Board Office Use: **Legislative File Info.**	
File ID Number	14-1328
Introduction Date	6-26-14
Enactment Number	14-1342
Enactment Date	6-25-14

OAKLAND UNIFIED SCHOOL DISTRICT | *Community Schools, Thriving Students*

Memo

To	Board of Education
From	Vernon Hal, Deputy Superintendent of Business and Operations Ruth Alahydoian, Chief Financial Officer Jerry Johnson, Risk Management Officer
Board Meeting Date	June 25, 2014
Subject	Approval by the Oakland Unified School District Board of Education of an Employee Benefits Consulting Services Agreement

Action Requested

Approval by the Board of Education of an Employee Benefits Consulting Services Agreement between the District and The Segal Company ("Segal") in an amount not to exceed $195,000 annually, for the period of July 1, 2014 through June 30, 2017.

Background

The District provides more than $55 million per year worth of health and welfare benefits to its employees. Those benefits are provided through insurance contracts and self-insured programs that are administered by the Employee Benefits function of Risk Management.

Risk Management engages a benefits broker/consulting firm to assist in the review of current programs, placement and annual renewal of coverages, and related problem solving assistance.

The District's current benefits broker has been in place for more than a decade without formal consideration of other possible vendors.

Discussion

District staff issued an RFP on March 11, 2014 to the incumbent benefits broker and other firms on an approved bidder list. Five proposals were received by the due date of March 28th.

Representative leaders from the District's labor unions, along with District staff from Human Resources, Risk Management and Labor relations came together in the forum of the Health Benefits Improvement Committee ("HBIC") to interview all five bidders and rank them through an open ballot process.

Three rounds of extensive interviews were conducted, during which the incumbent and three other bidders were eliminated. Through each stage of the process, Segal emerged as the clear, and ultimately unanimous, consensus choice of both labor leadership and the District's staff.

The HBIC was impressed with Segal's professionalism, technical knowledge, overall rates of, and transparency in, compensation. Of particular note was Segal's willingness to place 100% of its compensation at risk, subject to periodic performance review by the HBIC.

Recommendation

Approval by the Board of Education of the Employee Benefits Consulting Services Agreement with Segal in an amount not to exceed $195,000 annually, for the period of July 1, 2014 through June 30, 2017.

Fiscal Impact

Fund 76 (Employee Benefits), not to exceed $195,000 annually. This amount represents an annual, ongoing savings of not less than $35,000 over the incumbent agreement.

STANDARD SEGAL COMPANY PUBLIC SECTOR
Consulting Agreement

This Agreement between The Segal Company (Western States) ("Segal"), a Maryland corporation and Oakland Unified School District (the "Client") is entered into as of July 1, 2014.

Accordingly, and in consideration of the mutual premises and provisions hereof, the parties hereby agree as follows:

1. DESCRIPTION OF SERVICES

Segal shall provide to the Client the services described in the Proposal to the Health Benefits Insurance Committee dated May 16th 2014 and shall be incorporated by reference as if fully set forth herein.

2. CHANGES IN SCOPE OF SERVICES

Any worked requested by the Client that is not included in Exhibit A or any revisions of work requested by the Client shall be subject to a written agreement. Prior to performing any services not contemplated in the Proposal, the parties must reach agreement on the terms of the change(s) and signify their agreement in writing. Any such accepted change shall be attached hereto as an Exhibit to this Agreement.

From time to time, the Client may request or Segal may propose in writing future services. If such proposal is accepted by the parties, then such additional services will be governed by the terms and conditions of this Agreement and any such proposal shall be attached hereto as an Exhibit to this Agreement.

3. RESPONSIBILITY OF CLIENT

A. **Data Request.** The annual actuarial valuation report, any required government filings and any required present value calculations and other reports or analyses of benefit and compensation programs require extensive data from the Client. Segal will prepare a detailed data request outlining what is necessary to perform these services. Segal will also request the financial data required and any other data or information needed to complete its analysis, including a copy of the up-to-date plan provisions and any plan amendments. Data will be requested in a computer format compatible with Segal's computer system and year 2000 compliant (that is, appears in a four-digit year representation, for example 2004, instead of '04).

Upon receipt of the data, Segal will examine it for missing information and internal consistency. There may be additional fees based on hourly time charge rates to convert data not presented in the format requested and for the additional processing time required to reconcile data that contains errors, duplicate records or missing information.

B. **Timely Provision of Information.** Client will assure that its other professionals and vendors cooperate with Segal and provide the information requested or needed by Segal on a timely basis.

4. **PAYMENT TERMS**

A. **Basic Annual Services.**

Fees will be charged on a time charge basis.

The time charges will be based on rate specified in the Proposal.

Invoices will be sent monthly.

Fees will be paid within 30 days of receipt of an invoice.

Travel expenses will not be billed to the Client.

Routine expenses such as photocopying, telephone calls, facsimiles, mailing costs, and secretarial and word processing services are included in our fees. Unusual or unexpected expenses for the basic services will be discussed with the Client and may be billed separately.

If this Agreement is terminated or authorized services or projects are suspended, Segal will be reimbursed for all time charges incurred to the date of termination or suspension, up to a maximum of the fee and travel expenses, incurred up to that date.

Total fees shall not exceed $195,000 per year.

B. **Supplemental and Specialized Consulting Services.** Fees for Specialized Consulting Services and Supplemental Services generally will be charged on a time charge basis or, in some instances, may be charged on a project basis. Segal will provide an estimate of such charges before the work is commenced. The time charges shall be based on Segal's time charge rates unless otherwise agreed to. Supplemental and Specialized Consulting Service charges will be billed monthly unless agreed to otherwise.

Projects Outside the Scope: Fees for projects outside the scope of this Agreement will be mutually agreed upon with the Client before beginning work on the project.

C. **Commissions.**

We will be compensated for the placement and ongoing maintenance of insurance (other than Fiduciary Liability Insurance) by commissions paid by the insurance carrier with whom the coverage is placed. The Commissions will offset our fees in appropriate cases. The amount of commission we will receive each year is a percentage of the policy or bond premium. The HBIC will be notified in writing of the rate and amount of commissions we receive each year for these services.

5. **NON-APPROPRIATION**

Funding for this Agreement between the Client and Segal is dependent at all times upon the appropriation of funds by the organization authorized to appropriate such funds. In the event that funding to support this Agreement is not appropriated, whether in whole or in part, then the Agreement may be terminated effective the last day for which appropriated funding is available.

6. **TERM OF AGREEMENT**

The term of this Agreement shall commence on July 1st, 2014 and continue in effect until June 30th, 2017.

7. TERMINATION OF AGREEMENT

Either party may terminate this Agreement on ninety (90) days written notice to the other party. Segal will continue to provide services hereunder to the effective date of any such termination and will cooperate with the Client to provide for an orderly transition of the Services to the Client at the time of any such termination. Notwithstanding the foregoing, in the event that the Client is not current in the payment of Segal's invoices at the time that such notice is given, then Segal may choose not to provide Services during the aforementioned ninety (90) day period. Segal will render final billing to the Client after the date of any such termination, and the Client will pay the same in accordance with Section 4.

8. PROFESSIONAL STANDARDS

All Services will be performed by competent personnel with the care, skill, prudence and diligence under the circumstances that a prudent consultant would use in discharging its services and in accordance with applicable professional standards. If any element of the Services does not conform to the foregoing, Segal will re-perform such element in a manner that does conform, except that if such re-performance is impracticable, Segal will refund the fees allocable to such nonconforming element.

9. CONFIDENTIALITY

Both parties acknowledge that in the negotiation and performance of this Agreement, confidential and proprietary information of each has been and will be made available to the other. The parties agree to use reasonable efforts to maintain the confidentiality of such material, but in no event lesser than was used with like material of the receiving party and not to make any internal use of such material not required or permitted under this Agreement. Neither party will disclose the information to any third party without prior written authorization from the disclosing party. The information received by a receiving party will only be used by those of its employees, agents and consultants whose duties justify the need for access to the information provided and who have agreed to abide by the obligations of secrecy and limited use commensurate in scope with this Agreement. These obligations will apply to verbal information as well as specific portions of the information that are disclosed in writing or other tangible form and marked to indicate its confidential nature. These obligations will not apply to any of the information which:

i) Was known to the receiving party prior to receipt under this Agreement as demonstrated by the receiving party's records; or

ii) Was publicly known or available prior to receipt under this Agreement, or later becomes publicly known or available through no fault of the receiving party; or

iii) Is disclosed to the receiving party without restrictions on disclosure by a third party having the legal right to disclose the same; or

iv) Is disclosed to a third party by the disclosing party without an obligation of confidentiality, unless such information must be retained by that party for that party to fulfill its legal or agreement obligations under this Agreement; or

v) Is independently developed by an employee, consultant, or agent of the receiving party without access to the information as received under this Agreement; or

vi) The receiving party is obligated to produce as required by law, lawfully issued subpoena, or court order, provided that the disclosing party has been given notice thereof and if there is sufficient time, an opportunity to waive its rights to seek a protective order or other appropriate remedy.

To the extent that particular information is subject to specific statutory confidentiality requirements, the requirements of such statute, rather than this section, shall be controlling.

10. INDEPENDENT CONTRACTOR

Segal is an independent contractor. No provision of this Agreement or act of the parties hereunder pursuant to this Agreement will be construed to express or imply a joint venture, partnership, or relationship other than vendor and purchaser of the services. No employee or representative of Segal will at any time be deemed to be under the control or authority of the Client, or under the joint control of both parties. Segal is liable for all workers' compensation premiums and liability, and federal, state and local withholding taxes or charges with respect to its employees.

11. SUBCONTRACTORS

Any subcontractors to be utilized on this project will be subject to the Client's approval.

12. NO ASSIGNMENT

This agreement may not be assigned by either of the parties without the written consent of the other party.

13. FORCE MAJEURE

Segal will not be liable for any delay in performance or inability to perform due to force majeure, including without limitation any acts of God, acts or omissions of the Client, major equipment failures, fluctuations or non availability of electrical power or telecommunications equipment, or other conditions beyond the control of Segal. If Segal's performance is delayed by force majeure, Segal will discuss the situation with the Client and agree upon an extended period for performance. If an event of force majeure continues for more than thirty (30) days, either party may, at its option, terminate this Agreement and any Statements of Work thereunder. Segal will render a final billing to the Client after the date of any such termination, and Client will pay the same in accordance with Section 4.

14. THIRD PARTY BENEFICIARIES

This Agreement is for the benefit of the parties to the Agreement and does not confer any rights or privileges upon any third parties.

15. DISPUTE RESOLUTION

A. **Mediation.** Any disputes between the parties hereto are subject to mediation in accordance with the Judicial Arbitration and Mediation Service ("JAMS") as a condition precedent to the commencement of any legal proceeding hereunder.

B. **Waiver of Jury Trial.** Each party hereby waive any right to a trail by jury in any action, suit, or proceeding arising out of this agreement, or any other agreement or transaction between the parties.

C. **Notice.** In the event that either party believes that the other party has not complied with its obligations hereunder, such party shall send written notice of such non-compliance to the other party. In the event that such other party does not cure such non-compliance within thirty (30) days of the date of such notice, then the party sending notice may avail itself of the terms of Section 15A above.

16. DAMAGES

Each party shall be liable to the other for any direct damages that result from such party's misconduct, negligence or other wrongful conduct arising out of or relating to this Agreement. In no event shall either party be liable to the other or any third party, whether in contract or tort (including negligence), warranty or otherwise, for any indirect, incidental, special, consequential, exemplary or punitive damages arising out of or relating to this Agreement, even if the party has been advised of the possibility of such damages.

17. CONFLICT OF INTEREST

Segal hereby affirms that there are no relevant facts or circumstances now giving rise or which could, in the future, give rise to a Conflict of Interest. A Conflict of Interest means that because of other activities or relationships with other persons, Segal or its subcontractor is unable or potentially unable to render impartial assistance or advice to the Client, or Segal's objectivity in performing the agreement work is or might be otherwise impaired.

If an actual or potential Conflict of Interest arises subsequent to the date of this agreement, Segal shall make a full disclosure in writing to the Client of all relevant facts and circumstances. This disclosure shall include a description of actions that Segal has taken and proposes to take to avoid, mitigate, or neutralize the action or potential conflict of interest. Segal will continue performance of work under the agreement until notified by the Client of any contrary action to be taken.

18. NON-DISCRIMINATION

Segal agrees: (a) not to discriminate in any manner against an employee or applicant for employment because of race, color, religion, creed, age, sex, marital status, national origin, ancestry or disability of a qualified individual with a disability; (b) to include a provision similar to that contained in subsection (a), above, in any subcontract except a subcontract for standard commercial supplies or raw materials; and (c) to post and to cause subcontractors to post in conspicuous places available to employees and applicants for employment notices setting forth the substance of this clause.

19. AUDIT OF SEGAL'S FEES

Upon reasonable notice and during normal business hours, the Client reserves the right to audit or cause to be audited Segal's books and accounts with respect to fees and expenses under this Agreement at any time during the term of this Agreement and for three years thereafter except for confidential or proprietary information or trade secrets of Segal or any third party.

20. NOTICES

All notices, claims, and approvals given under this Agreement must be in writing and delivered in person, by first class or express mail or facsimile addressed a set forth below or such other address that a party gives by notice. Notice given in accordance with this subsection will be deemed given when received.

A.	If to the Client:	Jerry Johnson Risk Officer, OUSD 1000 Broadway, 3rd Floor Oakland, CA 94607
B.	Copy to:	Office of General Counsel Oakland Unified School District 1000 Broadway, Suite 398 Oakland, CA 94607
C.	If to Segal:	Benefit Consultant: 100 Montgomery Street 5th Floor - Suite 500 San Francisco, CA 94104-4308D
	Copy to:	General Counsel The Segal Company 333 West 34th Street New York, NY 10001-2402

21. **AMENDMENT OR MODIFICATION**

No amendment or modification of this Agreement shall be valid or binding unless set forth in writing and duly executed by the parties hereunder.

22. **ENTIRE AGREEMENT**

This Agreement constitutes the entire agreement between the parties hereto with respect to the subject matter hereof and it supersedes all prior oral or written agreements, commitments or understandings with respect to such matters.

23. **SEVERABILITY**

The invalidity, in whole or part, of any provision of this Agreement will not affect the remainder of that provision or this Agreement

24. **BUSINESS ASSOCIATE AGREEMENT**

The parties, if required by law, shall enter into a business associate agreement, which shall be annexed hereto as Exhibit B.

25. **WAIVER OF DEFAULT**

Waiver by a party of any default by the other will not be deemed a waiver of any other default irrespective of whether such default is similar.

26. **CONSTRUCTION OF LAWS AND JURISDICTION OF COURTS**

This Agreement will be governed in all respects by the laws of **California**, without regard to any conflicts of law principle, decisional law, or statutory provision, which would require or permit the application of another jurisdiction's substantive law.

27. **DULY AUTHORIZED SIGNATURES**

For the Client:

The undersigned, Jerry Johnson is Risk Management Officer of Oakland Unified School District and as such has been duly authorized by the Client to sign this Agreement on behalf thereof.

For Segal:

The undersigned **representative** of Segal and as such is duly authorized to sign this agreement in behalf thereof, thereby binding Segal to the provisions of this Agreement.

Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion OUSD or the District verifies that Segal does not appear on the Excluded Parties List at http://www.epls.gov/epls/search.do

IN WITNESS THEREOF, the parties have executed this Agreement as of the date hereinabove set forth.

THE SEGAL COMPANY (Western States), INC.

June 24, 2014 Thomas M. Morrison Jr.
Date **By**
THOMAS M. MORRISON Jr
SENIOR VICE PRESIDENT

Oakland Unified School District

File ID Number: 14-1528
Introduction Date: 6-25-14
Enactment Number: 14-1342
Enactment Date: 6-25-14
By:

6-26-14
President, Board of Education
Oakland Unified School District

6-26-14
Secretary, Board of Education
Oakland Unified School District

Approved as to form & content:

Jacqueline P. Minor, General Counsel
Oakland Unified School District

Segal Consulting

OAKLAND UNIFIED SCHOOL DISTRICT

PROPOSAL TO PROVIDE HEALTH AND WELFARE BROKERAGE AND CONSULTING SERVICES

March 28, 2014

Prepared by:

Thomas M. Morrison, Jr.
Senior Vice President
(818) 956-6777
tmorrison@segalco.com

Robert Mitchell
Consultant
(818) 956-6744
rmitchell@segalco.com

The Segal Group
330 North Brand Boulevard, Suite 1100
Glendale, California 91203-2337
www.segalco.com

Table of Contents

Proposal to Provide Health & Welfare Brokerage and Consulting Services
March 28, 2014

Cover Letter

Segal Consulting

330 North Brand Boulevard Suite 1100 Glendale, CA 91203-2308
T 818.956.6777 www.segalco.com

Thomas M. Morrison, Jr.
Senior Vice President
tmorrison@segalco.com

March 28, 2014

Ms. Pamela Goo
Oakland Unified School District
Risk Management Department
1000 Broadway, Suite 295
Oakland, CA 94607

Re: Proposal to Provide Health and Welfare Brokerage and Consulting Services

Dear Ms. Goo:

The Segal Company ("Segal") appreciates the opportunity to submit this proposal to provide Health and Welfare consulting services for the Oakland Unified School District ("District"). We are excited to assist the District as you pursue these important initiatives. The attached proposal describes our qualifications, an overview of our team's extensive expertise, and our proposed approach to help you meet your goals.

Segal has extensive experience in consulting to public sector organizations and their unique issues. Nationally, Segal has been engaged by approximately 400 public sector entities.

Our proposal describes how we intend to approach this engagement using our extensive experience with public sector organizations for whom we provide similar services. However, we do not advocate an "off the shelf" solution. Rather, we consider the unique needs of each client and customize our work accordingly. Segal is the best-qualified firm to provide comprehensive benefits consulting services for the District because we offer:

- unparalleled technical and actuarial expertise coordinated by Segal's credentialed and responsive staff
- successful and on-time deliverables
- industry-recognized leadership in and knowledge of Public Sector benefits, compensation, and human resources issues and legislation
- an innovative, and client-focused approach to consulting

- independent, objective consulting -- we are not affiliated with any insurance company, investment firm, bank or any other entity which may present a conflict of interest
- established quality control and effective communication procedures, and
- competitive pricing.

Additionally, through our analytic approach and creativity, we have consistently enabled plan sponsors to achieve quantifiable cost savings. These savings, which have been as high as 40% of prior or projected costs, have been achieved through such solutions as:

- data driven negotiations
- funding variations, including self-funded HMOs
- managed pharmacy programs
- joint purchasing initiatives
- targeted carve-outs.

Segal's qualifications as the leading consultant to the unique needs of Public Sector have been contributed by our:

Commitment to Satisfaction and Quality: We exercise rigorous internal Quality Control procedures. We are proud to have some of the longest-standing client relationships in the industry, and believe this is a testimony to our dedication to providing responsive and creative solutions for our clients.

Relevant Experience: We have been independent benefit consultants since our founding in 1939. Our specialized Public Sector group has helped our clients address similar challenges and issues similar to the ones you face.

Dependability: We will work with you to establish work schedules and will dedicate the staff and resources necessary to meet those deadlines.

Innovation: For over 70 years, we have developed cutting-edge total reward approaches that provide quality health care, secure retirement, and competitive compensation programs for public employees. Offering comprehensive benefits requires governments to search continually for cost efficiencies and innovations. Many widely accepted benefit practice and cost containment solutions were originally designed by Segal.

Leadership: Segal is active in the review and development of public sector employee benefit programs, and serves as a source of information and resources to the public sector. Our publications for the public sector community include: *The Evolution of Public Sector Pension Plans*, published by the National Conference on Public Employee Retirement Systems (NCPERS), *An Elected Official's Guide to Public Retirement Plans*, published by the Government Finance Officers Association, and *Employers' Guide to HIPAA Privacy*

Requirements published by Thompson Publishing Group. Whether it be through our *Managing Through Fiscal Stress* initiative or our many informative publications, Segal's accomplished team of actuaries and consultants helps our clients retain high performers and accomplish cost savings.

Our professionals are frequent speakers, authors and advisors to organizations such as the State and Local Government Benefits Association, National Association of State Retirement Administrators, National Council on Teacher Retirement, Government Finance Officers Association, National Association of Government Defined Contribution Administrators, International Foundation of Employee Benefit Plans, College and University Professionals Association – Human Resources, International Personnel Management Association – Human Resources, and WorldatWork.

Stakeholder Sensitivity: Our consultants regularly work in environments with multiple levels of oversight and various interests. We pride ourselves in our integrity and professionalism leading to successful outcomes.

Segal is proposing as the sole contractor, and is able to perform all of the required services and adhere to the requirements described in this RFP. Robert D. Mitchell and I, Thomas M. Morrison, Jr., will be the Principal Contacts throughout the RFP process. Robert Mitchell will be the prime point of contact. Our contact information is as below:

Robert D. Mitchell & Thomas M. Morrison, Jr.
330 N. Brand Boulevard, Suite 1100
Glendale, CA 91203-2337
Phone: 818-956-6700
Fax: 818-484-2697
Email: rmitchell@segalco.com & tmorrison@segalco.com
Segal Tax ID #94-1503999

This proposal shall remain in effect for 120 days after the date of the proposal opening.

Segal would be privileged to be engaged to be consultants to the District. Our proposal is intended to be fully responsive to the RFP and represents Segal's firm offer to provide the scope of services specified in the RFP. We would welcome the opportunity to meet with the District or a selection committee to answer any questions or to discuss our experience and qualifications in detail.

Sincerely,

Thomas M. Morrison, Jr.
Senior Vice President

Section A: Vendors Checklist

Vendors Checklist

Submit this Vendors checklist with your proposal.

Required

1. Vendors Checklist
2. Prime Point of Contact Sheet
3. Proposal Qualification Signature Form
4. Non Collusion Declaration
5. Special Terms and Conditions Response

If Applicable

1. Addenda – signature page of All Addenda issued

Submitted By

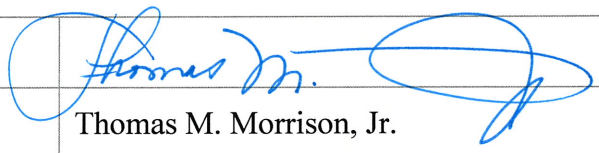
Company Name	Segal Consulting
Contact Person	Thomas M. Morrison, Jr.
Address	330 North Brand Boulevard, Suite 1100, Glendale, CA 91203
Telephone	818-956-6700
Email	tmorrison@segalco.com

Prime Point of Contact

Company Name	Segal Consulting
Contact Person	Robert Mitchell
Address	330 North Brand Boulevard, Suite 1100, Glendale, CA 91203
Telephone	818-956-6700
Email	rmitchell@segalco.com

Qualifications Signature Form to be Executed and Submitted with Response

The undersigned declares under penalty of perjury under the laws of the State of California that the representations made are true and correct.

Signature	
Print Name	Thomas M. Morrison, Jr.
Name of Company	Segal Consulting
Address	330 North Brand Boulevard, Suite 1100, Glendale, CA 91203

The receipt of the following addenda to the specifications is acknowledged.

Addenda No. Date _____

Addenda No. Date _____

Addenda No. Date _____

Noncollusion Declaration to the Executed and Submitted with Proposal

The undersigned, duly authorized to represent the persons, firms and corporations joining and participating in the submission of the foregoing bid (such persons, firms and corporations hereinafter being referred to as the Vendor), being duly sworn, on his/her oath, states that to the best of his/her belief and knowledge no person, firm or corporation, nor any person duly representing the same joining and participating in the submission of foregoing bid, has directly or indirectly entered into any agreement or arrangement with any other vendors, or with any official of Oakland Unified School District or any employee thereof, or any person, firm or corporation under contract with OUSD whereby the Vendor, in order to induce the acceptance of the foregoing bid by OUSD, has paid or is to pay to any other vendor or to any of the aforementioned persons anything of value whatsoever, and that the Vendor has not, directly or indirectly entered into any arrangement or agreement with any other vendor or vendors which tends to or does lessen or destroy free competition in the letting of the award sought for by the foregoing bid.

Segal Consulting
(Name of Company)

(Signature)

March 28, 2014
(Date)

Section B: Questionnaire

1. *State the name, email address, mailing address, title, firm name, telephone number, of the contact person for your firm for this RFP.*

Robert D. Mitchell
Consultant
Segal Consulting
330 N. Brand Boulevard, Suite 1100
Glendale, CA 91203-2337
Phone: 818-956-6700
Fax: 818-484-2697
Email: rmitchell@segalco.com

2. *What is the ownership structure of your firm? Are any ownership changes planned? Describe any ownership changes that have occurred in the last three years.*

The Segal Group, founded in 1939 by Martin E. Segal as The Segal Company, is an independent, privately held consulting firm. It has been employee-owned by its officers since 1978. There are currently 245 employee owners. An 11-member Board of Directors sets policy and governs the organization. Implementation of policies, development of strategies and day-to-day operations are the responsibilities of the Chief Executive Officer.

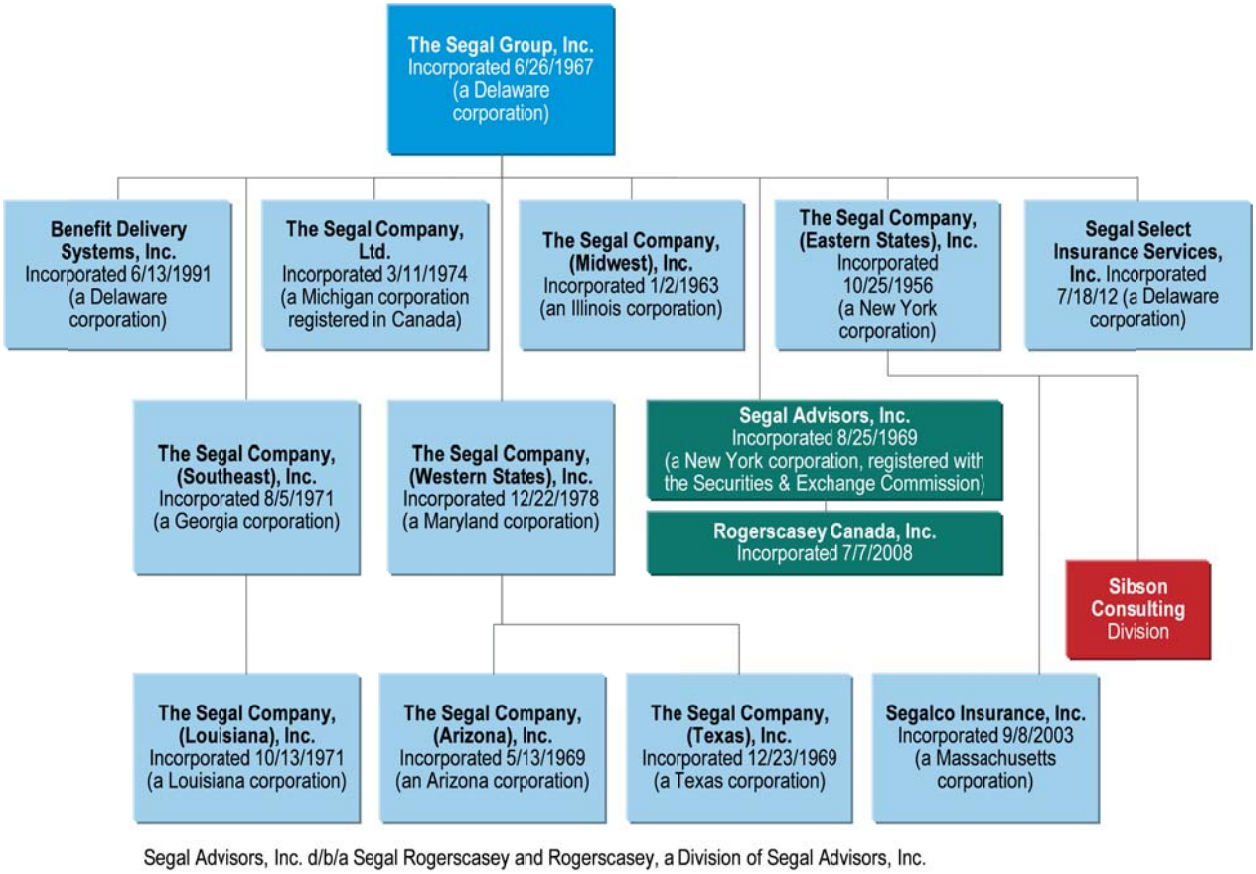
Since its founding in 1939, The Segal Group has become the parent of Segal Advisors, Inc. (dba Segal Rogerscasey; Segal Rogerscasey Canada; and Rogerscasey, A Division of Segal Advisors) Segal Select Insurance Services, Inc., and Segal Waters.

There have not been changes in ownership or personnel reorganization. However, we have continued to seek the best ways to serve clients who could benefit from our expertise. In alignment with that objective, in 2012 Segal Advisors, our SEC-registered investment consulting affiliate, acquired the business of Rogerscasey, a global investment solutions firm that has served institutional asset owners and others for more than 40 years. This combination of resources expanded our already strong investment research capabilities. The combined entity, called Segal Rogerscasey, is privately held with headquarters in New York and offices in Atlanta, Boston, Chicago, Cleveland, Darien, Houston, Los Angeles, Toronto and Ireland. Rogerscasey Canada (now called Segal Rogerscasey Canada) was also part of the transaction. Our management and 11-member Board of Directors, who govern the organization, were unchanged by the acquisition.

In 2014, The Segal Group acquired the assets of the Human Resources Consulting Services Group of The Waters Consulting Group, Inc., located in Dallas, Texas. This acquisition expanded Segal's resources and client base in one of the fastest growing areas of public sector consulting – compensation, job analysis, job evaluation and performance management consulting.

As an independent, non-biased firm owned by its employees, Segal chooses to carefully maintain and protect our model of incremental and planned growth.

THE SEGAL GROUP CONSULTING CHART



Segal Advisors, Inc. d/b/a Segal Rogerscasey and Rogerscasey, a Division of Segal Advisors, Inc.

The Segal Group, Inc. is the parent company of Benefit Delivery Systems, Inc. The Segal Company, Ltd. The Segal Company (Midwest), Inc., The Segal Company (Eastern States), Inc., Segal Select Insurance Services, Inc., The Segal Company (Southeast), Inc., The Segal Company (Western States), Inc., Segal Advisors, Inc., and Segal Waters.

The Segal Company (Louisiana), Inc. is a wholly owned Subsidiary of The Segal Company (Southeast), Inc.

The Segal Company (Arizona), Inc. and The Segal Company (Texas), Inc. are wholly owned subsidiaries of The Segal Company (Western States), Inc.

Segalco Insurance, Inc. is a wholly owned subsidiary of The Segal Company (Eastern States), Inc. Sibson Consulting is a division of The Segal Company (Eastern States), Inc.

Rogerscasey Canada, Inc. is a wholly owned subsidiary of Segal Advisors, Inc.

3. *Identify the policy limits and deductible of your errors and omissions insurance policy. Identify the limits of your fidelity bond. List any other relevant insurance coverage your firm maintains.*

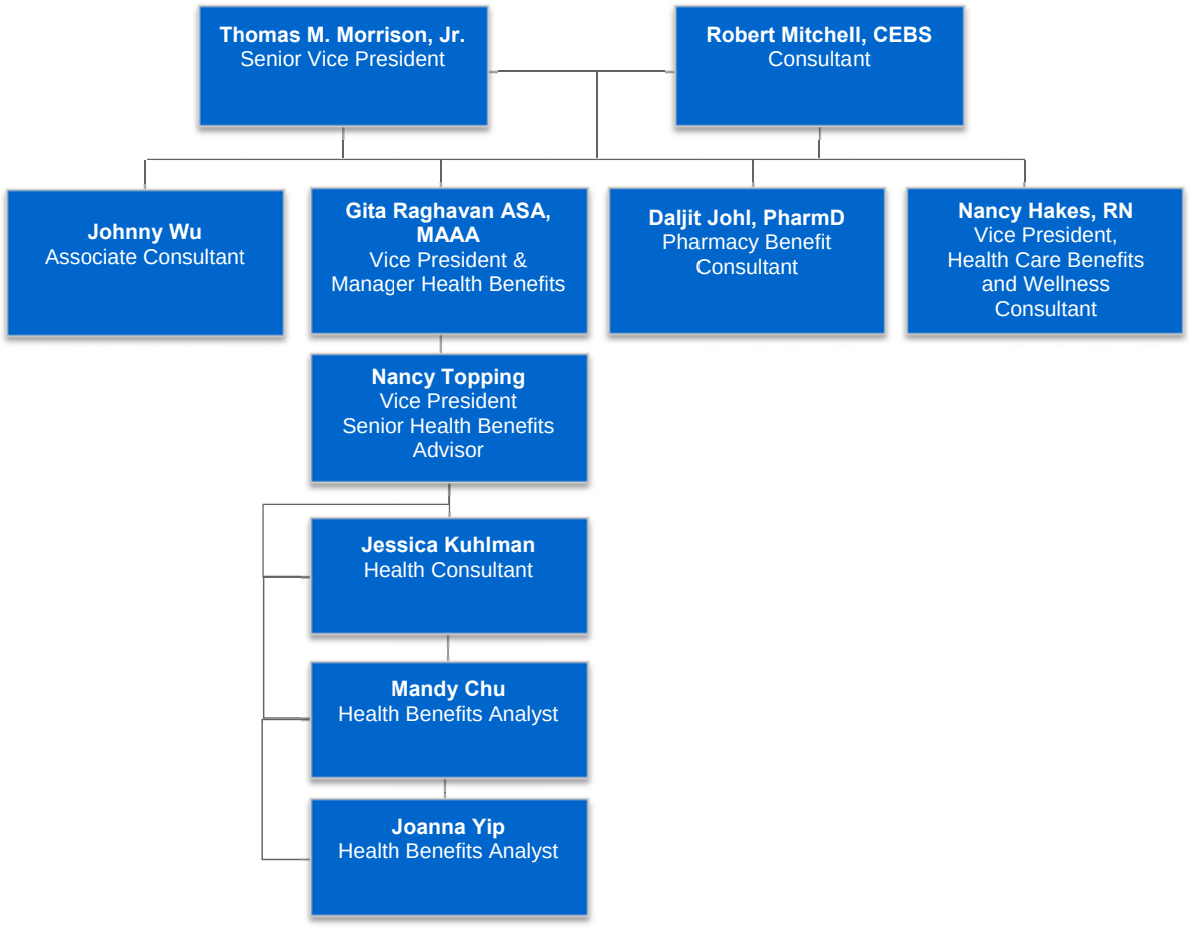
The Segal Company maintains General Liability in the amount of $2,000,000, underwritten by Great Northern Insurance Company, a Chubb insurance entity. Auto in the $1,000,000, underwritten by Federal Insurance Company, a Chubb insurance entity. Workers' Compensation in the statutory amount, underwritten by Pacific Indemnity Company, a

Chubb insurance entity. Employers Liability in the amount of $500,000/$500,000/$500,000, underwritten by Pacific Indemnity Company, a Chubb insurance entity. Excess Liability in the amount of 20,000,000 (excludes Errors and Omissions), underwritten by Federal Insurance Company, a Chubb insurance entity. Crime Liability Insurance in the amount of $5,000,000 underwritten by Westchester Fire Insurance Company. We will be glad to provide appropriate certificates of insurance to the procurement officer as requested by contract.

4. *Describe the consulting team you propose for this account. Identify the lead consultant. Provide resumes for all team members. Do you guarantee that the lead consultant will attend all District meetings? What is the location from which the team will operate?*

Segal confirms that the lead consultant will attend all District meetings. The team will be operating out of our Los Angeles (Glendale) office.

SEGAL'S PROPOSED CLIENT TEAM FOR THE CITY



Segal will bring to this engagement a top team of consultants, actuaries and analysts, all of whom have significant experience working with public sector clients. Tom Morrison will be the District's lead consultant, and he will be supported by Robert Mitchell, who will serve as the day-to-day contact for the District. This dual consulting arrangement will provide depth and continuity for the District. Mr. Mitchell and Mr. Morrison are backed up by a core team; including technical Consultants; Nancy Topping (Health Consultant), and Jessica Kuhlman

(Health Consultant), Benefits Analysts Mandy Chu, and Joanna Yip, who currently perform analytic analysis and projections for the District; an HBA Manager, Gita Raghavan, who is an Actuary and quality champion within the company; and many other specialized resources including Compliance and Communications departments just to name a couple. This proposed team has many years of experience working with public sector clients in northern California. Mr. Morrison and Mr. Mitchell are seasoned innovators in helping public sector entities develop unique solutions for their most complex benefit needs.

With national health care reform as one of the major pending changes that could affect the District in their benefit offerings, Segal's team also includes Kathryn L. Bakich, J.D. (resume attached), our national Health Compliance Director. Kathy has been at the forefront working with U.S. House and Senate committee staffs and the various regulatory agencies in interpreting how proposed changes will affect public sector health benefit programs.

Segal's actuarial and consulting team members locally conduct many competitive procurements to help clients select and negotiate vendors for all types of benefit programs, and annually calculate the premium and contribution rates, reserve needs and retiree liability numbers needed for a large number of self-insured health benefit programs. Our communications consulting team works with state and local governments to convey the appropriate messaging for their benefit changes. Our claims auditors examine the operational performance of insurance carriers and administrators across the country to help our public sector clients assure that contracts are being administered as agreed.

We have specialized practices that encompass every area of employee benefits, including actuarial, rating, communications and legal compliance. The Los Angeles (Glendale) office that is proposing to the District has immediate access to specialists in all of these disciplines. We have included detailed resumes of proposed team members in ***Appendix C***.

Our core team includes the following individuals:

THOMAS M. MORRISON, JR., ***Senior Vice President,*** is a Health Plan Consultant with over 30 years of experience. He will service as the lead consultant and be responsible for the overall relationship with the District. Mr. Morrison will attend meetings with the District as required.

ROBERT MITCHELL, ***CEBS,*** is a Benefits Consultant with The Segal Company. Mr. Mitchell is the proposed co-consultant and day-to-day contact for the District. Mr. Mitchell will attend meetings with the District as required.

GITA RAGHAVAN, ***ASA, MAAA*** is a Health Actuary and Manager of the Health Benefits technical unit in Los Angeles. Ms. Raghavan is the regional actuary responsible for Medicare Part D attestation and submissions for clients for subsidies. Ms. Raghavan works out of the Los Angeles office and would be responsible for the senior review of all technical data that is provided to the District.

NANCY TOPPING, ***Vice President, Group Benefits.*** Ms. Topping is a Health Consultant and will provide senior review of technical work related to the District's health and welfare plans.

NANCY HAKES, ***RN***, is a technical expert on operational issues regarding managed care. She is also a regional health compliance expert. She will provide detailed research on specific

healthcare issues pertinent to medical coverage, plan design, and quality of care, including but not limited to disability, workers' compensation, wellness, EAP and behavioral health, prescription drugs, disease management, telephonic nurse triage programs, and utilization management. She also regularly updates the health plan documents/summary plan descriptions for plan sponsors. She also produces amendments to these documents, as needed.

DALJIT JOHL, ***PharmD,*** is a Pharmacy Benefits Consultant in Segal's San Francisco office, supporting the West Region. Dr. Johl is a member of Segal's National Pharmacy Consulting Practice and assists clients in optimizing benefit design and formularies. She also serves as an expert in client management, strategic planning, PBM clinical programs, product and formulary strategies and analysis of prescription data.

KATHRYN L. BAKICH, J.D, is a Senior Vice President in Segal's Washington, DC office with over 20 years of experience in health care compliance. She is the firm's National Health Compliance Practice Leader.

JOHNNY WU is an Associate Consultant with The Segal Company. Mr. Wu will attend meetings as necessary and is a proposed day-to-day contact and resource for the District.

JESSICA KUHLMAN is a Health Consultant in the Los Angeles office. She will be responsible for analysis of technical data with regard to the District's health and welfare benefit plans.

MANDY CHU AND JOANNA YIP are Health Benefits Analysts in the Los Angeles office. They will also be responsible for analysis of technical data with regard to the District's health and welfare benefit plans.

5. *Identify all of the California public school districts for which you provide health consulting services. Identify any California public school districts for which you have ceased providing consulting services in the last three years and explain why.*

Current:

- Los Angeles Unified School District (LAUSD)
- Fresno County Office of Education

Ceased:

- Solano County Schools (Solano County Medical Benefits Association)
  - The Association disbanded
- Sacramento City Unified School District
  - A new Superintendent was hired and brought her own consultant to the District

Ceased: Project Based (Individual ACA Strategic Consulting Project completed for each District (Each of these occurred between 2013 and 2014))

- Kern High School District
- Atwater Elementary School District
- Edison Elementary School District
- Fairfax Elementary School District
- Fruitvale School District
- Mojave Unified School District
- Palmdale School District
- Rio Bravo-Greeley School District
- Rosedale Union School District
- Standard School District
- Wasco Union School District
- Lakeside Union School District

6. *Describe your firm's experience with the Oakland medical community.*

Below is a list of Segal's clients in and around the Oakland area.

- City of Oakland
- Contra Costa County Employees' Retirement Assoc.
- County of Marin
- County of Sonoma
- City of American Canyon
- City of Benicia
- City of Concord
- City of Cupertino
- City of Modesto
- City of Napa
- City of Stockton
- County of San Benito
- Sacramento Employees' Retirement Assoc.
- University of California Retirement System

7. *Describe your firm's experience with direct contracting with hospitals and medical groups.*

In addition to our public sector expertise, we have also have hospital/healthcare market expertise as it is another focus of our organization. The combined knowledge of both markets ensures that our consulting approach always takes into account the unique environment and issues that both higher education and healthcare organizations operate in and face. We also know that every facility and health system is unique. We will invest the time to understand the System's unique issues. Our hospital/healthcare market experience and the investment we will make in understanding the System will ensure that our consulting is customized to your needs and targeted at addressing your key issues in the context of solutions that make sense in the hospital/healthcare space.

In addition, we are one of the only consulting firms that is active in the national, regional and local chapters of ASHHRA, HFMA and ACHE. The benefit to the System is that the hospital/healthcare marketplace is a focus of the firm.

Segal is experienced in procurements for network management vendors for public sector self-insured clients. The network management vendor, under Segal's and the District's direction, would set up a trust in which the District would be the trustee and the network manager would be the administrator of the trust. Thus, the trust ultimately holds the contract in event of change of trust administrator. In this instance, claims would be submitted to the network management vendor to re-price and then send it back to the TPA to adjudicate based on the benefits design.

8. *Describe your firm's experience with the patient-centered "medical homes" concept or with Accountable Care Organizations.*

We are very familiar with the ACO/Patient Centered Care concept. While the results of a recently (February 25, 2014) published 3-year study by the Rand Corporation were disappointing (few improvements in quality, and no reductions in hospitalizations, Emergency Department visits, or total costs of care), the concept still warrants further development and research.

One example of our cutting edge knowledge of this concept is we just received word that Anthem is in the process of launching a new "Enhanced Personal HealthCare" campaign (program not externally communicated yet), which is focuses on this concept and changes the way providers are compensated to reward Primary Care Physicians (PCPs) when they meet nationally recognized quality measures while reducing health care cost trend.

9. *Describe your firm's experience with wellness programs, especially ones not affiliated with nation-wide firms offering nurse call services.*

Segal views Employee Assistance and Wellness Programs as another segment of the overall benefits package, and has significant experience in designing, marketing, and renewing these plans. We believe that it is important to consider these offerings in light of your overall benefits package, and the overall employee value proposition you are presenting. Once the menu of offerings is determined, the process for managing these benefits is very similar to other benefit plans and our approach to renewals and management will be the same.

The programs listed above have a place in an overall employee health and wellness program and Segal has significant experience in designing, marketing, and renewing these plans. We believe that it is important to consider these offerings in light of your overall benefits package, and the overall employee value proposition you are presenting. Far too many employers hear about a program that worked well for another employer and simply add it, thinking it will automatically have the same impact. The "mud-on-the-wall" technique has proven to be popular, but ineffective for employers. Careful planning and a combined, strategic approach is a necessity.

Segal has found that the three best ways to implement a wellness program are to:

A. **Inventory the wellness services you already offer** so you have a clear understanding of the wellness services made available to employees and dependents and the wellness services not yet offered. (This is a service Segal offers and is explained below.)

B. **Dedicate a person to be your Wellness Director/Coordinator**. Without a dedicated person many plan sponsors cannot get organized and stay on task for the implementation of a wellness program.

C. Enlist the **support of top management** for the advancement of your Wellness program.

Once these three steps are taken, you are well on your way to the design of an effective and comprehensive wellness program where your worksite will gradually model wellness behaviors. In terms of what Segal can offer, the following is a synopsis of our approach:

Segal regularly works with a variety of employer/plan sponsors including corporate, public sector (city/town, county, state and school districts), and multiemployer union funds to help them implement, evaluate and manage both wellness (also called disease prevention or health promotion) and disease management (DM) programs. Because of the uniqueness of these Wellness and Disease Management Programs, no two plan sponsor projects are ever exactly alike…they are highly customized to you and your unique needs. Our consulting process for Wellness and Disease Management services is arranged in these phases:

- **Phase One: Inventory and Organization by Risk Factor** — This phase involves finding out exactly what you are wanting to accomplish (your goals), what group of individuals you want to reach (employees only or employees plus dependents, retirees, etc.), your financial resources for these programs, what health/wellness/disease management services are already available either through your own internal sources or through your existing vendor relationships and benefit programs (an inventory/gap analysis), what is working and not working with any current wellness and disease management services and your desired timeframe to implement new/enhanced wellness and/or disease management services.

  To do this assessment we use our proprietary **Segal Wellness and Disease Management Inventory** tools to assist in gathering comprehensive information about your current Wellness and Disease Management services. For example, the Wellness Inventory currently lists 165+ wellness ideas. While you may often only be performing 1/4 or 1/3 of these ideas, the results of the inventory give you numerous new wellness program ideas. Some of these ideas are no cost or low cost while some ideas need to have a fee projection to determine the financial impact of adding the new service.

  We then outline the wellness and disease management services you already offer and the array of other wellness/disease management options available organized on a chart by health risk factor using **Segal's Wellness Action Plan** (and by disease for the disease management Action Plan). This assures that there is no accidental duplication of wellness and disease management services and fees, unless you want such an overlap. You can then see exactly which wellness services you offer to control health risk factors like weight, exercise, stress/depression/anxiety, smoking, etc., and what support you offer to participants who already have a chronic disease like diabetes or heart disease. This Action Plan organizes your wellness program so you can focus future wellness program enhancements on the risk factors you want to help your participants reduce/eliminate. The Disease Management Action Plan organizes your current efforts to assist participants to better control their chronic disease and gives ideas on other ways to assist them.

  Incentives/Rewards/Penalties — It is also at this point that you, like most plan sponsors, will want to discuss incentives for encouraging participation in wellness services or for actually changing behavior (stop smoking, lose weight, reduce blood pressure) or incentives for both participation and behavior change. Here, Segal discusses your philosophy and budget constraints as it relates to incentives/rewards or penalties.

- **Phase Two: Employee Communication Material** — Some plan sponsors like to take this inventory/outline of existing wellness and disease management services and have Segal create a brochure for distribution to all plan participants letting them know what is

available, any out-of-pocket costs, and how to access the existing wellness and disease management services/benefits.

Additionally you, like many plan sponsors, may want a formal **12-month strategic communications plan of action** to help implement ideas from the Wellness and Disease management inventory projects. Segal's Communications Department prepares this strategic plan along with any brochures, magnets, flyers, posters, videos, website enhancements, etc. you want in order to boost interest and enrollment in the wellness and disease management programs offered.

- **Phase Three: RFP Preparation and Analysis** — This phase (when desired) includes Segal's creation of a customized Request for Proposal for either or both Wellness and Disease Management Services. This phase also includes creation of custom vendor bid lists, analysis of bids, coordination of vendor interviews/reference checks and management of the best and final process to allow you to make an appropriate selection of vendors.

- **Phase Four: Vendor Implementation** — This phase (when RFP phase is selected) typically consists of meetings between your staff, the newly selected vendor and Segal to work through all the steps of the implementation process including contract language, performance guarantees, reports style/content, frequency and ongoing vendor management.

- **Phase Five: Formal Written Wellness Business Plan** — This phase is available if you would like to formalize your wellness program. The written business plan is a custom document to outline your wellness program mission, vision, goals, and objectives along with the design of an employee wellness committee, short and long-term goals, incentives, etc. The Business Plan becomes the framework for the program and guides your month-to-month wellness program activity.

Segal understands the need to help you develop a wellness program that assists your participants in making voluntary behavior changes that reduce their health risks and enhance their individual productivity/quality of life. Basically, you want to keep healthy people healthy, and have any unhealthy people learn to become healthy.

We are prepared to assist you in designing or redesigning a program to reduce the modifiable risk factors that affect your population (such as smoking, obesity, stress/depression, high blood pressure, inactivity/lack of exercise, dyslipidemia, etc.). **Segal is fully prepared to assist you in the design of a health promotion program** that emphasizes the four crucial phases:

- **Communication/awareness** (such as personalized communication, reminders, tools that identify for participants where wellness services already exist in the benefits program, etc.).

- **Screening and assessment** (including Health Risk Appraisals/Assessment-HRA questionnaires, biometric testing including blood tests, blood pressure, body fat, etc.).

- **Education** (personalized coaching for individuals with risk factors, group and individual classes, etc.).

- **Behavior change systems** (including rewards/incentives, worksite modifications, etc.).

In the event you also wish to investigate Disease Management programs, Segal is prepared. We understand that people with chronic diseases (like heart disease, diabetes, asthma, etc.) significantly impact health care costs and that certain people need the support of a Disease Management Program to improve their self-care techniques in order to better manage their chronic diseases.

Much of the cost associated with chronic disease is related to the complications that result from not complying with recommended treatment plans. Improved self-care and adherence to recommended treatment plans allows these people to take better care of themselves, reducing the complications associated with chronic disease, thereby impacting health claim costs.

Segal will provide you with the key attributes of a successful Disease Management program including program design, population identification, risk stratification and behavior change techniques needed to affect change. We will also provide you with an assessment of the degree to which your current medical/dental/vision plans support the management of chronic diseases.

We will discuss the extent to which you can offer rewards, incentives, and penalties for program participation or offer incentives/penalties to help individuals actually change their behavior. Segal understands the legal ramifications of incentives/penalties and can give you guidance in the design of any wellness and disease management incentives or penalties.

Further, Segal can assist you in finding vendors who will create the type and frequency of reporting to allow you to track and trend the impact of the Disease Management services on your population.

Segal possesses the skills to provide quality and timely consulting, bidding and analysis of Wellness and Disease Management services. We will assign an expert team of Segal professionals to work on this project with you along with attorneys in our Washington DC office who specialize in understanding legally permissible wellness/disease management program incentives/penalties. This team brings professionalism and expertise in the development and analysis of Wellness and Disease Management projects.

Return on Investment

Measurement of hard dollar savings will depend on whether the plan sponsor has documented a baseline for data measurement. For example, if a measure of hard dollar savings on the wellness program is the degree to which the program helped employees be healthier and not absent as much, then we would look to you for your baseline data on absenteeism before the wellness program was initiated, and the impact on absenteeism data at various mileposts (*e.g.* at one year, two years or three years after the wellness program has been in place). This data multiplied times a cost per day per employee factor could estimate the financial impact that an increase or decrease in absenteeism produced.

Generally hard dollar savings from a wellness program are difficult to measure because the variables impacting such a measurement are nearly impossible to control. To say that medical claims are lower in 2011 because you implemented a wellness program in 2010 is likely not able to be substantiated with facts, and more likely is related to random claim variations, changes in plan enrollment or plan design or the adoption of a network with deeper discounts than from the participation of a percent of employees in a wellness program.

The impact of an effective wellness program can initially be seen in terms of increased employee productivity, lower use of sick time and FMLA, fewer STD claims and lower workers comp costs as employees begin to focus on staying healthy. Studies suggest that the impact on medical claims may be realized three to five years later as employees who have participated in the wellness program are well on their way to reducing risk factors - have lost weight, stopped smoking, reduced blood pressure.

Most wellness programs measure their impact in the main ways:

- **Participation** — The extent to which each of the wellness program services are used by the eligible participants (*e.g.* 35% completed the health risk appraisal, 14% of smokers attended the Quit Smoking classes, etc.).

- **Behavior Change** — The extent to which the wellness program helped motivate individuals to change their risky behavior (*e.g.* 8% of the people who signed up for the weight management program lost at least ten pounds in the twelve week program, 22% of the people who had an elevated cholesterol level in 2010 have reduced that cholesterol level at least five points from the 2009 measurement).

- **Satisfaction** — The extent to which participants were pleased with the wellness program (*e.g.* 76% of the employees who attended the health fair rated it as good or excellent, 59% of the employees who participated in the Quit Smoking classes found them helpful or very helpful).

- **Impact on Non-Claim Costs** — Comparing the baseline metrics the employer keeps on sick time, productivity, FMLA use, STD use and work comp use/costs to those same metrics after each year of the wellness program can yield some interesting and positive findings, which when multiplied by salary impact can show significant savings from the wellness program.

Effective wellness and disease management programs must be tailored to the needs of the audience who will be using the programs. Medical plan design must be adapted to provide financial support for health promotion and disease management efforts. You and your worksites must develop a creative and sustained "culture of health" day in and day out. Segal is ready and able to assist you with your future wellness and disease management benefits.

10. *Describe your firm's experience working with date aggregation firms.*

Segal routinely works with a number of different data management and data warehousing vendors for our various clients across the country. Segal has an expert national data mining team that includes health actuarial and data mining analytics expertise and clinicians. This

model will allow us to bring a multidisciplinary approach to the District to make the best use of data and patterns.

Segal contracted directly with Medstat for claim data management services through 2001. We had several mutual clients but terminated our relationship with Medstat in 2001. Some of our clients utilize Medstat currently and our consultants work with Medstat on those engagements.

Segal purchased MarketScan normative data (which contained inpatient, outpatient, and total medical costs and utilization data) from Medstat through 2002. Subsequent to that, we purchased comparable benchmark data from Ingenix and other sources.

Segal has also done client work with other data management firms, including: Ingenix, InforMed, HDMS, CareAdvantage, Dynamic Health Strategies, Benefit Informatics, and Verisk Health. We have interacted with many data mining vendors and are familiar with their methodology and processes through capabilities surveys that we have performed.

We have entered into an agreement with Verisk Health to provide clients with comprehensive and in-depth medical data mining services. Verisk Health is an independent medical data management company with sophisticated medical data scrubbing and evaluation tools. Contracting with Verisk gives Segal access to applications developed by DXCG and D2Hawkeye, which were acquired by Verisk. Access to these tools enables us to work with our clients to better manage the performance of their health plans. Being able to dissect complex health plan cost and quality issues requires the use of more powerful data management tools.

11. *Describe your firm's experience working with union-management boards, focusing on the public sector but also including Taft-Hartley boards of trustees.*

Segal was founded in October 1939 as the Martin E. Segal Company. The firm's first services focused on consulting for group health insurance. During World War II, wages were frozen, but employers were allowed to offer new benefits or to expand existing benefits to attract and retain valuable employees, especially in industries that supported the war effort. By the war's end in 1945, increased percentages of workers covered by retirement plans prompted Segal to develop an expertise in this area of consulting.

Soon after World War II ended, Segal began offering retirement plan consulting, including actuarial services. By the early 1950s, our leadership in retirement consulting services for collectively bargained plans brought us national recognition when our firm was asked to help set up the first multiemployer pension plan under the Taft-Hartley Act. Within a few years, Segal assisted in the establishment of numerous national industry-wide pension plans. These activities aided employees of industries such as entertainment, apparel, transportation and construction in which employees do not typically have prolonged employment with a single employer.

Segal began to provide services to private sector and public sector plans, and, by the 1950s, the number of public sector clients grew to include many large government plans, including state and municipal plans. Within the private sector, our expertise in collectively bargained plans benefited private employers staffed by both collectively bargained and salaried workers. By the early 1960s, the company began regularly evaluating investment

performance for sponsors of retirement plans. This work expanded through the decade and in 1969 Segal Advisors, Inc., the Securities and Exchange Commission registered investment-consulting affiliate of the company, was incorporated in New York State.

Segal's retirement and health and welfare practices are known for the depth of our knowledge. Many of our consultants are recognized as national experts, testifying before legislatures, leading professional associations and committees, and speaking at national and regional conferences and forums. Our consultants are also regular contributors to professional magazines and journals.

Both of the proposed consultants for the District, Tom Morrison and Robert Mitchell, had individual sessions as conference speakers at the December 2012 California Public Employer Labor Relations Association (CALPELRA) conference in Monterey, CA.

12. *Describe any care management and health improvement programs your firm has developed in the last three years in the terms of success, cost, and integration with the employer's overall healthcare strategy. Describe key health projects on which the consulting team has worked.*

Segal uses its proprietary Total Health Management (THM) consulting methodology to advise organizations with the challenges of medical trend management. This is a long-term approach for clients to achieve better control over their plan finances.

Segal's THM addresses the root cause of medical cost escalation: consumer health habits, waste in the health care system, poor quality care and poor preventive care. THM emphasizes the care that individual participants receive. It aims to encourage participants to play an active role in their own health care. THM represents a major shift from plan sponsor passivity in their approach managing medical trend to results oriented participant engagement.

Core characteristics of our THM initiative are:

- Promoting healthy behavior to improve treatment outcomes
- Encouraging the use of diagnostic screening and early detection, which can save lives and dollars
- Removing barriers to necessary care inadvertently created by aspects of plan design
- Encouraging high-risk participants and at-risk participants (i.e., those who have asymptomatic illness or disease) to comply with medical treatment
- Providing participants who need care with information about high-performance, high-quality providers, especially for elective procedures driving a large percentage of plan cost, and access to appropriate care that follows evidence-based guidelines.
- The elimination of plan design features that have low medical efficacy. These includes features that may impede access to care and discourage treatment compliance and medication adherence.

- Use state of the art data mining and predictive modeling technology to identify prevalence of disease, severity of chronic conditions, gaps in care, a plan population's burden of illness, and to focus the priorities of developing wellness and medical management solutions.

- Strengthen the Patient/Physician relationship through open access to medical information to facilitate care coordination and medical management.

- Facilitate the use of diagnostic screening and early detection, which can save lives and dollars.

- Use incentives for high-risk participants and at-risk participants (i.e., those who have asymptomatic illness or disease) to comply with medical treatment and select a cost-effective health delivery system.

Trends

Much of the ineffectiveness of medical trend management, is directly connected to the specific plan design of an organization's health plan. Segal's THM approach addresses the root cause of medical cost escalation: consumer health habits, waste in the health care system, poor quality care and poor preventive care. THM emphasizes the care that individual participants receive and what they should be receiving.

THM requires ongoing analysis of plan-specific features related to the claims costs that result. This type of analysis is used to develop a health risk profile of a population. Knowing what diseases, conditions, facilities, and treatments are driving cost increases helps identify cost savings opportunities. Data analysis can also identify gaps in needed treatment for participants who might need targeted intervention (in collaboration with physicians) to ensure compliance with recommended care, reduce the risk of complications and the need for more intensive and costly treatment.

The objective of the analysis is to determine the key drivers of health plan costs and utilization. This is accomplished by benchmarking the costs and utilization patterns against peer groups and best-in-class standards.

Our analysis will include numerous suggestions and recommendations. The cost impact, both today and over the next ten years, will be vital to the decision process. While a program that improves health is laudatory on its own, the impact on the cost to the State will be one of the many variables that should be examined.

Determining the impact on future costs, or said another way, the impact on trend, is not as simple as determining the impact of a change in deductibles or copays. Behavior changes do not happen overnight and the impact of the behavior change may not be realized for many years.

We will use the following five-step method to project the effect on trend. We will model the impact on trend for these initiatives separately from the impact of any discrete plan changes. This will allow the trend impact to be seen separately from other factors.

1. Estimate number of covered persons or events that have the condition or status that is the target of each initiative. This will be based mostly on an examination of demographics, profiles and claims history of the covered population as well as on public information.

2. Estimate the percentage of such persons or events that will be affected by each component of the program. We understand that the trend impact must be forecast separately for each program initiative. This will also be based mostly on the same data as utilized in Step 1 as well as other information and data that Segal has collected and on public information.

3. Estimate the percentage of individuals who will change behavior. This will be based mostly on public information. This result is very dependent on the quality of the program such as frequency of intervention as well as whatever incentives apply. Since the actual program details will not likely be available, we will use our best judgment.

4. Determine the financial savings from the changes in behavior. This will be based mostly on public information and other data sets. Over time, we would expect the financial savings to increase.
5. Remove expected financial savings from trends. We will remove the expected savings from the cost projections, resulting in a net increase from year-to-year, which will be converted to an expected trend.

About Segal's Total Health Management Approach

An effective Total Health Management (THM) program is tailored to the needs of the population that will be using the program and the medical plan design must be refined to support health promotion and disease management efforts, as each worksite develops a culture of health day in and day out. Segal is ready and able to assist you in all aspects of your Total Health Management initiatives.

Total Health Management is an approach to develop cost control measures and measure ROI. The THM methodology follows a disciplined process that includes:

- **Analytics:** utilize medical and Rx drug claims data to identify the medical cost drivers of the plan, develop a population health risk profile, and detail the potential opportunities to reduce medical trend and lower population health risk factors.
- **Planning:** establish a vision among decision makers about the future state of the health plan by defining the plan's guiding principles, key objectives, and how success will be measured in the short-term and long-term.
- **Design:** review and modernize plan design features to eliminate barriers that inhibit effective medical management and support the objectives of the total health management strategy, while providing a gap analysis of service needs with recommendations to remedy the gaps identified.
- **Communication:** create a multi-faceted communication strategy for educating plan participants about the health management/wellness design elements and program features; and determine the media requirements to implement the key communication messages. Initiate outreach to plan participants identified with high health risks and begin more effective support and medical delivery to these patients.

- **Management:** develop the reporting requirements to monitor success metrics to measure progress toward achieving key program objectives and develop a schedule for regular vendor reporting of those success metrics.

Hard dollar savings produced from medical management program will depend on whether the plan sponsor has documented baseline measures from which savings can be derived. A measure of hard dollar savings of the health management/wellness program is the degree to which the program was successful in helping employees be healthier, necessitating the use of fewer medical services. Generally, hard dollar savings from a health management/wellness program are difficult to measure because the variables influencing such a measurement are nearly impossible to control for. To say that medical claims are lower in 2011 because an employer implemented a wellness program in January of 2011 is likely not able to be substantiated with facts. More likely, the savings in the short-term are related to random claim variations, than from the participation of a percent of employees in a wellness program.

Segal has found that by using a focused approach to monitor key factors linked to the success of a health management/wellness program, an organization can develop a solid financial model to measure savings. The primary methods for measuring the success of any health management/wellness program are through monitoring:

- **Participation:** the extent to which each of the program services are used by the eligible participants (e.g., 35% completed the health risk appraisal, 14% of smokers attended the Quit Smoking classes, etc.) will be an effective data point to monitor.
- **Behavior Change:** the extent to which the health management/wellness program motivates individuals to change their risky behavior, such as 8% of the people who signed up for the weight management program lost at-least 10 pounds in the 12-week program, or 22% of the people who had an elevated cholesterol level reduced their cholesterol level at least 5%. Other key changes in behavior that reduce medical costs include medication adherence, treatment compliance to medical guidelines for specific chronic conditions.
- **Satisfaction:** the extent to which participants were pleased with the wellness program (e.g. 76% of the employees who attended the health fair rated it as good or excellent, 59% of the employees who participated in the Quit Smoking classes found them helpful or very helpful).
- **Impact on Non-Claim Costs:** Comparing the baseline metrics the plan sponsor keeps on sick time, productivity, FMLA use, STD use and work comp use/costs to those same metrics after each year of the wellness program can yield some interesting and positive findings, which when multiplied by salary impact can show significant savings from the wellness program.

The impact of an effective health management/wellness programs will initially be seen in terms of increased employee productivity, lower use of sick time and FMLA, fewer STD claims and lower workers comp costs as employees begin to focus on staying healthy. Studies suggest that the impact on medical claims may be realized 1 – 3 years later as employees who have participated in the health management/wellness program reduce their personal health risk factors. Lower health risk factors are associated with managing weight,

quitting smoking, reducing blood pressure, lowering cholesterol, increasing regular exercise, taking medications regularly, and following the treatment guidelines for chronic conditions.

Using the Segal Total Health Management methodology, we have developed effective approaches to measuring the ROI of health management/wellness programs. Our research shows that by focusing on the above four primary areas of monitoring success, medical trend will be reduced as follows:

- Annual improvements of 10% in medication adherence produces a 0.25% reduction in annual claims, up to a maximum of 2%.
- Annual improvements of 10% in treatment compliance produces a 0.25% reduction in annual claims costs, up to a maximum of 2%.

Ultimately, the actual return on investment for a health management/wellness program is measured by an actual reduction in the District's medical trend. Segal will work with the District to develop strategies that reduce medical trend over the short-term and long-term.

13. *Provide references, including name, email address, telephone number, mailing address, for three clients, preferably public school district or trust clients.*

Name	Contact	Address/Telephone	Email Address
Los Angeles Unified School District	Thomas Beatty, Chairman of the Health Benefits Committee	333 S. Beaudry Ave., 28th Fl Los Angeles, CA 90017-5141 (213) 220-6455	tbeatty@teamsters572.org
City of San Buenaventura	Ms. Whitney Ganczewski HR Director	P.O. Box 99 Ventura, CA 93002-0099 (805) 654-7852	wganczewski@ci.ventura.ca.us
Coachella Valley Water District	Ms. Heidi Keeran, HR Director	P.O. Box 99 Ventura, CA 93002-0099 (760) 398-2661, ext. 2371	hkeeran@cvwd.org
County of Sonoma	Ms. Marcia Chadbourne, Risk Manager	575 Administration Drive, Suite 116C Santa Rosa, CA 95403 (707) 565-2473	mchadbou@sonoma-county.org

14. *Describe any conflicts of interest your firm may have in providing services for this account.*

At the current time, we do not see potential for conflict of interest. Should this situation change due to changes within the District, we will proceed in accordance with all required legal regulations.

15. *Has your firm ceased providing service to any health plan in the last three years? Explain why.*

Segal is known in the benefits, compensation, and human capital industry for the longevity of our client relationships. With over 2,300 clients, we gain and lose some clients each year. Some of our client relationships span a period of as much as 50 years. In a number of cases, former clients that retained the services of other consultants have returned to us.

Although any company anticipates some amount of client turnover, tracking numbers of lost clients is difficult because these numbers often misrepresent the situations. For example, much of our work for corporate clients involves project-based assignments, which come to natural conclusions. (It should be noted that the quality of our work often affords us the opportunity to bid on additional assignments, thereby continuing the relationship.) As another example, a number of our clients have merged into larger entities for cost-saving reasons. In many of these cases, we are already the consultant for the larger entity, so although we have maintained the client relationship we value, from a technical standpoint we have lost a client although we continue to consult on benefits for the same participant population under the now-larger plan. And, occasionally, clients have been subject to political changes with respect to the control of benefit issues, which have resulted in a complete turnover of service providers, including the attorneys, the accountants and the benefit consultants.

Despite these issues, the number of clients has grown in each of the last few years, closely following our business model for long-term, steady growth. The number of lost clients for Segal is a miniscule 1-2%.

See our response to Question #5 for specific examples.

Has your firm been involved in any litigation or regulatory proceedings with respect to your provision of health consulting services?

With over 2,500 clients, The Segal Company is occasionally named as a party in litigation involving the performance of its services. Past litigation did not affect Segal's ability to perform services for its clients nor did any litigation have a material effect on its financial position.

Have you tendered to your E&O insurer any claim for negligence or improper conduct with respect to your provision of health consulting services?

No, Segal has not.

16. *Is your firm able to provide all of the services listed in section III of this RFP?*

Yes, Segal is able to provide all of the services listed in section III of this RFP.

17. *Does your firm take any exceptions to the contract terms set forth in this RFP?*

Segal has no exceptions to the contract terms set forth in this RFP.

18. *Will you guarantee your flat fee monthly fee and your hourly rates for two years? For three years?*

Yes, Segal is willing to guarantee our stated flat monthly fee, and hourly rates for 3 years as requested.

19. *Does your firm meet all of the minimum qualifications set forth in section II?*

Yes, Segal meets all of the minimum qualifications set forth in section II of this RFP.

20. *Describe your ability to provide actuary services as needed for self-funded employee benefit plans and to recommend appropriate premium rates and reserves to maintain the viability of the plans and ensure compliance with mandated benefit offerings.*

We routinely provide the following support to our self-funded clients:

- Actuarial Calculations of Self-Funded Required Rates and Reserves
- Third Party Vendor Plan Document and SPD Review
- Contract Management Renewals and RFPs
- Review of vendor capabilities, procedures, and compliance updates
- National Bulletins
- Assisting with Interpretation of the Regulations
- Standard Forms/Workbooks

Segal maintains the greatest level of expertise in all of the funding arrangements, understanding in detail the commonalities and differences in the various funding arrangements, both from a financial and legal perspective. We have experienced, and have been informed by the marketplace, that our expertise exceeds that of many of our competitor's consulting teams.

Segal's expertise in the large employer marketplace is focused around flexible funding: participating contracts, experience-rated contracts, minimum premium contracts, and self-funding.

Although we do not track this data specifically, we estimate that approximately 60% of our 850 health clients in the Region are self-funded. Therefore, approximately 500 are self-funded. Over 80% of our self-funded clients have 500 or more employees.

Our approach is proactive and strives to prevent or resolve service issues at the root. Rather than serving as an extension of your Human Resources department in managing routine matters, we demonstrate our value by holding your vendors accountable to prevent administrative and customer service failures. We are your liaison in resolving complex matters and addressing concerns related to employer and employee service, ideally before the matter escalates to a level of failure. As in all matters related to our relationship, we follow issues, projects, requests, and concerns from inception to resolution and keep you informed.

Self-funded employers hire Third Party Administrators (TPAs) to pay and manage medical/vision and dental claims, interface with your stop-loss carrier, maintain their own or

lease provider network and a Pharmacy Benefit Manager. Your TPA will either subcontract or perform utilization review, preauthorization, and large case management.

Segal will apply our many years of experience in analyzing and working with all types of service delivery platforms to help the District ensure that you select and utilize the most cost effective plans with the greatest service available to the District's members.

Segal identifies the most advantageous plan or administrator by matching the District's needs in the order of importance and appropriate weight as defined by you and our partnership to the vendor capabilities. This includes the vendor's specific area of strength and expertise; program capabilities and offerings; their client and employee service philosophy, flexibility, compliance, financial stability, ability to manage claims and/or work with and transfer information to other vendors; contain your exposure to costs and other risks, network and other discounts; claims payment accuracy, turnaround time, problem resolution, reporting and other information capabilities; quality control measures to include edits and automation, on-line tools, dedicated resources and people, and other tools; willingness to implement performance standards and guarantee performance; and demonstrate needed flexibility. Further, considerations include employee access and available networks, and employer and employee costs, as well as the vendor's capacity and ability to grow their capability consistent with the growth and objectives of the client, the ability to facilitate smooth transitions and implement changes, as well as any other factor as identified by the you, that might include environmental responsibility, support to local schools, or others.

Segal has extensive experience with self-funded clients and routinely performs a bidding process for Third Party Administrators and/or ASO (Administrative Services Only) arrangements. Our RFP can be modified for a variety of alternative funding arrangements.

21. *Indicate what services your firm directly provides and which services must be contracted with an outside agency.*

Segal is able to provide all of the services listed in section III of this RFP. Segal will not utilize any outside agencies to supplement our staff.

Section C: Fees

The qualified consulting firm will provide services for a three year period with 2 one year options commencing after Board of Education approval. Prices shown in proposals must be guaranteed for a minimum of one year from date of award.

1. *Provide a monthly flat fee ("retainer") proposal for the services set forth in subsection B of section III of this RFP.*

Pricing Proposal – As requested, Segal is proposing its fees to the District on a flat fee basis on an initial three-year term with the option to extend for up to two additional years. Segal can accommodate other arrangements if the District so desires.

Segal is able to offset these stated fees with commissions if that is the District's preference, but prefers zero commission arrangements. If commission offsets are preferred, the District would receive a full accounting of the commissions received and if it is in excess of the stated fees, the District would be able to request reimbursement of the surpluses, or use them to offset out of scope projects if necessary.

Without exception, Segal would **not** accept **any** vendor indirect compensation (volume bonuses, overrides, contingencies, etc.) on behalf of District provided benefits.

Phase 1 – Pre-Conversion

Years 1 – 3 - July 1, 2014 to June 30, 2017 - **$19,500/month (annualized: $234,000)**
Year 4 - July 1, 2017 to June 30, 2018 - **$20,000/month (annualized: $240,000)**
Year 5 - July 1, 2018 to June 30, 2019 - **$20,500/month (annualized: $246,000)**

Phase 2 – Conversion

For Self-Insurance Analysis only (if the decision is not to pursue and no RFP's are issued)
Project Flat Fee - $20,000 (In addition to Phase 1 Fees)

For Complete Conversion Scope listed in the District's "Conversion Period Technical Services Specifications" (if the decision is to pursue and implement self-insurance)
Project Flat Fee - $150,000 (In addition to Phase 1 Fees)

Phase 3 – Post-Conversion

For Self-Insurance Analysis only (if the decision is not to pursue self-insurance)
Fee in lieu of Phase 1 Monthly Retainer fee - N/A (Continue Phase 1 Fee Schedule)

For Complete Conversion Scope listed in the District's "Post-Conversion Technical Services Specifications" (after self-insurance is implemented)
Fee in lieu of Phase 1 Monthly Retainer fee -
Years 1 – 3 - July 1, 2014 to June 30, 2017 - **$21,600/month (annualized: $259,200)**
Year 4 - July 1, 2017 to June 30, 2018 - **$22,200/month (annualized: $266,400)**
Year 5 - July 1, 2018 to June 30, 2019 - **$22,900/month (annualized: $274,800)**

2. *Specify any services relevant to self-funded health plans such as the District's plan that your firm provides and that are not included in subsection B of section III of this RFP. Specify your fees for those services.*

See proposed fees in previous answer.

3. *Provide hourly rates for each member of your proposed consulting team.*

For ease of administration and billing, Segal is proposing a fixed composite hourly rate for the District, regardless of the team member that performs the work.

Composite Hourly Rate	$350/hour

Segal's proposed fees include all administrative costs. Segal does not bill separately for clerical or secretarial support rendered in the normal activities relating to our clients.

Segal's proposed fees include all expenses. Segal's fees include all costs for duplication, delivery and messenger services, computer charges, telephone and travel costs. There are no supplemental charges for these services.

Section D: Pre-Conversion Technical Service Specifications

i. *Review Column A for a listing of key services sought in this RFP.*
ii. *On a separate Word document, please describe your approach to providing each service in Column B.*
iii. *Fill in a recommended frequency in Column C.*
iv. *Fill in Column D based on the estimated number of hours for your organization to fulfill this function.*
v. *Fill in Column E based on the blended hourly rate for professional fees from your organization. Separately, provide respective hourly rates that your firm would use.*
vi. *Provide work product substantiating your ability to deliver the requested service, if indicated "Y" in Column F.*

A. Service Areas	B. Your Approach	C. Should the service occur regularly on an ad hoc monthly, quarterly, semi-Annual, or annual basis?	D. Estimated Hours total hours in year	E. Blended Hourly Rate	F. Work Product Sample Requested
1. Plan Design Changes	See Appendix A				
1.1. Comprehensive report on options for plan design changes		Annual or Quarterly	10	$350	See Appendix F: Exhibit 1
1.2. Ongoing monitoring and analysis supporting recommendation at monthly meetings		Quarterly (recommended) or Monthly	40	$350	See Appendix F: Exhibit 8
1.3. N/A					
1.4. Plan document/booklet revisions		Ad hoc	10	$350	
1.5. Open enrollment planning and oversight		Annual	40	$350	See Appendix F: Exhibit 2
1.6. District Benefits Office training		Ad hoc	40	$350	
2. Financial Information Flow	See Appendix A				
2.1. N/A					
2.2. N/A					

A. Service Areas	B. Your Approach	C. Should the service occur regularly on an ad hoc monthly, quarterly, semi-Annual, or annual basis?	D. Estimated Hours total hours in year	E. Blended Hourly Rate	F. Work Product Sample Requested
2.3. N/A					
2.4. Comparisons to national, state, local, industry benchmarks		Quarterly, Annual, Ad hoc	8	$350	See Appendix F: Exhibit 3.1 & 3.2
3. Business Partner Management	See Appendix A				
3.1 Sourcing					
3.1.1 Identify and evaluate potential new business partners		Annual, Ad hoc	10	$350	
3.1.2 Use RFPs or other processes to create relationships with new business partners. RFPs include due diligence, scoring, and finalist interviews.		Annual, Ad hoc	40-85 hours per RFP (depending on the coverage)	$350	
3.1.3 Please address your competency in establishing a pharmacy benefit manager (PBM) function for OUSD		Ad hoc	100	$350	
3.2 Negotiation with new vendors and incumbent vendors seeking renewals; topics include data sharing terms, service level agreements, and performance guarantees.		Annual	80	$350	
3.2.1 N/A					
3.3 Serve as default liaison between OUSD's labor-management benefits design committee and business partners on all topics including					
3.3.1 Escalation of Business Partner performance issues		Ad hoc	8	$350	
3.3.2 Implementation of Business Partner programs		Annual, Ad hoc	15	$350	

A. Service Areas	B. Your Approach	C. Should the service occur regularly on an ad hoc monthly, quarterly, semi-Annual, or annual basis?	D. Estimated Hours total hours in year	E. Blended Hourly Rate	F. Work Product Sample Requested
3.4 Serve as default liaison between OUSD's labor-management benefits design committee and business partners on all topics including					
3.4.1 In conjunction with reports on vendor programs					
3.4.1.1 Review all materials submitted by vendors		Monthly	24	$350	
3.4.1.2 Validate program budget		Ad hoc	8	$350	
3.4.1.3 Provide performance benchmarks based on national, state, local or industry standards		Ad hoc	16	$350	
3.4.1.4 Recommend next steps to be performed by Vendor, Benefits Consultant or other parties		Monthly	12	$350	
3.4.2 Review the plan's COBRA and HIPAA compliance, including the status of business associate agreements		Annual	10	$350	
4. Internal Resource Management					
4.1 Designate and maintain single point of accountability within our firm for all work product	See Appendix A	**n/a**	**n/a**	**n/a**	**n/a**
4.2 Oversight of specialist outside consultants as applicable	Not proposing with outside consultants	n/a	n/a	n/a	n/a
4.2.1 Review all work product as needed	Not proposing with outside consultants	n/a	n/a	n/a	n/a

A. Service Areas	B. Your Approach	C. Should the service occur regularly on an ad hoc monthly, quarterly, semi-Annual, or annual basis?	D. Estimated Hours total hours in year	E. Blended Hourly Rate	F. Work Product Sample Requested
4.2.2 Resolve coordination issues	Not proposing with outside consultants	n/a	n/a	n/a	n/a
4.2.3 Participant in regularly recurring meetings if needed	Not proposing with outside consultants	n/a	n/a	n/a	n/a

Other Areas of Interest Applicable to the Pre-Conversion Period

1. OUSD's labor-management benefits design committee will adopt a review process that will be used to determine your performance relative to the requirements in this RFP. Your firm will be an active participant in guiding the committee's review of your services, but the final scoring will be at the sole discretion of the committee. What portion of fees are you willing to put at risk based on review of your services?

   100% of Segal's fees are at risk for client satisfaction. If you are not satisfied with any project or service provided by Segal, we do not want you to pay for it. As an employee-owned company, we do not work for shareholders, we work for our clients and we pride ourselves in delivering the best service available. We have never had a client take us up on this offer, and we do not intend to give the District a reason to.

Section E: Conversion Period Technical Service Specifications

i. *Review Column A for a listing of key services sought in this RFP.*
ii. *On a separate Word document, please describe your approach to providing each service in Column B.*
iii. *Fill in a recommended frequency in Column C.*
iv. *Fill in Column D based on the estimated number of hours for your organization to fulfill this function.*
v. *Fill in Column E based on the blended hourly rate for professional fees from your organization. Separately, provide respective hourly rates that your firm would use.*
vi. *Provide work product substantiating your ability to deliver the requested service, if indicated "Y" in Column F.*

A. Service Areas	B. Your Approach	C. Identify as Step on Conversion Timeline	D. Estimated Hours total hours in year	E. Blended Hourly Rate	F. Work Product Sample Requested
1. Plan Design Changes	See Appendix A				
1.1. Pricing plan design changes		**Y**	8	$350	
1.1.1. Determine appropriate accrual funding rates between multiple self-funded plan offerings			16	$350	
2. Financial Information Flow	See Appendix A				
2.1. Educate OUSD on pros/cons of self-funding and/or pooling with a JPA or trust for medical PPO and Rx. Note: Respondents should not assume that OUSD and its labor units have decided to become a self-insured plan.		**Y**	12	$350	
2.2. Determine a) if OUSD is a good candidate for self-funding and/or pooling with a JPA or trust for all aspects of benefit and b) options for addressing self-funded Keenan Delta Dental pool in the event that Keenan no longer serves as broker/consultant.		**Y**	24	$350	
2.3. Please provide a sample presentation of how self-funding and/or pooling with a JPA or trust works.	**n/a**	**n/a**	**n/a**	**n/a**	Will Present Upon the Selection as a Finalist

A. Service Areas	B. Your Approach	C. Identify as Step on Conversion Timeline	D. Estimated Hours total hours in year	E. Blended Hourly Rate	F. Work Product Sample Requested
2.4. Perform actuarial analysis for self-funded and/or pooling with a JPA or trust plan.		Y	80	$350	
2.4.1 If you do this in-house, do you have an actuary on staff? If so, please provide their actuarial credentials and biography.	Yes. Gita Raghavan, ASA, MAAA, oversees our Los Angeles Health Technical Unit. Please see her attached bio in Appendix C. Ms. Raghavan is one of many actuaries that Segal has on staff.		n/a	n/a	
2.4.2 If you use an outside actuarial firm, please provide the scope of services they typically provide, the name of the firm, and whether your fee is all inclusive of their actuarial services.	**n/a**	**n/a**	**n/a**	**n/a**	
2.5. Please provide samples of the following reports **2.5.1 Historical claims experience (compared to accrual funding)** **2.5.2 Claims trend analysis** **2.5.3 Large claimant listings** **2.5.4 Utilization analysis**	**n/a**	**n/a**	**n/a**	**n/a**	See Appendix F: Exhibit 4
2.6. Calculate the accrual funding rates		Y		$350	
2.6.1 Please provide a sample self-funded accrual premium projection	**n/a**	**n/a**	**n/a**	**n/a**	See Appendix F: Exhibit 5
2.6.2 Make adjustments if fully-insured claims experience is not available			4	$350	
2.7. Determine the appropriate reserving (IBNR) levels		Y	4	$350	
2.7.1 Determine data sources and publish methodology			4	$350	
2.7.2 Please provide a sample reserving (IBNR) analysis	**n/a**	**n/a**	**n/a**	**n/a**	See Appendix F: Exhibit 6

A. Service Areas	B. Your Approach	C. Identify as Step on Conversion Timeline	D. Estimated Hours total hours in year	E. Blended Hourly Rate	F. Work Product Sample Requested
2.8. For trust/JPA formation or participation, please address your approach to evaluating and recommending: **2.8.1 Participation agreements/bylaws** **2.8.2 Funding mechanisms** **2.8.3 Entrance and exit procedures** **2.8.4 Rules on less-than-half-time employee participation** **2.8.5 Surplus and deficit sharing rules** **2.8.6 Susceptibility to a "death spiral" if a large district pulls out** **2.8.7 Biases towards labor/management control**			80	$350	
3. Business Partner Management	See Appendix A				
3.1 Stop Loss				$350	See Appendix F: Exhibit 7
3.1.1 Determine advantages/disadvantages of procuring a 3rd party stop loss vendor.		**Y**	2	$350	
3.1.2 Determine range of stop loss deductible would you recommend for a group with >5,000 members.		**Y**	2	$350	
3.1.3 Do you perform a stop loss marketing yourself or rely on outside vendor to obtain stop loss quotes and evaluate the proposals?	In-house		60	$350	
3.1.4 Other than price, how do you evaluate stop loss proposals between several			N/A	N/A	

A. Service Areas	B. Your Approach	C. Identify as Step on Conversion Timeline	D. Estimated Hours total hours in year	E. Blended Hourly Rate	F. Work Product Sample Requested
carriers?					
3.1.5 How do you evaluate whether aggregate stop loss is needed?			N/A	N/A	
3.1.6 What type of stop loss policy do you prefer and why?			N/A	N/A	
3.2 Determine network discount advantages/disadvantages between networks		Y	20	$350	
3.3 Determine advisability and feasibility of self-insuring through Kaiser		Y	15	$350	
3.4 RFP for TPA		Y	50	$350	
3.5 RFP for any other vendor services		Y	TBD	$350	
4. Internal Resource Management	See Appendix A				
4.1 Work with the District to ensure appropriate health fund accounting and reporting throughout conversion to self-insurance.		Y	16	$350	
4.2 Create labor-management processes to oversee OUSD's health fund			8	$350	
4.2.1 Create model language for incorporation to collectively bargained agreements for each unit			5	$350	
4.2.2 Facilitation of adoption of bylaws by an OUSD labor management benefit design committee			8	$350	
4.3 Define and staff any additional consulting roles to support joint labor-management operations					
4.3.1 Legal counsel		Y	TBD	$350	

A. Service Areas	B. Your Approach	C. Identify as Step on Conversion Timeline	D. Estimated Hours total hours in year	E. Blended Hourly Rate	F. Work Product Sample Requested
4.3.2 Board administrator		Y	TBD	$350	
4.3.3 Integrator		Y	TBD	$350	
4.3.4 Any other vendors necessary		Y	TBD	$350	
4.4 Determine advisability and plan for converting plan year from fiscal year to calendar year		Y	2	$350	
4.5 Determine plan for improving cash-in-lieu option		Y	8	$350	

Additional Considerations Applicable to Conversion Period

1. Please provide a timeline as described in the instructions. At a minimum, indicated approximate timing during which tasks identified in Column C would be performed.

   See Appendix B.

2. OUSD's labor-management benefits design committee will adopt a review process that will be used to determine your performance relative to the requirements in this RFP. Your firm will be an active participant in guiding the committee's review of your services, but the final scoring will be at the sole discretion of the committee. What portion of fees are you willing to put at risk based on review of your service?

   100% of Segal's fees are at risk for client satisfaction. If you are not satisfied with any project or service provided by Segal, we do not want you to pay for it. As an employee-owned company, we do not work for shareholders, we work for our clients and we pride ourselves in delivering the best service available. We have never had a client take us up on this offer, and we do not intend to give the District a reason to.

Section F: Post-Conversion Technical Service Specifications

vii. Review Column A for a listing of key services sought in this RFP.
viii. On a separate Word document, please describe your approach to providing each service in Column B.
ix. Fill in a recommended frequency in Column C.
x. Fill in Column D based on the estimated number of hours for your organization to fulfill this function.
xi. Fill in Column E based on the blended hourly rate for professional fees from your organization. Separately, provide respective hourly rates that your firm would use.
xii. Provide work product substantiating your ability to deliver the requested service, if indicated "Y" in Column F.

A. Service Areas	B. Your Approach	C. Should the service occur regularly on an ad hoc monthly, quarterly, semi-Annual, or annual basis?	D. Estimated Hours total hours in year	E. Blended Hourly Rate	F. Work Product Sample Requested
1. Plan Design Changes	See Appendix A				
1.1. Comprehensive report on options for plan design changes			20	$350	See Appendix F: Exhibit 1
1.2. Ongoing monitoring and analysis supporting recommendations at monthly meetings			40	$350	See Appendix F: Exhibit 8
1.3. Design and implementation of Transform the Plan projects			TBD	$350	
1.4. Plan document/booklet revisions			40	$350	
1.5. Open enrollment planning and oversight			40	$350	See Appendix F: Exhibit 2
1.6. District Benefits Office training			40	$350	
2. Financial Information Flow	See Appendix A				
2.1. Quarterly fund report			8	$350	See Appendix F: Exhibit 5

A. Service Areas	B. Your Approach	C. Should the service occur regularly on an ad hoc monthly, quarterly, semi-Annual, or annual basis?	D. Estimated Hours total hours in year	E. Blended Hourly Rate	F. Work Product Sample Requested
2.2. Budget report			8	$350	See Appendix F: Exhibit 8
2.3. Projections			20	$350	See Appendix F: Exhibit 5
2.4. Comparisons to national, state, local, industry benchmarks			8	$350	See Appendix F: Exhibit 3.1 & 3.2
3. Business Partner Management	See Appendix A				
3.1 Sourcing					
3.1.1 Identify and evaluate potential new business partners			10	$350	
3.1.2 Use RFPs or other processes to create relationships with new business partners. RFPs include due diligence, scoring, and finalist interviews.			40-85 hours per RFP (depending on the coverage)	$350	
3.2 Negotiation with new vendors and incumbent vendors seeking renewals; topics include data sharing terms, service level agreements, and performance guarantees.			40	$350	
3.2.1 Make arrangements with Kaiser for mutually agreeable party to execute Business Associate Agreement, undergo IT audit, and obtain analyze encounter data containing PHI for Kaiser members.			8	$350	
3.3 Serve as default liaison between the OUSD labor management committee and business partners on all topics including					
3.3.1 Escalation of Business Partner performance issues			8	$350	

A. Service Areas	B. Your Approach	C. Should the service occur regularly on an ad hoc monthly, quarterly, semi-Annual, or annual basis?	D. Estimated Hours total hours in year	E. Blended Hourly Rate	F. Work Product Sample Requested
3.3.2 Implementation of Business Partner programs			15	$350	
3.4 Serve as lead subject matter expert in review processes including					
3.4.1 In conjunction with reports on vendor programs					
3.4.1.1 Review all materials submitted by vendors			24	$350	
3.4.1.2 Validate program budget			8	$350	
3.4.1.3 Provide performance benchmarks based on national, state, local, or industry standards			16	$350	
3.4.1.4 Recommend next steps to be performed by Vendor, Benefits Consultant, or other parties			12	$350	
3.4.2 In conjunction with Audits					
3.4.2.1 Arrange for independent audits			8 (If outside vendor performs)	$350	
3.4.2.2 Publish and maintain calendar with recommended audit frequency, including: • Medical claims • Pharmacy claims • MBHO claims • EAP claims • District financial audit • Eligibility and enrollment audit			5	$350	

A. Service Areas	B. Your Approach	C. Should the service occur regularly on an ad hoc monthly, quarterly, semi-Annual, or annual basis?	D. Estimated Hours total hours in year	E. Blended Hourly Rate	F. Work Product Sample Requested
3.4.2.3 Recommend next steps to be performed by Vendor, Benefits, Consultant, or other parties			4	$350	
3.4.3 Review the plan's COBRA and HIPAA compliance, including the status of business associate agreements			40	$350	
4. Internal Resource Management	See Appendix A				
4.1 Designate and maintain single point of accountability within your firm for all work product		n/a	n/a	n/a	n/a
4.2 Oversight of specialist outside consultants as applicable		n/a	n/a	n/a	n/a
4.2.1 Review all work product as needed		n/a	n/a	n/a	n/a
4.2.2 Resolve coordination issues		n/a	n/a	n/a	n/a
4.2.3 Participate in regularly recurring meetings if needed		n/a	n/a	n/a	n/a

Other Areas of Interest Applicable to the Post-Conversion Period

A labor management committee will have a review process that will be used to determine your performance relative to the requirements in this RFP. Your firm will be an active participant in guiding the committee's review of your services, but the final scoring will be at the sole discretion of the committee. What portion of fees are you willing to put at risk based on review of your services?

100% of Segal's fees are at risk for client satisfaction. If you are not satisfied with any project or service provided by Segal, we do not want you to pay for it. As an employee-owned company, we do not work for shareholders, we work for our clients and we pride ourselves in delivering the best service available. We have never had a client take us up on this offer, and we do not intend to give the District a reason to.

C. Additional Specifications Applicable to Post-Conversion Period

The Benefits Consultant will be forbidden to receive any compensation from vendors in connection with Benefits Consultant services rendered to the District.

Agreed, Segal's prefers this stated arrangement.

SEGAL APPROACH TO TECHNICAL SERVICE SPECIFICATIONS TABLE

(AS REQUESTED BY THE DISTRICT)

APPENDIX A:
Section D: Pre-Conversion Technical Service Specifications

ii. On a separate Word document, please describe your approach to providing each service in Column B.

A. Service Areas	B. Your Approach
1. Plan Design Changes	
1.1. Comprehensive report on options for plan design changes	Far too often plan changes are made to save a percent or two off the renewal premium. Segal believes in making impactful plan design changes that help encourage proper plan utilization, and control cost trends for the long term. While some immediate cost savings should be a byproduct of any benefit reductions, the true value of plan changes should be in the long-term claims experience. Plan modification recommendations should have sound reasoning based off actual client specific claims experience.
1.2. Ongoing monitoring and analysis supporting recommendation at monthly meetings	Segal collects and monitors claims and enrollment information from existing contracts on a monthly basis as the means of projecting emerging health plan costs. This also allows us to report revisions to the long-term projections on a quarter-by-quarter basis to the District. Segal routinely provides these reports to all of its large Trusts within the public sector and Taft-Hartley plans.
1.3. N/A	
1.4. Plan document/booklet revisions	Segal can revise plan document/booklet on an as-needed basis. Our in-house compliance team who are based in our Washington D.C. office (with local regional staff available as well) keep us updated on all issue related to federal and state regulations, including the Affordable Care Act.
1.5. Open enrollment planning and oversight	Segal will assist the District with planning, benefit change education, and materials with regard to its Annual Open Enrollment.
1.6. District Benefits Office training	Segal will provide District Benefits Office training on an as needed basis as relevant legislation and benefit changes are required.
2. Financial Information Flow	
2.1. N/A	N/A
2.2. N/A	N/A
2.3. N/A	N/A
2.4. Comparisons to national, state, local, industry benchmarks	Segal updates its national trend data on a quarterly basis and provides a comprehensive national trend report on an annual basis. In additional, Segal also provides targeted survey for California public entities on employer contributions, plan costs, benefit designs and Other Post Employment Benefit (OPEB) liabilities.
3. Business Partner Management	
3.1 Sourcing	
3.1.1 Identify and evaluate potential new business partners	Segal maintains and constantly updates its vendor list. Segal has a National Marketing team that filters new business partners based on our established criteria.

A. Service Areas	B. Your Approach
3.1.2 Use RFPs or other processes to create relationships with new business partners. RFPs include due diligence, scoring, and finalist interviews.	If the District wishes to issue an RFP, Segal suggests six to nine months in advance of the annual open enrollment period to allow adequate time for implementation prior to the following plan year. Segal has a comprehensive RFP procedure that evaluates a new business partner on the 360-degree perspective. The whole process would break down into 7 steps. 1. RFP Development Planning – First, Segal will meet with the District to discuss District's procedure, procurement rules, RFP acquisition schedule, roles, and responsibility for each party. 2. RFP Development – using the intake from the planning process, the consultant will incorporate the universe of requirements in the RFP that will result in a completed scope of work. Then we would work with the District to develop an evaluation criteria and scoring metrics. Segal then incorporate previous template into its RFP model to include all the terms enumerated in the scope of work. 3. Final Review and Distribution – Segal will review the content of each proposal for completeness, coordinate electronic submission to the District and prepare a summary checklist of all of the respondents, versus those that received the RFP. 4. Proposal Evaluation – Segal will prepare an RFP summary presentation in assisting the District in narrowing down the finalist based on the scoring criteria. 5. Finalists Presentation – Segal will prepare all evaluation material for the District to use in its evaluation and interview process. Segal will present agenda and suggest questions from its analysis for the finalist presentation. 6. Final Negotiation – Segal will develop and document negotiation strategy and participate in negotiation. Segal will call upon our national health care practice to benchmark certain parameters to help leveraging negotiation. 7. Contract Development – Segal will assist in the technical review of the contract document. Secondly, Segal will assist with the transition process for any new vendors.
3.1.3 Please address your competency in establishing a pharmacy benefit manager (PBM) function for OUSD	Segal has a dedicated Pharmacy benefits consulting team that can provide pharmacy audits, request for proposal, contract reviews, benchmarking, and strategic consulting services. We have set up many self-funded pharmacy benefits plans for our clients including the Employee Group Waiver Program (EGWP) with a commercial wrap plan for Medicare retiree populations.
3.2 Negotiation with new vendors and incumbent vendors seeking renewals; topics include data sharing terms, service level agreements, and performance guarantees.	Our Health Technical unit will prepare requests for information on renewal information within the timeframe that is required by the District to be consistent with its deliberation schedule. In the most optimistic scenario, we commence this process at the close of the first quarter of the preceding plan year, September 30 on a fiscal year plan and March 31 on a calendar year plan. This information request is a compliment to the monthly reporting that we require of the vendors on all of our large clients. The information requests will be followed up with meetings with each of the carriers to assure that they are able to comply with the detailed information Segal will require in order to evaluate and substantiate the proposed renewal process and include a request for first proposed renewal rates. Upon receipt of the information requested in the renewal report, Segal will meet with each carrier to review the response and request additional information from each carrier. In the interim, we will issue a progress memorandum to the District indicating our analysis of the information, prior to review and negotiation. Segal will develop and implement a negotiations strategy and use all of our resources to best accomplish the objectives. Segal implements fact based negotiations as a successful means of achieving the best balance of cost and delivery of service in its carrier negotiation. The consultant will call upon National resources through the health care practice to benchmark certain parameters within the renewal process.
3.2.1 N/A	
3.3 Serve as default liaison between OUSD's labor-management benefits design committee and business partners on all topics including	

A. Service Areas	B. Your Approach
3.3.1 Escalation of Business Partner performance issues	Segal has a single point of contact within each of the major insurance company for all of its California clients. We prefer a top-down solution to resolve any performance/service issue. We also monitor the emerging claims on a monthly basis, and review vendor's performance report on a quarterly basis.
3.3.2 Implementation of Business Partner programs	Segal will assist the District in implementing new programs with its business partners
3.4 Serve as default liaison between OUSD's labor-management benefits design committee and business partners on all topics including	
3.4.1 In conjunction with reports on vendor programs	
3.4.1.1 Review all materials submitted by vendors	Segal will review all materials submitted by vendors
3.4.1.2 Validate program budget	Segal will review the validity of its program costs
3.4.1.3 Provide performance benchmarks based on national, state, local or industry standards	Segal constantly updates its national trend data on a quarterly basis and provides a comprehensive national trend report on an annual basis. In additional, Segal also provides targeted survey for California public entities on plan designs and Other Post Employment Benefit (OPEB) liability. Using the benchmark data, the District could achieve a highly effective plan design that not only attract and retain talents but also saves costs in modernizing the plan designs.
3.4.1.4 Recommend next steps to be performed by Vendor, Benefits Consultant or other parties	Segal will review the performance of the vendors and recommend the necessary follow up by the vendors.
3.4.2 Review the plan's COBRA and HIPAA compliance, including the status of business associate agreements	Segal has a dedicated compliance team that could review the plan's COBRA and HIPAA compliance. We could also do a HIPAA compliance training for the District's Benefits staff.
4. Internal Resource Management	
4.1 Designate and maintain single point of accountability within our firm for all work product	Tom Morrison will be your single point of contact.
4.2 Oversight of specialist outside consultants as applicable	Not proposing with outside consultants
4.2.1 Review all work product as needed	Not proposing with outside consultants
4.2.2 Resolve coordination issues	Not proposing with outside consultants
4.2.3 Participant in regularly recurring meetings if needed	Not proposing with outside consultants

APPENDIX A:
Section E: Conversion Period Technical Service Specifications

ii. On a separate Word document, please describe your approach to providing each service in Column B.

A. Service Areas	B. Your Approach
1. Plan Design Changes	
1.1. Pricing plan design changes	
1.1.1. Determine appropriate accrual funding rates between multiple self-funded plan offerings	Our health actuary will determined the appropriate accrual funding rates from the claims experience, stop loss premium, ACA related fees, margin, etc.
2. Financial Information Flow	
2.1. Educate OUSD on pros/cons of self-funding and/or pooling with a JPA or trust for medical PPO and Rx. Note: Respondents should not assume that OUSD and its labor units have decided to become a self-insured plan.	Segal will schedule a meeting with OUSD and its labor units for presentation on pros and cons of self-funded and JPA plan compared to the fully insured plan. Briefly, below are general pros and cons of a self-funded plan without looking at the specific data of OUSD. **Pros:** The plan sponsor will capitalize on all savings for a low cost year. Self-funded rates may be lower than the fully insured rates due to the lower administrative costs (and ACA's premium tax) Plan sponsor has more flexibility with respect to plan design and premium rate setting. **Cons:** The District has to establish reserves in addition to projected cost to protect the District and employees from higher than expected claim costs. The plan sponsor has the responsibility for full compliance under the ACA. The plan sponsor will ensure additional responsibility and administrative burden of dealing with the interpretation of the plan design and claims and appeal process. The plan sponsor may potentially run into budget deficit for a high costing year, especially when the reserves are not fully funded in the beginning process of transitioning into a self-insured plan.
2.2. Determine a) if OUSD is a good candidate for self-funding and/or pooling with a JPA or trust for all aspects of benefit and b) options for addressing self-funded Keenan Delta Dental pool in the event that Keenan no longer serves as broker/consultant.	a) Segal will request data from the current fully insured carrier and issue RFP for both fully insured rates and a self-funded ASO fee to compare costs. b) Segal could issue a Dental RFP to all major dental insurers for both self-funded and fully insured contract. We will also factor in the current dental reserve when projecting rates. We could also direct negotiate with Delta Dental for an equal or better contracted ASO fee. Segal would also request the data from Keenan for the pool data and District specific data to see if perhaps the District may be subsidizing the pool and may be better off to set the rates on its own experience.
2.3. Please provide a sample	N/A

A. Service Areas	B. Your Approach
presentation of how self-funding and/or pooling with a JPA or trust works.	
2.4. Perform actuarial analysis for self-funded and/or pooling with a JPA or trust plan.	Segal uses a process for collecting information from existing contracts on a monthly basis as the means of projecting and reporting health plan costs. This method produces a Health Benefit Report that includes the ability to adjust budget information on an as needed basis and to show the impact of existing rates. In addition, Segal will project any costs/savings for transitioning to a self-insured plan based on the current claims cost, estimated ASO fees, estimated stop loss premium, and estimated actuarial fees for reserve and rate calculation, etc. Furthermore, Segal has in-house MD and pharmacy consulting team that will assist the District in the possibility of implementing a self-insured pharmacy benefits program through a comprehensive RFP process.
2.4.1 If you do this in-house, do you have an actuary on staff? If so, please provide their actuarial credentials and biography.	Yes. Gita Raghavan, ASA, MAAA, oversees our Los Angeles Health Technical Unit. Please see her attached bio in Appendix C. Ms. Raghavan is one of many actuaries that Segal has on staff.
2.4.2 If you use an outside actuarial firm, please provide the scope of services they typically provide, the name of the firm, and whether your fee is all inclusive of their actuarial services (if not, please indicate what the additional fee will be).	N/A
2.5. Please provide samples of the following reports **2.5.1 Historical claims experience (compared to accrual funding)** **2.5.2 Claims trend analysis** **2.5.3 Large claimant listings** **2.5.4 Utilization analysis**	N/A
2.6. Calculate the accrual funding rates	
2.6.1 Please provide a sample self-funded accrual premium projection	N/A
2.6.2 Make adjustments if fully-insured claims experience is not available	Segal has a great relationship with all the major insurance companies and that includes Kaiser, HealthNet, Delta Dental, and VSP. We have not encountered in any situation that the insurance company would not share the data for a group your size. Segal will make sure this item is properly addressed in the contract renewal and negotiation. In the case of Keenan Delta program, if Keenen refuses to provide claims data, Segal would look to the current rates and the District's demographic data (compared to group industry averages) as the major indicator of a reasonable premium rate for the first year.
2.7. Determine the appropriate reserving (IBNR) levels	
2.7.1 Determine data sources and publish methodology	Segal would first request a lag data and enrollment from the carrier or TPA. IBNR reserves are calculated from prior histories of claim payments. The Segal IBNR model uses claims data that shows totals for each incurred month

A. Service Areas	B. Your Approach
	separately by paid month. Segal would then review the data and submit questions to carrier/TPA for any inconsistency and questionable payments. We also request large claims and pending large claims report. We would input all data into our Segal IBNR model and adjust the result based on these factors. Fun fact: The term Incurred But Not Reported (IBNR) is a misnomer. As used here it refers specifically to claims incurred but not paid. No distinction is made as to whether a claim has been reported or not. The term probably arose in the casualty insurance where claims that had been reported were reserved separately based on the information that had been reported. Nevertheless, the term has become so commonplace that we all continue to use it.
2.7.2 Please provide a sample reserving (IBNR) analysis	N/A
2.8. For trust/JPA formation or participation, please address your approach to evaluating and recommending:	
2.8.1 Participation agreements/bylaws	Segal would assist the District in reviewing the participation agreement for any potential JPA to ensure the District has acceptable terms for entry and, more importantly, exiting a JPA agreement if the situation sours. JPAs can be effective in grouping smaller populations into one large pool, which over time should produce smaller peaks and valleys as far as claims experience is concerned (assuming a fairly consistent demographic). The major challenge in participating in a JPA is relinquishing control. The District not only would give up control of its plan design, but it would also lose control over the population from which its rates are based. This risk is not only in that a large district pulls out of the pool, but also, if a new group joins the pool and experiences significantly worse claims compared to the prior pool. The ultimate challenge comes if/when the District decides to separate from the JPA. Without its own claims to provide potential bidders an accurate picture of the risk they will potentially be insuring, insurance companies will be conservative in their underwriting. (This will be the challenge with Keenen's Delta program, but slightly lesser so for Dental insurance compared to medical insurance)
2.8.2 Funding mechanisms	
2.8.3 Entrance and exit procedures	
2.8.4 Rules on less-than-half-time employee participation	
2.8.5 Surplus and deficit sharing rules	
2.8.6 Susceptibility to a "death spiral" if a large district pulls out	
2.8.7 Biases towards labor/management control	
2.8.8 If your firm manages a trust/JPA, how will your firm avoid bias when presenting that trust/JPA	
3. Business Partner Management	
3.1 Stop Loss	Segal has taken the extra step of identifying the unique nature of stop-loss insurance and compiled a dedicated "Stop-Loss Team". This team has received extensive training and performs all Segal stop-loss RFPs.
3.1.1 Determine advantages/disadvantages of procuring a 3rd party stop loss vendor.	Two central (and sometimes overlapping) criteria for determining the need for stop loss insurance are: a) Can the District accept the risk without such insurance?; and b) Is the price of transferring the risk to a stop loss carrier reasonable? For a self-funded client, we always recommend having some level of stop loss protection. This would insure that the plan sponsor would have a limited exposure to an unforeseen high claim cost year. From our experience with public entity, having a stable cost trend is a priority for long term planning.
3.1.2 Determine range of stop	The attachment point should be correlated with the preferred risk profile of the

A. Service Areas	B. Your Approach
loss deductible would you recommend for a group with >5,000 members.	individual client. That being said, with an adequate claims fluctuation and economic reserves, Segal would recommend an individual stop loss attachment point between $250,000 - $300,000 per claim for a group of your size.
3.1.3 Do you perform a stop loss marketing yourself or rely on outside vendor to obtain stop loss quotes and evaluate the proposals?	Segal performs Stop Loss RFPs in-house, with specific staff ("Stop Loss Team") that has specific training in stop-loss coverage and procurements.
3.1.4 Other than price, how do you evaluate stop loss proposals between several carriers?	We would assess a stop loss carrier based on their basis of cost, coverage, coverage terms and provisions, financial strength, and the underwriting of stop-loss insurance. Segal has taken the extra step of pre-qualifying specific stop-loss vendors (currently 8) based on many standard factors, such as financial stability, and contract terms.
3.1.5 How do you evaluate whether aggregate stop loss is needed?	Except in some instances for the smallest of self-insured clients (<1,000), we usually do not recommend aggregate stop loss because most reinsurance companies either do not issue an aggregate stop loss policy, or the rate is prohibitive. We recommend using those funds to set up adequate reserves.
3.1.6 What type of stop loss policy do you prefer and why?	We recommend individual stop loss coverage by the plan because it can significantly reduce the plan's exposure to catastrophic claims risk by ensuring a few catastrophic claims do not cause the plan to experience large spikes in claims, which would lead to District losses and large renewal increases… helping to smooth out the year to year trends.
3.2 Determine network discount advantages/disadvantages between networks	Negotiated network discounts vary greatly between carriers and are the main cost determinate when analyzing vendor proposals for ASO services. When comparing vendors, Segal utilizes actual claims and requires the vendors to re-price the claims using their discounts to get the most accurate cost analysis possible.
3.3 Determine advisability and feasibility of self-insuring through Kaiser	We are experienced in analyzing Kaiser's different product offerings, including self-insuring as well as POS offerings. Our experience in Kern County where they do not own any hospitals and thus are much more willing to self-insure would be beneficial for the District in this pursuit.
3.4 RFP for TPA	Segal has an Administration and Technology Consulting (ATC) division that focuses on TPA search and reviews. Our ATC division is familiar with most of the administrative software and its limitation. We will work with the District to develop a TPA RFP that meets the District's needs.
3.5 RFP for any other vendor services	In addition to medical, PBM, dental, vision, stop loss and TPA RFP, Segal is also experienced in issuing RFP for Life, AD&D and Disability benefits. Segal is also experienced in issuing RFP for utilization management and network contracting for self-insured plans.
4. Internal Resource Management	
4.1 Work with the District to ensure appropriate health fund accounting and reporting throughout conversion to self-insurance.	Segal will work with the District to ensure appropriate health fund accounting and reporting throughout conversion to self-insurance.
4.2 Create labor-management processes to oversee OUSD's health fund	
4.2.1 Create model language for incorporation to collectively bargained agreements for each unit	Segal will work with the District to assist in drafting CBA language.
4.2.2 Facilitation of adoption of bylaws by an OUSD labor	Segal will assist the District in drafting bylaws for a joint labor-management benefit design committee.

A. Service Areas	B. Your Approach
management benefit design committee	
4.3 Define and staff any additional consulting roles to support joint labor-management operations	
4.3.1 Legal counsel	Segal would train District staff in benefit and compliance areas when the need arises. In addition, Segal would assist the District in analyzing whether or not it would be beneficial and practical to hire an outside professional, such as independent legal counsel to provide legal opinions and interpretations, or an administrator to focus on running the plan(s).
4.3.2 Board administrator	
4.3.3 Integrator	
4.3.4 Any other vendors necessary	
4.4 Determine advisability and plan for converting plan year from fiscal year to calendar year	Segal has experience in assisting clients through plan year transitions. The obvious reason some employers choose a Fiscal Year plan year over calendar year plans is budgetary. Segal typically attempts to negotiate rate extensions in these cases to put the plan renewals on the January 1 basis.
4.5 Determine plan for improving cash-in-lieu option	Segal's proposed consulting team recently performed an extensive cash-in-lieu analysis for LAUSD and its Health Benefits Committee (HBC). Segal used the (then) current opt-out amount, the plan premium rates (employer paid), the enrollment distribution, and the number of employees currently opting out to project costs/savings depending on an array of illustrative opt-out percentages increases to find the break-even point and calculate realistic savings/costs.

APPENDIX A:
Section F: Post-Conversion Technical Service Specifications

ii. On a separate Word document, please describe your approach to providing each service in Column B.

A. Service Areas	B. Your Approach
1. Plan Design Changes	
1.1. Comprehensive report on options for plan design changes	Far too often plan changes are made to save a percent or two off the renewal premium. Segal believes in making impactful plan design changes that help encourage proper plan utilization, and control cost trends for the long term. While some immediate cost savings should be a byproduct of any benefit reductions, the true value of plan changes should be in the long-term claims experience. Plan modification recommendations should have sound reasoning based off actual client specific claims experience.
1.2. Ongoing monitoring and analysis supporting recommendations at monthly meetings	Segal collects and monitors claims and enrollment information from existing contracts on a monthly basis as the means of projecting emerging health plan costs. This also allows us to report revisions to the long-term projections on a quarter-by-quarter basis to the District. Segal routinely provides these reports to all of its large Trusts within the public sector and Taft-Hartley plans.
1.3. Design and implementation of Transform the Plan projects	Segal is continuously strategizing on how to best help its clients and provide the most attractive benefits at the lowest costs possible. Anytime we have an idea to present that would require out-of-scope services (and additional fees), we would prepare a proposal outlining the idea, why we think it would be advantageous for the District to pursue, and the proposed project fees. Only with prior District approval would we commence an out-of-scope project that would require additional consulting fees.
1.4. Plan document/booklet revisions	Segal can revise plan document/booklet on an as-needed basis. Our in-house compliance team who are based in our Washington D.C. office (with local regional staff available as well) keep us updated on all issue related to federal and state regulations, including the Affordable Care Act.
1.5. Open enrollment planning and oversight	Segal will assist the District with planning, benefit change education, and materials with regard to its Annual Open Enrollment.
1.6. District Benefits Office training	Segal will provide District Benefits Office training on an as needed basis as relevant legislation and benefit changes are required.
2. Financial Information Flow	
2.1. Quarterly fund report	Segal standardly produces Quarterly reports for self-funded plans.
2.2. Budget report	Segal standardly produces Budget reports.
2.3. Projections	Segal standardly produces Projections.
2.4. Comparisons to national, state, local, industry benchmarks	Segal updates its national trend data on a quarterly basis and provides a comprehensive national trend report on an annual basis. In additional, Segal also provides targeted survey for California public entities on employer contributions, plan costs, benefit designs and Other Post Employment Benefit (OPEB) liabilities.
3. Business Partner Management	

A. Service Areas	B. Your Approach
3.1 Sourcing	
3.1.1 Identify and evaluate potential new business partners	Segal maintains and constantly updates its vendor list. Segal has a National Marketing team that filters new business partners based on our established criteria.
3.1.2 Use RFPs or other processes to create relationships with new business partners. RFPs include due diligence, scoring, and finalist interviews.	If the District wishes to issue an RFP, Segal suggests six to nine months in advance of the annual open enrollment period to allow adequate time for implementation prior to the following plan year. Segal has a comprehensive RFP procedure that evaluates a new business partner on the 360-degree perspective. The whole process would break down into 7 steps. 1. RFP Development Planning – First, Segal will meet with the District to discuss District's procedure, procurement rules, RFP acquisition schedule, roles, and responsibility for each party. 2. RFP Development – using the intake from the planning process, the consultant will incorporate the universe of requirements in the RFP that will result in a completed scope of work. Then we would work with the District to develop an evaluation criteria and scoring metrics. Segal then incorporate previous template into its RFP model to include all the terms enumerated in the scope of work. 3. Final Review and Distribution – Segal will review the content of each proposal for completeness, coordinate electronic submission to the District and prepare a summary checklist of all of the respondents, versus those that received the RFP. 4. Proposal Evaluation – Segal will prepare an RFP summary presentation in assisting the District in narrowing down the finalist based on the scoring criteria. 5. Finalists Presentation – Segal will prepare all evaluation material for the District to use in its evaluation and interview process. Segal will present agenda and suggest questions from its analysis for the finalist presentation. 6. Final Negotiation – Segal will develop and document negotiation strategy and participate in negotiation. Segal will call upon our national health care practice to benchmark certain parameters to help leveraging negotiation. 7. Contract Development – Segal will assist in the technical review of the contract document. Secondly, Segal will assist with the transition process for any new vendors.
3.2 Negotiation with new vendors and incumbent vendors seeking renewals; topics include data sharing terms, service level agreements, and performance guarantees.	Our Health Technical unit will prepare requests for information on renewal information within the timeframe that is required by the District to be consistent with its deliberation schedule. In the most optimistic scenario, we commence this process at the close of the first quarter of the preceding plan year, September 30 on a fiscal year plan and March 31 on a calendar year plan. This information request is a compliment to the monthly reporting that we require of the vendors on all of our large clients. The information requests will be followed-up with meetings with each of the carriers to assure that they are able to comply with the detailed information Segal will require in order to evaluate and substantiate the proposed renewal process and include a request for first proposed renewal rates. Upon receipt of the information requested in the renewal report, Segal will meet with each carrier to review the response and request additional information from each carrier. In the interim, we will issue a progress memorandum to the District indicating our analysis of the information, prior to review and negotiation. Segal will develop and implement a negotiations strategy and use all of our resources to best accomplish the objectives. Segal implements fact based negotiations as a successful means of achieving the best balance of cost and delivery of service in its carrier negotiation. The consultant will call upon National resources through the health care practice to benchmark certain parameters within the renewal process.
3.2.1 Make arrangements with Kaiser for mutually agreeable party to execute Business Associate Agreement, undergo IT audit, and obtain analyze	Segal will use its relationships at the highest levels within Kaiser to assist the District in pursuing all objectives relative to Kaiser (and any other vender the District does business with)

A. Service Areas	B. Your Approach
encounter data containing PHI for Kaiser members.	
3.3 Serve as default liaison between the OUSD labor management committee and business partners on all topics including	
3.3.1 Escalation of Business Partner performance issues	Segal has a single point of contact within each of the major insurance company for all of its California clients. We prefer a top-down solution to resolve any performance/service issue. We also monitor the emerging claims on a monthly basis, and review vendor's performance report on a quarterly basis.
3.3.2 Implementation of Business Partner programs	Segal will assist the District in implementing new programs with its business partners
3.4 Serve as lead subject matter expert in review processes including	
3.4.1 In conjunction with reports on vendor programs	
3.4.1.1 Review all materials submitted by vendors	Segal will review all materials submitted by vendors
3.4.1.2 Validate program budget	Segal will review the validity of its program costs
3.4.1.3 Provide performance benchmarks based on national, state, local, or industry standards	Segal constantly updates its national trend data on a quarterly basis and provides a comprehensive national trend report on an annual basis. In additional, Segal also provides targeted survey for California public entities on plan designs and Other Post Employment Benefit (OPEB) liability. Using the benchmark data, the District could achieve a highly effective plan design that not only attract and retain talents but also saves costs in modernizing the plan designs.
3.4.1.4 Recommend next steps to be performed by Vendor, Benefits Consultant, or other parties	Segal will review and recommend the necessary follow up by the vendors.
3.4.2 In conjunction with Audits	
3.4.2.1 Arrange for independent audits	Segal can assist the District in procuring an outside auditing firm, or perform audits in-house (out-of-scope item).
3.4.2.2 Publish and maintain calendar with recommended audit frequency, including: • **Medical claims** • **Pharmacy claims** • **MBHO claims** • **EAP claims** • **District financial audit** • **Eligibility and enrollment audit**	Segal has been conducting on-site claims audits for insured and self-insured plans since 1973. As prior claims examiners, our auditors have extensive background in claims processing and auditing. The depth of their experience fosters open discussion with administrative staff during on-site reviews, maximizing cooperation and expediting efforts to resolve errors or inefficiencies. Each audit is tailored to the client's specific concerns and objectives. We offer a multitude of services relating to claims adjudication of all plan expenses (i.e., medical, dental, disability, vision, life insurance). They include: Administrative Procedures Review, Claims System Logic Testing, Electronic Eligibility Review, Duplicate Claims Analysis, Pre-Implementation Review, Stratified and/or Targeted Sample Audits, Specific Stop-Loss Coverage Analysis, and Performance Validation.

A. Service Areas	B. Your Approach
3.4.2.3 Recommend next steps to be performed by Vendor, Benefits, Consultant, or other parties	Segal will review and recommend the necessary follow up by the vendors.
3.4.3 Review the plan's COBRA and HIPAA compliance, including the status of business associate agreements	Segal has a dedicated compliance team that could review the plan's COBRA and HIPAA compliance. We could also do a HIPAA compliance training for the District's Benefits staff.
4. Internal Resource Management	
4.1 Designate and maintain single point of accountability within your firm for all work product	Tom Morrison will be your single point of contact.
4.2 Oversight of specialist outside consultants as applicable	Not proposing with outside consultants
4.2.1 Review all work product as needed	Not proposing with outside consultants
4.2.2 Resolve coordination issues	Not proposing with outside consultants
4.2.3 Participate in regularly recurring meetings if needed	Not proposing with outside consultants

CONVERSION TIMELINE

(AS REQUESTED BY THE DISTRICT)

APPENDIX B:
Conversion Timeline

Please provide a timeline as described in the instructions. At a minimum, indicate approximate timing during which tasks identified in Column C would be performed.

Category/Task	Responsibility	Timing
Task 1 – Plan Design Changes		
1.1. Pricing plan design changes	Lead Consultant Health Manager	As requested (Ad hoc)
Task 2 – Financial Information Flow		
2.1. Educate OUSD on pros/cons of self-funding and/or pooling with a JPA or trust for medical PPO and Rx	Lead Consultant Co-Consultant	12-15 months prior to planned effective date
2.2. Determine a) if OUSD is a good candidate for self-funding and/or pooling with a JPA or trust for all aspects of benefit and b) options for addressing self-funded Keenan Delta Dental pool in the event that Keenan no longer serves as broker/consultant.	Lead Consultant Co-Consultant HBA Manager, Actuary	12-15 months prior to planned effective date
2.4. Perform actuarial analysis for self-funded and/or pooling with a JPA or trust plan.	HBA Manager, Actuary	9 months prior to planned effective date
2.6. Calculate the accrual funding rates	HBA Manager, Actuary	9 months prior to planned effective date
2.7. Determine the appropriate reserving (IBNR) levels	HBA Manager, Actuary Technical Health Unit	9 months prior to planned effective date
Task 3 – Business Partner Management		
3.1.1 Determine advantages/disadvantages of procuring a 3rd party stop loss vendor.	Lead Consultant Co-Consultant	12 months prior to planned effective date
3.1.2 Determine range of stop loss deductible would you recommend for a group with >5,000 members.	Lead Consultant Co-Consultant	10-12 months prior to planned effective date
3.2 Determine network discount	Lead Consultant Co-Consultant	9 months prior to planned effective date

Category/Task	Responsibility	Timing
advantages/disadvantages between networks	HBA Manager, Actuary Technical Health Unit	
3.3 Determine advisability and feasibility of self-insuring through Kaiser	Lead Consultant Co-Consultant	7-9 months prior to planned effective date
3.4 RFP for TPA	Lead Consultant Co-Consultant HBA Manager, Actuary Technical Health Unit	7-9 months prior to planned effective date
3.5 RFP for any other vendor services	Lead Consultant Co-Consultant HBA Manager, Actuary Technical Health Unit	7-9 months prior to planned effective date
Task 4 – Internal Resource Management		
4.1 Work with the District to ensure appropriate health fund accounting and reporting throughout conversion to self-insurance.	Lead Consultant Co-Consultant HBA Manager, Actuary Technical Health Unit	9 months prior to planned effective date through implementation
4.3 Define and staff any additional consulting roles to support joint labor-management operations **4.3.1 Legal counsel** **4.3.2 Board administrator** **4.3.3 Integrator** **4.3.4 Any other vendors necessary**	Lead Consultant Co-Consultant	3-9 months prior to planned implementation
4.4 Determine advisability and plan for converting plan year from fiscal year to calendar year	Lead Consultant Co-Consultant	12 months prior to planned effective date
4.5 Determine plan for improving cash-in-lieu option	Lead Consultant Co-Consultant HBA Manager, Actuary Technical Health Unit	4-6 months prior to planned effective date

SEGAL TEAM BIOGRAPHIES AND RESUMES

SEGAL

THOMAS M. MORRISON, JR.
Senior Vice President,
Health and Retirement Plan Consultant, Los Angeles

Expertise

Mr. Morrison has over 30 years of experience in health care consulting, with specific expertise in the areas of managed care, custom PPO networks, prescription drug cost management, plan design and funding innovations. He has completed extensive project work in the areas of retiree medical plan design and funding, paid time-off and integrated disability management plans for multiemployer, public sector, and corporate clients throughout the United States. As the Industry Group Leader for the Entertainment Industry, Mr. Morrison constantly monitors relevant legislation, trends, and developments to ensure that Segal's Entertainment clients are prepared and informed.

Education/Professional Designations

Mr. Morrison received a BA in Finance and Accounting and Music Composition from the University of Miami, an MA in Music Composition and Orchestration from the University of Miami and an MBA from Indiana University.

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Expertise

Mr. Mitchell is a Consultant in Segal's Los Angeles office with over ten years of experience working with employee benefits, group health insurance, and retirement plans. He provides proactive consulting to his clients and is an expert in all aspects of the design, financing, bidding, and communications of employee and retiree health and welfare benefits for Public Sector and Taft-Hartley clients. Mr. Mitchell's responsibilities include the analysis of technical data and negotiation with insurance companies and network administrators.

Professional Background

Prior to joining Segal, Mr. Mitchell's work experience included financial planning for individuals and small businesses and underwriting group health insurance for companies of all sizes.

Education/Professional Designations

Mr. Mitchell received a BS from the University of Findlay, Ohio, with three independent majors in Finance, Marketing, and Business Management and minors in Economics and International Business.

He also completed the Certified Employee Benefit Specialist (CEBS) program from the Wharton School of the University of Pennsylvania in 2009. Within the CEBS program, he obtained the Group Benefits Associate (GBA) certification in 2008 and the Retirement Plans Associate (RPA) certification in 2009.

Mr. Mitchell has obtained his California Life Agent License.

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GITA RAGHAVAN, ASA, MAAA
Vice President,
Manager, Health Benefit Advisors, Los Angeles

Expertise

Ms. Raghavan joined Segal's Los Angeles office in 2001 as Manager of the Group Benefits Department. She was named Vice President in 2005. Ms. Raghavan's responsibilities include performing actuarial analysis, developing cost projections and providing high level strategic consulting.

Professional Background

Prior to joining Segal, Ms. Raghavan worked in the actuarial department of a large, publicly traded managed health care company. She has also worked in a managerial position for a leading network contracting organization and as a team member at the country's largest Medicaid Health Maintenance Organization, where she gained extensive experience in negotiating medical reimbursement rates.

Education/Professional Designations

Ms. Raghavan has an MA in Mathematics from the University of Madras. She is an Associate of the Society of Actuaries and a Member of the American Academy of Actuaries, and has obtained a California Life Agent License.

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Expertise

Ms. Topping is a Vice President in Segal's Los Angeles office with over 35 years of experience working with group benefits plans. Her responsibilities include performing statistical analyses of health benefit programs, preparing requests for proposal and bid analyses, premium and experience review, conducting self funding studies, preparing financial projections, benefit plan design and other group benefit and cost management services. As a senior member of the Health Benefits Department, Ms. Topping peer reviews the work of her colleagues.

Ms. Topping works with both local and national multiemployer clients as well as public sector clients (including school districts and city, county and state government benefit plans).

Professional Background

Ms. Topping joined The Segal Company's Los Angeles office as a Group Benefits Analyst in 1977. In 1983, she became Manager of the Group Benefits Department. Ms. Topping was named Vice President in 1989. Prior to joining Segal, she served as a Health Benefits Underwriter for a major insurance company for five years.

Education/Professional Designations

Ms. Topping attended Pasadena City College, majoring in Business. She is a state-licensed Life, Accident and Health Agent.

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Expertise

Dr. Johl is a Pharmacy Benefits Consultant in Segal's San Francisco office, supporting the West Region. She has more than 20 years of experience in pharmacy benefits. Dr. Johl is a member of Segal's National Pharmacy Consulting Practice and assists clients in optimizing benefit design and formularies. She also serves as an expert in client management, strategic planning, PBM clinical programs, product and formulary strategies and analysis of prescription data. Dr. Johl provides clinical consulting, analysis, support and strategic direction for clients nationally. She focuses on assisting Segal clients in vendor selection and implementation, contract negotiation, and clinical program development.

Professional Background

Prior to joining Segal, Dr. Johl served as a Clinical Program Manager for a PBM, where she utilized her clinical expertise to develop strategies for employers to optimize their prescription drug benefits. Prior to that, she worked as a benefits specialist at Blue Shield of California. Dr. Johl also worked as a manager at Statscript pharmacy, specializing in drug management and education in the HIV community.

Education/Professional Designations

Dr. Johl holds a Doctor of Pharmacy degree from the University of California, San Francisco, and a BS in Biology from California State University (Chico, CA). She is a registered Pharmacist and an active member of the Academy of Managed Care Pharmacy (AMCP), where she serves on the Community Pharmacy Outreach Advisory Council.

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SEGAL

KATHRYN BAKICH, JD
Senior Vice President, National Health Compliance
Practice Leader, Washington, DC

Expertise

Ms. Bakich is a Senior Vice President in Segal's Washington, DC office with over 20 years of experience in health care compliance. She is the firm's National Health Compliance Practice Leader.

Ms. Bakich is one of the country's leading experts on employer sponsored health coverage. She specializes in providing research and analysis on federal laws and regulations affecting health coverage, including: ERISA, Medicare, HIPAA, COBRA, the Newborns' and Mothers' Health Protection Act, the Mental Health Parity Act, and the Women's Health and Cancer Rights Act.

Ms. Bakich is a recognized expert on the Patient Protection and Affordable Care Act passed in 2010. She speaks regularly about the law, helps plan sponsors understand its short and long term effects on their plans, and assists clients with preparing comments on the legislation for submission to regulatory Departments (Treasury, Labor, and Health & Human Services).

Ms. Bakich leads the Segal team responsible for publishing information about new health care laws and regulations, and trains internal staff on all legislation and related developments. She and her staff disseminate health compliance information, monitor federal and state laws and regulations, and prepare amendments for health plans and summary plan descriptions based on national models.

Professional Background

Prior to joining Segal, Ms. Bakich was an attorney in private practice representing multiemployer health plans and an appellate administrative law judge.

Education/Professional Designations

Ms. Bakich graduated in 1979 with a BA in Political Science, in 1982 with an MA in Public Policy, and in 1985 with a JD from the University of Missouri. She has been admitted to the Bar in the District of Columbia, United States Supreme Court, and multiple federal district and appellate courts.

Ms. Bakich is a member of the Working Committee of the National Coordinating Committee for Multiemployer Plans (NCCMP), the Health Technical Issues Taskforce of the American Benefits Council (ABC), the Employers Council on Flexible Compensation (ECFC) Flex Advisory Council, and the American Bar Association (ABA). Ms. Bakich is co-chair of the ABA Joint Committee on Employee Benefits Subcommittee on Welfare Plan Regulation. She was also appointed to the Government Liaison Committee of the International Foundation of Employee Benefit Plans (IFEBP). Ms. Bakich was named a Fellow of the American College of Employee Benefits Counsel in 2012.

Published Works/Speeches

Ms. Bakich has published multiple articles about employee health and welfare benefits, including a series of articles discussing HIPAA Administrative Simplification, EDI, and Privacy in the *Benefits Law Journal*. She is a co-author of the *Employers' Guide to HIPAA Privacy Requirements*, published by Thompson Publishing Group, and a chapter editor of *Employee Benefits Law*. Ms. Bakich speaks regularly on issues related to group health plans.

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Expertise

Ms. Hakes is a Vice President and Health Care Benefits Consultant in Segal's Phoenix office. She is the Company's technical expert on operational issues regarding managed care. Ms. Hakes provides detailed research on specific health care issues pertinent to medical coverage, plan design, and quality of care, including disability; workers' compensation; wellness and associated incentive programs; EAP and behavioral health; prescription drugs; disease management; telephonic nurse triage programs; and utilization management. She is skilled in analyzing the effectiveness of health care delivery systems that guide managed care organizations. Ms. Hakes leads the development and maintenance of a proprietary Segal program, Q-Val[SM], which allows plan sponsors to assess the extent to which managed care organizations (such as PPOs, POS and HMO plans) oversee and assure the delivery of quality health care to their plan participants.

Ms. Hakes assists employers in the creation and interpretation of technical medical health care coverage language, the design of employee educational information, and the implementation of specific managed care techniques engineered to control health care costs. Additionally, as Health Compliance Manager for the West Region, she researches employee benefit laws and their impact on clients, creates plan amendments and writes plan documents. Ms. Hakes was instrumental in designing the medical text of the Segal Master Plan Document/Summary Plan Description for use with self-funded clients nationwide. Using her past experience as Chief Operating Officer of a nationwide managed health care review organization, she has developed techniques for assessing the comprehensiveness, effectiveness, progressiveness and quality of medical management organizations.

Ms. Hakes performs analyses of medical records as part of her research of complex claims appeals. She additionally conducts assessments of operations and savings assumptions by medical management organizations nationwide, and reviews health records for issues involving cost and quality of care. Ms. Hakes has also customized return-to-work programs and performance guarantees for clients. She is experienced in complex case management and in designing reports that help detail the effectiveness of managed care organizations.

Professional Background

Prior to her 20 years with Segal, Ms. Hakes' background as Director of Health Services and Quality Control for the Arizona division of a national HMO provided her with the expertise to assist Segal clients in the design, implementation, and analysis of unique risk-sharing arrangements for control of medical costs.

Education/Professional Designations

After graduating from the University of Arizona with a BS in Nursing and with an MS from the University of San Diego, Ms. Hakes spent over 10 years providing direct patient care as well as overall nursing unit management in a 650-bed teaching hospital in Southern California. She

maintains licensure as a Registered Nurse in Arizona and, until 2004, worked in an urgent care center on weekends.

Published Work/Speeches

Recent articles by Ms. Hakes include:

- "Thank You for Not Smoking," Christopher Calvert and Nancy R. Hakes, *Compensation & Benefits,* December 2009
- "Is Your Wellness Program a Scattershot Effort…or on Target to Serve Employees and the Organization?" Chris Calvert and Nancy R. Hakes, *Perspectives,* Volume 16, Issue 3, June 2008

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Expertise

Mr. Wu is an Associate Consultant in Segal's Los Angeles office. He assists the Health and Retirement Practice on all technical, design, strategic, and actuarial matters related to client benefits and retirement plans. Mr. Wu contributes to team consulting engagements for public sector and Taft-Hartley clients in California and Hawaii.

Professional Background

Mr. Wu joined Segal in 2011 as an Associate.

Education/Professional Designations

Mr. Wu received a BA in Economics from the University of California, Irvine. He passed SOA exam C and is currently pursuing his ASA designation from the Society of Actuaries.

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Expertise

Ms. Kuhlman is a Health Consultant in Segal's Los Angeles office. Ms. Kuhlman's responsibilities include analysis of technical data with regard to medical, dental and vision benefit plans in both traditional indemnity and managed care environments. She prepares budget projections, financial reports, plan pricing, claim cost and renewal analysis. Ms. Kuhlman is also involved with the preparation of requests for proposals and bid analyses for potential replacement of vendors.

Professional Background

Ms. Kuhlman joined Segal's Houston office in 2004 as an actuarial intern before transitioning to her role as Health Benefits Analyst in 2005. She was promoted to Senior Health Benefits analyst in 2010.

Education/Professional Designations

Ms. Kuhlman received her BA in Mathematics and a Minor in Economics from the University of Southern California. She is pursuing an actuarial career and is taking exams offered by the Society of Actuaries. Ms. Kuhlman has obtained a California Life Agent License.

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Expertise

Ms. Chu joined The Segal Company in 2009 as a Health Benefits Analyst. Her responsibilities include analyzing technical data with regard to medical, dental and vision benefit plans in both traditional indemnity and managed care environments. Ms. Chu prepares renewal analyses, requests for proposals and bid analyses for the potential replacement of vendors.

Professional Background

Prior to joining Segal, Ms. Chu worked for Anthem Blue Cross for about three years as a Data Analyst. In this position, she was responsible for analyzing medical and pharmacy data for more than 180 medical groups in California. Ms. Chu created cost and utilization reports, performed annual pay for performance program calculation and reconciliation, and provided support for the contracting team and medical directors.

Education/Professional Designations

Ms. Chu received a BA from the University of Irvine, California, with a major in Economics and a minor in Educational Studies. She is a licensed California Life Agent (Life-Only and Accidental and Health Agent).

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Expertise

Ms. Yip is a Health Benefits Analyst in Segal's Los Angeles office. She supports senior analysts with their projects, including analyzing technical data with regard to medical, dental and vision benefit plans in both traditional indemnity and managed care environments; preparing budget projections, financial reports, plan pricing, claim cost, renewal analysis, requests for proposals; and bid analyses for potential replacement of vendors.

Professional Background

Ms. Yip began her career at Segal as an Actuarial Analyst in the Retirement Practice before transitioning to her role as Health Benefits Analyst.

Education/Professional Designations

Ms. Yip received her BA from the University of California, Berkeley, with a double major in Economics and Statistics. She is an Associate of the Society of Actuaries and a Member of the American Academy of Actuaries. She is also licensed as a California Life Agent.

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EXAMPLES OF SEGAL'S HEALTH ANALYTICAL TOOLS AND RESOURCES

HEALTH ANALYTICAL TOOLS AND RESOURCES

 **Health Underwriting, Fees, Benchmarking, Reserving, Premium Calculation**	APEX, Ingenix Health Charge System, Multiemployer Health Plan Design Norms, Claims Cost Application (CCA), IBNR Model, Captiva UCR Outpatient Facility Charge Data, Physician Fee Modeler
 **Prescription Drug Benchmarking, Auditing Underwriting**	Rx Omni Pricer, Prescription Drug Program Analysis (PDPA), Medicare Part D Calculator, Prescription Drug Benchmarks, First Data Bank, Ingenix Rx Claims Database, NCPDP Pharmacy Database
 **Health Data Analysis, Health Claims Auditing**	Health Benefit Report (HBR), CareAdvantage RPNavigator, Interactive Projections Modeler, Claim Audit Software, Ingenix Encoder Pro
 **Electronic Request for Proposal Services (eRFP)**	Proposal Tech
 **Dental Underwriting, Fees and Benchmarking**	Dental Pricer, NDAS Pricing
 **Health Provider Accessibility, Quality Assessment**	GeoNetwork, Q-Val, CareAdvantage RPNavigator
 **Utilization Management Program Assessment**	UM Software, CareAdvantage RPNavigator

SAMPLE OF SEGAL'S PUBLICATIONS

- 2014 *Segal Health Plan Cost Trend Survey*
- 2012 *Study of State Employee Health Benefits* - Spring 2013
- 2014 TRENDS – 1st Quarter
- Capital Alert *"Final Rule Implementing the Affordable Care Act's 90-Day Waiting Period Limit" – March 14, 2014*
- Bulletin *"For 2014, Increases in Some IRS Dollar Limits and Social Security Figures"- November 2013*

2014 Segal Health Plan Cost Trend Survey

Segal Consulting

Slowest Rate of Increase in Health Plan Cost Trends in 14 Years Projected for 2014

Health benefit plan cost trend rates show the slowest growth in 14 years of trend forecasts, according to data compiled in the 2014 *Segal Health Plan Cost Trend Survey*, Segal Consulting's seventeenth annual survey of managed care organizations (MCOs), health insurers, pharmacy benefit managers (PBMs) and third-party administrators (TPAs).[1] (For a definition of trend, see the text box on page 2.) While this decline in the trend rate is positive news, it is important to note that medical health plan cost trends still outpace the consumer price index for all urban consumers (CPI-U) by a margin of at least three to one, which continues to serve as a drag on real wage growth.

As the Affordable Care Act[2] kicks into full gear in 2014 and as the economy continues to improve, it is unclear if health plan cost trends will continue to decline or return to the historic, inflationary underwriting cycle.

Trend Projections for 2014

Table 1 summarizes Segal's key findings on trend projections for 2014 and compares them to projections for 2013. Notes about the 2014 forecasted trends follow:

- All medical plan types are projected to experience trend rate declines in 2014.

[1] For information about the survey participants, see the text box on the last page of this report.

[2] The Affordable Care Act is the abbreviated name for the Patient Protection and Affordable Care Act (PPACA), Public Law No. 111-148, as modified by the subsequently enacted Health Care and Education Reconciliation Act (HCERA), Public Law No. 111-152.

Table 1: Projected Medical, Prescription Drug, Dental and Vision Trends: 2013 and 2014

	2013 Projected		2014 Projected	
	(without Rx)	(with Rx)[1]	(without Rx)	(with Rx)[1]
Medical (Actives & Retirees <Age 65)				
Fee-for-Service (FFS)/Indemnity Plans	10.8%	10.0%	**10.4%**	**9.7%**
High-Deductible Health Plans (HDHPs)[2]	9.1%	8.6%	**8.3%**	**7.9%**
Open-Access Preferred Provider Organizations (PPOs)/Point-of-Service (POS) Plans[3]	8.8%	8.3%	**7.9%**	**7.6%**
PPOs/POS Plans (with PCP Gatekeepers)	9.3%	8.8%	**8.4%**	**8.0%**
Health Maintenance Organizations (HMOs)	8.2%	7.9%	**7.2%**	**7.0%**
Medical (Retirees Age 65+)				
Medicare Advantage (MA)[4] FFS Plans or PPOs	5.5%	5.4%	**3.6%**	**4.3%**
Medicare Advantage HMOs	5.8%	5.6%	**3.3%**	**4.2%**
Medicare Supplemental (Medigap)	5.3%	5.3%	**4.9%**	**5.2%**
Prescription Drug (Rx) Carve-Out[5]				
Actives & Retirees <Age 65	6.4%		**6.3%**	
Retirees Age 65+	5.3%		**5.7%**	
Dental				
Schedule of Allowance Plans[6]	4.0%		**4.0%**	
FFS/Indemnity Plans	4.0%		**3.8%**	
Dental Provider Organizations (DPOs)	3.5%		**3.4%**	
Dental Maintenance Organizations (DMOs)	4.1%		**4.5%**	
Vision				
Schedule of Allowance Plans	2.8%		**2.9%**	
Reasonable & Customary (R&C) Plans	3.7%		**3.3%**	

[1] Trend projections were derived by proportionally blending medical trends and freestanding prescription drug trends.

[2] HDHPs with an employee-directed, tax-advantaged health account — a health savings account (HSA) or a health reimbursement account (HRA) — are referred to as account-based health plans and are designed to encourage consumer engagement, resulting in more efficient use of health care services. HDHPs are defined as those plans where the deductible is at least the minimum health savings account (HSA) level required by the Internal Revenue Service ($1,250 single, $2,500 family in 2014).

[3] Open-access PPO/POS plans are those that do not require a primary care physician (PCP) gatekeeper referral for specialty services.

[4] MA plans, part of the Medicare program, can be private HMOs, FFS plans, PPOs or special-needs plans. The 2013 survey collected information about projected trends for MA PPO plans separately. The 2014 survey combines FFS plans with PPOs.

[5] Prescription drug carve-out data was captured for retail and mail-order delivery channels combined.

[6] A schedule of allowance plan is a plan with a list of covered services with a fixed-dollar amount that represents the total obligation of the plan with respect to payment for services, but does not necessarily represent the provider's entire fee for the service.

- Health maintenance organization (HMO) trend rate projections for 2014 are 3 percentage points lower than HMO projections for 2011.
- Prescription drug benefit trends for retail and mail order combined are forecasted at 6.3 percent for active participants and early retirees. These projections are relatively consistent with last year's trend rate projections of 6.4 percent.
- Medicare-eligible retiree plans are also anticipating trend rate declines for Medicare Advantage (MA) preferred provider organizations (PPOs), MA HMOs and Medicare Supplemental plans. MA PPO trends are projected to decrease almost 2 percentage points below 2013 levels to their lowest point in 17 years. This predicted rate decrease for Medicare-eligible retiree plans is more than double the rate decline projected for PPOs for actives and pre-65 retirees.
- In 2014, Medicare-eligible retirees can expect lower trend rates for medical coverage compared to prescription drug coverage. For example, MA HMO trend rates are projected to be 3.3 percent while prescription drug trends (retail and mail order combined) are forecasted at 5.7 percent. These findings are a departure from last year's trends in which the forecasted medical and prescription drug trends rates were aligned. This is largely driven by the rise in specialty drug cost and significant price inflation on brand-name drugs without dramatic new gains in generic utilization. It is noteworthy that trend projections for MA plans are lower despite cutbacks in subsidies from the Centers for Medicare & Medicaid Services (CMS).
- Overall, dental plan trend rates are projected to remain relatively unchanged in 2014. Scheduled vision plan trend rates are projected at 2.9 percent and reasonable and customary plans are forecasted at 3.3 percent in 2014.

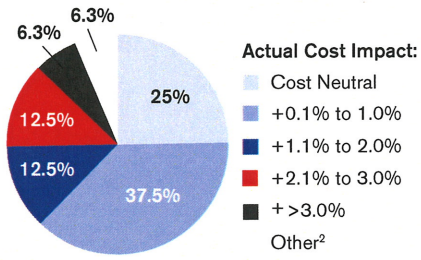
"HMO trend rate projections for 2014 are 3 percentage point lower than HMO projections for 2011."

The survey also looked for regional variations in trend rates. Projected 2014 trend rates for PPO and POS plans combined show regional variations, with the lowest rate of 5.8 percent in the South and highest rate of 10.0 percent in the West.

"For the first time, Segal asked insurers to indicate 2014 expected medical PPO cost trends by group size. Results indicate that individual and small groups will trend approximately 1 percentage point higher than large group plans."

For the first time, Segal asked insurers to indicate 2014 expected medical PPO cost trends by group size. Results indicate that individual and small groups will trend approximately 1 percentage point higher than large group plans.

Graph 1: Projected Cost Impact on 2014 Plan Trend of Implementing Preventive Care Coverage for Plans That Lost Their Grandfathered Status by Percentage of Survey Respondents[1]



[1] This data reflects responses from 16 of the health insurers, MCOs and TPAs that participated in the survey. Total exceeds 100% due to rounding.

[2] The survey did not collect data on what the respondents meant by "other."

Impact of Losing "Grandfathered" Status

Segal asked the survey respondents about the expected impact of the Affordable Care Act on costs. Survey findings indicate nearly two-thirds of respondents project a cost increase of 1 percent or less due to loss of "grandfathered" status,[3] with one-quarter of the respondents predicting the loss of grandfathered status will be cost neutral, as shown in Graph 1 above. Only 6 percent of survey respondents anticipate that implementing preventive care coverage for plans that lost their

What Is Trend?

Trend is a forecast of per capita *claims cost increases* that takes into account various factors, such as price inflation, utilization, government-mandated benefits, and new treatments, therapies and technology. Although there is usually a high correlation between a trend rate and the actual cost increase assessed by a carrier, trend and the net annual change in plan costs are *not* the same. Changes in the costs to plan sponsors can be significantly different from projected claims cost trends, reflecting such diverse factors as group demographics, changes in plan design, administrative fees, reinsurance premiums and changes in participant contributions.

[3] Group health plans in existence as of March 23, 2010, when the Affordable Care Act was signed into law, and that remain largely unchanged from that date are grandfathered.

grandfathered status under the Affordable Care Act will result in a cost trend increase of more than 3 percent.

Trend Components

The survey also examined 2014 projected medical trends by service type. Table 2 presents that data. Similar to prior-year projections, price inflation remains the largest component of cost increases and continues high for hospital services and brand-name medications. For prescription drugs, price inflation is projected to jump more than 1 percentage point compared to 2013 forecasts. On the other hand, the projected specialty drug/biotech trend rate, while very high at 16.5 percent, is almost 1 full percentage point lower than the 2013 projection.

In 2014, the utilization component of trend for hospital services is projected to remain unchanged at 2.2 percent. Two noteworthy results supporting lower overall trend rates are the modest price inflation for physician services (3.7 percent) and the flat prescription drug utilization rate. However, the continued upswing in generic dispensing rates based on brands losing patent protection is likely to begin leveling off.

"Price inflation remains the largest component of cost increases."

Accuracy of 2012 Projections

To assess the accuracy of the reported projections, Segal compared the average 2012 trend *forecasts* by national and regional insurers, MCOs, PBMs and TPAs for group medical, prescription drug benefit and dental plans to the *actual* average trend rates experienced by the health plans covered by those organizations for the same 12-month period, as reported by survey respondents. Actual trends for 2012 (the most recent full year for which actual data is available), were the lowest reported in more than 12 years.

Consistent with previous survey findings, this year's findings support our observation that insurers and PBMs tend to make conservative projections and confirm that forecasted trends have been generally higher than actual experience. The following are the most notable findings about the accuracy of trend projections based on the data shown in Table 3:

- The survey found a significant spread of nearly three percentage points between actual and projected trends for high-deductible health plans (HDHP), open-access PPOs/point-of-service (POS) plans for actives and retirees,

"The projected specialty drug/biotech trend rate, while very high at 16.5 percent, is almost 1 full percentage point lower than the 2013 projection."

Table 2: Components of 2013 & 2014 Projected Trends for Hospital Services, Physician Services and Prescription Drugs

	Hospitals[1]		Physicians[1]		Rx	
	2013	2014	2013	2014	2013	2014
Total Trend[2]	**8.7%**	**8.6%**	**6.8%**	**6.0%**	**6.3%**	**6.4%**
Trend Component						
Price Inflation	6.4%	6.3%	3.9%	3.7%	8.4%	6.8%
Utilization	2.2%	2.2%	2.8%	2.3%	0.2%	0.7%

[1] Hospital and physician trends are for open-access PPOs.

[2] The components do not add up to the totals because there are other components of trend not illustrated, reflecting such factors as the impact of cost shifting, technology changes and drug mix. Not all survey respondents provided a breakdown of trend by component.

Table 3: Comparison of 2012 Projected Trends to 2012 Actual Trends

	Projected	Actual
Medical (Actives & Retirees <Age 65)	(without Rx)	
FFS/Indemnity Plans	11.7%	10.0%
HDHPs	10.4%	7.7%
Open-Access PPOs/ POS Plans	10.0%	7.3%
PPOs/POS Plans (with PCP Gatekeepers)	10.4%	8.4%
HMOs	9.6%	6.7%
Medical (Retirees Age 65+)	(without Rx)	
MA PPO[1]	N/A	0.4%
MA HMOs	6.6%	3.0%
Rx Carve-Out[2] (Actives & Retirees <Age 65)	7.2%	5.5%
Rx Carve-Out[2] (Retirees Age 65+)	6.5%	2.2%
Dental		
Scheduled Plans	4.1%	2.9%
FFS/Indemnity Plans	4.2%	2.8%
DPOs	3.8%	2.6%
DMOs	4.4%	3.4%
Vision		
Scheduled Plans	3.8%	2.3%
R&C Plans	3.9%	2.9%

[1] For 2012, the survey asked for Medicare Supplement (Medigap) trends and MA HMO trends for retiree medical post-65. It did not ask for MA PPO trend rate information.

[2] The 2012 survey captured prescription drug carve-out data for retail and mail-order delivery channels combined.

PPOs/POS plans with a physician gatekeeper *and* HMOs for the active and retiree under 65 population.

- For prescription drugs, the differential between actual and forecasted trend rates was more than double for retirees age 65 and older than for actives and retirees under 65: 4.3 percentage points compared to 1.7 percentage points.

Table 4 shows selected trends (actual trends for 2002–2012 and projected trends for 2013 and 2014).

It should be noted that the accuracy of projections is subject to both underwriters' conservatism in predicting future events and a natural lag in the underwriting cycle. In periods where costs are decelerating, forecasters will tend to overestimate trends. Similarly, when costs are accelerating, trend projections will generally be underestimated for a period. Consequently, accuracy of trend assumptions is best measured by comparing projected trend to actual trend over multiple years. Graphs 2 and 3 illustrate the significant but declining variances between trend forecasts versus actual trends experienced in 2008 and 2009.

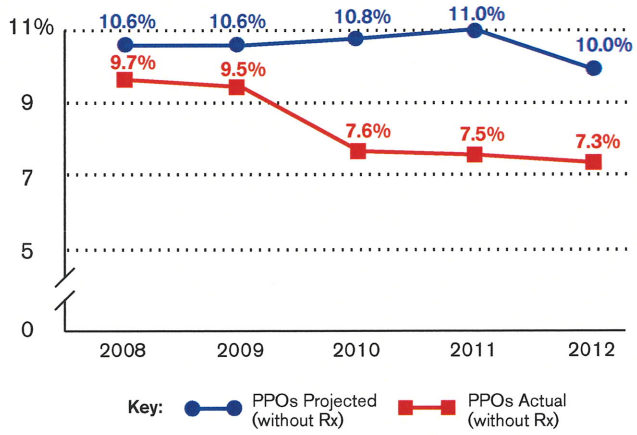
Table 4: Selected Medical, Rx Carve-Out and Dental Trends: 2002-2012 Actual and 2013 and 2014 Projected*

Year	PPOs (without Rx)	POS Plans (without Rx)	HMOs (without Rx)	MA HMOs (without Rx)	Rx	DPOs
2002 Actual	13.9%	12.2%	12.8%	12.9%	18.4%	6.4%
2003 Actual	12.0%	11.5%	11.5%	10.0%	14.3%	6.5%
2004 Actual	10.9%	11.6%	11.5%	11.4%	13.3%	6.2%
2005 Actual	10.4%	11.1%	10.6%	8.4%	10.5%	5.0%
2006 Actual	9.6%	10.0%	10.2%	7.2%	9.5%	5.1%
2007 Actual	8.9%	9.5%	9.8%	7.0%	7.9%	5.0%
2008 Actual	9.7%	9.4%	9.7%	7.7%	7.4%	5.5%
2009 Actual	9.5%	9.7%	10.2%	4.0%	7.9%	4.7%
2010 Actual	7.6%	8.3%	8.7%	3.6%	6.4%	3.0%
2011 Actual	7.5%	7.8%	8.0%	4.5%	5.0%	3.1%
2012 Actual	7.3%	8.4%	6.7%	3.0%	5.5%	2.6%
2013 Projected	8.8%	9.3%	8.2%	5.8%	6.4%	3.5%
2014 Projected	7.9%	8.4%	7.2%	3.3%	6.3%	3.4%

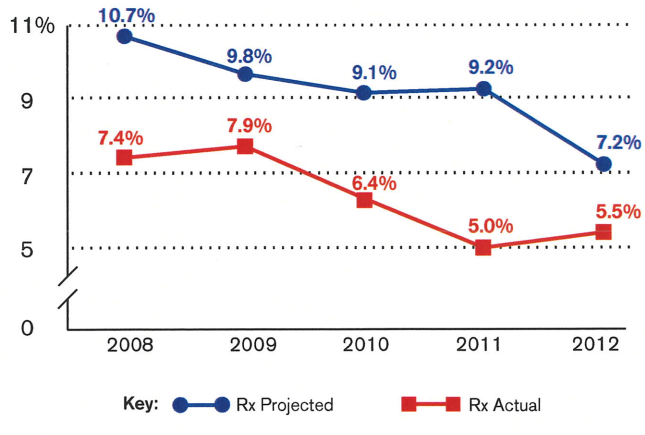
* All trends are illustrated for actives and retirees under age 65, except for the MA Plans. (A graph comparing 13 years of survey data — 2013 and 2014 projected trends to actual trends for 2002 through 2012 — is available on the following page of Segal's website: http://www.segalco.com/publications/surveysandstudies/2014TSsupp.pdf)

"The accuracy of projections is subject to both underwriters' conservatism in predicting future events and a natural lag in the underwriting cycle. In periods where costs are decelerating, forecasters will tend to overestimate trends."

Graph 2: Comparison of Projected to Actual Trends for PPOs for Actives and Retirees under Age 65: 2008–2012



Graph 3: Comparison of Projected to Actual Trends for Rx* Carve-Out Coverage for Actives and Retirees under Age 65: 2008-2012



* This data reflects retail and mail-order delivery channels combined.

Segal also asked the survey participants to indicate the top five major diagnostic categories (MDC) that had the highest actual cost trends in 2012. Table 5 shows the results, from highest to lowest, by rank in 2012 compared to rank in 2011.

In this year's survey, Segal asked the respondents to indicate the medical management strategies that are most effective in reducing medical plan cost trends based on their experience. Responses indicate that the most effective and widely used strategy is care management and specialty case management programs, such as those that focus on acute care, chronic care and oncology care. Another successful cost-containment option reported by survey respondents is the management of hospital admissions and readmissions using tools such as redirecting hospital outpatient services and overseeing inpatient admissions.

"Although it remains to be seen whether the deceleration in trends projected for 2014 has been influenced by short-term economic forces, the influence of the Affordable Care Act or some other factor not yet identified, there continue to be significant changes in the health care delivery system that could have long-term implications for health care costs."

Commentary & Outlook

Although it remains to be seen whether the deceleration in trends projected for 2014 has been influenced by short-term economic forces, the influence of the Affordable Care Act or some other factor not yet identified, there continue to be significant changes in the health care delivery system that could have long-term implications for health care costs. Some of these changes are noted below:

- Many plan designs now include greater levels of participant out-of-pocket costs.
- Provider reimbursement arrangements are beginning to shift from the fee-for-service model to alternative payment models, such as bundled payments, which are designed to encourage providers to coordinate care and reward efficiency.
- The Hospital Readmissions Reduction Program, which requires CMS to reduce payments to hospitals with excess readmissions, has helped to reduce overall hospital spending by including comprehensive strategies for discharge planning, medication management, and continuum of care.
- Participants are becoming more educated consumers through programs such as Choose Wisely, which lists five questions patients should discuss with physicians about medical tests and procedures that may be unnecessary (and, in some instances, can cause harm) and the Five-Star Quality Rating System created by CMS to help consumers compare how nursing homes' quality of care and services vary.
- Costs are becoming more transparent. A growing number of health insurers have invested heavily in new member-support decision tools that provide more information on health treatment costs. There are also publically available transparency tools, such as Hospital Compare (CMS-published data on what providers charge for common services, which shows significant variation across the country at over 4,000 Medicare-certified hospitals) and Fair Health, an independent not-for-profit

"The most effective and widely used strategy [for reducing medical plan cost trends] is care management and specialty case management programs, such as those that focus on acute care, chronic care and oncology care."

Table 5: Top Five Major Diagnostic Categories (MDC) with Highest PMPY Cost Trends in 2012 Compared to 2011

	Rank	
	2012	2011
Diseases and disorders of the digestive system	1	2
Diseases and disorders of the musculoskeletal system and connective tissue	2	1
Pregnancy, childbirth and the puerperium*	2	3
Diseases and disorders of the circulatory system	3	2
Diseases and disorders of the nervous system	3	Not in Top 5
Lymphatic, hematopoietic and other malignancies	4	3
Infectious and parasitic diseases, systemic or unspecified sites	4	Not in Top 5

*"Puerperium" is the period of adjustment after childbirth during which the mother's reproductive organs return to their non-pregnant state.

corporation with a web portal that allows consumers to access a medical cost transparency database for determining out-of-network reimbursement.

- Plan sponsors are encouraging participants to seek care for minor illnesses at lower-cost settings, such as telemedicine and walk-in clinics.
- There is growing use of Patient-Centered Medical Homes (PCMH), which focus an increased level of comprehensive health care resources on primary care and prevention for patients with chronic conditions. Also, as Accountable Care Organizations (ACOs)[4] and PCMHs expand, they will offer new options for plan sponsors.
- Reference-based pricing, in which the plan makes a defined contribution towards covering the cost of a particular service, to steer participants towards higher-quality hospitals or physicians for specific procedures or conditions (*e.g.*, the California Public Employees' Retirement System's use of maximum allowance for hip and knee replacement), is expanding.
- Network provider contracting is being improved to remove high-cost outlier providers who cannot prove their value.

While medical plan cost trend continues to decelerate, overall health plan costs are still on the rise. Faced with this reality, plan sponsors are becoming increasingly more progressive and creative in their efforts to manage costs while delivering high-quality, cost-effective health care. Plan sponsors must be ready to implement new requirements introduced by the Affordable Care Act[5] and to determine their impact on plan costs. Plan sponsors will need to play an active role to continue to get the most for their benefit dollars.

"While medical plan cost trend continues to decelerate, overall health plan costs are still on the rise."

■ ■ ■

For assistance with health care cost management strategies, contact your Segal consultant or the nearest Segal office. A list of Segal offices can be accessed from the second hyperlink in the blue box below.

[4] ACOs, which have mainly been developed for the Medicare population, are networks of providers and suppliers that agree to be jointly accountable for managing the health of participating populations across the care continuum.

[5] New guidance on the Affordable Care Act is released on a regular basis. As guidance is issued, it is summarized in Segal publications. All of Segal's publications on the Affordable Care Act can be accessed from the Health Care Reform Guide on the Segal website: http://www.segalco.com/publications-and-resources/health-care-reform/

The Survey Participants

The 2014 *Segal Health Plan Cost Trend Survey* was conducted in May and June of 2013. Survey participants were asked to provide the trend factors they will be applying to historical claims to predict expected claims for 2014. Segal received 99 responses to the survey. The following participants agreed to disclose their names: Aetna; Amalgamated Life; Amerihealth of New Jersey; Anthem Blue Cross and Blue Shield; Anthem Blue Cross of California; Arkansas Blue Cross and Blue Shield; Assurant Employee Benefits; Benecard; Blue Cross and Blue Shield of Illinois; BlueCross and BlueShield of Tennessee; Blue Cross Blue Shield of Michigan; Capital District Physician's Health Plan; Care Plus Dental Plans; Catamaran; CIGNA; ConnectiCare, Inc.; CVS Caremark; Delta Dental of Arizona, Delta Dental of Arkansas; Delta Dental Insurance Company (DDIC); Delta Dental of California; Delta Dental of Colorado; Delta Dental of Delaware; Delta Dental of the District of Columbia; Delta Dental of Idaho; Delta Dental of Illinois; Delta Dental of Indiana; Delta Dental of Kansas; Delta Dental of Massachusetts; Delta Dental of Michigan; Delta Dental of Minnesota; Delta Dental of Nebraska; Delta Dental of New Mexico; Delta Dental of New York; Delta Dental of North Carolina; Delta Dental of Ohio; Delta Dental of Pennsylvania; Delta Dental of Tennessee; Delta Dental of Virginia; Delta Dental of West Virginia; Delta Dental of Wisconsin; EmblemHealth; Envision Pharmaceutical Services; Excellus Health Plan, Inc.; Express Scripts, Inc.; Health Alliance Medical Plans; Health Net, Inc.; Horizon Blue Cross Blue Shield of New Jersey; Humana, Inc.; Independence Blue Cross; ING; Kaiser Foundation Health Plan; Lincoln Financial Group; Medical Mutual; Moda Health; MVP Health Care; Navitus Health Solutions; Nippon Life Insurance Company of America; OptumRx; Restat; The ODS Companies; Trustmark Life; Tufts Health Plan; UnitedHealthcare; United Concordia; and US Script.

Segal Consulting

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SPRING 2013

2012 Study of State Employee Health Benefits

The Segal Company's 2012 *Study of State Employee Health Benefits* presents an overview of state health plan cost-sharing arrangements and plan design. How states structure their health coverage for employees is always of interest to peer jurisdictions, particularly as states continue to address the increasing cost of health benefits. This year there is another reason for states to focus on employee health coverage: open enrollment in the health insurance Exchanges introduced by the Affordable Care Act[1] will begin in the fall for the 2014 calendar year. Like other employers, states will need to notify employees about the opening of the Exchanges. This will create a need to educate members about the Exchanges and how that coverage differs from the benefits provided through the employer's program.

[1] The Affordable Care Act is the abbreviated name for the Patient Protection and Affordable Care Act (PPACA), as modified by the subsequently enacted Health Care and Education Reconciliation Act (HCERA).

About the Study

Since the mid-1970s, Segal has periodically gathered data about state employee health benefits plans into a comparative analysis of benefits, costs, premiums, plan designs and related issues as a resource for government leaders. This report summarizes the results of the latest study, which is based on Segal's review of information available on state websites in 2012. The 2012 *Study of State Employee Health Benefits*, which covers all states and the District of Columbia,* reflects benefits offered to active, full-time employees of these jurisdictions in 2012.

* For simplicity, the text in this report uses the term "states" to refer to all of the jurisdictions studied.

Key Findings

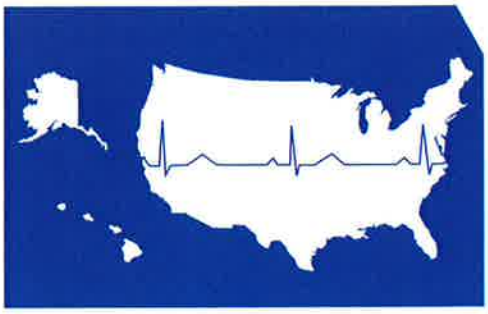
The following are among the key findings of the 2012 *Study of State Employee Health Benefits*:

- Among medical plans in which employees pay some of the premium cost, the percentage of total costs paid by employees did not change significantly from 2011 to 2012, remaining at 19 percent for employee-only coverage and 24 percent for family coverage for preferred provider organizations (PPOs)/point-of-service (POS) plans.
- The total premium cost paid by both employees and the states increased between 2011 and 2012. Among contributory plans, total premiums for employee-only coverage increased by 3 percent for PPOs/POS plans,[2] the most prevalent plan type, and 10 percent for health maintenance organizations (HMOs)/exclusive provider organizations (EPOs).[3]
- Compared to 2011, four more states offered a high-deductible health plan (HDHP)[4]/consumer-driven health plan (CDHP).

[2] In PPOs and POS plans, network providers (doctors, hospitals and others) typically have agreements with the insurer or administrator to provide services at fixed or discounted rates. POS plans generally have more managed care features and sometimes more limited availability of services outside the primary network than do PPO plans.

[3] Like HMOs, EPOs typically rely on primary care physicians (PCPs) to act as gatekeepers, directing their patients' care from other network providers and coordinating that care. HMOs may compensate PCPs on a per-person basis, where EPOs typically pay according to services performed. Both HMOs and EPOs typically limit the availability of benefits for use of providers outside their network.

[4] An HDHP may be combined with a Health Savings Account (HSA) plan, which requires an annual deductible of $1,250 or more in 2013, or may be a stand-alone option without the HSA component.



- State plan costs for employee-only coverage increased 4 percent on average for PPO/POS plans, but were basically unchanged for HDHP/CDHPs.
- Average monthly employee premium contributions for HDHP/CDHPs were roughly half the cost of the premiums for PPOs/POS plans for employee-only coverage and 57 percent of the cost of family coverage.
- Overall, annual deductibles increased between 2011 and 2012. For employee-only coverage, the average PPO/POS plan deductible rose by 3 percent and the average HDHP/CDHP deductible rose by 12 percent.
- There was no significant change between 2011 and 2012 in primary care physician copayments for PPOs/POS plans and HMOs/EPOs.
- Between 2011 and 2012, the average generic retail prescription drug copayment increased 6 percent and the average generic mail-order prescription drug copayment increased 7 percent.

This report provides details about these and other study findings and concludes with some commentary on the findings and observations on the outlook for state employee health benefits in the coming year.

Medical Plan Types Offered

The large majority of states (48) continued to offer PPOs/POS plans in 2012. Between 2011 and 2012, there was no change in the number of states offering HMOs/EPOs (30) and indemnity plans (six).

In contrast, four more states (District of Columbia, Florida, New Jersey, and Washington) offered at least one HDHP/CDHP in 2012 than in 2011, raising the total to number of states offering that type of coverage to 28. In 2012, more data about HDHPs/CDHPs was available than in previous years. As a group, the four states that added that type of coverage offered a total of nine HDHPs/CDHPs.

There are some notable differences in medical plan offerings by region. Table 1 shows a regional breakdown of the number of states that offered each medical plan type in 2012.

Jurisdiction population size does not seem to be a factor in the plan types offered, with the exception that the largest states (those with populations of 10 million or more) are less likely to offer an HDHP/CDHP option.[5]

[5] A table with the results of an analysis by population size is available as an online supplement to this study report: http://www.segalco.com/publications/surveysandstudies/2012statestudysupp1.pdf

Table 1: Number of States Offering Medical Plan Types by Region*

	Northeast (9 States)	South (17 States)	Midwest (12 States)	West (13 States)	Total
PPO/POS Plan**	9	16	11	12	48
HMO/EPO	6	11	5	8	30
HDHP/CDHP	3	12	6	7	28
Indemnity Plan	2	0	1	3	6***

* The total for each region exceeds the number of states in the region because many states offer more than one option. The regional breakdown of the data follows the regional breakdown used by the U.S. Census Bureau: **Northeast** = CT, MA, ME, NH, NJ, NY, PA, RI and VT; **South** = AL, AR, DC, DE, FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA and WV; **Midwest** = IL, IN, IA, KS, MI, MN, MO, ND, NE, OH, SD and WI; and **West** = AK, AZ, CA, CO, HI, ID, MT, NM, NV, OR, UT, WA and WY.

** The three states that do *not* offer a PPO/POS plan are Alaska, which only offers indemnity plans, Georgia and Minnesota, which only offer HMOs/EPOs and HDHPs/CDHPs.

*** These states are Alaska (as noted in the footnote above), Idaho, Iowa, Massachusetts, Montana and Vermont.

"Four more states…offered at least one HDHP/CDHP in 2012 than in 2011."

Medical Coverage Tiers Offered

All states offer employee-only and family medical coverage. As shown in Graph 1, more than half of states also offer coverage tiers for employee+spouse and employee+children. Relatively few states offer employee+1 or employee+child coverage tiers.

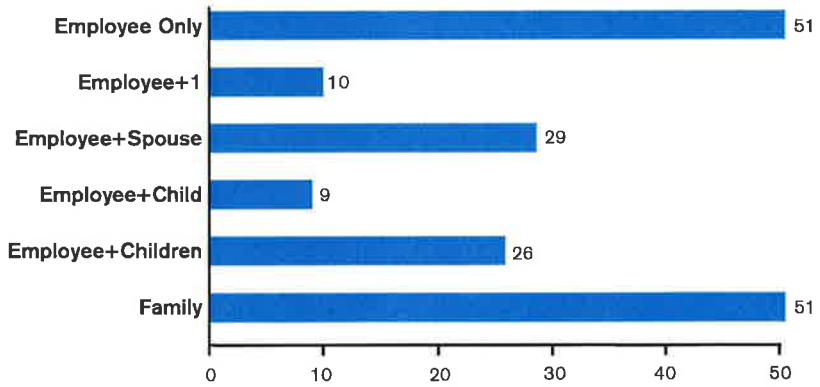
Graph 2 shows the number of states offering different coverage tiers. The large majority of states (90 percent) offered four or fewer coverage tiers.

Medical Premium Cost Sharing

Table 2 on the next page provides a detailed breakdown of medical premium cost-sharing ranges for employee-only coverage in 2012 by plan type.[6] Table 3 on the next page presents similar data for family coverage. For each of the three plan types shown in Tables 2 and 3, the majority of medical plans have employee cost sharing under

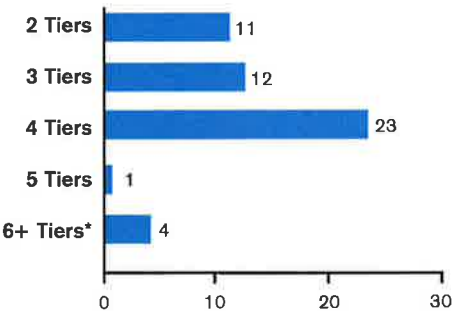
[6] A table on total monthly costs is available as an online supplement to this study report: http://www.segalco.com/publications/surveysandstudies/2012statestudysupp2.pdf

Graph 1: Number of States Offering Tiers for Medical Coverage*



* The total exceeds the number of all states because all states offer more than one tier.

Graph 2: Number of States Offering Number of Tiers for Medical Coverage



* 6+ cost tiers vary by the specific number of dependents covered and their ages. The three states that have 6+ cost tiers are Idaho, Missouri, Oklahoma and South Dakota.

Table 2: Portion of Monthly Cost of Employee-Only Coverage Medical Coverage Paid by the Employee by Plan Type and Percentage of Plans*

	PPO/POS Plan* (121 Plans)	HMO/EPO** (140 Plans)	HDHP/CDHP** (45 Plans)
0	13%	10%	31%
1-9%	25%	11%	38%
10-19%	28%	54%	4%
20-29%	23%	16%	20%
30-39%	2%	3%	4%
40-49%	4%	2%	0
50-59%	4%	3%	2%
60%+	0	0	0

* In this table and the tables that follow, data is not shown for indemnity plans because there are so few of that plan type.

** The total of the percentages in this column does not equal 100% due to rounding.

Table 3: Portion of Monthly Cost of Family Medical Coverage Paid by the Employee by Plan Type and Percentage of Plans

	PPO/POS Plan* (121 Plans)	HMO/EPO* (140 Plans)	HDHP/CDHP (45 Plans)
0	7%	4%	13%
1-9%	12%	9%	18%
10-19%	29%	44%	33%
20-29%	31%	27%	24%
30-39%	10%	10%	7%
40-49%	5%	1%	0
50-59%	5%	3%	2%
60%+	2%	1%	2%

* The total of the percentages in this column does not equal 100% due to rounding.

Table 4: Average Monthly Employee Contribution to Medical Plan Costs for Contributory Plans in Dollars by Plan Type, 2011 and 2012, and Percent Change

	Employee-Only Coverage			Family Coverage		
	2011	2012	Percent Change	2011	2012	Percent Change
PPO/POS Plan	$112	$115	3%	$354	$364	3%
HMO/EPO	$95	$104	10%	$294	$314	7%
HDHP/CDHP	$44	$58	30%	$220	$206	-7%*

* The decrease in the average employee contribution for family HDHP/CDHP coverage from 2011 to 2012 is partially attributable to the additional four states that added that type of coverage in 2012. For those states, the average employee cost for family coverage was $141.17 and the employee costs for all but one of these plans was below the 2012 average for all plans.

30 percent for employee-only coverage and family coverage.

Although the cost-sharing rrangements were similar from 2011 to 2012, in general, the premium amount paid by both employees and the states increased over that period. Table 4 shows the average employee premium contribution for contributory plans in 2011 and 2012. For PPOs/POS plans, the average premium amount paid by employees increased 3 percent for both employee-only and family coverage. For HMOs/EPOs, the average employee premium increased by 10 percent for employee-only coverage and 7 percent for family coverage. For HDHPs/CDHPs, the average employee premium paid by employees increased by 30 percent for employee-only coverage and the average employee premium for family coverage decreased by 7 percent. One reason that the average employee premium contribution decreased for HDHPs/CDHPs family coverage is that many of the HDHPs/CDHPs added in 2012 have relatively lower employee premium contribution amounts for family coverage.

From 2011 to 2012, across all medical plan types and coverage tiers, there was no significant change in the percentage of medical plan premiums paid by employees in contributory plans, as shown in Table 5. For PPOs/POS plans,

Table 5: Average Percent of Total Medical Plan Costs Paid by Employees for Contributory Plans by Plan Type, 2011 and 2012

	Employee-Only Coverage		Family Coverage	
	2011	2012	2011	2012
PPO/POS Plan	19%	19%	24%	24%
HMO/EPO	14%	15%	19%	20%
HDHP/CDHP	10%	13%	19%	18%

Table 6: Average Monthly State Medical Plan Costs in Dollars by Plan Type, 2011 and 2012 and Percent Change*

	Employee-Only Coverage			Family Coverage		
	2011	2012	Percent Change	2011	2012	Percent Change
PPO/POS Plan	$482	$498	4%	$1,131	$1,169	3%
HMO/EPO	$563	$586	4%	$1,218	$1,250	3%
HDHP/CDHP	$395	$396	0.4%	$957	$983	3%

* This reflects the states' portion of monthly premiums as described in public materials about each state's plans. These amounts may not reflect the actual *net* state cost for a self-insured medical plan.

the average contribution level was 19 percent for employee-only coverage and 24 percent for family coverage for plans that require employees to pay some of the premium cost. For HMOs/EPOs, the average contribution level was 15 percent for employee-only coverage and 20 percent for family coverage for contributory plans. For HDHPs/CDHPs, the average contribution level was 13 percent for employee-only coverage and 18 percent for family coverage.

The average *state* medical plan costs increased from 2011 to 2012.[7] For both PPOs/POS plans and HMOs/EPOs, the average state monthly cost increased 4 percent for employee-only coverage and 3 percent for family coverage. For HDHPs/CDHPs, the average state monthly cost increased 0.4 percent for employee-only coverage and 3 percent for family coverage. See Table 6.

[7] This reflects the states' portion of monthly premiums as described in public materials about each state's plans. These amounts may not reflect the actual *net* state cost for a self-insured medical plan.

Table 7: Annual Per-Person Deductibles by Plan Type and Percentage of Plans

	PPO/POS Plan* (120 Plans)	HMO/EPO** (116 Plans)	HDHP/CDHP*** (45 Plans)
0	20%	79%	0
$1-499	42%	19%	0
$500-999	33%	1%	0
$1,000-1,499	3%	1%	27%
$1,500-1,999	2%	0	49%
$2,000-2,499	0	0	9%
$2,500-2,999	0	0	2%
$3,000+	0	0	13%

* These deductibles are for in-network services. The total of the percentages in this column does not equal 100% due to rounding.

** These deductibles are for in-network services. (HMOs/EPOs do not have annual deductibles for out-of-network services because those services are not covered.)

*** The total of the percentages in this column does not equal 100% due to rounding.

Deductibles & Copayments

As shown in Table 7, 62 percent of PPOs/POS plans had annual deductibles under $500 in 2012. A large majority of the HMOs (79 percent) required no annual deductibles. Just under half of HDHPs/CDHPs (49 percent) had annual deductibles in the $1,500 to $1,999 range and 13 percent had significantly higher annual deductibles of $3,000 or more.

Between 2011 and 2012, the average annual deductible for both PPO/POS plans and HDHPs/CDHPs rose across all coverage tiers. The increase was more significant in HDHPs/CDHPs than PPO/POS plans. For HDHPs/

Table 8: Average Annual Deductible by Plan Type, 2011 and 2012 and Percent Change*

	Employee-Only Coverage			Family Coverage		
	2011	2012	Percent Change	2011	2012	Percent Change
PPO/POS Plan	$366	$375	3%	$817	$887	9%
HDHP/CDHP	$1,606	$1,798	12%	$3,211	$3,605	12%

* Data is not shown for HMOs/EPOs because the majority of these plans do not have a deductible for both coverage tiers.

Table 9: Average Office Visit Copayment by Plan Type, 2011 and 2012 and Percent Change*

	Primary Care Physician Office Visits			Specialist Office Visits		
	2011	2012	Percent Change	2011	2012	Percent Change
PPO/POS Plan	$19.68	$19.93	1%	$31.24	$31.32	0
HMO/EPO	$18.44	$18.59	1%	$26.68	$27.69	4%

* Data is not shown for indemnity plans and HDHPs/CDHPs because there are so few of that plan type.

CDHPs, the average annual deductible increased 12 percent for both employee-only and family coverage. See Table 8.

From 2011 to 2012, there was no significant change in average primary care physician office copayments for both PPO/POS plans and HMOs/EPOs. There was also no change in the average specialist office copayment for PPO/POS plans over that period. However, for HMOs/EPOs, the average specialist office copayment increased 4 percent from 2011 to 2012. See Table 9.

An equal percentage of PPOs/POS plans (33 percent) had copayments for primary care physicians in the $15-19 and $20-24 ranges. The majority of PPOs/POS plans (56 percent) had copayments of $30 or more for specialist office visits. The most prevalent copayment ranges for office visits for HMOs/EPOs were similar: $15-19 for primary care physicians and $30 or more for specialists. See Table 10.

Out-of-Pocket Maximums

As shown in Table 11, a majority of PPOs/POS plans and HMOs/EPOs continued to maintain out-of-pocket maximums for employee-only coverage under $3,000 for in-network services in 2012. The most prevalent annual out-of-pocket maximum for employee-only coverage was $1,000-1,999 for both PPOs/POS plans and HMOs/EPOs. However, more than 25 percent of plans had an out-of-pocket maximum of $3,000 or more. By design, the most prevalent out-of-pocket maximum for

Table 10: Copayments for Primary Care Physician and Specialist Office Visits by Plan Type and Percentage of Plans

	Primary Care Physician Office Visits		Specialist Office Visits	
	PPO/POS Plan (In-Network) (98 Plans)	HMO/EPO* (115 Plans)	PPO/POS Plan (In-Network)* (71 Plans)	HMO/EPO* (83 Plans)
0	1%	0	0	0
$1-4	0	0	0	0
$5-9	1%	3%	1%	4%
$10-14	3%	9%	3%	4%
$15-19	33%	42%	15%	10%
$20-24	33%	23%	8%	27%
$25-29	18%	16%	15%	11%
$30+	11%	8%	56%	46%

* The total of the percentages in this column does not equal 100% due to rounding.

"The most prevalent annual out-of-pocket maximum for employee-only coverage was $1,000-1,999 for both PPOs/POS plans and HMOs/EPOs. However, more than 25 percent of plans had an out-of-pocket maximum of $3,000 or more."

Table 11: Annual Out-of-Pocket Maximums for Employee-Only Coverage for In-Network Services by Plan Type and Percentage of Plans*

	PPO/POS Plan (120 Plans)	HMO/EPO** (120 Plans)	HDHP/CDHP (45 Plans)
$1-999	11%	25%	0
$1,000-1,999	35%	32%	2%
$2,000-2,999	27%	12%	16%
$3,000-4,999	21%	13%	58%
$5,000+	2%	3%	24%
No Maximum	5%	16%	0

* Data is not shown for indemnity plans because those plans do not have networks. Out-of-pocket maximums include deductible.

** As a reminder, HMOs/EPOs do not have out-of-pocket maximums for out-of-network services because those services are not covered. The total of the percentages in this column does not equal 100% due to rounding.

Table 12: Copayments for Retail and Mail-Order Generic Prescription Drugs by Percentage of Plans

	Retail* (272 Plans)	Mail Order (218 Plans)
0	0	0
$1-4	1%	0
$5-9	43%	6%
$10-14	45%	43%
$15-19	8%	6%
$20-24	2%	26%
$25-29	0	6%
30+	0	14%

* The total of the percentages in this column does not equal 100% due to rounding.

HDHPs/CDHPs was much higher than other plan types, with 82 percent of plans having an employee-only maximum of $3,000 or more.

Prescription Drug Coverage

The majority of plans had retail generic prescription drug copayments in the $5-9 or $10-14 ranges (43 percent and 45 percent, respectively). The most prevalent generic copayment for purchase via mail order, which typically cover a 90-day supply, is in the $10-14 range, offered by 43 percent of plans. Only 2 percent of plans had copayments in the $20-24 range for retail generics compared to 26 percent of plans with copayments in that range for mail-order generics. The difference in cost is attributable to the fact that mail-order prescriptions usually provide a 90-day instead of a 30-day supply. See Table 12 (at left).

Table 13 (below left) shows how state plans' copayments differed in 2012 for *retail* prescription drugs depending on whether they were generics, preferred or non-preferred drugs. Almost all state plans had copayments of $19 or less for generics. Copayments for preferred brand-name drugs were higher — ranging between $10 and $39 for most plans. Copayments were highest for non-preferred brand-name drugs with

Table 14: Copayments for Mail-Order Generic Prescription Drugs as a Percentage of Retail Generic Prescription Drugs by Percentage of Plans

Mail Order Generic Rx Copay as Percent of Retail Generic Rx Copay	Percentage of Plans
Less Than 100%	2%
100%	3%
150%	3%
170%	1%
200%	78%
250%	9%
300%	3%

"Almost all state plans had copayments of $19 or less for [retail] generics. Copayments for preferred brand-name drugs were higher — ranging between $10 and $39 for most plans."

Table 13: Copayments for *Retail* Prescription Drugs* by Drug Category (Generic, Preferred and Non-Preferred) and Percentage of Plans

	Generic (271 Plans)	Preferred Brand Name* (259 Plans)	Non-Preferred Brand Name* (248 Plans)
0	0	0	0
$1-9	45%	0	0
$10-19	53%	23%	2%
$20-29	2%	47%	4%
$30-39	0	21%	25%
$40-49	0	7%	19%
$50-59	0	1%	30%
$60-69	0	0	10%
$70-79	0	0	1%
$80+	0	0	7%

* Retail prescription drugs typically cover a 30-day supply.

** The total of the percentages in this column does not equal 100% due to rounding.

Table 15: Copayments for *Mail-Order* Prescription Drugs* by Drug Category (Generic, Preferred and Non-Preferred) and Percentage of Plans

	Generic** (218 Plans)	Preferred Brand Name (207 Plans)	Non-Preferred Brand Name* (171 Plans)
0	0	0	0
$1-9	6%	0	1%
$10-19	48%	3%	0
$20-29	32%	5%	0
$30-39	11%	22%	5%
$40-49	3%	26%	6%
$50-59	1%	13%	5%
$60-69	0	14%	6%
$70-79	0	5%	3%
$80-89	0	6%	8%
$90-99	0	1%	4%
$100-109	0	4%	26%
$110-119	0	0	6%
$120+	0	1%	29%

* Mail-order prescription drugs typically cover a 90-day supply.

** The total of the percentages in this column does not equal 100% due to rounding.

more than half of state plans setting copayments in the $40-69 range.

Both because the costs for mail-order prescriptions can be significantly less than for retail dispensing and because (as noted on page 6) mail order is usually designed to provide a 90-day instead of a 30-day supply, most plan designs encourage mail-order utilization by reducing the participant's copayment per day's supply to less than the copayment for a retail prescription. As shown in Table 14 on page 6, the large majority of plans (97 percent) encourage the use of mail-order prescription drugs by making the mail-order copayment less than three times the retail copayment. There is more variation in mail-order copayments for generic, preferred and non-preferred drugs, as shown in Table 15 on page 6.

Dental Coverage

The 2012 *Study of State Employee Health Benefits* found that 48 states offered dental plans in 2012. Dental provider organizations (DPOs) were the most common plan type, offered by the vast majority of states: 44 states or 86 percent of states. Other types of dental plans were offered by far fewer states: dental maintenance organizations (DMOs) were offered by 14 states; dental indemnity plans, which pay a portion of reasonable and customary charges, were offered by nine states; prepaid plans[8] were offered by five states.

Commentary & Outlook

As Affordable Care Act coverage and operational mandates take full effect, state government plans must continue to assess their health benefit programs and make changes that meet the needs of employees and retirees while still complying with the new laws. These new requirements add to the continued budget pressure on employer health plan funding.[9] Examining what other states are offering can be helpful in making tough decisions about potential changes in coverage, including the number and types of plans offered and how costs are shared with employees.

States are already considering and implementing a number of plan design and program changes to comply with Affordable Care Act requirements beyond the initial coverage mandates and limits, such as the out-of-pocket maximum that will take effect in 2014.[10] With federal guidance and regulations being issued almost daily, this is an important time for state employee and retiree health plans to reassess how to provide benefits to those groups.

State employers are now looking into their rules for counting full-time employees eligible for health plan coverage to meet the new 30-hour Affordable Care Act requirements.[11] Where significant groups of part-time and seasonal employees have traditionally not been eligible for employer health insurance, or have been eligible at reduced or no employer subsidy, the new Affordable Care Act employer shared responsibility penalty forces a reassessment of how those employees may need to be offered coverage.

State employers are also looking closely at how to cover the various participant groups (*e.g.*, active employees, non-Medicare retirees, Medicare retirees) to maximize cost efficiency and the potential of federal subsidies for each group. For example, some states are studying the possibility of moving their non-Medicare retirees into the health insurance Exchanges when those

Implications of the Affordable Care Act's Health Insurance Exchanges for State Employee Health Benefits

As the Affordable Care Act's health insurance Exchanges, Internet marketplaces through which certain individuals and small employers will be able to buy health insurance, go into operation for 2014, a new health benefit insurance delivery system will begin to show up on states' comparisons. Based on the latest survey data on the most common features offered by states today, the majority of state employees are enrolled in what would be considered comparable to a "gold" plan.* Sponsors of state employee plans will be able to compare the cost and value of those plan offerings to what the public Exchanges are offering. In addition, public sector employers will need to review employees that have traditionally been considered less than full time to see whether those employees must be offered coverage and at what subsidy levels to avoid employer shared responsibility penalties.

*** Health insurance coverage purchased through an Exchange must provide benefits at various actuarial levels: bronze, silver, gold and platinum. For more information about those levels, refer to Segal's August 18, 2011 *Capital Checkup*, "Proposed Rule Implementing the Affordable Care Act's State Exchanges Published": http://www.segalco.com/publications-and-resources/public-sector-publications/capital-checkup/archives/?id=1720**

[8] A prepaid dental plan provides tightly defined benefits with a limited set of dental providers who are usually paid a fixed amount per month for the patient's care. Prepaid plans may have very low copayments and scheduled benefits.

[9] Segal's annual *Health Plan Cost Trend Survey* indicates that medical and prescription drug plan rates are still being projected at significantly higher levels than general inflation. The most recent survey report is on the following web page: http://www.segalco.com/publications/surveysandstudies/2013trendsurvey.pdf

[10] In 2014, cost sharing incurred under a plan will not be allowed to exceed the out-of-pocket maximums for an HDHP combined with a Health Savings Account (HSA). In subsequent years, the amount will be indexed and not linked to the HSA levels. Cost sharing is defined in the Affordable Care Act to include deductibles, coinsurance, copayments or similar charges. Recent guidance recognizes that plan sponsors may use multiple services providers (*e.g.*, a third-party administrator for medical coverage, a pharmacy benefit manager, and/or a behavioral health organization). These providers may use separate cost sharing during the 2014 transition year.

[11] For more information about these requirements, see Segal's January 25, 2013 *Capital Checkups*, "IRS Proposes Rule on Employer Penalty Under the Affordable Care Act": http://www.segalco.com/publications-and-resources/public-sector-publications/capital-checkup/archives/?id=2295) and "IRS Proposed Rule Addresses How Employers Will Calculate Employees' Full-Time Status Under the Affordable Care Act": (http://www.segalco.com/publications-and-resources/public-sector-publications/capital-checkup/archives/?id=2296).

exchanges are operational, either as individuals potentially eligible for the Exchange subsidy or as a group with limited, defined contribution subsidies from the state. (For more information on the implications of the health insurance Exchanges for state coverage, see the text box on the previous page.) As these major changes are being discussed, states are also looking at the impact on current funding of moving from rates that are based on the entire covered population to rates developed using the separate experience of each major demographic group (*e.g.*, active employees, non-Medicare eligible retirees, Medicare eligible retirees).

With the coming expansion of Medicaid in many states, state employee health plans are exploring how lower-paid employees and their dependents will be affected, and whether eligibility for extended Medicaid coverage should be coordinated with the active employee and early retiree health programs.

State employers are also reviewing the continued need for the highly detailed rate tiers noted in Graph 1 on page 2 of this report in light of the more simplified individual and family rate tiers anticipated for the health insurance Exchanges. The key issue in changing the number of tiers is balancing the accuracy of the cost for different groups against the added complexity of maintaining multiple rate tiers.

In addition, state employers are considering alternative medical plan delivery models, including HDHPs/CDHPs with a Health Reimbursement Arrangement (HRA) or Health Savings Account (HSA) funding buffer. While these plan designs appeal to certain employee groups more than others, states are now looking at them as a vehicle to begin shifting the responsibility for health care cost management more to participants.

"At the same time they grapple with all of these coming changes and new requirements (including state-specific changes), state employers still need to continue managing their group benefit plans to achieve current and longer-term savings."

At the same time they grapple with all of these coming changes and new requirements (including state-specific changes[12]), state employers still need to continue managing their group benefit plans to achieve current and longer term savings. As part of that process, Segal suggests the following as key action items:

- Encourage healthy lifestyles that lead to lower medical costs and fewer chronic conditions.
- Design and offer medical plans to encourage early detection of disease, step therapy and the use of low-cost/low-intensity services (*e.g.*, clinics and generics), where appropriate.
- Manage population health through contracted specialty vendors that focus on savings available through case management and medication adherence programs.
- Review Medicare retiree health and prescription drug benefit programs to make sure they are receiving the maximum federal subsidies available.
- Renegotiate and bid vendor contracts to obtain the most up-to-date market pricing and discounts.
- Review contribution strategies and varying contribution rates based on participation in healthy lifestyle programs (*e.g.*, different rates for smokers and non-smokers), preferred plans or targeted wellness programs.
- Design treatment/condition-specific networks to maximize the quality and value of care.
- Educate participants about how to make wise and healthy choices.

[12] For example, in states that passed right-to-work laws in 2012, legislators are working to oppose the establishment of new collective bargaining agreements by state employees before the new laws take effect. In addition, some state legislatures are already considering how they might allow and/or encourage state employees and retirees to use the state health insurance exchange as an option or replacement for the current health benefit programs.

■ ■ ■

The 2012 Study of State Employee Health Benefits *reports just some of the information in The Segal Company's extensive database of public sector employee health benefits. Segal can be retained to provide custom data reports, including comparisons of coverage costs among plan types, regions and/or population size. For more information about Segal's state database or the design of health benefit plans for state employees, contact one of the following experts:*

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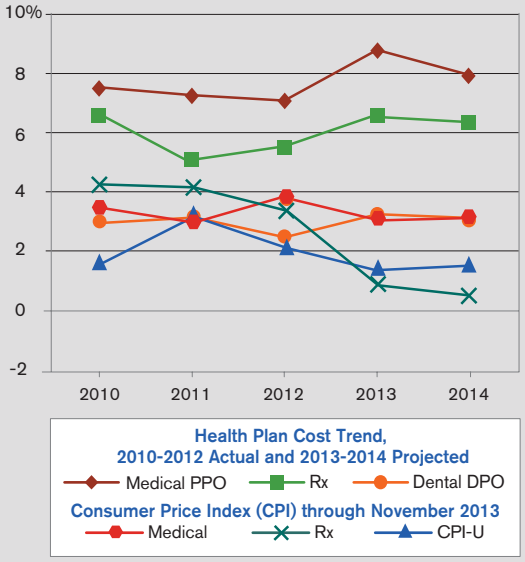
TRENDS Noteworthy Developments of Interest to Sponsors of Public Sector Health Plans

FIRST QUARTER 2014

TREND AND CPI

Health benefit plan cost trend rates projected for 2014 show the slowest growth in 14 years of trend forecasts.



Sources: 2014 *Segal Health Plan Cost Trend Survey* (http://www.segalco.com/publications/surveysandstudies/2014trendsurvey.pdf) and Bureau of Labor Statistics for CPI (http://www.bls.gov/cpi/)

Trend is the forecasted change in claims cost determined by insurance carriers, managed care organizations (MCOs), pharmacy benefits managers (PBMs) and third party administrators (TPAs). Trend can be influenced by a variety of factors including price inflation, the leveraging effect of copayments, cost shifting and utilization. The **Consumer Price Index** (CPI) is a measure of the average change in prices over time of goods and services purchased by households. The CPI for All Urban Consumers (CPI-U) is often used as an economic indicator.

THE AFFORDABLE CARE ACT (ACA) AND COMPLIANCE NEWS

Guidance addresses preventive services provided through high-deductible health plans (HDHPs) paired with Health Savings Accounts (HSAs). Preventive services that the ACA requires non-grandfathered plans cover at no cost to employees, will qualify as preventive care under the rules applicable to HDHPs and HSAs.[1]

A stand-alone Health Reimbursement Arrangement (HRA) that is not a retiree-only plan will violate the annual dollar-limit prohibition and, therefore, will not be permitted, effective with the plan year beginning on or after January 1, 2014. (Retiree-only HRAs do not have to comply with the annual dollar-limit rules).[2]

Grandfathered group health plans that provide dependent coverage for children must offer that coverage to all adult children up to age 26, regardless of whether the adult child has other coverage, effective for plan years beginning on or after January 1, 2014.[3]

Modifications to health Flexible Spending Arrangements (FSAs) and Cafeteria Plans "use-it-or-lose-it" rule were announced. Cafeteria plans can also be amended by employers to carry over up to $500 for use during the next plan year.[4]

The Centers for Medicare & Medicaid Services (CMS) announced the 2014 standard Medicare Part B premium and deductible will remain unchanged from 2013. The Part A amounts will increase by less than 3 percent. Base Part D beneficiary premiums will increase slightly to $32.42.[5]

The government published a proposed rule that would expand the definition of "excepted benefits" on December 24, 2013, which would remove the requirement that dental/vision coverage be separately paid for (but would still need to be elected) in order to be a "limited scope"; provide for "wraparound" coverage that would not disqualify an individual from the premium assistance tax credit in a public Exchange; and clarify rules for Employee Assistance Programs (EAPs).[6]

The Health Care Reform Guide on Segal Consulting's website links to all publications and other resources related to the ACA: http://www.segalco.com/publications-and-resources/health-care-reform/

WHAT HEALTH PLAN SPONSORS ARE DOING TO MANAGE COSTS: SELECTED STRATEGIES

Examine the merits of private Exchange-based health benefit delivery models for participants and/or retirees. Consider the business rationale for such a model, understand how private Exchanges work and the advantages/disadvantages of implementing this type of program.

The ACA has changed Medicare Part D in ways that have significant implications for employers that provide prescription benefits to Medicare-eligible retirees. Employers that provide prescription drug benefits to their Medicare-eligible retirees can offer them an Employer Group Waiver Plan (EGWP). The ACA significantly expanded the subsidies to EGWPs, making them an attractive financial option. However, with an EGWP, significant plan changes may be needed in order to realize cost savings.

As employers remove annual maximums and limits on employees' out-of-pocket expenses to comply with ACA, they should reexamine their potential excise tax liability and consider ways to minimize its impact. Beginning in 2018, the 40 percent excise tax will be assessed on the excess value of health plans that exceed an annual threshold of $10,200 for individual coverage and $27,500 for family. The thresholds will increase for retirees over the age of 55, individuals engaged in high-risk professions, and workers employed to repair or install electrical or telecommunications lines by $1,650 for individual coverage and $3,450 for family coverage. Value is generally measured by the plan's COBRA rate.

THE VENDOR MARKETPLACE

Express Scripts (ESI) home delivery pharmacy will no longer dispense compound medications effective January 1, 2014. They have cited that the reason for their decision was due to the guidelines developed by the U.S. Pharmacopeial Convention on expiration dates. CVS Caremark is still dispensing compound medications through its mail-order pharmacies.

[1] See Segal's *Capital Checkup*, "Guidance on Providing Preventive Services Required by the Affordable Care Act Through High-Deductible Health Plans": http://www.segalco.com/publications-and-resources/public-sector-publications/capital-checkup/archives/?id=2422

[2] See Segal's *Capital Checkup*, "New Guidance Requires Immediate Action by Employers that Sponsor Health Reimbursement Arrangements": http://www.segalco.com/publications-and-resources/public-sector-publications/capital-checkup/archives/?id=2435

[3] See Segal's *Health Care Reform Insights*, "Agencies Continue to Clarify Rules on Coverage for Children": http://www.segalco.com/publications/HCRI/nov2010DepCov.pdf

[4] See Segal's *Capital Checkup*, "New Rules for Health FSAs and Cafeteria Plans": http://www.segalco.com/publications-and-resources/public-sector-publications/capital-checkup/archives/?id=2457

[5] See Segal's *Capital Checkup*, "2014 Medicare Premiums, Deductibles and Coinsurance": http://www.segalco.com/publications/capitalcheckup/2014Medicarenumbers.pdf

[6] See http://www.gpo.gov/fdsys/pkg/FR-2013-12-24/pdf/2013-30553.pdf

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For information about the strategies above or any of the developments discussed on this page, contact your Segal benefits consultant or send an e-mail to info@segalco.com

Segal Consulting

CAPITAL CHECKUP

March 14, 2014

Final Rule Implementing the Affordable Care Act's 90-Day Waiting Period Limit

The Departments of Labor, Treasury and Health and Human Services (collectively, the "Departments"), which are responsible for implementing the Affordable Care Act,[1] have issued a final regulation implementing the law's ban on waiting periods exceeding 90 days.[2] The final rule is applicable for plan years beginning on or after January 1, 2015, and is very similar to the proposed rule published last year.[3]

The Departments also issued a proposed rule that coordinates with the final rule to address "orientation periods," which can be used in addition to the 90-day waiting period.[4] The Departments have requested comments on the proposed rule by April 25, 2014.

This *Capital Checkup* summarizes both the final rule and the proposed rule, which provide practical guidance for sponsors of group health plans. It concludes with a list of steps plan sponsors should take to implement the Affordable Care Act's 90-day waiting period rule.

The Final Rule

A summary of the key interpretations in the final rule, which follow the guidance in last year's proposed rule, follows:

- ***Definition of the "Waiting Period"*** Group health plans must cover participants within 90 days of the date on which the individual is "otherwise eligible." Being "otherwise eligible to enroll" means that the employee has met the plan's substantive eligibility conditions, such as being in an eligible job classification or achieving job-related licensure requirements specified in the plan's terms. **A new provision in the final rule adds that** a plan can require that an individual "satisfy a reasonable and bona fide employment-based orientation period" prior to receiving an offer of coverage. The orientation period is further defined by the new proposed rule, discussed below.
- ***Definition of "90 Days"*** Ninety days refers to calendar days — not three months or a quarter.
- ***Limit on Eligibility Conditions Based Solely on the Lapse of a Time Period*** Such eligibility conditions are permissible for no more than 90 days.
- ***Limit on Cumulative-Service Requirements*** Plans that require completion of cumulative hours of service may do so provided the hours-of-service requirement does not exceed 1,200 hours.
- ***Requirements for Variable Hour Employees*** If the plan conditions eligibility on a specified number of hours of service, and it cannot be determined that an employee is reasonably expected to regularly work that number of hours, the plan may have up to 12 months to measure whether the employee meets the

eligibility criteria. In that case, coverage must begin no later than 13 months from the employee's start date, plus, if the start date was not the first day of the month, the time remaining until the first day of the next month.

- ***Certificates of Creditable Coverage Eliminated*** After December 31, 2014, plans will no longer be required to issue certificates of creditable coverage, which were introduced by Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Proposed Rule

The new proposed rule would provide that if a group health plan conditions eligibility on an employee's having completed a "reasonable and bona fide employment-based orientation period," the maximum 90-day waiting period would begin on the first day after the orientation period. Under this proposed rule, an orientation period would be considered reasonable and bona fide if it is no longer than one month. The one-month period would be determined by adding one calendar month and subtracting one calendar day, measured from an employee's start date.

For example, if an employee's start date is October 16, the orientation period could last until November 15. The 90-day waiting period would begin on the first day after the orientation period. The employee would have to be offered coverage beginning no later than February 14 (the 91st day after the employee completes the orientation period).

The proposed rule is apparently intended to address concerns related to the inflexibility of the 90-day measurement period — particularly in light of the fact that coverage often starts at the beginning of the third or fourth month after employment begins. As noted at the beginning of this *Capital Checkup*, the Departments have requested comments on the proposed rule, which must be received by April 25, 2014.

Implications for Plan Sponsors

Because the Affordable Care Act's 90-day waiting period rule took effect for plan years beginning on or after January 1, 2014, many plan sponsors have already implemented it. Those that have not yet done so should:

- Review all eligibility requirements to determine if any are based solely on the lapse of time. Eliminate any requirements that exceed 90 calendar days, and ensure that employees already in a waiting period when the ban takes effect are not subject to a waiting period that exceeds 90 calendar days.
- Determine which groups of employees will meet the plan's eligibility requirements as of their start date and which groups should be classified as variable hour employees.
- For employees who will meet the plan's eligibility requirements as of their start date (*e.g.*, full-time employees), ensure that the waiting period between the employee's start date and the date that health coverage begins is no longer than 90 calendar days (including any election period).
- For employees who are offered health coverage once they work a certain number of hours, make sure that the hours requirement does not exceed 1,200 hours.
- Coordinate the plan's approach to the 90-day rule with the approach adopted by the employer to avoid or minimize the employer penalty. For example, consider whether similar measurement periods should be used for both determining full-time status for purposes of the employer penalty and determining whether the employee meets the plan's eligibility requirements.

• • •

As with all issues involving the interpretation or application of laws and regulations, plan sponsors should rely on their legal counsel for authoritative advice on the interpretation and application of the Affordable Care Act and related guidance, including the guidance summarized in this Capital Checkup. *Segal Consulting can be retained to work with plan sponsors and their attorneys on compliance issues.*

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1 The Affordable Care Act is the shorthand name for the Patient Protection and Affordable Care Act (PPACA), Public Law No. 111-48, as modified by the subsequently enacted Health Care and Education Reconciliation Act (HCERA), Public Law No. 111-152. The Affordable Care Act added Section 2708 to the Public Health Service Act, which provides that, effective for plan years beginning on or after January 1, 2014, a group health plan or health

insurer offering group health insurance coverage shall not apply any waiting period that exceeds 90 days. (Return to the *Capital Checkup*.)

2 The final rule was published in the February 24, 2014 *Federal Register*. (Return to the *Capital Checkup*.)

3 The proposed rule was discussed in Segal's April 23, 2013 *Capital Checkup,* "Proposed Rule on the Affordable Care Act's 90-Day Waiting Period Provides Flexibility for Employers." (Return to the *Capital Checkup*.)

4 The proposed rule was published in the February 24, 2014 *Federal Register*. (Return to the *Capital Checkup*.)

Capital Checkup is Segal Consulting's periodic electronic newsletter summarizing activity in Washington with respect to health care and related subjects. *Capital Checkup* is for informational purposes only and should not be construed as legal advice. It is not intended to provide guidance on current laws or pending legislation. On all issues involving the interpretation or application of laws and regulations, plan sponsors should rely on their attorneys for legal advice.

Segal Consulting

Bulletin

Benefits, Compensation and HR Consulting

November 2013

For 2014, Increases in Some IRS Dollar Limits and Social Security Figures

This *Bulletin* reports indexed Internal Revenue Service (IRS) and Social Security figures for 2014 that are of interest to public sector retirement plan sponsors. Because some state and local government employees are covered by Social Security, the *Bulletin* also reports Social Security figures for 2014.

IRS RETIREMENT PLAN LIMITS

The 2014 IRS dollar limits for qualified plans and other tax-favored retirement plans are determined using the Consumer Price Index (CPI) data released on October 30, 2013. Because of rounding rules, the CPI increase of 1.2 percent over the 12 months that ended September 30, 2013, will cause only some of the IRS dollar limits to increase in 2014. The press release is on the following page of the IRS website: http://www.irs.gov/uac/Newsroom/In-2014,-Various-Tax-Benefits-Increase-Due-to-Inflation-Adjustments. The table below compares the 2014 limits to the 2013 limits.

SOCIAL SECURITY BENEFITS

In 2014, Social Security benefits will increase by 1.5 percent. A fact sheet on this cost-of-living adjustment and other 2014 Social Security changes is on the Social Security Administration (SSA) website: http://www.ssa.gov/pressoffice/factsheets/colafacts2014.pdf. The table on the next page compares the 2014 figures to the 2013 figures.

IRS RETIREMENT PLAN LIMITS

	2013	2014
Maximum Annual §415 Payout at Age 62 from a Defined Benefit Plan*	$205,000	**$210,000**
Maximum Annual Addition to an Individual's Defined Contribution Account under §415(c)	51,000	**52,000**
Maximum Elective §401(k) and §403(b) Deferrals	17,500	**Unchanged**
Deferral Limit for §457(b) Plans	17,500	**Unchanged**
§401(k), §403(b) and §457(b) Catch-Up Limit for Individuals Age 50 and Older	5,500	**Unchanged**
Maximum Amount of Annual Compensation that Can Be Taken into Account for Determining Benefits or Contributions under a Qualified Plan	255,000	**260,000**
Compensation Limit under §401(a)(17) for Public Sector Plans That Were Able to Grandfather the Old Dollar Limit	380,000	**385,000**

* There are late-retirement adjustments for benefits starting after age 65.

SOCIAL SECURITY BENEFIT TESTS AND LIMITS

	2013	2014
Wage Base: a) for Social Security Tax b) for Medicare	$113,700 No Limit	**$117,000** **No Limit**
COLA Increase	1.7%	**1.5%**
Social Security National Average Wage Index[1]	$42,979.61 (for 2011)	**$44,321.67** **(for 2012)**
Primary Insurance Amount (PIA) Formula:[2] a) First Bend Point b) Second Bend Point	 $791 $4,768	 **$816** **$4,917**
Maximum Social Security Benefit at Social Security Normal Retirement Age (SSNRA)[3]	$2,533/ Month	**$2,642/** **Month**
Earnings Test — Early Retirement (Age 62) (Amount that Can Be Earned before Benefits Are Cut)[4]	$15,120/ Year	**$15,480/** **Year**

[1] This amount is not tied to the CPI, but rather to earnings as reported to the SSA. The 2012 average and background can be found on the following page of SSA's website: http://www.ssa.gov/oact/cola/AWI.html.

[2] PIA formula "bend points" are updated each year to reflect changes in the National Average Wage Index. The 2014 bend points can be found on the following page of the SSA's website: http://www.ssa.gov/oact/cola/piaformula.html.

[3] The maximum Social Security benefit at SSNRA is not tied to the CPI. It is based on the PIA formula (reflecting updated bend points) where a worker's earnings are at the maximum taxable amount for his or her career. For workers born in 1943-1954, the SSNRA is age 66. For information on how SSNRA varies by birth year, see the following page of SSA's website: http://www.ssa.gov/OACT/ProgData/nra.html.

[4] In the year of attaining SSNRA, the early retirement earnings test is higher. In 2014, it will be $41,400/year ($3,450/month), up from $40,080/year ($3,340/month) in 2013. After attaining SSNRA, individuals can receive their full benefits regardless of how much they earn.

If you would like additional information about any of these items, please contact your Segal consultant or the Segal office nearest you.

Segal Consulting

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EXHIBITS - WORK PRODUCT SAMPLES

SAMPLE REPORT ON OPTIONS FOR PLAN DESIGN CHANGES

XYZ
Benefit Changes

				Estimated Annual Savings [1]	
				Low Estimate	High Estimate
Hospital		1/1/2013 Benefits	Proposed Plan		
1.	**Plan I Hospital benefit changes**			$2,290,000	$2,540,000
	Deductible (single / family)	$250 / $500	$250 / $500		
	Co-insurance	90%	90%		
	Out-of-pocket maximum (single / family)	$1,750 / $3,500	**$2,500 / $5,000**		
2.	**Plan II Hospital benefit changes**			$930,000	$1,030,000
	Deductible (single / family)	$500 / $1,000	$500 / $1,000		
	Co-insurance	90%	**80%**		
	Out-of-pocket maximum (single / family)	$1,750 / $3,500	$1,750 / $3,500		
3.	**Plan II Hospital benefit changes**			$1,790,000	$1,990,000
	Deductible (single / family)	$500 / $1,000	$500 / $1,000		
	Co-insurance	90%	**80%**		
	Out-of-pocket maximum (single / family)	$1,750 / $3,500	**$2,500 / $5,000**		
4.	**Plan II Hospital benefit changes**			$890,000	$990,000
	Deductible (single / family)	$500 / $1,000	$500 / $1,000		
	Co-insurance	90%	90%		
	Out-of-pocket maximum (single / family)	$1,750 / $3,500	**$2,500 / $5,000**		
Medical		1/1/2013 Benefits	Proposed Plan		
5.	**Plan I Major Medical benefit changes**			$1,230,000	$1,370,000
	Deductible (single / family)				
	In-network	$250 / $500	$250 / $500		
	Non-network	$500 / $1,000	$500 / $1,000		
	Co-insurance (in-network / non-network)	90% / 70%	**90% / 60%**		
	Out-of-pocket maximum (single / family)				
	In-network	$1,000 / $2,000	$1,000 / $2,000		
	Non-network	$2,500 / $5,000	$2,500 / $5,000		
6.	**Plan I Major Medical benefit changes**			$740,000	$820,000
	Deductible (single / family)				
	In-network	$250 / $500	$250 / $500		
	Non-network	$500 / $1,000	$500 / $1,000		
	Co-insurance (in-network / non-network)	90% / 70%	90% / 70%		
	Out-of-pocket maximum (single / family)				
	In-network	$1,000 / $2,000	**$1,250 / $2,500**		
	Non-network	$2,500 / $5,000	**$3,000 / $6,000**		
7.	**Plan I Major Medical benefit changes**			$2,430,000	$2,700,000
	Deductible (single / family)				
	In-network	$250 / $500	$250 / $500		
	Non-network	$500 / $1,000	$500 / $1,000		
	Co-insurance (in-network / non-network)	90% / 70%	**90% / 60%**		
	Out-of-pocket maximum (single / family)				
	In-network	$1,000 / $2,000	**$1,250 / $2,500**		
	Non-network	$2,500 / $5,000	**$3,000 / $6,000**		

Note: Savings estimates do not include an adjustment for operating expense.

[1] Savings based on the following projected 2014 eligibles:

Earned Eligibles	
Plan I	9,005
Plan II	4,890
Alternative Age & Service	980
Retirees	7,355

XYZ
Benefit Changes

				Estimated Annual Savings [1]	
				Low Estimate	High Estimate
Medical		1/1/2013 Benefits	Proposed Plan		
New	**8. Plan II Major Medical benefit changes**			$250,000	$280,000
	Deductible (single / family)				
	In-network	$500 / $1,000	$500 / $1,000		
	Non-network	$750 / $1,500	$750 / $1,500		
	Co-insurance (in-network / non-network)	90% / 70%	**90% / 60%**		
	Out-of-pocket maximum (single / family)				
	In-network	$1,000 / $2,000	$1,000 / $2,000		
	Non-network	$2,500 / $5,000	$2,500 / $5,000		
	9. Plan II Major Medical benefit changes			$1,250,000	$1,390,000
	Deductible (single / family)				
	In-network	$500 / $1,000	$500 / $1,000		
	Non-network	$750 / $1,500	$750 / $1,500		
	Co-insurance (in-network / non-network)	90% / 70%	**80% / 60%**		
	Out-of-pocket maximum (single / family)				
	In-network	$1,000 / $2,000	$1,000 / $2,000		
	Non-network	$2,500 / $5,000	$2,500 / $5,000		
	10. Plan II Major Medical benefit changes			$450,000	$500,000
	Deductible (single / family)				
	In-network	$500 / $1,000	$500 / $1,000		
	Non-network	$750 / $1,500	$750 / $1,500		
	Co-insurance (in-network / non-network)	90% / 70%	90% / 70%		
	Out-of-pocket maximum (single / family)				
	In-network	$1,000 / $2,000	**$1,250 / $2,500**		
	Non-network	$2,500 / $5,000	**$4,000 / $8,000**		
	11. Plan II Major Medical benefit changes			$1,780,000	$1,980,000
	Deductible (single / family)				
	In-network	$500 / $1,000	$500 / $1,000		
	Non-network	$750 / $1,500	$750 / $1,500		
	Co-insurance (in-network / non-network)	90% / 70%	**80% / 60%**		
	Out-of-pocket maximum (single / family)				
	In-network	$1,000 / $2,000	**$1,250 / $2,500**		
	Non-network	$2,500 / $5,000	**$4,000 / $8,000**		
New	**12. Increase office visit copays by $5**				
	In-network only				
	Plan I	$15	**$20**	$670,000	$740,000
	Plan II	$25	**$30**	$220,000	$250,000
	13. Change Plan II Major Medical benefits to in-network only			$2,740,000	$3,040,000
	14. Change non-network usual and customary percentage from the 80th percentile to the 70th percentile			$100,000	$130,000

Note: Savings estimates do not include an adjustment for operating expense.

[1] Savings based on the following projected 2014 eligibles:

Earned Eligibles	
Plan I	9,005
Plan II	4,890
Alternative Age & Service	980
Retirees	7,355

XYZ
Benefit Changes

	Estimated Annual Savings [1]	
	Low Estimate	High Estimate
Medical		
15. Eliminate Acupuncture Benefit		
Plan I	$338,000	
Plan II	$84,000	
16. Eliminate Chiropractic Benefit		
Plan I	$506,000	
Plan II	$139,000	
17. Reduce Chiropractic Quarterly Visit Max from 12 to 8 Visits [2]		
Plan I	$28,000	
Plan II	$8,000	
18. Reduce Acupuncture and Chiropractic Quarterly Visit Max from 12 for Chiropractic and 8 for Acupuncture to 6 Visits Each [2]		
Plan I	$74,000	
Plan II	$20,000	
Dental		
19. Eliminate dental coverage:		
Plan I	$13,610,000	
Plan II	$3,150,000	
20. Plan I Dental benefit changes [3]		
a. Change Non-PPO maximum from $2,500 to $2,000 per patient per year	$560,000	
b. Change Non-PPO maximum from $2,500 to $1,500 per patient per year	$1,440,000	
c. Increase Non-PPO deductible from $75 single/$200 family to $100 single/$225 family	$280,000	
d. Change Non-PPO coinsurance for Basic services from 75% to 60%	$700,000	
21. Plan II Dental benefit changes [3]		
a. Change Non-PPO coinsurance for Diagnostic, Preventive and Basic services from 60% to 50%	$190,000	
b. Change PPO/Non-PPO annual maximum from $1,000/$1,000 to $750/$500	$570,000	
c. Change to a plan that covers Diagnostic and Preventive services only with $1,000 annual maximum per person, and no annual maximum for children. PPO services covered at 100% and non-PPO services covered at 75%.	$1,270,000	

Note: Savings estimates do not include an adjustment for operating expense.

[1] Savings based on the following projected 2014 eligibles:

Earned Eligibles	
Plan I	9,005
Plan II	4,890
Alternative Age & Service	980
Retirees	7,355

[2] Assumes continuation of the Plan's cross-over provision wherein the Plan will not consider more than 12 outpatient sessions every calendar quarter for any combination of acupuncture and chiropractic treatment. In addition, visits for occupational, osteopathic, physical, speech and vision therapy will count toward the 12-visit quarterly maximum.

[3] Savings provided by Delta.

XYZ
Benefit Changes

	Estimated Annual Savings [1]	
	Low Estimate	High Estimate
Prescription Drug		
22. Prescription drug benefit changes - increase deductible from $150 / $300		
Plan I	$560,000	
Plan II	$210,000	
23. Prescription drug benefit changes - increase deductible from $150 / $300 to $250 / $500 [2]		
Plan I	$1,090,000	
Plan II	$400,000	
24. Prescription drug benefit changes - add additional drug categories to the preferred drug step therapy program [2]	$940,000	
Other		
25. Change coordination of benefits		
a. Actives carve out (change max paid from plan allowed to plan benefit amount)	$370,000	$410,000
b. Retiree Medicare carve out (change max paid from plan allowed to plan benefit amount)	$280,000	$310,000
26. Eliminate conversion option for participants losing medical eligibility [3]	$60,000	
27. Eliminate Life and AD&D Coverage		
Plan I Earned	$379,000	
Retirees	$1,022,000	
Total	$1,401,000	

Note: Savings estimates do not include an adjustment for operating expense.

[1] Savings based on the following projected 2014 eligibles:

Earned Eligibles	
Plan I	9,005
Plan II	4,890
Alternative Age & Service	980
Retirees	7,355

[2] Savings provided by Express Scripts represents mature savings. For item #22, savings would be lower in the first year of implementation. Savings estimates have not been adjusted based on the recently concluded Request for Proposal.

[3] Savings provided by Anthem.

PLANNING ANNUAL ENROLLMENT COMMUNICATIONS

Planning/Executing Annual Enrollment Communications

Open enrollment is a critical benefits communications event. It's the one time of year when you can count on having the attention of most of your employees as you explain changes, convey costs and cost-sharing for the coming year, reinforce wellness messages and meet annual compliance requirements.

Assisting clients with the creation of communications for annual enrollment is one of Segal's core services. We can provide everything you need to conduct an effective annual enrollment campaign that drives targeted decision-making. Our approach may include the following deliverables; our cost proposal provides an estimate for each.

- **Postcards** (leveraged for email, text messaging and/or intranet publication, as well). We typically produce two postcards. The first postcard tees-up the coming enrollment period and highlights key changes and dates. The second postcard promotes an important plan change or feature and reminds employees of the deadline and process to complete enrollment.

- **A brief (3-minute) "whiteboard" video** regarding the annual enrollment process or an important program change or feature. **Employees love these videos.** They make benefits and enrollment seem easy, and they are inexpensive to produce. (Refer to www.ben.omb.delaware.gov/oe and www.scufcwfundslearning.com for illustrations of our recent work.)

- **A 4-page newsletter** (if warranted due to the volume or nature of changes). The newsletter may introduce critical program changes and/or reinforce important behavior and wellness messages.

- **A 20- to 24-page enrollment guide** (published in print and/or online). The guide includes information about program changes, enrollment dates and process details, benefit plan details and

comparisons, eligibility information and premium cost information. Segal works with many of our clients to update their current enrollment guides; we also develop guides from scratch. For example, OUSD may consider introducing "choice architecture concepts" into your messaging. This can be as simple as changing your medical plan names and the order in which they are organized. We'd be happy to share recent examples and the results achieved with you.

- **An enrollment meeting presentation and assistance with meetings as needed.** We work with most of our annual enrollment communications clients to develop an enrollment presentation that explains program changes, enrollment dates and process details, benefit plan highlights, eligibility information and premium cost information. Our presentations are scripted and delivered in both an in-person setting and through web/mobile platforms. We encourage you to take a look at our recent work. (Go to http://elearning.shpnc.org/2014-open-enrollment and https://scufcwfundslearning.com/view-video-for-hra-dollars.aspx (to start the presentation, use 0000012 for member ID and TEST for first name). Note, the SCUFCW presentation is optimized for viewing via smartphone; give it a try.)

  Segal's communicators are also experienced presenters. We are available to conduct train-the-trainer sessions with OUSD's benefits staff, and we can conduct meetings with faculty and staff onsite, on your behalf.

- **Updates to premium rate sheets, if needed.** With our public sector and school district clients, we are frequently asked to develop stand-alone "rate sheets," which reflect the many constituencies in the active and retired employee populations. We've also developed web-based rate tools for our clients. (View one client's premium calculator at http://go.segalco.com/SHPNC_calc/index.html.)

- **Updates to required plan communications.** Most of our clients distribute annually required communications (e.g., Medicare Part D Notice of Creditable Coverage) with their enrollment materials each year. However, rather than using valuable real estate in the enrollment guide, we work with them to publish these pieces online or distribute under separate cover.

- **Frequently asked questions.** For simplicity, we draft much of our content in question and answer format. We leverage this approach to publish stand-alone FAQs (e.g., through your intranet), and as questions come in during the enrollment period, we add to the list as needed.

2014 TREND SURVEY

2014 Segal Health Plan Cost Trend Survey

Segal Consulting

Slowest Rate of Increase in Health Plan Cost Trends in 14 Years Projected for 2014

Health benefit plan cost trend rates show the slowest growth in 14 years of trend forecasts, according to data compiled in the 2014 *Segal Health Plan Cost Trend Survey*, Segal Consulting's seventeenth annual survey of managed care organizations (MCOs), health insurers, pharmacy benefit managers (PBMs) and third-party administrators (TPAs).[1] (For a definition of trend, see the text box on page 2.) While this decline in the trend rate is positive news, it is important to note that medical health plan cost trends still outpace the consumer price index for all urban consumers (CPI-U) by a margin of at least three to one, which continues to serve as a drag on real wage growth.

As the Affordable Care Act[2] kicks into full gear in 2014 and as the economy continues to improve, it is unclear if health plan cost trends will continue to decline or return to the historic, inflationary underwriting cycle.

Trend Projections for 2014

Table 1 summarizes Segal's key findings on trend projections for 2014 and compares them to projections for 2013. Notes about the 2014 forecasted trends follow:

- All medical plan types are projected to experience trend rate declines in 2014.

[1] For information about the survey participants, see the text box on the last page of this report.

[2] The Affordable Care Act is the abbreviated name for the Patient Protection and Affordable Care Act (PPACA), Public Law No. 111-148, as modified by the subsequently enacted Health Care and Education Reconciliation Act (HCERA), Public Law No. 111-152.

Table 1: Projected Medical, Prescription Drug, Dental and Vision Trends: 2013 and 2014

	2013 Projected		2014 Projected	
	(without Rx)	(with Rx)[1]	(without Rx)	(with Rx)[1]
Medical (Actives & Retirees <Age 65)				
Fee-for-Service (FFS)/Indemnity Plans	10.8%	10.0%	**10.4%**	**9.7%**
High-Deductible Health Plans (HDHPs)[2]	9.1%	8.6%	**8.3%**	**7.9%**
Open-Access Preferred Provider Organizations (PPOs)/Point-of-Service (POS) Plans[3]	8.8%	8.3%	**7.9%**	**7.6%**
PPOs/POS Plans (with PCP Gatekeepers)	9.3%	8.8%	**8.4%**	**8.0%**
Health Maintenance Organizations (HMOs)	8.2%	7.9%	**7.2%**	**7.0%**
Medical (Retirees Age 65+)				
Medicare Advantage (MA)[4] FFS Plans or PPOs	5.5%	5.4%	**3.6%**	**4.3%**
Medicare Advantage HMOs	5.8%	5.6%	**3.3%**	**4.2%**
Medicare Supplemental (Medigap)	5.3%	5.3%	**4.9%**	**5.2%**
Prescription Drug (Rx) Carve-Out[5]				
Actives & Retirees <Age 65	6.4%		**6.3%**	
Retirees Age 65+	5.3%		**5.7%**	
Dental				
Schedule of Allowance Plans[6]	4.0%		**4.0%**	
FFS/Indemnity Plans	4.0%		**3.8%**	
Dental Provider Organizations (DPOs)	3.5%		**3.4%**	
Dental Maintenance Organizations (DMOs)	4.1%		**4.5%**	
Vision				
Schedule of Allowance Plans	2.8%		**2.9%**	
Reasonable & Customary (R&C) Plans	3.7%		**3.3%**	

[1] Trend projections were derived by proportionally blending medical trends and freestanding prescription drug trends.

[2] HDHPs with an employee-directed, tax-advantaged health account — a health savings account (HSA) or a health reimbursement account (HRA) — are referred to as account-based health plans and are designed to encourage consumer engagement, resulting in more efficient use of health care services. HDHPs are defined as those plans where the deductible is at least the minimum health savings account (HSA) level required by the Internal Revenue Service ($1,250 single, $2,500 family in 2014).

[3] Open-access PPO/POS plans are those that do not require a primary care physician (PCP) gatekeeper referral for specialty services.

[4] MA plans, part of the Medicare program, can be private HMOs, FFS plans, PPOs or special-needs plans. The 2013 survey collected information about projected trends for MA PPO plans separately. The 2014 survey combines FFS plans with PPOs.

[5] Prescription drug carve-out data was captured for retail and mail-order delivery channels combined.

[6] A schedule of allowance plan is a plan with a list of covered services with a fixed-dollar amount that represents the total obligation of the plan with respect to payment for services, but does not necessarily represent the provider's entire fee for the service.

- Health maintenance organization (HMO) trend rate projections for 2014 are 3 percentage points lower than HMO projections for 2011.
- Prescription drug benefit trends for retail and mail order combined are forecasted at 6.3 percent for active participants and early retirees. These projections are relatively consistent with last year's trend rate projections of 6.4 percent.
- Medicare-eligible retiree plans are also anticipating trend rate declines for Medicare Advantage (MA) preferred provider organizations (PPOs), MA HMOs and Medicare Supplemental plans. MA PPO trends are projected to decrease almost 2 percentage points below 2013 levels to their lowest point in 17 years. This predicted rate decrease for Medicare-eligible retiree plans is more than double the rate decline projected for PPOs for actives and pre-65 retirees.
- In 2014, Medicare-eligible retirees can expect lower trend rates for medical coverage compared to prescription drug coverage. For example, MA HMO trend rates are projected to be 3.3 percent while prescription drug trends (retail and mail order combined) are forecasted at 5.7 percent. These findings are a departure from last year's trends in which the forecasted medical and prescription drug trends rates were aligned. This is largely driven by the rise in specialty drug cost and significant price inflation on brand-name drugs without dramatic new gains in generic utilization. It is noteworthy that trend projections for MA plans are lower despite cutbacks in subsidies from the Centers for Medicare & Medicaid Services (CMS).
- Overall, dental plan trend rates are projected to remain relatively unchanged in 2014. Scheduled vision plan trend rates are projected at 2.9 percent and reasonable and customary plans are forecasted at 3.3 percent in 2014.

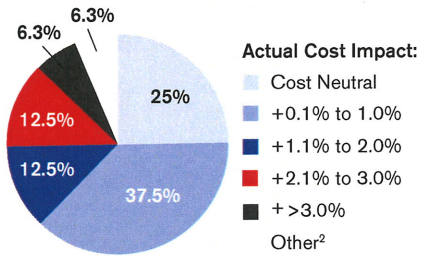
"HMO trend rate projections for 2014 are 3 percentage point lower than HMO projections for 2011."

The survey also looked for regional variations in trend rates. Projected 2014 trend rates for PPO and POS plans combined show regional variations, with the lowest rate of 5.8 percent in the South and highest rate of 10.0 percent in the West.

"For the first time, Segal asked insurers to indicate 2014 expected medical PPO cost trends by group size. Results indicate that individual and small groups will trend approximately 1 percentage point higher than large group plans."

For the first time, Segal asked insurers to indicate 2014 expected medical PPO cost trends by group size. Results indicate that individual and small groups will trend approximately 1 percentage point higher than large group plans.

Graph 1: Projected Cost Impact on 2014 Plan Trend of Implementing Preventive Care Coverage for Plans That Lost Their Grandfathered Status by Percentage of Survey Respondents[1]



[1] This data reflects responses from 16 of the health insurers, MCOs and TPAs that participated in the survey. Total exceeds 100% due to rounding.

[2] The survey did not collect data on what the respondents meant by "other."

Impact of Losing "Grandfathered" Status

Segal asked the survey respondents about the expected impact of the Affordable Care Act on costs. Survey findings indicate nearly two-thirds of respondents project a cost increase of 1 percent or less due to loss of "grandfathered" status,[3] with one-quarter of the respondents predicting the loss of grandfathered status will be cost neutral, as shown in Graph 1 above. Only 6 percent of survey respondents anticipate that implementing preventive care coverage for plans that lost their

What Is Trend?

Trend is a forecast of per capita *claims cost increases* that takes into account various factors, such as price inflation, utilization, government-mandated benefits, and new treatments, therapies and technology. Although there is usually a high correlation between a trend rate and the actual cost increase assessed by a carrier, trend and the net annual change in plan costs are *not* the same. Changes in the costs to plan sponsors can be significantly different from projected claims cost trends, reflecting such diverse factors as group demographics, changes in plan design, administrative fees, reinsurance premiums and changes in participant contributions.

[3] Group health plans in existence as of March 23, 2010, when the Affordable Care Act was signed into law, and that remain largely unchanged from that date are grandfathered.

grandfathered status under the Affordable Care Act will result in a cost trend increase of more than 3 percent.

Trend Components

The survey also examined 2014 projected medical trends by service type. Table 2 presents that data. Similar to prior-year projections, price inflation remains the largest component of cost increases and continues high for hospital services and brand-name medications. For prescription drugs, price inflation is projected to jump more than 1 percentage point compared to 2013 forecasts. On the other hand, the projected specialty drug/biotech trend rate, while very high at 16.5 percent, is almost 1 full percentage point lower than the 2013 projection.

In 2014, the utilization component of trend for hospital services is projected to remain unchanged at 2.2 percent. Two noteworthy results supporting lower overall trend rates are the modest price inflation for physician services (3.7 percent) and the flat prescription drug utilization rate. However, the continued upswing in generic dispensing rates based on brands losing patent protection is likely to begin leveling off.

"Price inflation remains the largest component of cost increases."

Accuracy of 2012 Projections

To assess the accuracy of the reported projections, Segal compared the average 2012 trend *forecasts* by national and regional insurers, MCOs, PBMs and TPAs for group medical, prescription drug benefit and dental plans to the *actual* average trend rates experienced by the health plans covered by those organizations for the same 12-month period, as reported by survey respondents. Actual trends for 2012 (the most recent full year for which actual data is available), were the lowest reported in more than 12 years.

Consistent with previous survey findings, this year's findings support our observation that insurers and PBMs tend to make conservative projections and confirm that forecasted trends have been generally higher than actual experience. The following are the most notable findings about the accuracy of trend projections based on the data shown in Table 3:

- The survey found a significant spread of nearly three percentage points between actual and projected trends for high-deductible health plans (HDHP), open-access PPOs/point-of-service (POS) plans for actives and retirees,

"The projected specialty drug/biotech trend rate, while very high at 16.5 percent, is almost 1 full percentage point lower than the 2013 projection."

Table 2: Components of 2013 & 2014 Projected Trends for Hospital Services, Physician Services and Prescription Drugs

	Hospitals[1]		Physicians[1]		Rx	
	2013	2014	2013	2014	2013	2014
Total Trend[2]	**8.7%**	**8.6%**	**6.8%**	**6.0%**	**6.3%**	**6.4%**
Trend Component						
Price Inflation	6.4%	6.3%	3.9%	3.7%	8.4%	6.8%
Utilization	2.2%	2.2%	2.8%	2.3%	0.2%	0.7%

[1] Hospital and physician trends are for open-access PPOs.

[2] The components do not add up to the totals because there are other components of trend not illustrated, reflecting such factors as the impact of cost shifting, technology changes and drug mix. Not all survey respondents provided a breakdown of trend by component.

Table 3: Comparison of 2012 Projected Trends to 2012 Actual Trends

	Projected	Actual
Medical (Actives & Retirees <Age 65)	(without Rx)	
FFS/Indemnity Plans	11.7%	10.0%
HDHPs	10.4%	7.7%
Open-Access PPOs/ POS Plans	10.0%	7.3%
PPOs/POS Plans (with PCP Gatekeepers)	10.4%	8.4%
HMOs	9.6%	6.7%
Medical (Retirees Age 65+)	(without Rx)	
MA PPO[1]	N/A	0.4%
MA HMOs	6.6%	3.0%
Rx Carve-Out[2] (Actives & Retirees <Age 65)	7.2%	5.5%
Rx Carve-Out[2] (Retirees Age 65+)	6.5%	2.2%
Dental		
Scheduled Plans	4.1%	2.9%
FFS/Indemnity Plans	4.2%	2.8%
DPOs	3.8%	2.6%
DMOs	4.4%	3.4%
Vision		
Scheduled Plans	3.8%	2.3%
R&C Plans	3.9%	2.9%

[1] For 2012, the survey asked for Medicare Supplement (Medigap) trends and MA HMO trends for retiree medical post-65. It did not ask for MA PPO trend rate information.

[2] The 2012 survey captured prescription drug carve-out data for retail and mail-order delivery channels combined.

PPOs/POS plans with a physician gatekeeper *and* HMOs for the active and retiree under 65 population.

- For prescription drugs, the differential between actual and forecasted trend rates was more than double for retirees age 65 and older than for actives and retirees under 65: 4.3 percentage points compared to 1.7 percentage points.

Table 4 shows selected trends (actual trends for 2002–2012 and projected trends for 2013 and 2014).

It should be noted that the accuracy of projections is subject to both underwriters' conservatism in predicting future events and a natural lag in the underwriting cycle. In periods where costs are decelerating, forecasters will tend to overestimate trends. Similarly, when costs are accelerating, trend projections will generally be underestimated for a period. Consequently, accuracy of trend assumptions is best measured by comparing projected trend to actual trend over multiple years. Graphs 2 and 3 illustrate the significant but declining variances between trend forecasts versus actual trends experienced in 2008 and 2009.

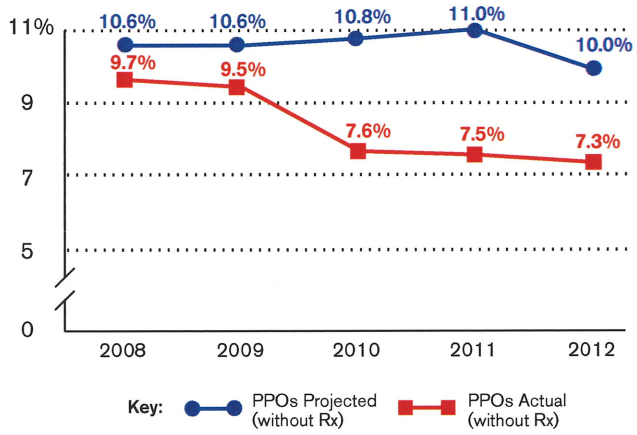
Table 4: Selected Medical, Rx Carve-Out and Dental Trends: 2002-2012 Actual and 2013 and 2014 Projected*

Year	PPOs (without Rx)	POS Plans (without Rx)	HMOs (without Rx)	MA HMOs (without Rx)	Rx	DPOs
2002 Actual	13.9%	12.2%	12.8%	12.9%	18.4%	6.4%
2003 Actual	12.0%	11.5%	11.5%	10.0%	14.3%	6.5%
2004 Actual	10.9%	11.6%	11.5%	11.4%	13.3%	6.2%
2005 Actual	10.4%	11.1%	10.6%	8.4%	10.5%	5.0%
2006 Actual	9.6%	10.0%	10.2%	7.2%	9.5%	5.1%
2007 Actual	8.9%	9.5%	9.8%	7.0%	7.9%	5.0%
2008 Actual	9.7%	9.4%	9.7%	7.7%	7.4%	5.5%
2009 Actual	9.5%	9.7%	10.2%	4.0%	7.9%	4.7%
2010 Actual	7.6%	8.3%	8.7%	3.6%	6.4%	3.0%
2011 Actual	7.5%	7.8%	8.0%	4.5%	5.0%	3.1%
2012 Actual	7.3%	8.4%	6.7%	3.0%	5.5%	2.6%
2013 Projected	8.8%	9.3%	8.2%	5.8%	6.4%	3.5%
2014 Projected	7.9%	8.4%	7.2%	3.3%	6.3%	3.4%

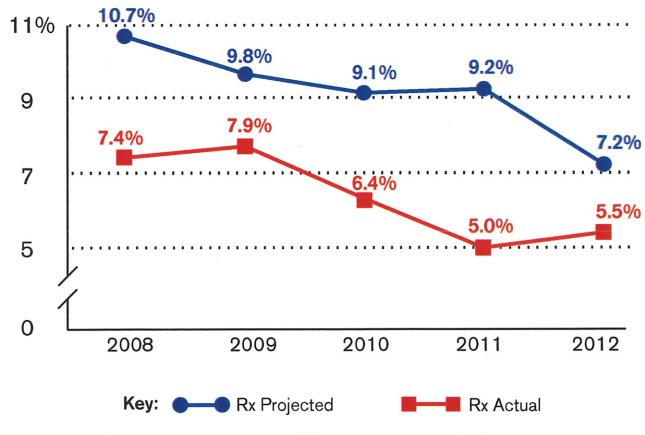
* All trends are illustrated for actives and retirees under age 65, except for the MA Plans. (A graph comparing 13 years of survey data — 2013 and 2014 projected trends to actual trends for 2002 through 2012 — is available on the following page of Segal's website: http://www.segalco.com/publications/surveysandstudies/2014TSsupp.pdf)

"The accuracy of projections is subject to both underwriters' conservatism in predicting future events and a natural lag in the underwriting cycle. In periods where costs are decelerating, forecasters will tend to overestimate trends."

Graph 2: Comparison of Projected to Actual Trends for PPOs for Actives and Retirees under Age 65: 2008–2012



Graph 3: Comparison of Projected to Actual Trends for Rx* Carve-Out Coverage for Actives and Retirees under Age 65: 2008-2012



* This data reflects retail and mail-order delivery channels combined.

Segal also asked the survey participants to indicate the top five major diagnostic categories (MDC) that had the highest actual cost trends in 2012. Table 5 shows the results, from highest to lowest, by rank in 2012 compared to rank in 2011.

In this year's survey, Segal asked the respondents to indicate the medical management strategies that are most effective in reducing medical plan cost trends based on their experience. Responses indicate that the most effective and widely used strategy is care management and specialty case management programs, such as those that focus on acute care, chronic care and oncology care. Another successful cost-containment option reported by survey respondents is the management of hospital admissions and readmissions using tools such as redirecting hospital outpatient services and overseeing inpatient admissions.

"Although it remains to be seen whether the deceleration in trends projected for 2014 has been influenced by short-term economic forces, the influence of the Affordable Care Act or some other factor not yet identified, there continue to be significant changes in the health care delivery system that could have long-term implications for health care costs."

Commentary & Outlook

Although it remains to be seen whether the deceleration in trends projected for 2014 has been influenced by short-term economic forces, the influence of the Affordable Care Act or some other factor not yet identified, there continue to be significant changes in the health care delivery system that could have long-term implications for health care costs. Some of these changes are noted below:

- Many plan designs now include greater levels of participant out-of-pocket costs.
- Provider reimbursement arrangements are beginning to shift from the fee-for-service model to alternative payment models, such as bundled payments, which are designed to encourage providers to coordinate care and reward efficiency.
- The Hospital Readmissions Reduction Program, which requires CMS to reduce payments to hospitals with excess readmissions, has helped to reduce overall hospital spending by including comprehensive strategies for discharge planning, medication management, and continuum of care.
- Participants are becoming more educated consumers through programs such as Choose Wisely, which lists five questions patients should discuss with physicians about medical tests and procedures that may be unnecessary (and, in some instances, can cause harm) and the Five-Star Quality Rating System created by CMS to help consumers compare how nursing homes' quality of care and services vary.
- Costs are becoming more transparent. A growing number of health insurers have invested heavily in new member-support decision tools that provide more information on health treatment costs. There are also publically available transparency tools, such as Hospital Compare (CMS-published data on what providers charge for common services, which shows significant variation across the country at over 4,000 Medicare-certified hospitals) and Fair Health, an independent not-for-profit

"The most effective and widely used strategy [for reducing medical plan cost trends] is care management and specialty case management programs, such as those that focus on acute care, chronic care and oncology care."

Table 5: Top Five Major Diagnostic Categories (MDC) with Highest PMPY Cost Trends in 2012 Compared to 2011

	Rank	
	2012	2011
Diseases and disorders of the digestive system	1	2
Diseases and disorders of the musculoskeletal system and connective tissue	2	1
Pregnancy, childbirth and the puerperium*	2	3
Diseases and disorders of the circulatory system	3	2
Diseases and disorders of the nervous system	3	Not in Top 5
Lymphatic, hematopoietic and other malignancies	4	3
Infectious and parasitic diseases, systemic or unspecified sites	4	Not in Top 5

*"Puerperium" is the period of adjustment after childbirth during which the mother's reproductive organs return to their non-pregnant state.

corporation with a web portal that allows consumers to access a medical cost transparency database for determining out-of-network reimbursement.

- Plan sponsors are encouraging participants to seek care for minor illnesses at lower-cost settings, such as telemedicine and walk-in clinics.
- There is growing use of Patient-Centered Medical Homes (PCMH), which focus an increased level of comprehensive health care resources on primary care and prevention for patients with chronic conditions. Also, as Accountable Care Organizations (ACOs)[4] and PCMHs expand, they will offer new options for plan sponsors.
- Reference-based pricing, in which the plan makes a defined contribution towards covering the cost of a particular service, to steer participants towards higher-quality hospitals or physicians for specific procedures or conditions (*e.g.*, the California Public Employees' Retirement System's use of maximum allowance for hip and knee replacement), is expanding.
- Network provider contracting is being improved to remove high-cost outlier providers who cannot prove their value.

While medical plan cost trend continues to decelerate, overall health plan costs are still on the rise. Faced with this reality, plan sponsors are becoming increasingly more progressive and creative in their efforts to manage costs while delivering high-quality, cost-effective health care. Plan sponsors must be ready to implement new requirements introduced by the Affordable Care Act[5] and to determine their impact on plan costs. Plan sponsors will need to play an active role to continue to get the most for their benefit dollars.

"While medical plan cost trend continues to decelerate, overall health plan costs are still on the rise."

■ ■ ■

For assistance with health care cost management strategies, contact your Segal consultant or the nearest Segal office. A list of Segal offices can be accessed from the second hyperlink in the blue box below.

[4] ACOs, which have mainly been developed for the Medicare population, are networks of providers and suppliers that agree to be jointly accountable for managing the health of participating populations across the care continuum.

[5] New guidance on the Affordable Care Act is released on a regular basis. As guidance is issued, it is summarized in Segal publications. All of Segal's publications on the Affordable Care Act can be accessed from the Health Care Reform Guide on the Segal website: http://www.segalco.com/publications-and-resources/health-care-reform/

The Survey Participants

The 2014 *Segal Health Plan Cost Trend Survey* was conducted in May and June of 2013. Survey participants were asked to provide the trend factors they will be applying to historical claims to predict expected claims for 2014. Segal received 99 responses to the survey. The following participants agreed to disclose their names: Aetna; Amalgamated Life; Amerihealth of New Jersey; Anthem Blue Cross and Blue Shield; Anthem Blue Cross of California; Arkansas Blue Cross and Blue Shield; Assurant Employee Benefits; Benecard; Blue Cross and Blue Shield of Illinois; BlueCross and BlueShield of Tennessee; Blue Cross Blue Shield of Michigan; Capital District Physician's Health Plan; Care Plus Dental Plans; Catamaran; CIGNA; ConnectiCare, Inc.; CVS Caremark; Delta Dental of Arizona, Delta Dental of Arkansas; Delta Dental Insurance Company (DDIC); Delta Dental of California; Delta Dental of Colorado; Delta Dental of Delaware; Delta Dental of the District of Columbia; Delta Dental of Idaho; Delta Dental of Illinois; Delta Dental of Indiana; Delta Dental of Kansas; Delta Dental of Massachusetts; Delta Dental of Michigan; Delta Dental of Minnesota; Delta Dental of Nebraska; Delta Dental of New Mexico; Delta Dental of New York; Delta Dental of North Carolina; Delta Dental of Ohio; Delta Dental of Pennsylvania; Delta Dental of Tennessee; Delta Dental of Virginia; Delta Dental of West Virginia; Delta Dental of Wisconsin; EmblemHealth; Envision Pharmaceutical Services; Excellus Health Plan, Inc.; Express Scripts, Inc.; Health Alliance Medical Plans; Health Net, Inc.; Horizon Blue Cross Blue Shield of New Jersey; Humana, Inc.; Independence Blue Cross; ING; Kaiser Foundation Health Plan; Lincoln Financial Group; Medical Mutual; Moda Health; MVP Health Care; Navitus Health Solutions; Nippon Life Insurance Company of America; OptumRx; Restat; The ODS Companies; Trustmark Life; Tufts Health Plan; UnitedHealthcare; United Concordia; and US Script.

Segal Consulting

To receive survey reports and other Segal Consulting publications as soon as they are available online, register your e-mail address via Segal's website: www.segalco.com/register/

For a list of Segal's 22 offices, visit www.segalco.com/about-us/contact-us-locations/

Segal Consulting is a member of The Segal Group (www.segalgroup.net).

www.segalco.com

SAMPLE PLAN DESIGN SURVEY

Benefit Summary Comparison

		Coinsurance		PPO Deductible		Out-of-Pocket Maximum	
Surveyed Cities	**Offer a PPO**	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**
City A	Yes	90%	60%	$350/$700/$1,050	combined	$1,500/$4,500	$4,500/$9,000
City B	Yes	80%	70%	$1,000/$3,000	combined	$6,000/$12,700	$9,000/$27,000
	Yes	90%	60%	$500/$1,000	combined	$2,000/$4,000	no max
City C	Yes (Self-Insured)	80%	50%	$200/$600		Plan pays first $15,200. 100% Thereafter except hospital copay and other services listed in SPD	
City D	Yes	90%	70%	$750/$1,500	$1,250/$2,500	$2,000/$4,000	combined
City E	Yes (HD)	70%	50%	$2,000/$4,000	combined	$5,000/$10,000	combined
City F	Yes	80%	60%	$500/$1,500		$3,000/$9,000	$6,000/$18,000
City G	Yes (Self-Insured)	85%	50%	$250/$750	$250/$750	$3,750/person	$7,500/person
City H	Yes	90%	70%	$100/$200		$2,100/$4,200	
	Yes	80%	60%	$3,500/$7,000		$6,350/$12,700	$13,500/$27,000
City I	Yes	90%	50%	$150/$300	$350/$700	$2,650/$5,300	no max
City J	Yes (HD)	100%	70%	$3,000/$6,000	$6,000/$12,000	$6,000/12,000	$10,000/$20,000
	Yes (HD)	80%	60%	$3,000/$6,000	$6,000/$12,000	$5,000/$10,000	$12,000/$24,000
City K	PERS Choice	80%	60%	$500/$1,000		$3,000/$6,000	N/A
	PERSCare	90%	60%	$500/$1,000		$2,000/$4,000	N/A

Benefit Summary Comparison

	Coinsurance		Cost Sharing by Tier			Cost Sharing
Surveyed Cities	**In-Network**	**Out of Network**	**Single**	**2-Party**	**Family**	**MOU**
City A	90%	60%	80%	80%	80%	80/20
City B	80%	70%	80%	79%	79%	By plan based on a formula. Currently 80/20 for the illustrated plan
	90%	60%	76%	75%	75%	By plan based on a formula. Currently 75/25 for the illustrated plan
City C	80%	50%	80%	80%	80%	80/20
City D	90%	70%	100%	97%	85%	Covers up to Kaiser family rate
City E	70%	50%	100%	61%	62%	EE : Lowest cost non ABHP plan + lowest cost Dental EE+1 : $850 + 50% of the lowest cost non-ABHP plan + lowest cost dental EE+2 : $1200 + 50% of the lowest cost non-ABHP plan+ lowest cost dental
City F	80%	60%	52%	33%	27%	Flex plan by BU : Unrepresented tier cost share is shown
City G	85%	50%	100%	51%	36%	Most BU: 100% employee only
City H	90%	70%	64%	64%	64%	City pays 90% of the lowest cost plan.
	80%	60%	78%	78%	78%	
City I	90%	50%				
City J	100%	70%	94%		66%	Fixed dollar - Single: 310.50 Family : 550.00
	80%	60%	102%		71%	Excess City Contribution will deposit into a Health Savings Account
City K	80%	60%	100%	100%	88%	Allowance of $1,521.95 to purchase medical and dental
	90%	60%	100%	70%	54%	

CLAIMS ANALYSIS SAMPLE REPORT

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Local XYZ Welfare Fund

Claims Analysis Report - Fiscal Year Ending 2011

SEGAL

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THE SEGAL COMPANY
GLENDALE
330 North Brand Boulevard
Suite 1100
Glendale, CA 91203-2308
T (818) 956-6700 F (818) 956-6790 www.segalco.com

April 15, 2011

Board of Trustees
Local XYZ Welfare Fund
1313 Mockingbird Lane
Hollywood, CA 90000

Dear Trustees:

We are pleased to present this fiscal 2010 Claims Analysis Report for the Local XYZ Welfare Fund.

We look forward to reviewing this report with you and answering any questions you may have at the next meeting of the Board of Trustees. However, if there are any questions that need to be addressed prior to the meeting, please do not hesitate to contact us.

Sincerely,

THE SEGAL COMPANY

By:

Jim Smith
Health Consultant

Joan Anderson
Health Consultant

cc: *Jane Doe*
Bill Williams
Doug Saxon

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Claims Analysis for
Local XYZ Welfare Fund

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Key Findings, Recommendations

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Claims Analysis for
Local XYZ Welfare Fund

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SUMMARY

Part Time	Dec-06	Dec-07	Dec-08	Dec-09	Dec-10
Aggregate Total	$5,550,000	$5,975,000	$5,925,000	$6,520,000	$6,225,000
% change		7.7%	-0.8%	10.0%	-4.5%
Per Employee Per Month	$231.25	$237.10	$253.21	$265.05	$288.19
% change		2.5%	6.8%	4.7%	8.7%
Full Time	**Dec-06**	**Dec-07**	**Dec-08**	**Dec-09**	**Dec-10**
Aggregate Total	$13,325,000	$16,125,000	$16,150,000	$16,900,000	$16,425,000
% change		21.0%	0.2%	4.6%	-2.8%
Per Active Per Month	$740.28	$839.84	$791.66	$853.53	$912.49
% change		13.4%	-5.7%	7.8%	6.9%
Retiree < 65			**Dec-08**	**Dec-09**	**Dec-10**
Aggregate Total			$6,100,000	$7,005,000	$8,085,000
% change				14.8%	15.4%
Per Retiree Per Month			$968.26	$1,061.36	$1,171.74
% change				9.6%	10.4%
Retiree 65+			**Dec-08**	**Dec-09**	**Dec-10**
Aggregate Total			$2,250,000	$2,375,000	$2,700,000
% change				5.6%	13.7%
Per Subscriber Per Month			$625.00	$638.44	$692.31
% change				2.2%	8.4%
Active	**Dec-06**	**Dec-07**	**Dec-08**	**Dec-09**	**Dec-10**
Aggregate Total	$18,875,000	$22,100,000	$22,075,000	$23,420,000	$22,650,000
% change		17.1%	-0.1%	6.1%	-3.3%
Per Active Employee Per Month	$971.53	$1,076.94	$1,044.87	$1,118.58	$1,200.68
% change		10.8%	-3.0%	7.1%	7.3%
Retiree			**Dec-08**	**Dec-09**	**Dec-10**
Aggregate Total			$8,350,000	$9,380,000	$10,785,000
% change				12.3%	15.0%
Per Retiree Per Month			$1,593.26	$1,699.80	$1,864.05
% change				6.7%	9.7%
Total			**Dec-08**	**Dec-09**	**Dec-10**
Aggregate Total			$30,425,000	$32,800,000	$33,435,000
% change				7.8%	1.9%
Per Participant Per Month			$566.58	$599.42	$663.39
% change				5.8%	10.7%

Claims Analysis for
Local XYZ Welfare Fund

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TOTAL BENEFITS PAID - AGGREGATE - ACTIVE

	Dec - 09			Dec - 10		
Expense:	**Part Time**	**Full Time**	**Total**	**Part Time**	**Full Time**	**Total**
Hospital	$2,500,000	$6,250,000	$8,750,000	2,400,000	6,250,000	8,650,000
Medical	1,950,000	6,000,000	7,950,000	1,900,000	5,750,000	7,650,000
Prescription Drugs	1,050,000	2,500,000	3,550,000	1,000,000	2,450,000	3,450,000
Dental	425,000	1,225,000	1,650,000	400,000	1,100,000	1,500,000
Vision	195,000	325,000	520,000	175,000	275,000	450,000
Disability	225,000	325,000	550,000	200,000	425,000	625,000
Life	175,000	275,000	450,000	150,000	175,000	325,000
Total	**$6,520,000**	**$16,900,000**	**$23,420,000**	**$6,225,000**	**$16,425,000**	**$22,650,000**
% Change	**10.0%**	**4.6%**	**6.1%**	**-4.5%**	**-2.8%**	**-3.3%**

Claims Analysis for
Local XYZ Welfare Fund

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TOTAL BENEFITS PAID - AGGREGATE - RETIREE

	Dec - 09			Dec - 10		
Expense:	**Retiree < 65**	**Retiree 65+**	**Total**	**Retiree < 65**	**Retiree 65+**	**Total**
Hospital	$2,750,000	$500,000	$3,250,000	3,000,000	600,000	3,600,000
Medical	2,500,000	775,000	3,275,000	3,000,000	850,000	3,850,000
Prescription Drugs	1,400,000	1,100,000	2,500,000	1,700,000	1,250,000	2,950,000
Dental	300,000	0	300,000	325,000	0	325,000
Vision	55,000	0	55,000	60,000	0	60,000
Total	**$7,005,000**	**$2,375,000**	**$9,380,000**	**$8,085,000**	**$2,700,000**	**$10,785,000**
% Change	**14.8%**	**5.6%**	**12.3%**	**15.4%**	**13.7%**	**15.0%**

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TOTAL BENEFITS PAID - AGGREGATE - COMBINED

	Dec - 09			Dec - 10		
Expense:	**Active**	**Retiree**	**Total**	**Active**	**Retiree**	**Total**
Hospital	$8,750,000	$3,250,000	$12,000,000	8,650,000	3,600,000	12,250,000
Medical	7,950,000	3,275,000	11,225,000	7,650,000	3,850,000	11,500,000
Prescription Drugs	3,550,000	2,500,000	6,050,000	3,450,000	2,950,000	6,400,000
Dental	1,650,000	300,000	1,950,000	1,500,000	325,000	1,825,000
Vision	520,000	55,000	575,000	450,000	60,000	510,000
Disability	550,000	0	550,000	625,000	0	625,000
Life	450,000	0	450,000	325,000	0	325,000
Total	**$23,420,000**	**$9,380,000**	**$32,800,000**	**$22,650,000**	**$10,785,000**	**$33,435,000**
% Change	**6.1%**	**12.3%**	**7.8%**	**-3.3%**	**15.0%**	**1.9%**

Claims Analysis for
Local XYZ Welfare Fund

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TOTAL BENEFITS PAID - PER ACTIVE EMPLOYEE PER MONTH

	Dec - 09			Dec - 10		
Expense:	**Part Time**	**Full Time**	**Total**	**Part Time**	**Full Time**	**Total**
Hospital	$101.63	$315.66	$197.07	$111.11	$347.22	$218.43
Medical	79.27	303.03	179.05	87.96	319.44	193.18
Prescription Drugs	42.68	126.26	79.95	46.30	136.11	87.12
Dental	17.28	61.87	37.16	18.52	61.11	37.88
Vision	7.93	16.41	11.71	8.10	15.28	11.36
Disability	9.15	16.41	12.39	9.26	23.61	15.78
Life	7.11	13.89	10.14	6.94	9.72	8.21
Total	**$265.05**	**$853.53**	**$527.47**	**$288.19**	**$912.49**	**$571.96**
% Change	**4.7%**	**7.8%**	**-6.9%**	**8.7%**	**6.9%**	**8.4%**
Average Number of Active Employees	**2,050**	**1,650**	**3,700**	**1,800**	**1,500**	**3,300**

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TOTAL BENEFITS PAID - PER RETIREE PER MONTH

	Dec - 09			Dec - 10		
Expense:	**Retiree < 65**	**Retiree 65+**	**Total**	**Retiree < 65**	**Retiree 65+**	**Total**
Hospital	$416.67	$134.41	$314.92	$434.78	$153.85	$333.33
Medical	378.79	208.33	317.34	434.78	217.95	356.48
Prescription Drugs	212.12	295.70	242.25	246.38	320.51	273.15
Dental	45.45	0.00	29.07	47.10	0.00	30.09
Vision	8.33	0.00	5.33	8.70	0.00	5.56
Total	**$1,061.36**	**$638.44**	**$908.91**	**$1,171.74**	**$692.31**	**$998.61**
% Change	**9.6%**	**2.2%**	**60.4%**	**10.4%**	**8.4%**	**9.9%**
Average Number of Retirees	**550**	**310**	**860**	**575**	**325**	**900**

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TOTAL BENEFITS PAID - PER SUBSCRIBER PER MONTH

	Dec - 09			Dec - 10		
Expense:	**Active**	**Retiree**	**Total**	**Active**	**Retiree**	**Total**
Hospital	$197.07	$314.92	$219.30	$218.43	$333.33	$243.06
Medical	179.05	317.34	205.14	193.18	356.48	228.17
Prescription Drugs	79.95	242.25	110.56	87.12	273.15	126.98
Dental	37.16	29.07	35.64	37.88	30.09	36.21
Vision	11.71	5.33	10.51	11.36	5.56	10.12
Disability	12.39	0.00	10.05	15.78	0.00	12.40
Life	10.14	0.00	8.22	8.21	0.00	6.45
Total	**$527.47**	**$908.91**	**$599.42**	**$571.96**	**$998.61**	**$663.39**
% Change	**-49.5%**	**-43.0%**	**5.8%**	**8.4%**	**9.9%**	**10.7%**
Average Number of Subscribers	**3,700**	**860**	**4,560**	**3,300**	**900**	**4,200**

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CLAIMS HISTORY - PART TIME

	Aggregate Totals - Claims				
Expense:	**Dec-06**	**Dec-07**	**Dec-08**	**Dec-09**	**Dec-10**
Hospital	$2,000,000	$2,200,000	$2,200,000	$2,500,000	$2,400,000
Medical	1,900,000	1,900,000	1,850,000	1,950,000	1,900,000
Prescription Drugs	800,000	950,000	1,000,000	1,050,000	1,000,000
Dental	350,000	400,000	350,000	425,000	400,000
Vision	150,000	175,000	175,000	195,000	175,000
Disability	250,000	200,000	250,000	225,000	200,000
Life	100,000	150,000	100,000	175,000	150,000
Total	**$5,550,000**	**$5,975,000**	**$5,925,000**	**$6,520,000**	**$6,225,000**
% Change		**7.7%**	**-0.8%**	**10.0%**	**-4.5%**

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CLAIMS HISTORY - PART TIME - PER EMPLOYEE PER MONTH

	Claims per Employee per Month				
Expense:	**Dec-06**	**Dec-07**	**Dec-08**	**Dec-09**	**Dec-10**
Hospital	$83.33	$87.30	$94.02	$101.63	$111.11
Medical	79.17	75.40	79.06	79.27	87.96
Prescription Drugs	33.33	37.70	42.74	42.68	46.30
Dental	14.58	15.87	14.96	17.28	18.52
Vision	6.25	6.94	7.48	7.93	8.10
Disability	10.42	7.94	10.68	9.15	9.26
Life	4.17	5.95	4.27	7.11	6.94
Total	**$231.25**	**$237.10**	**$253.21**	**$265.05**	**$288.19**
% Change		**2.5%**	**6.8%**	**4.7%**	**8.7%**
Average Number of Employees	**2,000**	**2,100**	**1,950**	**2,050**	**1,800**

Claims Analysis for
Local XYZ Welfare Fund

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CLAIMS HISTORY - FULL TIME

	Aggregate Totals - Claims				
Expense:	**Dec-06**	**Dec-07**	**Dec-08**	**Dec-09**	**Dec-10**
Hospital	$5,000,000	$6,000,000	$5,500,000	$6,250,000	$6,250,000
Medical	4,500,000	6,000,000	6,250,000	6,000,000	5,750,000
Prescription Drugs	2,000,000	2,000,000	2,200,000	2,500,000	2,450,000
Dental	1,000,000	1,250,000	1,200,000	1,225,000	1,100,000
Vision	300,000	275,000	325,000	325,000	275,000
Disability	400,000	350,000	450,000	325,000	425,000
Life	125,000	250,000	225,000	275,000	175,000
Total	**$13,325,000**	**$16,125,000**	**$16,150,000**	**$16,900,000**	**$16,425,000**
% Change		**21.0%**	**0.2%**	**4.6%**	**-2.8%**

Claims Analysis for
Local XYZ Welfare Fund

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CLAIMS HISTORY - FULL TIME - PER ACTIVE PER MONTH

	Claims per Enrollee per Month				
Expense:	**Dec-06**	**Dec-07**	**Dec-08**	**Dec-09**	**Dec-10**
Hospital	$277.78	$312.50	$269.61	$315.66	$347.22
Medical	250.00	312.50	306.37	303.03	319.44
Prescription Drugs	111.11	104.17	107.84	126.26	136.11
Dental	66.67	80.13	71.43	72.92	73.33
Vision	20.00	17.63	19.35	19.35	18.33
Disability	22.22	18.23	22.06	16.41	23.61
Life	5.95	11.57	9.87	12.39	8.58
Total	**$740.28**	**$839.84**	**$791.67**	**$853.54**	**$912.50**
% Change		**13.4%**	**-5.7%**	**7.8%**	**6.9%**

Claims Analysis for
Local XYZ Welfare Fund

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CLAIMS HISTORY - RETIREE < 65

	Aggregate Totals - Claims			Claims per Retiree per Month		
Expense:	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-08**	**Dec-09**	**Dec-10**
Hospital	$2,500,000	$2,750,000	$3,000,000	$396.83	$416.67	$434.78
Medical	2,000,000	2,500,000	3,000,000	317.46	378.79	434.78
Prescription Drugs	1,250,000	1,400,000	1,700,000	198.41	212.12	246.38
Dental	300,000	300,000	325,000	47.62	45.45	47.10
Vision	50,000	55,000	60,000	7.94	8.33	8.70
Total	**$6,100,000**	**$7,005,000**	**$8,085,000**	**$968.26**	**$1,061.36**	**$1,171.74**
% Change	**0.0%**	**14.8%**	**15.4%**	**0.0%**	**9.6%**	**10.4%**
Average Number of Retirees				**525**	**550**	**575**

Claims Analysis for
Local XYZ Welfare Fund

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CLAIMS HISTORY - RETIREE 65+

	Aggregate Totals - Claims			Claims per Subscriber per Month		
Expense:	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-08**	**Dec-09**	**Dec-10**
Hospital	$500,000	$500,000	$600,000	$138.89	$134.41	$153.85
Medical	750,000	775,000	850,000	208.33	208.33	217.95
Prescription Drugs	1,000,000	1,100,000	1,250,000	277.78	295.70	320.51
Total	**$2,250,000**	**$2,375,000**	**$2,700,000**	**$625.00**	**$638.44**	**$692.31**
% Change	**0.0%**	**5.6%**	**13.7%**	**0.0%**	**2.2%**	**8.4%**
Average Number of Subscribers				**300**	**310**	**325**

Claims Analysis for
Local XYZ Welfare Fund

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CLAIMS HISTORY - ACTIVE

	Aggregate Totals - Claims				
Expense:	**Dec-06**	**Dec-07**	**Dec-08**	**Dec-09**	**Dec-10**
Hospital	$7,000,000	$8,200,000	$7,700,000	$8,750,000	$8,650,000
Medical	6,400,000	7,900,000	8,100,000	7,950,000	7,650,000
Prescription Drugs	2,800,000	2,950,000	3,200,000	3,550,000	3,450,000
Dental	1,350,000	1,650,000	1,550,000	1,650,000	1,500,000
Vision	450,000	450,000	500,000	520,000	450,000
Disability	650,000	550,000	700,000	550,000	625,000
Life	225,000	400,000	325,000	450,000	325,000
Total	**$18,875,000**	**$22,100,000**	**$22,075,000**	**$23,420,000**	**$22,650,000**
% Change		**17.1%**	**-0.1%**	**6.1%**	**-3.3%**

Claims Analysis for
Local XYZ Welfare Fund

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CLAIMS HISTORY - ACTIVE - PER ACTIVE EMPLOYEE PER MONTH

	Claims per Active Employee per Month				
Expense:	**Dec-06**	**Dec-07**	**Dec-08**	**Dec-09**	**Dec-10**
Hospital	$361.11	$399.80	$363.63	$417.29	$458.33
Medical	329.17	387.90	385.43	382.30	407.40
Prescription Drugs	144.44	141.87	150.58	168.94	182.41
Dental	70.14	80.97	73.78	79.15	79.63
Vision	22.92	21.26	23.41	24.34	23.38
Disability	32.64	26.17	32.74	25.56	32.87
Life	11.11	18.97	15.30	21.00	16.66
Total	**$971.53**	**$1,076.94**	**$1,044.87**	**$1,118.58**	**$1,200.68**
% Change		**10.8%**	**-3.0%**	**7.1%**	**7.3%**
Average Number of Active Emplo	**10,250**	**10,800**	**11,500**	**11,250**	**10,200**

Claims Analysis for
Local XYZ Welfare Fund

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CLAIMS HISTORY - RETIREE

	Aggregate Totals - Claims			Claims per Retiree per Month		
Expense:	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-08**	**Dec-09**	**Dec-10**
Hospital	$3,000,000	$3,250,000	$3,600,000	$535.72	$551.08	$588.63
Medical	2,750,000	3,275,000	3,850,000	525.79	587.12	652.73
Prescription Drugs	2,250,000	2,500,000	2,950,000	476.19	507.82	566.89
Dental	300,000	300,000	325,000	47.62	45.45	47.10
Vision	50,000	55,000	60,000	7.94	8.33	8.70
Total	**$8,350,000**	**$9,380,000**	**$10,785,000**	**$1,593.26**	**$1,699.80**	**$1,864.05**
% Change	**0.0%**	**12.3%**	**15.0%**	**0.0%**	**6.7%**	**9.7%**
Average Number of Retirees				**825**	**860**	**900**

Claims Analysis for
Local XYZ Welfare Fund

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CLAIMS HISTORY - TOTAL

	Aggregate Totals - Claims			Claims per Participant per Month		
Expense:	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-08**	**Dec-09**	**Dec-10**
Hospital	$10,700,000	$12,000,000	$12,250,000	$199.26	$219.30	$243.06
Medical	10,850,000	11,225,000	11,500,000	202.05	205.14	228.17
Prescription Drugs	5,450,000	6,050,000	6,400,000	101.49	110.56	126.98
Dental	1,850,000	1,950,000	1,825,000	34.45	35.64	36.21
Vision	550,000	575,000	510,000	10.24	10.51	10.12
Disability	700,000	550,000	625,000	13.04	10.05	12.40
Life	325,000	450,000	325,000	6.05	8.22	6.45
Total	**$30,425,000**	**$32,800,000**	**$33,435,000**	**$566.58**	**$599.42**	**$663.39**
% Change	**37.7%**	**7.8%**	**1.9%**	**13.8%**	**5.8%**	**10.7%**
Average Number of Participants				**4,475**	**4,560**	**4,200**

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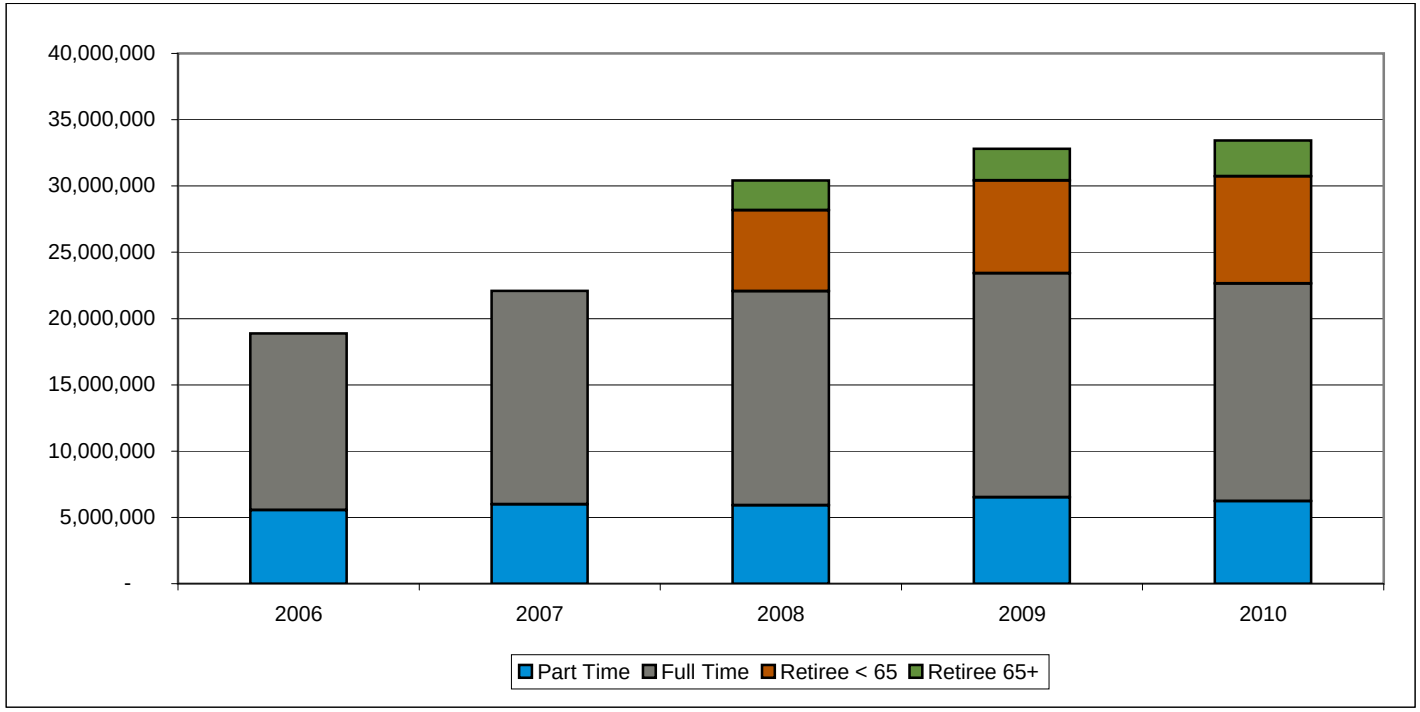
PAID CLAIMS BY ELIGIBILITY CLASS



Claims Analysis for
Local XYZ Welfare Fund

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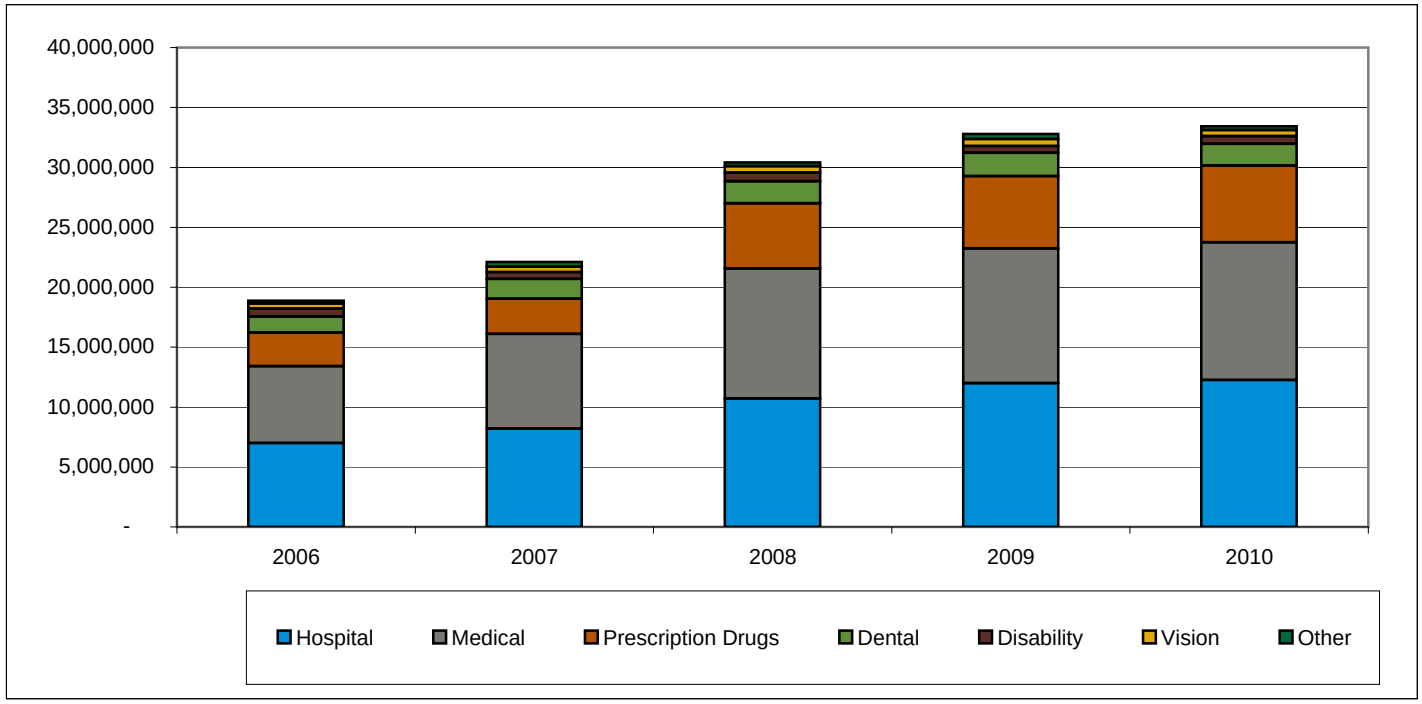
PAID CLAIMS BY COVERAGE



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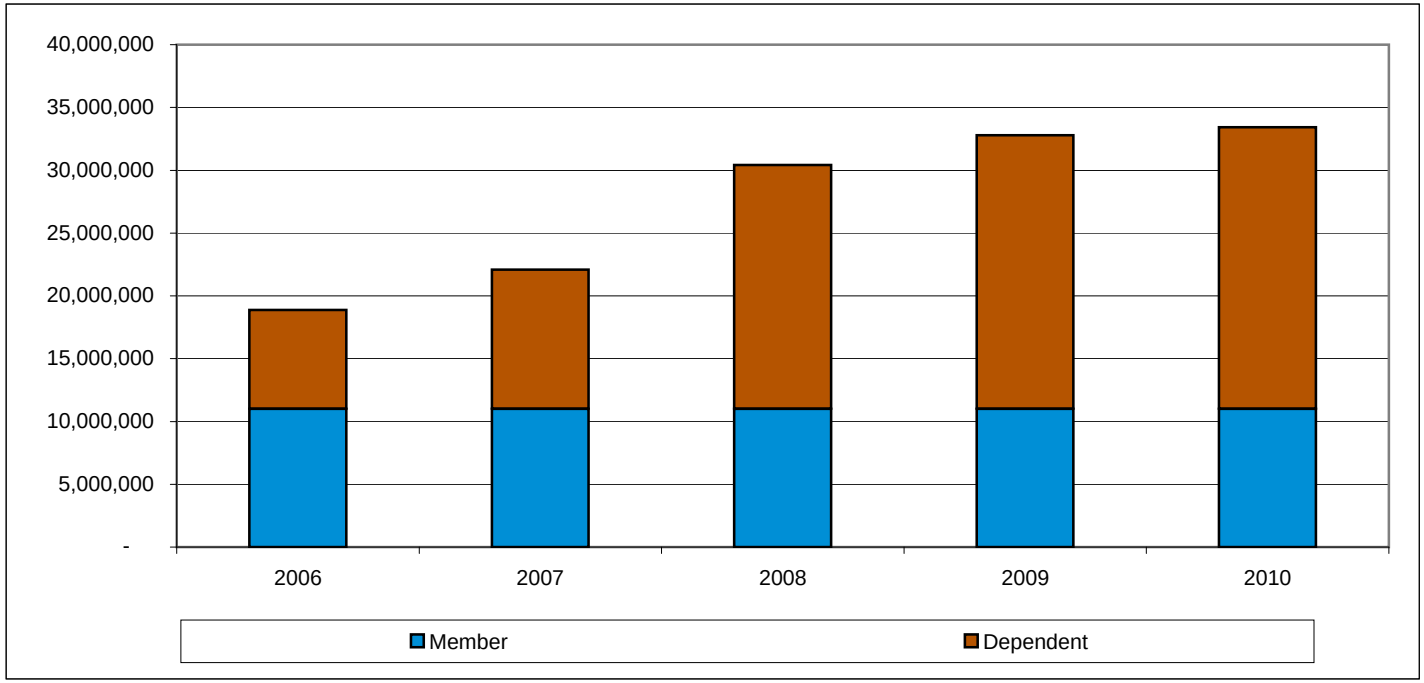
PAID CLAIMS BY PARTICIPANT TYPE



Claims Analysis for
Local XYZ Welfare Fund

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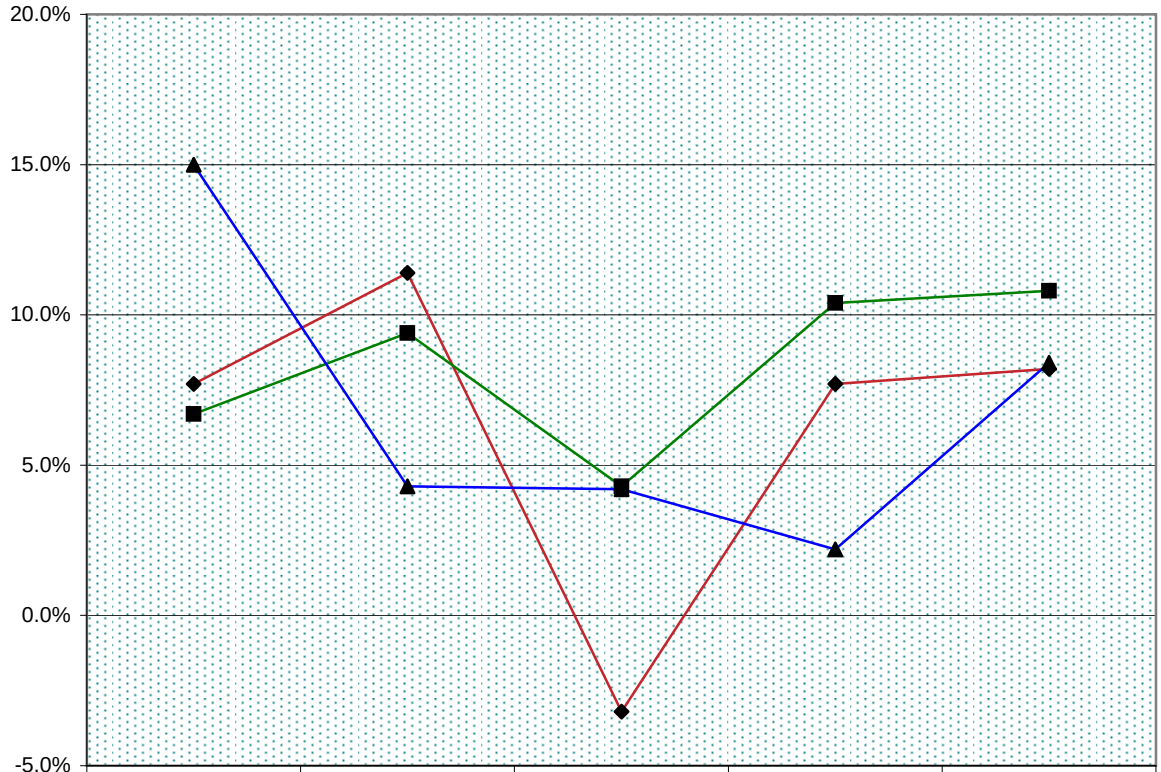
PAID CLAIMS TREND



	2006	2007	2008	2009	2010
Active Medical	7.7%	11.4%	-3.2%	7.7%	8.2%
Retiree <65 Medical	6.7%	9.4%	4.3%	10.4%	10.8%
Retiree 65+ Medical	15.0%	4.3%	4.2%	2.2%	8.4%

Claims Analysis for
Local XYZ Welfare Fund

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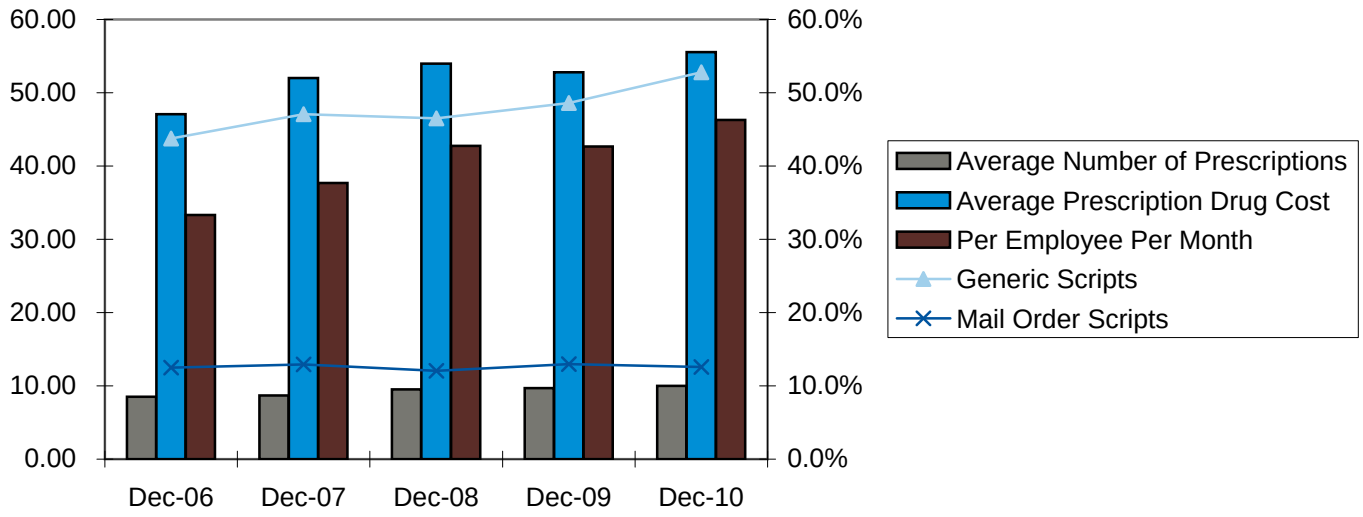
PRESCRIPTION DRUG ANALYSIS - PART-TIME

	Dec-06	Dec-07	Dec-08	Dec-09	Dec-10
Average Number of Employees	2,000	2,100	1,950	2,050	1,800
Total Number of Prescriptions	17,000	18,270	18,525	19,885	18,000
Average Number of Prescriptions	**8.50**	**8.70**	**9.50**	**9.70**	**10.00**
Total Prescription Drug Cost	$800,000	$950,000	$1,000,000	$1,050,000	$1,000,000
Increase (Decrease)	6.7%	18.8%	5.3%	5.0%	-4.8%
Average Prescription Drug Cost	$47.06	$52.00	$53.98	$52.80	$55.56
Increase (Decrease)	0.4%	10.5%	3.8%	-2.2%	5.2%
Total Prescription Drug Cost					
Per Employee Per Month	$33.33	$37.70	$42.74	$42.68	$46.30
Increase (Decrease)	6.7%	13.1%	13.4%	-0.1%	8.5%
Generic Scripts	**43.8%**	**47.1%**	**46.5%**	**48.6%**	**52.8%**
Mail Order Scripts	**12.5%**	**12.9%**	**12.0%**	**13.0%**	**12.6%**



Claims Analysis for
Local XYZ Welfare Fund

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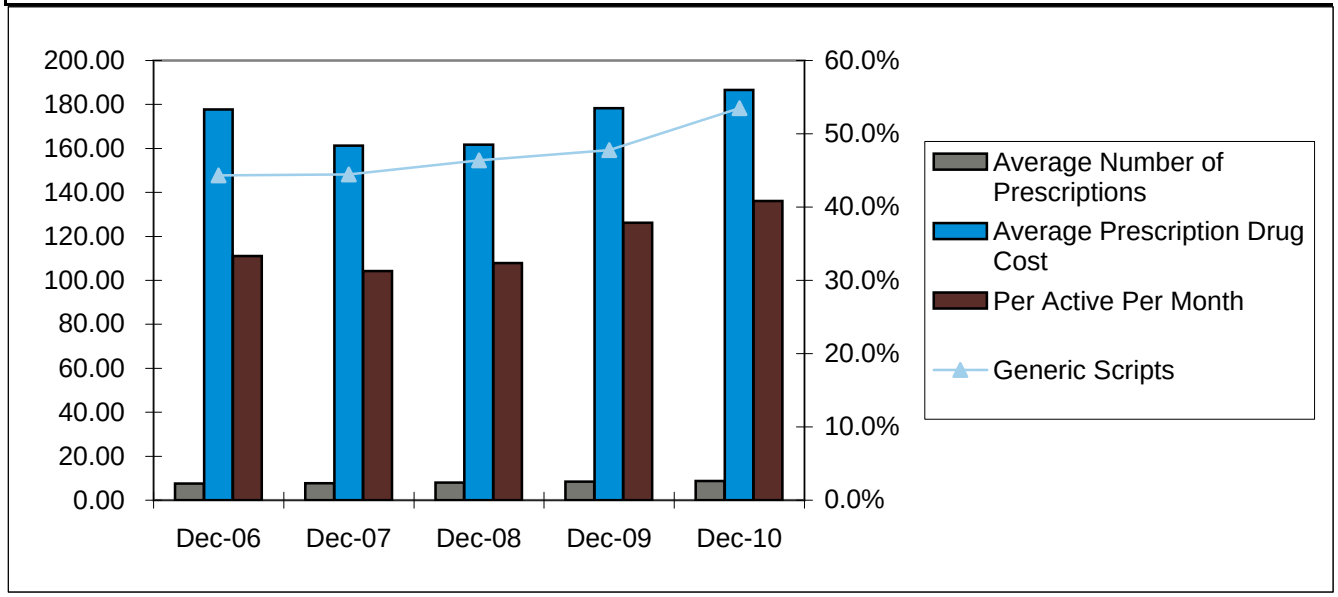
PRESCRIPTION DRUG ANALYSIS - FULL-TIME

	Dec-06	Dec-07	Dec-08	Dec-09	Dec-10
Average Number of Actives	1,500	1,600	1,700	1,650	1,500
Total Number of Prescriptions	11,250	12,400	13,600	14,025	13,125
Average Number of Prescriptions	**7.50**	**7.75**	**8.00**	**8.50**	**8.75**
Total Prescription Drug Cost	$2,000,000	$2,000,000	$2,200,000	$2,500,000	$2,450,000
Increase (Decrease)	11.1%	0.0%	10.0%	13.6%	-2.0%
Average Prescription Drug Cost	$177.78	$161.29	$161.76	$178.25	$186.67
Increase (Decrease)	0.2%	-9.3%	0.3%	10.2%	4.7%
Total Prescription Drug Cost					
Per Active Per Month	$111.11	$104.17	$107.84	$126.26	$136.11
Increase (Decrease)	7.4%	-6.2%	3.5%	17.1%	7.8%
Generic Scripts	**44.3%**	**44.4%**	**46.4%**	**47.8%**	**53.5%**



Claims Analysis for
Local XYZ Welfare Fund

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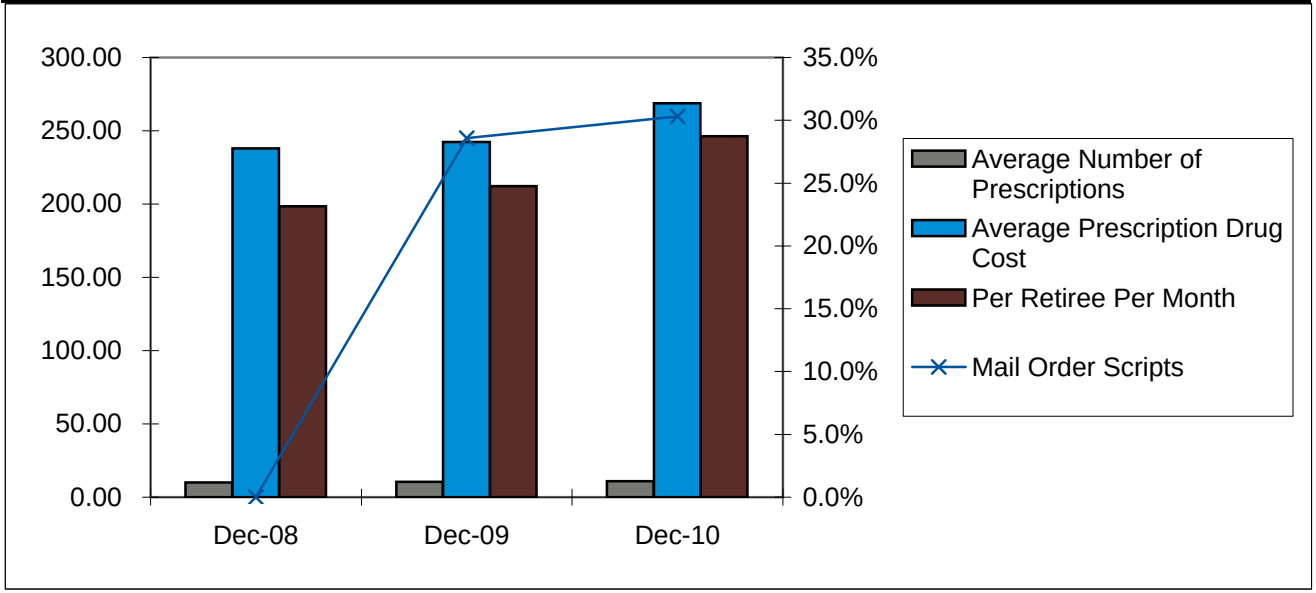
PRESCRIPTION DRUG ANALYSIS - RETIREE < 65

	Dec-08	Dec-09	Dec-10
Average Number of Retirees	525	550	575
Total Number of Prescriptions	5,250	5,775	6,325
Average Number of Prescriptions	**10.00**	**10.50**	**11.00**
Total Prescription Drug Cost	$1,250,000	$1,400,000	$1,700,000
Increase (Decrease)	25.0%	12.0%	21.4%
Average Prescription Drug Cost	$238.10	$242.42	$268.77
Increase (Decrease)	18.8%	1.8%	10.9%
Total Prescription Drug Cost			
Per Retiree Per Month	$198.41	$212.12	$246.38
Increase (Decrease)	25.0%	6.9%	16.2%
Mail Order Scripts	**0.0%**	**28.6%**	**30.3%**



Claims Analysis for
Local XYZ Welfare Fund

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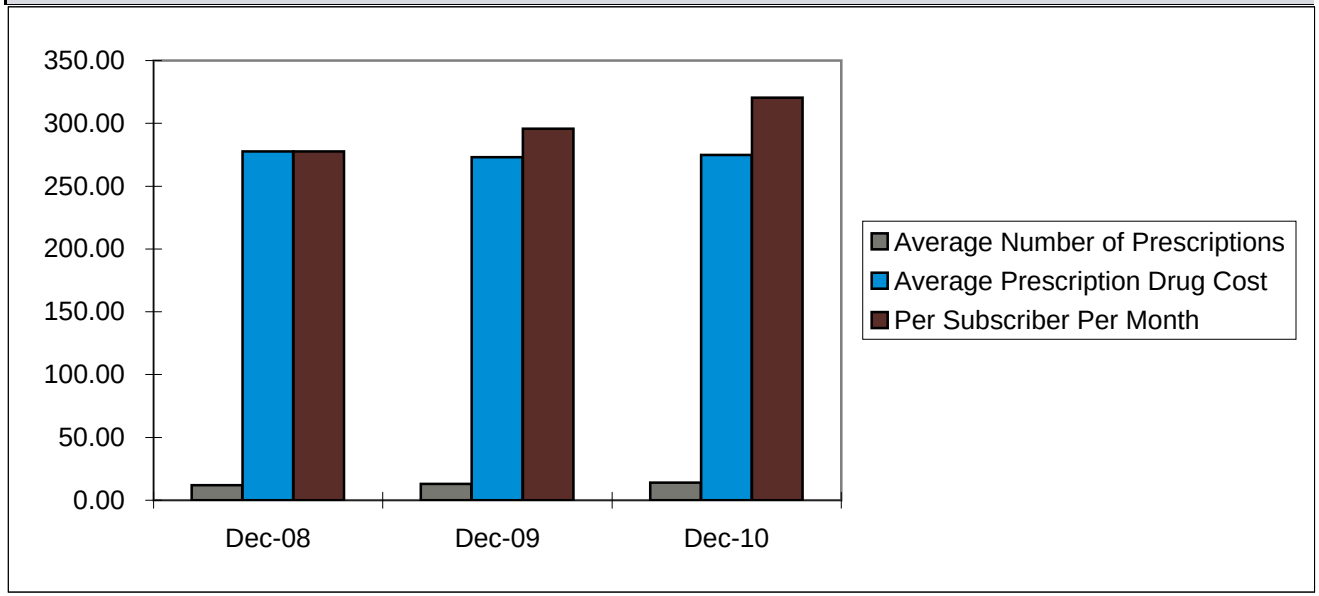
PRESCRIPTION DRUG ANALYSIS - RETIREE 65+

	Dec-08	Dec-09	Dec-10
Average Number of Subscribers	300	310	325
Total Number of Prescriptions	3,600	4,030	4,550
Average Number of Prescriptions	**12.00**	**13.00**	**14.00**
Total Prescription Drug Cost	$1,000,000	$1,100,000	$1,250,000
Increase (Decrease)	11.1%	10.0%	13.6%
Average Prescription Drug Cost	$277.78	$272.95	$274.73
Increase (Decrease)	6.5%	-1.7%	0.7%
Total Prescription Drug Cost			
Per Subscriber Per Month	$277.78	$295.70	$320.51
Increase (Decrease)	11.1%	6.5%	8.4%



Claims Analysis for
Local XYZ Welfare Fund

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LARGE CLAIMS

12 Months ending	Dec-06		Dec-07		Dec-08		Dec-09		Dec-10	
Claims By Amount Paid Per Individual	Number	Amount	Number	Amount	Number	Amount	Number	Amount	Number	Amount
$1 to $24,999	39,000	$7,800,000	52,500	$10,500,000	51,000	$10,200,000	55,500	$11,100,000	53,500	$10,700,000
$25,000 to $49,999	50	1,750,000	45	1,575,000	35	1,225,000	40	1,400,000	60	2,100,000
$50,000 to $99,999	25	1,500,000	20	1,200,000	35	2,100,000	15	900,000	32	1,920,000
$100,000 to $149,999	4	500,000	5	625,000	2	250,000	3	375,000	1	125,000
$150,000 to $199,999	3	450,000	2	350,000	1	175,000	3	525,000	4	700,000
$200,000 and above	5	1,400,000	2	500,000	3	750,000	3	750,000	0	0
Total	**39,087**	**$13,400,000**	**52,574**	**$14,750,000**	**51,076**	**$14,700,000**	**55,564**	**$15,050,000**	**53,597**	**$15,545,000**
Total above $100,000	**12**	**$2,350,000**	**9**	**$1,475,000**	**6**	**$1,175,000**	**9**	**$1,650,000**	**5**	**$825,000**
Dollars above $100,000		**$1,150,000**		**$575,000**		**$575,000**		**$750,000**		**$325,000**
% of Total Claims:		**17.5%**		**10.0%**		**8.0%**		**11.0%**		**5.3%**
Claims By Relationship Category	Number	Amount	Number	Amount	Number	Amount	Number	Amount	Number	Amount
Member	16,500	$5,000,000	21,000	$6,000,000	20,000	$6,000,000	21,000	$5,500,000	21,000	$6,000,000
Spouse	17,000	6,000,000	23,000	6,500,000	22,000	6,500,000	24,000	6,000,000	23,500	6,500,000
Child	5,587	2,400,000	8,574	2,250,000	9,076	2,200,000	10,564	3,550,000	9,097	3,045,000
Total	**39,087**	**$13,400,000**	**52,574**	**$14,750,000**	**51,076**	**$14,700,000**	**55,564**	**$15,050,000**	**53,597**	**$15,545,000**
Claims Above $100,000 By Diagnosis	Number	Amount	Number	Amount	Number	Amount	Number	Amount	Number	Amount
Transplants	2	$750,000	3	$500,000	1	$450,000	4	$625,000	0	$0
Neonatal	2	450,000	3	325,000	0	0	2	500,000	1	225,000
Cardiac	8	1,150,000	3	650,000	5	725,000	3	525,000	4	600,000
Stop-Loss Experience										
Specific Stop-Loss Point		$75,000		$75,000		$100,000		$100,000		$100,000
Basis		12/15		12/15		12/15		12/15		12/15
Stop-Loss Premium		$1,260,000		$1,554,000		$1,533,000		$1,776,000		$1,782,000
Claims Reimbursement		$1,900,000		$1,175,000		$575,000		$750,000		$325,000

Claims Analysis for
Local XYZ Welfare Fund

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NETWORK USE AND DISCOUNTS - HOSPITAL

	Dec-06	Dec-07	Dec-08	Dec-09	Dec-10
In-Network Contracted Charges	$6,000,000	$6,950,000	$6,700,000	$7,550,000	$7,250,000
Out-of-Network Charges	$1,000,000	$1,250,000	$1,000,000	$1,200,000	$1,400,000
Total Charges	$7,000,000	$8,200,000	$7,700,000	$8,750,000	$8,650,000
Percentage In-Network	**85.7%**	**84.8%**	**87.0%**	**86.3%**	**83.8%**
In-Network Eligible Billed Charges	$10,000,000	$10,500,000	$11,000,000	$11,000,000	$11,500,000
In-Network Contracted Charges	$6,000,000	$6,950,000	$6,700,000	$7,550,000	$7,250,000
Discounts from Billed Charges	$4,000,000	$3,550,000	$4,300,000	$3,450,000	$4,250,000
In-Network Discount Percentage	**40.0%**	**33.8%**	**39.1%**	**31.4%**	**37.0%**
Access Fees	$1,260,000	$1,554,000	$1,533,000	$1,776,000	$1,782,000
Net Discount after Access Fees	$2,740,000	$1,996,000	$2,767,000	$1,674,000	$2,468,000
Net In-Network Discount Percentage	**27.4%**	**19.0%**	**25.2%**	**15.2%**	**21.5%**

Claims Analysis for
Local XYZ Welfare Fund

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NETWORK USE AND DISCOUNTS - MEDICAL

	Dec-07	Dec-08	Dec-09	Dec-10
In-Network Contracted Charges	$7,100,000	$7,350,000	$7,100,000	$6,650,000
Out-of-Network Charges	$800,000	$750,000	$850,000	$1,000,000
Total Charges	$7,900,000	$8,100,000	$7,950,000	$7,650,000
Percentage In-Network	**89.9%**	**90.7%**	**89.3%**	**86.9%**
In-Network Eligible Billed Charges	$10,100,000	$10,200,000	$10,200,000	$10,250,000
In-Network Contracted Charges	$7,100,000	$7,350,000	$7,100,000	$6,650,000
Discounts from Billed Charges	$3,000,000	$2,850,000	$3,100,000	$3,600,000
In-Network Discount Percentage	**29.7%**	**27.9%**	**30.4%**	**35.1%**
Access Fees	$976,800	$1,095,000	$1,110,000	$1,188,000
Net Discount after Access Fees	$2,023,200	$1,755,000	$1,990,000	$2,412,000
Net In-Network Discount Percentage	**20.0%**	**17.2%**	**19.5%**	**23.5%**

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NETWORK USE AND DISCOUNTS - DENTAL

	Dec-08	Dec-09	Dec-10
In-Network Contracted Charges	$850,000	$900,000	$700,000
Out-of-Network Charges	$700,000	$750,000	$800,000
Total Charges	$1,550,000	$1,650,000	$1,500,000
Percentage In-Network	**54.8%**	**54.5%**	**46.7%**
In-Network Eligible Billed Charges	$1,250,000	$1,300,000	$1,200,000
In-Network Contracted Charges	$850,000	$900,000	$700,000
Discounts from Billed Charges	$400,000	$400,000	$500,000
In-Network Discount Percentage	**32.0%**	**30.8%**	**41.7%**
Access Fees	$131,400	$133,200	$138,600
Net Discount after Access Fees	$268,600	$266,800	$361,400
Net In-Network Discount Percentage	**21.5%**	**20.5%**	**30.1%**

HEALTH BENEFIT SAMPLE REPORT

Local XYZ Plan/Trust/Fund

Health Benefits Reports - Fiscal Year Ending 2011

SEGAL

THE SEGAL COMPANY
330 North Brand Boulevard
Suite 1100
Glendale, CA 91203-2308
T (818) 956-6700 F (818) 956-6790 www.segalco.com

April 15, 2011

Board of Trustees
Local XYZ Plan/Trust/Fund
One World Plaza
Hollywood, CA 9000

Dear Trustees:

We are pleased to present these fiscal 2011 Health Benefits Reports for the Local XYZ Plan/Trust/Fund.

We look forward to reviewing this report with you and answering any questions you may have at the next meeting of the Board of Trustees. However, if there are any questions that need to be addressed prior to the meeting, please do not hesitate to contact us.

Sincerely,

THE SEGAL COMPANY

By: _____

Jim Smith
Health Consultant

cc: *Jim Green*
Linda Black

Section 1 **Financial Experience and Budget Projections**

The projections in this report are estimates of future costs and are based on information available to The Segal Company at the time the projections were made. The Segal Company has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, health trend rates and claims volatility. The accuracy and reliability of health projections decrease as the projection period increases. Unless otherwise noted, these projections do not include any cost or savings impact resulting from the new health care reform legislation or other recently passed state or federal regulations.

The Plan/Trust/Fund Assets do not take into account the cost of paying for benefits which are based on the participants' accumulated eligibility under the Fund's extended eligibility rules.

Projection of retiree costs takes into account only the dollar value of providing benefits for retirees during the period referred to in the projection. It does not reflect the present value of any future retiree benefits for active, disabled or terminated employees during a period other than that which is referred to in the projection.

Section 1

Financial Experience and Budget Projections for Local XYZ Plan/Trust/Fund

Key Findings, Recommendations

- *Based on the audited financial statements for the fiscal year ended December 31, 2010, the Plan experienced an operating surplus of $4,539,056. Net gains of $5,309,208 on investments and an experience refund of $87,303 from Insured PPO increased the total addition to Plan Assets to $9,935,567.*
- *We have projected that the Plan will have an operating deficit of $1,429,200 for the 12 months ended December 31, 2011. The Plan is projected to operate with a deficit of $11,156,200 and $25,530,900 for 2012 and 2013, respectively.*
- *As of December 31, 2010, Plan Assets amounted to $85,388,512 and represented 113 percent of targeted reserves. If all assumptions are met, we project that Plan Assets will decrease by 45 percent to $47,272,212 as of December 31, 2013, which will represent 47 percent of targeted reserves.*
- *The number of actives remained relatively stable at 10,437 for fiscal 2010, compared to 10,400 for fiscal 2009. We have assumed 10,435 active employees for the projected years.*
- *Projected employer contributions are based on the 10,435 actives assumption, including 7,495 Regular Actives working a total of 13,266,200 hours annually, about the same as actually experienced for the fiscal 2010. The projected average hourly contribution rates of $5.97 for 2011 and $6.11 for 2012 and 2013 include the negotiated contribution rates through June 1, 2011.*
- *The number of retirees decreased slightly to 2,146 for fiscal 2010 compared to 2,162 for fiscal 2009. Based on the SOP 92-6, we have assumed slight increases for the number of retirees for the projected years. We encourage the Trustees to continue to review their retiree contribution strategy.*
- *Total income is projected to increase 7.8 percent for calendar year 2011 (5.1 percent annually), 2.6 percent for 2012, and then remain relatively flat for 2013, whereas total expenses are projected to increase 13.5 percent for 2011 (8.8 percent annually), and 10.3 percent for each 2012 and 2013.*
- *In light of the economic downturn, we thought it would be useful to estimate the impact of a change in employer contribution hours during the projected period. The alternate scenarios are shown on the Variations in Hours Assumption page. Since we are unable to estimate whether such a change in contributions will also result in a change in the number of participants that are eligible, we have not anticipated a change in the number of eligibles for the projected period.*
- *We note that the Trustees have authorized the implementation of the Total Health Management programs, including the cardiac care and diabetes targeted programs under the Indemnity Medical program.*
- *These budget projections incorporate the PBM contract pricing improvements and the addition of step therapy. We recommend that the Plan continue participant communication and education promoting the use of generic drugs.*
- *The Plan may want to consider the continued value of offering the Insured HMO plan. As shown on the Per Enrollee Per Month exhibit, the Insured HMO plan costs on a per capita basis are significantly greater than the other medical plans that are offered.*

Financial Experience and Budget Projections for
Local XYZ Plan/Trust/Fund

Plan Assets are shown net of Incurred But Not Reported (IBNR) claims reserve.

Based on the assumptions shown on page 3, the Plan's continuation value is projected to be less than four months by December 31, 2013.

SUMMARY

	Historical Results			Projections		
12 Months Ending	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-11**	**Dec-12**	**Dec-13**
Average Number of Actives	9,834	10,400	10,437	10,435	10,435	10,435
Average Contribution Hours Per Month	149	146	147	148	148	148
Aggregate Hours	12,606,703	13,077,119	13,240,937	13,266,200	13,266,200	13,266,200
Average Contribution Rate	$4.49	$5.12	$5.55	$5.97	$6.11	$6.11
Average Number of Retirees	2,072	2,162	2,146	2,171	2,204	2,226
Total Income	$91,336,259	$106,638,219	$116,218,611	$125,301,300	$128,584,500	$128,549,600
Total Expenses	$87,833,947	$104,374,578	$111,679,555	$126,730,500	$139,740,700	$154,080,500
Average Income Per Active	$773.99	$854.48	$927.93	$1,000.65	$1,026.87	$1,026.58
Average Expenses Per Active	$744.32	$836.34	$891.71	$1,012.08	$1,115.97	$1,230.49
Breakeven Contribution Rate	$4.30	$5.00	$5.31	$6.05	$6.72	$7.49
Recommended Margin				$0.00	$0.00	$0.00
Breakeven Contribution Rate with Margin				$6.05	$6.72	$7.49
Plan/Trust/Fund Assets	$70,379,321	$75,452,944	$85,388,512	$83,959,312	$72,803,112	$47,272,212
Continuation Value (Months)	8.1	8.1	8.1	7.2	5.7	3.3

Observations:

- *Based on the audited financial statements for the fiscal year ended December 31, 2010, the Plan experienced a 13.2 percent increase in assets.*
- *Projected employer contributions are based on 10,435 total active eligibles using the hour and employer contribution rates shown on the following page.*
- *Given the employer and employee contribution rates approved for June 1, 2011 and assuming no further increase, total expenses are projected to exceed total income for the next three calendar years, resulting in operating deficits in each year.*
- *As in prior years, the Plan's continuation value as of December 31, 2010 has remained at 8.1 months. Based on our projection of Plan expenses, the continuation value of Plan assets is expected to decrease to 3.3 months by December 31, 2013, assuming no additional changes to employer contribution rates or changes to the plan of benefits.*

Financial Experience and Budget Projections for Local XYZ Plan/Trust/Fund

Based on projection from SOP 92-6, we have projected slight increases in the number of retirees for future years.

The Trustees may wish to consider soliciting competitive bids for stop loss insurance.

ASSUMPTIONS

12 Months Ending	Dec-11	Dec-12	Dec-13
Average Number of Actives			
Plan A	7,495	7,495	7,495
Plan B	2,115	2,115	2,115
Apprentices	825	825	825
Average Number of Retirees:	2,171	2,204	2,226
Average Contribution Hours per Month:			
Plan A	147.5	147.5	147.5
Plan B	Not Applicable	Not Applicable	Not Applicable
Apprentices	Not Applicable	Not Applicable	Not Applicable
Aggregate Hours	13,266,200	13,266,200	13,266,200
Average Contribution Rate			
Plan A (Per Hour)	$6.55	$6.70	$6.70
Plan B (Per Month)	$697.50	$720.00	$720.00
Apprentices (Per Month)	$570.00	$580.00	$580.00
Trend Factors			
Indemnity Medical	11.00%	11.00%	11.00%
Insured HMO	Renewal	11.00%	11.00%
Insured PPO	Renewal	11.00%	11.00%
Insured POS	Renewal	11.00%	11.00%
Prescription Drugs	10.00%	10.00%	10.00%
Prescription Drug Rebate	6.00%	6.00%	6.00%
Insured Stop Loss	Renewal	16.50%	16.50%
Indemnity Dental	7.00%	7.00%	7.00%
Prepaid Dental	Renewal	2nd Year	5.00%
Vision	3.00%	3.00%	3.00%
EAP, Hearing Aid	3.00%	3.00%	3.00%
Medicare Part D Subsidy	9.00%	9.00%	9.00%
Insured Life and AD&D	0.00%	0.00%	0.00%
Medical ASO Fees	5.00%	5.00%	5.00%
Operating Costs	5.00%	5.00%	5.00%
Investment Yield	3.00%	3.00%	3.00%

Financial Experience and Budget Projections for Local XYZ Plan/Trust/Fund

Projected employer contributions reflect the current negotiated contribution rate increases. Actual contributions include net reciprocity.

Projected Indemnity Medical expenses have been adjusted for benefit design changes that became effective January 1, 2011. The full impact of the Total Health Management

Projected results have not been adjusted for any plan changes that may be needed to comply with Mental Health Parity & Addiction Equity Act of 2008 or other new legislations.

AGGREGATE

	Historical Results			Projections		
12 Months Ending	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-11**	**Dec-12**	**Dec-13**
Income						
Employer Contributions	$79,079,713	$93,352,708	$102,348,287	$110,238,800	$112,898,800	$112,898,800
Employee Contributions	5,148,204	5,985,264	6,596,712	6,655,500	6,665,400	6,665,400
COBRA Contributions	1,125,067	1,182,940	1,237,138	1,394,900	1,536,600	1,693,500
Retiree Contributions	2,833,012	3,194,837	3,517,292	4,591,900	5,113,700	5,661,500
Investment Income	3,150,263	2,922,470	2,519,182	2,420,200	2,370,000	1,630,400
Total Income	**$91,336,259**	**$106,638,219**	**$116,218,611**	**$125,301,300**	**$128,584,500**	**$128,549,600**
Expenses						
Indemnity Medical	$21,942,301	$26,594,237	$27,184,499	$31,824,300	$35,342,100	$39,239,100
Insured HMO	31,260,874	38,597,782	41,252,533	46,177,100	51,262,700	56,903,600
Insured PPO	10,915,272	12,459,619	14,516,328	15,591,500	17,356,300	19,286,100
Insured POS	4,121,529	4,590,977	5,129,592	5,943,100	6,596,800	7,322,500
Prescription Drugs	6,707,325	7,830,751	8,617,453	9,969,900	10,966,400	11,981,800
Prescription Drug Rebate	(668,038)	(757,187)	(815,696)	(897,900)	(958,500)	(1,021,900)
Insured Stop Loss	568,326	596,394	594,772	785,300	915,100	1,066,400
Indemnity Dental	5,666,076	6,314,221	7,404,957	8,558,700	9,163,600	9,809,300
Prepaid Dental	1,035,595	1,131,567	1,164,150	1,253,700	1,254,500	1,317,600
Vision	1,413,256	1,507,853	1,528,245	1,668,100	1,719,200	1,771,600
EAP, Hearing Aid	350,265	373,721	404,021	422,800	436,000	449,500
Medicare Part D Subsidy	0	(185,968)	(682,618)	(497,700)	(550,900)	(606,200)
Insured Life and AD&D	745,050	868,664	631,000	765,900	766,400	766,800
Medical ASO Fees	397,887	437,539	454,951	478,000	502,000	527,200
Operating Costs	3,378,229	4,014,407	4,295,367	4,687,700	4,969,000	5,267,100
Total Expenses	**$87,833,947**	**$104,374,578**	**$111,679,555**	**$126,730,500**	**$139,740,700**	**$154,080,500**
Operating Surplus (Deficit)	**$3,502,312**	**$2,263,641**	**$4,539,056**	**($1,429,200)**	**($11,156,200)**	**($25,530,900)**
Insured POS Experience Deficit	0	(264,879)	0			
Insured PPO Dividend	34,029	0	87,303			
Life/AD&D Stabilization Reserve Refund	83,250	34,924	0			
Gains (Losses) on Investments	(623,677)	3,039,937	5,309,208			
Total Addition (Reduction) to Plan/Trust/Fu	**$2,995,914**	**$5,073,623**	**$9,935,567**	**($1,429,200)**	**($11,156,200)**	**($25,530,900)**
Beginning Plan/Trust/Fund Assets	**$67,383,407**	**$70,379,321**	**$75,452,944**	**$85,388,512**	**$83,959,312**	**$72,803,112**
Ending Plan/Trust/Fund Assets	**$70,379,321**	**$75,452,944**	**$85,388,512**	**$83,959,312**	**$72,803,112**	**$47,272,212**
Breakeven Contribution Rate	**$4.30**	**$5.00**	**$5.31**	**$6.05**	**$6.72**	**$7.49**
Recommended Margin				**$0.00**	**$0.00**	**$0.00**
Breakeven Contribution Rate with Margin				**$6.05**	**$6.72**	**$7.49**

Note that 2009 & 2010 Indemnity Medical expenses are net of Stop-Loss reimbursements in the amount of $1,419,650 and $30,790, respectively.

Financial Experience and Budget Projections for
Local XYZ Plan/Trust/Fund

The Indemnity Medical Plan had favorable claims experience (lower than projected) for the fiscal year ended December 31, 2010.

Total expenses are projected to increase 13.5% for 2011 and 10.3% for 2012 and 2013. This compares to income that is estimated to increase 7.8% for 2011, 2.6% for 2012, and remains flat for 2013.

PER ACTIVE PER MONTH

	Historical Results			Projections		
12 Months Ending	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-11**	**Dec-12**	**Dec-13**
Income						
Employer Contributions	$670.12	$748.02	$817.19	$880.36	$901.60	$901.60
Employee Contributions	43.63	47.96	52.67	53.15	53.23	53.23
COBRA Contributions	9.53	9.48	9.88	11.14	12.27	13.52
Retiree Contributions	24.01	25.60	28.08	36.67	40.84	45.21
Investment Income	26.70	23.42	20.11	19.33	18.93	13.02
Total Income	**$773.99**	**$854.48**	**$927.93**	**$1,000.65**	**$1,026.87**	**$1,026.58**
Expenses						
Indemnity Medical	$185.94	$213.09	$217.05	$254.15	$282.24	$313.36
Insured HMO	264.90	309.28	329.38	368.77	409.38	454.43
Insured PPO	92.50	99.84	115.90	124.51	138.61	154.02
Insured POS	34.93	36.79	40.96	47.46	52.68	58.48
Prescription Drugs	56.84	62.75	68.81	79.62	87.58	95.69
Prescription Drug Rebate	(5.66)	(6.07)	(6.51)	(7.17)	(7.65)	(8.16)
Insured Stop Loss	4.82	4.78	4.75	6.27	7.31	8.52
Indemnity Dental	48.01	50.59	59.12	68.35	73.18	78.34
Prepaid Dental	8.78	9.07	9.30	10.01	10.02	10.52
Vision	11.98	12.08	12.20	13.32	13.73	14.15
EAP, Hearing Aid	2.97	2.99	3.23	3.38	3.48	3.59
Medicare Part D Subsidy	0.00	(1.49)	(5.45)	(3.97)	(4.40)	(4.84)
Insured Life and AD&D	6.31	6.96	5.04	6.12	6.12	6.12
Medical ASO Fees	3.37	3.51	3.63	3.82	4.01	4.21
Operating Costs	28.63	32.17	34.30	37.44	39.68	42.06
Total Expenses	**$744.32**	**$836.34**	**$891.71**	**$1,012.08**	**$1,115.97**	**$1,230.49**
Operating Surplus (Deficit)	**$29.67**	**$18.14**	**$36.22**	**($11.43)**	**($89.10)**	**($203.91)**
Insured POS Experience Deficit	0.00	(2.12)	0.00			
Insured PPO Dividend	0.29	0.00	0.70			
Life/AD&D Stabilization Reserve Refund	0.71	0.28	0.00			
Gains (Losses) on Investments	(5.29)	24.36	42.39			
Total Addition (Reduction) to Plan/Trust/F	**$25.38**	**$40.66**	**$79.31**	**($11.43)**	**($89.10)**	**($203.91)**
Average Number of Actives	**9,834**	**10,400**	**10,437**	**10,435**	**10,435**	**10,435**
Breakeven Contribution Rate	**$4.30**	**$5.00**	**$5.31**	**$6.05**	**$6.72**	**$7.49**
Recommended Margin				**$0.00**	**$0.00**	**$0.00**
Breakeven Contribution Rate with Margin				**$6.05**	**$6.72**	**$7.49**

Financial Experience and Budget Projections for Local XYZ Plan/Trust/Fund

PER ENROLLEE PER MONTH

Expenses for each benefit item are shown on a per capita basis for those enrolled in each benefit, including both actives and retirees.

The number of enrollees include actives and retirees. We have assumed no change in active plan enrollment and the number of retirees is projected to increase based on SOP 92-6 valuation as of December 31, 2008

				Projections		
12 Months Ending	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-11**	**Dec-12**	**Dec-13**
Average Expenses Per Enrollee Per Month						
Indemnity Medical	$435.47	$504.02	$518.04	$605.21	$670.27	$742.83
Insured HMO	576.73	670.66	709.98	794.40	881.35	977.93
Insured PPO	383.64	412.52	475.88	508.53	562.13	621.73
Insured POS	419.37	449.04	517.51	600.31	666.34	739.65
Prescription Drugs	100.17	111.09	122.38	141.34	155.10	169.21
Prescription Drug Rebate	(9.98)	(10.74)	(11.58)	(12.73)	(13.56)	(14.43)
Insured Stop Loss	13.52	13.52	13.52	17.85	20.79	24.22
Indemnity Dental	69.39	72.92	84.97	87.74	93.79	100.29
Prepaid Dental	28.49	29.62	30.56	31.82	31.82	33.41
Vision	11.98	12.08	12.20	12.18	12.54	12.91
EAP, Hearing Aid	5.23	5.30	5.74	5.99	6.17	6.35
Medicare Part D Subsidy	0.00	(21.49)	(80.46)	(58.01)	(63.23)	(68.92)
Insured Life and AD&D	5.60	6.18	4.47	5.42	5.41	5.40
Medical ASO Fees	9.47	9.92	10.34	10.86	11.40	11.97
Operating Costs	23.65	26.63	28.45	30.99	32.76	34.67
Average Number of Enrollees						
Indemnity Medical	4,199	4,397	4,373	4,382	4,394	4,402
Insured HMO	4,517	4,796	4,842	4,844	4,847	4,849
Insured PPO	2,371	2,517	2,542	2,555	2,573	2,585
Insured POS	819	852	826	825	825	825
Prescription Drugs	5,580	5,874	5,868	5,878	5,892	5,901
Prescription Drug Rebate	5,580	5,874	5,868	5,878	5,892	5,901
Insured Stop Loss	3,503	3,676	3,666	3,667	3,668	3,669
Indemnity Dental	6,805	7,216	7,262	8,129	8,142	8,151
Prepaid Dental	3,029	3,184	3,175	3,283	3,285	3,286
Vision	9,834	10,400	10,437	11,412	11,427	11,437
EAP, Hearing Aid	5,580	5,874	5,868	5,878	5,892	5,901
Medicare Part D Subsidy	696	721	707	715	726	733
Insured Life and AD&D	11,087	11,710	11,757	11,781	11,814	11,836
Medical ASO Fees	3,503	3,676	3,666	3,667	3,668	3,669
Operating Costs	11,906	12,562	12,583	12,606	12,639	12,661
Total Number of Employees and Retirees	**11,906**	**12,562**	**12,583**	**12,606**	**12,639**	**12,661**

Financial Experience and Budget Projections for Local XYZ Plan/Trust/Fund

VARIATIONS IN HOURS ASSUMPTIONS

12 Months Ending	Dec-11	Dec-12	Dec-13
Current Assumptions			
Average Hours	147.5	147.5	147.5
Ending Plan/Trust/Fund Assets	$83,959,312	$72,803,112	$47,272,212
Continuation Value (Months)	7.2	5.7	3.3
Breakeven Contribution Rate	$6.05	$6.72	$7.49
Alternate Assumption 1			
Average Hours	157.5	157.5	157.5
Ending Plan/Trust/Fund Assets	$90,022,512	$85,110,512	$66,211,512
Continuation Value (Months)	7.7	6.6	4.7
Breakeven Contribution Rate	$5.65	$6.28	$6.99
Alternate Assumption 2			
Average Hours	137.5	137.5	137.5
Ending Plan/Trust/Fund Assets	$78,063,542	$60,559,962	$28,691,682
Continuation Value (Months)	6.7	4.7	2.0
Breakeven Contribution Rate	$6.49	$7.22	$8.06
Average Contribution Rate Per Hour	$5.97	$6.11	$6.11

Projected contributions were based on 13,266,200 annual aggregate hours for Regular Actives, consistent with the Plan's historical norm. We have shown the impact if actual hours differ from this assumption.

A change in the hourly assumption by 10 hours per active per month (899,400 annually) impacts the asset level at the end of 2013 by approximately $19 million.

Given the current economic and industry outlook, we look to the Trustees for guidance on making the appropriate work-level assumption.

Observations:

- *The results of this projection are based on the employer contribution assumption of 7,495 Plan A Actives, a total of 13,266,200 hours annually. The alternate scenarios shown above are intended to illustrate the general effect of changes in employment levels.*
- *Using the current hours assumption, we have projected the Plan to incur a deficit of $1,429,200, $11,156,200 and $25,530,900 for 2011, 2012 and 2013, respectively.*
- *If average hours increase by 10 hours per active per month as shown in the first alternate scenario, the Plan is projected to incur a surplus of $4,634,000 in 2011. The deficits for 2012 and 2013 decrease to $4,912,000 and $18,899,000, respectively. Plan assets as of December 31, 2013 would be about 40 percent greater than currently projected, and the continuation value would increase to 4.7 months.*
- *If average hours decrease by 10 hours per active per month as shown in the second alternate scenario, the deficit in 2011 increases to 7,625,000. The deficits for 2012 and 2013 increase to $17,503,600 and $31,868,300, respectively. Plan assets as of December 31, 2013 would be about 39 percent less than currently projected, and the continuation value would decrease to 2.0 months.*

Financial Experience and Budget Projections for Local XYZ Plan/Trust/Fund

The year-to-date financials are shown here on a paid basis, which differs from the results of the projections, which are shown on an incurred basis.

The Trustees may wish to consider conducting a claims audit for the Indemnity Medical Plan, as the last audit was completed in 2001.

Also note that the year-to-date financial experience does not reflect the full impact of the January 2011 renewals and the seasonality of work.

PAID FINANCIAL INFORMATION – FROM JANUARY 2011 THROUGH SEPTEMBER 2011

	Aggregate	Per Employee Per Month
Income		
Employer Contributions	$80,327,275	$863.93
Employee Contributions	4,873,161	52.41
COBRA Contributions	983,165	10.57
Retiree Contributions	3,381,892	36.37
Investment Income	0	0.00
Total Income	**$90,729,052**	**$975.79**
Expenses		
Indemnity Medical	$23,055,988	$247.97
Insured HMO	33,670,802	362.13
Insured PPO	11,268,857	121.20
Insured POS	4,243,031	45.63
Prescription Drugs	7,141,900	76.81
Prescription Drug Rebate	(651,121)	(7.00)
Insured Stop Loss	569,468	6.12
Indemnity Dental	6,206,429	66.75
Prepaid Dental	909,133	9.78
Vision	1,209,640	13.01
EAP, Hearing Aid	306,598	3.30
Medicare Part D Subsidy	0	0.00
Insured Life and AD&D	257,800	2.77
Medical ASO Fees	347,776	3.74
Operating Costs	0	0.00
Total Expenses	**$91,935,633**	**$952.21**
Operating Surplus (Deficit)	**$(1,206,581)**	**$23.58**
Losses on Investments	**$(1,749,204)**	**$(18.81)**
Total Addition/(Reduction) to Plan/Trust/Fund Assets	**$(2,955,785)**	**$4.77**
Plan/Trust/Fund Assets	**$82,432,727**	
Average Number of Actives	**10,331**	**10,331**

Financial Experience and Budget Projections
Local XYZ Plan/Trust/Fund

The investment income is allocated amongst the actives based on the percentage of total employer contributions attributable to each active group.

The Plan had two significant large claims during the 2009 fiscal year, for which $1.4 million in reimbursements were received in 2008-2010. The amount of reimbursement received during the last three years has offset over 80% of the $1.7 million in stop loss premiums.

PLAN A ACTIVES - AGGREGATE

	Historical Results			Projections		
12 Months Ending	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-11**	**Dec-12**	**Dec-13**
Income						
Employer Contributions	$58,028,700	$68,628,700	$74,175,700	$79,597,200	$80,923,800	$80,923,800
COBRA Contributions	908,494	950,830	1,000,441	1,136,800	1,252,000	1,379,700
Investment Income	2,644,210	2,449,475	2,126,239	2,042,900	2,007,400	1,380,900
Total Income	**$61,581,404**	**$72,029,005**	**$77,302,380**	**$82,776,900**	**$84,183,200**	**$83,684,400**
Expense						
Indemnity Medical	$20,160,969	$25,906,944	$25,013,365	$29,252,100	$32,469,800	$36,041,500
Insured HMO	20,894,289	25,717,123	26,917,596	30,397,100	33,740,800	37,452,300
Insured PPO	4,859,980	5,452,699	6,150,519	6,558,300	7,279,800	8,080,500
Prescription Drugs	4,501,075	5,367,560	5,905,198	6,814,300	7,461,700	8,133,200
Prescription Drug Rebate	(507,482)	(574,433)	(621,488)	(678,400)	(719,100)	(762,300)
Insured Stop Loss	558,592	586,173	584,875	772,000	899,400	1,047,800
Stop Loss Reimbursement	0	(1,391,285)	(20,395)	0	0	0
Indemnity Dental	4,636,320	5,242,129	6,139,249	6,792,800	7,268,200	7,777,000
Prepaid Dental	490,670	544,282	561,226	576,000	576,000	604,800
Vision	1,087,332	1,172,634	1,168,036	1,221,300	1,257,900	1,295,700
EAP, Hearing Aid	298,254	316,937	340,782	356,500	367,200	378,200
Insured Life and AD&D	645,500	800,250	483,000	657,800	657,800	657,800
Medical ASO Fees	391,069	430,039	447,382	469,700	493,200	517,800
Operating Costs	1,999,655	2,383,598	2,559,134	2,787,200	2,946,400	3,118,200
Total Expenses	**$60,016,224**	**$71,954,650**	**$75,628,480**	**$85,976,700**	**$94,699,100**	**$104,342,500**
Operating Surplus (Deficit)	**$1,565,181**	**$74,355**	**$1,673,900**	**$(3,199,800)**	**$(10,515,900)**	**$(20,658,100)**
Average Number of Actives	**7,054**	**7,460**	**7,497**	**7,495**	**7,495**	**7,495**
Average Monthly Hours Per Active	**148.9**	**146.1**	**147.2**	**147.5**	**147.5**	**147.5**

Financial Experience and Budget Projections
Local XYZ Plan/Trust/Fund

Employer contributions shown for the Plan A Actives are net of amounts allocated for the retiree plan.

Assuming a monthly average of 147.5 hours per active, the Plan A Actives is projected to incur a deficit in each of the next three years.

PLAN A ACTIVES - PER HOUR

	Historical Results			Projections		
12 Months Ending	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-11**	**Dec-12**	**Dec-13**
Income						
Employer Contributions	$4.60	$5.25	$5.60	$6.00	$6.10	$6.10
COBRA Contributions	0.07	0.07	0.08	0.09	0.09	0.10
Investment Income	0.21	0.19	0.16	0.15	0.15	0.10
Total Income	**$4.88**	**$5.51**	**$5.84**	**$6.24**	**$6.34**	**$6.30**
Expense						
Indemnity Medical	$1.60	$1.98	$1.89	$2.21	$2.45	$2.72
Insured HMO	1.66	1.97	2.03	2.29	2.54	2.82
Insured PPO	0.39	0.42	0.46	0.49	0.55	0.61
Prescription Drugs	0.36	0.41	0.45	0.51	0.56	0.61
Prescription Drug Rebate	(0.04)	(0.04)	(0.05)	(0.05)	(0.05)	(0.06)
Insured Stop Loss	0.04	0.04	0.04	0.06	0.07	0.08
Stop Loss Reimbursement	0.00	(0.11)	0.00	0.00	0.00	0.00
Indemnity Dental	0.37	0.40	0.46	0.51	0.55	0.59
Prepaid Dental	0.04	0.04	0.04	0.04	0.04	0.05
Vision	0.09	0.09	0.09	0.09	0.09	0.10
EAP, Hearing Aid	0.02	0.02	0.03	0.03	0.03	0.03
Insured Life and AD&D	0.05	0.06	0.04	0.05	0.05	0.05
Medical ASO Fees	0.03	0.03	0.03	0.04	0.04	0.04
Operating Costs	0.00	0.00	0.00	0.00	0.00	0.00
Total Expenses	**$4.77**	**$5.49**	**$5.70**	**$6.48**	**$7.14**	**$7.88**
Operating Surplus (Deficit)	**$0.11**	**$0.02**	**$0.14**	**$(0.24)**	**$(0.80)**	**$(1.58)**
Average Number of Actives	**7,046**	**7,459**	**7,496**	**7,495**	**7,495**	**7,495**
Average Monthly Hours Per Active	**148.9**	**146.1**	**147.2**	**147.5**	**147.5**	**147.5**
Aggregate Hours	**12,606,703**	**13,077,119**	**13,240,934**	**13,266,200**	**13,266,200**	**13,266,200**

Financial Experience and Budget Projections
Local XYZ Plan/Trust/Fund

The current employee contribution is $240 per active per month for Plan B Actives.

Total income is projected to exceed total expenses for the Plan B actives in 2011 and 2012.

PLAN B AGGREGATE - AGGREGATE

	Historical Results			Projections		
12 Months Ending	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-11**	**Dec-12**	**Dec-13**
Income						
Employer Contributions	$12,286,560	$14,790,120	$16,497,000	$17,702,600	$18,273,600	$18,273,600
Employee Contributions	4,725,600	5,514,960	6,091,200	6,091,200	6,091,200	6,091,200
COBRA Contributions	192,141	208,633	209,995	227,400	250,800	276,600
Investment Income	519,254	490,499	434,137	416,200	412,700	283,900
Total Income	**$17,723,555**	**$21,004,212**	**$23,232,332**	**$24,437,400**	**$25,028,300**	**$24,925,300**
Expense						
Insured HMO	$9,629,764	$11,997,042	$13,399,662	$14,696,900	$16,313,500	$18,108,000
Insured POS	3,112,009	3,540,723	4,087,450	4,222,300	4,686,700	5,202,300
Prescription Drugs	547,130	632,137	671,409	771,800	845,100	921,200
Prescription Drug Rebate	(55,491)	(61,589)	(64,849)	(70,500)	(74,700)	(79,200)
Indemnity Dental	1,029,756	1,072,092	1,265,708	1,400,900	1,499,000	1,603,900
Prepaid Dental	278,940	306,432	318,240	326,400	326,400	342,700
Vision	237,280	244,358	267,031	279,100	287,500	296,100
EAP, Hearing Aid	30,825	32,854	35,726	37,200	38,300	39,500
Insured Life and AD&D	84,550	48,414	83,000	74,300	74,300	74,300
Operating Costs	558,802	667,561	722,061	786,500	831,400	879,900
Total Expenses	**$15,453,565**	**$18,480,024**	**$20,785,438**	**$22,524,900**	**$24,827,500**	**$27,388,700**
Operating Surplus (Deficit)	**$2,269,990**	**$2,524,188**	**$2,446,894**	**$1,912,500**	**$200,800**	**$(2,463,400)**
Average Number of Actives	**780**	**825**	**825**	**825**	**825**	**825**
Average Monthly Hours Per Active	**149**	**146**	**147**	**148**	**148**	**148**

Financial Experience and Budget Projections
Local XYZ Plan/Trust/Fund

After a 6% increase in 2009, the number of Plan B actives increased 1% in 2010. We have assumed the group remains at 2,115 actives for the next three years.

PLAN B - PER ENROLLEE PER MONTH

	Historical Results			Projections		
12 Months Ending	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-11**	**Dec-12**	**Dec-13**
Average Expenses Per Enrollee Per Month						
Insured HMO	$553.43	$647.93	$714.42	$782.58	$868.66	$964.22
Insured POS	499.68	540.40	617.07	639.74	710.11	788.22
Prescription Drugs	87.85	96.48	101.36	116.94	128.05	139.57
Prescription Drug Rebate	(8.91)	(9.40)	(9.79)	(10.68)	(11.33)	(12.00)
Indemnity Dental	73.47	71.53	83.38	92.29	98.75	105.66
Prepaid Dental	29.02	30.40	31.20	32.00	32.00	33.60
Vision	10.04	9.75	10.52	11.00	11.33	11.67
EAP, Hearing Aid	4.95	5.01	5.39	5.63	5.80	5.98
Insured Life and AD&D	3.58	1.93	3.27	2.93	2.93	2.93
Operating Costs	23.65	26.63	28.45	30.99	32.76	34.67
Average Number of Enrollees						
Insured HMO	1,450	1,543	1,563	1,565	1,565	1,565
Insured POS	519	546	552	550	550	550
Prescription Drugs	519	546	552	550	550	550
Prescription Drug Rebate	519	546	552	550	550	550
Indemnity Dental	1,168	1,249	1,265	1,265	1,265	1,265
Prepaid Dental	801	840	850	850	850	850
Vision	1,969	2,089	2,115	2,115	2,115	2,115
EAP, Hearing Aid	519	546	552	550	550	550
Insured Life and AD&D	1,969	2,089	2,115	2,115	2,115	2,115
Operating Costs	1,969	2,089	2,115	2,115	2,115	2,115

Financial Experience and Budget Projections
Local XYZ Plan/Trust/Fund

APPRENTICES - AGGREGATE

	Historical Results			Projections		
12 Months Ending	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-11**	**Dec-12**	**Dec-13**
Income						
Employer Contributions	$4,226,040	$4,703,040	$5,055,120	$5,643,000	$5,742,000	$5,742,000
Employee Contributions	422,604	470,304	505,512	564,300	574,200	574,200
COBRA Contributions	24,432	23,477	26,702	30,700	33,800	37,200
Investment Income	178,601	155,971	133,031	132,700	129,700	89,200
Total Income	**$4,851,677**	**$5,352,792**	**$5,720,365**	**$6,370,700**	**$6,479,700**	**$6,442,600**
Expense						
Insured POS	$4,121,529	$4,590,977	$5,129,592	$5,943,100	$6,596,800	$7,322,500
Dental DMO	265,985	280,853	284,684	309,900	309,900	325,400
Vision	88,644	90,861	93,178	97,300	100,200	103,200
Operating Costs	232,432	272,265	281,996	306,800	324,300	343,200
Total Expenses	**$4,708,590**	**$5,234,956**	**$5,789,450**	**$6,657,100**	**$7,331,200**	**$8,094,300**
Operating Surplus (Deficit)	**$143,087**	**$117,836**	**$(69,085)**	**$(286,400)**	**$(851,500)**	**$(1,651,700)**
Average Number of Actives	**780**	**825**	**825**	**825**	**825**	**825**
Average Monthly Hours Per Active	**149**	**146**	**147**	**148**	**148**	**148**

The Apprentices are required to enroll in the Insured POS medical and dental plans until they graduate to the Plan A Active Plan.

The number of Apprentices increased 4% in 2008, but decreased 3% last year. We have assumed the participation remains level for the next three years.

As the increase in income is not projected to keep pace with the increase in costs, the Trustees may wish to consider moderate benefit reductions to control costs.

Financial Experience and Budget Projections
Local XYZ Plan/Trust/Fund

Dental and vision benefits are offered to retirees on a 100% self-pay basis effective January 1, 2011. We have assumed that 45% of retirees would choose to self-pay for dental and vision coverage.

Per Trustee policy, retiree contributions equal 40% of the cost of medical, drug, and life and AD&D benefits.

Combined income in the retiree plan is projected to exceed expenses in 2011 and 202. There would be a subsidy in 2013 of $0.03 per hour. This subsidy is in addition to the employer contributions allocated for retiree benefits.

RETIREE - PER MONTH

	Historical Results			Projections		
12 Months Ending	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-11**	**Dec-12**	**Dec-13**
Income						
Employer Contributions	$182.53	$201.62	$257.09	$280.07	$300.96	$297.99
Retiree Contributions	113.94	123.14	136.58	176.26	193.35	211.95
Total Income	**$296.47**	**$324.76**	**$393.67**	**$456.33**	**$494.31**	**$509.94**
Expense						
Indemnity Medical	$71.64	$81.21	$85.50	$98.73	$108.60	$119.71
Insured HMO	29.63	34.06	36.32	41.57	45.69	50.29
Insured PPO	118.38	133.60	166.14	184.67	203.79	224.74
Prescription Drugs	66.73	70.58	79.25	91.50	100.56	109.59
Prescription Drug Rebate	(4.23)	(4.67)	(5.02)	(5.72)	(6.23)	(6.75)
Insurred Stop Loss	0.39	0.39	0.38	0.51	0.59	0.70
Stop Loss Reimbursement	0.00	(1.09)	(0.40)	0.00	0.00	0.00
Indemnity Dental	0.00	0.00	0.00	14.01	14.99	16.04
Dental DMO	0.00	0.00	0.00	1.59	1.60	1.67
Vision Claims	0.00	0.00	0.00	2.70	2.78	2.87
EAP, Hearing Aid	0.85	0.92	1.07	1.12	1.15	1.19
Medicare Part D Subsidy	0.00	(7.17)	(26.51)	(19.10)	(20.83)	(22.69)
Insured Life and AD&D	0.60	0.77	2.52	1.30	1.30	1.30
Medical ASO Fees	0.27	0.29	0.29	0.32	0.33	0.35
Operating Costs	23.65	26.63	28.45	30.99	32.76	34.67
Total Expenses	**$307.91**	**$335.52**	**$367.99**	**$444.19**	**$487.08**	**$533.68**
Operating Surplus (Deficit)	**$(11.44)**	**$(10.76)**	**$25.68**	**$12.14**	**$7.23**	**$(23.74)**
Subsidy Per Active Per Month	**(2.41)**	**(2.24)**	**5.28**	**2.53**	**1.53**	**(5.06)**
Subsidy Per Active Per Hour	**(0.02)**	**(0.02)**	**0.04**	**0.02**	**0.01**	**(0.03)**
Income as a % of Expense	**96.3%**	**96.8%**	**107.0%**	**102.7%**	**101.5%**	**95.6%**
Average Number of Retirees	**2,072**	**2,162**	**2,146**	**2,171**	**2,204**	**2,226**

Financial Experience and Budget Projections
Local XYZ Plan/Trust/Fund

There was one large claim in the non-Medicare retiree group. The reimbursements received have more than offset the cost for the stop loss coverage in the most recent three-year period.

Non-Medicare retirees represent only 10% of the retiree population but account for 37% of total retiree expenses.

NON-MEDICARE RETIREES - PER MONTH

	Historical Results			Projections		
12 Months Ending	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-11**	**Dec-12**	**Dec-13**
Income						
Employer Contributions	$182.53	$201.62	$257.09	$280.06	$300.95	$298.00
Retiree Contributions	422.39	463.83	514.14	603.72	668.17	739.56
Total Income	**$604.92**	**$665.45**	**$771.23**	**$883.78**	**$969.12**	**$1,037.56**
Expense						
Indemnity Medical	$312.44	$364.56	$382.32	$446.32	$496.77	$555.28
Insured HMO	112.77	124.29	130.45	148.66	162.85	179.18
Insured PPO	461.94	512.05	586.50	646.39	718.80	796.83
Prescription Drugs	162.66	168.52	192.71	221.80	243.39	265.68
Prescription Drug Rebate	(8.01)	(9.57)	(11.07)	(12.57)	(13.66)	(14.77)
Insurred Stop Loss	3.81	3.82	3.75	4.95	5.76	6.77
Stop Loss Reimbursement	0.00	(10.60)	(3.94)	0.00	0.00	0.00
Indemnity Dental	0.00	0.00	0.00	14.06	15.01	16.08
Dental DMO	0.00	0.00	0.00	1.56	1.54	1.60
Vision Claims	0.00	0.00	0.00	2.72	2.79	2.87
EAP, Hearing Aid	2.45	2.71	3.36	3.50	3.63	3.75
Insured Life and AD&D	3.91	1.87	0.00	1.30	1.28	1.31
Medical ASO Fees	2.67	2.80	2.87	3.09	3.23	3.42
Operating Costs	23.65	26.63	28.45	30.99	32.75	34.68
Total Expenses	**$1,078.29**	**$1,187.08**	**$1,315.40**	**$1,512.77**	**$1,674.14**	**$1,852.68**
Operating Surplus (Deficit)	**$(473.37)**	**$(521.63)**	**$(544.17)**	**$(628.99)**	**$(705.02)**	**$(815.12)**
Subsidy Per Active Per Month	**(10.25)**	**(11.18)**	**(11.47)**	**(13.50)**	**(15.34)**	**(17.89)**
Subsidy Per Active Per Hour	**(0.07)**	**(0.08)**	**(0.08)**	**(0.09)**	**(0.10)**	**(0.12)**
Income as a % of Expense	**56.1%**	**56.1%**	**58.6%**	**58.4%**	**57.9%**	**56.0%**
Average Number of Retirees	**213**	**223**	**220**	**224**	**227**	**229**

Financial Experience and Budget Projections
Local XYZ Plan/Trust/Fund

MEDICARE RETIREES - PER MONTH

	Historical Results			Projections		
12 Months Ending	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-11**	**Dec-12**	**Dec-13**
Income						
Employer Contributions	$182.53	$201.62	$257.09	$280.07	$300.96	$297.98
Retiree Contributions	78.60	83.96	93.46	127.08	138.83	151.44
Total Income	**$261.13**	**$285.58**	**$350.55**	**$407.15**	**$439.79**	**$449.42**
Expense						
Indemnity Medical	$44.05	$48.62	$51.60	$58.74	$64.03	$69.76
Insured HMO	20.11	23.68	25.57	29.25	32.24	35.51
Insured PPO	79.01	90.08	118.12	131.54	144.66	159.14
Prescription Drugs	55.74	59.31	66.29	76.51	84.16	91.69
Prescription Drug Rebate	(3.79)	(4.11)	(4.33)	(4.93)	(5.37)	(5.83)
Indemnity Dental	0.00	0.00	0.00	14.00	14.98	16.03
Dental DMO	0.00	0.00	0.00	1.59	1.60	1.68
Vision Claims	0.00	0.00	0.00	2.70	2.78	2.87
EAP, Hearing Aid	0.67	0.72	0.81	0.84	0.87	0.90
Medicare Part D Subsidy	0.00	(7.99)	(29.54)	(21.30)	(23.22)	(25.30)
InsuredLife and AD&D	0.22	0.64	2.81	1.30	1.30	1.30
Operating Costs	23.65	26.63	28.45	30.99	32.76	34.67
Total Expenses	**$219.66**	**$237.58**	**$259.78**	**$321.23**	**$350.79**	**$382.42**
Operating Surplus	**$41.47**	**$48.00**	**$90.77**	**$85.92**	**$89.00**	**$67.00**
Subsidy Per Active Per Month	**7.84**	**8.95**	**16.75**	**16.03**	**16.86**	**12.82**
Subsidy Per Active Per Hour	**0.05**	**0.06**	**0.11**	**0.11**	**0.11**	**0.09**
Income as a % of Expense	**118.9%**	**120.2%**	**134.9%**	**126.7%**	**125.4%**	**117.5%**
Average Number of Retirees	**1,859**	**1,939**	**1,926**	**1,947**	**1,977**	**1,997**

The Trustees may wish to consider alternatives to the Medicare Part D Retiree Drug Subsidy.

Financial Experience and Budget Projections for
Local XYZ Plan/Trust/Fund

OTHER OPTIONS/ADDITIONAL PAGES

	Historical Results			Projections		
12 Months Ending	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-11**	**Dec-12**	**Dec-13**

Financial Experience and Budget Projections for Local XYZ Plan/Trust/Fund

Plan Assets projected for December 31, 2013, represent 55% of the Plan Assets as of December 31, 2010.

Plan Assets are projected to be almost even with Targeted Reserves for 2011, but are projected to fall short of Targeted Reserves for 2012 and 2013.

PLAN/TRUST/FUND ASSET POSITION

	Historical Results			Projections		
12 Months Ending	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-11**	**Dec-12**	**Dec-13**
Plan/Trust/Fund Assets as of Period En	$70,379,321	$75,452,944	$85,388,512	$83,959,312	$72,803,112	$47,272,212
Incurred But Not Reported Claims	6,326,000	7,794,000	7,906,500	9,197,500	10,125,600	11,138,600
Auditor's Statement of Plan/Trust/Fun	$76,705,321	$83,246,944				

TARGETED RESERVES

	Historical Results			Projections		
12 Months Ending	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-11**	**Dec-12**	**Dec-13**
Claims Fluctuation	$9,801,500	$11,479,100	$12,057,000	$13,938,900	$15,233,900	$16,642,800
Accumulated Eligibility	7,375,500	7,800,000	7,827,800	7,826,300	7,826,300	7,826,300
Economic	43,917,000	52,187,300	55,839,800	63,365,300	69,870,400	77,040,300
Total Targeted Reserves	$61,094,000	$71,466,400	$75,724,600	$85,130,500	$92,930,600	$101,509,400

Claims Incurred But Not Reported Reserve

Purpose: This reserve represents an estimate of the liability at the end of the fiscal year for:

1. Claims that have already been submitted, but on which payment has not been made, and
2. Incurred claims that have not yet been submitted

Claims Fluctuation Reserve

Purpose: Amount set aside to cover the possibility of actual benefit payments exceeding projected claims, commonly due to variations in large claims, claims trend patterns, legislative changes, and other factors.

Accumulated Eligibility

Purpose: Amount needed to cover eligibility earned by active members but not yet provided as of the end of the period, commonly due to the lag between hours worked and eligibility for benefits.

Economic Reserve

Purpose: Amount set aside to preserve financial solvency during a prolonged, adverse economic situation.

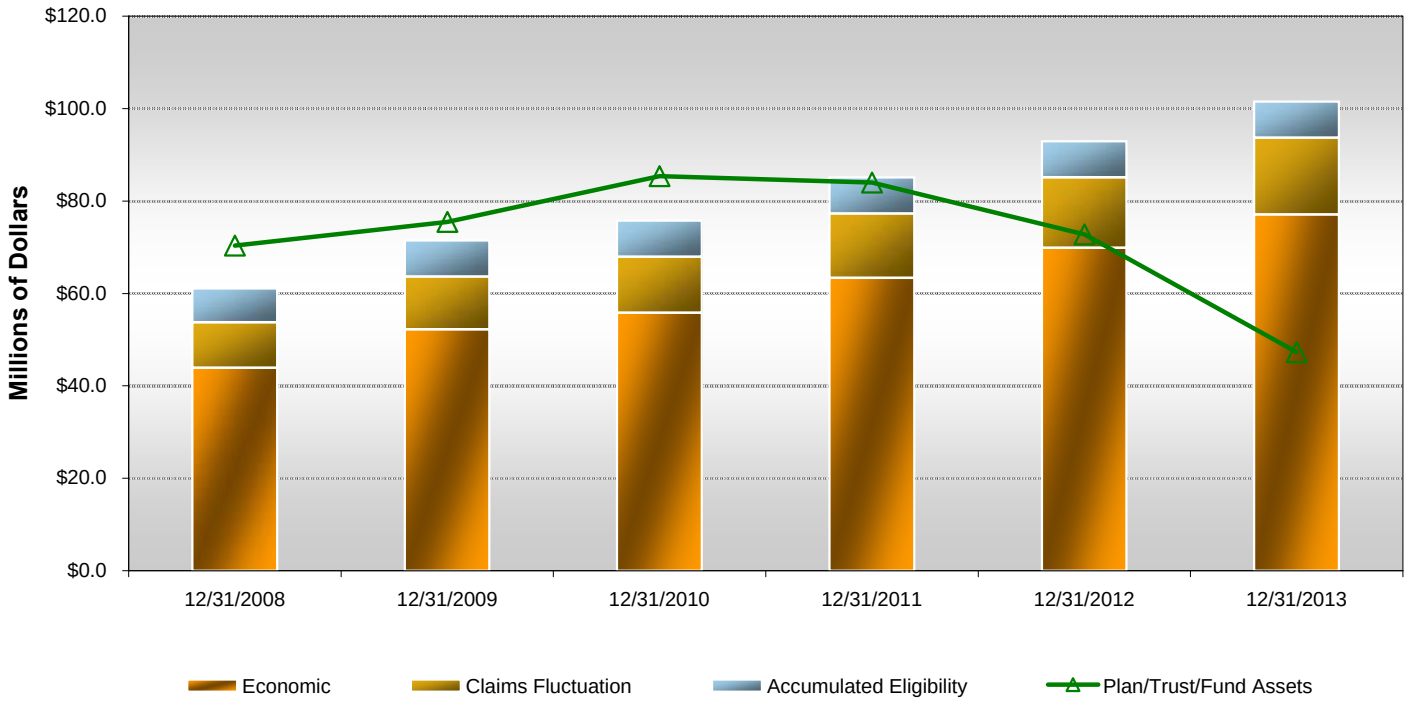
Financial Experience and Budget Projections for Local XYZ Plan/Trust/Fund

Targeted Reserves equal about 6 months of expenses. This compares to Plan Assets at 5.7 months and 3.3 months at the end of calendar years 2012 and 2013, respectively.

These projections are based on assumptions as set forth. We continue to look to the Trustees for input regarding industry outlook, the levels of work, and impact of current economic conditions.

PLAN/TRUST/FUND ASSET POSITION AND TARGETED RESERVES GRAPH

	Historical Results			Projections		
12 Months Ending	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-11**	**Dec-12**	**Dec-13**
Ratio of Plan/Trust/Fund Assets to Targeted Reserve	115.2%	105.6%	112.8%	98.6%	78.3%	46.6%
Ratio of Plan/Trust/Fund Assets to Next Year's Expe	67.4%	67.6%	67.4%	60.1%	47.3%	27.8%
Continuation Value (Months)	8.1	8.1	8.1	7.2	5.7	3.3



Financial Experience and Budget Projections for Local XYZ Plan/Trust/Fund

These rates are based on collective bargaining agreements in effect through December 31, 2011.

KNOWN CONTRIBUTION RATES

Plan A	**6/1/2007**	**12/1/2007**	**6/1/2008**	**6/1/2009**	**6/1/2010**	**6/1/2011**
Active Benefits -Per Hour	$4.80	$4.90	$5.25	$5.25	$5.60	$5.90
Retiree Benefits -Per Hour	$0.25	$0.33	$0.39	$0.40	$0.50	$0.60
Plan B	**6/1/2007**	**12/1/2007**	**6/1/2008**	**6/1/2009**	**6/1/2010**	**6/1/2011**
Plan B -Per Month	$500.00	$510.00	$530.00	$590.00	$650.00	$690.00
Apprentices	**6/1/2007**	**6/1/2007**	**6/1/2007**	**6/1/2007**	**6/1/2007**	**6/1/2007**
Apprentices -Per Month	$400.00	$420.00	$440.00	$460.00	$510.00	$560.00
Aggregate Hours						

Financial Experience and Budget Projections for
Local XYZ Plan/Trust/Fund

HISTORICAL INSURANCE PREMIUM RATES AND/OR VENDOR FEES

Medical ASO	**1/1/2007**	**1/1/2008**	**1/1/2009**	**1/1/2010**	**1/1/2011**	**Next Renewal**
Plan A Actives - Composite	$9.45	$9.73	$10.07	$10.07	$10.58	1/1/2012
Non-Medicare Retirees - Composite	$9.45	$9.73	$10.07	$10.07	$10.58	1/1/2012
Insured Stop Loss	**7/1/2007**	**7/1/2008**	**7/1/2009**	**7/1/2010**	**7/1/2011**	**Next Renewal**
Plan A Actives - Composite	$13.52	$13.52	$13.52	$17.05	$18.65	7/1/2012
Non-Medicare Retirees - Composite	$13.52	$13.52	$13.52	$17.05	$18.65	7/1/2012
Insured PPO	**5/1/2007**	**5/1/2008**	**5/1/2009**	**5/1/2010**	**5/1/2011**	**Next Renewal**
Plan A Actives - Composite	$526.25	$549.39	$623.43	$632.63	$697.71	5/1/2012
Plan B Actives - Composite	$480.46	$524.66	$610.96	$629.66	$646.94	5/1/2012
Non-Medicare Retirees - Per Person	$451.07	$444.74	$504.68	$576.72	$640.69	5/1/2012
Medicare Retirees - Per Person	$123.63	$139.96	$173.83	$181.09	$189.57	5/1/2012
Insured HMO	**7/1/2007**	**7/1/2008**	**7/1/2009**	**7/1/2010**	**7/1/2011**	**Next Renewal**
Plan A Actives - Composite	$608.17	$704.27	$729.00	$770.22	$877.32	7/1/2012
Plan B Actives - Composite	$553.42	$648.00	$714.40	$731.71	$833.45	5/1/2012
Non-Medicare Retirees - Per Person	$553.46	$465.68	$514.32	$557.80	$635.89	5/1/2012
Medicare Retirees - Per Person	$144.05	$174.30	$197.43	$225.03	$245.29	5/1/2012
Insured POS	**1/1/2007**	**1/1/2008**	**1/1/2009**	**1/1/2010**	**1/1/2011**	**Next Renewal**
Apprentice - Composite	$411.48	$414.92	$485.45	$548.56	$600.31	1/1/2012
Insured Dental	**1/1/2007**	**1/1/2008**	**1/1/2009**	**1/1/2010**	**1/1/2011**	**Next Renewal**
Plan A Actives - Composite	$26.70	$29.60	$31.20	2nd Year	$32.00	1/1/2013
Plan B Actives - Composite	$26.70	$29.60	$31.20	2nd Year	$32.00	1/1/2013
Dental DMO	**1/1/2007**	**1/1/2008**	**1/1/2009**	**1/1/2010**	**1/1/2011**	**Next Renewal**
Apprentice - Composite	$27.00	2nd Year	$28.00	$29.40	$31.30	1/1/2013

Financial Experience and Budget Projections for
Local XYZ Plan/Trust/Fund

HISTORY OF PLAN CHANGES

Effective Date	Plan Change
1/1/2000	Office visit copay under the HMO plans were decreased from $15 to $5 for both actives and retirees.
1/1/2000	Prescription drug copay for generic drugs was eliminated and for brand name drugs was decreased from $20 to $5 for all plans.
4/1/2003	Due to compliance with mental health parity, Insured HMO does not allow carve out of mental health and chemical dependency benefits. Therefore, these coverages were added to the Insured HMO plan for Insured HMO participants.
8/1/2004	Apprentices joined the Plan, for whom a medical plan and a dental plan through Insured Dental were added.
3/1/2006	The Indemnity Medical Plan was eliminated for Plan B Actives.
1/1/2007	The calendar year deductible under the Indemnity Medical Plan was increased from $200 to $400.
1/1/2007	The plan coinsurance level for the Indemnity Dental Plan were decreased from 100%/90%/80% to 100%/80%/60%.
1/1/2008	A $50 calendar year per-person deductible was added under the Indemnity Prescription Drug Plan.
1/1/2011	Total Health Management programs, including the cardiac care and diabetes targeted programs, were added to the Indemnity Medical Plan.
1/1/2011	Coverage for dental and vision benefits became available to retirees on a 100% self-paid basis.

Definition of Key Terms

Accumulated Eligibility Credits Reserve *– Amount needed to cover eligibility earned by active members but not yet provided as of the end of the period, commonly due to the lag between hours worked and eligibility for benefits.*

Breakeven Contribution Rate – *The income needed to cover benefit expenses, net of participant contributions and investment income. It does not include the amount needed to maintain or achieve targeted reserves.*

Claims Fluctuation Reserve – *Amount set aside to cover the possibility of actual benefit payments exceeding projected claims, commonly due to variations in large claims, claims trend patterns, legislative changes, and other factors.*

Continuation Value *– Plan/Trust/Fund Assets divided by the following year Benefit Expenses times 12 months. A measure of*

Economic Reserve *– Amount set aside to preserve financial solvency during a prolonged, adverse economic situation.*

Incurred But Not Reported Claims *– Reserve needed to cover claims that are known but not yet paid (pending), as well as unknown claims that have been incurred but not yet submitted (unrevealed), as of the end of the period.*

Investment Income *– Amount of interest from fixed income securities and dividends from equities. This does not include other realized or unrealized gains or losses on investments.*

A realized gain or loss is the difference between the proceeds from the sale of an asset and the cost of acquiring the asset. An unrealized gain or loss is the difference between the market value of an asset that is still being held and the cost of acquiring the asset.

Margin *– A recommended amount added to the breakeven contribution rate to cover future fluctuations in expenses.*

Operating Surplus / (Deficit) *– Income less expenses, not including impact of unpredictable items such as realized or unrealized gains or losses on investments.*

Plan/Trust/Fı *– Net assets available for benefits, less Incurred But Not Reported Claims reserves.*

Targeted Reserves - *Minimum desired level of Plan/Trust/Fund Assets, generally including Accumulated Eligibility Credit Claims Fluctuation Reserves, Economic Reserves, and other reserves as determined by Trustee policy.*

Trend Factors *– Expected future increases in benefit and other expenses, expressed as a percentage of the prior year's expense. For insurance premiums and vendor fees, trend is the projected or estimated increases in rates or fees.*

For self-insured benefit expenses, trend is the projected change in per capita claims costs and is influenced by price inflation, utilization changes, the leveraging impact of fixed deductibles and copayments, legislative changes and advances in health care technology.

Section 2

XYZ Health Plan 2014/2015 Projection

Contents

XYZ Health Plan 2014/2015 Projection

Key Findings, Recommendations

COST PROJECTION FOR JULY 2013 - JUNE 2014 PLAN YEAR
ACTIVE AND RETIREE COMBINED EXPERIENCE

		Based on December 2012 - November 2013 Experience
a.	Expected monthly incurred total claims per enrollee for 2013/2014	$800.00
b.	Claims margin	**1%**
c.	Expected monthly incurred claims with margin per enrollee for 2013/2014 (a. x (1 + b.))	$808.00
d.	Expected number of enrollees in 2013/2014 (based on projected 2013/2014 enrollment)	1,500
e.1	Expected incurred claims for 2013/2014 (c. x d. x 12)	$14,544,000
e.2	Expected federal subsidy for 2013/2014 re: Medicare Part D	($725,000)
e.3	Expected prescription drug rebates for 2013/2014	($475,000)
e.4	Expected final incurred claims for 2013/2014 (e.1 + e.2 + e.3)	$13,344,000
e.5	Expected final incurred claims per enrollee 2013/2014 (e.4 / d. / 12)	$741.33
f.	Estimated annual administrative and ASO expenses	$1,750,000
g.	Expected claim and expense costs for 2013/2014 (e.4 + f.)	$15,094,000
h.	Expected monthly costs per enrollee for 2013/2014 (g. / d. / 12)	$838.56
i.	Current 2013/2014 per enrollee premium (based on projected 2013/2014 enrollment)	$900.00

COST PROJECTION FOR JULY 2014 - JUNE 2015 PLAN YEAR
ACTIVE AND RETIREE COMBINED EXPERIENCE

		2014/2015 Projection
a.	Expected monthly incurred total claims per enrollee for 2014/2015	$875.00
b.	Claims margin	**1%**
c.	Expected monthly incurred claims with margin per enrollee for 2014/2015 (a. x (1 + b.))	$883.75
d.	Expected number of enrollees in 2014/2015 (based on projected 2014/2015 enrollment)	1,500
e.1	Expected incurred claims for 2014/2015 (c. x d. x 12)	$15,907,500
e.2	Expected federal subsidy for 2014/2015 re: Medicare Part D	($775,000)
e.3	Expected prescription drug rebates for 2014/2015	($500,000)
e.4	Expected final incurred claims for 2014/2015 (e.1 + e.2 + e.3)	$14,632,500
e.5	Expected final incurred claims per enrollee 2014/2015 (e.4 / d. / 12)	$812.92
f.	Estimated annual administrative and ASO expenses	$1,900,000
g.	Expected claim and expense costs for 2014/2015 (e.4 + f.)	$16,532,500
h.	Expected monthly costs per enrollee for 2014/2015 (g. / d. / 12)	$918.47
i.	Current 2013/2014 per enrollee premium (based on projected 2014/2015 enrollment)	$900.00
j.	Projected 2014/2015 Increase	2.1%

ASSUMPTIONS

The financial projection is based on the following assumptions:

1. Claims - Paid claims as provided by *Carrier Name* for the one-year period from December 1, 2012 through November 30, 2013.

2. Trend (Based on Industry Trends)

Medical Claims	9%
Prescription Drug Claims	7%
Prescription Drug Rebates	2%
Medicare Part D Subsidy	5%

3. Enrollment

	November 2013 Enrollment	2013/2014 Average Premium (Based on Nov 2013 Enrollment)	Projected 2013/2014 Enrollment	Projected 2014/2015 Enrollment	Percent Increase / Decrease from Projected 13/14
Actives	300	$1,250	300	300	0%
Non-Medicare Retirees	300	$1,150	300	300	0%
Medicare Retirees	900	$700	900	900	0%
Total	**1,500**	**$900**	**1,500**	**1,500**	**0%**

ASSUMPTIONS

4. Enrollment Distribution

	November 2012 Percent of Total	November 2013 Percent of Total
Actives		
Single	60.0%	65.0%
Two-party	25.0%	20.0%
Family	15.0%	15.0%
Retirees		
Single	65.0%	75.0%
Two-party	30.0%	20.0%
Family	5.0%	5.0%

5. Margin - The financial projection includes a 1% claims margin for 2013/2014 and 2014/2015.

6. Stop-Loss - Claims over the stop-loss amount for the one-year period from December 1, 2012 through November 30, 2013 were provided by *Carrier Name* .

7. Administrative Expenses - 2013/2014 administrative expenses were provided by the Plan/Trust/Fund. We assumed a 5% increase in administrative expenses for 2014/2015. The administrative expenses include the Affordable Care Act Comparative Effectiveness Research Fee per covered life per year of $2.00 for 2013/2014 and $2.06 for 2014/2015. The 2013/2014 and 2014/2015 expenses also include the Transitional Reinsurance Fee of $5.25 per covered life per month (excluding Medicare eligibles) effective January 1, 2014, which is proposed to decrease to $3.67 effective January 1, 2015.

IBNR SAMPLE REPORT

Draft

Local XYZ Welfare Fund

Incurred But Not Reported Claim Reserves - Fiscal Year Ending December 31, 2010

SEGAL

Draft

THE SEGAL COMPANY
330 North Brand Boulevard
Suite 1100
Glendale, CA 91203-2308
T (818) 956-6700 F (818) 956-6790 www.segalco.com

April 15, 2011

Mr. Williams
ABC Accounting
1313 Mockingbird Lane
Hollywood, CA 90000

Dear Mr. Williams:

We are a firm of independent actuaries and consultants for benefit Funds such as this one. We are independent of the Local XYZ Welfare Fund, its officers or key personnel, and we have no relationship with any party that impairs our independence. We consider the Fund to be an ongoing entity with no plan by the sponsor to fully or partially terminate the Fund.

We have been requested to provide you with the incurred but not reported claim reserves, accumulated eligibility, and Large Claim reserves for the Fund's fiscal year ended December 31, 2010.

Our figures include both pending (known but not paid) and unrevealed (unknown) claim reserves. If you calculate actual payable amounts in the course of your audit, that amount may be split from the amount above, as long as the total amount remains the same.

The projections in this report are estimates of future costs and are based on information available to The Segal Company at the time the projections were made. The Segal Company has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, health trend rates and claims volatility. The accuracy and reliability of health projections decrease as the projection period increases.

We trust this provides the information requested. However, if you have any questions regarding this information, please give us a call.

Sincerely,

THE SEGAL COMPANY

By: _____

Jim Smith
Health Consultant

cc: *John Green*
Janet Orange

Claims Payable and Currently Due and Incurred but Not Report Claims (IBNR)
Local XYZ Welfare Fund

Draft

IBNR

12 Months Ending	Dec-09	Dec-10	Change		Dec-09	Dec-10	Change	
Actives:	**Paid Claims**	**Paid Claims**	**Percent**	**Amount**	**IBNR**	**IBNR**	**Percent**	**Amount**
Medical	$7,680,000	$8,760,300	14.1%	$1,080,300	$1,228,800	$1,445,000	17.6%	$216,200
Prescription Drugs	1,000,000	1,111,000	11.1%	111,000	50,000	44,600	-10.8%	(5,400)
Dental	488,000	536,000	9.8%	48,000	78,100	71,300	-8.7%	(6,800)
Vision	75,000	148,500	98.0%	73,500	18,800	40,400	114.9%	21,600
Total	**$9,243,000**	**$10,555,800**	**14.2%**	**$1,312,800**	**$1,375,700**	**$1,601,300**	**16.4%**	**$225,600**
Retirees	**Paid Claims**		**Percent**	**Amount**	**IBNR**		**Percent**	**Amount**
Medical	$1,000,000	$1,200,000	20.0%	$200,000	$240,000	$264,000	10.0%	$24,000
Prescription Drugs	600,000	750,000	25.0%	150,000	30,000	37,500	25.0%	7,500
Total	**$1,600,000**	**$1,950,000**	**21.9%**	**$350,000**	**$270,000**	**$301,500**	**11.7%**	**$31,500**
Total	**$10,843,000**	**$12,505,800**	**15.3%**	**$1,662,800**	**$1,645,700**	**$1,902,800**	**15.6%**	**$257,100**

Accumulated Eligibility Credits			**Change**	
Full-Time	**01/01/10**	**01/01/11**	**Percent**	**Amount**
(1) Cost Per Active Member	$662.00	$762.07	15.1%	$100.07
(2) Months of Accumulated Eligibility	6,000	5,100	-15.0%	(900)
Total Accumulated Eligibility Obligation (1)*(2)	**$3,972,000**	**$3,886,600**	**-2.2%**	**-$85,400**
Part-Time	**01/01/10**	**01/01/11**	**Percent**	**Amount**
(1) Cost Per Active Member	$428.00	$456.48	6.7%	$28.48
(2) Months of Accumulated Eligibility	2,800	2,700	-3.6%	(100)
Total Accumulated Eligibility Obligation (1)*(2)	**$1,198,400**	**$1,232,500**	**2.8%**	**$34,100**

Large Claim			**Change**	
	01/01/10	**01/01/11**	**Percent**	**Amount**
Total Reserves	**$425,000**	**$468,000**	**10.1%**	**$43,000**

Incurred But Not Reported Claims (IBNR) *– Reserve needed to cover claims that are known but not yet paid (pending), as well as unknown claims that have been incurred but not yet submitted (unrevealed), as of the end of the period.*

Accumulated Eligibility Credits Reserve (AEC) *– Amount needed to cover eligibility earned by active members but not yet provided as of the end of the period, commonly due to the lag between hours worked and eligibility for benefits.*

Large Claim -

These reserves have been calculated based on formulas representative of reasonable levels of such claims as established by industry standards. The standards are based upon insurance company studies, lag studies, and actuarial assumptions. The formulas may vary depending upon plan design, specific lag studies, and claims backlog data.

LOCAL XYZ WELFARE FUND

Actuarial Certification of Reserve Calculations

Draft

I am an Associate of the Society of Actuaries and a member of the American Academy of Actuaries. I meet the Qualification Standards for health plan valuations and experience analyses set forth by the American Academy of Actuaries.

I have been retained by the Local XYZ Welfare Fund for the purpose of estimating the liabilities as of December 31, 2010. My work included an evaluation of claim payment lag and historical financial experience where appropriate. For my evaluations, I have relied upon data provided by the Fund.

This opinion does not address any liabilities required under AICPA Statement of Position 92-6 regarding retiree health and welfare obligations.

The liabilities for the Future Eligibility have been estimated based on the average expected cost of benefits per eligible participant and the accumulated eligibility credits. The liabilities for IBNR claims have been estimated using claims lag data and standard methodologies. These liabilities have been computed in accordance with generally accepted and consistently applied actuarial standards, and are fairly stated in accordance with actuarial principles given the available data.

The estimated liabilities as of December 31, 2010 are as follows:

Incurred But Not Reported Claims	$1,902,800
Accumulated Eligibility Credits	5,119,100
Large Claim	43,000
Total	$7,064,900

By: _____ 4/15/2011

Jane Doe
Health Actuary

SEGAL

SAMPLE STOP LOSS CONTRACT REVIEW

SEGAL

THE SEGAL COMPANY
333 West 34th Street New York, NY 10001-2402
T 212.251.5000 F 212.251.5490 www.segalco.com

MEMORANDUM

To:

From:

Date: November 19, 2010

Re: Medical Stop Loss Contract Review

Objectives ot the Stop Loss Contract Review

The following report provides an technical assessment of the current contract terms provided by ING/Reliastar (ING) for XYZ Health Fund. Our review is based on current industry practices and is intended to provide the Trustees with critical gaps and weaknesses in the insurer contract language that lead to gaps in coverage or non-competitive terms. Areas for improvement may presented to the insurer to be remedied in the form of amendments to the contract.

Below are contract items that we have identified that the Trustees should be aware of, or that could be a potential concern [organized by ING contract heading]:

Excess Risk Schedule:

1. In many instances, the stop loss policy contract period is not the same as the underlying plan's "plan year".. If the plan year is different than the stop loss policy term, then the XYZ Health Fund will change the stop loss policy period to match the health plan policy period.
2. The plan will have to remove any lifetime maximums on essential benefits to conform with the Affordable Care Act (ACA). If this is the case, the ***Trustees may want to amend the stop loss policy to remove the $2 million lifetime maximum.***

Individual Excess Risk Insurance -- coverage exclusions and limitations section:

1. Under item C, ING will not reimburse for claims in excess of "reasonable and customary". ***The Health Fund should confirm that ING's definition of "reasonable and customary" is the same as that defined by the plan document and administered by the Third Party Administrator.***

2. Under item I, ING will not reimburse for expenses incurred outside of the United States, unless it is an emergency. Presumably, this would include "Medical Tourism" claims, if any members take part in having surgeries done outside of the U.S. ***This may be negotiable only during competitive bids.***
3. Under letters K and M, ING assumes that any benefits that were not properly coordinated with another plan, (eg. Medicare, other primary coverage) will not be reimbursable. This is a standard industry practice.

Request for Amendment Form

1. It is noted that prescription drugs were added to the stop loss policy on August 1, 2009. Does this include specialty (injectable) medications? ***The contract should explicitly include the coverage of specialty medications***. Otherwise, the value of the stop loss plan is reduces as gaps in coverage of high cost medications could fall directly on the plan in the form of additional claim expenses.

Definitions

1. Page. 3, under "Employee", ING includes "Actively at Work" exclusion language, but presumably this does not apply, as the box on the Excess Risk Schedule to waive Actively at Work has been checked. In paragraph 1, there is a limitation in that the benefits payable will be subject to the prior carrier's lifetime maximum benefit (if less than ING's) until that person becomes active, at which time ING's maximum benefit will apply. ***This contradiction should be fixed by removing the exclusion in the definition of "Employee"***
2. Page, 3. Experimental or Investigational -- Do these definitions from ING conflict with the plan sponsor's plan documents in any way? ***The stop loss policy definition should mirror the health plan document.***
3. Page. 4. "Maximum Individual Lifetime Benefit". ING indicates that that they will pay out up to the lifetime maximum of the policy for any individual. If benefits are restored in any way, they will not apply restored benefits to that individual. It also says, "This amount will not be affected … by a change in the Plan Sponsor's Excess Risk Insurer". Presumably, they mean if someone had reached the lifetime maximum prior to ING's policy effective date, expenses for this individual will not be covered by this policy -- which is typical.

Miscellaneous Provisions

1. p. 5, under "Premiums". "The premium rates may also be changed on any premium due date after the first Contract Period." ***We would typically like to have language that would require at least a 60-day notice if this were to occur***. This allows Trustees time to negotiate the renewal or seek competitive bids in the event that acceptable terms can not be reached
2. p. 5, under "Data Required". Note that ING indicates that it is the Plan Sponsor responsibility for providing the necessary claim and supporting documentation information. ***As a result, the Trustees should make sure they have contractual commitments from their claim payer/Third Party Administrator to meet the necessary data reporting requirements imposed by ING..***
3. p. 6, under "Policy Amendments/Changes". This defines ING/ Reliastar's ability to amend the policy, but there is no provision allowing the Trustees to do so. ***The contract should specify what the protocols are for the Trustees to amend the policy.***

4. p. 6, under "Employee Benefit Plan Amendments". ING expects to be notified prior to the effective date of any amendment. (In practice, this often does not happen, but there is a provision under the ACA requiring plan sponsors to do this as well -- to notify members of changes before they happen.) In addition, ING reserves the right to revise their premiums or expected claim rates upon an amendment. If ING does not receive such amendments, they have the right not to pay the claim. ***It is essential for the plan sponsor to notify ING of all plan changes to ensure no gaps in coverage arise from failure of notification.***
5. p. 6, under "Reimbursement'. This pertains to claim recoveries -- for example, if a claim is a result of an automobile accident, and the Health Fund's Third Party Administrator recovers claims that were payable under an automobile policy. ING requires that the Health Fund assign its rights to recover sums paid on behalf of an individual. ***Rather than assigning <u>all</u> rights (which it appears that is what is being said) it should be qualified to say that the rights will be assigned to ING to the payments made by ING.*** The Health Fund is required to notify ING within 10 days of initiating a recovery.

Other Recommendations

1. We did not see any "hold harmless" language for either party. The Trustees may want to pursue adding a hold harmless clause against errors and omissions made by ING.
2. The Trustees may want to include a clause that grants them the right to audit INGs ability to meet HIPAA privacy and security regulations
3. The Health Fund should confirm with the Third Party Administrator that it is providing ING the necessary information according to their policy.
4. The Health Fund should inventory plan changes made each year and provide all up to date plan documents and policy amendments to ING to avoid gaps in coverage.
5. The Trustees may determine that a competitive bid is warranted to obtain more favorable contract terms and pricing. The competitiveness of stop loss premium rates can be determined through competitive bidding and should be conducting periodically.

cc:

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SAMPLE BUDGET SUMMARY

XYZ
Summary of Total Budget

	2010		2011		2012		2013		2014		Total
	XYZ Contribution per MOU Unit Cost and Nov 2009 enrollment	Cost - Based on actual renewals and average 2010 enrollment	XYZ Contribution per MOU Unit Cost and Nov 2010 enrollment	Cost - Based on actual renewals and average 2011 enrollment	XYZ Contribution per MOU Unit Cost and Nov 2011 enrollment	Projected - Based on actual renewals and average 2012 enrollment	XYZ Contribution per MOU Unit Cost and Nov 2012 enrollment	Projected - Based on actual renewals and Aug 2013 enrollment	XYZ Contribution per MOU Unit Cost and Aug 2013 enrollment	Projected - Based on actual renewals and Aug 2013 enrollment	
Annual Per Capita Cost											
Actives	$ 3,120.78	$ 2,787.28	$ 3,227.72	$ 3,056.60	$ 3,227.72	$ 3,523.50	$ 3,379.32	$ 3,671.83	$ 3,530.92	$ 3,997.25	
Retirees under 65	$ 4,687.37	$ 4,181.90	$ 4,847.99	$ 4,311.42	$ 4,847.99	$ 4,762.75	$ 5,075.69	$ 4,944.76	$ 5,303.39	$ 5,322.60	
Retirees over 65	$ 2,222.85	$ 1,821.96	$ 2,299.03	$ 1,882.19	$ 2,299.03	$ 1,696.30	$ 2,407.01	$ 1,873.86	$ 2,514.99	$ 1,975.27	
Annual Cost (Millions)	$ 106.5	$ 92.4	$ 106.5	$ 95.6	$ 103.4	$ 101.0	$ 103.2	$ 102.0	$ 106.6	$ 110.3	
Difference in Anthem Total Claims Target Liability and Total Claims Target Charges Paid by District						$ 10.1					
Difference (Millions)		$ (14.1)		$ (10.9)		$ (12.4)		$ (1.1)		$ 3.7	$ (34.9)
Aggregate Contribution per MOU (Millions)	$ 963.0		$ 996.0		$ 958.1		$ 1,003.1		$ 1,048.1		
Enrollment	November 2009*	Average 2010**	November 2010*	Average 2011**	November 2011**	Average 2012**	November 2012*	August 2013**	August 2013**	August 2013**	
Actives	24,095	23,488	22,827	22,258	21,789	21,117	20,254	19,779	19,779	19,779	
Retirees under 65	2,287	2,300	2,340	2,205	2,175	2,090	2,075	2,059	2,059	2,059	
Retirees over 65	9,261	9,497	9,345	9,577	9,790	9,830	10,059	10,266	10,266	10,266	
Total	35,643	35,285	34,512	34,040	33,753	33,037	32,388	32,104	32,104	32,104	

*Provided by XYZ
**Reported by the Carriers

XYZ

Annual Projection (Thousands)

Version - November 2013
(Based on Average 2012 Enrollment, August 2013 Enrollment and 2014 Renewals)

Calendar Year Projection by Carrier / Product	2012	2013	2014
Anthem Blue Cross			
HMO Select Actives	$309.8	$294.6	$338.2
HMO Select < 65 Retirees	$31.8	$29.2	$33.8
EPO Actives	$81.8	$72.8	$72.8
EPO <65 Retirees	$29.0	$25.2	$23.6
EPO 65+ Retirees	$80.2	$105.0	$112.4
Sub Total	**$532.6**	**$526.8**	**$580.8**
PacifiCare / Health Net			
Health Net HMO	$197.2	$193.2	$215.8
Health Net Retiree < 65	$17.2	$19.2	$21.4
Health Net Seniority Plus	$5.6	$7.0	$7.2
PacifiCare Secure Horizons (Medicare)	$10.4	$11.4	$9.6
Sub Total	**$230.4**	**$230.8**	**$254.0**
Kaiser			
HMO	$567.2	$568.2	$608.2
Retirees Under 65	$77.8	$85.2	$92.4
Retirees Over 65 (Kaiser Senior Advantage)	$72.2	$73.6	$76.6
Composite Retiree (for Comparison only)	$150.0	$158.8	$169.0
Sub Total	**$717.2**	**$727.0**	**$777.2**
MetLife Dental			
HMO Actives	$18.0	$15.8	$16.2
HMO Retirees	$12.8	$12.4	$12.8
PPO Actives	$120.4	$112.4	$115.2
PPO Retirees	$66.4	$70.8	$72.4
Sub Total	**$235.6**	**$227.2**	**$232.8**
Western Dental			
HMO Actives	$3.6	$3.2	$3.2
HMO Retirees	$0.4	$0.4	$0.4
HMO Plus Plan Actives	$2.0	$2.4	$2.0
HMO Plus Plan Retirees	$0.4	$0.4	$0.4
Sub Total	**$6.4**	**$6.4**	**$6.0**
Vision Service Plan			
VSP Actives	$10.0	$9.2	$10.8
VSP Retirees	$10.0	$10.4	$12.0
Sub Total	**$20.0**	**$19.6**	**$22.8**
EyeMed Vision Care			
EyeMed Actives	$10.0	$9.6	$9.6
EyeMed Retirees	$1.6	$1.6	$1.6
Sub Total	**$11.6**	**$11.2**	**$11.2**
MHN			
EAP (Actives Only)	$1.2	$1.2	$1.2
Sub Total	**$1.2**	**$1.2**	**$1.2**
CVS Caremark Rx (including Rebates)			
Actives	$124.8	$130.4	$146.0
Retirees	$213.2	$245.6	$265.2
Sub Total	**$338.0**	**$376.0**	**$411.2**
ING			
Life Insurance	$5.2	$4.8	$3.6
Sub Total	**$5.2**	**$4.8**	**$3.6**
Opt Outs with $3,000 Credit			
Opt Outs for Cash	$38.4	$37.6	$37.6
Sub Total	**$38.4**	**$37.6**	**$37.6**
District Administrative Cost	**$20.4**	**$20.4**	**$20.4**
Total in Thousands	**$3,637.2**	**$3,673.6**	**$3,970.8**
Year over Year % Change		1.04%	8.22%
Estimated Value of Medicare Part D	$39.07	$39.20	$39.20

Fiscal Year		2013	2014
Total Cost in Millions		$3,655.40	$3,822.20
Year over Year % Change			4.56%

The 2012 projection is based on average enrollment as reported by the carriers for 2012. The 2013-2014 projection is based on August 2013 enrollment as reported by the carriers. Rates used in the projection are based on actual rates for 2012-2014. Projections are subject to change due to actual claims for Blue Cross and CVS Caremark.

The projections in this report are estimates of future costs and are based on information available to Segal Consulting at the time the projections were made. Segal Consulting has not audited the information provided. Projections are not a guarantee of ***future results.*** *Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, health trend rates and claims volatility. The accuracy and reliability of health projections decrease as the projection period increases.*

It should be noted that our projection of retiree costs takes into account only the value of benefits for current retirees during the period referred to in the projection. It does not reflect the present value of any retiree benefits for active, disabled or terminated employees during periods other than the projection period.

XYZ

Enrollment Without COBRA

Enrollment by Carrier / Product	Average 2012[1]	August 2013[1]
Anthem Blue Cross		
HMO Select Actives	6,275	5,856
HMO Select < 65 Retirees	538	538
EPO Actives	1,143	1,073
EPO <65 Retirees	410	377
EPO 65+ Retirees	5,348	5,549
Total	**13,715**	**13,393**
Health Net		
HN HMO	2,988	2,661
HN Retiree <65	223	225
HN Seriority Plus	202	254
Total	**3,413**	**3,140**
PacifiCare		
Secure Horizons (Medicare)	407	442
Kaiser		
HMO	9,645	9,150
Retiree Under 65	918	919
Retiree Over 65	3,873	4,021
Retiree Combined	4,792	4,940
Total	**14,437**	**14,089**
Opt Outs	**(2)**	**(3)**
Opt Outs	1,065	1,039
MEDICAL Total		
ACTIVES	21,117	19,779
RETIREES	11,920	12,326
TOTAL	**33,037**	**32,104**
MetLife Dental		
HMO Actives	8,640	7,584
HMO Retirees	3,103	3,042
PPO Actives	10,992	10,269
PPO Retirees	8,788	9,363
Total	**31,523**	**30,257**
Western Dental		
Actives	1,148	1,006
Retirees	93	106
Plus Plan Actives	432	559
Plus Plan Retirees	77	106
Total	**1,750**	**1,777**
Vision Service Plan		
VSP Actives	10,760	9,979
VSP Retirees	10,778	11,035
Total	**21,538**	**21,014**
EyeMed Vision Care		
EyeMed Actives	9,823	9,314
EyeMed Retirees	1,402	1,513
Total	**11,225**	**10,827**
MHN		
EAP	24,418	24,812
CVS (Blue Cross Enrollment used)		
Actives	7,418	6,929
Retirees	6,297	6,465
Total	**13,715**	**13,393**
ING		
Life Insurance Basic Life	21,030	20,330

[1] Enrollment provided by the Carriers.

[2] Used the 2012 Open Enrollment counts provided by the District.

[3] Used the 2013 Open Enrollment counts provided by the District.

XYZ

Rate Summary

Carrier / Product	2013 Rates	2014 Rates	Percent Increase / Decrease
Anthem Blue Cross			
HMO Select Actives	$ 777.66	$ 892.90	14.8%
HMO Select < 65 Retirees	$ 841.51	$ 968.37	15.1%
EPO Actives	$ 1,050.44	$ 1,048.56	-0.2%
EPO <65 Retirees	$ 1,035.21	$ 965.37	-6.7%
EPO 65+ Retirees	$ 292.53	$ 313.02	7.0%
Health Net			
HN HMO	$ 1,121.93	$ 1,253.64	11.7%
HN Retiree <65	$ 1,316.81	$ 1,471.41	11.7%
HN Seriority Plus	$ 427.10	$ 434.60	1.8%
UHC			
Secure Horizons (Medicare)	$ 395.58	$ 332.79	-15.9%
Kaiser			
HMO	$ 960.04	$ 1,027.55	7.0%
Retiree Under 65	$ 1,432.10	$ 1,554.09	8.5%
	$ 283.20	$ 294.59	4.0%
MetLife Dental			
HMO Actives	$ 32.21	$ 33.02	2.5%
HMO Retirees	$ 31.85	$ 32.66	2.5%
PPO Actives	$ 84.53	$ 86.66	2.5%
PPO Retirees	$ 58.31	$ 59.78	2.5%
Western Dental			
Actives	$ 25.06	$ 24.21	-3.4%
Retirees	$ 21.45	$ 20.71	-3.4%
HMO Plus Actives	29.00	24.98	-13.9%
HMO Plus Retirees	$ 27.61	$ 23.78	-13.9%
Vision Service Plan			
Actives	$ 7.18	$ 8.48	18.1%
Retirees	$ 7.18	$ 8.48	18.1%
EyeMed Vision Care			
Actives	$ 7.95	$ 8.10	2.0%
Retirees	$ 7.95	$ 8.10	2.0%
MHN			
EAP	$ 0.32	$ 0.32	0.0%
CVS Caremark			
Actives	$ 145.45	$ 162.89	12.0%
Retirees	$ 293.71	$ 317.18	8.0%
ING			
Life Insurance Basic Life	$ 1.89	$ 1.31	-30.6%