HHS/GO COMM #1-2
March 27, 2014

MEMORANDUM

March 25, 2014

TO: Health and Human Services Committee
Government Operations and Fiscal Policy Committee

FROM: Linda McMillan, Senior Legislative Analyst

SUBJECT: **Procurement of 2014 Medical and Prescription Plans – Transition to Medicare D for 2015 Calendar Year and Contribution to OPEB**
Update on County Government Employee Wellness Program

Expected for this session:

Belinda Fulco, Montgomery County Government (MCG)
Sue DeGraba, Montgomery County Public Schools (MCPS)
Richard Johnstone, Montgomery County Public Schools (MCPS)
Tamathia Flowers, Montgomery College
Jennifer McDonald, Maryland-National Capital Park and Planning Commission (M-NCPPC)
Carole Silberhorn, Washington Suburban Sanitary Commission (WSSC)

1. Briefing on Transition to Medicare D Prescription Plan and Impact on Contribution to OPEB

The joint Committee will begin this session with a presentation from AON Consulting on the transition to Medicare D Employer Group Waiver Plan (EGWP) programs for Montgomery County Public Schools, Montgomery County Government, Montgomery College, and the Maryland-National Park and Planning Commission. The presentation will include information on the reasons organizations are moving to Medicare D EGWP, the changes to retirees accessing prescription benefits, and the impact on OPEB contributions because of the reduction in long-term liability to the agencies. Also present will be a representative from CVS, the plan provider for the four agencies.

WSSC is not moving to a Medicare D EGWP for calendar year 2015 and is still assessing the costs and benefits to its organization.

Background

The joint Committee previously discussed that the agencies' joint solicitation for medical and prescription plans requested responses on prescription plans for retirees that would coordinate with Medicare Part D. Savings would be realized as Medicare would become the primary payer. The coordination of benefits means that retirees would see little or no change in the benefits they receive.

Originally, MCPS had planned to move to a Medicare D EGWP program for the 2014 calendar year. MCPS had estimated savings of about $7 million over three years to its annual budget from this change. In addition, the change to a Medicare D program was estimated to reduce the Other Post Employment Benefits (OPEB) Accrued Liability for MCPS by $369 million and result in a $36 million savings per year in the annual contribution. The annual OPEB contribution is appropriated in the County Government Consolidated Retiree Health Benefits Trust Non-Departmental Account.

MCPS was not able to make the transition in 2014 as the Centers for Medicare and Medicaid Services (CMS) had imposed sanctions on the CVS/Silverscript Insurance Company that suspended its ability to market to and enroll to new participants because of problems with its ability to accurately process enrollment transactions. CMS said that these problems could cause an interruption in claims processing at the pharmacy which could result in a beneficiary having to leave the pharmacy without the prescribed drug unless the beneficiary can pay the entire cost out of pocket. These problems have been resolved and the agencies can now move forward with Medicare D EGWP for the 2015 plan year.

Attached to this packet are the information that has been provided by County Government to the Montgomery County Retiree Association (©1-3) and the May 2013 memo to the Board of Education recommending the transition to a Medicare D EGWP plan and estimating the savings to the MCPS budget and to OPEB (©4-5).

OPEB Assumptions

The County Executive's FY15 Recommended Budget includes significantly reduced contributions to OPEB from what was assumed in the June 2013 Fiscal Plan. There was a reduction shown in the updated December 2013 Fiscal Plan but the March 17, 2014 budget recommends an even lower amount. The table on the next page shows the assumptions. The December 2013 amount for MCPS is consistent with the $36 million in savings from Medicare D that has previously discussed by the Committee. While no estimated amount for County Government had been provided as a part of the Committee's employee wellness updates, the $12 million savings seems reasonable given the difference in the number of retirees. However, the Executive is recommending $51.7 million less for MCPS than expected last June and $27.5 million less for County Government. Reductions for M-NCPPC and Montgomery College are also assumed.

It is important for the joint Committee to understand how much of the total recommended change is from the transition to Medicare D EGWP programs and how much is due to any other factors in the actuarial estimates.

Total FY15 OPEB Contribution in $000s

	June 2013	December 2013	Difference	March 2014	Difference from Dec 2013	Difference from June 2013
MC Government	66.1	54.1	(12.0)	38.6	(15.5)	(27.5)
MC Public Schools	110.0	74.4	(35.6)	58.3	(35.6)	(51.7)
Montgomery College	3.3	3.3	(0.0)	2.0	(1.3)	(1.3)
Park and Planning*	2.5	2.5	(0.0)	1.8	(0.7)	(0.7)

*provided by outside actuary

Leveraging Medicare to reduce both annual cost and future liabilities for retiree health care is an important strategy and one already used by the agencies for medical care. Attached at ©6-12 is a brief from Moody's Investor Service, "US Municipal Governments Can Leverage Federal Medicare to Lower OPEB Costs," that looks at the impact on the State of Maryland from leveraging Medicare and making other changes to retiree health benefits. The brief notes that Maryland, while not typical, reduced its liabilities by about 40% from changes that included increasing prescription drug co-payments, retiree premium contributions, co-payments, and deductibles and requiring enrollment in Medicare Part D in 2020 when the "Donut Hole" is eliminated. Exhibit 5 in the brief (©11) shows that most of the reduction in future liability comes from the change to a Medicare D EGWP which can be included in the actuarial assumption even though it takes place in the future.

The brief also explains that a Medicare D EGWP program is treated differently under accounting rules than the Retiree Drug Subsidy program (which is how the agencies currently receive discounts) as savings from the Retiree Drug Subsidy can not be counted against future liabilities. Savings from a Medicare D EGWP can be counted against liabilities and therefore result in substantial savings to OPEB.

Impacts to Retirees

The information at ©1-3 explains the changes to County Government retirees. All Medicare eligible retirees will have to participate in Medicare D to be eligible for participation in the County's prescription plans (with the exception of Kaiser where prescription coverage coordinated by Kaiser; also details for retirees in the Indemnity Plan are still in process.) The "wrap" component should mean that retirees will have the same co-pays at the pharmacy and that the Medicare D "donut hole" will be covered.

For some individuals, Medicare requires payment of a premium based on income. This premium is in addition to the premium that is paid to the County Government (or other agency). For example, an individual retiree with an income above $85,000 up to $107,000 will have to pay $12.10 per month to Medicare in addition to the premium paid to the County Government (or other agency). Some retirees may receive a federal subsidy based on income. The presentation from AON will more fully cover this requirement.

In addition, retirees will receive information directly from Medicare and, as Medicare sends to each individual enrollee, a household with two Medicare eligible people will each receive information as opposed to the way information is sent in a group plan.

Representatives from the agencies can discuss with the joint Committee whether their process will be similar to that which is included in the information to County Government retirees.

2. Consolidated Health Plan Data Study

The Task Force on Employee Wellness and Consolidation of Agency Group Insurance Programs urged the Council to think across agency lines and look at data on the approximately 100,000 people covered by agency health plans. The Council agreed and in October 2012 reviewed the InforMed Cross-Agency Health Plan Data Study. This study gave the Council an overview on how health care dollars are spent for all enrollees (except those in Kaiser). Some of the points brought to light in the study were:

- From Year 1 to Year 2 there was a 2.31% increase in the number of people covered in the CareFirst, United Healthcare, and Cigna health plans and Caremark prescription plan that are the subject of this report.

- From Year 1 to Year 2, medical claims costs increased 4.96% and prescription claims costs increased by 6.6%. Year 2 total health plan expense was about $447 million.

- The per-member per-month (PMPM) plan cost is within a reasonable range for medical claims, but over twice what InforMed normally sees for prescription plans. Generally prescription costs run 20-25% of the total expenses. For county agencies the Year 2 prescription costs are over 47% of total expenses.

- In Year 2, 72% of dollars were spent on 14% of plan participants. This was relatively unchanged from Year 1.

- InforMed does predictive modeling around members that are projected to have large claims (over $10,000 in a year). The three major practice categories are: Cardiology, Endocrinology, and Orthopedics and Rheumatology. The most prevalent conditions in these practices are: joint degeneration, hypertension, hyperlipidemia, and diabetes.

- InforMed also looks at Evidence Based Medicine Adherence and has noted that in comparison to its Book of Business. County agency plans' adherence falls below benchmarks in four areas: cervical cancer screenings, diabetes care, congestive heart failure, and colorectal cancer screening. The lower adherence with diabetes and congestive heart failure correlates with the expected large spends in cardiology and endocrinology.

The joint Committee agreed that a similar report should be prepared each year. At the joint Committee's last session, it was informed that County Government would be entering into a contract for data aggregation and disease management and that this would facilitate the completion of a similar type of report. The joint Committee heard that while the other agencies felt that the disease management services they would be procuring through health plans were sufficient, the plan provider could provide the type of information that was previously provided to InforMed.

Council staff continues to believe that the cross-agency report provided important insights to the Council on how health care dollars are spent, the types of conditions that use substantial amounts of health care dollars, and areas for potential savings if either underlying health problems are prevented or better controlled. Now that decisions have been made by the agencies on whether they are entering into the data warehouse contract, **Council staff requests that the joint Committee ask the agencies to commit to providing the needed data. Council staff believes that County Government can act as the coordinator for production of this report. The agencies should be asked to provide an estimate of any costs associated with providing the information to OHR and OHR should provide an estimate by April 15th for the cost of producing the report so that it may be considered during the FY15 budget worksession for OHR at the GO Committee.**

3. Montgomery County Wellness Program

While the main focus of this session is to review the transition to Medicare D and the resulting OPEB estimates, attached at ©13-19 is a brief update on the implementation of MCG's Wellness Program. The information highlights the expanded Employee Assistance Program (©15) and also provides a summary of events for all employees that are currently scheduled (©16) and summary information on efforts targeted to specific department and types of jobs. Circle 18 outlines the efforts to focus on improved health and wellness for Ride-On drivers. This was one of the areas the joint Committee discussed at the October session. An overview is also included for employees at the Department of Liquor Control (©19). The summary (©17) indicates that plans are also being developed for the Department of Correction and Rehabilitation, Fire and Rescue Service, and the Public Safety Communication Center (ECC). Council staff suggests that a session be scheduled after budget to have a more in depth discussion of these efforts.

PRESCRIPTION PLAN CHANGES FOR RETIREES AND COVERED FAMILY MEMBERS WHO ARE MEDICARE ELIGIBLE

Montgomery County Government has decided to embrace Medicare Prescription Drug coverage, known as Medicare Part D, because it will save the County $12 million in funding the Other Post Employment Benefits (OPEB) trust. There will be minimal cost and plan changes for most retirees.

This change will affect those in the CVS/Caremark prescription plans and the CareFirst Indemnity plan. It will not impact Kaiser members. The details of how the drug coverage in the Indemnity plan will be integrated with medical coverage are still being worked out.

Please do not call the OHR Health Insurance Team (formerly the Benefits Team) or MCREA about this change. We are providing you with all of the information that is available at this time. As additional details are available, the OHR Health Insurance Team and CVS/Caremark will communicate them to you throughout the year.

Retirees who are eligible for Medicare, regardless of age will begin participating in Part D (as our primary drug coverage) starting January 1, 2015. The County plan will change to offer supplemental coverage known as a "wrap" because it wraps around Part D as a supplement, and covers the "donut hole" of Part D. It will be a plan customized for us.

Making this change to Part D is complex. The County is trying to minimize the impact on retirees. More information will be sent to you by the OHR Health Insurance Team and CVS/Caremark throughout the year as more details are known. The Fall Open Enrollment packet will contain the new plan information.

The Medicare Part D plan allows you to opt out if you wish. **Please note that if you opt out of the County's Part D Medicare prescription plan, you will not be eligible for coverage by any of the County's prescription plans and you will have to obtain prescription coverage elsewhere.**

How will the new plan work? CVS/Caremark has a prescription drug insurer who provides Part D coverage, known as "SilverScript". You can go on the web and look it up but remember that the plans that are shown are not the final plans for the County retirees and covered family members who are Medicare eligible. Our plan will be customized for us.

The County has contracted with CVS/Caremark/SilverScript to administer this program. They will be responsible for enrolling plan participants in Part D and administering both Part D and the County's supplemental prescription drug plan. CVS/Caremark and SilverScript will work together to process claims for both the Medicare Part D and the County's supplemental prescription drug plan. This includes responding to questions about both plans.

At Open Enrollment you can still choose the High or Standard option for your Prescription plan. Later, you will receive a SilverScript prescription card that you will show at a pharmacy to obtain your prescriptions. You will pay only for your co-pay. You will receive a monthly benefit statement for each month that you have had a prescription filled.

Will the cost of the County's plans go down? Probably not, because you will be paying the County for both the cost of Part D and the County's supplemental plan since they go together. The implementation of this plan may help to stabilize future increases.

Can I sign up for Part D on my own? Yes, you can get Part D coverage on your own through the Medicare individual market, but you will not get the County's supplemental prescription drug program. The County's drug coverage is deemed "Creditable Coverage" so anyone opting out of the County's plan will not be penalized for signing up for Part D on their own. But remember that if you opt out of the County's Part D plan, you will have no coverage through the County's CVS Caremark/SilverScript plans.

What about the donut hole in Part D? The County's supplemental plan covers that. Also, as part of the Affordable Care Act, the donut hole will be phased out by 2020.

Will I have to deal with the Social Security bureaucracy? No. All claims, questions, and appeals will be handled by staff at SilverScript. However, if you think you will qualify for low income subsidies that are available under a Part D plan (including the County's Part D plan) you will need to apply for that low income assistance through the Social Security Administration.

What if I am not 65 years old yet? If you are not Medicare eligible, the County's current prescription drug plans will still be in effect. If you are under age 65 and eligible for Medicare, you will be enrolled in the County's Part D plan.

If I have high income will I have to pay more? Yes, following Medicare guidelines, if you are paying an "income-related monthly adjusted amount" for Medicare Part B coverage, you will also pay a higher premium for Part D. Any extra cost will be deducted from your Social Security benefit or you will be billed directly by Medicare. See Section 6 page 91 in your Medicare & You 2014 booklet.

Is there a subsidy if I am in a lower income bracket? Yes, if you qualify. For a single person in 2014, the income must be less than $17,235 and resources less than $13,300 a year. See Section 7 page 103 in your Medicare & You 2014 booklet.

Will I have to use CVS pharmacies? No, there will be a network of pharmacies including CVS for you to use as well as the mail order option.

I am in the Indemnity Plan, what happens to me? Details for this change are in process. OHR is getting legal advice from several sources on how to handle this, since the medical and prescription components in the Indemnity Plan are treated as one.

I do not live in the U.S., what do I do? The Health Insurance Team is working on a solution for retirees living outside the United States and Medicare eligible areas.

Is there more information? This is a complex change and details are still being worked out. MCREA knows that this is an important change and wants to make sure you know what we have learned.

Will Open Enrollment be at the same time? Yes, but you will begin receiving information related to this change much earlier. The Health Insurance Team is hoping to begin communications this spring. There will be special information sessions on just the Prescription Drug Plan and Part D. Plus, special information brochures will be prepared for this and mailed out as soon as possible.

Are we the only County agency doing this? No. Montgomery County Public Schools will implement their integrated Part D plan beginning January 2015, creating an estimated savings of $36 million in the County's OPEB trust.

For more information:
A presentation is scheduled by OHR and their consultants from AonHewitt to the County Council's subcommittees, Government Operations and Health and Human Services, on **Thursday, March 27th at 2:00** p.m.

(1) Follow the meeting on your computer live or from the archives at http://www.montgomerycountymd.gov/council/OnDemand/index.html.
(2) Watch it on the County's cable channel, at Comcast/RCN channel 6 and Verizon channel 30.
(3) On and/or after Monday, March 24th review the Council's briefing packet at www.montgomerycountymd.gov/council/packet/index.html; the packet is titled "Update-Procurement of 2014 Medical and Prescription plans".
(4)Attend MCREA's Annual Meeting, Wednesday, June 4, 2014, 7 – 9 p.m. See front page of this newsletter for details. Also check MCREA's website for updates as they become available.

ACTION
4.3.1

Office of the Superintendent of Schools
MONTGOMERY COUNTY PUBLIC SCHOOLS
Rockville, Maryland

May 30, 2013

MEMORANDUM

To: Members of the Board of Education

From: Joshua P. Starr, Superintendent of Schools

Subject: Prescription Program for Medicare-eligible Retirees

Montgomery County Public Schools (MCPS) currently provides prescription drug coverage to eligible retirees and their dependents. The current retiree prescription coverage offered to retirees aged 65 and over has benefited from rebates offered through the federal Retiree Drug Subsidy program over the past six years. Those rebates have been declining as a result of healthcare legislation directed at Medicare Part D drug programs. This legislation has provided incentives for employers to move to Medicare Part D plans, much like health coverage where retirees receive their primary coverage from Medicare Parts A and B and employers like MCPS provide supplemental coverage.

Staff and the MCPS benefits consultant, AON Consulting, Inc., have evaluated the financial impact and recommend modifying the retiree prescription coverage for retirees who are Medicare eligible as of January 1, 2013, to adopt a Medicare Part D Plan. This recommendation has been reviewed with the employee associations, the MCPS Retirees Association, Inc., and the Board of Education Fiscal Management Committee. Each of these groups has expressed support for the change. This change will be based on a calendar year plan instead of the current fiscal year cycle. An open enrollment period will be offered this fall to address these changes.

Adopting the Medicare Part D program will not result in any changes to retirees' benefits or co-pays. Some retirees may receive a federal subsidy for their Medicare premiums directly from Medicare based on federal income guidelines. A few higher income retirees may be charged an additional fee from Medicare similar to how they currently are charged for their hospital coverage under Medicare Part B.

The MCPS budgetary savings realized from this change to the Medicare Part D program will be approximately $7 million over the next three years. Additionally, the county will realize a one-time reduction on the Other Post Employment Benefit Accrued Liability of $369 million and $36.4 million per year in the Annual Required Contribution.

(4)

I am recommending that the retiree prescription plan for Medicare eligible retirees be changed to a Medicare Part D program.

WHEREAS, The Board of Education by Resolution 563-58 established in 1958 an Employee Benefit Plan to provide life and health insurance to eligible employees and retirees; and

WHEREAS, The Board of Education expanded the Employee Benefit Plan by Resolution 448-72, 457-72, and 43-76 to include dental coverage, vision coverage, a prescription drug plan, and dependent life insurance; and

WHEREAS, The current retiree prescription coverage offered to retirees aged 65 and over has benefited from rebates offered through the federal Retiree Drug Subsidy program over the past six years; and

WHEREAS, Those rebates have been declining as a result of healthcare legislation directed at Medicare Part D drug programs, and this legislation has provided incentives for employers to move to Medicare Part D plans; and

WHEREAS, Based on projected savings, it is recommend that retiree prescription coverage for Medicare-eligible retirees become a Medicare Part D plan; and

WHEREAS, As a result of the change to a Medicare Part D plan, Montgomery County Public Schools and its retirees will continue to have a high-quality prescription drug plan without any changes to benefits or co-pays and will achieve an estimated $7 million in savings over the next three years; now therefore be it

Resolved, That the prescription coverage plan for Medicare-eligible retirees become a Medicare Part D plan; and be it further

Resolved, That the Board of Education president and the superintendent of schools be authorized to execute the documents necessary for this transaction.

JPS:LAB:lsh

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SPECIAL COMMENT

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US Municipal Governments Can Leverage Federal Medicare to Lower OPEB Costs

Table of Contents:

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Summary

The availability of federal Medicare health insurance coverage for most US state and local government retirees provides an option for many of these governments to better control retiree health care costs. Commonly referred to as Other Post-Employment Benefits (OPEB), retiree health care costs are rising with the aging of the workforce. OPEB, along with pensions, present an increasing credit risk for many US municipal governments. For retirees over age 65, this liability consists primarily of Medicare premium subsidies and supplemental health insurance benefits.

The option of leveraging federal health insurance coverage for municipal retirees aged 65 and over is an attractive one, especially because Medicare-eligible retirees are growing as a share of government retirees. Even small reductions in the cost of health benefits for Medicare-eligible retirees can have a considerable impact on future costs because savings compound over retirees' increasingly long lifetimes.

» **Cost savings are significant because the unfunded OPEB liabilities of US municipal government are large.** For states, total reported OPEB liabilities of $530 billion rival their outstanding debt.

» **Medicare-eligible retirees will comprise a growing portion of total state and local government retirees, increasing the boon to government finances if costs are controlled for this group.** The relative benefit to state governments is potentially greater than local governments, where police and fire employees tend to retiree younger.

» **Some governments have reduced OPEB liabilities simply by requiring employees to pay a greater share of supplemental health insurance ("Medigap") costs and reducing prescription drug costs.** The latter include employer group waiver plans and Medicare Part D. While not typical, Maryland reduced its liabilities more than 40% almost entirely due to prescription drug savings.

» **The Medicare cushion is advantageous for municipal retirees because governments can more easily reduce or eliminate retiree health insurance than pension benefits.** This cushion is particularly important in stressed municipalities where OPEB reductions have recently been part of bankruptcy plans of adjustment. Stockton, CA has proposed eliminating retiree health benefits in Chapter 9, while Detroit's proposed plan would also sharply curtail them.

6

Large OPEB Liabilities Rival Debt Outstanding for Some Governments

Many state and local governments can save money by changing health benefits provided to retirees who are eligible for Medicare because they are at least age 65. Nearly two-thirds of state governments offered supplemental health insurance to Medicare-eligible retirees in 2010 (the most recent data available) as did a similar proportion of large local governments, according to survey data from the US Department of Health and Human Services. The survey also shows that smaller local governments are less likely to offer supplemental health coverage to Medicare-eligible retirees, likely due to cost.

Such cost-savings are credit positive for governments able to implement them. Providing health benefits is increasingly expensive as health costs have increased generally and retirees are living longer. Similar to pensions, the promise to provide health and other benefits to retirees in the future results in a long-term liability to the employing government. Referred to as "other post-employment benefits" (OPEB) these liabilities can be significant and consist overwhelmingly of subsidized health insurance costs.

States listed a total of more than $530 billion in unfunded OPEB liabilities in their fiscal 2012 financial reports, although the liabilities are highly variable and concentrated within a subset of states. As demonstrated in Exhibit 1 this amount is similar to the magnitude of total state net tax-supported debt of about $516 billion as of our most recent State Debt Medians report. Local governments are likely to also have a significant collective liability.[1]

OPEB liability accounting presents comparability challenge and can alter behavior

Both governmental and private sector OPEB liabilities are calculated based on the projected future flow of retiree health benefit payments, discounted to arrive at a present value. In the public sector, the factors that reduce comparability of pension liabilities apply similarly to OPEB liabilities: the use of multiple actuarial cost methods, discount rates based on investment rates of return rather than market interest rates, and the lack of reported allocations of cost-sharing plan liabilities to participating employers. Although subject to different accounting rules, public and private sector employers share the need to incorporate forecasts of health care costs far into the future when calculating OPEB liabilities. Because even small forecasting differences when compounded over many years can have a large impact on liabilities, this variable adds to issues of comparability for both public and private sector OPEB disclosures.

Public sector accounting rules do not require that OPEB liabilities be reported on the government's balance sheet: instead they are reported in the notes to the financial statements. A measure of accumulated employer contribution shortfalls to single-employer and agent OPEB plans, known as the "Net OPEB Obligation," is the only liability reflected on government balance sheets. In contrast, private sector accounting rules require that both pension and OPEB liabilities be reported on the balance sheet. The Governmental Accounting Standards Board (GASB) is in the early stages of considering revisions to its OPEB accounting guidelines, which may result in a change to balance sheet treatment and other reporting requirements. New GASB pension accounting guidelines, to be phased in over the next two years, will require pension liabilities to appear on the balance sheet.

As with pensions, the US public sector is late in addressing its OPEB risk compared to the corporate sector. Companies began reducing or eliminating OPEB liabilities in the early 1990s following mandated disclosure under FASB accounting. US municipal governments have only recently started to trim OPEB costs in earnest.

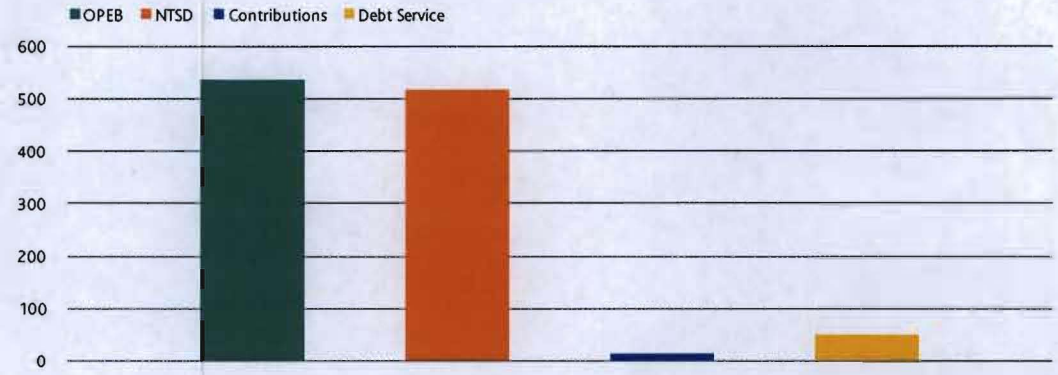
[1] As in the case of pensions, some liabilities reported by states relate to cost-sharing plans in which different levels of government may participate. We have not allocated liabilities of health benefit cost-sharing plans to sponsoring employers.

7

Exhibit 1 also shows current annual reported budget costs associated with servicing debt and paying for retiree health costs. Although the outstanding liabilities are similar, debt service payments are nearly four times larger than contributions for retiree health costs. In contrast to debt service payments which amortize the principal liability over a fixed period, most governments pay for OPEB on a "pay-as-you-go" basis, paying only an amount sufficient to provide the annual health insurance subsidy for current retirees.[2] Most do not pre-pay the liabilities for future retiree benefits being promised to current employees or an amount to amortize the costs of previously accrued liabilities. At least in the near term, these payments would be considerably greater than the pay-go amount depicted in the exhibit.

EXHIBIT 1

State OPEB Liabilities Rival Net Tax Supported Debt



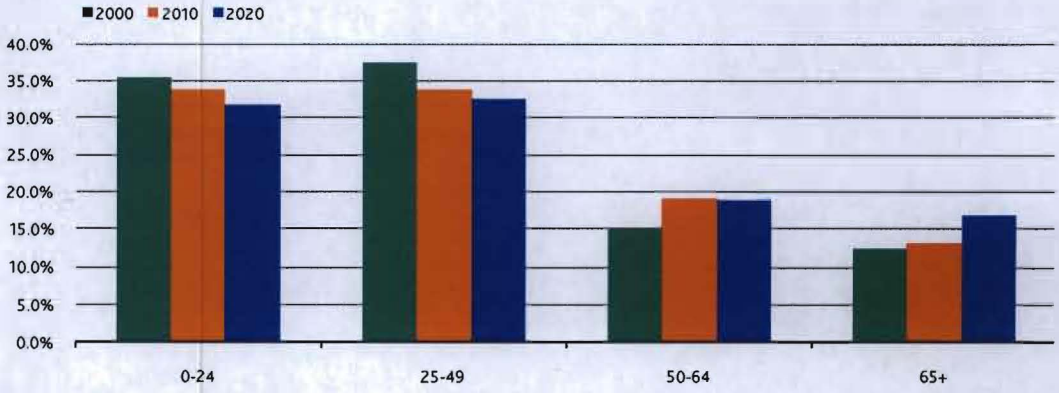
Source: State Comprehensive Annual Financial Reports, fiscal 2012

Demographic Trends and Policy Changes Point to More Liability for 65+ Retirees

In coming years, state and local OPEB liabilities will become increasingly concentrated among retirees over age 65. As the baby boom ages and longevity increases, this cohort as a percentage of the total population is growing nationwide. (See Exhibit 2).

EXHIBIT 2

US Age 65+ Population Grows



Source: US Census Bureau; Moody's Analytics

[2] Reported annual payments may include payments for cost sharing plans and on-behalf payments made for other levels of government. The total includes OPEB ARC payments made by a small number of states.

8

In addition to demographic trends, two policy-related factors will drive down the proportion of retirees who are ineligible for Medicare relative to eligible retirees. First, while ineligible retirees consist primarily of those retiring before age 65, a portion includes retirees entering government service prior to 1986, when Medicare participation for state and local government employees became mandatory. Over time this group will shrink relative to those covered by Medicare.[3] In this regard, the public sector is up to twenty years behind the private sector, given the creation of the federal program and its broader applicability to private sector employees in 1966.

Second, the proportion of retirees younger than 65 will also decline over the longer run due to recent pension reforms by governments that have raised retirement ages. Many governments have already implemented such reforms for new employees, and some are also making changes to retirement age for previous hires, though the legal ability to do so varies based by state. Rising retirement ages will have the effect of reducing the growth of OPEB liability for those younger than 65 and increasing the share of liability related to the Medicare-eligible population.

Local governments have a higher proportion of retirees younger than 65 because they have more retirees from police and fire departments where retirement ages tend to be lower than for other government employees. Benefits provided to younger retirees are generally more comprehensive than those provided to Medicare-eligible retirees and therefore will feature more expensive premiums and may account for a large proportion of total OPEB liabilities. Whether cost changes to benefits for younger or older retirees save more money in the long run will depend in part on the mix of retirees and the relative generosity of benefits.

Exhibit 3 compares the composition of OPEB liabilities for New York City and Maryland. Both entities document liabilities for Medicare-eligible retirees separately from liabilities for ineligible retirees in their OPEB valuations, a useful level of disclosure which is not typical. Nearly half the total present value of New York's $71 billion in fiscal 2013 actuarial accrued liability of retiree health benefits pertain to promises to cover pre-Medicare retirees. New York's liability for Medicare-eligible retirees includes its promise to pay Medicare Part B (outpatient care) premiums, an unusually generous benefit which Maryland does not provide. Without the Medicare Part B liability, Medicare-eligible benefits would account for only 40% of New York's adjusted total. In contrast, Maryland's smaller $9.7 billion accrued liability (in fiscal 2011) is predominantly due to benefits for Medicare-eligible retirees.[4] This difference in the distribution of liability between Medicare and pre-Medicare liabilities is partially explained by the greater presence of police and firefighters among NYC retirees. This difference demonstrates that Medicare-based reforms will provide greater long-run cost savings in some jurisdictions than in others depending on the mix of retirees, posing additional challenges to local governments with more uniformed personnel eligible for early retirement.

[3] Many municipalities participated in the program prior to 1986 under special arrangements with the US Social Security Administration.

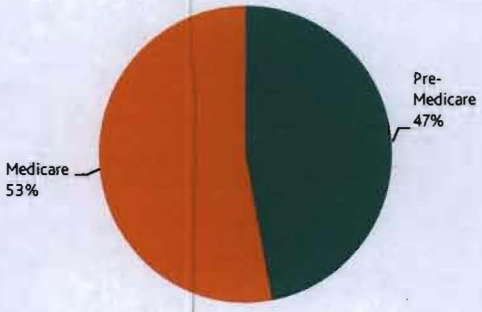
[4] The Medicare share would be considerably larger in previous valuations before Maryland implemented reforms related to prescription drug coverage for Medicare-eligible retirees.

9

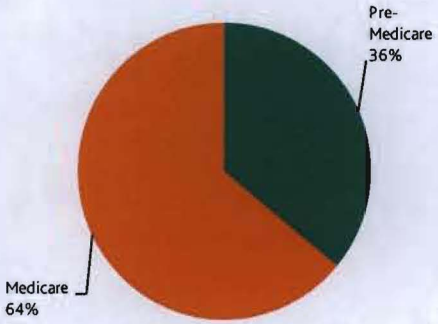
EXHIBIT 3

State Government OPEB Liability Weighted Toward Medicare-Eligibles

New York City



State of Maryland



Source: State of Maryland - fiscal year 2011; NYC Office of the Actuary - fiscal year 2013. NYC total net of Cadillac tax.

Many Governments are Trimming OPEB

Many governments have already moved to trim the cost of benefits for Medicare-eligible retirees. These initiatives include cost-shifting, such as requiring increased co-payments or premium contributions from retirees for supplemental benefits, as well as initiatives to reduce the growth of health costs more directly ("bending the curve"). Cost shifting provides more immediate reductions in employer liabilities and annual expenses but does not directly affect growth rates going forward because it merely redistributes some of the existing cost burden to retirees from employers.

Surveys indicate that state and local governments have widely pursued initiatives to contain retiree health costs. About two-thirds of governments responding to surveys cited by the Center for State and Local Government Excellence indicated that they had made changes to retiree health care in recent years, with the most common changes being increases to retiree premium contributions, co-payments and deductibles.[5] These changes affect all retirees, not just those that are Medicare eligible.

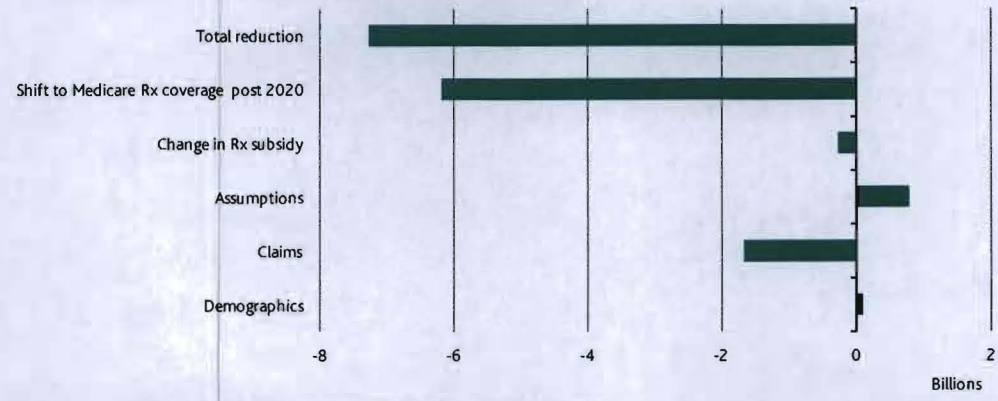
Maryland (Aaa stable) significantly reduced its OPEB liability, to $9.4 billion from $16.1 billion in 2010, with a 2011 change that increased prescription drug copayments, retiree premium payments and out-of-pocket maximums. The reforms also increased the service requirement for retiree health benefit eligibility and will require retirees to enroll in Medicare Part D (prescription drug coverage) in 2020 when the Part D federal coverage is scheduled to improve through eliminating the coverage "donut hole". Even though it will take place several years hence, the shift of prescription drug coverage from state-funded insurance to federally-funded Part D accounted for the bulk of the reduction in liability, as shown in Exhibit 5.

[5] Joshua Franzel and Alex Brown, "Spotlight on Retiree Health Care Benefits for State Employees in 2013," June 18, 2013, http://slge.org/publications/spotlight-on-retiree-health-care-benefits-for-state-employees-in-2013

10

EXHIBIT 5

Medicare Part D Switch Chops Maryland OPEB Liability in 2011



Source: State of Maryland Retiree Health Plan Actuarial Valuation Report as of July 2011

Where benefits in excess of Medicare are most generous there are the greatest opportunities to find savings. While some municipalities provide no or minimal retiree health insurance subsidies, many employers subsidize both Medicare premiums and so-called "Medigap" insurance plans designed to supplement Medicare because it does not provide comprehensive coverage – for example, regular physician well visits are not covered. Some local governments in Rhode Island historically offered retiree health benefits that were generous enough to discourage entirely the utilization of Medicare among eligible retirees. Recent state legislation has enabled local governments to require eligible retirees to use Medicare for their primary insurance, which has been acted upon by financially-troubled municipalities Providence (Baa1 stable), Central Falls (B1 positive) and Woonsocket (B3 negative).[6] In the case of Central Falls, which restructured its liabilities in a Chapter 9 proceeding, implementing this shift and taking other actions resulted in a 55% reduction in the city's OPEB liability.

Medicare Components

Medicare has four components. The Medicare components are associated with various patient premiums, copayments and deductibles.

- Medicare Part A covers hospitalization and some rehabilitation/convalescence costs;
- Medicare Part B covers certain outpatient costs;
- Medicare Part C rolls the different components of Medicare coverage into one plan (essentially an HMO) and may include supplemental coverage;
- Medicare Part D covers prescription drug costs up to a certain level of spending, after which there is no coverage until the recipients exceed a specified level of "catastrophic spending." This coverage gap is popularly referred to as the "donut hole" and is scheduled to be phased out in 2020.

[6] See Moody's report, Rhode Island Municipalities Look to ACA Exchanges and Other Strategies to Reduce Growing Health Care Exchanges.

With pharmacy costs a rapidly growing portion of health spending, savings in this area can have significant impacts. Governments who provide pharmacy coverage for older retirees receive federal subsidies through the Medicare Part D plan. Prior to 2010's Affordable Care Act (ACA), employers received subsidies through the Retiree Drug Subsidy (RDS) program. The ACA created the Medicare Part D employer group waiver plan (EGWP), which provides subsidies and also allows employers to take advantage of manufacturers' discounts. In addition to deepening the annual cost savings on prescription coverage, the EGWP has the added benefit of its treatment under state and local government accounting rules. Under those rules, subsidy savings under the RDS could not be counted against future liabilities and therefore could not be reflected in governmental financial statements. However, EGWP savings can be counted against liabilities because the savings are programmatic rather than based on grants from the federal government. While this shift could be viewed as an accounting gimmick, the subsidy program does provide real savings which should be reflected in the financial statements of state and local governments.

Government employers including New York (Aa2 positive), Maryland, Delaware (Aaa stable) and Louisiana (Aa2 stable) have obtained such waivers. For New York State, implementing the employer group waiver along with other OPEB reforms was reflected in an OPEB liability decline of 9% from the 2010 valuation to the 2012 valuation. In Maryland, a reduction of $356 million in the 2013 OPEB valuation was due to the transition to an EGWP effective January 1, 2014.

Federal Health Insurance Cushion for Retirees Contrasts with Pension Benefits

We believe the less stringent legal protections of retiree health benefits place them on a different footing than pensions when a government is contemplating reductions in its liabilities. At the same time, the availability of Medicare for most state and local government retirees means that many retirees continue to receive health insurance benefits in the event a municipal employer cuts or eliminates its OPEB liability. While the loss of supplemental coverage from the employer may stress retiree households, those age 65 or older who are enrolled in Medicare continue to benefit from the federal program on the same footing as their private-sector counterparts.

In contrast to OPEB, municipalities have less legal flexibility to reduce retiree pension costs, and retirees are more likely to rely heavily on their government pension for retirement security. Pensions typically have stronger protections under contract law than retiree health benefits and in most distressed municipal situations we observe that pension cuts for current retirees have been avoided. In two California bankruptcy cases, Vallejo and Stockton each reduced or eliminated retiree health coverage while leaving pension benefits untouched, although the Stockton plan has not been finalized. Similarly, Detroit's plan of adjustment proposes a slight reduction to pension benefits, but significant cuts to OPEB benefits.

In addition to pensions' legal status, the avoidance of pension benefit reductions may stem from the fact that more than one-quarter of public employees are not covered by social security and rely entirely on government-funded pensions, their savings and spousal eligibility for social security for retirement income.[7] Lack of access to social security benefits is concentrated in a handful of states, including California, Texas, Louisiana, Ohio, and Colorado among others. This circumstance presents an additional barrier to significant pension cost reductions for many governments.

[7] US GAO, Management Oversight Needed to Ensure Accurate Treatment of State and Local Government Employees, September 2010.

12

OFFICE OF HUMAN RESOURCES

Isiah Leggett
County Executive

Joseph Adler
Director

MEMORANDUM

March 25, 2014

TO: Government Operations and Fiscal Policy Committee
Health and Human Services Committee

FROM: Belinda Fulco, Manager
OHR Health and Employee Welfare Division

SUBJECT: County Wellness Program Update

Thank you for this opportunity to brief you on the status of the County's wellness program.

Since last we met, the County, UFCW Local 1994 MCGEO, MCCFFA/IAFF Local 1664 and Fraternal Order of Police Lodge 35 continue to meet to review the programs in place as well as those being planned for launch in 2014. The two overarching strategies discussed were; 1) to increase employee health literacy and medical self-care, and 2) reducing gaps in care through disease management.

Health literacy and medical self-care began in January 2014 with monthly Benefit Employee Assistance Days to educate employees on the appropriate use of their insurance benefits. Health carrier representatives are on-site providing one on one counseling sessions to answer questions or issues about coverage. In addition, new employees are introduced to the Wellness Program at New Employee Orientation. Department presentations, email blasts and mailers about the wellness offerings from ComPsych, the County's new EAP vendor, have started as well. The Wellness Program will address not only physical wellbeing, but also mental wellbeing to assist in creating a life/work balance. A flyer outlining the EAP basic and concierge services is attached for your information.

Disease management will be addressed not only with individual carrier contracts, but also through partnership with Conifer. We are in the process of collecting claims data to fill in the gaps from the last data study so that there will be 4 to 5 years of County data maintained in the warehouse to begin. Once the data is properly housed, analysis and stratification will be performed to determine cost drivers, trends in care, compliance with evidence based medicine, etc. We will then move on to targeted disease management to reduce health status migration from low-risk to moderate and high-risk. Conifer is responsible for disease management to the high risk population and, along with its Wellness partner, LifeWork Strategies, in developing targeted wellness strategies.

UFCW Local 1994 MCGEO invited Brenda Salas to hold wellness briefings for the Stewards on the development of targeted department programs. Two briefings have taken place to date for the Stewards in the Department of Transportation, Transit Division, and Department of Liquor Control, both warehouse and retail. Both presentations were very well received. The MCGEO Stewards engaged in a robust discussion of these programs and will assist in building a culture of wellness by communicating targeted event dates and information for employees of their departments.

These are the first critical steps in building a culture of health and wellness for Montgomery County employees. Attached are slides outlining the Wellness Program events for 2014.

I will be available to discuss this report and the attached information at the Council Committees' meeting on March 27, 2014.

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15

2014 Events For All Employees

May	June	July	Aug	Sept	Oct	Nov	Dec
Program Launch	•Biometric Screenings •On-site Fitness classes begin (PSHQ) •"Our Weigh Together" On-site Weight Mgmt begins (Regional Training Centers) •Wellness Lunch and Learns	•"Walking Works" Program Launch •Biometric/ Screenings Health Assessmen t launch	•"Know Your Numbers" launch •DPCA Screening (PSHQ)	•YMCA DPP Program Launch •Prevent Influenza Education Campaign	•Health Fair at Open Enrollment •"Thrive Across America" Launch	•"Holiday Boot Camp" Launch	Biometric Screenings/ Health Assessment

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91

2014 Targeted Department Programs

AGENCY	PROGRAM	DESIRED OUTCOME(S)	LAUNCH
DOT	"Ride On to Better Health"	↓ CHD and Diabetes Risk Factors ↓ Musculoskeletal Issues	4/1/14
DLC	"Healthy Backs"	↓ Musculoskeletal Issues	5/1/14
DOCR	"Stress-Less for Corrections"	↓ Stress related absences ↑ Resilience in employees	Summer 2014
FIRE	"Fire Station Nutrition"	↓ CHD Risk Factors ↑ Healthy Eating Concepts at Fire Stations	Fall 2014
ECC	"911 for Better Health"	↓ Stress related absences ↑ Resilience in employees	TBD

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(11)

DOT Wellness: "Ride On to Better Health" 2014 Timeline

Program Component	April 2014	May 2014	June 2014	July 2014	August 2014
Event	•DOT Wellness Program Launch Announcement •On-site Biometric Screening, Vision Screen and Health Fair (all 3 depots) •Participation by WPM at CS Trainings begins, held monthly throughout 2014	•PA areas identified at each bus depot (outdoor walking routes and indoor stretching areas) •Placement of BP/BMI stationary screening stations at each depot •"WE CARE" manual distributed	•DOT Seminar: "Healthy Backs at Work" (each depot)	•DOT Seminar: "Healthy Dining on the Road"	•DOT Seminar: "Take a Stretch Break!"

Program Component	September 2014	October 2014	November 2014	December 2014	January 2015
Event	DOT Seminar: "Bus-ercise: Exercise At Your Bus!"	DOT On-site Biometrics and Postural Assessments	DOT Seminar: "Healthy Backs at Work"	DOT Seminar: "Posture Perfect or Imperfect?"	TBD

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18

DLC Warehouse & Retail Wellness
"Healthy Backs at Work" 2014 Timeline

Program Component	April 2014	May 2014	June 2014	July 2014	August 2014
Event	DLC Wellness Program Launch Announcement	•DLC On-site Biometrics and Postural Assessments •Completion of on-site exercise area (posters and large mat) in mezzanine area of DLC Warehouse	•DLC Seminar: •"Healthy Backs at Work" •DLC Seminar: On-site demonstration of Back Care Exercises and Safe Lifting Techniques	•DLC Seminar: "Posture Perfect or Imperfect?"	•DLC Seminar: "Injury Prevention" DLC Seminar: On-site demonstration of Back Care Exercises and Safe Lifting Techniques
Program Component	**September 2014**	**October 2014**	**November 2014**	**December 2014**	**January 2015**
Event	•DLC Seminar: "Be a Warrior for Life: Men's Health"	•DLC Seminar: "Healthy Backs at Work"	•DLC On-site Biometrics and Postural Assessments •DLC Seminar: On-site Back Care Exercises and Safe Lifting Techniques	•DLC Seminar: "Posture Perfect or Imperfect?"	TBD

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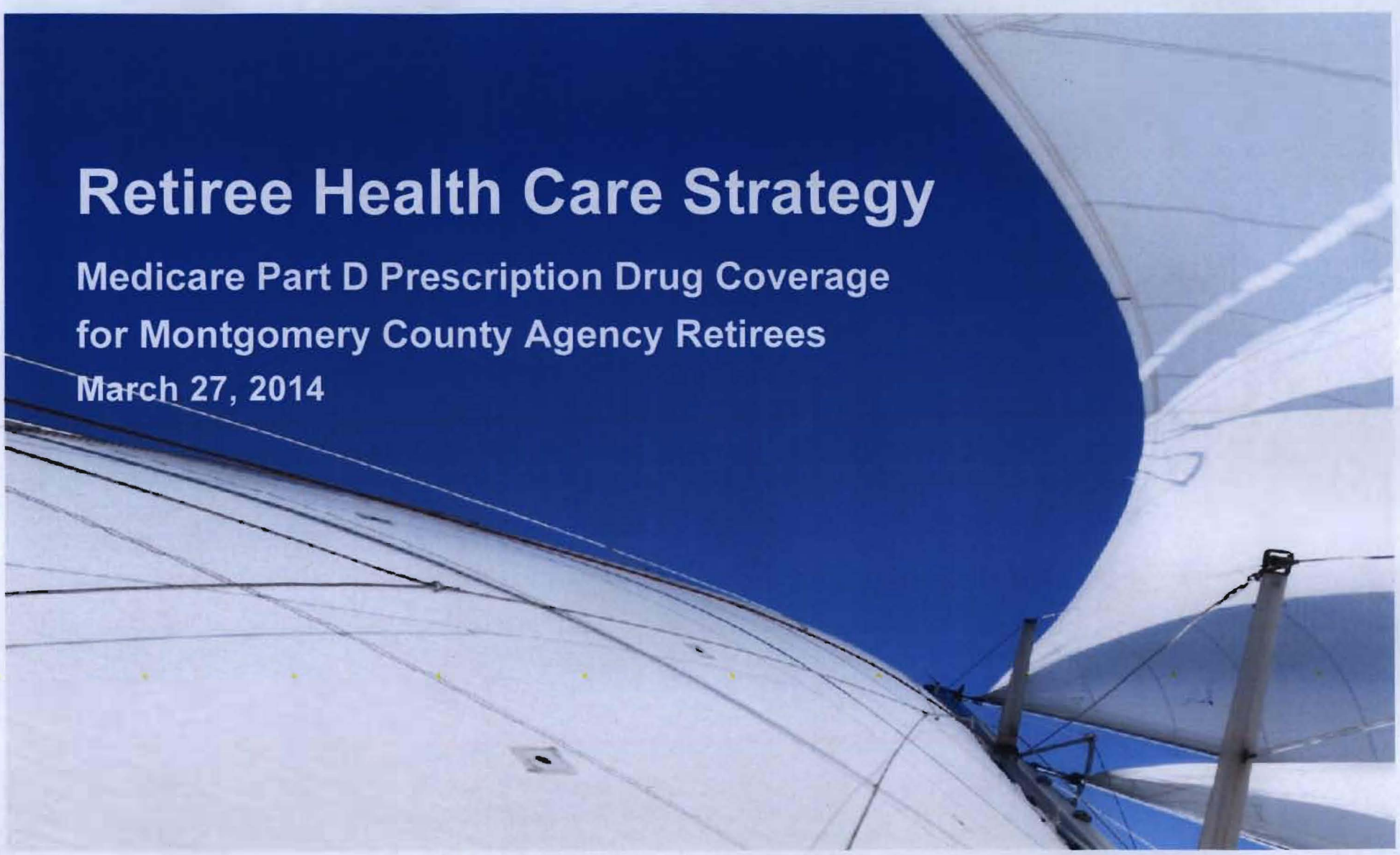
61

Retiree Health Care Strategy

Medicare Part D Prescription Drug Coverage for Montgomery County Agency Retirees

March 27, 2014



Prepared by Consulting
Health & Benefits | Retirement

AON

The Impact of Health Care Reform on Retiree Strategy

Challenges

2011: Group insurance market reforms including benefit design and compliance requirements

2011: Medicare Advantage program changes

2012: New taxes and fees

2013: Loss of RDS tax deductibility

2014: Individual coverage mandate and additional group market reforms

2018: Excise tax on high-cost plans

Opportunities

2010: Early Retiree Reinsurance Program

2011: 50% discount on brand drugs dispensed in the Medicare Part D "donut hole"

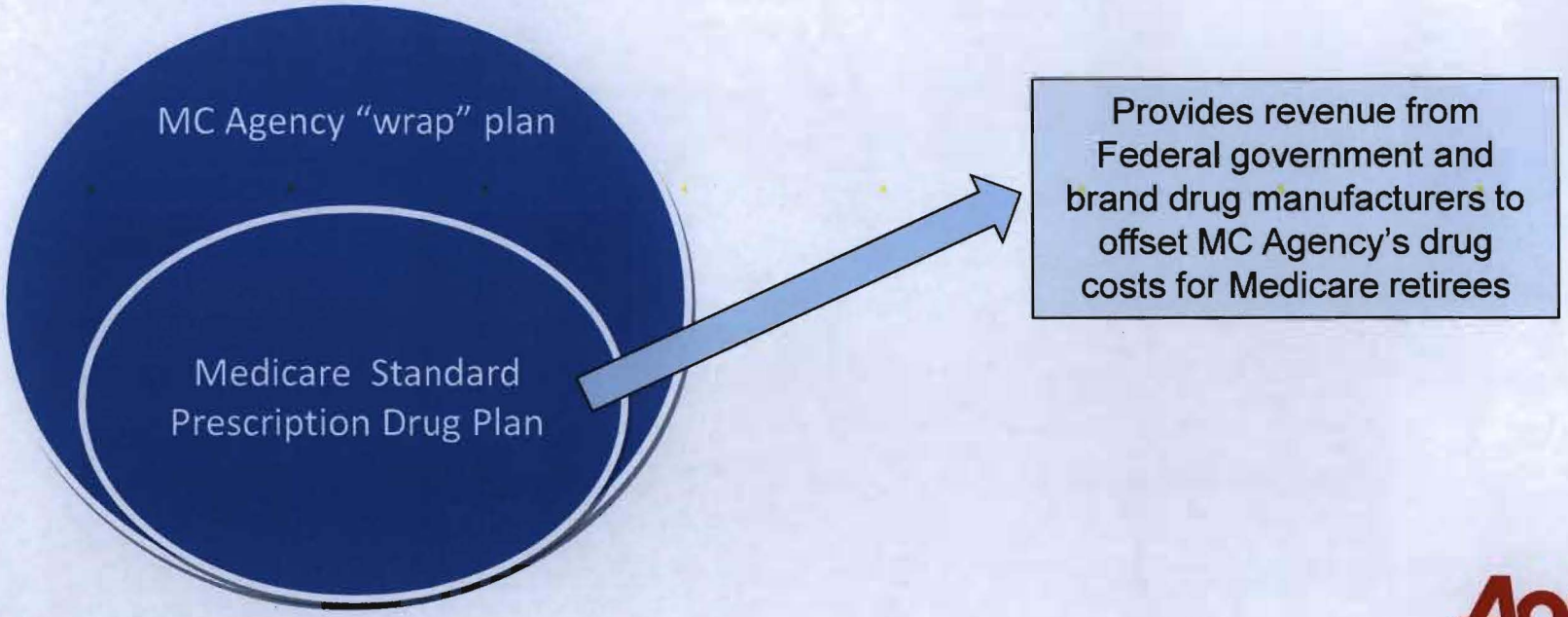
2011: Closing of Medicare Part D "donut hole" (through 2020)

2014: Introduction of individual insurance market reforms and state-sponsored health insurance exchanges

Health care reform introduces significant challenges and opportunities for plan sponsors and creates the impetus for change

Medicare Retirees Prescription Drug Coverage

- MC Agency converts the current Rx arrangement into a **group Standard Part D plan design**
- MCA Agency provides a **secondary, or "Wrap", plan design around the Standard Part D plan** which attempts to **preserve the current prescription drug plan design (copays) and formulary strategy (covered drugs),** from the retiree's perspective
  - The Standard Part D and Wrap coordinate at the pharmacy, with one ID card, so that retirees only experience the Wrap plan design and formulary strategy
  - **This can ensure that virtually no benefit disruption is created for the retiree**
- Called an **"EGWP+Wrap"**



What is an EGWP?

Employer Sponsored Group-Based Medicare Part D Plan

- Plan sponsor contracts directly with one or more Prescription Drug Plans (PDPs) to provide at least Part D level prescription drug coverage to its Medicare-eligible participants on a group basis
  - **Plan sponsor typically converts the current commercial prescription drug program into a group-based Medicare Part D plan supported by the current PBM (PDP)**
- CMS has established a federal waiver process ("800-Series" EGWP) in order to facilitate group-based offerings
  - Intended to eliminate some requirements and provide plan sponsors with flexibility
  - Waives the need for the PDP to provide numerous individual local market filings in support of a regional or national plan sponsor strategy
- PDP handles main administrative requirements, manages all federal interaction, collects federal Part D plan subsidies, and assumes compliance responsibilities
  - Removes administrative burden of collecting Retiree Drug Subsidy (RDS) reimbursements from plan sponsor
  - Minimizes plan sponsor federal audit risk
- Retirees enroll in the Part D program through the plan sponsor's PDP

Why is the EGWP Financially Appealing?

Medicare Part D Subsidies to EGWPs are Significant Relative to the RDS

- Federal subsidy to EGWP takes the form of:
  - **Direct capitation payments**: fixed dollar, based on the national average individual market PDP competitive bids for the year
    - Adjusted for risk-profile of plan sponsor's population
  - **Reinsurance payments**: for catastrophic coverage, if applicable
  - On average, CMS expects these subsidies to represent 74.5% of Standard Part D Plan costs
- Health care reform closes the Standard Part D Plan "donut hole" over time
  - As the "donut hole" is phased-out, Medicare will assume an increasing share of cost in the coverage gap
  - **This will permit EGWP strategies to be eligible for greater federal capitation payments over time as the donut hole is phased-out**
- **Creates material cash and accounting savings opportunities for plan sponsors relative to the RDS strategy**
  - Public sector plan sponsors subject to GASB accounting rules are not permitted to reflect the RDS in their liability and expense calculations, but EGWP revenue directly offsets plan costs in the GASB valuation, **which makes EGWP-based strategies very valuable to GASB-based plan sponsors**

Phase-Out of Medicare Part D "Donut Hole"

Exhibit 1

Standard Medicare Prescription Drug Benefit, 2020

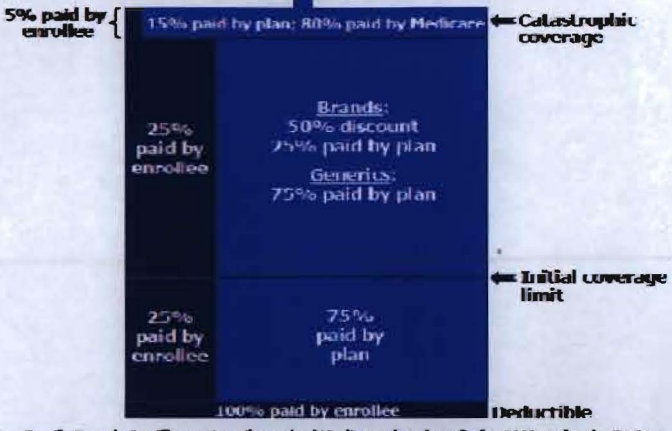
Without Health Reform

SOURCE: Kaiser Family Foundation illustration of standard Medicare drug benefit in 2020 without health reform legislation.

Exhibit 2

Standard Medicare Prescription Drug Benefit, 2020

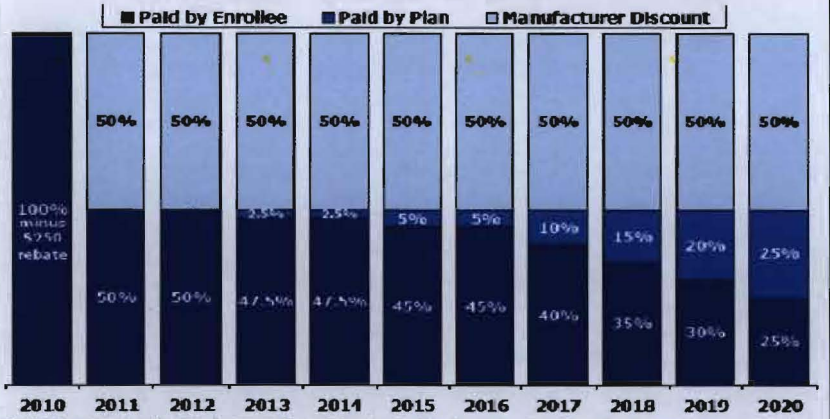
With Health Reform



SOURCE: Kaiser Family Foundation illustration of standard Medicare drug benefit for 2020 under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.

Exhibit 3

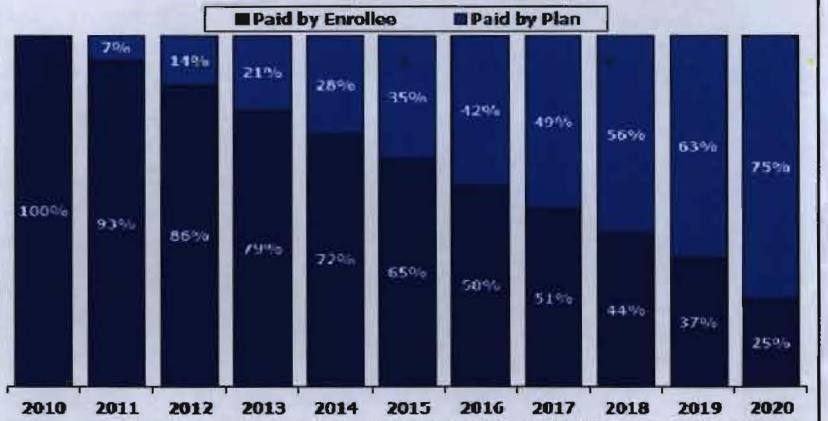
Cost Sharing for Brand-Name Drugs in the Medicare Part D Coverage Gap, 2010-2020



SOURCE: Kaiser Family Foundation analysis of the standard Medicare drug benefit under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.

Exhibit 4

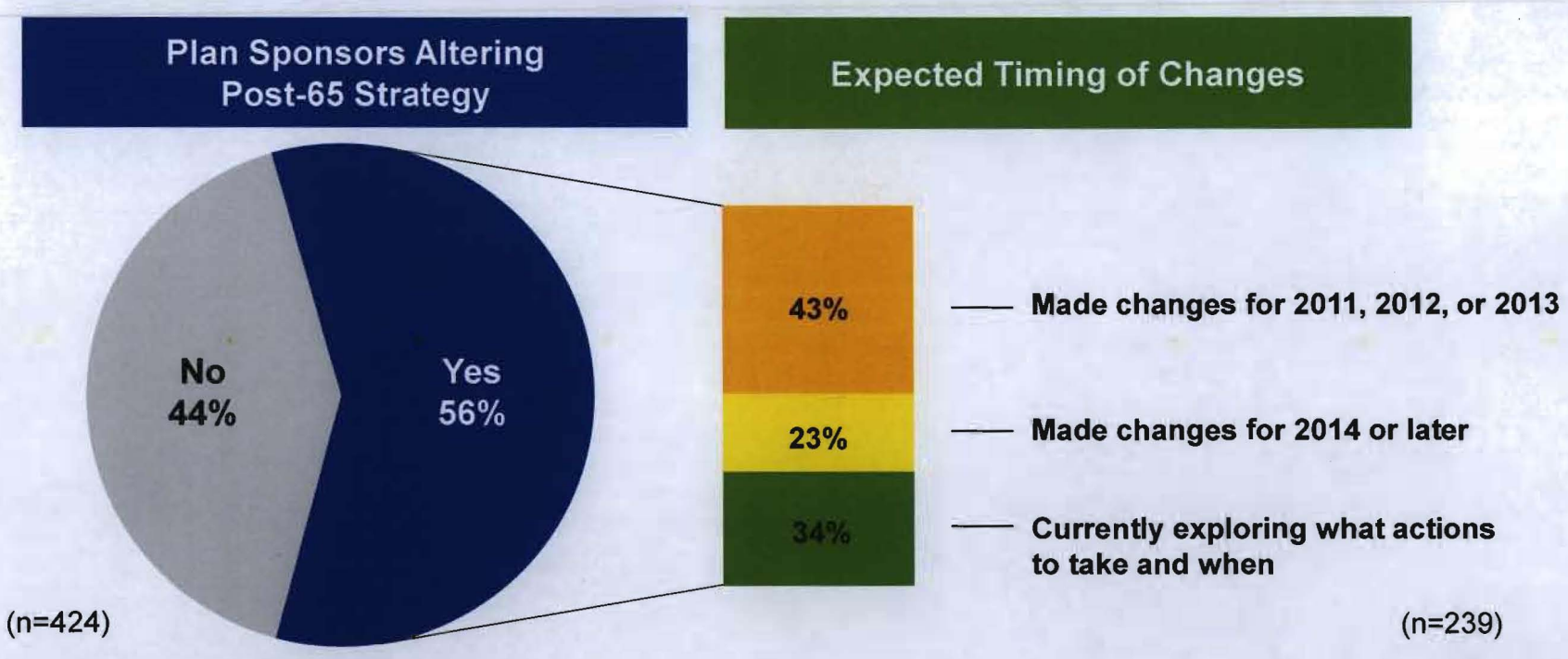
Cost Sharing for Generic Drugs in the Medicare Part D Coverage Gap, 2010-2020



SOURCE: Kaiser Family Foundation analysis of the standard Medicare drug benefit under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.

Medicare Part D Strategy

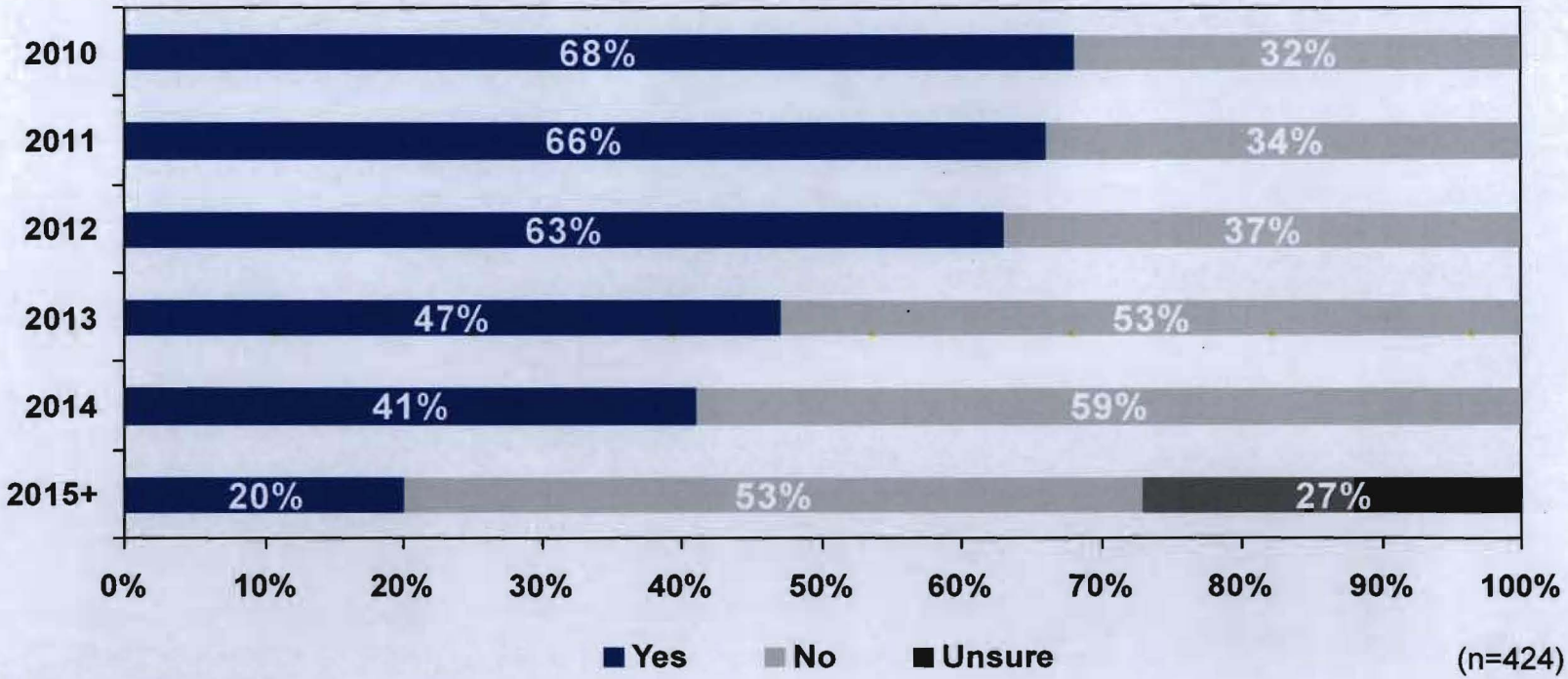
- **56%** of plan sponsors anticipate changing their **Medicare Part D or broader Post-65 retiree strategy due to reform**, with about two-thirds of them having already decided on a new approach, generally due to two specific reform provisions
  - Loss of tax deductibility of the RDS beginning in 2013
  - Enhancements in subsidies to Part D plans over time due to phase-out of the "donut hole," including the introduction of the 50% pharma discount on brand drugs in 2011



Source: 2014 Aon Hewitt Retiree Health Care Strategy Survey

Medicare Part D Strategy—Phase-Out of RDS Strategy

- **68%** of plan sponsors filed for the RDS in 2010, but by 2015, as few as **20%** may continue
  - The change in RDS tax treatment for 2013 and the Medicare Part D program enhancements are key drivers of change; more and more plan sponsors are expected to abandon the RDS strategy over time for more favorable alternatives
  - Medicare Trustees predict that the 17% of Part D eligibles currently covered under employer-sponsored RDS strategies will fall to 2% by 2016



Source: 2014 Aon Hewitt Retiree Health Care Strategy Survey

Medicare Retirees Prescription Drug Coverage: EGWP + Wrap

- Proposed effective date: January 1, 2015
  - Need at least six (6) months to implement, but suggest longer due to several clients looking to implement with Caremark for 2015
- Each MC Agency contracts with Caremark's Medicare Part D plan, SilverScript
- Currently, each MC Agency applies for and receives Retiree Drug Subsidy (RDS) from the federal government for its Medicare eligible retiree members' drug utilization
  - EGWP + Wrap **replaces the RDS** and will result in **more revenue to offset costs** than RDS
- Illustrative **net cash savings** in total plan Medicare retiree Rx costs, over RDS approach:

Montgomery Agency	Illustrative Incurred Cash Savings * ($ millions)
Government	$0.9
Schools	$2.3
College	$0.1
Park and Planning	$0.3

Results for calendar year 2014, except College and Park and Planning are 2015 estimates

Medicare Retirees Prescription Drug Coverage: EGWP + Wrap

- Estimated **net GASB OPEB savings** for EGWP approach over RDS approach for FY2015
  - RDS is not recognized in GASB OPEB valuation as an offset to costs or liability for the plan
  - EGWP subsidies are recognized as an offset to plan costs and therefore they offset GASB OPEB costs

Change for FY2015	Accrued Liability ($Millions)	Annual Required Contribution (ARC)
Government	$134.7	$12.0
Schools	$224.5	$20.0
College	$18.5	$1.0
Park and Planning*	$43.0	$2.6

*Provided by outside actuary

Medicare Retirees Prescription Drug Coverage: EGWP + Wrap

- The impact on Medicare retirees is minimal to none
- Plan design (copays) under the current retiree plan will continue for Medicare retirees
- Caremark's formulary (covered drugs and preferred status) for the plan covering early retirees and actives, which will likely change annually as it does today, will continue for Medicare retirees
  - EGWP+Wrap will first process under Medicare Part D EGWP formulary, but then the Wrap will protect the member experience at the pharmacy and honor early retirees' plan formulary
  - Because the EGWP formulary is different than the early retirees' formulary, Medicare Part D requires additional communications to retirees when they submit for a drug different than how the EGWP formulary would cover it
    - Could result in increased communications for some retirees
    - SilverScript customer service can assist with retiree questions
  - Some retirees may be required to gain prior authorization for certain drugs they are taking that could result in waiting for their medication at the pharmacy
    - During implementation, retirees currently on these drugs will be advised to get with their physician to prepare for the prior authorization request the first time they need this medication after the effective date

Medicare Retirees Prescription Drug Coverage: EGWP + Wrap

- Some retirees eligible for low income subsidies under the Part D program will pay less for coverage
  - Low income status is determined by the federal government after the retiree applies for it through Social Security
  - Applies to individuals with income less than 150% of Federal Poverty Level ($17,200 in 2013 for single person) and assets less than $11,570 (for single person in 2013)
- Subsidies vary by income levels and take the form of premium subsidies and cost share subsidies
- Typically, employer groups have a small segment of their retiree population who qualify for low income subsidies from Medicare Part D

Medicare Retirees Prescription Drug Coverage: EGWP + Wrap

- High income retirees will see additional premiums for Rx coverage just as they do now for Medicare Part B coverage, based on their filing status and yearly income (adjusted gross income) 2 years prior
  - Extra premiums range from $12 - $69 per person per month in 2014, based on adjusted gross income (AGI) in 2012
  - Triggers at $85,000 AGI for single income tax filer and $170,000 for joint income tax filer

File individual tax return	File joint tax return	File married & separate tax return	You pay (in 2014)
$85,000 or less	$170,000 or less	$85,000 or less	your plan premium
above $85,000 up to $107,000	above $170,000 up to $214,000	not applicable	$12.10 + your plan premium
above $107,000 up to $160,000	above $214,000 up to $320,000	not applicable	$31.10 + your plan premium
above $160,000 up to $214,000	above $320,000 up to $428,000	above $85,000 up to $129,000	$50.20 + your plan premium
above $214,000	above $428,000	above $129,000	$69.30 + your plan premium