MERCER

TALENT • HEALTH • RETIREMENT • INVESTMENTS

EVERETT SCHOOL EMPLOYEE BENEFIT TRUST
2014 RENEWAL STRATEGY RECOMMENDATIONS

April 17, 2013

MARSH & McLENNAN COMPANIES

Agenda

- Health Care Reform update
- Mercer Survey Results – Market Update
- Benchmarking Summary
- Legislative Update
- Planning for 2014 and Beyond for ESEBT
- 2014 Renewal Calendar

Health Care Reform Update

2014 employer requirements

Employers are focused on understanding the impact of the 2014 Shared Responsibility requirements and making plans to mitigate impact and be in compliance

What are the penalties?

- Offer coverage to less than 95% of full-time employees and the children of those full-time employees, with potential monthly penalty of **$166.66 times the number of full-time employees** (minus the first thirty) during that month
- Offer unaffordable coverage, with potential monthly penalty of $250.00 times the number of full-time employees who receive income-based assistance to buy coverage on the public exchange for that month

Who are your full-time employees?

- The law says a full-time employee is an employee averaging 30 hours per week in a month
- Employers can use a "Look-Back Safe Harbor" to determine if employees work full-time.
- Special rules apply to educational institutions

Health Care Reform fees
Summary

Fee	Effective Year	Who Pays	Impact
Manufacturers of Branded Prescription Drugs	2011 and continues thereafter	Companies who manufacture or sell branded prescription drugs to certain government programs	Fees likely to be passed through indirectly to employers (impact unclear)
Patient-Centered Outcomes Research Institute (PCORI) Fee	Policy or plan year that ends on or after Oct. 1, 2012, and before Oct. 1, 2019	Insurer for fully insured plans; group health plan sponsor for self insured plans (e.g., employer maintaining a single-employer plan)	$1.00 PMPY for policy or plan years ending on or after Oct. 1, 2012 but before Oct. 1, 2013, increasing in subsequent years
Manufacturers of Medical Devices	2013 and continues thereafter	Companies who manufacture or sell medical devices	2.3% of every sale
Fee on Health Insurance Providers	Begins in 2014 and continues thereafter	Health insurance companies offering fully insured coverage	Estimated at 1.9% - 2.3% in 2014
Transitional Reinsurance Fee	2014 and sunsets in 2016	Insurance providers; TPAs on behalf of self-insured plans	$63.00 PMPY in 2014, decreasing in subsequent years

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

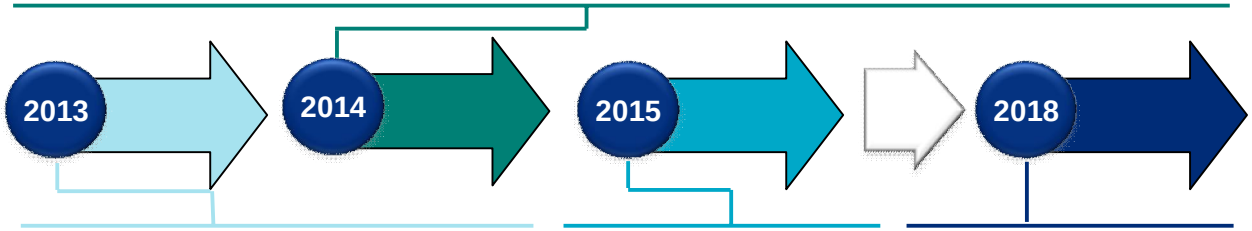
- No lifetime dollar limits on essential health benefits[1]
- Restricted annual dollar limits on essential health benefits, phased amounts until 2014[1]
- Dependent coverage to 26 (grandfathered plans may limit to children without access to other employer coverage, other than parent's coverage)[1]
- 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]

- Health insurance exchange coverage
- Individual coverage mandate
- Financial assistance for exchange coverage of lower-income individuals
- State Medicaid expansion (possibly only some states)
- Employer shared responsibility
- Dependent coverage to age 26 for any covered employee's child[2]
- No annual dollar limits on essential health benefits[2]
- No pre-existing condition limits[2]
- No waiting period over 90 days[2]
- 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



- $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
- 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

- Temporary reinsurance fees first due in late 2014/early 2015
- Additional employee-specific reporting and disclosure of 2014 coverage

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

Footnotes

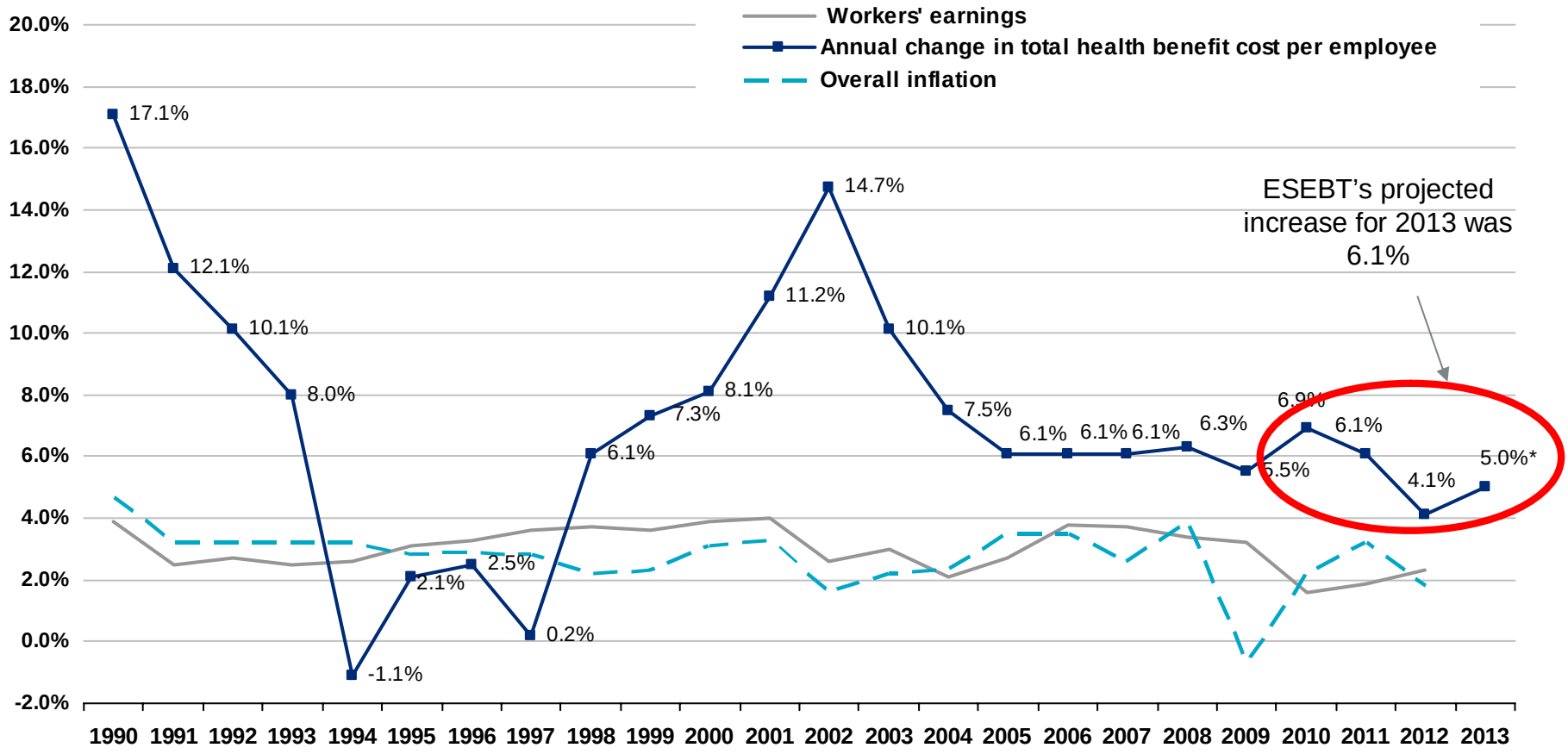
1. *Applies to all plans, including grandfathered plans, effective for plan years beginning on or after Sept. 23, 2010 (Jan. 1, 2011, for calendar year plans).*
2. *Applies to all plans, including grandfathered plans, effective for plan years beginning on or after Jan. 1, 2014.*
3. *Applies to non-grandfathered 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 August 1, 2012.*

Mercer Survey Results — Market Update

About the survey

- The largest and most comprehensive annual survey on the subject
- Established in 1986, national probability sample used since 1993
- 2,809 employers with 10 or more employees completed the survey in 2012
- The national, regional and major industry group results are weighted to represent all US employers. However, results for smaller groups – city, state and other special employer groups – are unweighted and represent only the respondents in the group.

Growth in total health benefit cost per employee slows to 15-year low of 4.1% in 2012 with a 5.0% increase expected for 2013

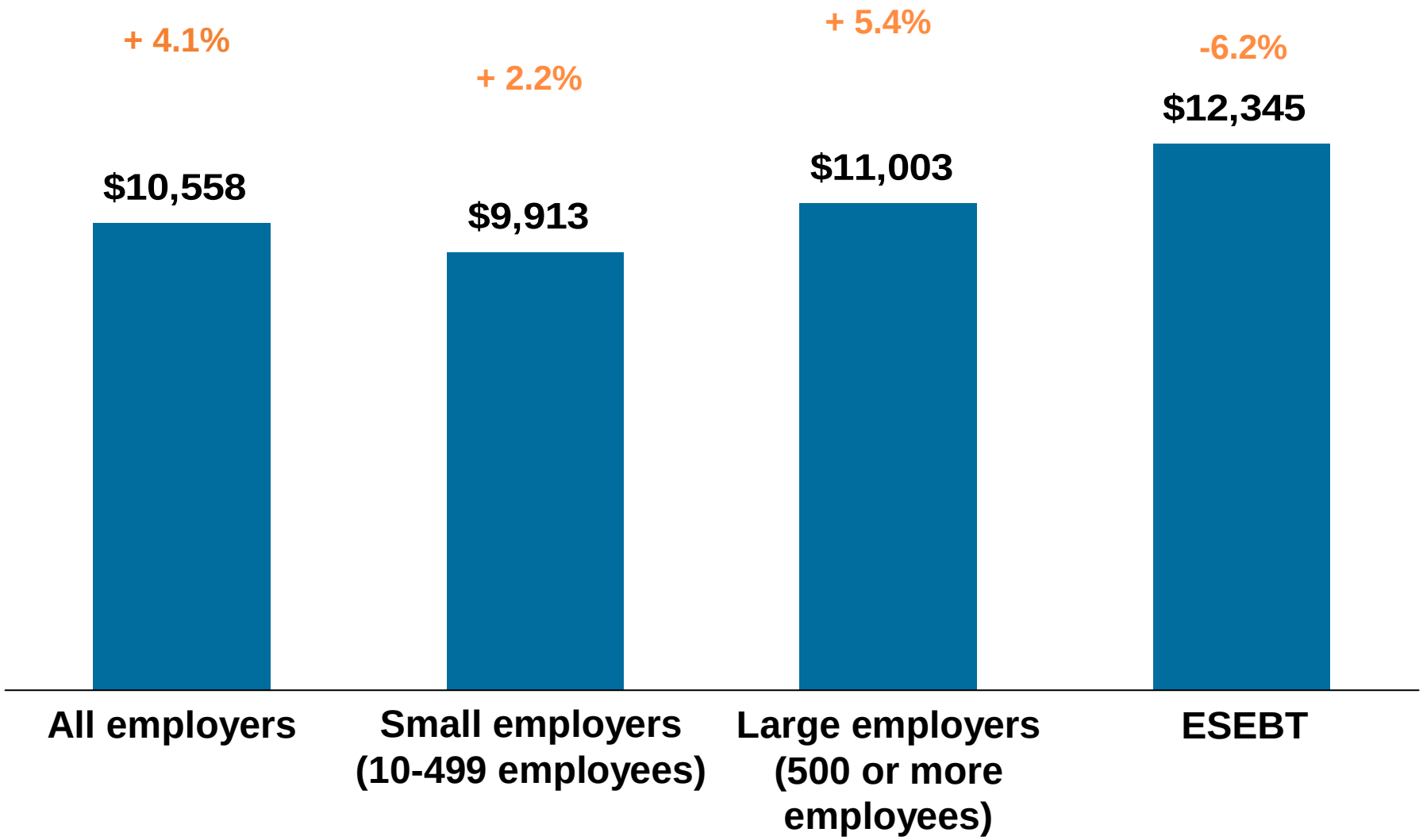


* Projected

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) 1990-2012; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey (April to April) 1990-2012.

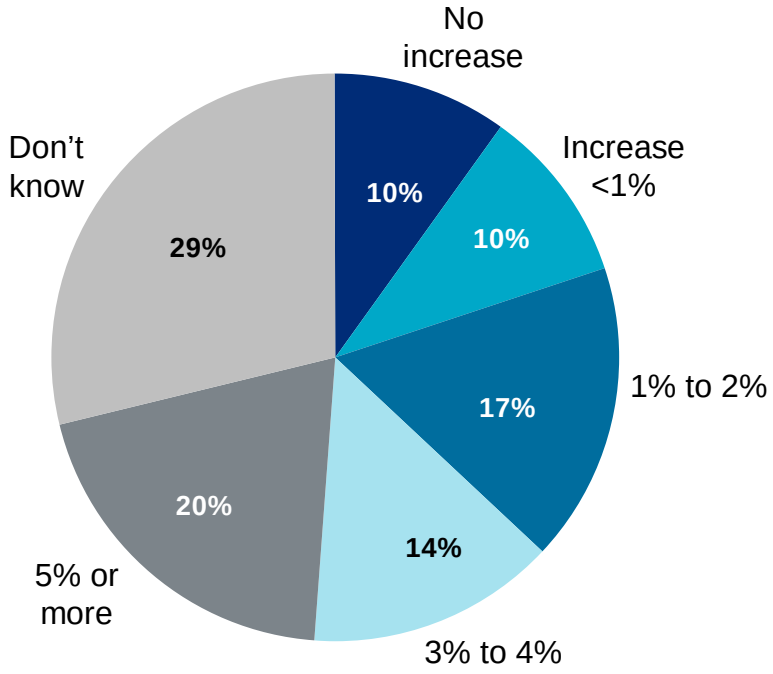
With cost averaging well over $10,000 per employee, employers are wary of covering more employees in 2014

Total health benefit cost per employee in 2012, by employer size



Increased costs for employers

Anticipated cost increase due to PPACA requirements effective in 2014



Plan design

- No lifetime dollar limits
- Restricted annual dollar limits
- No pre-existing condition limits
- Waiting period <90 days

Higher plan enrollment

- Dependents to age 26
- 30-hour eligibility
- Auto enrollment

Fees

- Comparative effectiveness research
- Fees on insurers
- Manufacturer's fees
- Temporary reinsurance programs

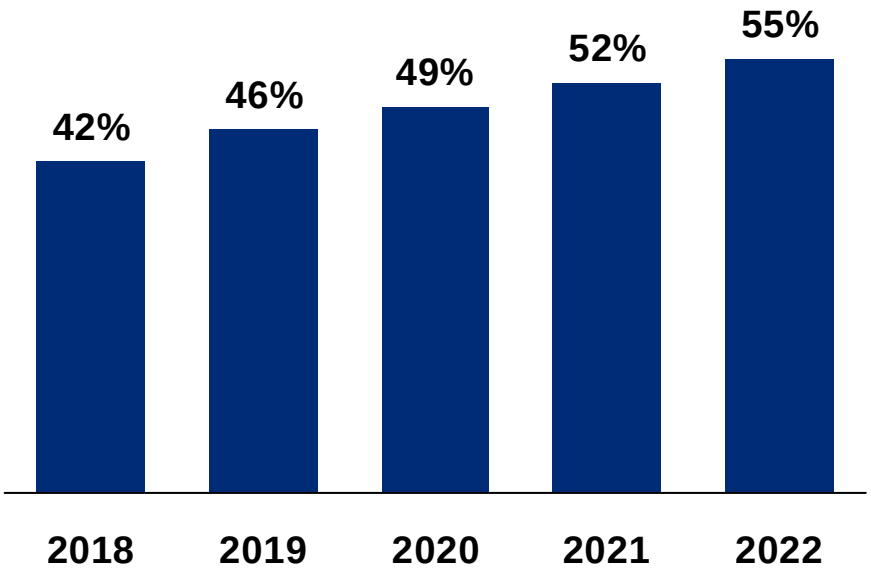
Employer mandate and shared responsibility

Minimum plan and contribution requirements

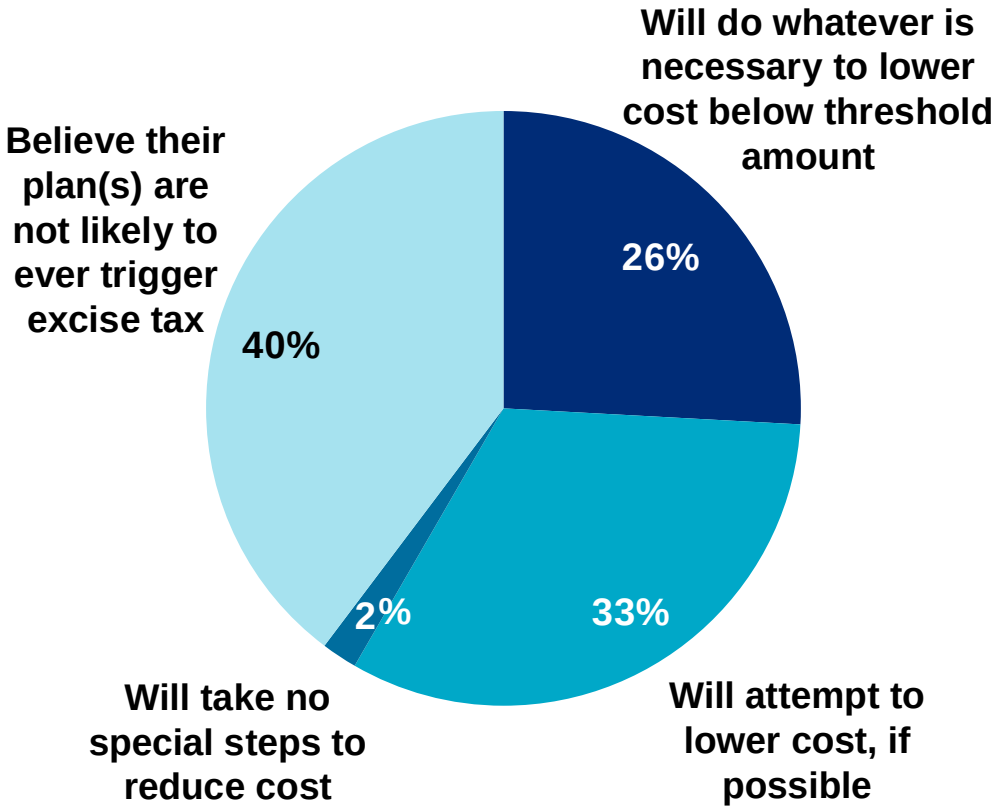
Source: Health Care Reform: After the Decision

And the 2014 requirements are just the beginning
Majority of employers in danger of getting hit with excise tax by 2020

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



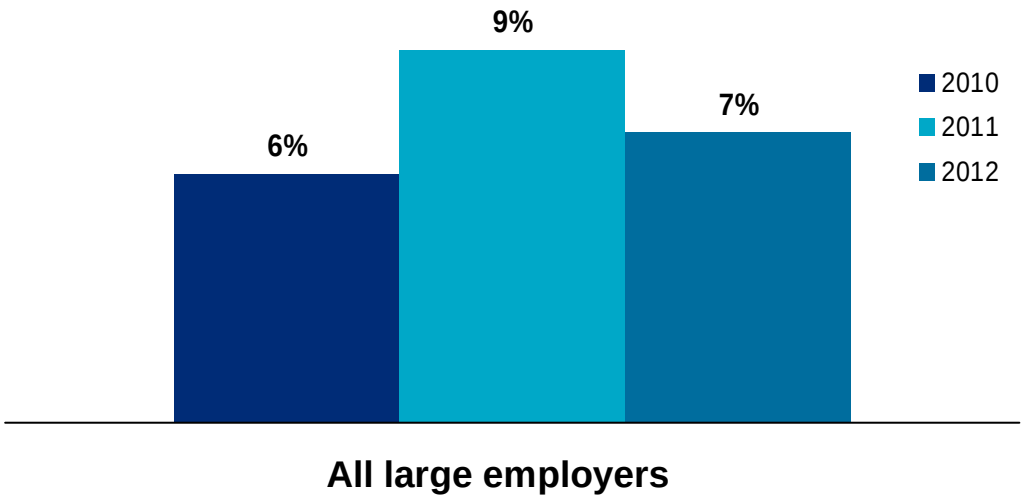
…but most say they will take steps to avoid the tax



Source: 2011 National Survey of Employer-Sponsored Health Plans

Despite added cost pressure, most employers will continue to provide health benefits but they are changing the terms

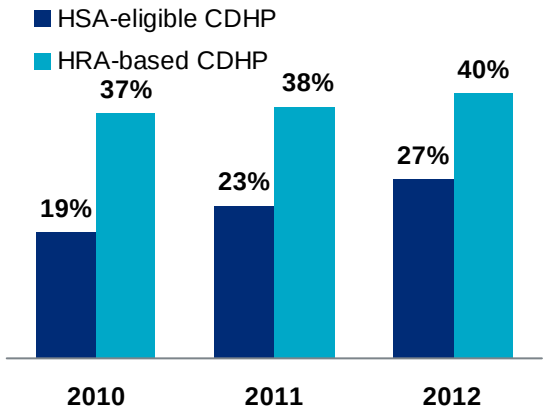
Percent of employers that are likely to terminate plans within the next five years



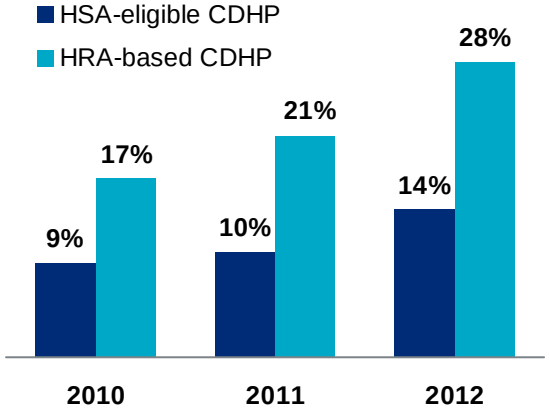
- Resetting benefit value
- Actively engaging employees in improving their own health
- Focusing on choice
- Exploring new options: private health exchanges

Growing employee acceptance spurs growth in CDHP-only programs
Large employers

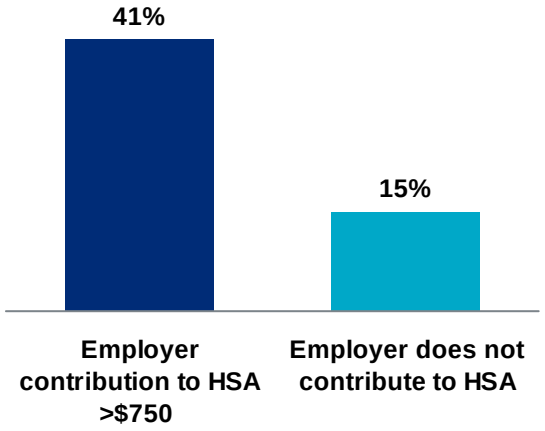
More employees choosing CDHP
% choosing CDHP when offered w/other medical plans



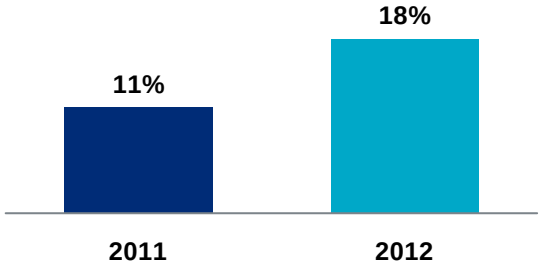
Full replacement becomes more common
% of CDHP sponsors offering no other plan



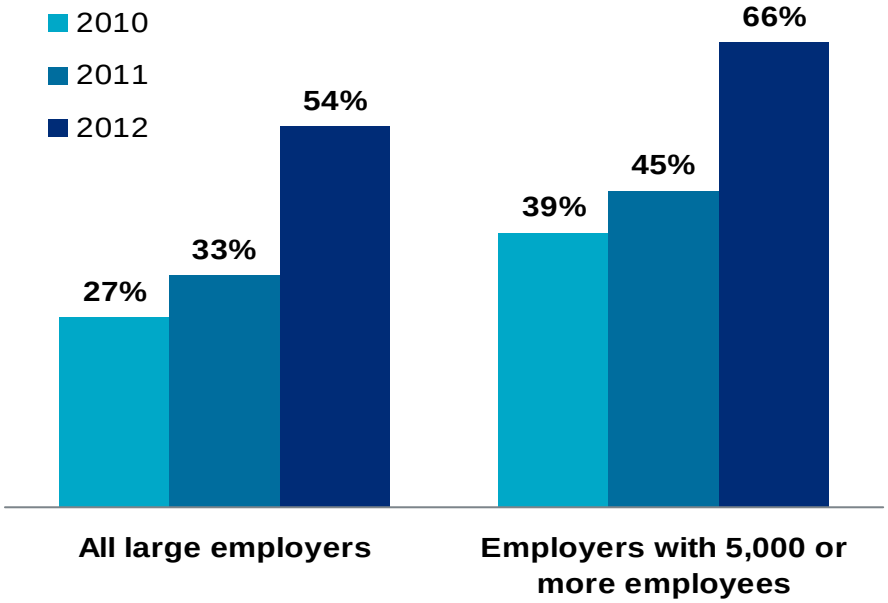
Employer HSA funding drives enrollment
% of employees enrolled



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

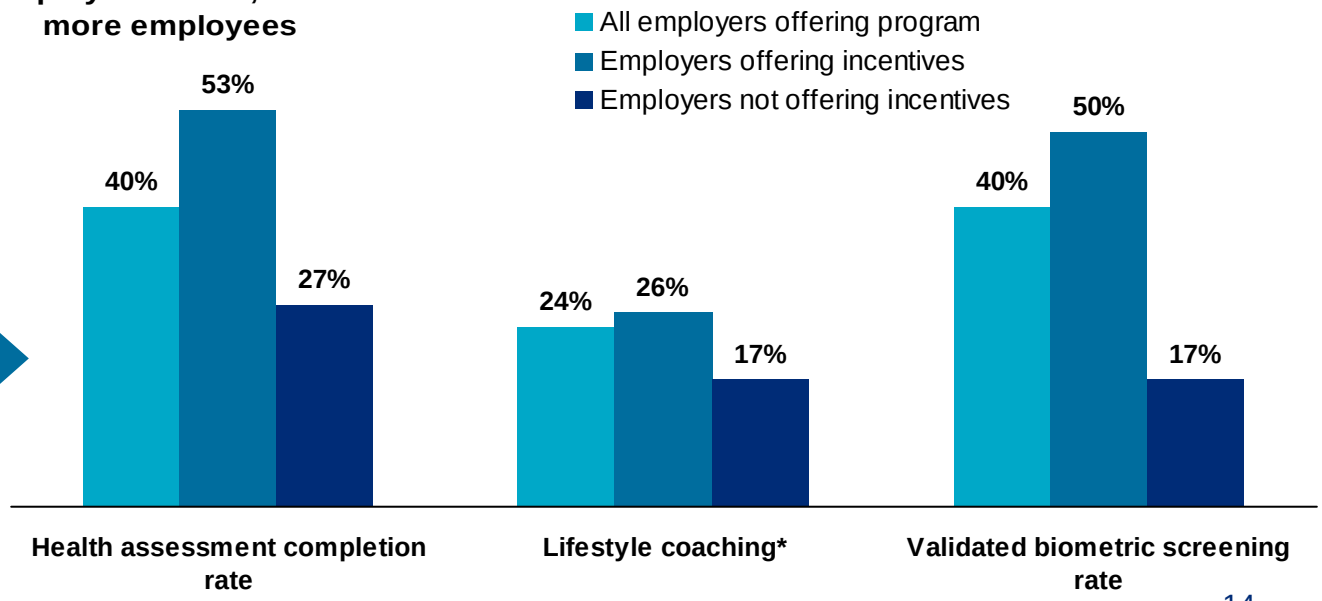


Employers are now focused on building employee engagement – and are seeing results



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

Large employers using incentives report higher participation rates

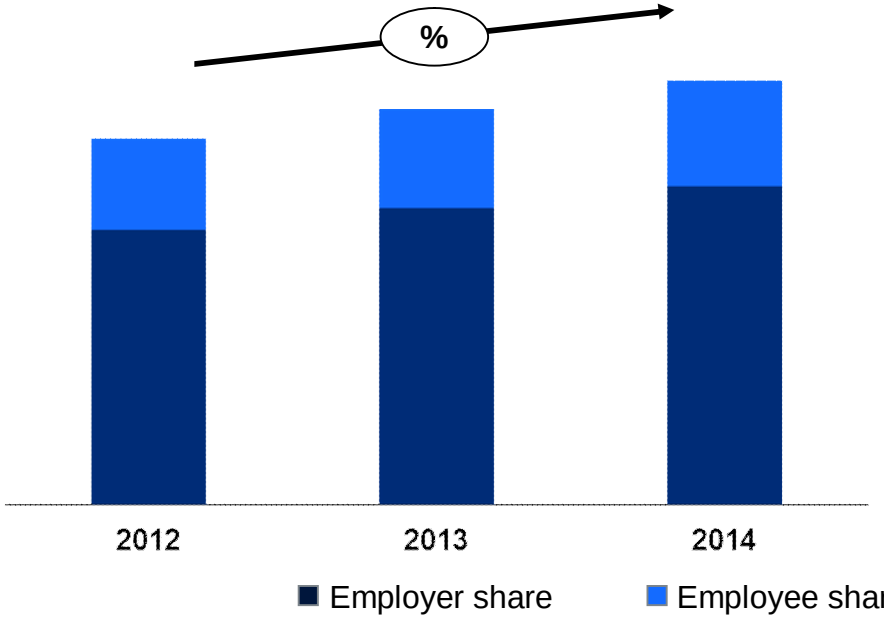


*Average % of identified persons actively engaged in program

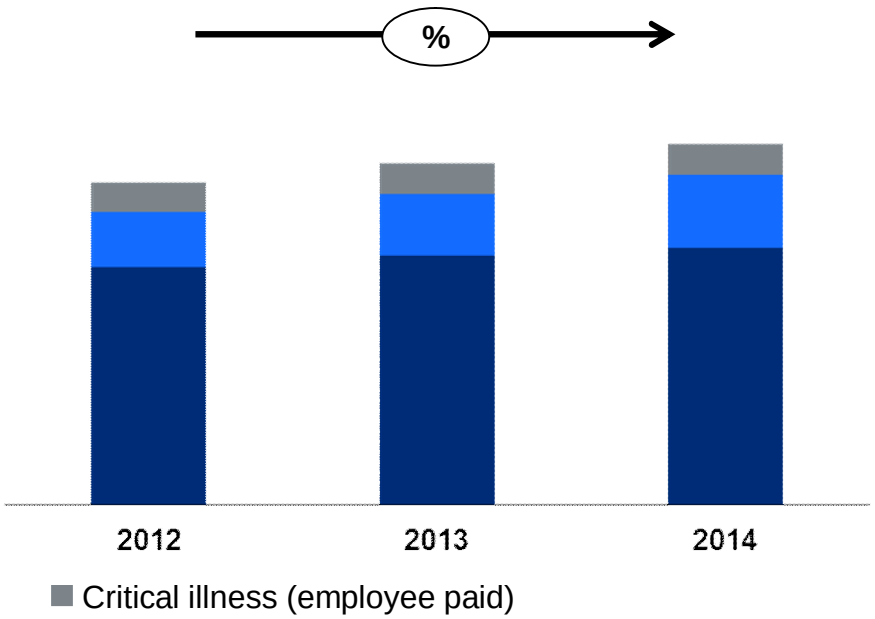
Defined contribution
Creating different choices

Resetting benefit value

TODAY'S STRATEGY: DEFINED BENEFIT



EMERGING STRATEGY: DEFINED CONTRIBUTION



Increase in annual costs varies – and is shared by employer and employee

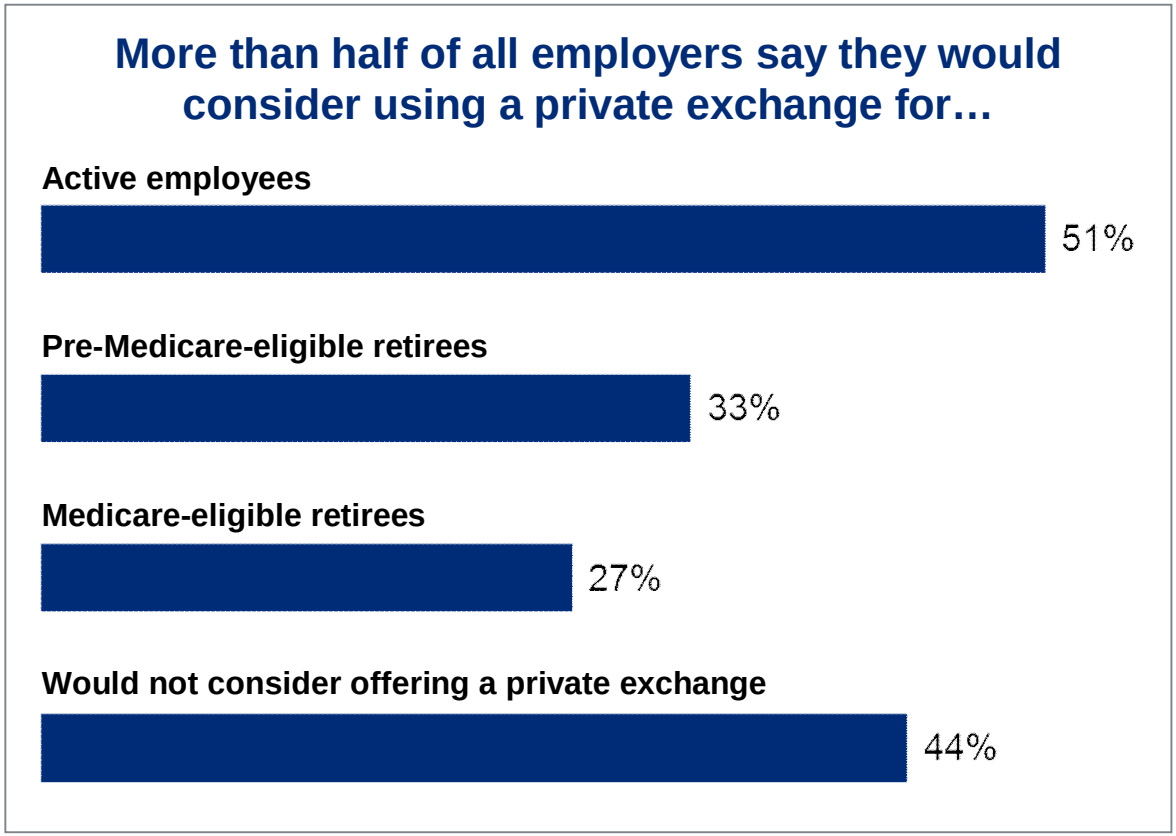
Employer can set "flat" contribution amount

Employee receives money to spend on voluntary benefits like critical illness

Employer + employee save

Private exchanges are already evolving

- **One-stop shopping** across core medial, life, disability and voluntary benefits
- **Technology** eases employee decision-making
- **Collective buying power** and influence will control total benefit cost
- Some allow employers to **retain control**
- Employees are not necessarily opposed to change as long as they see **financial benefit**



Source: Mercer's National Survey of Employer-Sponsored Health Plans 2012

Benchmarking Summary

2013 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	Lower contributions for most prevalent plans (both employee and dependent; higher contributions for HDHP
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 2012 Mercer National Survey of Employer-Sponsored Health Plans

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

Planning for 2014 and Beyond for ESEBT

Recommended renewal strategy

Plan	2013 Renewal Result	2014 Recommendation
WEA – *Medical, dental and vision*	• Medical rate change between -2.5% and +7.5%, elimination of WEA Plan 1, addition of QHDHP, benefit changes to Plan 5, 100% coverage of women's preventive services • WDS rate decrease of 4.0% • Willamette rate decrease of 2.5% • Vision rate increase of 2.8%	• Renew plans • Consider change in plan year, see next page for details
Group Health Cooperative – *Medical HMO*	• 8.68% rate increase, 100% coverage of women's preventive • Tier ratio adjustment to match WEA Plan 3	• Renew plan
MetLife – *Life and AD&D*	• Rate guarantee	• No renewal – guaranteed through 2014
Standard – *LTD, STD*	• Rate pass	• No renewal – guaranteed through 2014
Magellan – *EAP*	• Rate guarantee	• Renew plan – review current pricing to ensure competitive
Alere – *Weight management and smoking cessation*	• New fee structure based on participation phases • Mind & Body program rebranded to "Weight Talk"	• Renew tobacco cessation • Do not renew weight management
Unum - *LTC*	• No change to rates	• State has approved 25% increase for renewals after 3/1/2014 (so 1/1/2015 for ESEBT); potential for increases in 2015 and 2016 as well • Renew plan
HealthForce Partners – *Wellness*	• No changes	• Renew plan, last year of two year rate guarantee

Potential change in plan year

- In 2013, the WEA plan year will change from October 1 to November 1
- ESEBT's plans renew on January 1 of each year while going forward the WEA plans will renew on November 1 of each year
- Most school districts participating in the WEA program align their plan year with the WEA plan year (currently 10/1), although some do not
- Pros and cons of a change in plan year are included below

Pros	Cons
• Avoid the financial impact of "floating" the premium increase from 11/1 to 1/1 – Total 2013 premium approximately $13.4M – An 8% increase funded by the Trust for 2 months is approximately $180,000 • More support from Premera during open enrollment (OE), since the majority of districts observe a plan year in alignment with the WEA plan year • COBRA rates will align with the district plan year	• Timing issues – OE in September, renewal decisions made by end of July or into early August • Collective bargaining ramifications • Less support from Premera during OE • Two OEs in a shorter time period – Short plan year from 1/1 through 10/31, then new plan year runs 11/1 through 10/31

11/1/2014 proposed renewal calendar

January 2014	February 2014	March 2014	April 2014
		• Renewal planning kickoff meeting	• Present renewal strategy recommendations to trustees for approval
May 2014	**June 2014**	**July 2014**	**August 2014**
• Request employee census data from district • Issue renewal requests to carriers	• Receive, review, and negotiate vendor renewals • Receive WEA renewal for 2014-2015	• Develop budget projections • Renewal review meeting including budget projections	• Finalize renewal decisions and issue renewal confirmation letters • Deliver final projections, employee contributions, and rate sheets • Begin development of open enrollment communications
September 2014	**October 2014**	**November 2014**	**December 2014**
• District holds open enrollment		• WEA renewal effective date on 11/1/2014	

2014 Renewal calendar

1/1/2014 renewal calendar

January 2013	February 2013	March 2013	April 2013
		• Renewal planning kickoff meeting	• Present renewal strategy recommendations to trustees for approval
May 2013	**June 2013**	**July 2013**	**August 2013**
• Request employee census data from district • Issue renewal requests to carriers	• Receive, review, and negotiate vendor renewals	• Develop budget projections	• Renewal review meeting including budget projections • Finalize renewal decisions and issue renewal confirmation letters
September 2013	**October 2013**	**November 2013**	**December 2013**
• Deliver final projections, employee contributions, and rate sheets • Begin development of open enrollment communications		• District holds open enrollment • WEA renewal effective date on 11/1/2013	• Renewal effective date for other plans on 1/1/2014

APPENDIX

Benchmarking

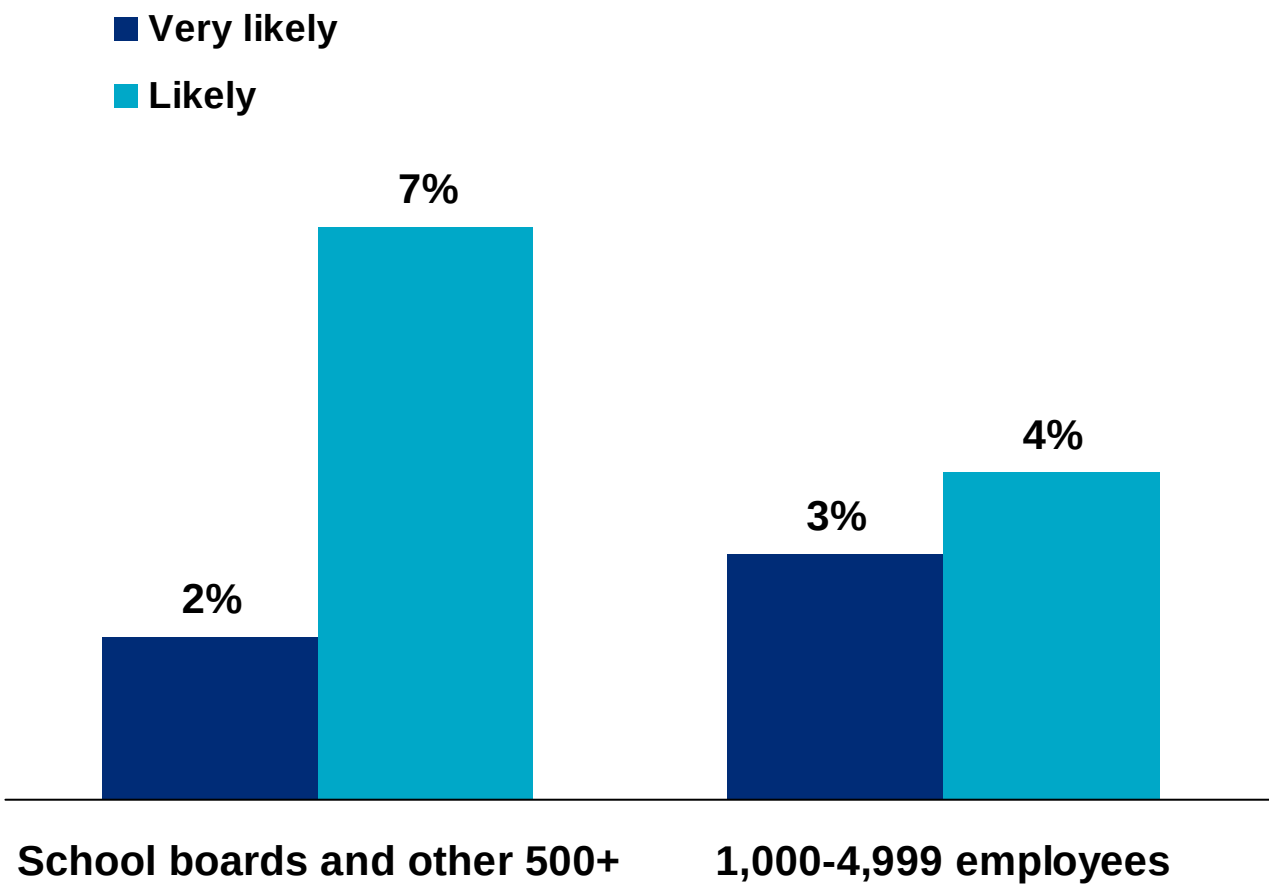
Use (or considering using) a "defined contribution" approach to funding health coverage

	School boards and other 500+	1,000-4,999 employees
Raise employer contribution by a set amount each year, employees absorb the rest of the increase	18%	9%
Provide same dollar contribution for all plans, employees pay more for more expensive coverage	36%	26%
Provide employees with subsidy to purchase coverage on their own	13%	9%
Some other defined contribution approach	8%	7%
Not currently using or considering defined contributions	47%	62%

Would consider offering private health exchanges, as they become generally available

	School boards and other 500+	1,000-4,999 employees
To active employees	29%	28%
To pre-Medicare-eligible retirees	25%	21%
To Medicare-eligible retirees	18%	17%
Would not consider a private health exchange	66%	62%

Likelihood of terminating medical plan(s) within the next five years



Employee contribution for individual coverage
Average monthly contribution ($)

	School boards and other 500+	1,000-4,999 employees	ESEBT*
PPO / POS	$143	$110	$201/116/83/303
HMO	$109	$109	$96
HSA-eligible CDHP	$43	$63	$65
Dental	$21	$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	22%	22%	30/19/19/38%
HMO	18%	22%	15%
HSA-eligible CDHP	8%	15%	19%
Dental	67%	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	$548	$392	$478/321/227/828
HMO	$443	$369	$282
HSA-eligible CDHP	$463	$238	$175
Dental	$57	$49	$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	41%	30%	32/24/24/45%
HMO	34%	28%	19%
HSA-eligible CDHP	37%	22%	24%
Dental	75%	53%	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
Individual deductible			
% requiring for in-network services	78%	85%	Yes
Median in-network deductible	$500	$500	$200
% requiring for out-of-network services	89%	95%	Yes
Median out-of-network deductible	$550	$800	$200
Family deductible			
% requiring for in-network services	79%	86%	Yes
Median in-network deductible	$1,000	$1,000	$600
% requiring for out-of-network services	90%	95%	Yes
Median out-of-network deductible	$1,500	$2,000	$600

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	86%	84%	Yes
% requiring coinsurance	18%	21%	No
No cost-sharing is required	2%	2%	No
Median copay amount	$20	$20	$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	39%	50%	No
Median copay amount, when higher than PCP	$40	$35	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	19%	20%	Yes
% requiring coinsurance	57%	74%	No
No cost-sharing is required	29%	14%	No
Median deductible amount	$270	$250	$300/day
Median coinsurance amount	20%	20%	N/A

PPO / POS emergency room visit cost-sharing

	School boards and other 500+	1,000-4,999 employees	ESEBT WEA Plan 3
% requiring copay	83%	79%	Yes
% requiring coinsurance	35%	36%	No
No cost-sharing is required	2%	3%	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	$2,325	$2,200	$2,750
Median for out-of-network services	$4,000	$4,000	$2,750
Family OOP maximum			
Median for in-network services	$5,000	$5,000	$8,250
Median for out-of-network services	$8,000	$9,000	$8,250

* Includes deductible

HMO primary care physician (PCP) visit cost-sharing

	School boards and other 500+	1,000-4,999 employees	ESEBT
% requiring copay	97%	96%	Yes
% requiring coinsurance	0%	2%	No
No cost-sharing is required	3%	2%	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	42%	51%	No
Median copay amount, when higher than PCP	$40	$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	50%	60%	Yes
% requiring coinsurance	14%	26%	No
No cost-sharing is required	39%	23%	No
Median deductible amount	$250	$250	$100/day Max $300
Median coinsurance amount	20%	20%	0%

HMO emergency room visit cost-sharing

	School boards and other 500+	1,000-4,999 employees	ESEBT
% requiring copay	89%	89%	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	$2,400	$1,500	$1,500
Median for out-of-network services	$2,800	$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

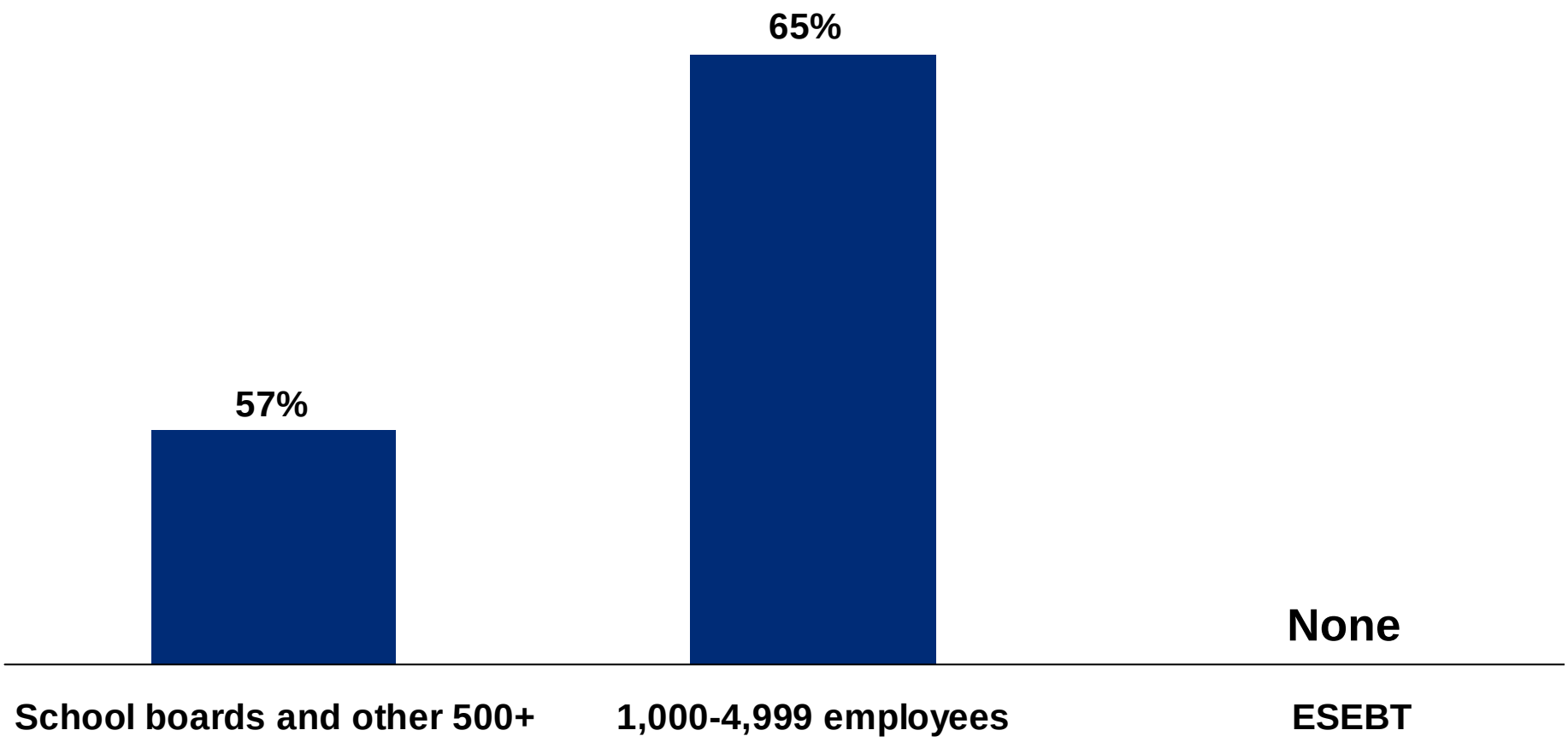
	School boards and other 500+	1,000-4,999 employees	ESEBT
% requiring copay	7%	5%	No
% requiring coinsurance	43%	69%	Yes
No cost-sharing is required	50%	27%	No
Median coinsurance amount	20%	20%	20%

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	$3,500	$3,200	$4,000
Median for out-of-network services	$5,000	$6,000	Unlimited
Family OOP maximum			
Median for in-network services	$5,975	$6,600	$8,000
Median for out-of-network services	$9,800	$12,000	Unlimited

*Includes deductible

Percent of employers making an HSA account contribution



Dental plan deductibles for restorative services

	School boards and other 500+	1,000-4,999 employees	ESEBT
Individual deductible			
% requiring deductible	64%	84%	No
Median deductible	$50	$50	$0
Family deductible			
% requiring deductible	59%	80%	No
Median deductible	$100	$150	$0
Preventive care is subject to deductible	14%	7%	0%

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

Everett School Employee Benefit Trust 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.

Services provided by Mercer Health & Benefits LLC.