MERCER

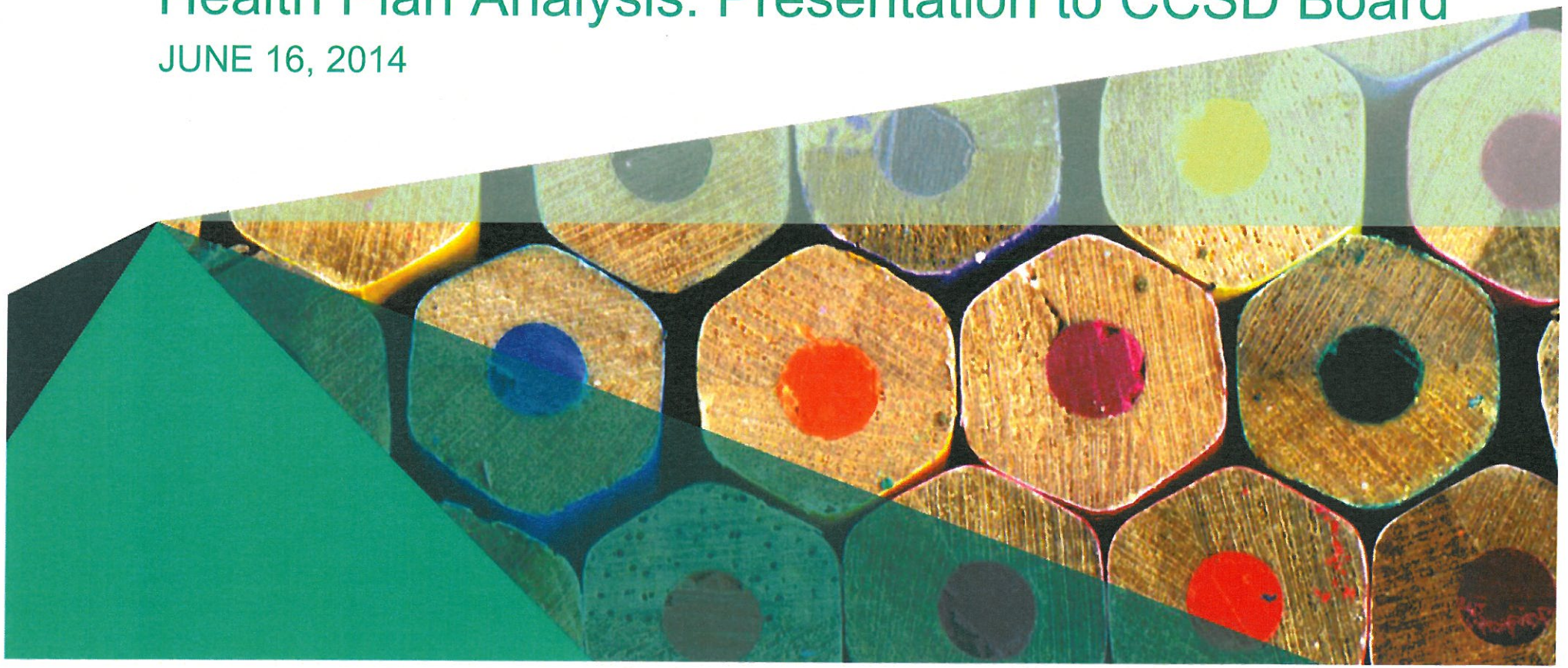
TALENT • HEALTH • RETIREMENT • INVESTMENTS

Not Peer Reviewed

Clark County School District (CCSD) and Clark County Education Association (CCEA)

Health Plan Analysis: Presentation to CCSD Board

JUNE 16, 2014



MARSH & McLENNAN COMPANIES

Table of Contents

Section #1

CURRENT DYNAMICS

Current Situation

- CCSD offers 6 plans across 3 managed care platforms (HMO, POS, and PPO)
- CCEA offers 2 PPO options
- Both organizations are limited by State funding
- CCSD has historically modified coverage and contributions to fit the State allocation
- CCEA has historically covered any funding shortfalls through a reserve in order to maintain the level of benefits
- Both organizations have delivered competitive, cost effective benefits
- Both organizations are concerned with their ability to continue to provide affordable health care coverage over the long term

Current Situation: CCSD vs Benchmark Data

Managed Care (HMO)

Lower — At Market — Higher

	CCSD	National 500+	Southwest 500+	Government 500+	School Districts 500+
Average Age	48	42	41	44	42
Annual HMO Cost per Employee	$6,694	$11,134	$9,280	$11,920	$11,800
Monthly Employee Contribution					
Single	$53	$119	$95	$77	$121
Family	$253	$401	$382	$267	$377
Contribution as a % of premium					
Single	16%	23%	23%	12%	24%
Family	30%	31%	30%	18%	32%
Cost-sharing					
Physician	$10	$20	$25	$20	$20
Specialist	$10	$35	$40	$40	$43
Inpatient	$300 Max	$250 + 10%	$300 + 20%	$250 + ID	$250 + 10%
Outpatient Surgery	$50	$125 + 10%	$150 + 20%	$75 + ID	$175 + 10%
Emergency Room	$25	$100	$150	$100	$100

Current Situation: CCSD vs Benchmark Data
Managed Care (HMO)

Lower **At Market** **Higher**

	CCSD HMO	National 500+	Southwest 500+	Government 500+	School Districts 500+
Retail					
Generic	$5	$11	$11	$10	$9
Brand-name Formulary	$15	$31	$35	$26	$26
Brand-name Non-formulary	$25	$50	$53	$43	$44
Mail-order					
Generic	NA	$21	$22	$16	$19
Brand-name Formulary	NA	$62	$72	$49	$55
Brand-name Non-formulary	NA	$105	$116	$89	$98

Current Situation: CCEA vs Benchmark Data

PPO Plan

Lower **At Market** **Higher**

	CCEA	National 500+	Southwest 500+	Government 500+	School Districts 500+
Average Age	43	43	42	45	42
Annual Cost per Employee	$9,304	$10,658	$9,879	$11,478	$11,715
Monthly Employee Contrib.					
Single	$34	$121	$100	$89	$115
Family	$177	$416	$418	$334	$522
Contrib. as a % of premium					
Single	12%	23%	22%	15%	20%
Family	12%	31%	34%	25%	39%
Deductible (INN/OON)					
Single	$0	$500 / $1,000	$500 / $1,000	$400 / $500	$500 / $550
Family	$0	$1,000 / $2,000	$1,000 / $2,000	$900 $1,200	$1,000 / $1,500
Out-of-Pocket Maximums					
Single	$5,000	$2,250 / $4,000	$2,675 / $5,000	$2,000 / $3,000	$2,500 / $4,000
Family	$10,000	$5,000 / $9,000	$6,000 /$11,800	$4,000 / $6,000	$6,000 / $10,000
Cost-sharing (INN/OON)					
Physician	$20 / 30%	$25 / 40%	$25 / 40%	$20 / 30%	$20 / 40%
Specialist	$20 / 30%	$40 / 40%	$40 / 40%	$40 / 30%	$40 / 40%
Lab/ X-Ray	$10 / 30%	20% / 40%	20% / 40%	20% / 30%	20% / 40%
Inpatient	$150/Day; $450 Max	20% / 40%	20% / 40%	20% / 30%	20% / 40%
Emergency Room	$150	$100 + 20%	$150 + 20%	$100 + 20%	$100 + 20%

Current Situation: CCEA vs Benchmark Data
PPO Plan

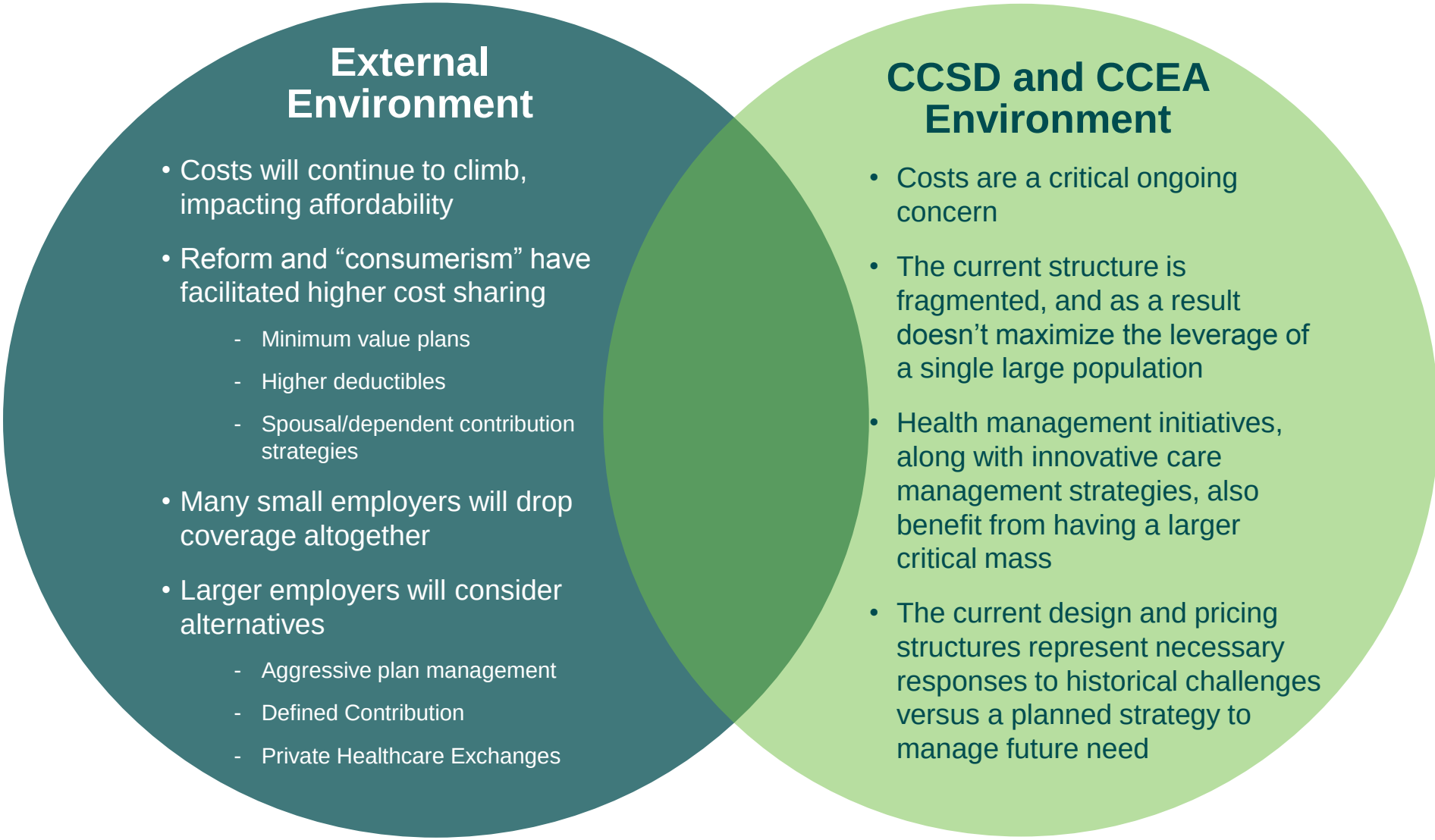
Lower **At Market** **Higher**

	CCEA PPO	National 500+	Southwest 500+	Government 500+	School Districts 500+
Retail					
Generic	$0 ■	$11	$11	$10	$9
Brand-name Formulary	25%; $25Min/$50 Max ■	$31	$35	$26	$26
Brand-name Non-formulary	40%; $40 Min/$80Max ■	$50	$53	$43	$44
Mail-order					
Generic	$0 ■	$21	$22	$16	$19
Brand-name Formulary	$70 ■	$62	$72	$49	$55
Brand-name Non-formulary	$105 ■	$105	$116	$89	$98

Section #2

FORCES DRIVING THE NEED FOR CHANGE

Forces Driving The Need For Change



Potential Options Considered

Maintain Status Quo

- In the short run, existing structures will deliver a favorable result
- In the long run, we anticipate significant cost increases for both plans. Current CCSD insured rates relative to claims experience could magnify the effect of its anticipated trend.
- The current insured rates are locked through 2015, which limits the potential for change
- Left unchecked, anticipated trends are not sustainable

Remain Independent and Implement Plan Changes

- For CCSD, plan changes could lessen the impact of anticipated future rate increases due to the current rating approach
- For both organizations, traditional solutions will be able to marginally bend the cost curve
- While separate initiatives could have an impact, a combined population will create a broader range of options and leveraging opportunities

Create a Consolidated Program

- A consolidated approach would create a broader pool in order to maximize the value of any cost management initiatives
- A broader pool also creates additional market leverage when selecting third party partners to administer the program
- In general, the combined structure better positions the organizations for the future

Section #3

CCSD/CCEA CONSOLIDATION STRATEGY

Key Elements Considered For Consolidation Strategy

- Underlying Funding (Fully Insured vs Self Funded)
- Governance
- Plan Design
- Cost Management Initiatives
- A Key First Step
- Overall Timing

Funding

Funding: Key Issues/Topics

- What are the primary funding options, and how are they different?
- What does current experience reveal?
- Is there a preferred funding approach?
- If so, under what circumstances?
- How should funding strategy evolve over time?

Fully Insured Vs. Self-Funded Programs

The basic difference between Fully Insured and Self-Funded programs is ownership of "risk"

Fully Insured – Vendor "Owns" Risk

- Vendor/carrier is paid a fixed premium based on the number of employees enrolled, or the volume of insurance coverage in exchange for full financial responsibility for the plan. The employer's exposure in that policy year is capped. Vendor's opportunity to recoup losses is with the renewal offer (higher rates the following year).

Self-Funded – Employer "Owns" Risk

- Vendor is providing Administrative Services Only (ASO) for a fee, while the employer is funding the claim expenses from general assets or a trust. The employer has full financial responsibility for the plan. To manage this responsibility on the medical plan, the employer will purchase individual and/or aggregate stop loss insurance.

Primary Cost Components

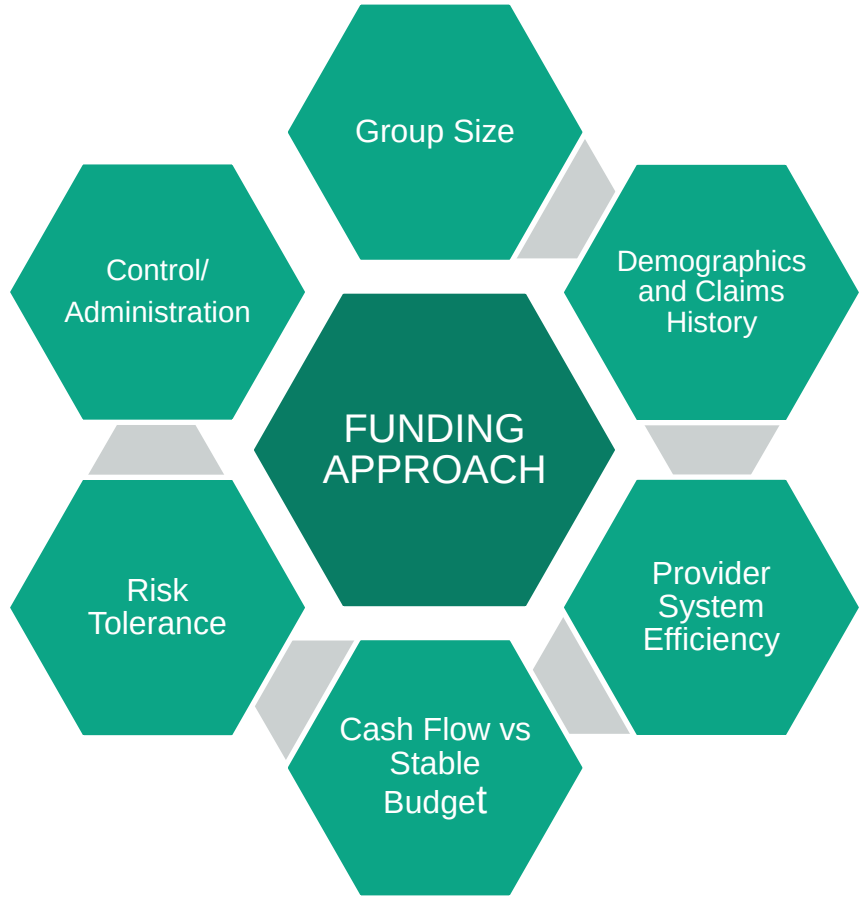
Claims	Retention	Reserves
Actual Claims Experience	Portion of premium or ASO fees retained by an insurer or TPA to cover expenses, risk, and profit	Established at inception of plan, and used to pay “runout” at termination • Runout = claims incurred before termination, but not paid until after termination due to “lag” • Lag = the time period from when a service is provided to when a claim is paid (generally about 2 months)
Claims represent 80% of the cost regardless of funding approach	Self Funded Retention will equal 10% to 20% of plan costs	**Fully Insured** – Insurance company holds reserves to pay the runout
Claims will drive the overall cost of the plan	Fully Insured Retention will equal 20% to 25% of plan costs	**Self-Funded** – Employer holds reserves to pay the runout. Can be fully funded or booked as liability

PROS And CONS of Self-Funding

- **Cash flow advantages:**
  - Pay as you go approach
  - Maintaining reserves
  - Utilizing the float on claim payments
- **Cost savings:**
  - No state premium tax
  - Interest on funds otherwise held by the insurer
  - Avoid costly state mandated benefits
- **Plan control:**
  - Easier monitoring of claims costs
  - Claims data provided
- **Plan design flexibility:**
  - Not bound by state mandates
  - Not required to cover conversions, mental health or alcoholism
- **Stability of self-funding:**
  - Employers rarely return to fully insured
  - Claims are claims: why pay more than what *your* claims are?
- **Fiduciary Responsibility:**
  - Fiduciary options available
  - Employer does not need to assume full liability

- **Acknowledged claim experience:**
  - Worse than average claim experience could cause higher costs
- **Budgeting the program:**
  - Monthly fluctuation
  - Devise a method of anticipating monthly expenditures
- **Increased employer involvement:**
  - Verifying eligibility
  - Maintaining banking arrangements
  - Additional HIPAA responsibilities
- **Terminating program**
  - Self-funded to fully insured is a double wammy. Paying run-out plus paying fully insured premium.

Variables Influencing Preferred Approach



Funding Analysis:
Summary of Findings

- While CCSD claims experience increased between 2012 and 2013, the Insured premium decreased
- The above relationship is somewhat counter intuitive, and could be driven by any/all of the following:
  - Data accuracy
  - Variation in significant outlier claims
  - Significant variation in provider discounts, and/or provider mix
  - Significant variation in medical management
  - Carrier pricing accuracy
  - Carrier business decisions
- Additional analysis would be required to determine the underlying cause for the unusual cost dynamic
- Overall, the CCSD plan has exhibited a favorable trend pattern over time

Funding Analysis:
Summary of Findings

- The CCEA plan also experienced a favorable shift in claims between 2012 and 2013
- Similar factors as those identified in our CCSD observations could be responsible for the positive CCEA experience, including:
  - Data accuracy
  - Variation in significant outlier claims
  - Significant variation in provider discounts, and/or provider mix
  - Significant variation in medical management
- Additional analysis would be required to determine the underlying experience driver(s)
- Overall, the CCEA plan has also exhibited a favorable trend pattern over time

Funding Analysis:
Consolidation Assumptions

In exploring the impact associated with adopting a uniform funding approach, we applied the following set of assumptions:

- Claims under a self-funded arrangement are the same as claims under a fully-insured arrangement
- Administration fees under a CCSD hypothetical self-funded program would be identical to those under the THT self-funded program
- Commission costs under a self-funded plan would be identical to those under the CCSD fully-insured plan
- The current CCSD fully-insured premium rates are effective through December 31, 2015
- Cost projections under a CCSD hypothetical self-funded program incorporate trend assumptions of 8% for medical claims and 7% for drug claims
- For CCEA, premiums under a hypothetical fully-insured program would include risk charges and premium taxes not currently being imposed on the self-funded program

Funding Analysis:
Consolidation Comments/Observations

- The current CCSD insured arrangement is transferring a significant amount of risk to the carrier
- As a result, any transition to a self funded solution while the current agreement is in force will likely increase overall costs
- Since current rates do not seem to be set appropriately relative to claims experience, at some future point, CCSD is likely to face a dramatic increase in costs
- The current CCEA self funded arrangement appears to be cost effective
- As a result, any CCEA transition to a fully insured solution will likely increase overall costs under the assumption that existing rates being extended to CCSD would apply to the entire population

Funding Analysis:
Consolidation Comments/Observations

- However:
  - A consolidated population would provide the carrier with an opportunity to re-rate the plan
  - As pointed out in our CCSD observations, the current rates do not seem to be set appropriately relative to claims experience. As a result, any re-rating, or any ongoing rate setting could result in significant cost increases if claims are to be reflected accurately
- As a result, a phased in strategy may yield the greatest value, as it allows the group to use the upcoming plan year to establish a foundation for the future:

Governance

Governance: Key Issues/Topics

- What are the primary Fiduciary roles?
- What documents need to be in place?
- What steps need to be taken to create a Governance Structure?
- Sample Governance Structures

Definitions, Roles and Responsibilities*
Fiduciary Roles

- **Trustee** – An organization or group of individuals who hold the plan assets in trust
  - Responsible for administering the plan per the plan document
  - May be limited if "directed" trustee role
- **Plan Sponsor** – Operating through its Board of Directors or other governing body
- **Plan Board or Committee** – Can be one board or committee that oversees both plan investments and plan operations, or there can be multiple sub-committees, with one primarily focused on plan performance and the other on administrative matters
- **Plan Administrator** – Operates all activities of the plan. Duties may include:
  - Providing complete and accurate employee data
  - Maintaining participant records
  - Advising participants and beneficiaries of their rights
  - Ruling on claims, benefits and distribution of benefits

Note: Duties may be delegated and outsourced to the vendor, but delegation does not relieve the fiduciary from liability – you still have an ongoing obligation to monitor

Documentation
Key Plan Documents

Operating a plan according to the written terms of the plan documents is one of a fiduciary's core duties, is at the heart of most administrative errors, and is the focus of most plan audits since plan documents memorialize 125 tax-qualification requirements.

- **Plan document**
  - **Must be current and must be signed** – up to date with recent plan changes
    - *This is the legal and fiduciary responsibility of the plan sponsor (even if vendor provides products)*
  - Should be reviewed annually with your plan advisors and administrators
  - Prior plan documents are helpful to create an audit trail
  - **NOTE:** Plan administration manuals are NOT substitute for the plan document
  - If your vendor relies only on plan administration manual, you should review it to be sure that it is consistent with plan terms and updated to reflect plan amendments

Documentation
Key Plan Documents

- **Trust agreement**
  - May or may not be a stand-alone document (instead, may be incorporated into plan)
- **Summary Plan Description (SPD) and Summaries of Material Modifications (SMM)**
- **Service agreements**
  - Identify services to be provided, extent to which fiduciary duties have been delegated, measurable standards of performance, and limits on liability/indemnification rights
- **ERISA fidelity bond**

Creating a Consolidated Governance Structure
10 Key Steps

1. √ Identify appropriate fiduciaries overseeing plan administration
- Committee charter/bylaws with delegation of authority
- Minutes and periodic reports to Board of Directors or Committee

2. √ Inventory all plan documents – be sure you have the most current, completed and executed versions
- Plan and trust documents
- Vendor/service agreements
- SPDs, SMMs
- Summary Annual Reports and other required notices
- ERISA bond and fiduciary liability insurance coverage

3. √ Review plan documents for accuracy and consistency with other systems
- Eligibility
- Payroll

4. √ Review informal plan documents against plan terms
- Review SPDs, benefit summaries, statements in employee handbooks, plan administration manuals to be sure they conform to plan terms

Creating a Consolidated Governance Structure
10 Key Steps

5. √ Regular review of legislative changes

- Monitor legislative changes and their implications on plans
- Modify plans, policies and documentation as needed to comply with regulatory changes.

6. √ Provide all required materials and notices, to all the right people, on time

- Provide all required enrollment materials, SPDs, and notices to current and former participants in a timely manner
- Comply with limitations on electronic methods for disclosure

7. √ Communicate with your plan providers/TPA

- **Know what your service agreement does (and does not) cover**
  - Plan documentation, amendments & SPDs
  - Required notices – safe harbor, auto enrollment,
  - Census data
  - QDRO determinations
- **Required testing**
  - Employer ACA Shared Responsibility and Affordability
  - Non-discrimination testing section 125
- **Keep them informed about changes in your business**

Creating a Consolidated Governance Structure
10 Key Steps

8. √ Keep up with ongoing plan oversight and maintenance

- Put ticklers on calendar to annually renew bond, fiduciary liability insurance, and check with plan vendor to see if any amendments to plan need to be executed
- Accurate census, enrollment and eligibility records
- Calculation & confirmation of contributions including employer contributions

9. √ Fix mistakes thoroughly and promptly

10. √ Seek professional advice, as needed

- Legal, Accountant, Retirement Plan Consultant

Differences Under a Shared Structure

	Current Structure	Shared Structure
Budget rates	• District	• District
Benefits Levels	• Each group has the ability to make their own choices • Benefits options vary for employees	• Need to come to consensus • Common benefits contributions for all employees
Employee Contributions	• Each determines their own • Varying levels for employees	• Consensus decision • Common contributions for all employees
Eligibility determination	• Labor agreements	• Labor agreements
Eligibility Administration	• Multiple sources of administration. • Potentially some duplication of effort	• Reduced duplication of administration. • May need resources for higher volume
Claims Administration	• Trust fund for under self-funded and self administered programs	• Consolidate number of plan offerings • Some economies of scale on retention
Governance	• Independent Authority	• Joint Authority

Potential Alternatives

	Joint Board or Committee w/ Outside Trust Administrators	Joint Board or Committee w/County program Administration
Budget rates	• District	• District
Benefits Levels	• Board or Committee	• Board or Committee
Employee Contributions	• Board or Committee	• Board or Committee
Eligibility determination	• Labor agreements	• Labor agreements
Eligibility Administration	• Trust	• County Benefits Administration
Claims Administration	• Trust fund for self-funded or self administered programs • Health plan under insured products	• TPA for self-funded • Health plan under insured products
Governance	• Union representatives and management • Requires a quorum to vote	• Union representatives and management • Requires a quorum to vote

Sample Governance Structures

	City of Los Angeles	LA Metro
Employee Populations	• Active Civilian, Sworn Police, Sworn Fire, Dept. Water Power	• Non-Contract, ATU, TCU, UTU
Budget rates	• City CAO – Subject to MOU provisions	• LA Metro – subject to MOU provisions
Benefits Levels	• Civilian – Joint Labor Management Committee • Police – Police relief • Fire – Fire relief • DWP Management and City council for non-contract employees, Bargained benefit levels for union employees	• Non-contract – Management and MTA board • ATU – Joint labor management committee • UTU/TCU union groups determine their benefit levels
Employee Contributions	• Civilian – Joint Labor Management Committee • Police – Police relief • Fire – Fire relief • DWP Management and City council for non-contract employees, Bargained benefit levels for union employees	• Non-contract – Management and MTA board • ATU – Labor agreements determine EE contributions • UTU – Labor agreements determine EE contributions • TCU – Labor agreements determine EE contributions

Sample Governance Structures

	City of Los Angeles	LA Metro
Eligibility determination	• Labor agreements	• Labor agreements
Eligibility Administration	• Civilian – City • Police – Police relief • Fire – Fire relief • DWP - DWP	• Non-contract – LA Metro • ATU – LA Metro • UTU – UTU Trust • TCU – TCU Trust
Claims Administration	• Civilian – Insured HMO and PPO administered by health plans • Police – HMO and PPO administered by health plans various findings • Fire – HMO and PPO administered by health plans various findings • DWP - Insured HMO and PPO administered by health plans	• Non-contract – Insured HMO and PPO administered by health plans • ATU Insured HMO and PPO administered by health plans • UTU – HMO and PPO administered by health plans various findings • TCU – HMO and PPO administered by health plans various findings

Sample Governance Structures

	City of Los Angeles	LA Metro
Governance	• Civilian – Joint Labor Management committee with union and management representation. • Police – Police relief • Fire – Fire relief • DWP – management and council for non-contract employees. Labor management agreements for bargained employees	• Non-contract – management and LA Metro board • ATU – Joint Labor Management committee with union and management representation. • UTU – UTU Trust • TCU – TCU Trust

Plan Design

Plan Design Consolidation Considerations

In exploring the creation of a consolidated design platform, our initial direction was to present several options for the group to consider

The group's objective was to have a new structure in place for 1/1/15

The current CCSD rate structure, however, makes consolidation for 1/1/15 a challenge unless the CCEA is willing to transition to Health Plan of Nevada (HPN), and HPN is willing to extend existing rates to the combined population

Given transition uncertainty, along with the potentially compressed timing associated with other required activities (strategic planning, Governance development, etc), we did not feel that a 1/1/15 solution would be viable

As an alternative, we focused on approaches that would delay the consolidation transition to 1/1/16, and would not be dependent on any specific carrier

Plan Design Consolidation Considerations

We created two design platforms:

Option 1: The first option is a more conventional model that attempts to create a streamlined consolidated structure while still providing meaningful choice

Option 2: The alternative model reflects an expanded choice architecture

Both options could also be incorporated into a Private Exchange model which would:

- Facilitate a defined contribution funding approach
- Provide the infrastructure and participant support necessary to effectively deliver a program with an expanded choice architecture

Plan Consolidation Option 1:

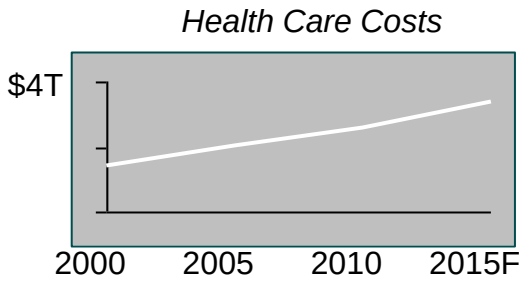
	HMO 1 (90% AV)	HMO 2 (80% AV)	PPO 1 (85% AV)		PPO 2 (75% AV)	
	HMO Plan Providers	HMO Plan Providers	Plan	Non Plan	Plan	Non Plan
Deductible						
Single	None	None	$500	$1,000	$1,000	$2,000
Family	None	None	$1,000	$2,000	$2,000	$4,000
Out of Pocket Max						
Single	$2,500	$4,000	$4,000	$8,000	$5,000	$10,000
Family	$5,000	$8,000	$8,000	$16,000	$10,000	$20,000
Medical Benefits						
Convenient Care/Telemedicine Copay	$5	$10	$5	30%	$10	40%
Primary Care Visit	$10	$40	$20	30%	$40	40%
Specialist Visit	$10	$60	$40	30%	$80	40%
Other Practitioner	$10	$60	$40	30%	$80	40%
Mental Health Outpatent	$10	$40	$20	30%	$40	40%
Mental Health Inpatient	$0	$250/day, $500 max	10%	30%	20%	40%
Substance Abuse Outpatient	$10	$40	$20	30%	$40	40%
Substance Abuse Inpatient	$0	$250/day, $500 max	10%	30%	20%	40%
Urgent Care Copay	$10	$50	10%		20%	
Emergency Room Visit (Emergency)	$25	$250	10%		20%	
Emergency Room Visit (Non Emergency)	$25	$250	10%		20%	
Inpatient Hospital Stay or Surgery	$0	$250/day, $500 max	10%	30%	20%	40%
Outpatient Hospital Surgery	$25 per Surgery	$300 per Surgery	10%	30%	20%	40%
Ambulatory Surgical Facility	$25 per Surgery	$300 per Surgery	10%	30%	20%	40%
Prescription Drugs						
Retail						
Generic	$5	$10	$10		$20	
Brand	$10	$30	$20		$40	
Non-Formulary	$10	$60	$40		$80	
Mail Order						
Generic	$12.50	$25	$25		$50	
Brand	$25	$75	$50		$100	
Non-Formulary	$25	$150	$100		$200	
Relative Value						
Relative Value	90%	80%	85%		75%	

Plan Consolidation Option 2:

	HMO 1 (90% AV)	HMO 2 (80% AV)	HMO 3 (75% AV)	PPO (85% AV)		PPO/HDHP 1 (70% AV)		PPO/HDHP 2 (65% AV)	
	HMO Plan Providers	HMO Plan Providers	HMO Plan Providers	Plan	Non Plan	Plan	Non Plan	Plan	Non Plan
Deductible									
Single	None	None	None	$500	$1,000	$1,500	$3,000	$2,500	$5,000
Family	None	None	None	$1,000	$2,000	$3,000	$6,000	$5,000	$10,000
Out of Pocket Max									
Single	$2,500	$4,000	$6,250	$4,000	$8,000	$4,500	$9,000	$4,500	$9,000
Family	$5,000	$8,000	$12,500	$8,000	$16,000	$9,000	$18,000	$9,000	$18,000
Medical Benefits									
Convenient Care/Telemedicine Copay	$5	$10	$10	$5	30%	20%	40%	20%	40%
Primary Care Visit	$10	$40	$40	$20	30%	20%	40%	20%	40%
Specialist Visit	$10	$60	$80	$40	30%	20%	40%	20%	40%
Other Practitioner	$10	$60	$80	$40	30%	20%	40%	20%	40%
Mental Health Outpatent	$10	$40	$40	$20	30%	20%	40%	20%	40%
Mental Health Inpatient	$0	$250/day, $500 max	$250/day, $1000 max	10%	30%	20%	40%	20%	40%
Substance Abuse Outpatient	$10	$40	$40	$20	30%	20%	40%	20%	40%
Substance Abuse Inpatient	$0	$250/day, $500 max	$250/day, $1000 max	10%	30%	20%	40%	20%	40%
Urgent Care Copay	$10	$50	$50	10%		20%		20%	
Emergency Room Visit (Emergency)	$25	$250	$400	10%		20%		20%	
Emergency Room Visit (Non Emergency)	$25	$250	$400	10%		20%		20%	
Inpatient Hospital Stay or Surgery	$0	$250/day, $500 max	$250/day, $1000 max	10%	30%	20%	40%	20%	40%
Outpatient Hospital Surgery	$25 per Surgery	$300 per Surgery	$500 per Surgery	10%	30%	20%	40%	20%	40%
Ambulatory Surgical Facility	$25 per Surgery	$300 per Surgery	$500 per Surgery	10%	30%	20%	40%	20%	40%
Prescription Drugs									
Retail									
Generic	$5	$10	$25	$10		20%		20%	
Brand	$10	$30	$50	$20		20%		20%	
Non-Formulary	$10	$60	$100	$40		20%		20%	
Mail Order									
Generic	$12.50	$25	$62.50	$25		20%		20%	
Brand	$25	$75	$125	$50		20%		20%	
Non-Formulary	$25	$150	$250	$100		20%		20%	
Relative Value									
Relative Value	90%	80%	75%	85%		70%		65%	

Should CCSD and CCEA Consider an Exchange Model?
Current Market Dynamics

Continued Cost Pressure

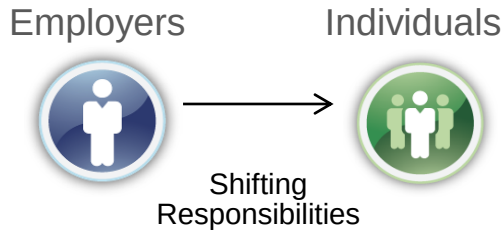


- ***A benefits strategy*** that drives cost efficiency through the healthcare and insurance supply chain
  - Creates new competition among insurers, providers
  - Reduces administrative costs and improves quality through standardization
  - Supports new market entrants enabling competition

Healthcare Reform

- ***Support healthcare reform compliance and leverage its benefits***
  - Streamlines compliance requirements
  - Mitigates 40% excise tax in 2018
  - Leverages ability to offer non-sponsored employees and retirees support for individual medical plan enrollment

Empower Employees



- ***Offers improved employee benefits appreciation***
  - More choice, greater support
- ***Can address the needs of all employees and retirees***
  - Full and part time employees, pre-Medicare and Medicare retirees

How Important Will Private Exchanges Become?

EMPLOYERS ARE MOVING RAPIDLY TO DEFINED CONTRIBUTION AND PRIVATE EXCHANGES

In 2014…

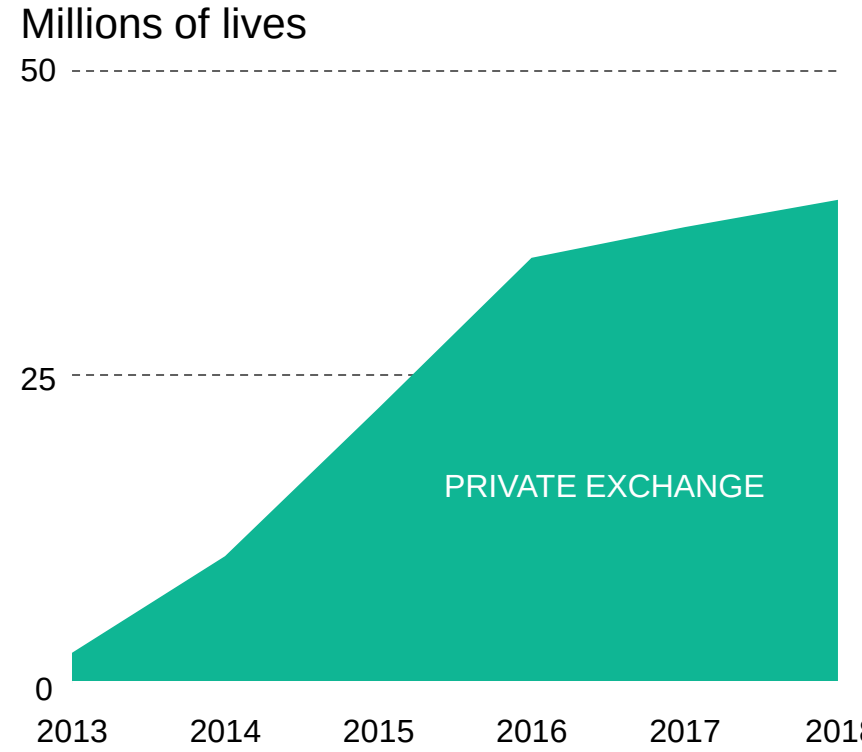
100+ large employers will be offering benefits through private exchanges

35+ exchange offerings will be in-market

180+ carriers will be participating on third-party exchanges

25+ types of products will be available through private exchanges

PRIVATE EXCHANGE GROWTH HAS JUST BEGUN



- 95% of private exchange lives will be employer-sponsored
- 65%+ of employees will likely choose different benefits than they have today

Should CCSD and CCEA Consider an Exchange Model?
Exchange Structure

Funding

Self insured or fully insured

Standard Plan Designs

Choice among multiple, pre-screened plans

Contributions

Traditional or DC

Employee Communications and Education

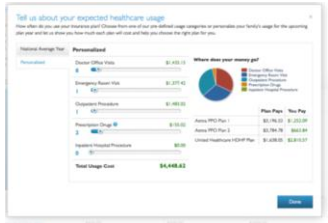
Online

Call Center

Video

Print and email

Enrollment



Administration

Eligibility determination

Data-driven events

Election management

Contribution calculation

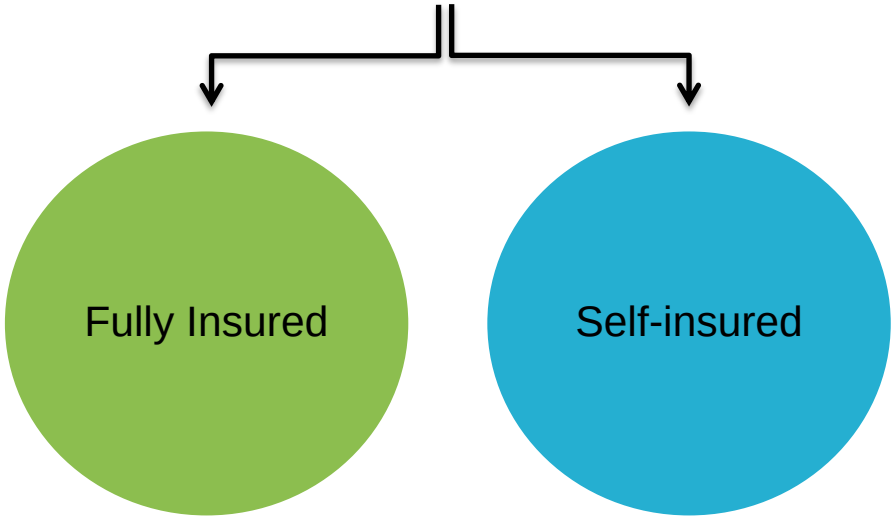
Election Data → Carriers

Deductions → Payroll

Reporting and Premium Data → HR Professionals

Should CCSD and CCEA Consider an Exchange Model?
Keys to Success - Flexibility

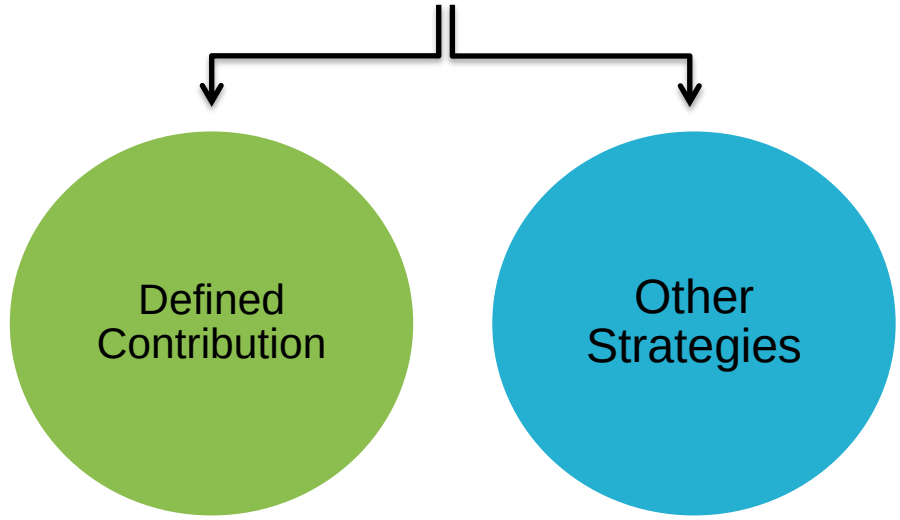
Funding Strategy



Avoids cost variability within the year, but costs more because of risk charges, taxes, mandates

For employers that can accept more risk and within-year variability, save at least 4% to 6%

Contribution Strategy

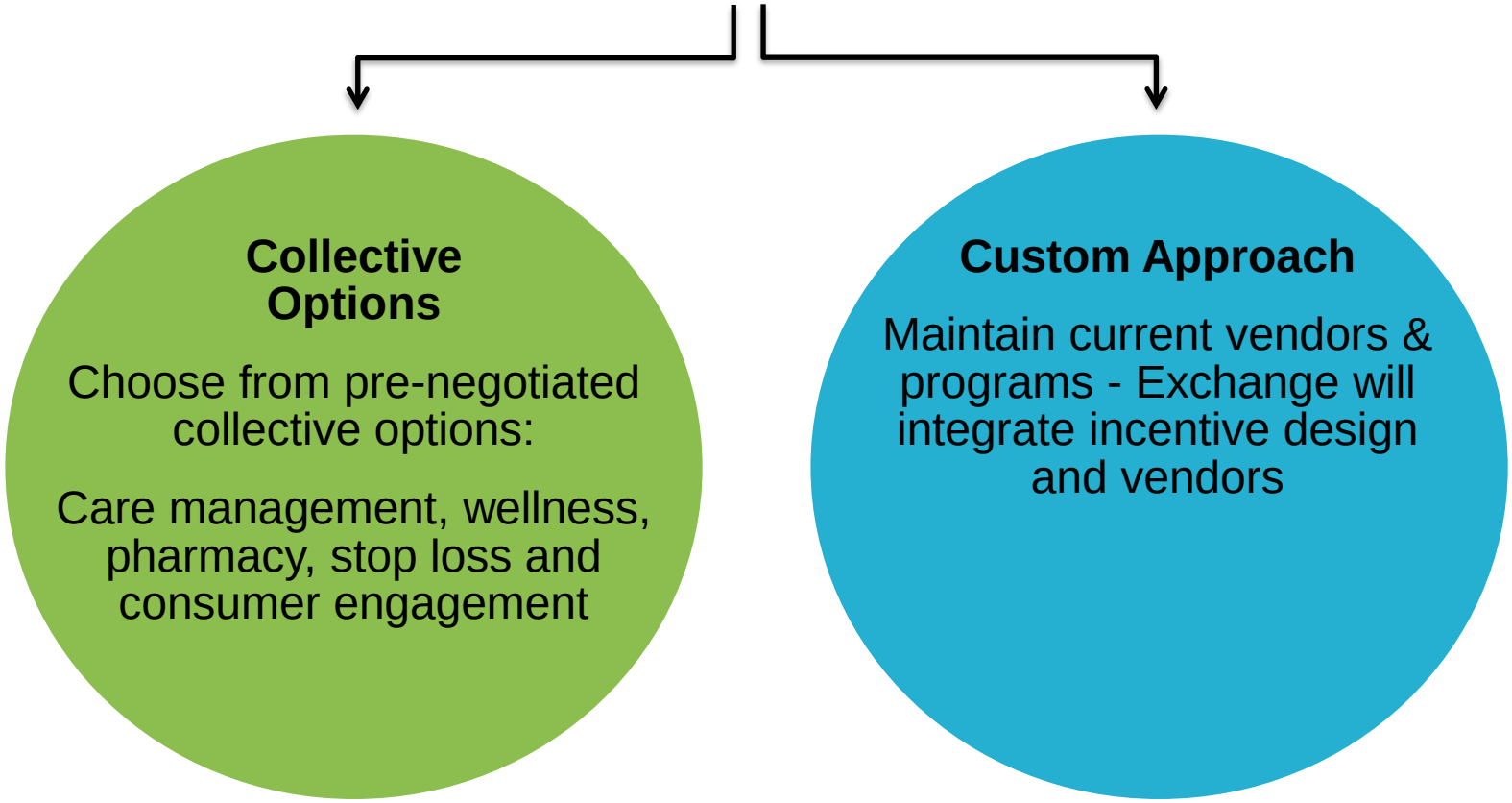


Set flat dollar or percentage employer contribution, regardless of underlying costs

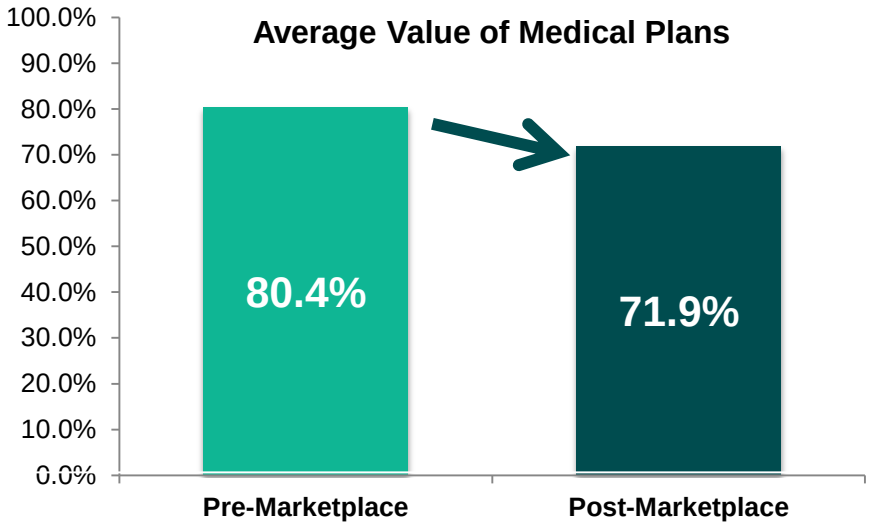
Maintain current contribution strategy, or establish multi-year “glidepath” to DC

Should CCSD and CCEA Consider an Exchange Model?
Keys to Success - Flexibility

Choose the approach that's best for you



Should CCSD and CCEA Consider an Exchange Model?
Initial Marketplace Experience



$800

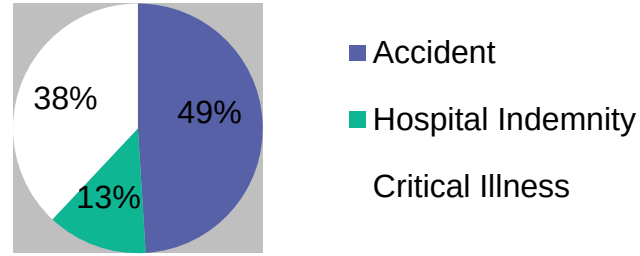
Per-employee cost reduction from right-sizing benefits

Strong Consumer Interest in Supplemental Benefits

24% Of all employees bought supplemental health

35% Of employees electing $1,500 or $2,500 deductible medical bought supplemental health

Supplemental Health Purchases



Cost Management

Maximizing Value

- Taking steps to manage costs effectively will minimize the need for aggressive cost sharing strategies going forward.
- A lower cost baseline will also assist in delaying the potential impact of the health care reform excise tax.
- Based on the current structure, a range of potential initiatives appears possible.
- We have segmented the initiatives into 4 categories:
  - Purchasing efficiency
  - Clinical efficiency
  - Service delivery
  - Consumerism
- Determining the exact impact of these and any other options would require additional evaluation

Potential Cost Management Initiatives

Maximizing Purchasing Efficiency	Maximize Clinical Efficiency	Maximize Service Delivery	Maximize Consumerism
Identify carrier partners who will create greatest pricing leverage: • Medical Discounts • RX "Deals"	As part of carrier selection process, conduct clinical review to assure that care is being managed effectively	As part of carrier evaluation process, select partner who is best positioned to offer alternative network structures • Tiered Networks • ACO models • Patient Centered Medical Home	Introduce Consumer Driven design options along with price transparency tools

Explore value of creating additional pricing leverage through collectives
• Stop Loss
• RX
	Explore value of specific care management initiatives:
	• Traditional Utilization, Condition, and/or Disease Management
	• Higher touch Care Management
	• Targeting of efficient providers
	  • Hospitalist
	  • Best Doctors
		Evaluate viability of:
		• Centers of Excellence
		• Telemedicine
		• Minute Clinics
			Consider Defined Contribution combined with expanded choice, decision support, and high deductible health plans

Determine ongoing cost differences between delivery models • HMO • PPO	Explore value of Quality Improvement Coalition	Evaluate viability of on-site clinic	Consider contributions linked to wellness/health management initiatives

Section #4

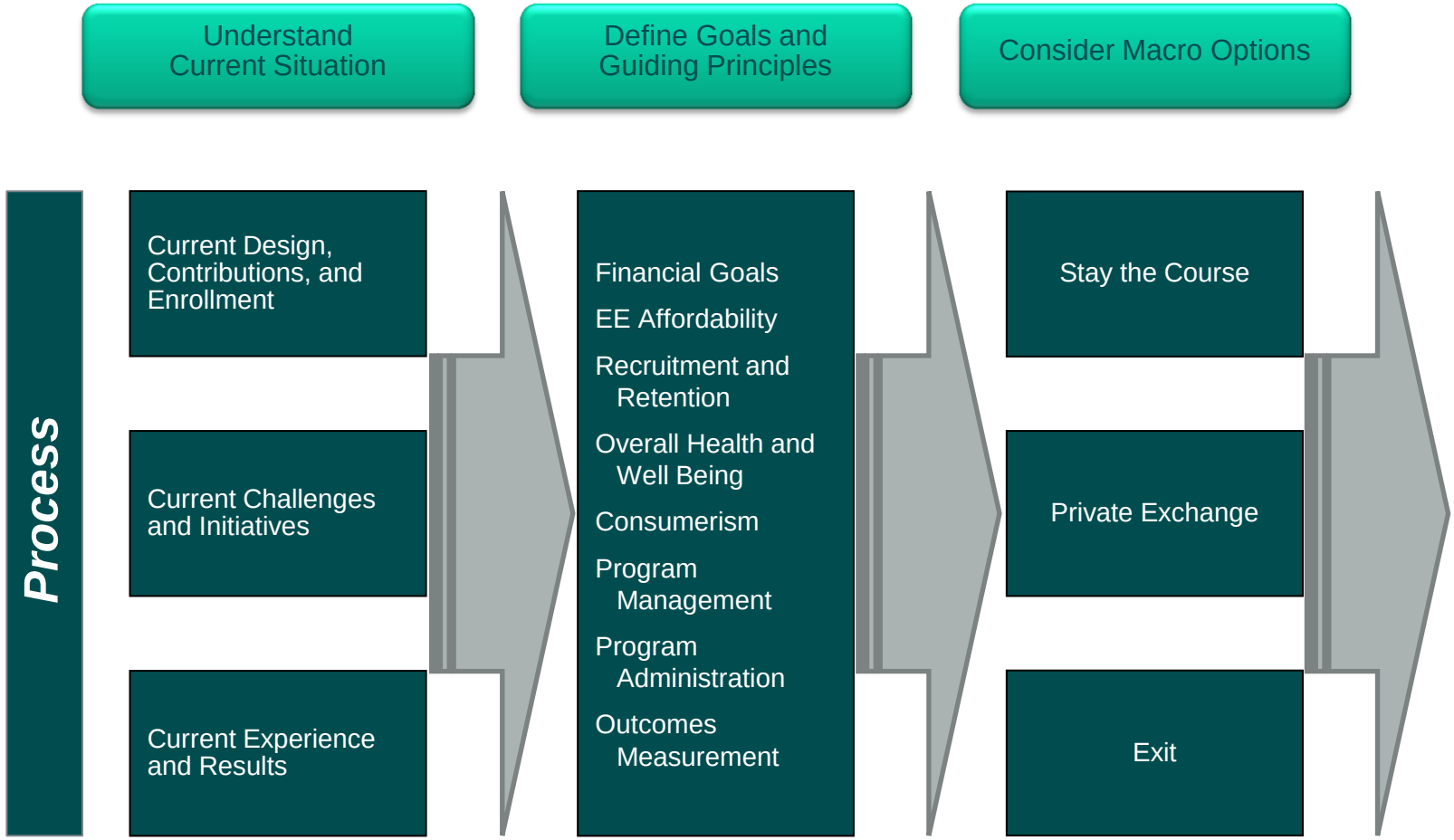
TRANSITION PLAN

A Key First Step:
Defining A Strategic Direction

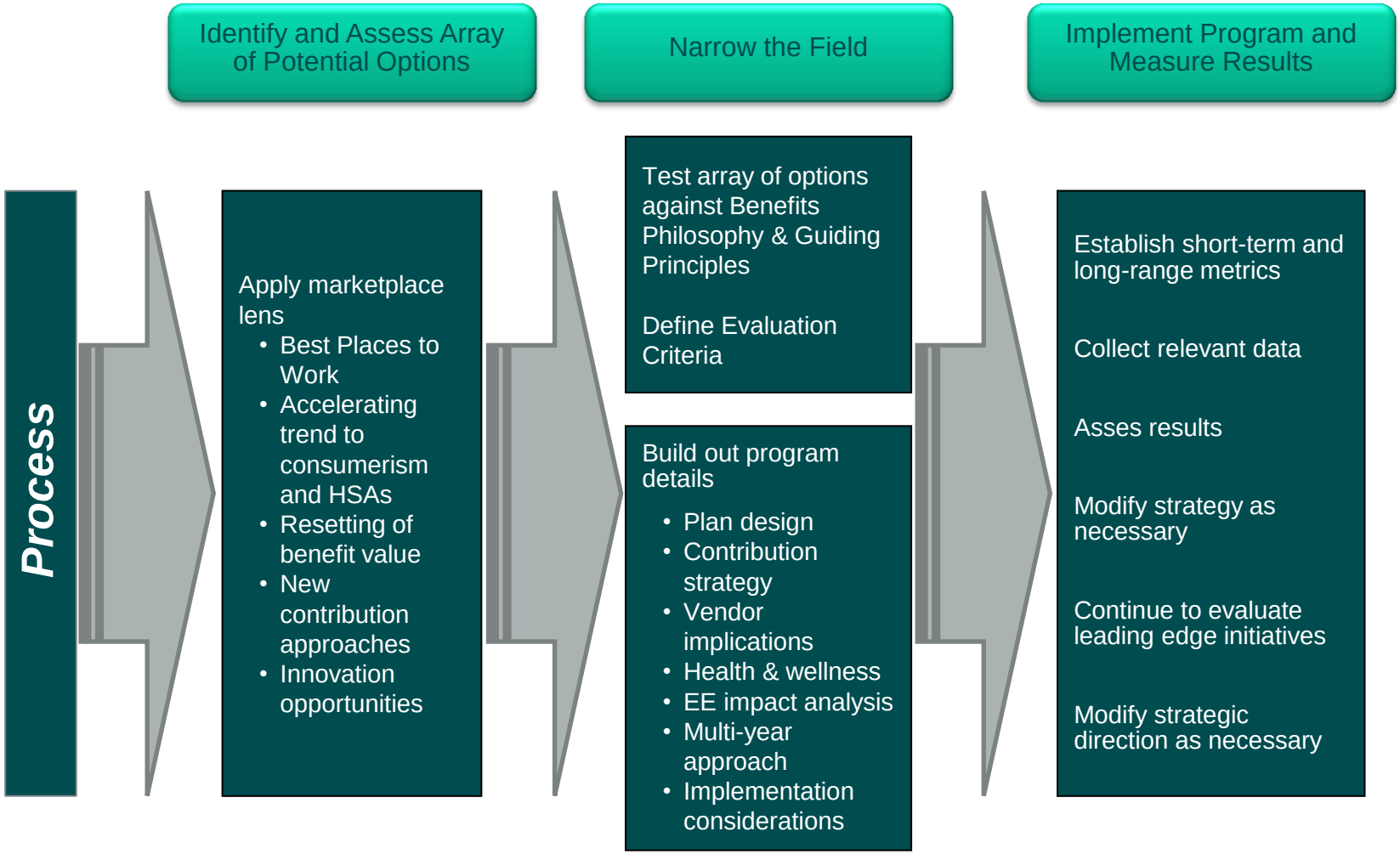
Plan Design Consolidation: Defining Direction

- The consolidation decision should be linked to fundamental Guiding Principles, and specific program objectives
- Development of Guiding principles should:
  - Be a collaborative effort
  - Establish the primary objectives for a common benefit platform
  - Define measures of success
- Once Guiding Principles are established, the appropriate strategic direction/tactical initiatives will become more evident
- The process is not likely to create an “ideal” end state for both organizations. Successful consolidation will require some level of compromise

Plan Design Consolidation: Defining Direction



Plan Design Consolidation: Defining Direction



Plan Design Consolidation: Defining Direction

Define Goals and Guiding Principles

Aggressively Manage Costs	Offer Competitive Level Of Benefits	Promote Health and Consumerism	Program Management
To what level do costs need to be managed in order to meet budget constraints? How will design and contributions be affected by financial requirements? What initiatives will be pursued to impact costs? How will program affordability be maintained over time? What trade offs are CCSD and CCEA willing to make in order to reduce costs?	To what benchmark will benefit levels be compared? How will service provider disruption impact the perceived value of benefits? How will the need for competitive benefits be balanced against financial pressures?	How will consumerism be defined? How should plan designs be structured to support the definition of consumerism? What return on investment expectations will govern any investments in health management/wellness? How should wellness incentives be incorporated into the overall design?	What role will the CCSD and CCEA play in the ongoing delivery of benefits? • Active manager? • Facilitator and funder? How will success be defined? • What metrics need to be established? • How will data be gathered and reported? • How will the results be used to manage the program ?

Transition Plan: Potential Impact on Resources and Overall Timing

Plan Design Consolidation: Additional Considerations

- Development of an effective consolidated structure is likely to require an investment of time and financial resources.
- Specific investments would include:
  - Development of a strategic plan
  - Development of a Governance structure
  - Identification and selection of third party administrative partners:
    - Overall program administration
    - Claims administration
    - Medical Management and Provider Network Management
  - Participant Communication/Education
  - Program implementation
- Any investment costs should be more than offset by the favorable results generated by the consolidation initiative

1/1/16 Transition

3rd Quarter 2014	4th Quarter 2014	1st Quarter 2015	2nd Quarter 2015	3rd Quarter 2015	4th Quarter 2015
Obtain Board approval to proceed with consolidation strategy	Finalize Governance Structure	Conduct market assessments to select program administration partners	Define service expectations and negotiate performance guarantees	Refine program as necessary	Complete annual enrollment
Initiate strategic planning process in order to define Guiding Principles	Depending on strategic direction, explore full range of cost management initiatives	Begin developing messaging to key stakeholders	Select program administration partners	Meet with Key stakeholders	
Finalize plan structure based on Guiding Principles	Identify initiatives that best support program objectives		Finalize communication materials	Communicate program changes	
Begin development of new Governance structure			Meet with Key stakeholders		
			Test for potential barriers to success		

Section #5

APPENDIX

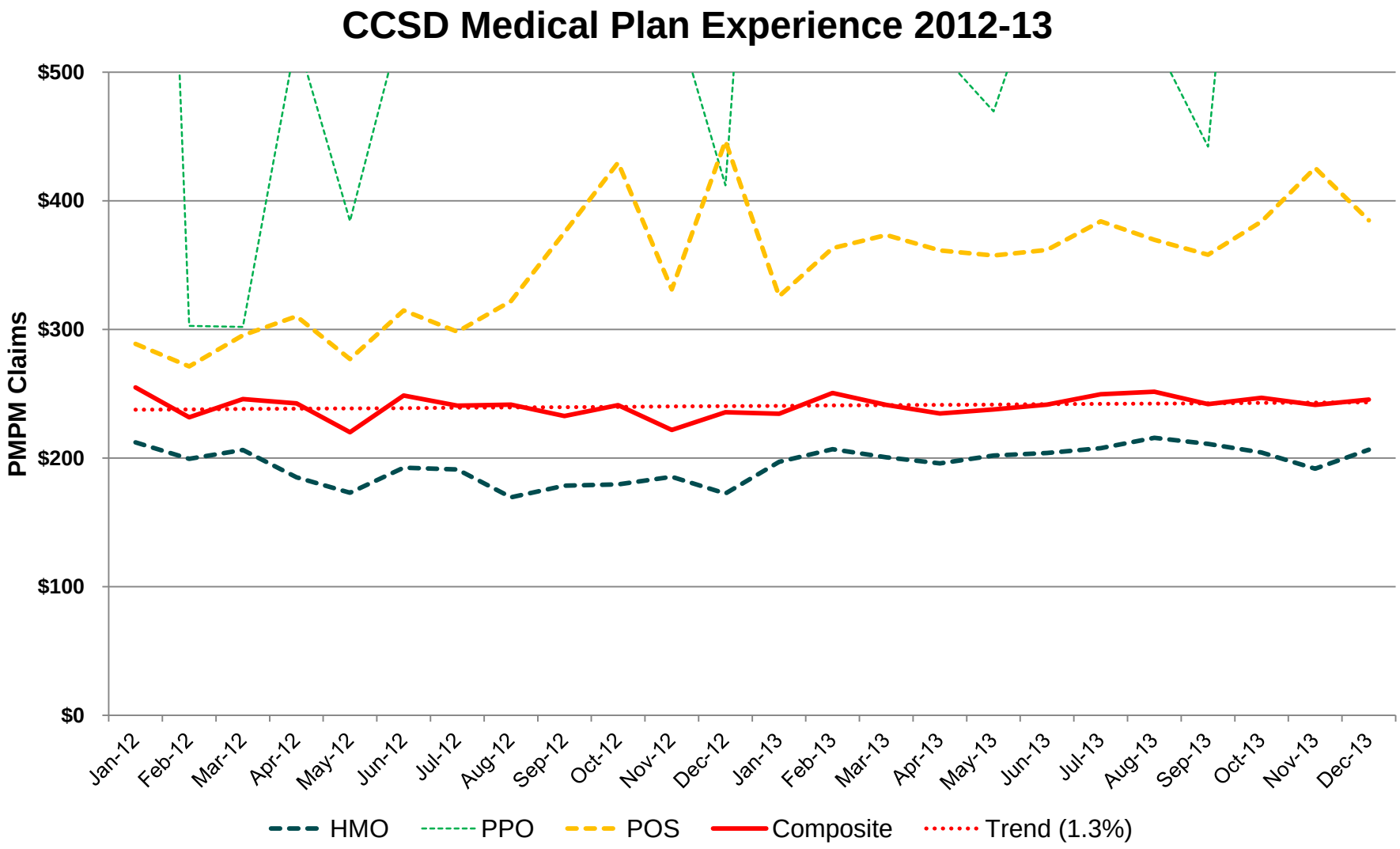
Current CCSD Designs

	HMO Plan 1 (Current)	HMO Plan 2 (New)	HMO Plan 3 (New)	POS Plan 1 (Current)			POS Plan 2 (New)			PPO Diamond	
	HMO Plan Providers	HMO Plan Providers	HMO Plan Providers	HMO	Plan	Non-Plan	HMO	Plan	Non-Plan	Plan	Non Plan
Deductible											
Single	None	None	None	NA	$500		NA	$500	$1,000	None	$1,500
Family	None	None	None	NA	$1,500		NA	$1,000	$2,000	None	$1,500
Out of Pocket Max											
Single	$6,000	$6,000	$6,250	$2,000	$2,000	$4,000	$3,500	$6,250	$12,500	$5,000	$5,000
Family	$12,000	$12,000	$12,500	$6,000	$6,000	$12,000	$7,000	$12,500	$25,000	$10,000	$10,000
Medical Benefits											
Convenient Care/Telemedicine Copay	$5	$10	$25	$5	$20	40%	$10	$25	50%	$5	30%
Primary Care Visit	$10	$20	$35	$10	$20	40%	$15	$30	50%	$20	30%
Specialist Visit	$10	$40	$70	$10	$20	40%	$35	$50	50%	$20	30%
Other Practitioner	$10	$40	$70	$10	$20	40%	$35	$50	50%	$20	30%
Laboratory Done by Lab	$10	$10	$15	$0	$5	40%	$10	$25	50%	$0	30%
Laboratory Done by Doctors Office	$10	$10	$15	$0	$5	40%	$10	$25	50%	$0	30%
Routine Radiology Copay	$10	$25	$25	$0	$0	30%	$25	$40	50%	$10	30%
Mental Health Outpatent	$10	$20	$35	$10	$20	40%	$15	$30	50%	$20	30%
Mental Health Inpatient	$100/day, $300 max	$500/Admission	$500/day, $1500 max	$100/day, $400 max	$0	40%	$100/admit	$0	50%	$150/day, $450 max	30%
Substance Abuse Outpatient	$10	$20	$35	$10	$20	40%	$15	$30	50%	$20	30%
Substance Abuse Inpatient	$100/day, $300 max	$500/Admission	$500/day, $1500 max	$100/day, $400 max	$0	40%	$100/admit	$0	50%	$150/day, $450 max	30%
Urgent Care Copay	$10	$25	$40		$15			$35		$20	30%
Emergency Room Visit (Emergency)	$25	$200	$400		$65			$150		$150	30%
Emergency Room Visit (Non Emergency)	$25	$200	$400		$65			$150		$150	30%
Inpatient Hospital Stay or Surgery	$100/day, $300 max	$500/Admission	$500/day, $1500 max	$100/day, $400 max	20%	40%	$100/admit	20%	50%	$150/day, $450 max	30%
Outpatient Hospital Surgery	$50 per Surgery	$250 per Surgery	$400 per Surgery	$100 per Surgery	20%	40%	$250 per Surgery	20%	40%	$150 per Surgery	30%
Ambulatory Surgical Facility	$50 per Surgery	$100 per Surgery	$250 per Surgery	$100 per Surgery	20%	40%	$100 per Surgery	20%	40%	$150 per Surgery	30%
Prescription Drugs											
Retail											
Generic	$5	$10	$25		$5			$10		$0	
Brand	$15	$35	$50		$15			$35		$50	
Non-Formulary	$25	$60	$75		$25			$60		$80	
Mail Order											
Generic	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Brand	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Non-Formulary	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Relative Value											
Relative Value	88%	82%	77%		94%			89%		88%	
Employee Contributions Per Paycheck											
Employee Only	$31.90	$11.90	$0.00		$65.90			$51.90		$65.90	
Employee +1	$101.90	$66.90	$33.45		$215.90			$131.90		$175.90	
Employee + 2 or more	$151.90	$96.90	$48.45		$412.90			$186.90		$375.90	
2 District Employees (Couple)	$0.00	$0.00	$0.00		$34.90			$7.90		$30.90	
2 District Employees (Family)	$65.90	$45.90	$22.95		$221.90			$111.90		$191.90	

Current CCSD Costs

	1/12-12/12			1/13-12/13			Total 2012-2013		
	Enrollees	Total $$	PEPM				Enrollees	Total $$	PEPM
HMO Enrollees	5,432			6,744			12,175		
HMO Premium		$36,440,227	$559.09		$46,235,228	$571.35		$82,675,455	$565.88
PPO Enrollees	125			179			304		
PPO Premium		$1,001,014	$670.02		$1,357,346	$630.17		$2,358,360	$646.49
POS Enrollees	4,794			3,499			8,293		
POS Premium		$38,163,956	$663.39		$23,146,850	$551.35		$61,310,806	$616.12
Total Enrollees	10,350			10,422			20,772		
Total Fully Insured Cost		$75,605,198	$608.73		$70,739,424	$565.65		$146,344,622	$587.12

CCSD Trend


CCSD Medical Plan Experience 2012-13
PMPM Claims
$500
$400
$300
$200
$100
$0
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
HMO
PPO
POS
Composite
Trend (1.3%)

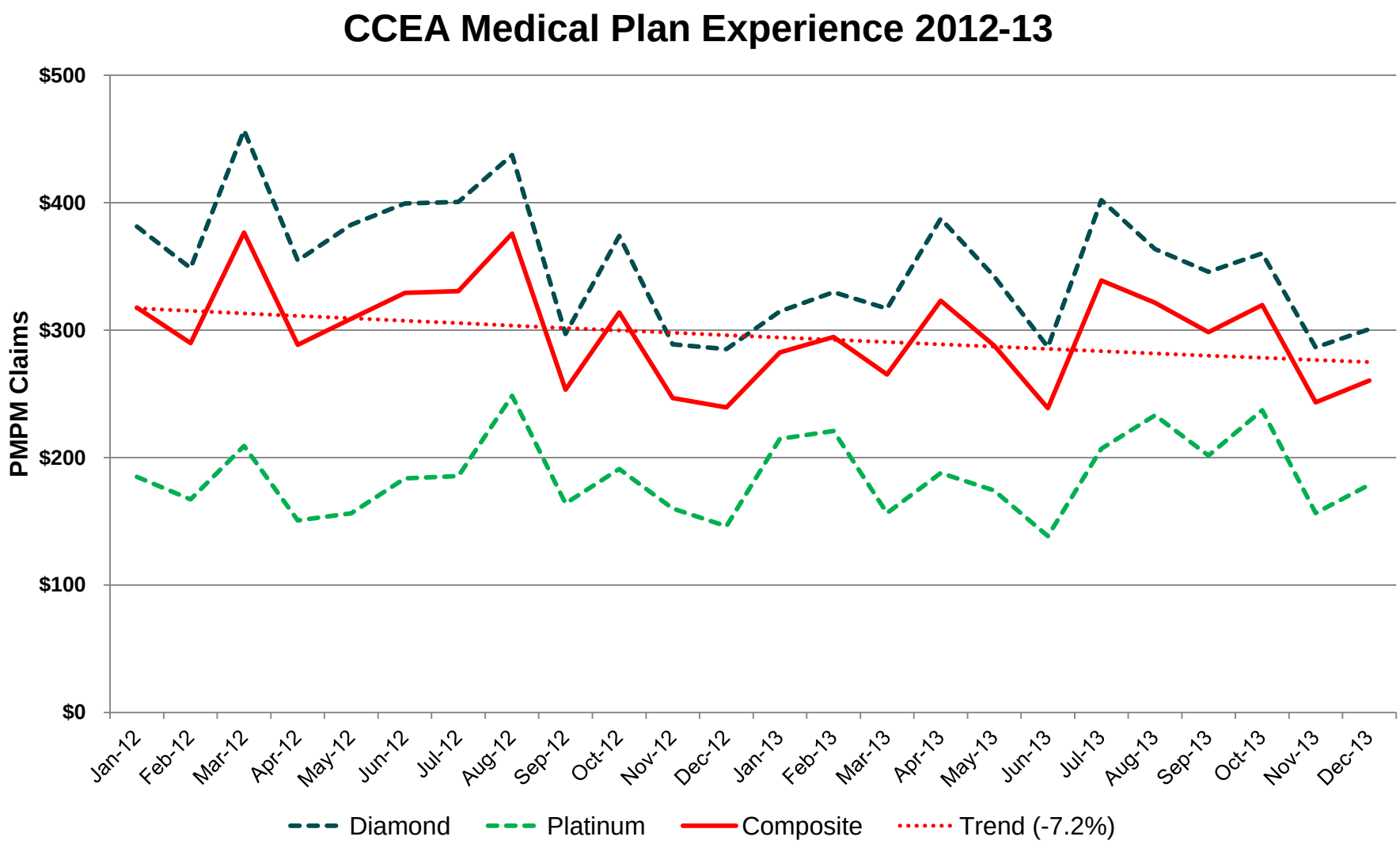
Current CCEA Designs

	PPO Diamond		PPO Platinum	
	Plan	**Non Plan**	**Plan**	**Non Plan**
Deductible				
Single	None	$1,500	None	$2,500
Family	None	$3,000	None	$5,000
Out of Pocket Max				
Single	$5,000	NA	$10,000	NA
Family	$10,000	NA	$20,000	NA
Medical Benefits				
Convenient Care/Telemedicine Copay	NA	NA	NA	NA
Primary/Routine Care Visit	$20	30%	$30	30%
Specialist Visit	$20	30%	$30	30%
Other Practitioner	$20	30%	$30	30%
Laboratory Done by Lab	$0	30%	$0	30%
Laboratory Done by Doctors Office	$10	30%	$15	30%
Routine Radiology Copay	$10	30%	$20	30%
Mental Health Outpatent	$20	30%	$30	30%
Mental Health Inpatient	$150/Day; $450 max	30%	$300/Day; $900 max	30%
Substance Abuse Outpatient	$20	30%	$30	30%
Substance Abuse Inpatient	$150/Day; $450 max	30%	$300/Day; $900 max	30%
Urgent Care Copay	$20	Covered in full	$30	Covered in full
Emergency Room Visit (Emergency)	$150	Covered in full	$300	Covered in full
Emergency Room Visit (Non Emergency)	$250	Covered in full	$400	Covered in full
Inpatient Hospital Stay or Surgery	$150/Day; $450 max; $150 Surgeon Fee; $100 Anesthesia Fee	Covered in full	$300/Day; $900 max; $250 Surgeon Fee; $150 Anesthesia Fee	Covered in full
Outpatient Hospital Surgery	$375 / visit	$50 / visit	$375 / visit	$50 / visit
Ambulatory Surgical Facility	$375 / visit	$15 / visit	$375 / visit	$15 / visit
Prescription Drugs				
Retail				
Generic	$0		$0	
Brand	25%; $25 min/$50 max		25%; $30 min/$60 max	
Non-Formulary	40%; $40 min/$80 max		40%; $45 min/$90 max	
Mail Order				
Generic	$0		$0	
Brand	$70		$75	
Non-Formulary	$105		$115	
Relative Value				
Relative Value	87%		84%	
Employee Contributions Per Paycheck				
Employee Only	$17.00		$0.00	
Employee + 1	$77.00		$45.00	
Employee + 2	$87.00		$53.00	
Employee + 3	$97.00		$61.00	
Additional Dependents	$10 for each additional dependent		$8 for each additional dependent	

Current CCEA Costs

	1/12-12/12			1/13-12/13			Total 2012-2013		
	Enrollees	Total $$	PEPM	Enrollees	Total $$	PEPM	Enrollees	Total $$	PEPM
Diamond Enrollees	10,962			11,079			22,041		
Diamond Cost (claims + admin)									
Medical claims		$78,221,871	$594.63		$73,306,132	$551.41		$151,528,003	$572.91
Rx claims		26,137,057	198.69		23,177,731	174.34		49,314,788	186.45
Fixed fees		6,404,722	48.69		5,851,067	44.01		12,255,789	46.34
Admin		5,850,904	44.48		5,339,392	40.16		11,190,296	42.31
Commission		553,818	4.21		511,675	3.85		1,065,493	4.03
Claims Margin		0	0.00		0	0.00		0	0.00
Total HMO:		$110,763,649	$842.00		$102,334,930	$769.77		$213,098,579	$805.70
Platinum Enrollees	5,300			5,337			10,637		
Platinum Cost (claims + admin)									
Medical claims		$18,944,491	$297.86		$21,757,575	$339.71		$40,702,066	$318.86
Rx claims		5,613,976	88.27		4,801,834	74.97		10,415,810	81.60
Fixed fees		2,966,517	46.64		2,718,712	42.45		5,685,229	44.54
Admin		2,828,892	44.48		2,572,322	40.16		5,401,214	42.31
Commission		137,625	2.16		146,391	2.29		284,016	2.22
Claims Margin		0	0.00		0	0.00		0	0.00
Total PPO		$27,524,984	$432.76		$29,278,122	$457.14		$56,803,106	$444.99
Total Enrollees	16,263			16,416			32,678		
Total Self Funding Cost:		$138,288,633	$708.63		$131,613,052	$668.12		$269,901,685	$688.28

CCEA Trend


CCEA Medical Plan Experience 2012-13
PMPM Claims
$500
$400
$300
$200
$100
$0
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Diamond
Platinum
Composite
Trend (-7.2%)

CCSD Funding Consolidation Analysis

CCSD									
Funding Review				HISTORICAL					
		1/12-12/12			1/13-12/13			Total 2012-2013	
	Enrollees	Total $$	PEPM				Enrollees	Total $$	PEPM
HMO Enrollees	5,432			6,744			12,175		
HMO Premium		$36,440,227	$559.09		$46,235,228	$571.35		$82,675,455	$565.88
PPO Enrollees	125			179			304		
PPO Premium		$1,001,014	$670.02		$1,357,346	$630.17		$2,358,360	$646.49
POS Enrollees	4,794			3,499			8,293		
POS Premium		$38,163,956	$663.39		$23,146,850	$551.35		$61,310,806	$616.12
Total Enrollees	10,350			10,422			20,772		
Total Fully Insured Cost		$75,605,198	$608.73		$70,739,424	$565.65		$146,344,622	$587.12
Self-Funded Cost		1/12-12/12			1/13-12/13			Total 2012-2013	
	Enrollees	Total $$	PEPM	Enrollees	Total $$	PEPM	Enrollees	Total $$	PEPM
HMO Enrollees	5,432			6,744			12,175		
HMO Cost (claims + admin)									
Medical claims		$27,485,355	$421.70		$37,558,313	$464.13		$65,043,668	$445.20
Rx claims		6,179,423	94.81		9,214,279	113.87		15,393,702	105.36
Fixed fees		3,879,048	59.51		4,574,947	56.54		8,453,995	57.86
Stop Loss		568,489	8.72		789,838	9.76		1,358,327	9.30
Admin		3,122,840	47.91		3,528,372	43.60		6,651,212	45.52
Commission		187,719	2.88		256,738	3.17		444,457	3.04
Total HMO:		$37,543,826	$576.02		$51,347,539	$634.53		$88,891,365	$608.43
PPO Enrollees	125			179			304		
PPO Cost (claims + admin)									
Medical claims		$1,397,704	$935.55		$1,781,726	$827.20		$3,179,430	$871.57
Rx claims		377,746	252.84		628,904	291.98		1,006,650	275.95
Fixed fees		112,059	75.01		169,005	78.46		281,064	77.05
Stop Loss		31,040	20.78		62,191	28.87		93,231	25.56
Admin		71,581	47.91		93,916	43.60		165,497	45.37
Commission		9,438	6.32		12,898	5.99		22,336	6.12
Total PPO		$1,887,509	$1,263.39		$2,579,635	$1,197.64		$4,467,145	$1,224.57
POS Enrollees	4,794			3,499			8,293		
POS Cost (claims + admin)									
Medical claims		$23,837,684	$414.36		$15,552,323	$370.45		$39,390,007	$395.84
Rx claims		9,477,734	164.75		6,492,680	154.65		15,970,414	160.49
Fixed fees		4,138,864	71.94		3,168,748	75.48		7,307,613	73.44
Stop Loss		1,195,256	20.78		1,212,165	28.87		2,407,421	24.19
Admin		2,756,337	47.91		1,830,514	43.60		4,586,851	46.09
Commission		187,271	3.26		126,069	3.00		313,340	3.15
Total PPO		$37,454,282	$651.06		$25,213,751	$600.58		$62,668,033	$629.76
Total Enrollees	10,350			10,422			20,772		
Total Self Funding Cost:		$76,885,618	$619.04		$79,140,926	$632.83		$156,026,543	$625.96
vs. Fully Insured Cost									
% Difference		2%	2%		12%	12%		7%	7%
Total dollar difference									
Insured vs. Self-funded		$1,280,420			$8,401,501			$9,681,921	

CCEA Funding Consolidation Analysis

Fully Insured Cost	1/12-12/12			1/13-12/13			Total 2012-2013		
	Enrollees	Total $$	PEPM				Enrollees	Total $$	PEPM
Diamond Enrollees	10,962			11,079			22,041		
Diamond Premium		$113,061,431	$ 859.47		$104,475,939	$ 785.87		$217,537,370	$ 822.48
Platinum Enrollees	5,300			5,337			10,637		
Platinum Premium		$28,172,335	$ 442.94		$29,952,936	$ 467.67		$58,125,271	$ 455.35
Total Enrollees	16,263			16,416			32,678		
Total Fully Insured Cost:		$141,233,766	$723.72		$134,428,875	$682.42		$275,662,641	$702.97

Self-Funded Cost	1/12-12/12			1/13-12/13			Total 2012-2013		
	Enrollees	Total $$	PEPM	Enrollees	Total $$	PEPM	Enrollees	Total $$	PEPM
Diamond Enrollees	10,962			11,079			22,041		
Diamond Cost (claims + admin)									
Medical claims		$78,221,871	$594.63		$73,306,132	$551.41		$151,528,003	$572.91
Rx claims		26,137,057	198.69		23,177,731	174.34		49,314,788	186.45
Fixed fees		6,404,722	48.69		5,851,067	44.01		12,255,789	46.34
Admin		5,850,904	44.48		5,339,392	40.16		11,190,296	42.31
Commission		553,818	4.21		511,675	3.85		1,065,493	4.03
Claims Margin		0	0.00		0	0.00		0	0.00
Total HMO:		$110,763,649	$842.00		$102,334,930	$769.77		$213,098,579	$805.70
Platinum Enrollees	5,300			5,337			10,637		
Platinum Cost (claims + admin)									
Medical claims		$18,944,491	$297.86		$21,757,575	$339.71		$40,702,066	$318.86
Rx claims		5,613,976	88.27		4,801,834	74.97		10,415,810	81.60
Fixed fees		2,966,517	46.64		2,718,712	42.45		5,685,229	44.54
Admin		2,828,892	44.48		2,572,322	40.16		5,401,214	42.31
Commission		137,625	2.16		146,391	2.29		284,016	2.22
Claims Margin		0	0.00		0	0.00		0	0.00
Total PPO		$27,524,984	$432.76		$29,278,122	$457.14		$56,803,106	$444.99
Total Enrollees	16,263			16,416			32,678		
Total Self Funding Cost:		$138,288,633	$708.63		$131,613,052	$668.12		$269,901,685	$688.28
vs. Fully Insured Cost									
% Difference		-2%	-2%		-2%	-2%		-2%	-2%
Total dollar difference vs. Fully Insured		-$2,945,133			-$2,815,823			-$5,760,956	

Funding Consolidation Analysis: Summary

CCSD - Self-funding Retrospective			
	Plan year		Total
Plan/funding	2012	2013	2012-2013
HMO insured premium	$36,440,227	$46,235,228	$82,675,455
HMO self-funded estimated cost	$37,543,826	$51,347,539	$88,891,365
Cost/(Savings) to Self-Fund	$1,103,599	$5,112,311	$6,215,910
PPO insured premium	$1,001,014	$1,357,346	$2,358,360
PPO self-funded estimated cost	$1,887,509	$2,579,635	$4,467,145
Cost/(Savings) to Self-Fund	$886,495	$1,222,289	$2,108,784
POS insured premium	$38,163,956	$23,146,850	$61,310,806
POS self-funded estimated cost	$37,454,282	$25,213,751	$62,668,033
Cost/(Savings) to Self-Fund	($709,674)	$2,066,901	$1,357,227
Total insured premiums	$75,605,198	$70,739,424	$146,344,622
Total self-funded estimated cost	$76,885,618	$79,140,926	$156,026,543
Cost/(Savings) to Self-Fund	$1,280,420	$8,401,501	$9,681,921
	1.7%	11.9%	6.6%

Funding Consolidation Analysis: Summary

CCEA - Self-funding Retrospective			
	Plan year		Total
Plan/funding	2012	2013	2012-2013
Diamond insured premium	$113,061,431	$104,475,939	$217,537,370
Diamond self-funded estimated cost	$110,763,649	$102,334,930	$213,098,579
Cost/(Savings) to Self-Fund	($2,297,782)	($2,141,009)	($4,438,791)
Platinum insured premium	$28,172,335	$29,952,936	$58,125,271
Platinum self-funded estimated cost	$27,524,984	$29,278,122	$56,803,106
Cost/(Savings) to Self-Fund	($647,351)	($674,814)	($1,322,165)
Total insured premiums	$141,233,766	$134,428,875	$275,662,641
Total self-funded estimated cost	$138,288,633	$131,613,052	$269,901,685
Cost/(Savings) to Self-Fund	($2,945,133)	($2,815,823)	($5,760,956)
	(2.1%)	(2.1%)	(2.1%)

Disclosures

This presentation discusses concepts that have significant legal implications.

Our discussion of these concepts is intended to convey our general understanding of the applicable principles, but is not intended as legal or tax advice for a particular situation or client.

Since neither Mercer, nor its representatives can give legal or tax advice, we recommend that you consult your advisers for possible application of these concepts to your specific factual situation.


MERCER