Benefits Strategies

The Boards' joint benefits strategy is to maintain a benefit program that is slightly above that of our adopted market. This is a challenging time for organizations as they seek to balance ever-rising medical costs, plan compliance requirements under the Affordable Care Act, and the needs of employees in a rapidly changing insurance marketplace. Our goal is to continue to offer excellent, affordable medical insurance coverage to our employees while maintaining the sustainability of our strategic medical reserves.

Medical Insurance

The Health Care Executive Committee (HCEC) is comprised of representative staff from several departments in the School Division and Local Government, as well as members from other affiliated organizations who participate in our health and dental plans. The HCEC develops recommendations for our medical and dental plans based on the following objectives:

- Offer affordable options that meet varying needs of employees and their families
- Maintain reserves at approximately 25% of claims
- Ensure plans are in compliance with Health Care Reform
- Maintain our competitive position for benefits (slightly above market)

Plan Review Process

The HCEC works routinely with KSPH Employee Benefit Management to review our health care plan. This includes:

- Detailed reviews of claims utilization with Coventry's medical director
- Analysis of market information on plan design and employee/employer premiums
- Plan design, including: inpatient/outpatient coinsurance; provider, emergency room and prescription drug co-payments; annual deductibles; out-of-pocket maximums
- Employee/employer premiums (includes market data from KSPH and our adopted market)
- Employee feedback--input from employees via focus groups and surveys
- Review and projections of reserve balance

FY15-16 Medical Plan

We currently offer two traditional plans (Basic and Plus) through Coventry, both of which offer the same benefit coverage, but which differ in cost sharing (co-pays, co-insurance, out-of-pocket maximums, deductibles) and employee premium requirements. Effective October 1, 2015, we implemented a $500 individual deductible ($1000/family). Employee premiums were increased by $40/month and Board contributions were increased by 9.6% for the 2015-2016 plan year. Additionally, we made changes to spousal eligibility for coverage on the medical plan. As of the start of the 2015-2016 plan year, spouses with access to "affordable" medical coverage that meets "minimum essential value" (both as defined by the Affordable Care Act) are no longer eligible for coverage on the plan. Spouses who are not employed, do not have access to affordable coverage under their own employer, or who are currently on Medicare, retain eligibility for coverage on our plan.

FY16-17 Medical Plan

Reallocating Rates:
Historically, the Board medical contribution for full-time employees has been a flat amount ($8,542 for the 15-16 plan year), regardless of type or tier of coverage that an employee elects. However, a reallocation of Board contributions, based on coverage tiers, will be necessary in order for us to avoid potentially substantial ACA [Affordable Care Act] "Cadillac tax" liability on our plan in 2018. Information regarding this proposed reallocation was presented to the BOS and School Board on October 8, 2014. Reallocation would result in smaller contributions toward single coverage, and greater contributions toward dependent coverage, more accurately reflecting usage. These would, however, be set in such a way that the total contributions into the Health Care Reserve would not be impacted. Our market data supports this differentiated employer contribution strategy, as nearly 70% of our adopted market contributes a higher amount for dependent coverage.
The reallocation of Board medical contributions for the 16-17 plan year leaves us with a few residual issues that will require additional discussions in order to resolve, namely how to apply Board medical contributions to:

- Part-time employees (who currently receive a prorated Board contribution based on their FTE %; see "affordability" discussion below)
- Retirees under our VERIP (early retirement program)
- "County Spouses" (married couples who are both employees/participants on the medical plan)

Affordability:
We must further be mindful of the "affordability" standard under the ACA in regard to employee premiums. This mandates that the least expensive, employee only plan (that meets "minimum essential value" standards) cannot cost in excess of 9.5% of certain benchmarks (we're using w-2 income) in order to be considered "affordable." This standard is applied to employees classified as "full-time" under the ACA (30 hours per week, or the equivalent). As significant employer penalties can be assessed on plans that are deemed "unaffordable;" a concerted effort toward ensuring that all "full-time" (as defined by the ACA) employees have access to "affordable" coverage will be an ongoing concern when determining medical premium rates and employee compensation.

Plan Design/Market Competitiveness:
Offering competitive medical plans that balances the benefit design against the cost to fund the program is a major consideration each year. The HCEC continues to evaluate our plan offerings and is recommending a change to our current plan options. Rather than continuing to offer two traditional plans that are not significantly different in terms of cost-sharing (employee premiums/out of pocket expenses), the Committee is recommending that we offer one traditional plan (resembling our current "Basic" plan) and one High Deductible Health Plan HDHP) with a qualified Health Savings Account (HSA) for the 2016-2017. This option would feature an employer contribution. The HDHP/HSA plan would provide employees with a tax-advantaged way to save for future retiree health needs, allow employees with fewer health care expenses to avoid paying more expensive traditional plan premiums while still having catastrophic medical coverage, and create more educated healthcare consumers. While a successful rollout of this new benefit would require significant educational resources, and could likely take 3-5 years before this plan sees desired participation levels, the HCEC believes that this option (in addition to more appropriately pricing the traditional plan offering to more accurately reflect enrollment/utilization) is the best course of action in order to ensure the

sustainability of our strategic medical reserves and our continued ability to offer excellent, affordable medical insurance options to our employees. The following chart illustrates the plan options and the associated projected rate increases:

	Projected premium increases
No changes – keep current traditional plan options	17.1%
Proposed changes; offer two plans: Traditional (based on current Basic plan) High Deductible/Health Savings Account *Assumes 5% enrollment in HDHP/HSA plan	14.8%
Proposed changes; offer two plans: Traditional (based on current Basic plan) High Deductible/Health Savings Account *Assumes 15% enrollment in HDHP/HSA plan; does not include and cost for tools to educate/engage employees – estimated $55k - $100k annually	13.6%

Wellness Initiatives

The BeWell program is expanding into more areas of wellness while continuing to offer the programs and services employees count on, such as onsite flu clinics and mobile mammography screenings. For 2015-2016, a variety of health promotion campaigns are planned, in addition, the Wellness Champions and small grants program will be expanded. We are evaluating incentivized programs in the 2016-17 year such as more robust disease management and health risk assessments in combination with biometric screenings or annual physicals.

Health Care Reserve Fund

As our medical plan is self-insured, the County is responsible for all claims. Reserve funds serve to cover any difference between claims paid, but not covered by the revenues (employee premiums collected & Board contributions). If claims exceed our revenue collections, the difference is paid from our reserves; if revenue exceeds claims, the difference is added to our reserves. Ideally, a reserve balance of at least 25% of total claims should be maintained. However, a reluctance to increase employee premiums during times of little to no salary increases, increased medical/pharmacy costs, and utilization in excess of projections have left our reserves well below recommended levels. A concerted effort to replenish our reserves (in terms of premium increases, Board contribution increases, and plan design/plan offerings) will be an essential component or our strategy toward maintaining sustainable medical plan options.

FY 15-16 Dental Plan

We offer two plans (Basic and High) through United Concordia. As our dental reserve balance was favorably above targeted levels, a 5% decrease in Board contributions was applied for the 15-16 plan year (employee premiums held steady, following two rate holidays in the previous year).

FY15-16 Dental Plan Year

Continue to offer two plans with no coverage changes.

Virginia Retirement System:

Effective January 1, 2014, VRS implemented a mandated "Hybrid Plan" for all full-time new hires without active prior VRS service (note: hazardous duty members may not be in the hybrid plan). The Hybrid Plan is a combination of a defined benefit plan (which VRS Plan 1 and Plan 2 members currently participate in) and a defined contribution plan. Also, unlike the current VRS Plan 1 and Plan 2, the Hybrid Plan does not offer a disability retirement benefit.

The Hybrid Plan and the state-mandated leave benefits associated with the Hybrid Plan's short-term and long-term disability coverage, Virginia Local Disability Plan (VLDP)), has created a separate set of employee leave benefits associated solely with membership in the Hybrid Plan. In order to assess the impact of these state-mandated benefits for one set of employees on the County's current leave policies and practices, and to seek solutions as to how the County can best manage the coming changes, staff worked with KSPH to address the goals of:

- Providing adequate sick leave for all employees, regardless of VRS status
- Creating/maintaining one leave program that is simple to explain and administer
- Providing benefits that are consistent with the County's total compensation strategies

Background:

Significant effort was expended to engage all employee groups regarding leave issues associated with the advent of the Hybrid Plan. Focus groups and departmental meetings sought feedback on possible changes and allowed for valuable interaction with Human Resource staff. Over 700 employees were addressed in approximately 10 focus group meetings or in-person for Local Government and the School Division, and over 1200 teachers and 400 Local Government employees were sent a custom-made video and survey by email; additionally, the information was posted on the School Division's news blog. Feedback from non-Hybrid employees was mixed on how to transition to a VLDP-like plan, particularly when discussing the option of capping sick leave balances (vs. employees' current ability to accrue sick leave without caps). The ability to keep at least a portion of their accrued sick leave was a major concern, since a VLDP-like plan would only cover individual employees (i.e., not for use in family leave situations). Most employees, however, were positive regarding the VLDP-like plan design once they understood its benefits. Further, market data for the County's adopted market was analyzed. There is no clear market trend; however, many localities are currently evaluating this issue.

Staff considered the following:

Option1: Implement one leave program for all benefits-eligible employees, to include employer-paid short-term and long-term disability benefits for all benefits-eligible employees. Considerations for this option:

- Avoids having two classes of employees resulting in morale issues and benefit inequities between employee groups
- Avoids the long-term complexities and cost of permanently administering two (or more) leave systems by not acting now
- Provides a superior and more consistent leave benefit for employees in most situations
- Third Party Administrator - managed short-term disability (STD) claims, which is expected to result in less usage due to increased oversight and more proactive return-to-work resource provision
- Provides a predictable amount of employee leave for use, rather than an amount that may not be accessed beyond the 60-day FMLA eligibility period

- Consider implementing a lower accrual rate for sick leave than the 8 hours per month currently provided (would incentivize employees to save leave to cover the 7 day STD waiting period)
- Employees with large leave balances may have a negative perception of the change to a different system

Option 2: Retain the current leave policies for Non-Hybrid Plan employees and create new, fiscally responsible leave policies that coordinate with state-mandated leave benefits for Hybrid Plan employees. Considerations for this option:

- Slower increase in costs of VLDP mandated system as employee base transitions to mostly Hybrid membership (estimated 5-6 years)
- Employees would receive different leave benefits based on their VRS status, creating disparate treatment of leave issues
- Need to hire at least one additional leave administrator to manage the communication, systems and manual tracking for these different groups of employees. Most organizations of similar size have a time-tracking system and some have as many as three leave administrators to manage their policies/programs. Currently, we have 1 full time HR Specialist who is responsible for the administration of all leave processing for over 3,000 employees
- Prolonging long-term commitment to two leave systems regardless of the eventual change in ratio of the County's Hybrid vs. non-Hybrid employees
- Need to maintain a sick bank program (or equivalent) for first year of employment for hybrid employees; however, this bank will likely become unsustainable given the increasing ratio of Hybrid to non-Hybrid staff