MERCER

TALENT • HEALTH • RETIREMENT • INVESTMENTS

2015 STRATEGY AND RENEWAL PLANNING
EVERETT SCHOOL EMPLOYEE BENEFIT TRUST

April 9, 2014

Sean White
Principal

Seattle

MARSH & McLENNAN COMPANIES

Agenda

- Compliance update
- Market update
- Potential strategies and program additions for 2015+
- 2015 vendor renewals
  - Benchmarking summary
  - Review of 2014 renewal results
  - 2015 vendor renewal discussion
- Renewal calendar and next steps

Compliance update

Key Elements of Health Care Reform for Employers

2010

- Change in tax treatment for over-age dependent coverage
- Early retiree medical reinsurance
- Accounting impact of change in Medicare retiree drug subsidy tax treatment
- Medicare prescription drug "donut hole" beneficiary rebate
- Break time/private room for nursing moms

2011

- No lifetime dollar limits on essential health benefits[1]
- Restricted annual dollar limits on essential health benefits, phased amounts until 2014[1]
- Dependent coverage to 26 (grandfathered plans may limit to children without access to other employer coverage, other than parent's coverage)[1]
- No pre-existing condition limitations for enrollees up to age 19[1] and no rescissions[1]
- No health FSA/HRA/HSA reimbursement for non-prescribed drugs
- Increased penalties for non-qualified HSA distributions
- Additional standards for non-grandfathered health plans, including preventive care in network with no cost-sharing, appeal and external review, provider choice, and non-discrimination rules for insured plans[3]
- Income-based Medicare Part D premiums
- Pharmaceutical importers and manufacturers' fees start
- Medicare, Medicare Advantage benefit and payment reforms
- Insurers subject to medical loss ratio rules

2012

- Employers to distribute uniform summary of benefits and coverage (SBC) to participants (deadlines vary with group of recipients)
- 60-day advance notice of mid-year material modifications to SBC content
- Form W-2 reporting for health coverage (track in 2012 for W-2 form provided in early 2013)[4]
- Coverage for additional women's preventive care services [5]

2013

- $2,500 per plan year health FSA contribution cap (plan years on or after January 1, 2013)
- Comparative effectiveness group health plan fees first due
- Annual dollar limits on essential health benefits cannot be lower than $2 million
- Employers notify employees about exchanges by Oct. 1, 2013
- Medical device manufacturers' fees start
- Higher Medicare payroll tax on wages exceeding $200,000/individual; $250,000/couples
- Change in Medicare retiree drug subsidy tax treatment takes effect
- Health Insurance exchanges initial open enrollment period

2014

- Health insurance exchange coverage
- Individual coverage mandate[6]
- Financial assistance for exchange coverage of lower-income individuals
- State Medicaid expansion (states opting to expand)
- Dependent coverage to age 26 for any covered employee's child[2]
- No annual dollar limits on essential health benefits[2] (generally banning standalone HRAs)
- No pre-existing condition limits[2]
- No waiting period over 90 days[2]

2015

- Temporary reinsurance fees first due in late 2014/early 2015
- Possible additional reporting and disclosure
- Employer shared responsibility[7]
- Wellness limit increase allowed[2]
- Health insurance industry fees
- Additional standards for non-grandfathered health plans, including limits on out-of-pocket maximums, provider nondiscrimination, and coverage of routine medical costs of clinical trial participants
- Small market, non-grandfathered insured plans must cover essential health benefits with limited deductibles (initially $2,000/individual, $4,000/family), using a form of community rating
- Insurers must apply guaranteed issue and renewability to non-grandfathered plans of all sizes
- Auto enrollment some time after 2014

2018

- 40% excise tax on "high cost" or Cadillac coverage

Footnotes

1. *Applies to all plans, including grandfathered plans, effective for plan years beginning on or after Sept. 23, 2010 (Jan. 1, 2011, for calendar year plans).*
2. *Applies to all plans, including grandfathered plans, effective for plan years beginning on or after Jan. 1, 2014.*
3. *Applies to non-grandfathered plans, effective for plan years beginning on or after Sept. 23, 2010, except that insured plan discrimination ban is delayed until regulations issued.*
4. *A temporary exemption applies to certain categories of employers.*
5. *Applies to nongrandfathered plans, effective for plan years on or after Aug. 1, 2012.*
6. *A temporary exemption applies to employees of employers with non-calendar-year plans.*
7. *Effective 2015 for applicable large employers with 100 or more employees; effective 2016 for applicable large employers with 50 or more employees*

Health Care Reform requirements in 2015

- Employer Shared Responsibility — it was delayed, not eliminated, though recently released guidance provides for a phased in implementation
  - New concept of full-time employee
  - Safe harbor (measurement and stability periods)
  - Minimum plan value (All WEA Select Medical Plans meet the minimum essential coverage requirements)
  - Affordable contributions (Offering EasyChoice and QHDHP WEA plans meets the affordability provisions in most cases)
- New employer reporting requirements
  - Minimum Essential Coverage
  - Employer Shared Responsibility
- Changes to out of pocket limit requirements for non-grandfathered plans
  - For 2014, benefits administered by separate vendors (e.g., pharmacy) were not required to have a limit on member out of pocket costs
  - Starting in 2015, total out of pocket costs across all essential health benefits cannot exceed proposed limits of $6,750/$13,500
  - Separate out of pocket limits can be established for different benefits as long as the combined amount does not exceed the maximum

Health Care Reform requirements in 2015 (cont'd)

- Changes to definition of integrated dental and vision plans
  - Dental and vision plans that are considered integrated are subject to certain ACA requirements, including the elimination of dollar limits and the maximum out of pocket costs
  - Previous guidance said that a plan was considered integrated unless it had both a separate election and a separate employee contribution
  - New guidance has been issued which removes the requirement for a separate contribution
  - The separate election requirement could be satisfied by amending the plan to allow members to opt out of dental or vision rather than requiring active enrollment
  - This change gives ESEBT some additional flexibility to consider returning to self-insured dental coverage in the future without impacting the plan design
  - However, it is important to note that insured standalone dental is not subject to the excise tax while a self-insured standalone plan would be

Market update

About Mercer's National Survey of Employer-Sponsored Health Plans

Oldest
Marking 29 years of measuring health plan trends

Largest
2,842 employers participated in 2013

Most comprehensive
Extensive questionnaire covers a full range of health benefit issues and strategies

Statistically valid
Based on a probability sample — only Mercer and Kaiser survey this way

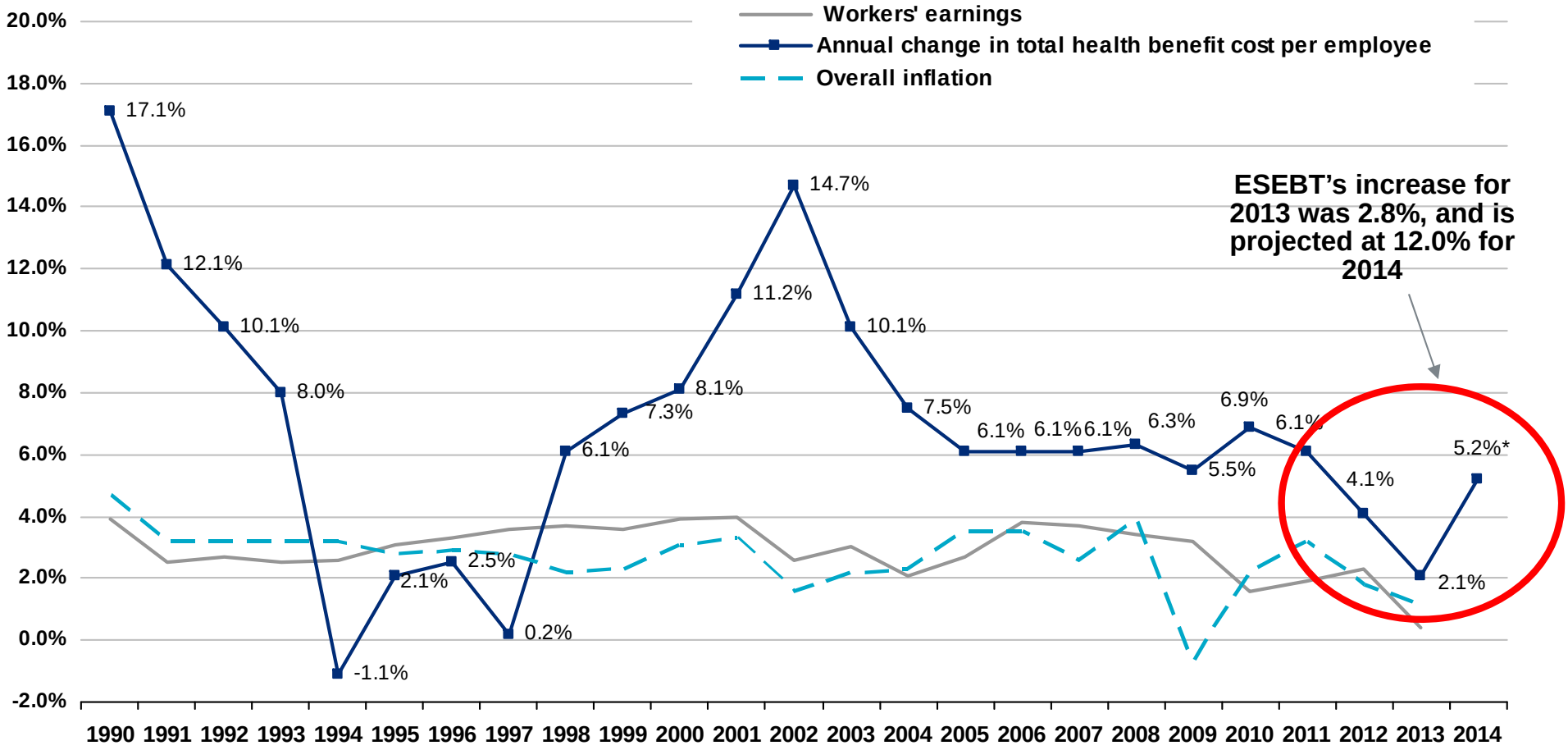
Covers employers of all sizes, all industries, all regions
Results project to all US employers with 10 or more employees

Employer size groups in presentation
Small: 10-499 employees / Large: 500+ employees / Very large: 5,000+ employees

Cost

Cost growth slowed again in 2013, with higher increases expected this year

Average total health benefit cost per employee rose just 2.1% in 2013

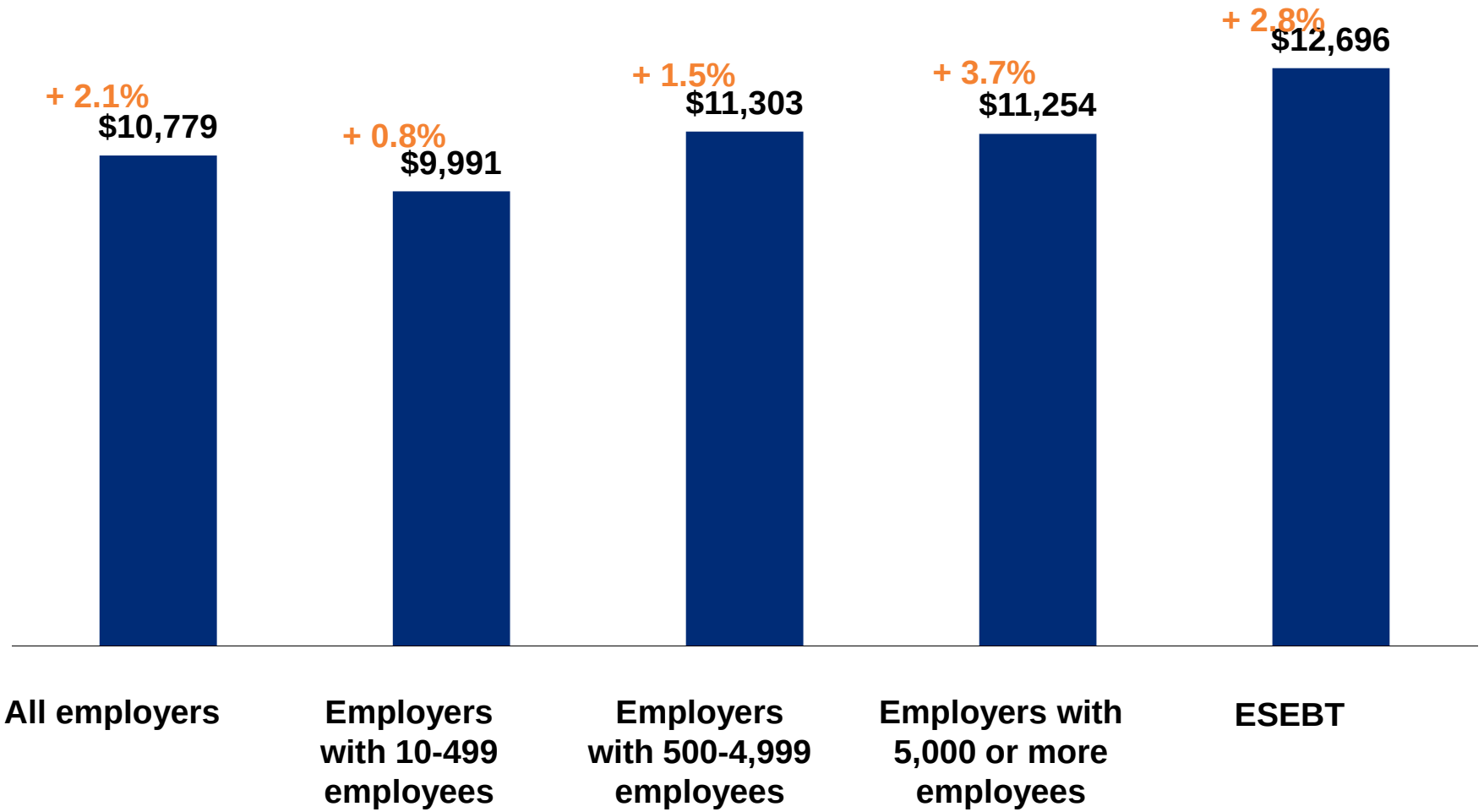


* Projected

Source: Mercer's National Survey of Employer-Sponsored Health Plans; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April) 1990-2013; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey (April to April) 1990-2013.

Cost

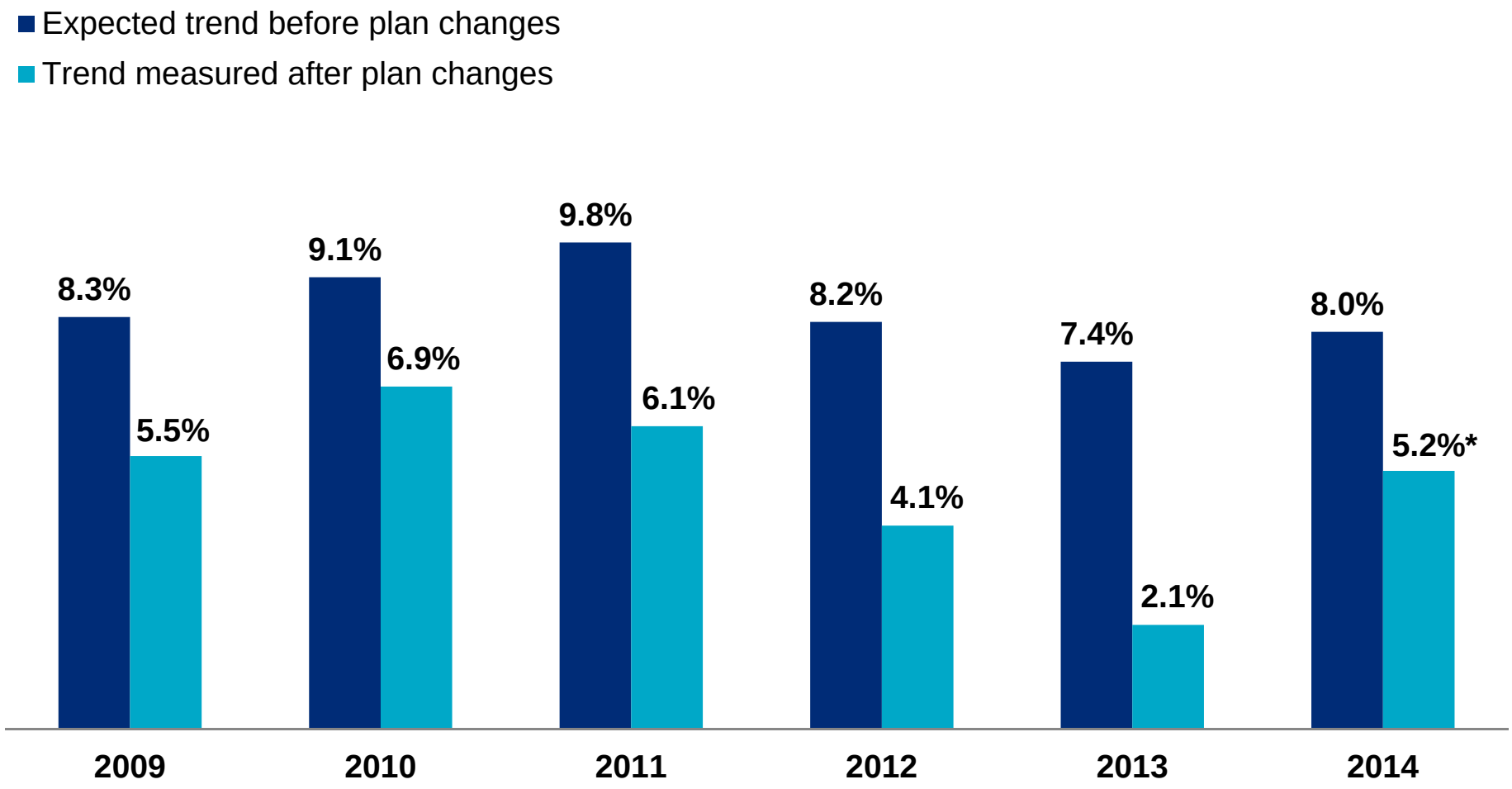
Cost rose faster among larger employers, but mid-sized employers experienced the highest cost per employee



Cost

Underlying cost trend still high at 8%, but employers plan to hold the average increase in per-employee cost to about 5%

Estimated cost increase to renew plans with no changes vs. actual increase after plan changes

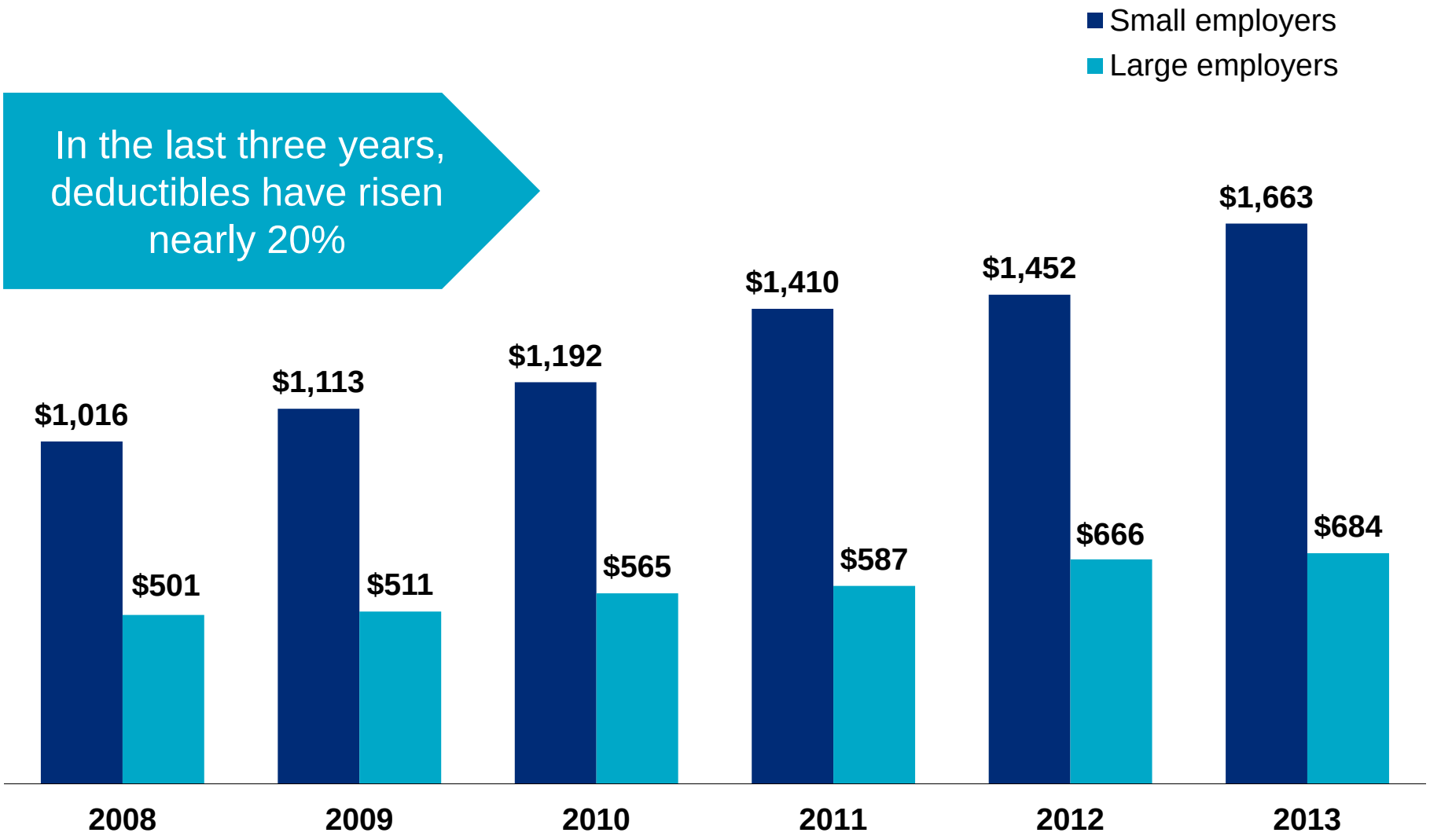


* Projected

Cost

Cost shifting has been considerable

Average PPO deductible for individual, in-network coverage



Cost

The typical employer plan still meets the ACA's plan value requirement of 60% of covered expenses — with room for further cost shifting

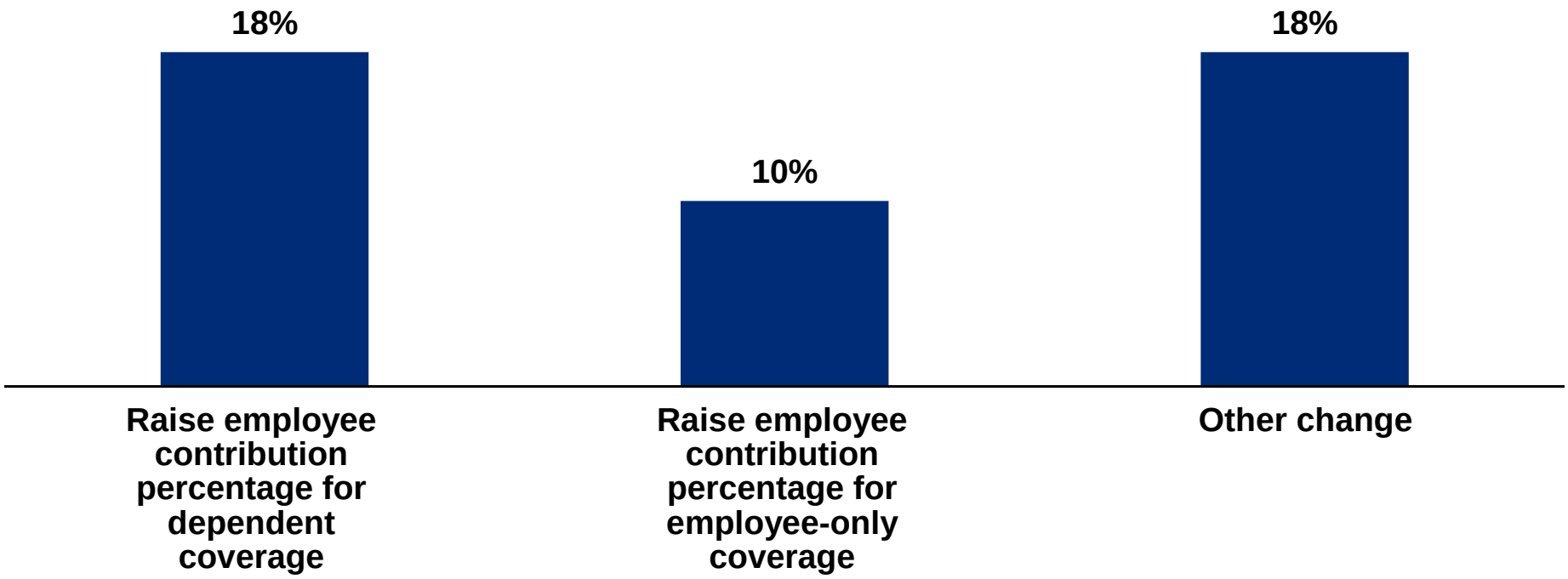
Large employers

		Median cost sharing* amounts for:		
	60% plan	**PPO**	**HMO**	**HSA-eligible CDHP**
Deductible	$2,000	$500	$500	$1,500
Hospital coinsurance/copay	50%	20%	$250	--
Out-of-pocket maximum	$6,000	$2,250	--	$3,000

* Cost sharing for individual, in-network coverage

ACA

Managing growth in enrollment by changing contribution strategies
Large employers

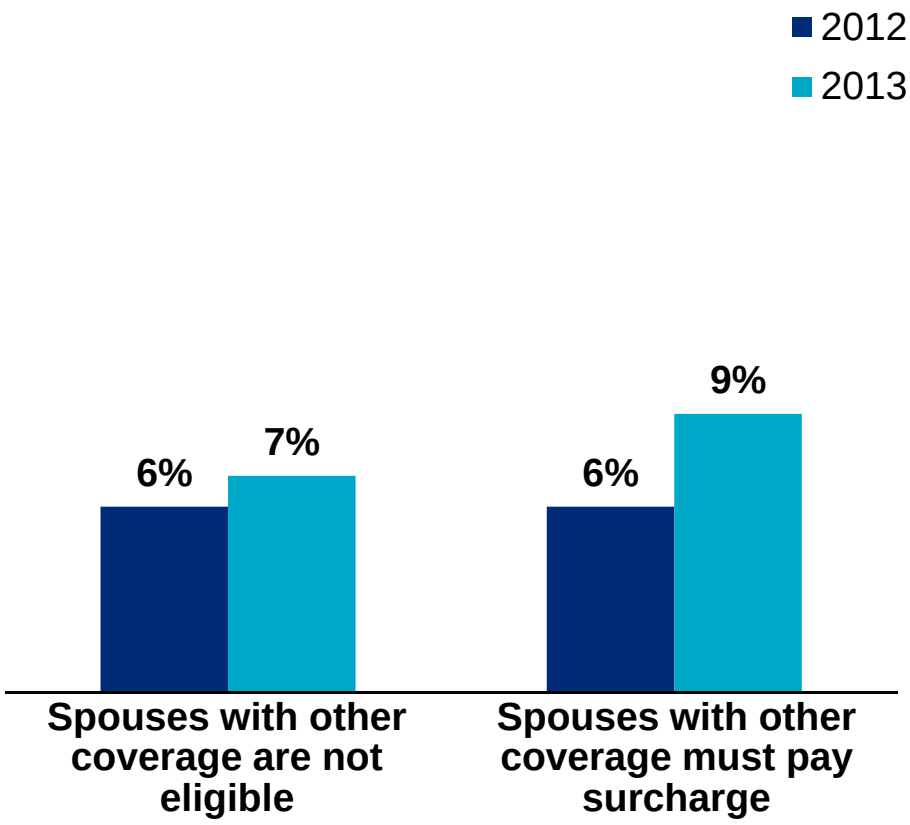


ACA

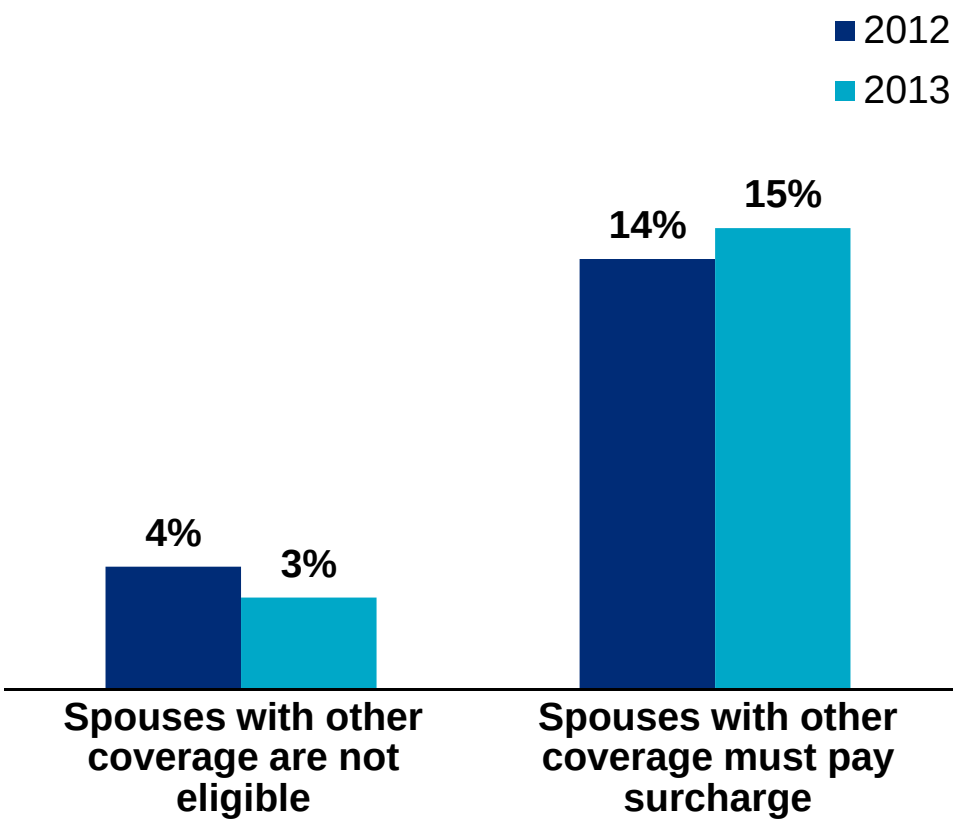
Employers taking bolder action to steer spouses to other coverage

Special provisions concerning spouses with other coverage available

Large employers



Very large employers

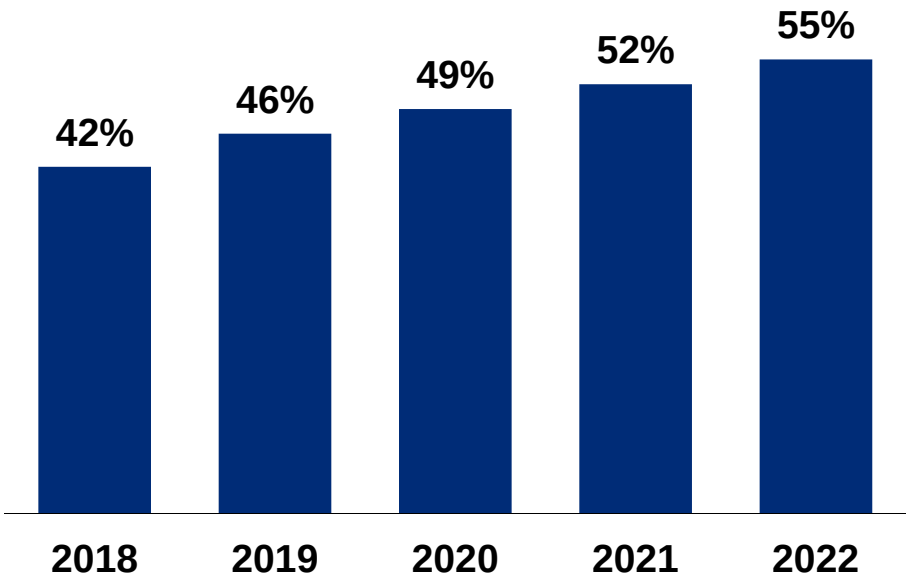


ACA

But the shared responsibility requirements are just the beginning

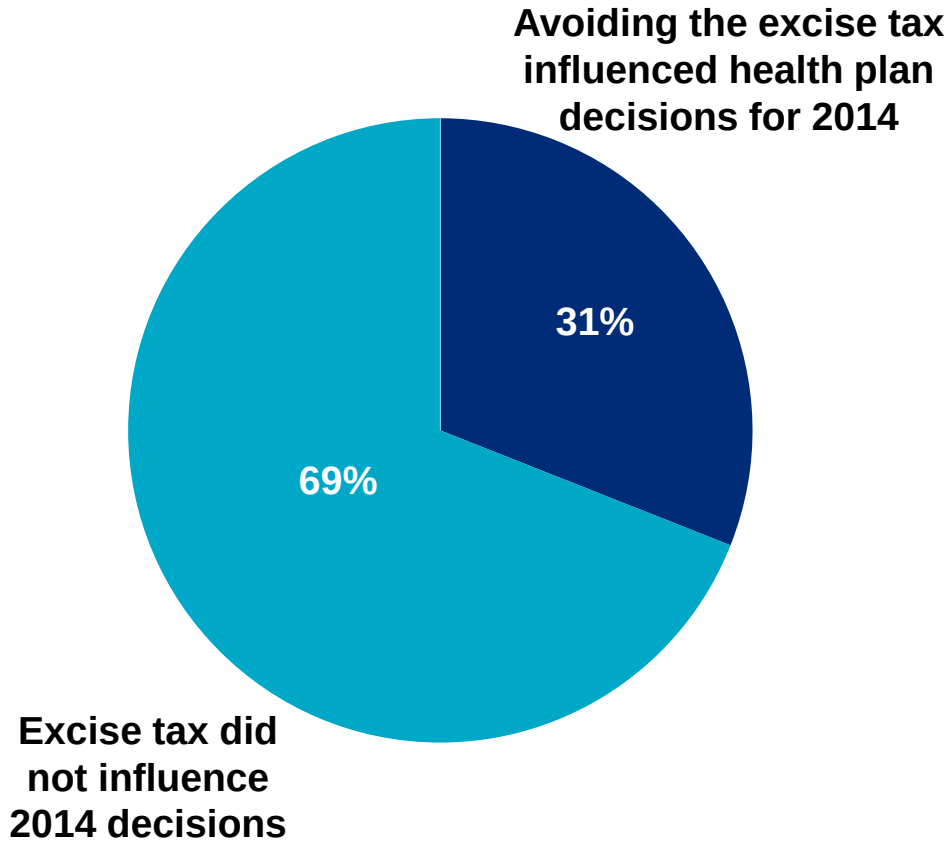
Majority of large employers in danger of getting hit with excise tax by 2022

Percent of employers that would be subject to the excise tax *if they made no changes to their current plan…*



Source: 2011 National Survey of Employer-Sponsored Health Plans

…but almost a third said avoiding the tax influenced health plan decisions for 2014



ACA

Taking steps now to avoid the excise tax in 2018
Large employers

For nearly a third of employers — 31% — concerns over the 2018 excise tax influenced decisions for 2014	
Introduced a CDHP or took steps to increase enrollment in an existing CDHP	19%
Added or expanded health management programs	12%
Dropped a higher-cost health plan	11%
Unbundled dental and medical plans	4%
Other change(s)	12%

CDHP

CDHPs have become mainstream… and prevalence is likely to accelerate over the next three years

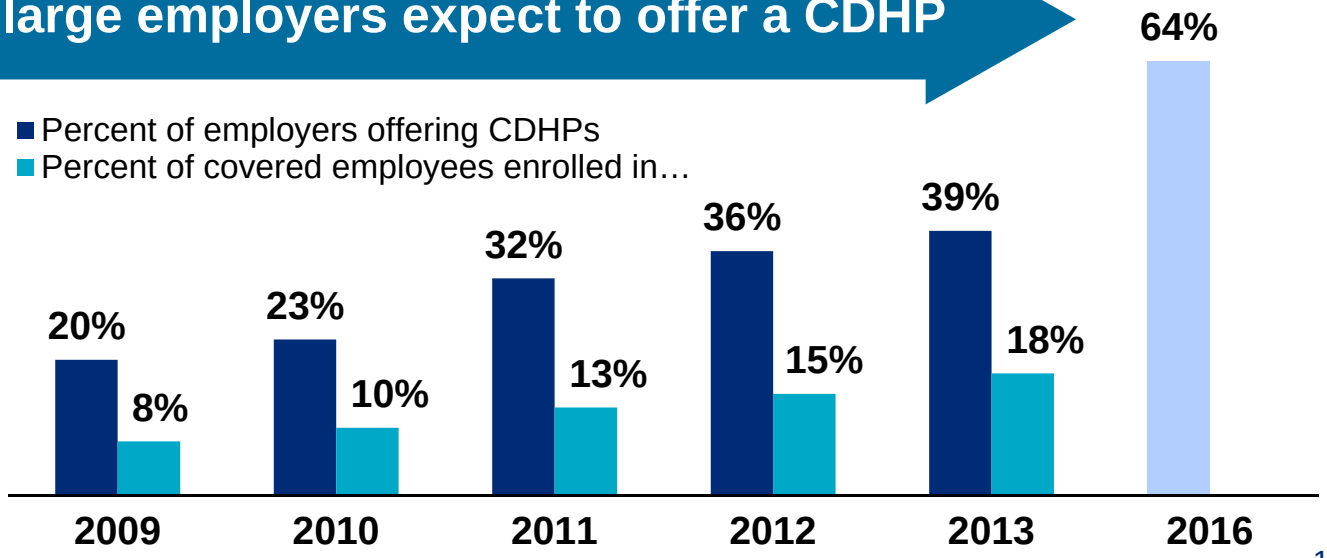
CDHPs seen as central to meeting the challenges of health reform

Provide a low-cost plan to newly eligible employees

Encourage employees to use the health care system wisely

Avoid the excise tax

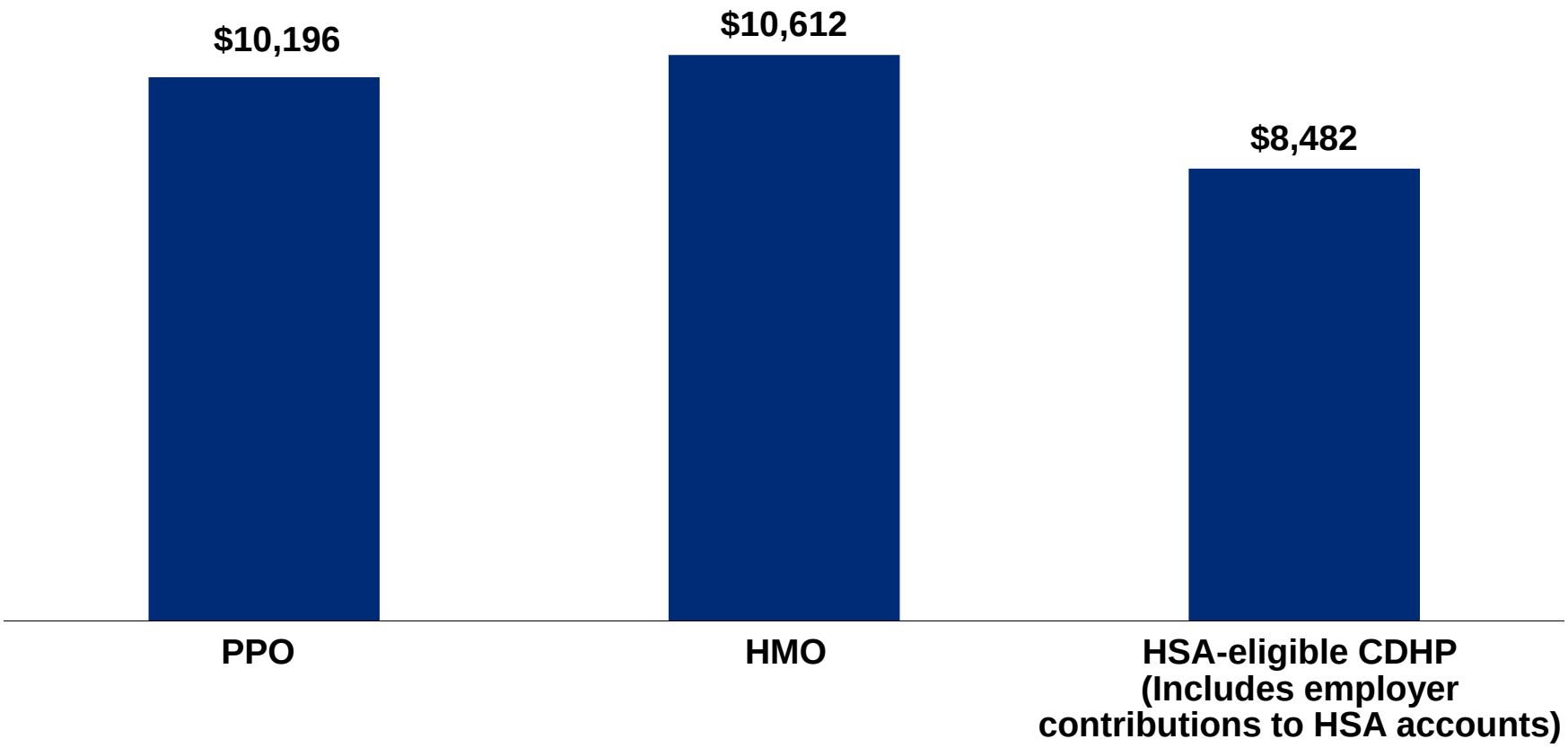
By 2016, 64% of large employers expect to offer a CDHP



CDHP

CDHPs typically pass the 60% “test” but cost about 20% less than PPO and HMO coverage

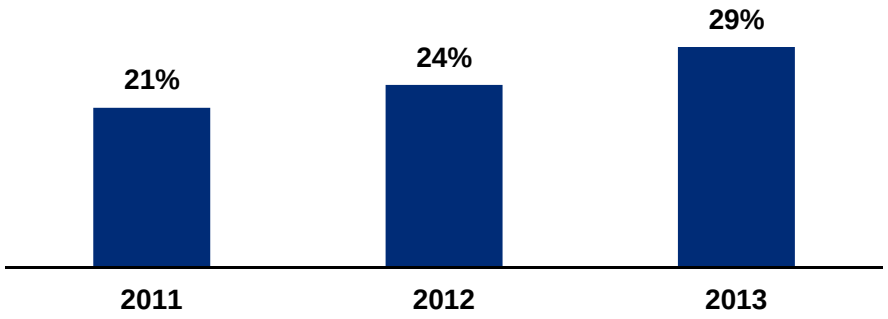
Medical plan cost per employee



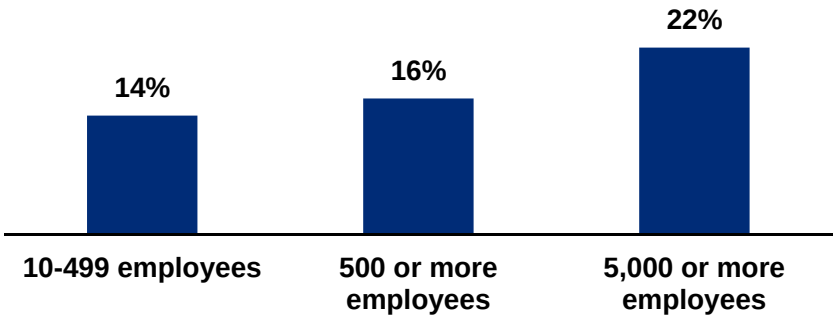
CDHP

Employers working to build enrollment in CDHPs
Large employers

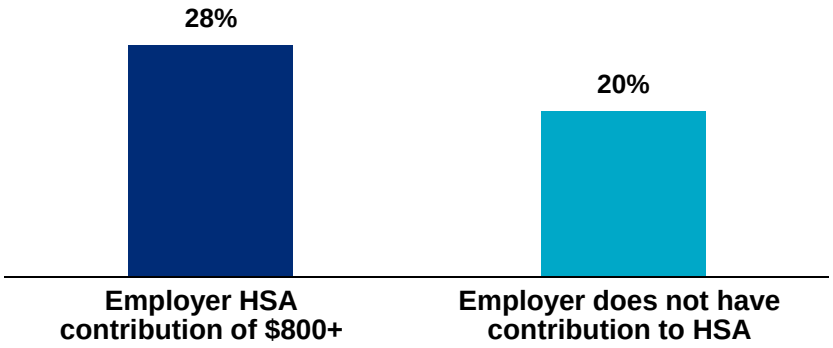
HSA-based CDHP enrollment rises over time
% choosing CDHP when offered w/other medical plans



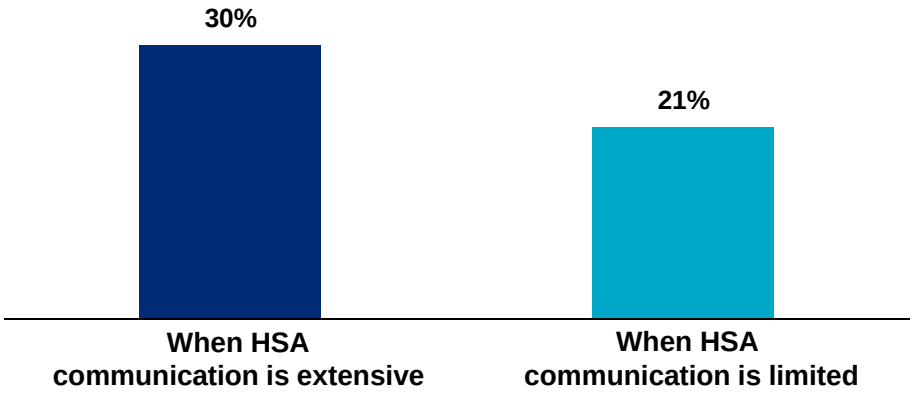
Expect to offer a CDHP as full replacement three years from now



Employer HSA funding drives enrollment . . .
% choosing HSA when offered with other medical plans



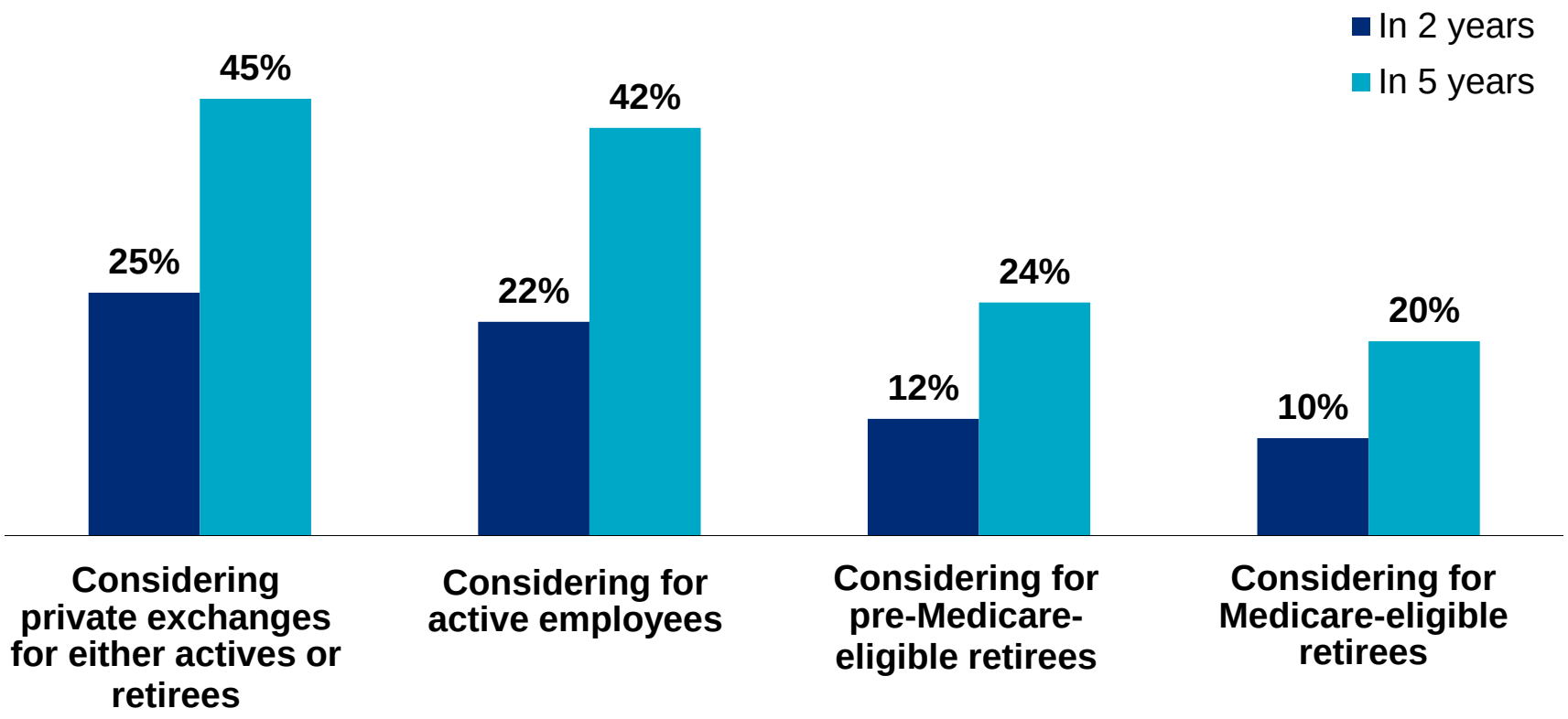
. . . but extensive communication is also important
% choosing HSA when offered with other medical plans



Choice

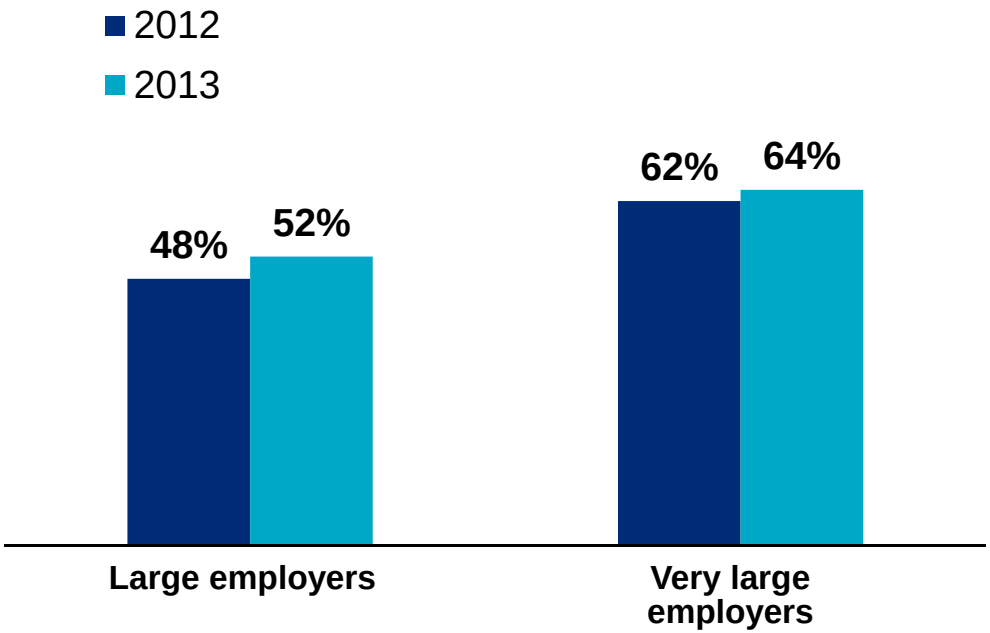
Private health care exchanges poised for rapid growth

One-fourth of employers are considering switching to a private exchange within two years, and 45% would consider switching within five years



Health

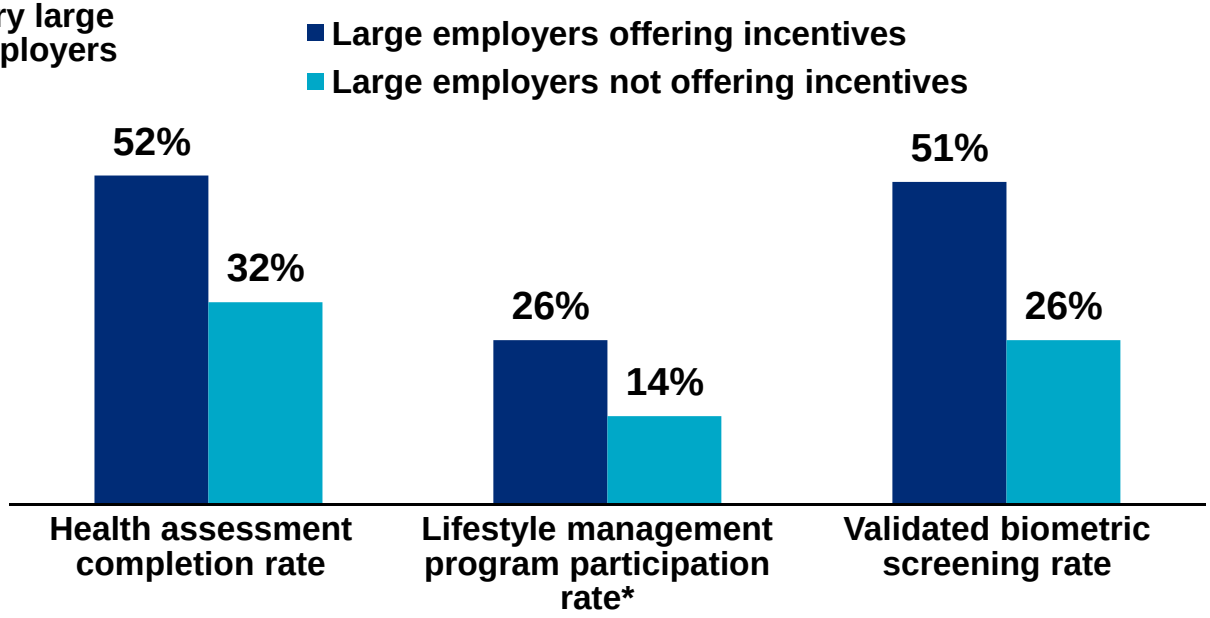
Financial incentives are becoming the norm in health management programs, and participation rates are rising as a result



More employers are driving engagement through financial incentives, most often cash or contribution reductions

Large employers using incentives report higher participation rates

*Average % of identified persons actively engaged in program

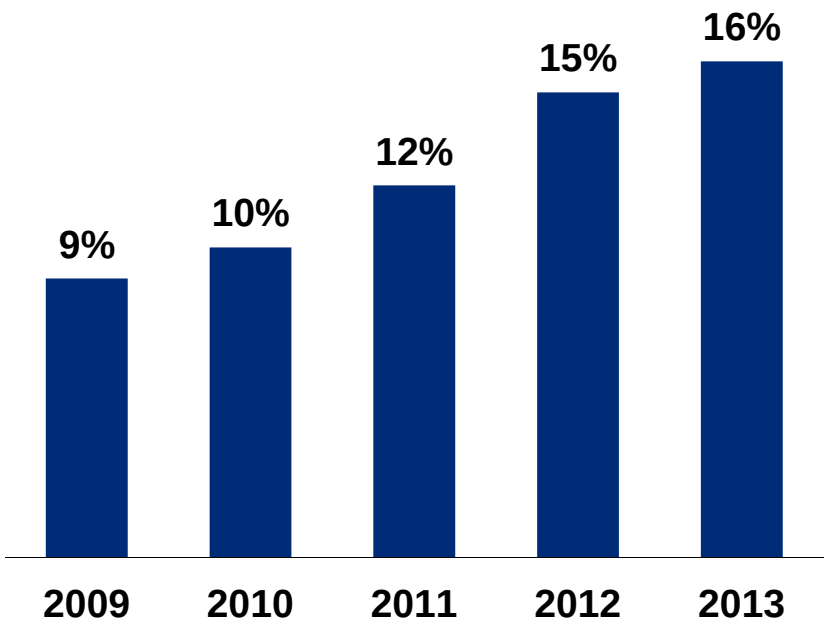


Health

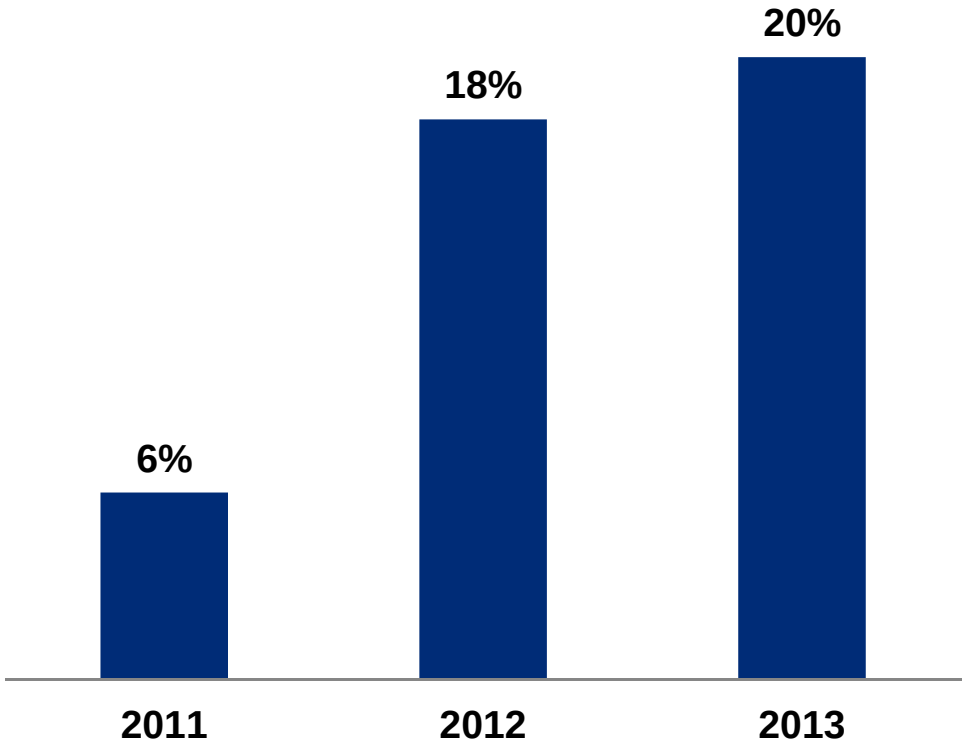
Continued growth in use of outcomes-based incentives

More large employers linking incentives to what employees *do about their health*

Offer lower premium contributions to non-tobacco users



Provide incentives for achieving or maintaining targets for BP, BMI, cholesterol



2014 Overview

2014 health plan offerings
Understanding ESEBT's current market position

Plan component	Current Position to the School Boards Benchmark	Commentary
Medical/Rx plan design	Varies	• WEA Plan 3 – Lower deductible but higher OOP max; higher PCP copay • HDHP – Lower deductible but higher OOP max; no HSA contribution • HMO – Lower OV copay and inpatient hospital copay
Medical/Rx ee contributions	Varies	• Contributions for coverage are on par with the market as a percent of premium, though the dollar amount for PPO coverage is high in comparison, driven by the higher premium cost for individuals
Dental plan design	Above median	No deductible, higher annual maximum
Dental ee contributions	Above median	No employee contributions required

Market position based on comparison to results from the 2013 Mercer National Survey of Employer-Sponsored Health Plans

See the "Benchmarking" section of the Appendix for detailed comparisons

2014 Renewal overview

The following table summarizes rate adjustments by vendor for 2014

Coverage	Funding Arrangement	Carrier/Administrator	Renewal Status
WEA Select Benefit Plans			
Medical Plans	Fully-Insured	Premera Blue Cross	+16.4% to +17.0% depending on plan and tier
Dental	Fully-Insured	Washington Dental Service	0%
Dental	Fully-Insured	Willamette Dental	0%
Vision	Fully-Insured	Premera	+3.4%
HMO Medical	Fully-Insured	Group Health Cooperative (GHC)	+6.27%
Basic Accidental Death and Dismemberment	Fully-Insured	MetLife	+0% (last year of three-year guarantee through 12/31/2014)
Basic and Supplemental Life	Fully-Insured	MetLife	+0% (last year of three-year guarantee through 12/31/2014)
Long-Term Disability	Fully-Insured	Standard Insurance Company	+0% (last year of two-year guarantee through 12/31/2014)
Voluntary Short-Term Disability	Fully-Insured	Standard Insurance Company	+0% (last year of two-year guarantee through 12/31/2014)
EAP	Service Contract	Magellan	-2.4% (first year of two-year guarantee through 12/31/2015)
Voluntary Long Term Care	Fully-Insured	UNUM	+0%, will increase 25% in 2015 and expected to increase again in 2016
Health Programs	Service Contract	Alere	+0%
Health Programs	Service Contract	Health Force Partners	+0%

Proposed 2015 Renewal Actions

The following table summarizes proposed renewal actions for 2015, recommended marketing activity is summarized on the next page

Coverage	Funding Arrangement	Carrier/Administrator	Renewal Status
WEA Select Benefit Plans			Review WEA rates when available
Medical Plans	Fully-Insured	Premera Blue Cross	
Dental	Fully-Insured	Washington Dental Service	
Dental	Fully-Insured	Willamette Dental	
Vision	Fully-Insured	Premera	
HMO Medical	Fully-Insured	Group Health Cooperative (GHC)	Request status quo renewal
Basic Accidental Death and Dismemberment	Fully-Insured	MetLife	Request status quo renewal
Basic and Supplemental Life	Fully-Insured	MetLife	Request status quo renewal
Long-Term Disability	Fully-Insured	Standard Insurance Company	Request status quo renewal, plus options to increase plan maximum
Voluntary Short-Term Disability	Fully-Insured	Standard Insurance Company	Request status quo renewal, plus option to require use of sick leave accumulations before STD benefits commence
EAP	Service Contract	Magellan	First year of two-year guarantee through 12/31/2015
Voluntary Long Term Care	Fully-Insured	UNUM	Will increase 25% in 2015 and expected to increase again in 2016
Health Programs	Service Contract	Alere	Request status quo renewal for the smoking program
Health Programs	Service Contract	Health Force Partners	Terminate the plan

Proposed marketing activity

- Medical: request WEA carve-out proposals from:
  - Aetna
  - CIGNA
  - Group Health
  - Regence
  - UHC
- Dental and vision: request WEA carve-out proposals from MetLife
- Life and Disability: request full take-over proposals from both Standard and MetLife to consolidate the coverage with one carrier

Pros and cons of WEA participation

Background

- Prior to 2012, the trust maintained self-funded medical and Rx programs
- For the 1/1/2012 renewal, Mercer recommended an increase in funding of almost 15%, driven by the claims experience of the plans
  - The large medical increase, combined with no increase in the State allocation resulted in a projected deficit for 2012 of $5.5 million
  - Multiple options were explored:
    - Significantly reduce benefits and increase employee contributions
    - Eliminate self-funded program and offer only WEA medical plans alongside one fully insured HMO
  - The trustees elected the last option, which resulted in a savings of almost $3 million from the status quo scenario
    - The savings was driven by the fact that the trust's self-funded plan costs were significantly higher than the 10% discount WEA rates

Pros and cons of WEA participation

Pros

- Significant savings in the near term, especially if trust costs were to remain above the WEA costs
- Theoretically, savings on fixed costs through participation in a large pooled purchasing arrangement
- Simplified renewal decision making

Cons

- Loss of control of plan design
- Unavailability of group-specific claims cost information
  - Future carve out is difficult
  - Inability to know cost drivers and plan interventions
- Limited ability for positive impact on medical costs through wellness efforts

Current state

- WEA passed along the largest cost increase in many years effective 11/1/2013
- Continued administrative burden and issues associated with the requirement that all WEA plan participants comply with AON outsourcing system requirements
- Interest on the part of the trust to explore options to carve out from the WEA

Issues and considerations

- Carving out of the WEA is a difficult proposition
  - At the time of entry, your group-specific costs were well above the costs for the broader pool; if that relative position has not changed, carving out will ultimately lead to higher costs
  - With no access to current claims data, we have no way of knowing what the trust's costs will be
    - To carve out will require a two-year fully insured arrangement (WEA requirement)
    - Even if self-funding were possible, it would not be recommended due to the unknown nature of current costs
      - If an insurer will agree to the risk, first year rates will be based on age/gender and geographic factors
      - We will want assurances on the year two rate of increase to avoid a significant renewal action once claims are known
  - If an insurer will agree to quote and include a year two assurance and the trustees elect to pursue this option, a decision to self-fund or revert back to the WEA can be made for an 1/1/17 effective date

Renewal calendar

1/1/2015 renewal calendar

January 2014	February 2014	March 2014	April 2014
	• Strategy and Renewal Planning meeting 2/13/14	• Request employee census data from district	• Present renewal strategy recommendations to trustees for approval • Request WEA carve-out quotes
May 2014	**June 2014**	**August 2014**	**August 2014**
• Issue renewal requests to carriers • Present WEA carve-out quotes to trustees • Receive vendor renewal offers by end of the month	• Review and negotiate vendor renewals	• Develop budget projections	• Renewal review meeting including budget projections • Finalize renewal decisions and issue renewal confirmation letters
September 2014	**October 2014**	**November 2014**	**December 2014**
• Deliver final projections, employee contributions, and rate sheets • Begin development of open enrollment communications		• District holds open enrollment	• Renewal effective date on 1/1/2015

APPENDIX

Benchmarking

Employee contribution for individual coverage
Average monthly contribution ($)

	School boards and other 500+	1,000-4,999 employees	ESEBT*
PPO / POS	$115	$119	$240/157/112/375
HMO	$121	$112	$123
HSA-eligible CDHP	$84	$69	$88
Dental	$20	$17	$0

* WEA Premera Plan 2 / Plan 3 / EasyChoice / Plan 5

Employee contribution for individual coverage
Average contribution as a % of premium

	School boards and other 500+	1,000-4,999 employees	ESEBT*
PPO / POS	20%	23%	31/23/23/41%
HMO	24%	23%	18%
HSA-eligible CDHP	19%	17%	23%
Dental	65%	49%	0%

* WEA Premera Plan 2 / Plan 3 / EasyChoice / Plan 5

Employee contribution for family coverage*
Average monthly contribution ($)

	School boards and other 500+	1,000-4,999 employees	ESEBT**
PPO / POS	$522	$401	$604/420/297/1,013
HMO	$377	$384	$347
HSA-eligible CDHP	$395	$258	$230
Dental	$64	$53	$0

* Family coverage is defined as coverage for employee, spouse and two children
** WEA Premera Plan 2 / Plan 3 / EasyChoice / Plan 5

Employee contribution for family coverage*
Average contribution as a % of premium

	School boards and other 500+	1,000-4,999 employees	ESEBT**
PPO / POS	39%	31%	35/28/28/48%
HMO	32%	29%	23%
HSA-eligible CDHP	40%	23%	27%
Dental	71%	54%	0%

* Family coverage is defined as coverage for employee, spouse and two children
** WEA Premera Plan 2 / Plan 3 / EasyChoice / Plan 5

PPO / POS deductibles

	School boards and other 500+	1,000-4,999 employees	ESEBT WEA Plan 3
In-network			
Deductible required (% of employers)	87%	89%	Yes
Median individual deductible amount	$500	$500	$300
Median family deductible amount	$1,000	$1,000	$900
Out-of-network			
Deductible required (% of employers)	92%	95%	Yes
Median individual deductible amount	$550	$900	$300
Median family deductible amount	$1,500	$2,000	$900

PPO / POS in-network primary care physician (PCP) visit cost-sharing

	School boards and other 500+	1,000-4,999 employees	ESEBT WEA Plan 3
% requiring copay	83%	80%	Yes
% requiring coinsurance	23%	24%	No
No cost-sharing is required	3%	1%	No
Median copay amount	$20	$25	$30

PPO / POS in-network specialist visit cost-sharing

	School boards and other 500+	1,000-4,999 employees	ESEBT WEA Plan 3
% requiring higher copay for specialist	40%	48%	No
Median copay amount, when higher than PCP	$40	$40	N/A

PPO / POS in-network hospital stay cost-sharing

	School boards and other 500+	1,000-4,999 employees	ESEBT WEA Plan 3
% requiring deductible / per-admission copay	24%	22%	Yes
% requiring coinsurance	64%	77%	Yes
No cost-sharing is required	19%	10%	No
Median deductible amount	$175	$250	$300/day
Median coinsurance amount	20%	20%	20%

PPO / POS emergency room visit cost-sharing

	School boards and other 500+	1,000-4,999 employees	ESEBT WEA Plan 3
% requiring copay	81%	79%	Yes
% requiring coinsurance	36%	40%	Yes
No cost-sharing is required	0%	0%	No
Median copay amount	$100	$100	$100

PPO / POS out-of-pocket (OOP) maximums*

	School boards and other 500+	1,000-4,999 employees	ESEBT WEA Plan 3
Individual OOP maximum			
Median for in-network services	$2,500	$2,300	$2,750
Median for out-of-network** services	$4,000	$4,000	$2,750
Family OOP maximum			
Median for in-network services	$6,000	$5,000	$8,250
Median for out-of-network** services	$10,000	$9,000	$8,250

* Includes deductible
**In-network and out-of-network combined

HMO primary care physician (PCP) visit cost-sharing

	School boards and other 500+	1,000-4,999 employees	ESEBT
% requiring copay	97%	95%	Yes
% requiring coinsurance	0%	2%	No
No cost-sharing is required	3%	3%	No
Median copay amount	$20	$20	$15

HMO specialist visit cost-sharing

	School boards and other 500+	1,000-4,999 employees	ESEBT
% requiring higher copay for specialist	32%	47%	No
Median copay amount, when higher than PCP	$43	$35	N/A

HMO inpatient hospital stay cost-sharing

	School boards and other 500+	1,000-4,999 employees	ESEBT
% requiring deductible / per-admission copay	26%	53%	Yes
% requiring coinsurance	26%	24%	No
No cost-sharing is required	47%	32%	No
Median deductible amount	$250	$250	$100/day Max $300
Median coinsurance amount	10%	10%	0%

HMO emergency room visit cost-sharing

	School boards and other 500+	1,000-4,999 employees	ESEBT
% requiring copay	82%	87%	Yes
Median copay amount	$100	$100	$100

HSA-eligible CDHP deductibles

	School boards and other 500+	1,000-4,999 employees	ESEBT
Individual deductible			
Median for in-network services	$2,500	$1,500	$1,500
Median for out-of-network services	$2,500	$3,000	$3,000
Family deductible			
Median for in-network services	$4,000	$3,000	$3,000
Median for out-of-network services	$5,000	$6,000	$6,000

HSA-eligible CDHP in-network physician visit cost-sharing

	School boards and other 500+	1,000-4,999 employees	ESEBT
% requiring copay	0%	4%	No
% requiring coinsurance	60%	73%	Yes
No cost-sharing is required	40%	24%	No
Median coinsurance amount	20%	20%	20%

HSA-eligible CDHP out-of-pocket (OOP) maximums*

	School boards and other 500+	1,000-4,999 employees	ESEBT
Individual OOP maximum			
Median for in-network services	$4,000	$3,000	$4,000
Median for out-of-network services	$5,500	$6,000	Unlimited
Family OOP maximum			
Median for in-network services	$7,000	$6,000	$8,000
Median for out-of-network services	$12,000	$12,000	Unlimited

* Includes deductible

Dental plan maximums

	School boards and other 500+	1,000-4,999 employees	ESEBT
Median maximum annual benefit	$1,500	$1,500	$2,000/unlimited
Median lifetime maximum orthodontic benefit	$1,500	$1,500	N/A

ESEBT understands that Mercer is not engaged in the practice of law and this report, which may include commenting on legal issues or regulations, does not constitute and is not a substitute for legal advice. Accordingly, Mercer recommends that ESEBT secures the advice of competent legal counsel with respect to any legal matters related to this report or otherwise.

The information contained in this document and in any attachments is not intended by Mercer to be used, and it cannot be used, for the purpose of avoiding penalties under the Internal Revenue Code or imposed by any legislative body on the taxpayer or plan sponsor.