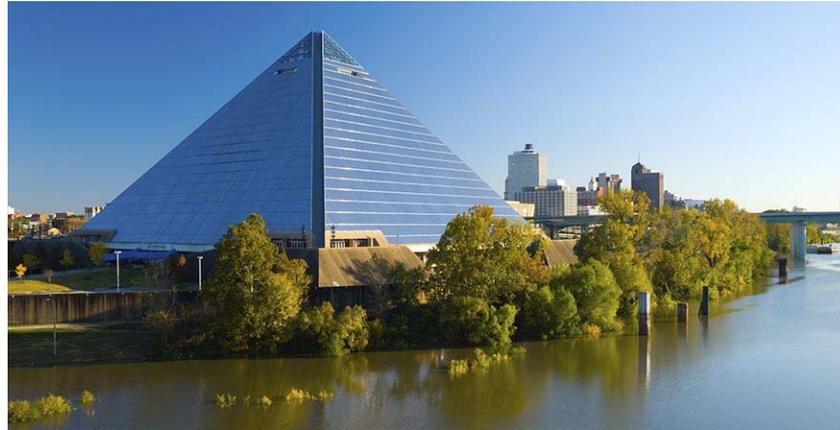


City of Memphis



HEALTH AND WELFARE BENEFITS OVERVIEW

June 10, 2015

 Segal Consulting

Project Scope

Segal Consulting was retained by the City of Memphis City Council in March 2015 to provide the following:

- 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)
 - Identifying inconsistencies/discrepancies between budget and actual income/expenses
- A review, or high-level audit, of income/expenditures of the City's Other Post-employment 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)
 - Identifying inconsistencies/discrepancies between budget and actual income/expenses
- Assistance with selecting five local public, or private, employers as part of peer group for benchmarking study
- Benchmark 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
- Benchmark 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
- Recommend plan changes or modifications to the City's Health Care and OPEB plan for consideration
- Estimate the impact on the City's Health Care and OPEB plan of recommended plan changes or modifications

Background

- In 2012, Mercer presented potential cost reduction opportunities of ~\$15M – \$20M annually
 - **Virtually none of the opportunities identified 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 100% funding of Actuarially Determined Contribution by FY19)
- 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
- **Less dramatic changes may have resulted had the City acted in 2012. However, hindsight is 20/20**

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 January 1 – June 30, 2016

Financial Review Findings

- Segal reviewed a wealth of financial information: CAFRs, 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 in replicating funding rates
- Inconsistencies in CAFR related to Health and OPEB funds; no significant impact since plan's are funded on pay-as-you-go basis
- Eligibility file includes inconsistencies (mainly minor):
 - Retirees with spousal surcharge
 - Premiums and rates not found on rate sheets
- 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
- 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

Benchmarking

Overview

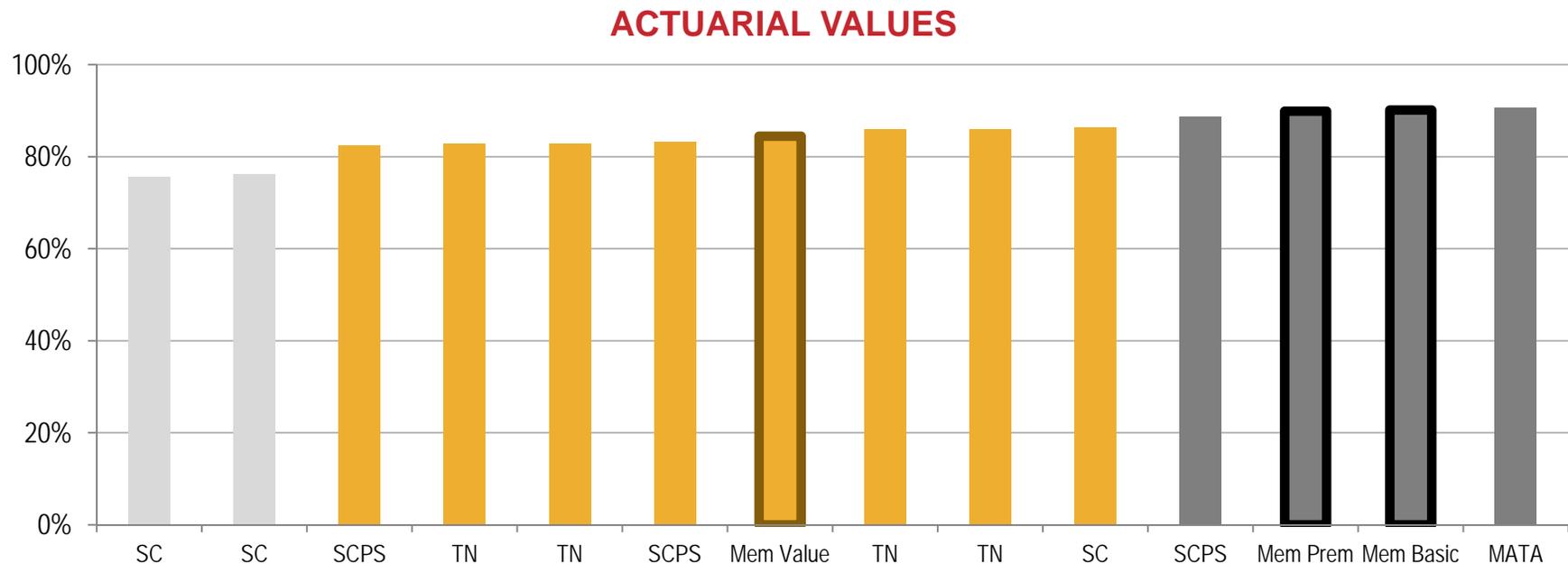
- We compared the **Actuarial Value** of City's plans with local peers
- **Actuarial Value** is the portion of total cost of coverage covered on average by the plan:
 - A plan with a 90% actuarial value results in the average member paying 10% of total costs via deductibles, copays, etc.
 - Plans on the Federal and State Health Care Marketplaces (or exchanges) use a metal level system (Platinum Plans provide 90% of Actuarial Value; Gold = 80%; Silver = 70%)
 - Our analysis utilizes the same convention for purposes of comparison and discussion
- **Overall**, the City's **Medical and Rx benefit levels** are **competitive** with 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 due to offering primarily access-only**

Benchmarking

Benefit Level Comparison

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

- Most of the City's local peers offer Gold plans (i.e., 80% actuarial value) with only Shelby County Schools and MATA offering Platinum plans (i.e., 90% actuarial value)
- The City's Basic and Premier plans have a significantly higher actuarial value (i.e., "richer") than its local peers as it provides 90% of the cost of coverage; the Value plan is competitive with its local peers



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

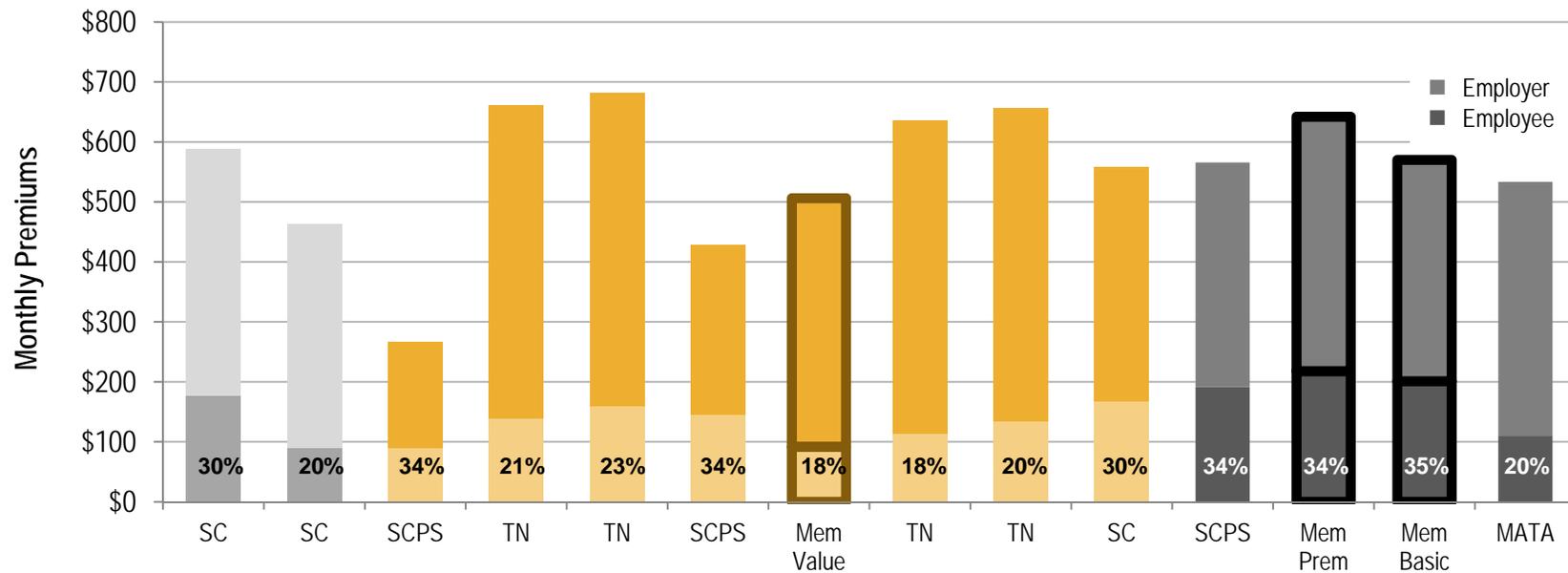
Benchmarking

Active Employee Cost Sharing

The following compares the total premium and cost sharing of the City's plans for active employees to their local peers:

- The total premium and employee cost share is higher than for other similar plans offered locally for the Premier and Basic plan options.
- The Value plan is competitive and the employee cost sharing is lower than the peer average.

EMPLOYER AND ACTIVE EMPLOYEE COST SHARE*



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

* Based on single coverage

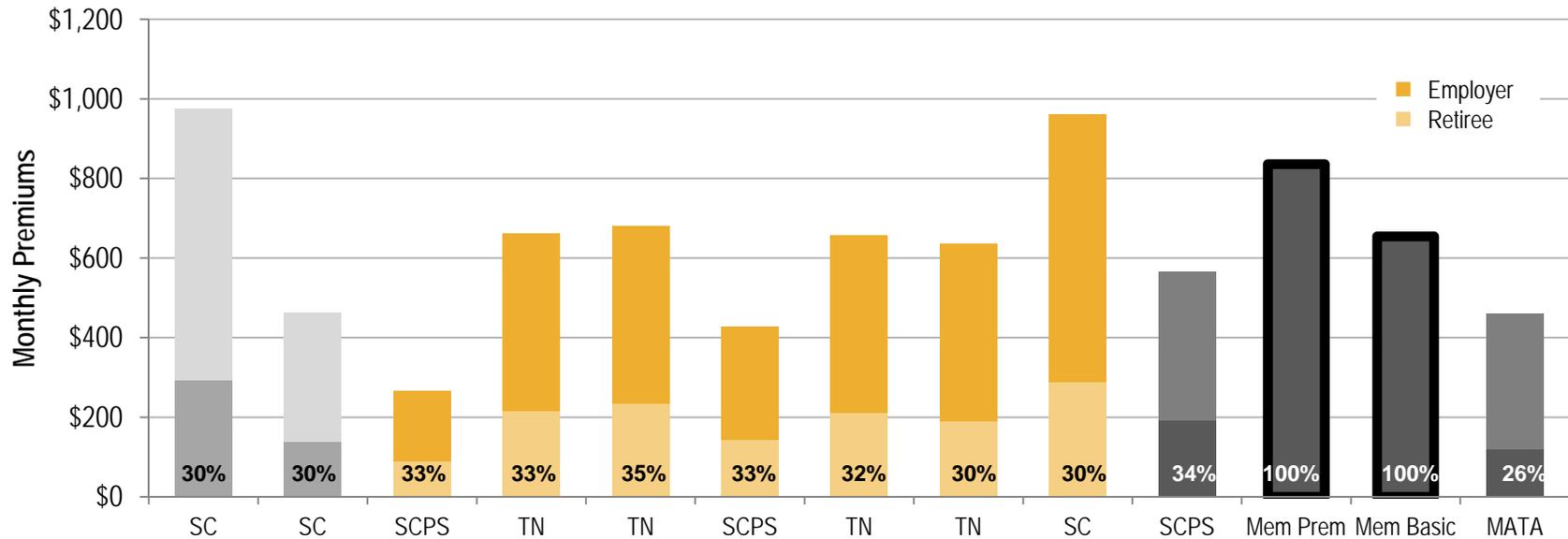
Benchmarking

Retiree Cost Sharing

The following compares the total premium and cost sharing of the City's plans for pre-65 retirees to their local peers:

- The peer group average retiree contributes about 1/3rd of the total premium.
- The total premium and employee cost share are higher than the City's local peers.
- City Retirees are the only ones locally to pay 100% of the total cost.

EMPLOYER AND PRE-65 RETIREE COST SHARE*



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

* Based on single coverage

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 employees in the South 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%

Benchmarking

Plan Design

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, two Medicare Advantage plans, three MedSupp plans and four 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 retirees who are eligible for benefits elsewhere:
 - Two of the four 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

Opportunities

Overview

Opportunities

- 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
- Changes to-date have focused on cost-shifting at the premium level
- The following are opportunities to design a more cost efficient program and reduce costs with minimal cost shifting to members:
 1. Enrolling retirees who are not eligible for Medicare Parts A & B in Medicare Part B
 2. Implementing a Medicare Advantage PPO plan for post-65 retirees
 3. Introducing Consumer Directed Health (CDH) plan for active employees and pre-65 retirees
 4. Reducing Excise Tax (i.e., “Cadillac” tax) exposure

Potential Annual Savings: \$15M – \$20M

Opportunities

Medicare Part B

- City currently has about 1,100 retirees who do not have Medicare Parts A or Part B:
 - Retirees are not eligible for Medicare Part D (Prescription drug coverage) if they don't have Part A or B
 - Medicare Part B eligibility is not tied to Part A eligibility or status
- Medicare Part B requires enrollment at age 65 or late enrollment penalty applies
 - Penalty of 10% per year assessed for late enrollment
 - **Part B requires a monthly premium of about \$100 per month but provides a monthly benefit of about \$400 per month**
- City could realize savings of about \$300 per member per month (pmpm):
 - Portion of savings could be used to pay premiums and/or late enrollment penalty directly to CMS
 - Retiree impact may be minimal depending on policy decisions related to premium and late enrollment
- The savings estimates below do not include other additional savings opportunities available with Part B coverage such as:
 - Eligible for Part D (RDS, EGWP, PDP, etc)
 - Eligible for Part B-only Medicare Advantage plans

Potential Annual Savings: \$2M – \$4M

Opportunities

Medicare Advantage Plan

- Implement Medicare Advantage-PPO option (MA-PPO):
 - Same provider access as current Medicare Advantage (MA) plan
 - 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
 - Offer “Part B only” MA options:
 - Can price separately for these retirees or blend premiums with full Medicare Mas
 - May continue to offer MA-HMO and MedSupp options, but not critical to strategy
- Introduce service based subsidy (tops out at 50% of lower cost MA):
 - Consider go forward approach

Potential Annual Savings: \$7M – \$9M

Opportunities

Consumer-Directed Healthcare (CDH)

- 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
- State of Tennessee and Shelby County are introducing, or have introduced, Consumer-Directed Health (CDH) plans
- 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 without significant cost shifting to members who complete those activities
- Replace Value, Basic, and Premier plans with two CDH options that provide Silver and Gold level benefits, respectively for active and pre-Medicare Retirees
- Provide Health Reimbursement Account credit to increase plan values to Gold and Platinum, respectively
- Require Risk Assessment, biometrics and disease management participation for those with chronic condition
- Increased engagement should reduce trend by 1% – 2% annually (and compound)
- Explore longer-term opportunities with CIGNA and CVS/Caremark to utilize value-based initiatives with provider payments

Potential Annual Savings: \$5M – \$10M

Opportunities

Illustrative CDH Plan Design vs Current Plans

	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.

Opportunities

Additional Considerations

- 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
- Continue nicotine surcharge until tobacco cessation is integrated into value-based strategy
- Streamline dental to two options and introduce more price competitive DHMO option (remains voluntary)
- Streamline vision to single option (remains voluntary)
- Review eligibility data to reduce inconsistencies
- Explore centralized data warehousing and reporting:
 - Measure and track risk using single methodology
 - Data mining to monitor utilization and assess trends

Opportunities

Additional Considerations cont.

- 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
- Monitor State exchange for opportunities:
 - Large employers can enter in 2017
- Conduct detailed assessment of Excise Tax exposure

Excise Tax

Overview

- 40% Tax, 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



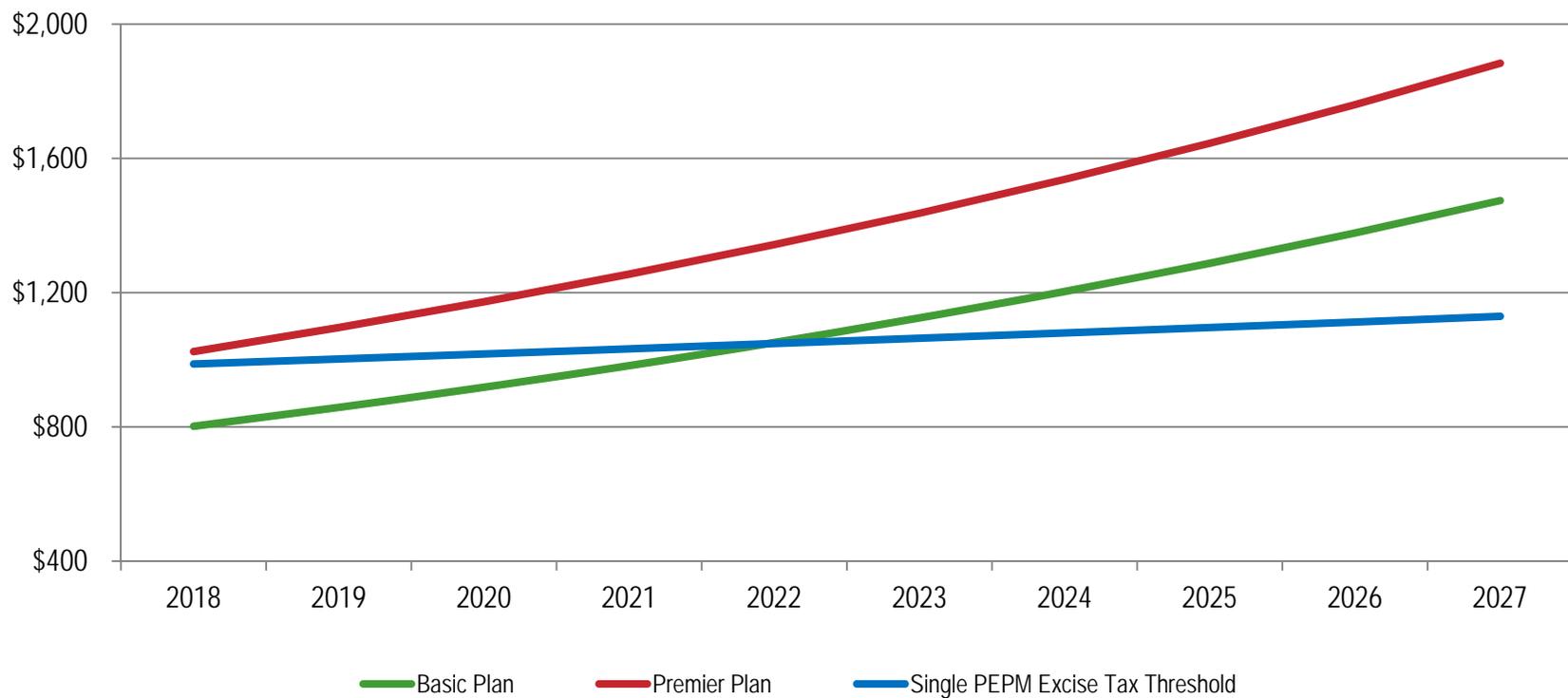
Tax is based on benefit value, regardless of how much of the premium is paid by the employee/retiree. Cannot manage exposure by shifting premium costs.

Excise Tax

(Impact and Timing—Retirees)

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

ILLUSTRATION OF POTENTIAL EXCISE TAX EXPOSURE PRE-MEDICARE RETIREE PLANS—SINGLE COVERAGE (Monthly Costs)

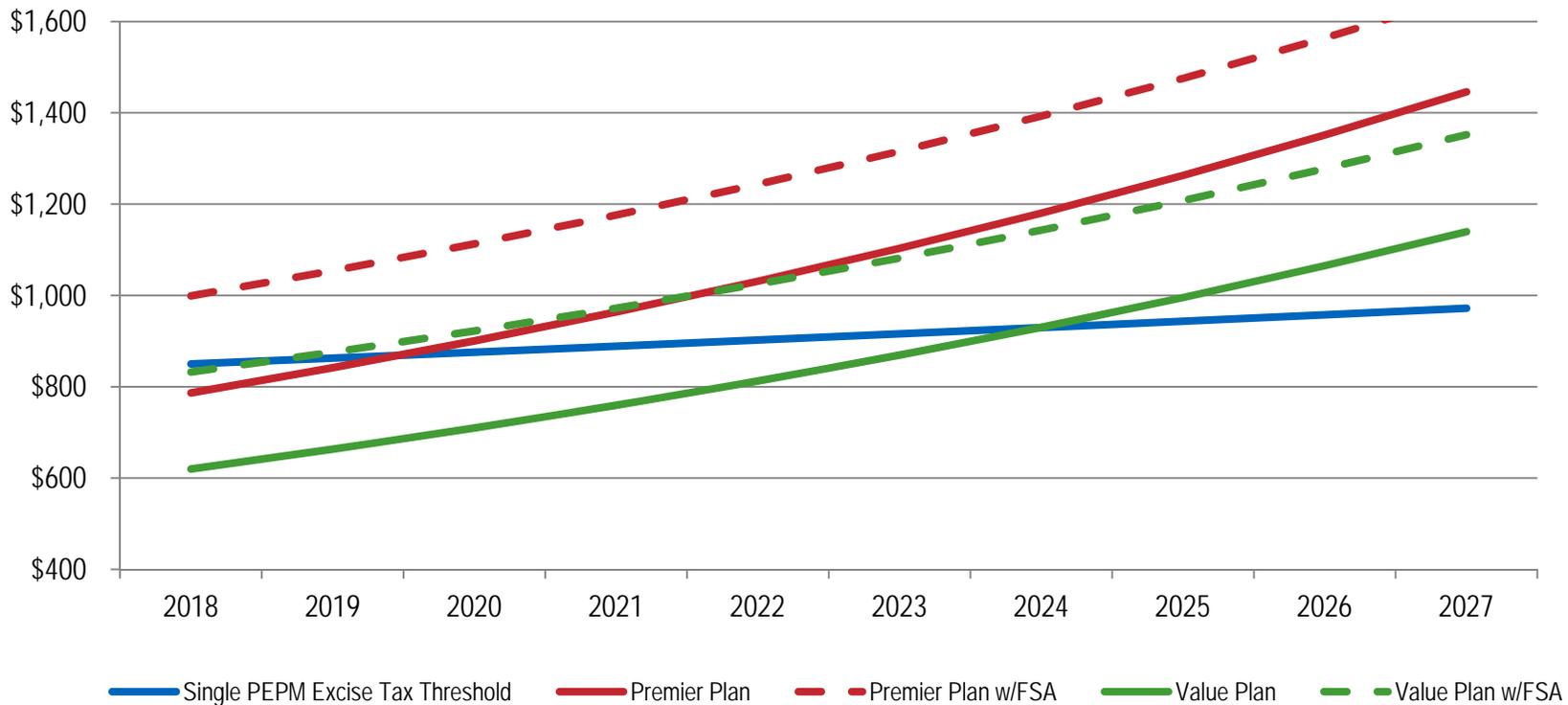


Excise Tax

(Impact and Timing—Active Employees)

- 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

ILLUSTRATION OF POTENTIAL EXCISE TAX EXPOSURE ACTIVE PLANS—SINGLE COVERAGE (Monthly Costs)



Long-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 savings will compound.

Questions & Discussion

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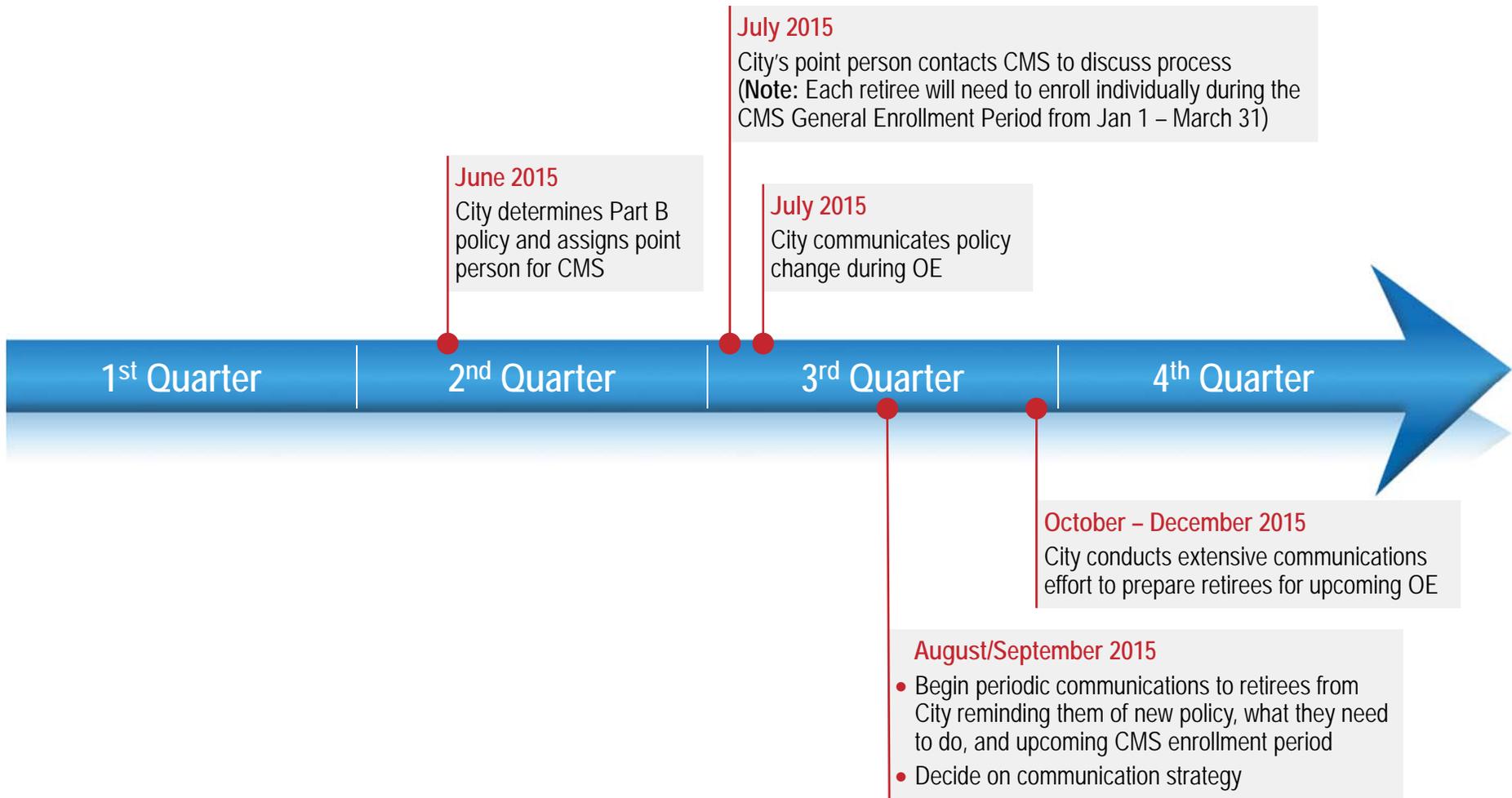
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Thank you!

Appendix



Medicare Part B Enrollment 2015



Medicare Part B Enrollment 2016

