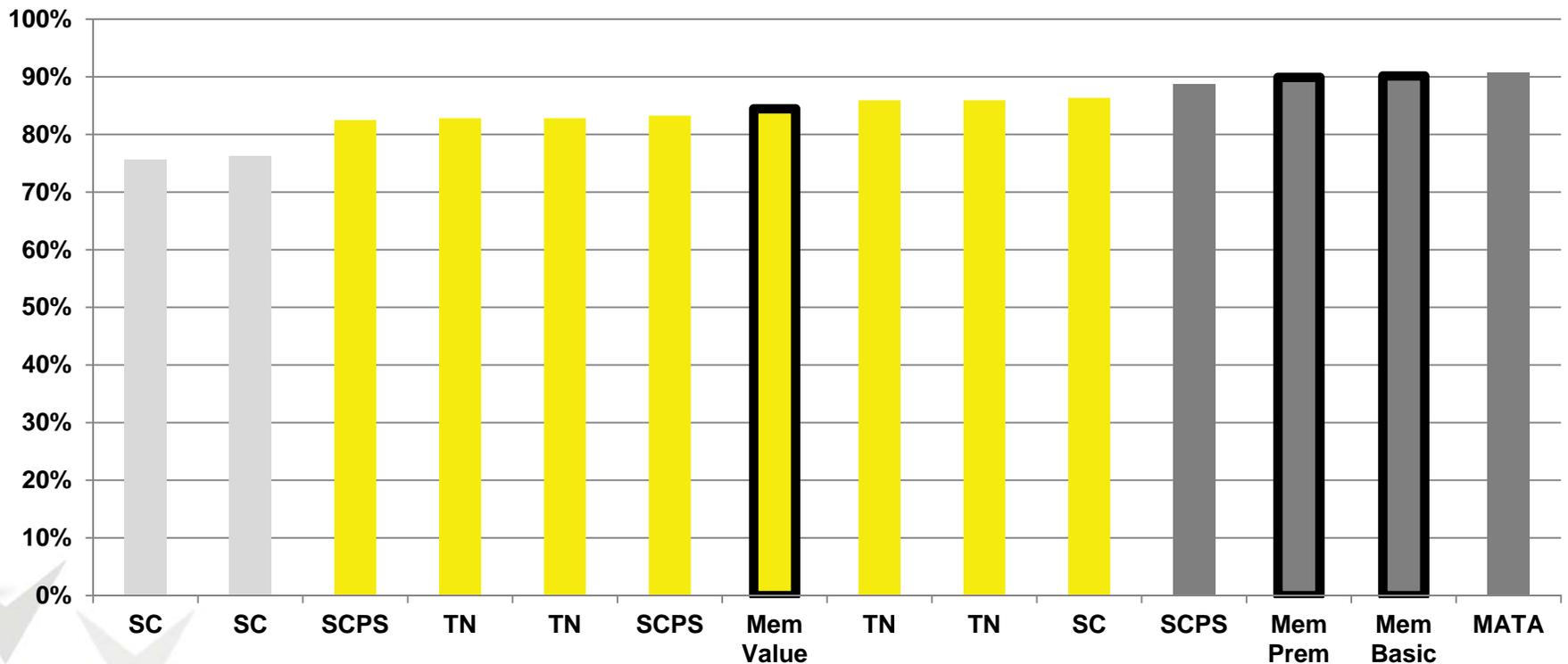
Local Comparison

The following compares the actuarial value of the City's plan's to their local peers:

- The City's Basic and Premier plans are offered to active participants and have a significantly higher actuarial value (i.e., "richer") than its peers' gold-level plans
- The City's Value plan is competitive with its peers

ACTUARIAL VALUES MEMPHIS AREA PUBLIC EMPLOYERS

SC – Shelby County
 SCPS – Shelby Co Pub Schools
 TN – State of TN
 MATA – Memphis Area Transit Authority

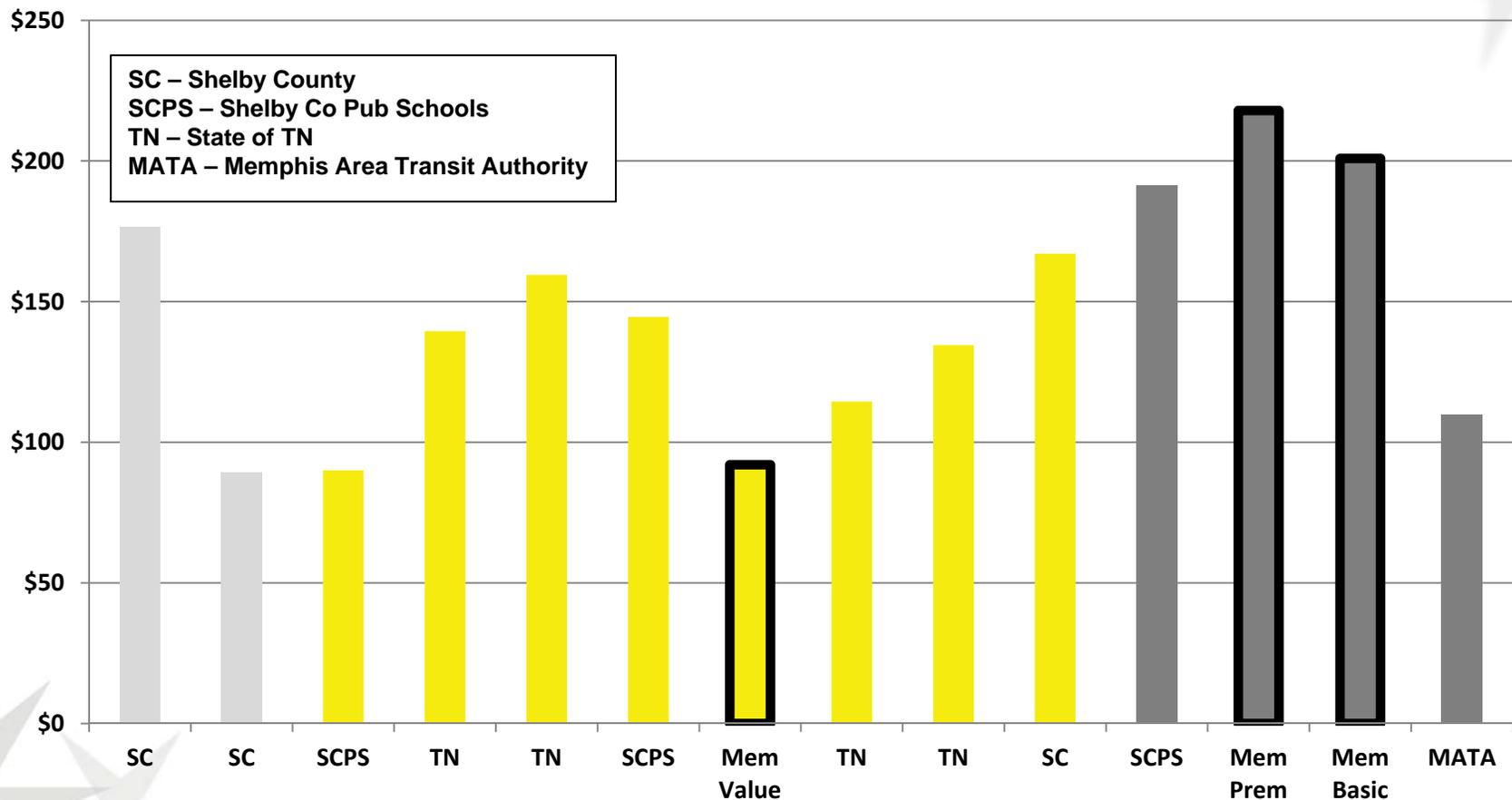


Benchmarking

Local Comparison

City employee premiums for Premier and Basic options are higher than premiums of similar value plans offered locally. Value Plan is priced competitively.

MONTHLY ACTIVE EMPLOYEE PREMIUMS (SINGLE) MEMPHIS AREA PUBLIC EMPLOYERS

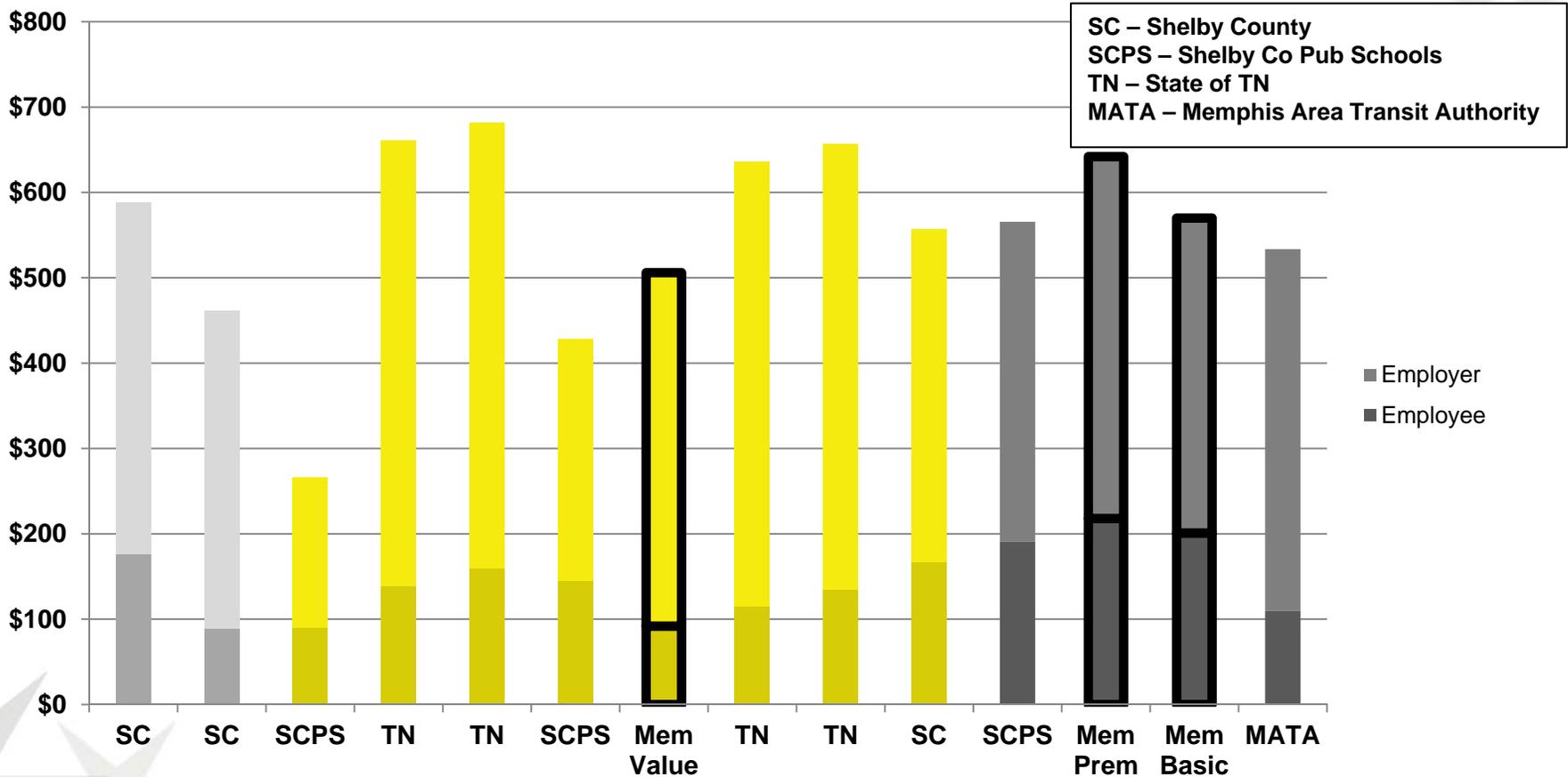


Benchmarking

Local Comparison

For Premier and Basic plan options, total premium and employee cost share is higher than for other similar plans offered locally. Value plan is competitive.

EMPLOYER & ACTIVE EMPLOYEE COST SHARE (SINGLE) MEMPHIS AREA PUBLIC EMPLOYERS

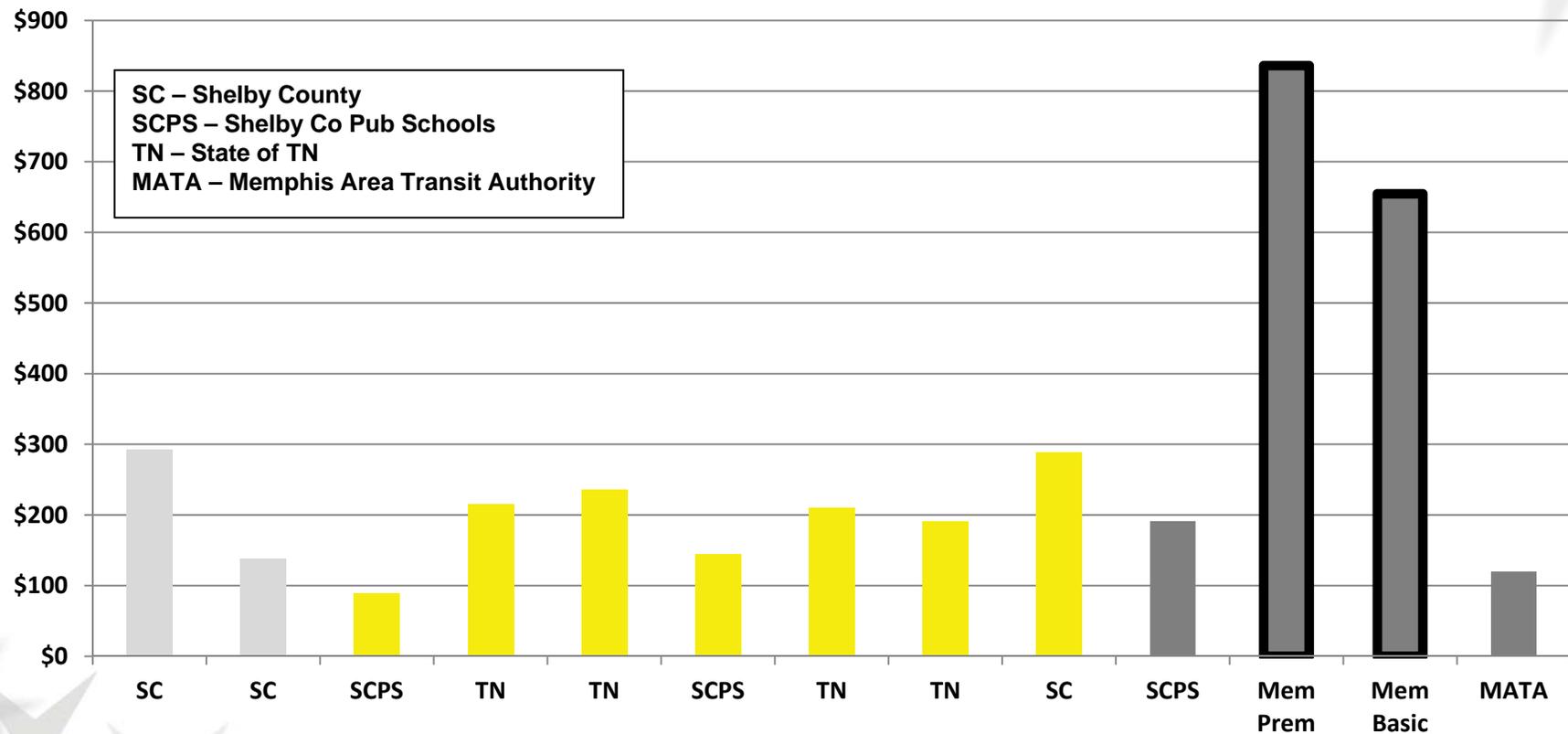


Benchmarking

Local Comparison

City retiree premiums for Premier and Basic options are significantly higher than for other plans of similar value offered locally.

MONTHLY PRE65 RETIREE PREMIUMS (SINGLE) MEMPHIS AREA PUBLIC EMPLOYERS

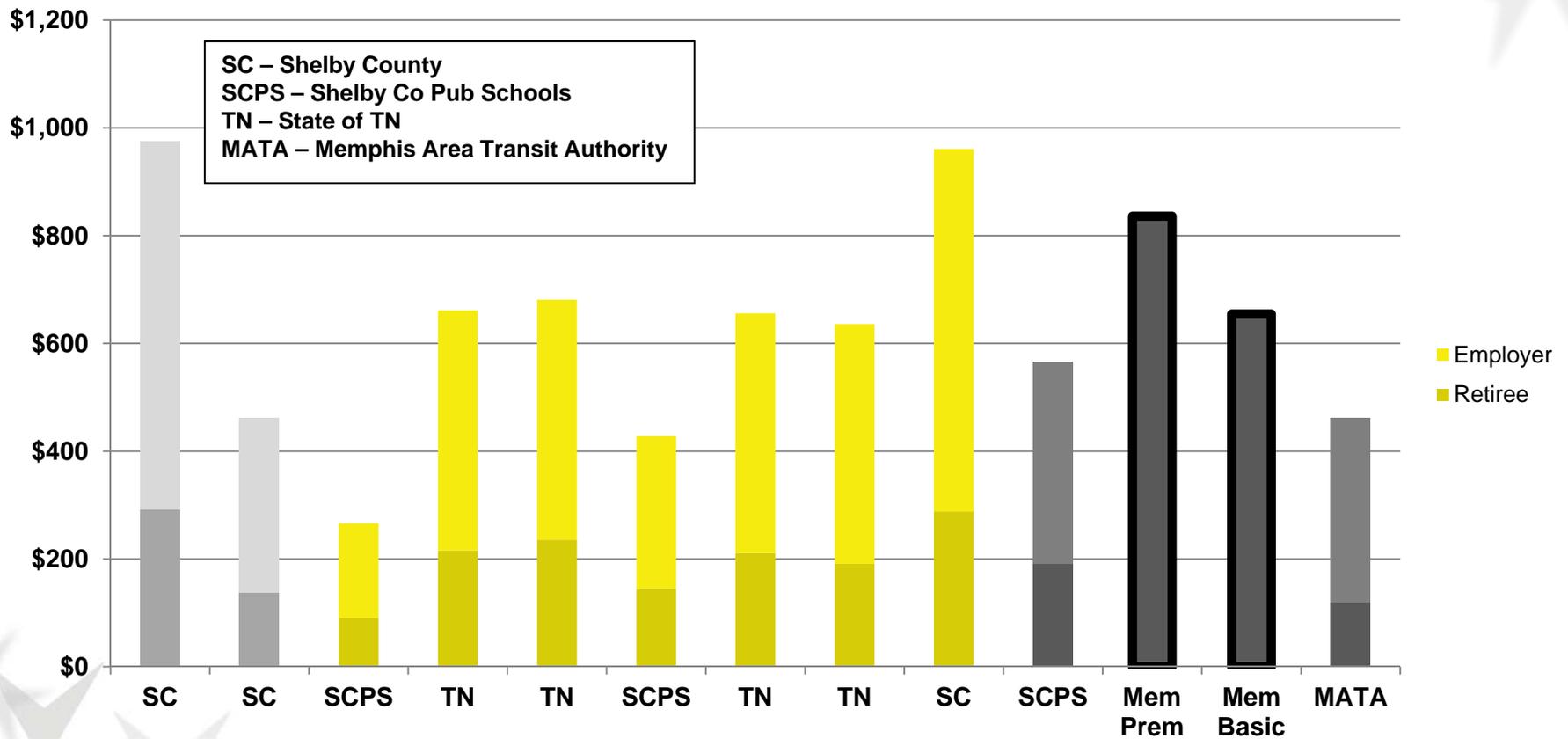


Benchmarking

Local Comparison

City Retirees are the only ones locally to pay 100% of the total cost.

EMPLOYER & RETIREE COST SHARE (SINGLE) PRE65 RETIREES



Benchmarking

Local OPEB Comparison

- Memphis offers a good variety of plan options to pre-65 and post-65 retirees, but required contribution is higher than local comparators
 - Only public employer in the Metro Memphis area to offer the active plans, 2 Medicare Advantage plans, and 3 MedSupp plans to retired employees
 - Only public employer in the Metro Memphis area to offer these plans on an “access-only” basis – requiring retirees to pay 100% of the cost, if eligible for coverage elsewhere
 - Proposing “access-only” coverage for all pre-65 retirees, effective 1/1/16
 - Retiree contributions are higher than the local comparators, even for those retiree groups with whom the City shares benefit costs

	Medicare Eligible Retiree Options									
	Medical			RX			Funding			Cost
	Active Plans	Medicare Advantage	MedSupp /COB	PDP	RDS	EGWP	Capped Subsidy	Service-Based	Access Only	REE-only Contribution Range
Memphis	X	X	X	X		X	X		X	\$152.96 - \$823.48
MATA	X		X			X				\$60.10 - \$192
Shelby County		X		X		X		X		\$36.13 - \$648.64
Shelby County Public Schools			X					X	X*	\$52.60 - \$102.60
State of TN			X				X	X	X*	\$86.68 - \$136.68

* Retirees in the lowest service range pay 100% of premium

Benchmarking

Regional/National OPEB Comparison

- When compared to published survey data from similar regional and national employers, Memphis' retiree contribution strategy does not differ significantly from national public and large employers; however, regionally, employers in the South are more likely to share retiree benefit costs
 - Only about 27% of Governments require their employees to pay for the full cost of pre-65 coverage.
 - The percentage of Medicare-eligible retirees (i.e., post-65) paying the full cost is slightly higher than pre-65 due to the availability of Medicare

Retiree Funding	Regional/National ¹		
	South	Government	5,000-9,999 EEs
Pre-Medicare Retirees			
Employer Pays All	7%	13%	7%
Cost is Shared	66%	51%	59%
Retiree Pays All	27%	36%	34%
Avg Contribution as a % of Prem	34%	26%	32%
Medicare Retirees			
Employer Pays All	16%	23%	12%
Cost is Shared	56%	30%	45%
Retiree Pays All	28%	47%	43%
Avg Contribution as a % of Prem	31%	31%	35%



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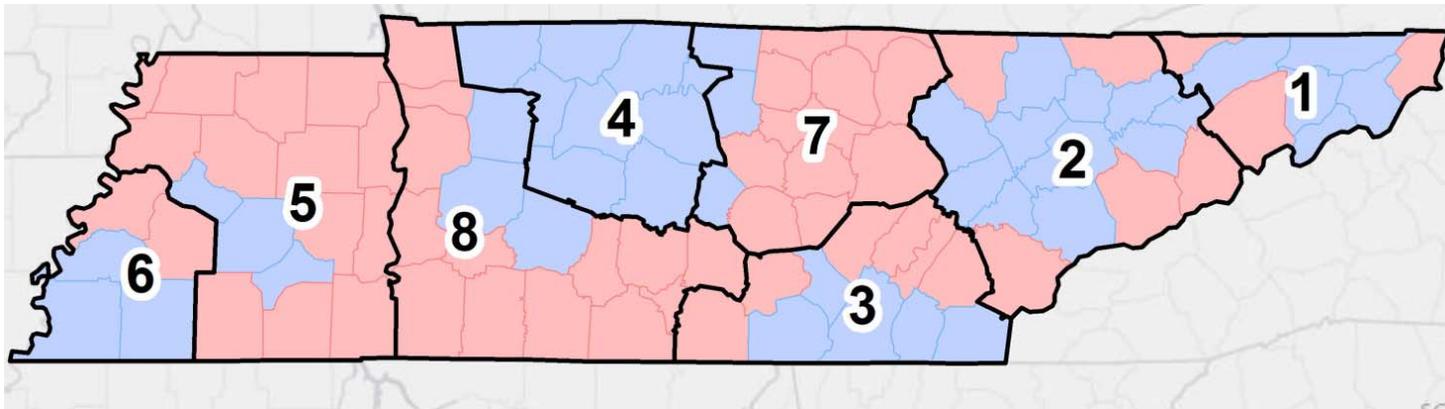
Appendix



Affordable Care Act

State Exchange

- Segal compared current City of Memphis plan premiums with premiums for comparable plans available in Shelby County on the Tennessee State Exchange
- Tennessee Exchange utilizes 8 rating areas with each rating area providing the same plan options across the area
 - Platinum Plans provide 90% Actuarial Value
 - Gold Plans provide 80% Actuarial Value
 - Silver Plan provide 70% Actuarial Value
 - Premiums vary by age, rating area and carrier
 - Rating Area 6: Shelby, Fayette, Haywood, Lauderdale, Tipton Counties



Affordable Care Act

State Exchange

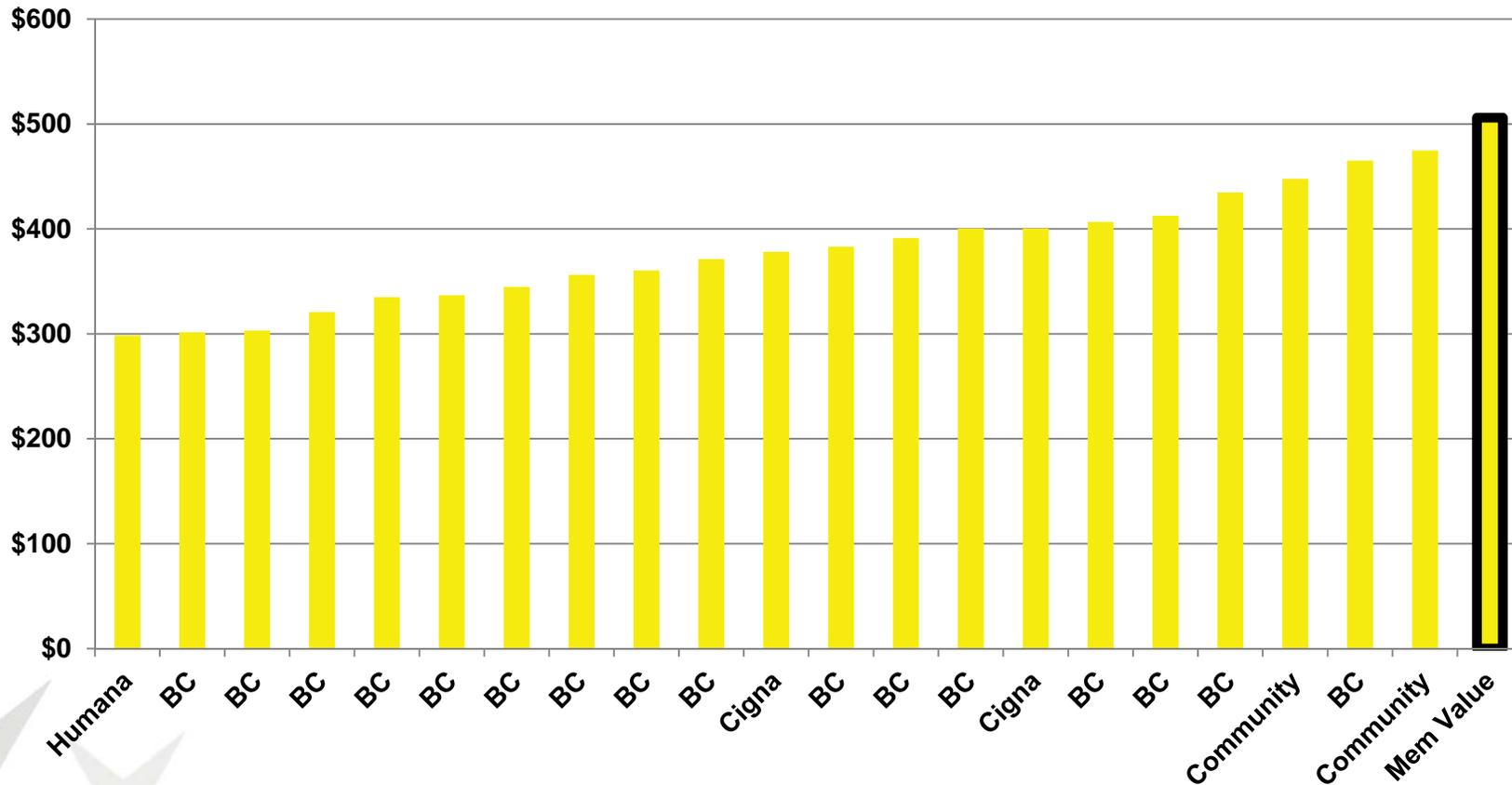
- A well-managed group program should operate more efficiently than Exchange plans. Exchange plans are individual policies:
 - Pay premium taxes and additional ACA fees not paid by self-insured group plans
 - Include costs for marketing, profit and risk
 - Richer plans (Platinum in particular) are loaded for higher selection risk
- For active employees, City total costs (EE+ER) are higher than for plans of similar value on the Exchange
- Suggests opportunity exists to introduce advanced strategies to improve efficiency and reduce the membership's health risk
 - In other words, reduce overall costs without significant cost shifting
- Some of the difference for the Value Plan is plan design
 - Actuarial value is 85% vs. 80% for Gold plans)
 - Actuarial value for Basic and Premier plans is 90%, same as for Platinum plans

Affordable Care Act

State Exchange (Active Gold Plan Comparison)

Total costs for the City's Value Plan are higher than Gold plans on the Exchange. We would expect the cost of a group plan like the City's to be significantly below private exchange individual plans

**GOLD PLANS OFFERED IN SHELBY COUNTY ON STATE EXCHANGE
MEMPHIS ACTIVE TOTAL COSTS VS. AGE 47 GOLD PREMIUMS**

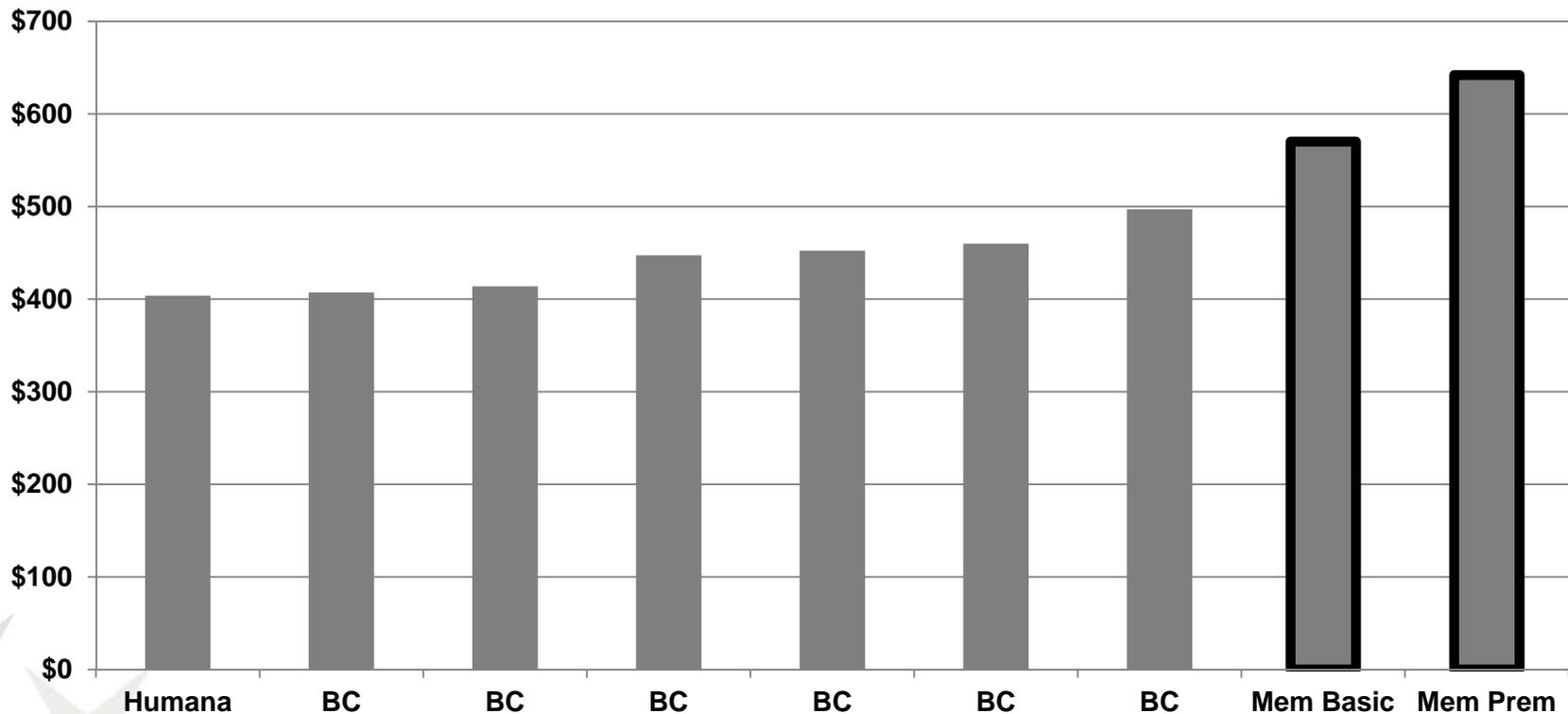


Affordable Care Act

State Exchange (Active Platinum Plan Comparison)

Total costs for the City's Basic and Premier plans are higher than Platinum plans on the Exchange. We would expect the cost of a group plan like the City's to be significantly below private exchange individual plans

PLATINUM PLANS OFFERED IN SHELBY COUNTY ON STATE EXCHANGE MEMPHIS ACTIVE TOTAL COSTS VS. AGE 47 PLATINUM PREMIUMS

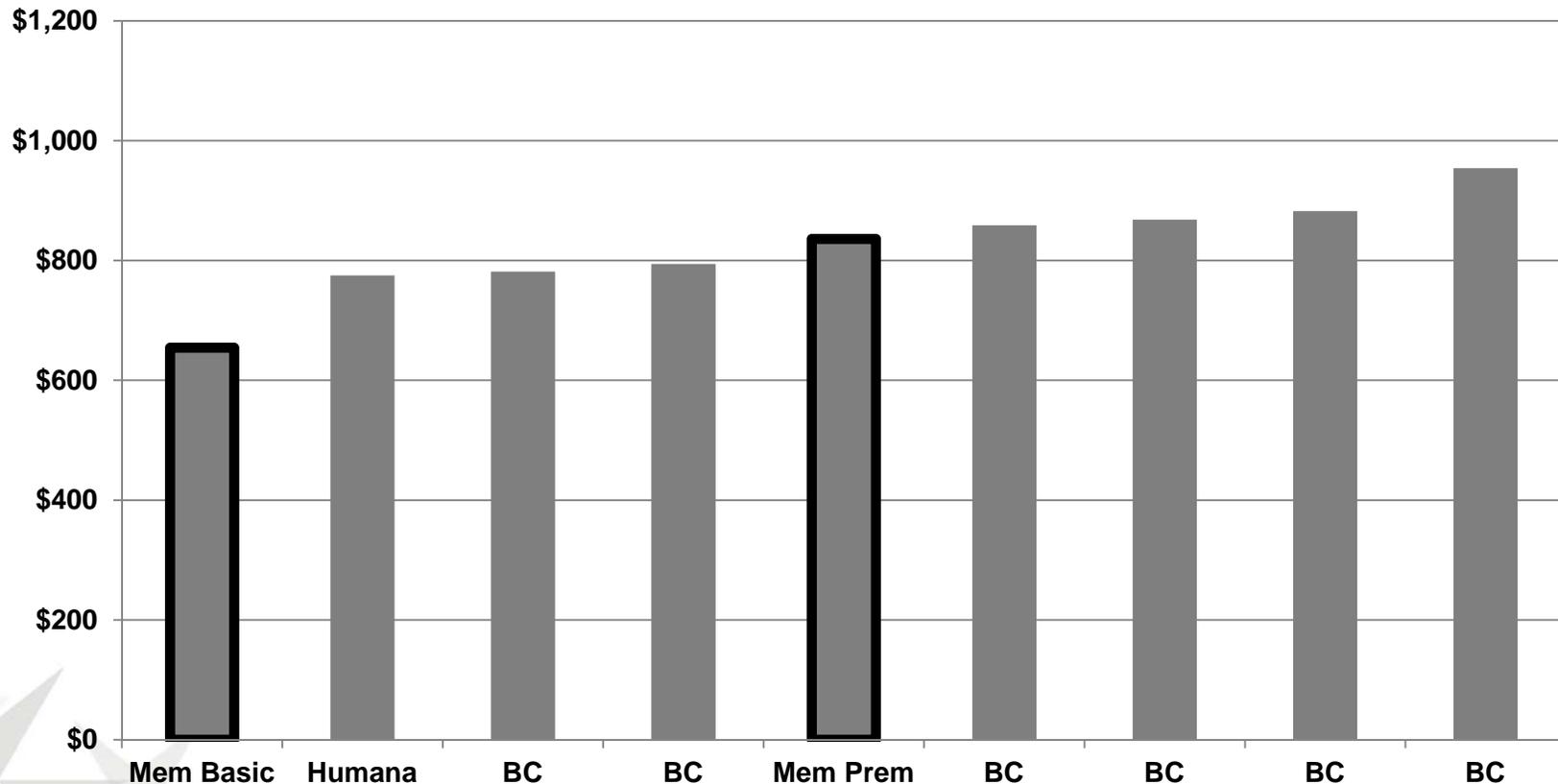


Affordable Care Act

State Exchange (Retiree Platinum Plan Comparison)

Total costs for the City's Basic and Premier plans are competitive compared to Platinum plans on the Exchange

PLATINUM PLANS OFFERED IN SHELBY COUNTY ON STATE EXCHANGE MEMPHIS RETIREE TOTAL COSTS VS. AGE 62 PLATINUM PREMIUMS



Affordable Care Act

Excise Tax

- 40% Tax, effective beginning in 2018
- Threshold **\$10,200/\$27,500** indexed to the CPI-U, not medical inflation
- Increased thresholds (**\$11,850/\$30,950**) for **retirees** and high risk professions
- Indexed at CPI-U + 1% in 2019, then CPI-U in 2020 and beyond
- Plans included under 40% Excise Tax
 - Medical / Hospitalization / Prescription drug
 - Dental and vision (unless, elected separately from the Medical)
 - Health Flexible Spending Accounts (FSAs) – includes EE contributions
 - Health Reimbursement Arrangements (HRAs)
 - Health Savings Accounts (HSAs)– includes EE contributions
 - Onsite Medical Clinic value

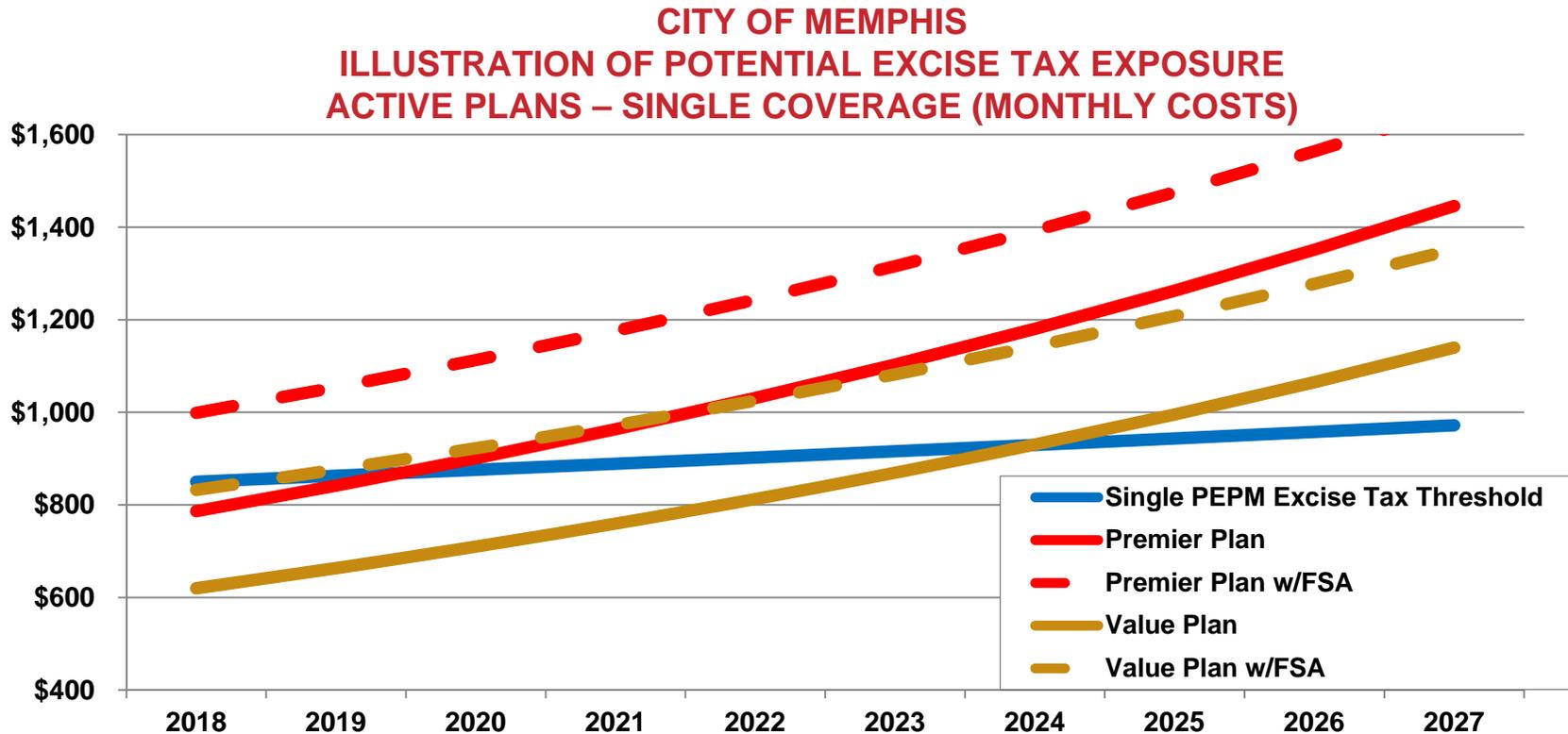


Tax is based on benefit value, regardless of how much of the premium is paid by the employee/retiree. Cannot manage exposure by shifting premium costs.

Affordable Care Act

Excise Tax (Impact and Timing — Active)

- Excise Tax presents significant potential liability
- Employees in plans with funding rate below threshold can generate tax due to FSA election
- Value plan reaches threshold in 5-7 years

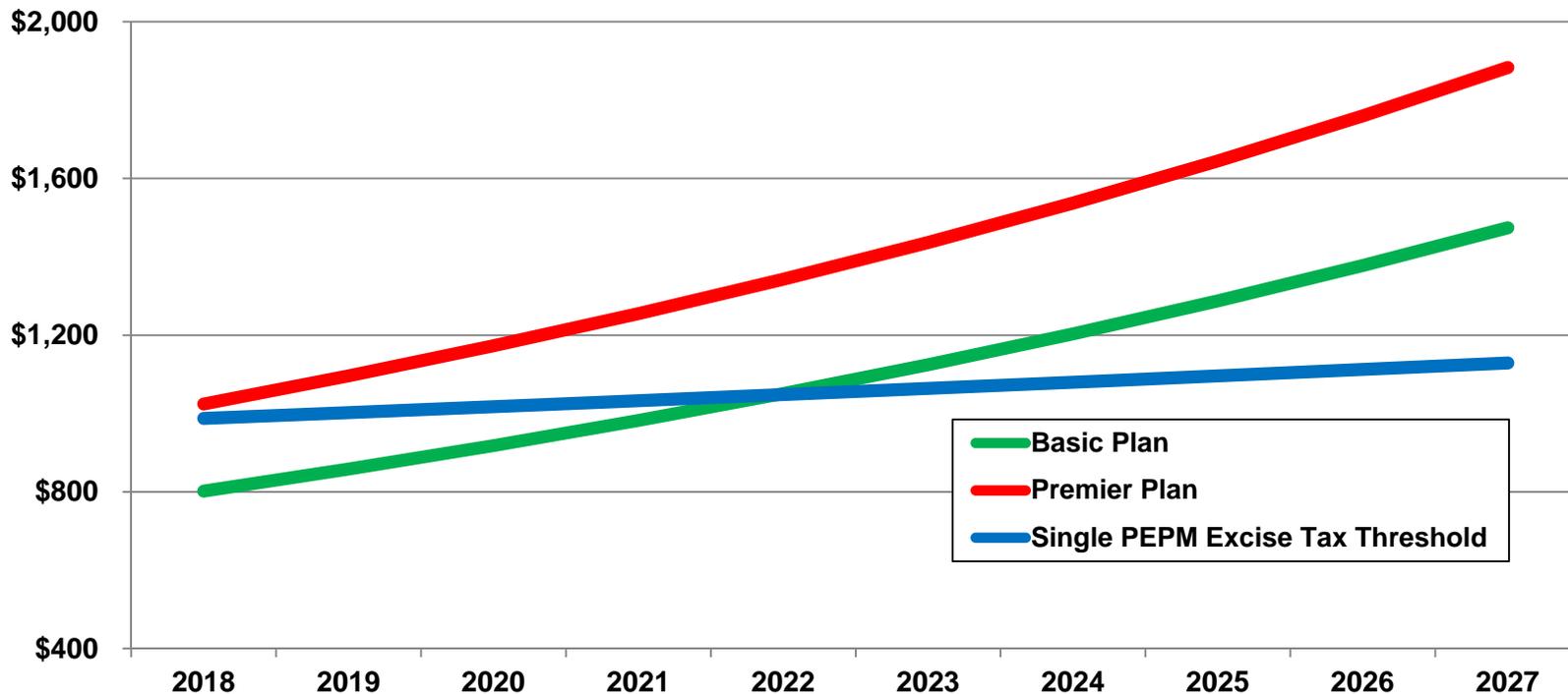


Affordable Care Act

Excise Tax (Impact and Timing — Retirees)

- Excise Tax presents significant potential liability
- Not reduced by access only approach

CITY OF MEMPHIS
ILLUSTRATION OF POTENTIAL EXCISE TAX EXPOSURE
PRE-MEDICARE RETIREE PLANS – SINGLE COVERAGE (MONTHLY COSTS)





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Comments and Considerations

Appendix



Comments and Considerations

Medical/Rx (Trends and Practices)

- Value-Based Benefit Design
- Delivery system innovations
 - Surgical Centers of Excellence
 - High performance networks
 - On-site Health Centers
- Patient-centered medical homes
- Accountable care organizations (ACO)
- Consumer-Directed Health Plans
- Reference-based pricing
- Data warehousing / mining
- Collective purchasing
- Defined contribution approaches with or without the use of private exchanges
- Physician Dispensing and Pharmacy Network Management
- Specialty Pharmaceutical Management
- Formulary Management (closed formularies)
- PBM “inflation protection”
- Telemedicine
 - Video conference consults

“Medical projections for 2015 are lower than or equal to projections for 2014 for actives and retirees under age 65”

—Segal’s 2015
Health Care Survey



Comments and Considerations

Medical/Rx

- Medical/Rx enrollment heavily favors Cigna Premier Plan
- Basic Plan provides similar benefit value, but enrollment is low
- Cost saving initiatives have focused on cost-shifting to employees/retirees
- Onsite clinic promotes cost efficient care, but additional opportunities exist to reduce program costs without cost-shifting:
 - Consumer-Directed Health Plans
 - Value-Based Benefits to promote wellness and health management
 - Explore ACO and provider value-based payment strategies with CIGNA
 - Pharmacy plan:
 - Tiered networks
 - Plan designs that further incent generic utilization and cost efficient utilization
- Not evident to Segal that claims and enrollment data is centrally housed
 - Best practice is to house medical/Rx claims, clinic encounter data and enrollment in single repository for analysis and plan management

Comments and Considerations

Medical/Rx

- Replace Value, Basic and Premier plans with two CDH options that provide Silver and Gold level benefits, respectively
- Provide account deposits as incentive to engage in wellness and health management programs
 - Require Risk Assessment, biometrics and disease management participation for those with chronic condition
 - Increased engagement should reduce trend by 1-2% annually (and compound)
 - Provide Health Reimbursement Account credit to increase plan values to Gold and Platinum, respectively
- Pharmacy – remove deductible: first dollar coverage
 - Cost share should promote efficient utilization
 - Reduce copay on generics
 - Convert brand to coinsurance (with maximums)
 - Introduce new 4th tier for specialty drugs with coinsurance (and maximum)
 - Additional clinical programs: step therapy, compound Rx management, etc
- Annual savings opportunity: \$5-10M

Comments and Considerations

Medical/Rx

Illustrative Program Comparison*

	Current City Plans			Illustrative CDH Plans	
	Basic PPO	Premier PPO	Value HMO	Standard Plan	Premium Plan
Deductible (In-network single/family)	\$350/\$1,050	\$100/\$300	\$1,500/\$3,000	\$2,500/\$5,000	\$1,250/\$2,500
Maximum OOP (In-network single/family)	\$1,500/\$3,000	\$3,000/\$7,000	\$3,000/\$6,000	\$6,600/\$13,200	\$5,000/\$10,000
Coinsurance (In/Out Network)	90%/70%	100%/60%	70%	80%/50%	90%/50%
Office Visit (In-network PCP/Specialist)	Ded + Coins.	\$20/\$40 copay	Ded + Coins.	\$30/\$60	\$20/\$40
Pharmacy					
Generic	\$10	\$10	\$10	\$10	\$5
Preferred Brand	\$20	\$20	\$20	20% (\$30 max)	20% (\$25 max)
Non-Preferred Brand	\$40	\$40	\$40	40% (\$60 max)	40% (\$50 max)
Specialty	No info	No info	No info	20% (\$120 max)	20% (\$100 max)
HRA Credit for Healthy Activity Completion (single/family)	N/A	N/A	N/A	\$750/\$1,500	\$750/\$1,500
Healthy Activities	<ul style="list-style-type: none"> > Cigna's 'MotivateMe' Wellness Program > Employee Fitness Centers > Employee Clinic 			<ul style="list-style-type: none"> > Health Risk Assessment > Biometrics > Participation in Disease Management (for diagnosed chronic condition) 	
City Subsidy	70%	70%	70%	70%	70%
Actuarial Value	85%	90%	90%	73% (81% with HRA)	82% (89% with HRA)

* Comparison of in-network benefits only – Basic, Premier, and illustrative CDH plans have out-of-network benefits, also.

Comments and Considerations

Medical/Rx

Additional Considerations

- Continue nicotine surcharge until tobacco cessation is integrated into value based strategy
- Consider 4-tier rating structure
 - Single, EE+Spouse, EE+Child(ren), Family
 - Reduce premiums for single parents
 - Higher premiums for full Family and, potentially, spouses
 - Policy decision to address equity, not a cost saving measure
- Explore centralized data warehousing and reporting
 - Measure and track risk using single methodology
 - Data mining to monitor utilization and assess trends
- Monitor State exchange for opportunities
 - Large employers can enter in 2017

Comments and Considerations

Medical/Rx

Additional Considerations

- Conduct detailed assessment of Excise Tax exposure
- Develop and implement formal reserving policy, such as
 - Define target range of 10%-15% of annual claims
 - If reserve is below 10%, then set funding rates to grow fund balance so that reserve is 10% at year end
 - If reserve is above 15%, then set funding rates to reduce fund balance so that reserve is 15% at year end
 - If reserve is within range, then set funding rates to cover expenses
 - IBNR is likely to be in the 7-10% range.
 - This sample policy funds the IBNR liability while providing solvency protection and cash flow flexibility
- Review eligibility data to reduce inconsistencies

Comments and Considerations

Medical/Rx

Longer Term Considerations

- Work with CIGNA on value-based provider reimbursement option
 - Capitation/Accountable Care Organizations
 - Tiered provider networks
 - Provider incentives, based on:
 - Generic Dispensing Rates
 - One-on-One coaching
 - Improved clinical metrics
 - CIGNA has similar programs in other cities:
 - Lower utilization rates and cost for hospitalizations, ER, urgent care
 - Higher GDR
 - Improved health risk
 - Trend rates <4%

Comments and Considerations

Medical/Rx

Longer Term Considerations

- Expand services and capabilities of clinic to support wellness and value based strategy
 - On-site health coaches
 - 340(b) pricing for Rx
 - Nutrition and lifestyle education classes
 - Review current physician referral practices to ensure referrals are to quality network providers
- Work with CVS/Caremark
 - Tiered pharmacy network options
 - Additional clinical programs
 - Aggressively manage new high cost drugs (Hep-C, PCSK-9 inhibitors, etc)

Combined savings potential 2-3% (CIGNA, CVS and clinic initiatives), or \$2M-\$4M annually, but some savings will compound

Comments and Considerations

Retirees and OPEB (Trends)

- Establish service based contributions to align OPEB benefit with (career) contribution to employer—much like pension benefits
- Establish new benefit class for new/recent hires (tighten eligibility, limit benefit choices, increase contributions)
- Mandatory MA/PDP (including Employer Group Waiver Plan (“EGWP”))
- Increase dependent contributions
- Concern over lack of funding and potential new GASB statement(s) - similar to pension?
- Exchanges:
 - Pre-Medicare retiree in State Exchanges now on wait-and-see basis
 - Carrier exchanges covering both Medicare and pre-Medicare retirees
 - Medicare Advantage Exchanges (One Exchange, Senior Solutions, etc.)
 - Lack of ability to customize plan design and to manage/monitor/negotiate premiums
 - Increased choice for retirees (varies by location)
 - Kaiser participation a question
 - Work best with a defined dollar strategy
 - Individual policies
 - Group required for national PPO
 - » Many retirees will only have Med Supp options
 - » Very limited, if any, options for disabled, Part B only and special needs

Comments and Considerations

OPEB and Retiree Health

- 1,100 retirees are over 65, without Part A and are not required to purchase Part B
 - Part B eligibility not tied to Part A eligibility or status
 - Not eligible for Part D (RDS, EGWP, PDP, etc)
 - Potential parity issues relative to those with Part A
 - Those with Part A paid Medicare taxes and must buy Part B
 - Those without Part A did not pay Medicare taxes and do not have to buy Part B
 - City can pay premium and/or late enrollment penalty directly to CMS

- Medicare Advantage Passive PPO:
 - Provides same access as MedSupp options
 - National access and uniform benefits to all retirees
 - MA options exist for retirees without Part A
 - Savings achieved from health management and Federal subsidies
 - Integrate with Rx for additional efficiencies

- Savings from both initiatives could be shared with retirees
 - Lower costs for the City and retirees

Comments and Considerations

OPEB and Retiree Health

- Require all retirees to purchase Part B
 - Monthly savings of \$300+ pmpm
- Implement MA-PPO options
 - Requires RFP since CIGNA does not support MA-PPOs
 - Offer two options on par with active plans
 - Set City subsidy at 50% of lower cost option
 - Anticipated premiums of \$175-\$225/month
 - May continue to offer MA-HMO and MedSupp options, but not critical to strategy
 - Offer “Part B only” MA options
 - Can price separately for these retirees or blend premiums with full Medicare MAs
- Introduce service based subsidy (tops out at 50% of lower cost MA)
 - Consider GF/go forward approach

Financial Impact: \$10M-\$12M in savings

Comments and Considerations

Dental

- Dental is offered as a voluntary benefit
 - More employers are offering dental on voluntary basis
- Memphis' dental plans are consistent with local, regional, and national markets
 - Annual maximums and lifetime ortho maximums are on the low end of the benchmark range
- Enrollment in Primary (DHMO) plan is low – plans with out-of-network benefits are more popular
 - Possible indicator that provider network is not adequate
- Lack of low cost option
 - Primary option premium is \$17.06/month, for single coverage
 - Should be able to offer DHMO at \$10-12/month, for single coverage

		Dental		
		Memphis		
		Primary DHMO	Basic DPPO	Premier DPPO
Dental				
Enrollment				
	Active & COBRA	288	2,452	1,039
	Retired	111	1,006	745
EE/REE Contributions				
	EE/REE Only	\$17.06	\$19.44	\$29.28
	EE/REE+1	\$33.92	\$40.00	\$60.22
	Family	\$62.76	\$58.22	\$87.62

Comments and Considerations

Dental

➤ Considerations

- Low cost DHMO option (\$10-12/month)
- More comprehensive DPPO option with ortho
- RFP may be necessary to obtain most efficient pricing

		Dental	
		DHMO	DPPO
Plan Scenarios			
<i>Deductible</i>			
	EE/REE	\$25	\$50
	Family	\$75	\$150
<i>Maximums</i>			
	Annual Maximum	\$1,000	\$1,500
	Lifetime Ortho Max	\$1,000	\$1,500
<i>Coinsurance</i>			
	Preventive	100%	100%
	Basic	Scheduled	80%
	Major	Scheduled	50%
	Orthodontia	Scheduled	50%

Comments and Considerations

Vision

- Vision is offered as a voluntary benefit
 - More employers are offering vision on voluntary basis

- Enrollment in Materials Only option is low and is not valued by employees
 - Premium difference between vision plans is \$1.20/month, for single coverage

		Vision	
		Memphis	
		Exam & Materials	Materials Only
Dental			
<i>Enrollment</i>			
	Active & COBRA	2,635	227
	Retired	1,339	114
<i>EE/REE Contributions</i>			
	EE/REE Only	\$4.60	\$3.40
	EE/REE+1	\$8.42	\$6.26
	Family	\$14.30	\$10.60

Comments and Considerations

Vision

Considerations

- Consolidate to single 'Exam and Materials' option
- RFP may be necessary to obtain most efficient pricing

		Vision
		Exam & Materials
Plan Scenario		
<i>Frequency Limitation</i>		
	Vision Exam	Once, per 12 months
	Frames & Lenses	Once, per 24 months
	Contact Lenses	Once, per 12 months
<i>Network Copays</i>		
	Vision Exam	\$15
	Frames & Lenses	\$15
<i>Network Allowances</i>		
	Frames & Lenses	\$150 Allowance
	Elective Contact Lenses	\$150 Allowance
	Medically Necessary Contact Lenses	Covered 100%
<i>Out-of-Network Allowances</i>		
	Vision Exam	\$45
	Frames & Lenses	\$40 - \$80
	Elective Contact Lenses	\$150
	Medically Necessary Contact Lenses	\$210

Questions & Discussion

★ Segal Consulting

Eric Atwater, FSA, EA, FCA, MAAA
Vice President
EAtwater@segalco.com

★ Segal Consulting

Richard Ward, FSA, FCA, MAAA
Senior Vice President
RWard@segalco.com

★ Segal Consulting

Gina Sander, FLMI
Health Consultant
GSander@segalco.com

Thank you!



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Benchmarking Detail

Active HMO

HMO					
In-Network	Memphis	Local Comparators	Regional/National ¹		
	Value HMO	Range	South	Government	5,000-9,999 EEs
Medical					
<i>Deductible</i>					
Single	\$1,500	\$0 - \$850	41% of employers require a deductible	39% of employers require a deductible	27% of employers require a deductible
Family	\$3,000	\$0 - \$2,125			
<i>Out of Pocket Maximum²</i>					
Single	\$3,000	\$1,000 - \$4,500	Not available	Not available	Not available
Family	\$6,000	\$2,000 - \$11,250	Not available	Not available	Not available
<i>Office Visits copay/coinsurance</i>					
Primary	30%	\$20 - \$35	\$20	\$20	\$20
Specialist	30%	\$30 - \$50	\$35	\$30	\$40
<i>Inpatient Hospital copay/coinsurance</i>					
Copay	\$100	\$250 - \$500	\$250	\$250	\$250
Coinsurance	30%	0% - 20%	20%	20%	20%
Prescription Drug					
<i>Retail - Copay</i>					
Generic	\$10	\$5 - \$20	\$10	\$10	\$10
Formulary/Preferred Brand	\$20	\$20 - \$100	\$30	\$25	\$30
Non-Formulary/Non-Preferred Brand	\$40	\$45 - \$120	\$50	\$45	\$50
<i>Retail - Coinsurance</i>					
Generic	N/A	0% - 20%	Not available	Not available	Not available
Formulary/Preferred Brand	N/A	0% - 30%	Not available	Not available	Not available
Non-Formulary/Non-Preferred Brand	N/A	0% - 40%	Not available	Not available	Not available
<i>Mail - Copay</i>					
Generic	\$20	\$10-\$30	\$20	\$15	\$20
Formulary/Preferred Brand	\$40	\$50-\$150	\$68	\$50	\$63
Non-Formulary/Non-Preferred Brand	\$80	\$100-\$225	\$120	\$90	\$100
<i>Mail - Coinsurance</i>					
Generic	N/A	0% - 20%	Not available	Not available	Not available
Formulary/Preferred Brand	N/A	0% - 30%	Not available	Not available	Not available
Non-Formulary/Non-Preferred Brand	N/A	0% - 40%	Not available	Not available	Not available
Actuarial Value					
	0.85	0.76 - 0.89			
Relative Value³					
	0.94	0.84 - 0.99			

¹ Mercer's National Survey of Employer-Sponsored Health Plans; 2014 Survey Tables

² In 2015, the Affordable Care Act's Out-of-Pocket Limit is \$6,600 for individual coverage and \$13,200 for family coverage.

³ This is the value of the medical and pharmacy benefits relative to the 2015 Memphis Premier PPO Plan.

Benchmarking Detail

Active PPO/POS

PPO/POS							
In-Network	Memphis		Local Comparators	Regional/National ¹			
	Basic PPO	Premier PPO	Range	South	Government	5,000-9,999 EEs	
Medical							
<i>Deductible</i>							
Single	\$350	\$100	\$450 - \$500	\$500	\$500	\$500	
Family	\$1,050	\$300	\$1,000 - \$2,000	\$1,500	\$1,000	\$1,000	
<i>Out of Pocket Maximum²</i>							
Single	\$1,500	N/A	\$2,300 - \$4,000	\$3,000	\$2,500	\$2,650	
Family	\$3,000	N/A	\$3,900 - \$12,000	\$6,000	\$5,000	\$6,000	
<i>Office Visits Copay</i>							
Primary	N/A	\$20	\$25 - \$30	\$25	\$20	\$25	
Specialist	N/A	\$40	\$35 - \$50	\$45	\$40	\$40	
<i>Office Visits Coinsurance</i>							
Primary	10%	N/A	N/A	20%	20%	20%	
Specialist	10%	N/A	N/A	20%	20%	20%	
<i>Inpatient Hospital copay/coinsurance</i>							
Copay	\$100	\$100	N/A	\$250	\$200	\$250	
Coinsurance	10%	N/A	10% - 20%	20%	20%	20%	
Prescription Drug							
<i>Retail - Copay</i>							
Generic	\$10	\$10	\$5 - \$10	\$10	\$10	\$10	
Formulary/Preferred Brand	\$20	\$20	\$20 - \$45	\$30	\$25	\$30	
Non-Formulary/Non-Preferred Brand	\$40	\$40	\$45 - \$95	\$50	\$45	\$50	
<i>Retail - Coinsurance</i>							
Generic	N/A	N/A	N/A	Not available	Not available	Not available	
Formulary/Preferred Brand	N/A	N/A	20%	Not available	Not available	Not available	
Non-Formulary/Non-Preferred Brand	N/A	N/A	30%	Not available	Not available	Not available	
<i>Mail - Copay</i>							
Generic	\$20	\$20	\$10 - \$30	\$20	\$15	\$20	
Formulary/Preferred Brand	\$40	\$40	\$60 - \$150	\$68	\$50	\$63	
Non-Formulary/Non-Preferred Brand	\$80	\$80	\$135 - \$225	\$120	\$90	\$100	
<i>Mail - Coinsurance</i>							
Generic	N/A	N/A	N/A	Not available	Not available	Not available	
Formulary/Preferred Brand	N/A	N/A	20%	Not available	Not available	Not available	
Non-Formulary/Non-Preferred Brand	N/A	N/A	30%	Not available	Not available	Not available	
Actuarial Value							
	0.90	0.90	0.83 - 0.86				
Relative Value³							
	1.00	1.00	0.92 - 0.96				

¹ Mercer's National Survey of Employer-Sponsored Health Plans; 2014 Survey Tables

² In 2015, the Affordable Care Act's Out-of-Pocket Limit is \$6,600 for individual coverage and \$13,200 for family coverage.

³ This is the value of the medical and pharmacy benefits relative to the 2015 Memphis Premier PPO Plan.

Benchmarking Detail

High Deductible Plans

HDHP/CDHP								
In-Network	Local Comparators		Regional/National ¹					
	Range		South		Government		5,000-9,999 EEs	
Medical			HRA	HSA	HRA	HSA	HRA	HSA
HSA - ER Contribution								
Single	N/A		N/A	\$540	N/A	\$500	N/A	\$500
Family	N/A		N/A	\$1,080	N/A	\$1,200	N/A	\$1,000
HRA - ER Contribution								
Single	\$500 - \$650		\$500	N/A	Not available	N/A	\$700	N/A
Family	\$1,000 - \$1,950		\$1,000	N/A	Not available	N/A	\$1,400	N/A
Deductible								
Single	\$1,500 - \$3,000		\$1,500	\$1,500	Not available	\$1,500	\$1,500	\$1,500
Family	\$3,000 - \$9,000		\$3,000	\$3,000	Not available	\$3,000	\$3,000	\$3,000
Out of Pocket Maximum²								
Single	\$2,250 - \$5,000		\$3,000	\$4,000	\$3,000	\$3,000	\$3,500	\$3,500
Family	\$5,500 - \$12,700		\$6,500	\$7,500	\$6,000	\$6,000	\$7,000	\$7,200
Office Visits Coinsurance								
Primary	10% - 20%		63% of plans require coinsurance; 12% require copay	20%	80% of plans require coinsurance; 10% require copay	20%	85% of plans require coinsurance; 12% require copay	20%
Specialist	10% - 20%			20%		20%		
Inpatient Hospital Coinsurance								
Coinsurance	10% - 20%			20%		20%		20%
Prescription Drug								
Retail - Copay								
Generic	\$8 - \$20		Not available	N/A	Not available	N/A	Not available	N/A
Formulary/Preferred Brand	\$20 - \$100		Not available	N/A	Not available	N/A	Not available	N/A
Non-Formulary/Non-Preferred Brand	\$45 - \$120		Not available	N/A	Not available	N/A	Not available	N/A
Retail - Coinsurance								
Generic	0% - 20%		42% of employers use coinsurance	20%	23% of employers use coinsurance	20%	51% of employers use coinsurance	20%
Formulary/Preferred Brand	20% - 30%			20%		20%		
Non-Formulary/Non-Preferred Brand	30% - 40%			20%		20%		
Mail - Copay								
Generic	\$24 - \$30		Not available	N/A	Not available	N/A	Not available	N/A
Formulary/Preferred Brand	\$60 - \$150		Not available	N/A	Not available	N/A	Not available	N/A
Non-Formulary/Non-Preferred Brand	\$135 - \$225		Not available	N/A	Not available	N/A	Not available	N/A
Mail - Coinsurance								
Generic	N/A		42% of employers use coinsurance	20%	23% of employers use coinsurance	20%	51% of employers use coinsurance	20%
Formulary/Preferred Brand	20%			20%		20%		
Non-Formulary/Non-Preferred Brand	30%			20%		20%		
Actuarial Value		0.76 - 0.86						
Relative Value³		0.84 - 0.96						

¹ Mercer's National Survey of Employer-Sponsored Health Plans; 2014 Survey Tables

² In 2015, the Affordable Care Act's Out-of-Pocket Limit is \$6,600 for individual coverage and \$13,200 for family coverage.

³ This is the value of the medical and pharmacy benefits relative to the 2015 Memphis Premier PPO Plan.

Benchmarking Detail

Spousal Carve-Out

	Spousal Carve-out				
	Memphis	Local Comparators	Regional/National ¹		
% of employers that . . .	Medical	Medical	South	Government	5,000-9,999 EEs
Cover spouse only if not eligible elsewhere	X	50%	No info	No info	No info
Will not cover spouse			8%	3%	6%
Require spousal surcharge	X		7%	5%	18%

¹ Mercer's National Survey of Employer-Sponsored Health Plans; 2014 Survey Tables

Benchmarking Detail

Dental Plans

Dental							
In-Network/Out-of-Network	Memphis			Local Comparators	Regional/National ¹		
	Primary DHMO	Basic DPPO	Premier DPPO	Range	South	Government	5,000-9,999 EEs
Dental							
<i>Deductible</i>							
Single	None	\$50 / \$100	\$50 / \$50	\$0 - \$50	\$50	\$50	\$50
Family	None	\$150 / \$300	\$150 / \$150	\$0 - \$150	\$150	\$150	\$150
<i>Maximums</i>							
Annual Non-Ortho Maximum	\$1,500	\$1,000 / \$750	\$1,000 / \$1,000	\$1,000 - Unlimited	\$1,500	\$1,500	\$1,500
Annual Ortho Maximum	N/A	\$500 / \$375	\$500 / \$500	\$1,000 - \$2,000	\$1,500	\$1,500	\$1,500
Lifetime Ortho Maximum	\$1,000	\$1,000 / \$750	\$1,000 / \$1,000	\$1,000 - \$2,000	\$1,500	\$1,500	\$1,500
<i>Coinsurance</i>							
Preventive	100%	100% / 80%	100% / 100%	80% - 100%	Not Available	Not Available	Not Available
Basic	\$35 - \$339	80% / 60%	80% / 80%	80%	Not Available	Not Available	Not Available
Major	\$25 - \$440	50% / 40%	50% / 50%	50% - 80%	Not Available	Not Available	Not Available
Ortho	50%	50% / 40%	50% / 50%	50% - 100%	Not Available	Not Available	Not Available

¹ Mercer's National Survey of Employer-Sponsored Health Plans; 2014 Survey Tables

Benchmarking Detail

Vision Plans

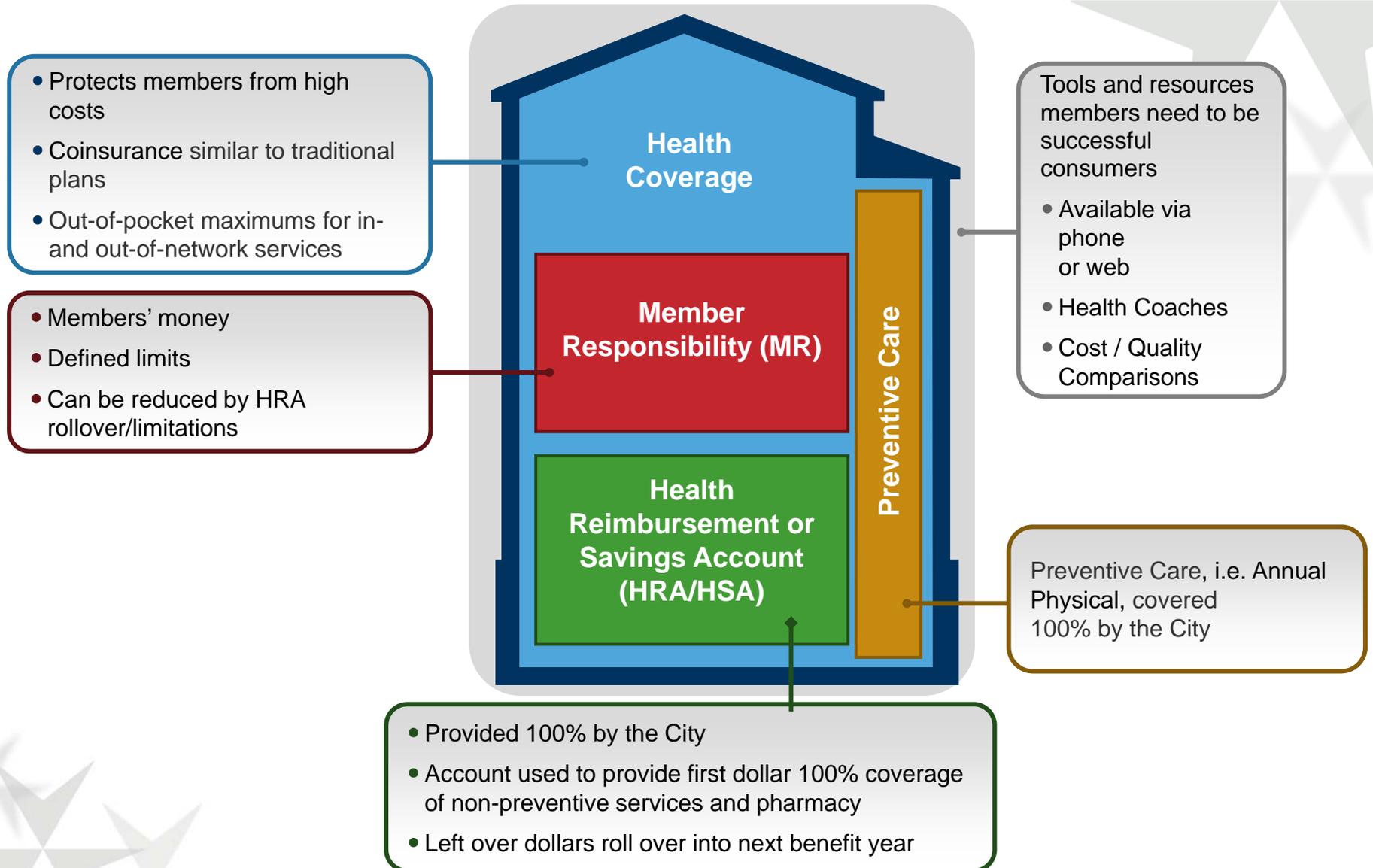
Vision				
In-Network	Memphis		Local Comparators	
	Exam & Materials	Materials Only	Range	
Vision				
<i>Frequency Limitation</i>				
	Vision Exam	Once, per 12 months	Once, per 12 months	Once, per 12-24 months
	Frames & Lenses	Once, per 24 months	Once, per 24 months	Once, per 12-24 months
	Contact Lenses	Once, per 12 months	Once, per 12 months	Once, per 12-24 months
<i>Network Copays</i>				
	Vision Exam	\$15	N/A	\$0 - \$20
	Frames & Lenses	\$15	\$15	\$0 - \$20
<i>Network Allowances</i>				
	Frames & Lenses	\$130	\$130	\$30 - \$75
	Elective Contact Lenses	\$150	\$150	\$50 - \$150
	Medically Necessary Contact Lenses	\$150	\$150	\$130 to 'Covered in full'
<i>Out-of-Network Allowances</i>				
	Vision Exam	\$45	\$45	'Not covered' to \$45
	Frames & Lenses	\$40 - \$80	\$40 - \$80	\$25 - \$80
	Elective Contact Lenses	\$150	\$150	\$50 - \$150
	Medically Necessary Contact Lenses	\$210	\$210	\$75 - \$210

Consumer Directed Healthcare

- Generally, a consumer-directed health plan is one in which the member has access to a “fund” to help cover member responsibility, such as deductibles, coinsurance, and other out-of-pocket costs
 - Two types of funds: Health Savings Accounts (HSA) and Health Reimbursement Arrangements (HRA)
- The intent is to give members access to funds that they perceive as “their own” thus motivating them to spend these funds wisely and carefully consider how they access and use the health care system, theoretically resulting in decreases in unnecessary expenditures
- Consumer-driven plans use the concept of the member having “skin in the game” to drive behavior change and reduce costs
- An effective, well-designed CDH program can reduce trend by 1 – 2% (based on market experience and reported by carriers/administrators)

Consumer Directed Healthcare

How It Works



Consumer Directed Healthcare

HSAs

➤ High Deductible Health Plan is Required

- 2016 requirements:
 - Minimum annual deductible of \$1,300/\$2,600 (single/family)
 - Maximum Out-of-Pocket Max of \$6,550/\$13,100 (single/family)
- Rx must be subject to annual deductible
- Preventive/wellness covered at 100% with no deductible

➤ HSAs

- Contributions allowed by member and the City
- Contributions are “cash” and belong to the member whether used or not
- Contributions are pre-tax and not taxed when used for covered expenses
 - Annual limits on contributions are higher for ages 55+
 - Can earn interest, also tax-free
- Covered expenses must be comprehensive—Section 213(d)
- Requires banking arrangement—can be sponsored by the City
- Account funds can be accessed by credit/debit card or checks

Consumer Directed Healthcare

HSAs

➤ Advantages

- Shared responsibility (City and member contributions)
- Member engagement
 - HSA balance is member's money
 - Med/Rx subject to deductible, followed by coinsurance

➤ Disadvantages

- City contributions to HSA are “cash” expenses
- Members with chronic conditions and/or that are on maintenance prescriptions will likely hit the “deductible gap” annually and not accrue an increasing HSA balance year over year
- Increased Excise Tax exposure

Consumer Directed Healthcare

HRAs

➤ **No requirements or restrictions on plan provisions**

- Can have lower deductible than HDHP
- Allows first dollar Rx coverage

➤ **HRA**

- No annual contribution limits
- Funded solely by City contributions
 - Not taxable to member
 - City can limit rollovers and retain unused balances by member that leave City employment
- Balances are notional — City incurs expenses only when claims are submitted against HRA balance
- Covered expenses can be more limited (i.e. not for Rx)
- HRA balance managed by TPA—no bank required

Consumer Directed Healthcare

HRAs

➤ **Advantages**

- No limitations on health plan benefits
- Improved cash flow relative to HSAs—balances are notional
- Can protect members with high cost maintenance prescriptions from deductible gap with first dollar Rx coverage
- Easier to administer than HSA—no bank
- Excise Tax exposure management since no EE contributions

➤ **Disadvantages**

- No member contributions
- Less engagement since HRA balance is not “cash”

Consumer Directed Healthcare

HSA vs. HRA

	HSA	HRA
Plan Requirements	HDHP Required	None
Member Contributions Allowed	Yes	No
Contribution Limits	Yes	No
Administrator	Bank	TPA
Account Balance Type	Cash	Notional
City Can Restrict Use Of Account Funds	No	Yes
Excise Tax Exposure	Increased	Managed

Medicare Part B Enrollment

- All eligible participants must enroll for Part B directly with the SSA (*The City cannot perform this function on behalf of their retirees*)
 - Enrollment takes place on January 1 through March 31 of each year, during the General Enrollment Period (GEP) (since retirees did not sign up for Part B when they were first eligible)
 - Retirees must contact the SSA at 1-800-772-1213
 - SSA will send Form 40-B to retirees to enroll in Part B (cannot get Form online)
 - Retiree completes Form and returns it to the SSA
 - The SSA sends the enrollment information to CMS
 - Generally, it takes 30-60 days for the SSA to process and update CMS' records of new enrollees



Medicare Part B Enrollment

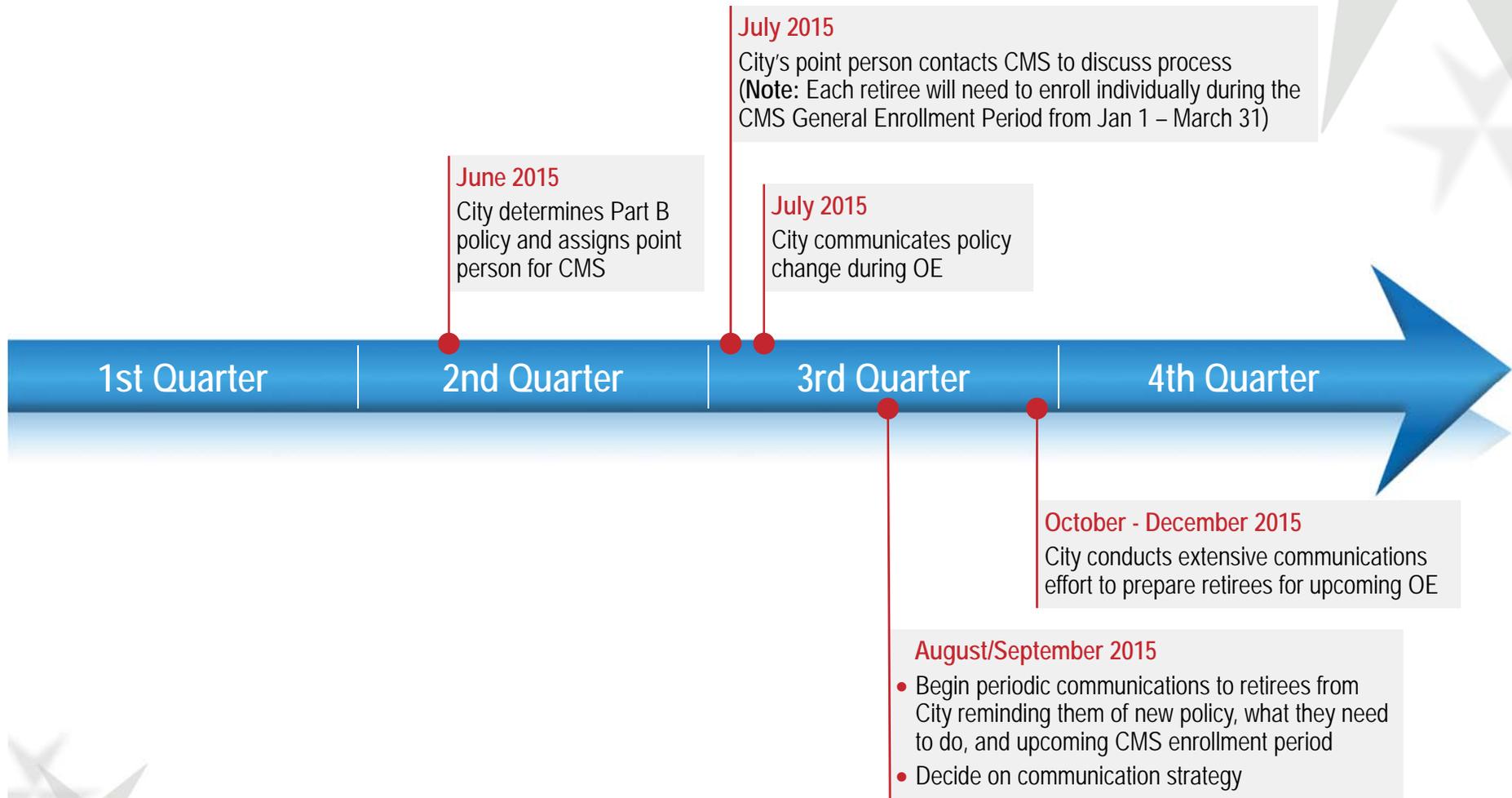
- Once CMS receives enrollment information, they apply Part B penalty to late enrollees
 - Late enrollment is defined as enrolling after the third month after 65th birthday month
 - Penalty equal to 10% of the Part B premium for each 12-month period that enrollment was delayed

Example: Mr. Smith's Initial Enrollment Period (IEP) ended September 30, 2012

 - He waited to sign up for Part B during the GEP in May 2015
 - His Part B premium penalty is 20%
 - While Mr. Smith waited a total of 30 months to sign up for Part B, this included only two full 12-month periods
- The City informs CMS what they are paying on behalf of enrollees
 - List of beneficiaries City is paying for must be received by CMS by May 1 in order for proper coordination with the SSA by July 1
 - Otherwise, a retroactive correction will be made in a later Social Security check
- CMS tells the SSA how much the City will pay on behalf of each enrollee, and the SSA will withhold the balance from the retirees' Social Security check
 - Retirees that do not receive a Social Security check sufficient to cover the balance will be invoiced directly by CMS



Medicare Part B Enrollment - 2015



Medicare Part B Enrollment - 2016

