



We Are Columbia

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**TO:** Honorable Stephen K. Benjamin, Mayor & Columbia City Council

**FROM:** Pam Benjamin, Human Resources Director *PRB*  
Missy Caughman, Budget & Program Management Director *MAC*

**DATE:** April 16, 2014

**RE:** Active & Retiree Health Care Strategy Findings & Recommendations

Please find enclosed the executive outline of the Active Employee & Retiree Health Care Strategies that will be presented by Mike Jones with Towers Waters during April 22 Budget Workshop.

The executive outline attached provides a high level overview of the Plan Design Alternatives that will be presented in more detail during Tuesday's meeting. The focus of Tuesday's presentation will be on active employees, pre-Medicare retirees plan design changes, wellness incentives and actuarial results of GASB 45 valuation study.

Should you have any questions or need additional information, please let us know.



**City of Columbia**

**Actives and Retirees Health Care Strategy**

April 22, 2014

# Executive Outline

TOWERS WATSON 

# Background

The City of Columbia engaged Towers Watson to assist with its 2015 health care benefit strategy, including development of alternative plan designs and contribution scenarios

This presentation includes a review of the following:

- Health Care Benefit Guiding Principles
- Considerations related to grandfathered status under the Affordable Care Act
- Opportunity to introduce a new lower cost plan option
- Use of wellness credits and tobacco user surcharges to promote healthy behaviors in the active employee population
- Scenarios for pre-Medicare retirees ensure that the Defined Dollar Benefit (DDB) adopted for 2013 and beyond is maintained so that the City's GASB 45 cost does not increase more than expected
- Post-Medicare retirees are enrolled in fully-insured plans sponsored by the City and are currently paying the full cost of the premium less the DDB
- Review of Health Insurance Marketplace premium rates available to pre-Medicare retirees in the Columbia area

# Health care guiding principles

<b>Cost Management</b>	The City of Columbia will develop, manage and maintain a fiscally responsible health care program. The objective is balanced cost control, weighing competitive health care benefits against limited resources.
<b>Cost Transparency</b>	The City of Columbia will ensure that the health care budget is transparent with regard to costs for active employees and dependents, pre-65 retirees and post-65 (Medicare eligible) retirees.
<b>Cost Sharing</b>	The City of Columbia's contribution strategy will be competitive and equitable, however, all employees and retirees participating in the health plan will be required to contribute toward the cost of the program.
<b>Participant Input</b>	The City of Columbia will invite the involvement of employees and retirees and will gather input from them on key benefit decisions.
<b>Flexibility and Choice</b>	The City of Columbia's health care program will strive to meet the needs of a diverse workforce, providing participants with meaningful health care plan choices and options.
<b>Health Improvement</b>	The City of Columbia's health care program will promote wellness, prevention and health improvement through design, education, incentives, tools and resources.
<b>Benefit Design</b>	The health care plans should: provide financial protection against catastrophic claims; encourage accountability for health care purchasing decisions; be easy to communicate, understand and administer.
<b>Program Administration</b>	The City of Columbia will contract with vendors who can provide: competitive fees and contract terms; superior customer service; excellent network access; strong provider discounts; effective and integrated wellness and care management programs; data to validate performance and results.
<b>Program Management</b>	The City of Columbia will monitor program performance (administration, cost, outcomes, health risk, return on investment) on a regular basis and make adjustments, as required. The City is open to innovative new approaches and will stay current with regard to market and regulatory changes.

# Explanation of grandfathered status under ACA

- Most employers gave up grandfathered status several years ago
  - Cost savings attributable to keeping grandfathered status were significantly less valuable than the savings opportunities available for non-grandfathered plans
- While still grandfathered, health plans are not required to comply with the following provisions:
  - Coverage for preventative health services without cost-sharing
  - Internal claims and appeals and external review processes
  - New patient protections such as in-network/out-of-network coverage of emergency services, direct access to pediatricians and OB/GYNs
  - Group health plan reporting and disclosure
  - Annual out-of-pocket maximums no greater than HDHP limits (e.g., 2015 limits of \$6,600 self-only/\$13,200 family)
- However, grandfathered plans were not allowed to make significant changes in plan design and contributions – hampering their ability to keep pace the health care market

# Explanation of grandfathered status under ACA *(continued)*

- Disadvantages of giving up Grandfathered Status
  - Mandatory plan design changes
    - Limited total out-of-pocket maximum (including copays) for medical and pharmacy to maximum for qualified HSA plan (\$6,600 / \$13,200 for single/family in 2015): Impact 0.25% - 1.0% (depends on implementation method)
    - Provide preventative benefits at 100% (including women's health) : the City currently covers some preventative benefits at 100%: Impact 0.5% - 1.25%
    - Cover pre-existing conditions: Impact 0.25% - 0.5%
  
- Advantages of giving up Grandfathered Status
  - Ability to making strategic decisions changes to plan design and employee contributions
    - Potential savings are far greater than the additional costs of mandatory plan design changes

# Areas for consideration – Plan design and contributions for active employees

## ***Active Employees***

- Alternative Design
  - Forego grandfathered status
  - Utilize wellness credits and/or tobacco user surcharges to promote healthy behaviors
    - Annual wellness credits (activity to receive credits is to be determined) of \$225 per adult (for employee and spouse) to offset deductible
    - Monthly tobacco user surcharge of \$25 (for employee and spouse) introduced
  - Introduce a third plan option (“Base” plan) alongside the Core and Buy Up plans
    - \$1,250/\$3,750 (single/family) deductible, OOP Max (including deductible) of \$6,250/\$13,200, 70% coinsurance, increase OV and brand Rx copays
  - Gross active plan cost savings of \$206K for CY 2015 (assumes 10% migration from current Core Plan into Base Plan)

# Areas for consideration – Plan design and contributions for pre-Medicare retirees

We have included three alternative scenarios for pre-Medicare retirees which assume that the monthly \$800/\$600 (retiree/spouse) Defined Dollar Benefit is maintained

## 1. Alternative 1: Retiree Exchange

- Move pre-Medicare retirees to the federal Health Insurance Marketplace established for South Carolina residents
- Retirees may receive a federal subsidy depending on annual household income
- Retirees would have access to a wider selection of plan options

## 2. Alternative 2: Mirror Active Plans

- Pre-Medicare retirees will have same three plan options as actives, including new Base plan
- Retiree premium rates would be set separately from actives and retirees will pay difference between premium equivalent rate and Defined Dollar Benefit (DDB)

## 3. Alternative 3: Dual Option

- Continue to offer two plans for pre-Medicare retirees
- Retiree contributions would increase approximately 25% from current 2014 rates
- Adjust plan design such that DDB is maintained (City cost equals \$800/retiree & \$600/spouse)

## 4. Alternative 4: Revert back to Pre-DDB Plan

- Eliminate the DDB and maintain the City's current cost share for pre-Medicare retirees
- This would significantly increase the City's AAL & OPEB Cost

## Postretirement healthcare valuation results

- GASB 45 results for Fiscal 2015 indicate that the City's OPEB Cost will be approximately \$8 million
  - This assumes that City's DDB for retirees is maintained beginning 1/1/2015
  - Eliminating the DDB and reverting back to your pre-2012 contribution cost structure would increase the City's OPEB Cost to approximately \$20 million

# Glossary

Term	Definition
Affordable Care Act (ACA)	The Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA), is a federal statute signed into law on March 23, 2010. Together with the Health Care and Education Reconciliation Act, it represents the most significant regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965.
Cadillac Tax	Beginning in 2018, a 40 percent excise tax will be imposed on the value of health insurance benefits exceeding a certain threshold. The estimated thresholds are \$10,200 for individual coverage and \$27,500 for family coverage.
Coinsurance	The percentage of cost that the Plan pays after the deductible is reached. The PPO option includes coinsurance
Copayment	A flat dollar amount that a PPO plan participant pays for a primary care or specialist physician office visit
Deductible	The amount of covered charges the teammate pays before the Plan pays anything
Out-of-Pocket Maximum (OOPM)	The total amount the plan participant pays for eligible expenses incurred in a calendar year while covered under the medical option, including the deductible. Once the participant reaches the out-of-pocket maximum, the plan pays 100% of the remaining eligible expenses for the rest of the year
Formulary	The list of drugs covered by the prescription drug benefit; drugs not on the formulary are not covered by the plan
FSA – Flexible Spending Account	Pre-tax dollars can be withheld from employee's paycheck and used to pay IRS approved health care costs if in the PPO plan. A separate FSA can be used for dependent care.
HDHP – High Deductible Health Plan	Health care plan design with higher deductibles and lower premiums. The IRS sets the minimum of \$1,250 deductible for single coverage and a maximum out of pocket expense of \$6,350.
HRA – Health Reimbursement Account	Health incentives and seed money provided by the employer are deposited into an HRA for PPO Plan participants. Dollars rollover each year but are forfeited at termination.
HSA – Health Savings Account	Dollars from the employee and the employer's health incentives and seed money are deposited into an HSA for the HDHP plan participants. Savings can be used to off-set IRS approved expenses or saved. Dollars rollover each year and the employee keeps the account after termination.
PPO	"Preferred Provider Organization" plan that provide medical services within network at a substantial discount.

# Glossary

Term	Definition
Premium Equivalent	For self-insured plans, the total cost per covered employee, or the amount the employer would expect to reflect the total cost of claims and administrative costs
Employee Contributions	An employee's contributions for medical coverage made through payroll deduction, often on a monthly or bi-weekly basis
Tobacco Surcharge	A tobacco surcharge is an increase in the premium amount paid by tobacco users. The surcharge can also be referred to as a tobacco premium or premium differential.
Actuarial Accrued Liability (AAL)	The present value of the portion of the projected benefits attributable to an employee's service before the actuarial valuation date
Governmental Accounting Standards Board (GASB)	Sets the generally accepted accounting principles used by State and Local governments in the United States
Postemployment Benefits Other than Pensions (OPEB)	Refers to benefits other than pension benefits, like healthcare or life insurance benefits, provided after the period of employment
Defined Dollar Benefit (DDB)	A specified annual or monthly benefit amount provided to a retiree to be used for the purchase of healthcare coverage