Segal Consulting

State of New Hampshire

RETIREE HEALTH BENEFITS

Long-Term Study

February 8, 2017

DRAFT

 9095v17/05855.103

State of New Hampshire

DEPARTMENT OF ADMINISTRATIVE SERVICES
OFFICE OF THE COMMISSIONER
25 Capitol Street – Room 120
Concord, New Hampshire 03301

VICKI V. QUIRAM
Commissioner
(603) 271-3201

Joseph B. Bouchard
Assistant Commissioner
(603) 271-3202

February 8, 2017

The Honorable Neal M. Kurk, Chairman
Fiscal Committee of the General Court
State House
Concord, New Hampshire 03301

Dear Representative Kurk:

At the request of the Fiscal Committee, the Department of Administrative Services (DAS) submits the enclosed draft report, prepared by the Segal Company (Segal). In the report, "Retiree Health Benefits Long-Term Study", Segal provides an overview of potential Retiree Health Benefit Plan (Plan) long-term options that could assist the State with meeting the increasing financial challenges the Plan is facing over the next biennium and in the years to come.

Segal has been the State's health benefit consultant since 2004. Their services provided to the Retiree Health Benefit Plan include the actuarial valuation of the State's Other Post-Employment Benefits (OPEB) and other plan design and financial modeling and consultation.

It is also important to note that this report is submitted in draft form in the event that the Fiscal Committee would like Segal to consider other potential long-term strategies not considered in this study.

Please let us know if you have questions or need additional follow up information from Segal.

Sincerely,

Vicki V. Quiram
Commissioner

Catherine A. Keane
Director, Risk & Benefits

Table of Contents

RETIREE HEALTH BENEFITS
Long-Term Study
Draft
February 8, 2017

Executive Summary

The State of New Hampshire (State) provides and funds a Retiree Health Benefit Plan (Plan) for eligible State retirees and their dependents. The Plan provides medical and prescription drug benefits for approximately 3,000 non-Medicare and 9,300 Medicare-eligible State retiree participants. It is administered by the Department of Administrative Services (DAS). The Plan for Medicare-eligible State retiree participants (Medicare Retiree Plan) provides supplemental medical coverage that coordinates with Medicare Parts A and B, and an employer-sponsored Medicare Part D prescription drug plan with enhanced prescription drug benefits. Under State law, DAS must manage the Plan within the limits of the funds appropriated at each biennial session.

The State faces significant financial challenges to continue offering the current Plan coverage. It must address a projected $25.4 million increase in costs in the short-term (FY 2018/2019 projected costs compared to the FY 2016/2017 budget). If the Plan does not receive additional funding in the budget, it can only continue to operate by relying on the tools currently permitted by law to make up the projected shortfall. DAS has three tools available today which require Fiscal Committee approval to implement: (1) making changes in medical benefit plan design (*e.g.*, increasing copayments and deductibles), (2) making changes in prescription drug benefit plan design (*e.g.*, increasing copayments and deductibles), and (3) increasing the non-Medicare retiree monthly retiree premium cost share. The State also faces a long-term projected liability of over $2.1 billion to pay for health care coverage for current and future retirees and their dependents**.**

For the purposes of this draft report, "short-term" is defined as the next biennium. "Long-term liability" is defined as the cost to pay for Retiree Health Benefits for all current and future retirees (*i.e.*, current actives who may retire in the future), and their spouses, for their lifetimes. Further definitions of these terms, and definitions of other key terms related to retiree health care, are provided in *Appendix A*.

Segal Consulting[1], the Plan's health benefit consultant, worked with DAS to study the Plan's short-term and long-term financial challenges. Segal has been the State's health benefit consultant since 2004. Segal has provided the actuarial valuation of the State's Other Postemployment Benefits (OPEB) since the December 31, 2006 reporting period. Segal has also assisted the State in addressing the more recent financials challenges relating to the retiree health program. Segal created this **draft** report, which describes the financial challenges the State faces, reviews possible options to address these challenges and shows the projected financial impact of each option. This draft report includes a high-level summary of the State's retiree Plan coverage, to assist the reader in understanding the State's current retiree health care program. Please see *Appendix E* for details.

This draft report also describes how the Governmental Accounting Standards Board's (GASB's) financial reporting requirements affect the State's Comprehensive Annual Financial Report (CAFR). GASB sets standards for financial reporting for government-sponsored benefit plans like pension plans and retiree health benefit plans. The standards ensure plans account for and

[1] Segal Consulting is a fully independent, privately-held firm that provides comprehensive employee benefits consulting, human capital consulting, and actuarial services consulting to public and private employers and to multi-employer health benefit trust and pension trust funds.

report all long-term liabilities appropriately on their balance sheets and other financial statements, as the State does in the CAFR. GASB uses the term "Other Post-Employment Benefits" (OPEB) to refer to non-pension retiree benefits, including retiree medical and prescription drug plans.

GASB recently revised its OPEB reporting requirements. For the State, revisions take effect with the financial statements for the fiscal year ending June 30, 2018. These revisions will affect the calculating and reporting of the Plan's long-term financial liability (currently $2.1 billion) on the State's balance sheet. The State could choose to allocate money to a trust or equivalent financial arrangement to reduce its OPEB liability. However, at this time it has not done so; as a "pay as you go" state, the State of New Hampshire funds all expenses for current retirees in its biennial budget.

The State's long-term financial liability has the potential to reduce the State's bond rating. If the State's bond rating is reduced, the State may pay higher interest to borrow money for future projects.

As noted above, long-term options to address the State's retiree health benefit funding challenges are described in detail in this draft report. Each option is discussed in its own section and will:

- Provide background and details on key concepts of a particular option
- Describe the potential impact on retirees
- Describe the potential impact on the State
- Provide financial modeling to illustrate the estimated impact on ten-year cash flows. Cash flow exhibits include the expected State costs associated with benefits provided to retirees
- Provide financial modeling to illustrate the estimated impact on projected GASB/OPEB long-term liability for coverage offered to retirees.

The estimated potential cash flow and liability reductions described in this draft report are intended to illustrate orders of magnitude of the projected savings associated with implementing changes to the retiree health plan. As a result, the estimated cash flow savings should not be used to set State budget levels in the short term (*e.g.*, FY 2018/2019). For State budgeting purposes, the estimated impact of the options described in this draft report would need to be modeled independently (*i.e.*, outside of this draft report).

While considering the options in this report, the State needs to be aware of the following:

- There is uncertainty on the future of the Affordable Care Act (ACA). Changes to this law could result in changes to the viability of the options presented in this report.
- Material changes in the benefits offered to current and future retirees and their dependents could result in legal challenges and other litigation.
- A significant number of the State's active employees are currently eligible to receive Retiree Health Benefits and have already reached or are approaching typical retirement age (see *Appendix G* for an age distribution of active employees). Any retiree plan changes that affect eligibility for benefits need to be constructed in such a way as to avoid a mass-retirement event that puts additional strain on the State's retiree health budget and adversely affects the State's pension plan.

Options at a Glance

Below is a summary of the options that are described in more detail in the body of this draft report.

Legislative Authorization Required

All of these options require legislative authorization for the State to implement.

Option 1 – Private Medicare Exchange with Defined Contribution to an HRA

This option includes replacing the current Medicare retiree medical and prescription drug plans with a Private Medicare Exchange and a Defined Contribution to a Health Reimbursement Arrangement (HRA).

A Private Medicare Exchange is a marketplace through which individuals can evaluate the differences in cost and coverage among available health care plan options and/or insurers and purchase the plan that best meets their needs, within their price range. Each Exchange is presented online, through a website. Each Exchange also provides a high level of call-center support to help retirees evaluate and choose a health care plan. Private Exchanges are owned and operated by private-sector companies and by non-profit organizations.

To help retirees purchase coverage under a plan offered through a Private Medicare Exchange, plan sponsors, like the State, can make an annual deposit to an HRA in each retiree's name. Retirees can then be reimbursed tax-free from their HRA to help pay for the cost of coverage.

An HRA is an employer-funded, tax-advantaged employer health benefit plan. It allows employees or retirees to be reimbursed tax-free for individual health insurance premiums and eligible out-of-pocket medical expenses (*e.g.*, deductibles, copays, coinsurance). Employers typically contribute to their employees' and retirees' HRAs each year.

Impact on Retirees

For retirees currently covered under the State's Medicare Retiree Health Plan, moving to a Private Medicare Exchange would mean that retirees could choose from among a number of plans. The number of plan choices and plan rates may vary depending on where retirees live, their age, their gender, and the Private Medicare Exchange that is implemented.

Retirees would pay their monthly premium from their pocket and then be reimbursed through their HRA for all or a part of their premium. The amount they are reimbursed depends on the amount of funds the State deposits to their HRAs and the amount of the premium for their chosen plan(s).

Currently, the State's Medicare retirees do not pay a monthly premium cost share for State-sponsored health care coverage; they pay prescription drug copays and the Medicare Part B deductible when they receive services. Medicare retirees also pay a Medicare Part B premium (most retirees currently pay $109 per month; new and/or high-income retirees pay more) and would continue to be responsible for this premium under a Private Medicare Exchange.

The majority of Medicare retirees are projected to have the option to choose coverage under a Private Medicare Exchange with total out-of-pocket costs that are comparable to or less than their current out-of-pocket costs. It is also projected that some retirees could have a remaining HRA account balance that could roll over to the following year, assuming the State provides an HRA contribution comparable to the 2017 Medicare retiree premium rate.

The cost of insurance in the individual Medicare market, including the plans available through a Private Medicare Exchange is often competitive, when compared to the cost of employer-sponsored Medicare coverage. The reasons include the large number of individuals in the Medicare risk pool as well as the large increase in the number of "baby boomer" retirees. In recent years, as baby boomers have aged into and continue to age into Medicare eligibility, the overall average age of individuals who are enrolled in Private Medicare Exchange plans has decreased. Younger retirees tend to have fewer health care needs and thus lower health care expenses. These lower expenses have slowed the growth in the average cost of plans available through a Private Medicare Exchange. Also, the larger number of individuals in the Medicare risk pool results in more stable year-over-year increases than most other group plans. Other factors resulting in lower costs under a Private Medicare Exchange include carrier competition and pricing efficiencies, which have led to competitive premiums.

Under a Private Medicare Exchange, retirees may elect to "buy-up" and purchase coverage that costs them more. If they do, they would likely pay less to receive care or services when needed. As an alternative, retirees can "buy-down" and purchase coverage that costs them less. If they do, they would likely pay more to receive care or services when needed. Details about the impact on Medicare retirees transitioning to a Private Medicare Exchange are shown in *Appendix B*.

Generally, individuals who would pay more would be those who are older, get sick more often and who have chronic health conditions—particularly those with high prescription drug use. It is anticipated that some (see *Appendix B* for the projected impact on a 75-year-old in New Hampshire at various medical care usage levels) of the State's Medicare retirees would pay more for coverage under a Private Medicare Exchange. The State can consider establishing a catastrophic coverage program to limit retirees' risk of potentially high out-of-pocket costs.

Impact on the State

By discontinuing the current State-sponsored Medicare medical and prescription drug plans and offering a Private Medicare Exchange instead, the State would eliminate third-party plan administration costs. The transition would require a significant investment of the State's staff resources and time. Typically, a transition of this kind requires at least an 18-month implementation timeframe, including a procurement process to choose an Exchange vendor.

Transitioning to a Private Medicare Exchange would require a robust communications campaign. The campaign would need to educate retirees about the transition, help them understand their new health plan options and ensure they understand the need to elect new health care coverage. It would also explain how and when to make a coverage election.

Most Private Medicare Exchange vendors provide some level of communications support to aid in the transition. However, if that level of support is not up to the State's standards, the State may find that it needs to purchase additional communications assistance from employee benefits communications consulting experts to support its retirees at the level it believes is necessary.

The State could see a significant reduction in its long-term liability for the cost of retiree health care and improve its cash flow by moving to a defined contribution approach with a Private Medicare Exchange.

See page 33 for a review of the financial impact of implementing a Private Medicare Exchange.

Option 2 – Medicare Retiree Premium Cost Share

This option entails introducing a monthly Medicare Retiree Premium Cost Share Currently, the State's Medicare retirees do not pay a premium cost share for the cost of having medical and prescription drug benefits. Assuming the law is changed to require a Medicare retiree premium cost share, this option could be implemented as early as January 1, 2018, thereby addressing short-term and long-term financial obligations.

As the cost of medical care and prescription drugs continues to rise at a rate greater than general inflation, many plan sponsors (including public employers) have implemented a monthly retiree premium cost share for all retirees, regardless of Medicare eligibility.

Impact on Retirees

Requiring all Medicare retirees to pay a monthly premium cost share would spread the cost equally across the Medicare retiree population enrolled in the plan. Sharing the cost equally would avoid having the sickest Medicare retirees pay the most for using their benefits. For example, assuming 9,000 Medicare retirees, every $5 in monthly premium cost share represents approximately $1 million in revenue to the Retiree Health Benefit Plan over the biennium. In contrast, if the State were to continue to increase prescription drug copayments, then those retirees filling the most prescriptions (presumably the sickest retirees or those with chronic conditions) would need to pay considerably more than the $5 monthly premium cost share so that the State could achieve the same level of savings.

Impact on the State

Introducing a monthly Medicare retiree premium cost share may not require changes to the current medical plan and/or prescription drug plan designs. This could allow the introduction of cost sharing to be implemented relatively quickly; however, the Medicare retiree premium contribution may only be implemented or changed on January 1. This is so that the Plan is in compliance with the Centers for Medicare and Medicaid Services (CMS) rules related to the State's prescription drug plan. DAS estimates that it requires three months to implement a premium contribution. Premium cost sharing could be used to address the State's current short-term budgetary shortfalls.

If the premium cost share is set as a flat dollar amount rather than as a percentage of monthly premium, the State would bear the full health care cost trend (*i.e.*, inflation) risk. For the State to avoid this, legislators would need to vote to increase the premium cost share annually. The reason is that, over time, the flat dollar amount would represent a decreasingly smaller percentage of the full premium. To eliminate this issue, the State can set up the retiree premium cost share as a percentage of premium. This would result in retirees and the State paying the same cost share percentage increase (or decrease) each year.

If the State chooses the percentage-of-premium approach, it must allocate resources and set up administrative procedures to invoice and collect money from retirees. This may be challenging for the State, particularly in situations where retirees do not receive a large enough pension benefit to pay their premium cost share (sufficient funds could not be withheld directly from pension checks). In addition, the State would be required to terminate from the Plan any non-paying retirees.

See page 39 for a review of the potential financial impact of introducing a monthly Medicare retiree premium cost share.

Option 3 – Eliminate the Medicare Retiree Prescription Drug Plan in 2020

As part of the Medicare Modernization Act enacted in 2003, Medicare was expanded to include prescription drug coverage, through the creation of Medicare Part D. Medicare Part D plans are offered by private insurance companies that are reimbursed by the federal government. The creation of this program introduced a standard prescription drug plan that included what was known as the "Doughnut Hole." Participants in the Doughnut Hole paid 100% of the cost of drugs after reaching a certain cost threshold.

With the introduction of the Affordable Care Act (ACA) in 2010, Medicare Part D was updated. Additional benefits were provided, including having the Doughnut Hole close over time. The first portion of the closure came through funding from pharmaceutical manufacturers. They were required to provide a 50% discount on the cost of brand-name drugs purchased within the Doughnut Hole. The remainder of the Doughnut Hole is closing gradually, through funding from various sources, until it reaches a member cost share of 25% in 2020. It is important to note the uncertainty of the ACA's future and that a repeal of the law could change Medicare Part D and the current scheduled closing of the Doughnut Hole.

The individual prescription drug insurance market now has a set of prescription drug plans available that provide comprehensive prescription drug coverage. These plans currently (in 2017) range in price for Medicare-eligible individuals in New Hampshire from approximately $15 to $145 per month, with an average monthly premium of approximately $50. The State could decide to contribute to an HRA to help reduce retirees' out-of-pocket costs for prescription drug coverage and other costs. With the Doughnut Hole closure level to be reached in 2020, some plan sponsors are considering eliminating prescription drug coverage for retirees in 2020.

Impact on Retirees

Eliminating the Medicare retiree prescription drug plan would require retirees to purchase their own prescription drug coverage in the individual market. They would pay 100% of the cost of coverage.

Individual marketplace Medicare Part D plans provide comprehensive prescription drug coverage. However, they are generally not as rich as the prescription drug benefit offered currently by the State. As a result, out-of-pocket costs for Medicare retirees would increase if the State eliminated the Medicare retiree prescription drug plan and retirees had to purchase coverage under individual marketplace Medicare Part D plans. Retirees with high prescription drug use would see the greatest out-of-pocket cost increases.

If the State eliminates Medicare retiree prescription drug coverage, Medicare retirees would have more prescription drug plans to choose from (dozens in many areas) compared with the State's current one-size-fits-all plan. However, with added choice comes the additional responsibility for retirees to choose from among many prescription drug plans the one that best meets their needs. In addition, many plans have more restrictive formularies than the State's current prescription drug coverage. (A formulary is a list of drugs covered by the prescription drug plan.) This can make each retiree's decision to choose the right plan more complicated. There is also a risk to retirees of a late enrollment penalty if they do not sign up for individual marketplace Medicare Part D coverage within a specific amount of time after their current coverage ends.

If the State's group Medicare retiree prescription drug coverage is eliminated, a Private Medicare Exchange could be used to facilitate retiree enrollment in a prescription drug plan sold in the individual market of prescription drug plans. The Private Medicare Exchange would provide administrative and advocacy support as described under Option 1. However, if only Prescription Drugs are moved to the Private Medicare Exchange, the State would likely be required to pay implementation costs, HRA administration fees, and communication fees, as the commissions included in individual Part D plans are not enough to support the service provided. In addition, some Medicare Exchange vendors may not be interested in providing the service in a prescription-drug-only arrangement. If a Private Medicare Exchange is not used, retirees would have limited plan-election decision support as they shopped for a prescription drug plan in the individual market.

Impact on the State

By eliminating the Medicare retiree prescription drug benefit, the State would eliminate roughly half of its OPEB liability. Additionally, starting in 2020, it would reduce, by roughly 60%, year-to-year cash payments associated with paying benefits for Medicare eligible participants. However, since the change would not take effect until 2020, it would not help close any State budget shortfalls for the next two fiscal years. Nonetheless, the State could also see some reduction in benefit administration responsibilities associated with managing the current Medicare retiree prescription drug plan.

The financial benefit to the State of eliminating the Medicare retiree prescription drug plan would likely be significant. However, the State should consider the potential impact on its medical claims budget. If the prescription drug plan is eliminated, Medicare retirees would pay more for prescription drug coverage. That could reduce the number of Medicare retirees who enroll for prescription drug coverage. In turn, this could reduce the rate at which retirees fill and take their prescriptions (typically referred to as "prescription drug compliance"). Reduced prescription drug compliance can lead to the need for additional medical care (*e.g.*, hospital stays, doctor visits). Therefore, the State could see higher medical costs relative to market trend.

If the State were to eliminate Medicare retiree prescription drug coverage, it could contribute money to an HRA for each Medicare retiree. This contribution would help retirees pay for the cost of purchasing individual Medicare Part D coverage and/or associated out-of-pocket prescription drug costs. There would be administrative costs associated with providing an HRA.

Providing defined contributions to an HRA for Medicare retirees to purchase prescription drug coverage would limit some of the State savings associated with eliminating prescription drug

coverage for Medicare retirees. However, doing so could reduce some of the negative reactions retirees are likely to have if prescription drug coverage ends.

See page 50 for a review of the potential financial impact of eliminating Medicare retiree prescription drug coverage by 2020.

Option 4A – Eliminate Retiree Health Benefits for New Hires

The State could choose to eliminate Retiree Health Benefits for new hires. In the past, the State has addressed retiree health liabilities by changing eligibility rules. Most recently, in 2011, the law was changed to require 20 years of service and the attainment of age 65 to receive retiree health. The elimination of Retiree Health Benefits for new hires is a long-term option that could be a next step in managing this liability through eligibility laws.

Impact on Retirees

If the State eliminates Retiree Health Benefits for new hires, affected future retirees would need to buy health care coverage in the individual insurance marketplace if they wished to have post-employment medical and prescription drug coverage. As an alternative, the State could allow retirees to buy into the State's retiree coverage and pay 100% of the premium cost of the State's Plan.

Impact on the State

If the State eliminated Retiree Health Benefits for new hires, there would be limited short-term impact on the State's obligation to pay Retiree Health Benefits and on its OPEB liability. If new hires are not eligible to earn Retiree Health Benefits, based on the State's current retiree health eligibility requirements, it would take 20 years before the State's payments for Retiree Health Benefits are reduced as a result of this change.

However, closing the Plan to new hires would help reduce the growth of retiree health care costs over time. Doing so would not have an impact on the Retiree Health Benefits for current retirees and current State employees. Fewer employers are providing health care benefits to retirees than in the past. However, the State should also consider that eliminating retiree health care benefits for new hires could hurt its ability to attract new employees. If the State allowed retirees to buy into the State's retiree coverage and pay 100% of the premium cost of the State's Plan, the State would need to consider the adverse selection risks associated with this alternative, and how that might raise total costs of the program.

See page 54 for a review of the potential financial impact of eliminating retiree health care coverage for new hires.

Option 4B – Eliminate Retiree Health Benefits for Spouses of Future Retirees

The State could choose to eliminate Retiree Health Benefits for the spouses of future non-Medicare and Medicare retirees. For illustrative purposes, the modeling in this report assumes that these changes would take place for individuals retiring on or after January 1, 2018. It is recommended that, to avoid a mass retiree exodus, the State set this date based on hire date. As

an alternative, the State could grandfather active employees currently eligible for retiree health coverage.

Impact on Retirees

If the State eliminates Retiree Health Benefits for the spouses of future retirees, health care benefits for future retirees would stay the same. However, future retirees who planned to cover their spouses may see this change as a significant cut in benefits.

Impact on the State

By eliminating Retiree Health Benefits for spouses of future retirees, the State would see a reduction of almost 25% in its OPEB liability. The State would also see a reduction in the amount it spends on retiree benefits in the long term. Since this change would only affect future retirees, it would not help address the State's short-term budget issues. However, it would likely help the Plan to be seen by retirees as more equitable, since all retirees would receive the same benefit (*i.e.*, retiree-only coverage), regardless of marital status. For active employees who are further away from retirement, eliminating Retiree Health Benefits for the spouses of future retirees could result in employment retention issues of valued State employees.

See page 54 for a review of the potential financial impact of eliminating Retiree Health Benefits for the spouses of future retirees.

Option 5 – Replace the Current Medicare Retiree Plan with a Group Medicare Advantage Plan

Segal analyzed and considered the option to move State Medicare retirees to a group Medicare Advantage plan and concluded that this is not a viable option for the State at this time. If there are future changes in the Medicare Advantage plan market (*e.g.*, additional carrier/member participation in the State, changes to group Medicare Advantage funding), moving to a Medicare Advantage plan could be an option for the State. Limited provider network development and limited vendor competition for Medicare Advantage plans in New Hampshire has resulted in a low enrollment rates in these plans in the state. As a result, savings opportunities and vendor choice are limited. In addition, since Segal's review, the Centers for Medicare and Medicaid Services updated the reimbursement process for group Medicare Advantage plans. This update is expected to raise premiums for group Medicare Advantage plans and further reduce the already limited savings opportunity for this option.

See page 59 for the review of replacing the current Medicare retiree medical and prescription drug plan with a group Medicare Advantage plan, including the potential financial impact.

Option 6 – Defined Dollar Amount for Non-Medicare Retiree Plan

This option includes changing the State's premium cost share for the Non-Medicare Retiree Plan from a percentage of the cost to a Defined Dollar Amount.

The State could opt to pay a defined dollar amount toward the cost of health benefits for non-Medicare retirees. In doing so, the State would adjust the premium share it provides towards the

cost of non-Medicare retiree medical and prescription drug coverage from a percentage contribution (currently 82.5%) to a flat dollar amount. This defined dollar amount would not change as the costs for medical and prescription drugs change each year unless the legislature decides to increase funding. Plan design changes (*e.g.*, increasing deductibles, copayments and out-of-pocket maximum amounts) could also generate savings for the State, but these savings are typically more short-term in nature. As such, they are not included in this long-term-focused report. The *Short-Term Options for the Retiree Health Benefit Plan* presented at the September 23, 2016 Fiscal Committee Meeting can be found in *Appendix H*.

Impact on Retirees

Using a defined dollar contribution approach, non-Medicare retirees would pay all future increases in the premium cost that the Plan experiences. The reason is that the annual premium share provided by the State would be fixed, rather than a percentage of the premium cost as it is today. Over time, the value of the benefit provided to non-Medicare retirees would decline. A continual rise in the retiree premium cost share could result in more non-Medicare retirees opting out of State-provided health benefits to purchase health care coverage elsewhere on their own (*e.g.*, the Public Marketplace). In addition, fewer employees may retire before reaching age 65.

Impact on the State

If the State adopted a defined dollar amount approach for non-Medicare retirees, the State would have health care cost trend and inflation protection against rising health care costs. The protection would come from shifting all future health care premium cost increases to non-Medicare retirees unless the State decides to increase the defined dollar amount it pays. This would result in a reduction in its OPEB liability. It would also generate short-term cash savings.

Since the State would continue offering group medical coverage to non-Medicare retirees, the State would still be responsible for paying any claims for retirees that exceed projected premium rates. The potential risk to the State of this approach is that non-Medicare retirees that remain covered under the State's plan would be individuals who use health care services the most (those who are most ill and/or have chronic health conditions). This could result in the State paying more for claims than they currently do on a per-participant basis.

See page 65 for a review of the potential financial impact of changing the State's premium cost share for the non-Medicare retiree plan from a percentage of the cost to a defined dollar amount.

PLEASE NOTE: The options described in this draft report are not recommendations for action; they are provided solely to help the Governor and State Legislature consider the steps that could be taken to manage the State's retiree health program costs and, in turn, reduce the State's short-term expenses and unfunded long-term financial liability. If the State were to implement any of these options, the State may choose to implement them individually or in various combinations with one another. Any options under consideration would need to be reviewed, debated and voted on by the State Legislature and, if passed by the legislature, signed by the Governor into law before they could be implemented.

Introduction

The Need to Study Long-Term Options to Reduce the State's Financial Liability for the Cost of Retiree Health Benefits

The State of New Hampshire's Retiree Health Benefit Plan (the Plan) was established in 1963. This was a time when the cost of health benefits was relatively low. Low costs were due in part to the existence of relatively few costly medical technology innovations compared with those available today, and the existence of relatively few expensive prescription drug options that today treat the serious illnesses and conditions associated with disease and aging.

Since the Plan was established, each of the State's biennium budgets has included funding to pay for the benefits provided under the Plan. However, allocating sufficient funds to support the Plan has become increasingly more difficult because of rising medical and prescription drug costs and increasing Plan enrollment. This challenge threatens the financial sustainability of the Plan.

The below chart shows the State's total Retiree Health Benefits budget for Fiscal Year 2014 through Fiscal Year 2017, as well as the projected budget needs for Fiscal Years 2018 and 2019.

STATE RETIREE HEALTH BUDGET
FY2014 – FY2019

	Adjusted Authorized Budget				Agency Maintenance Budget to Meet Current Need	
Retiree Health Budget Revenue and Expense	**FY14**	**FY15**	**FY16**	**FY17**	**FY18**	**FY19**
Revenue						
General Fund	$33,445,500	$34,451,200	$32,462,200	$33,380,100	$38,711,900	$44,212,700
Other State Revenue Sources	$29,833,200	$29,868,500	$32,751,100	$34,752,000	$35,359,200	$38,786,000
Non-Medicare Retiree Premium Contribution 12.5% / 17.5%	$4,663,100	$4,659,000	$4,187,900	$4,322,500	$6,345,100	$6,803,300
Self-payers (100% self-pay dependents and Legislators)	$466,400	$511,700	$481,200	$512,800	$537,100	$605,200
Total Budgeted Revenue	**$68,408,200**	**$69,490,400**	**$69,882,400**	**$72,967,400**	**$80,953,300**	**$90,407,200**
Total Budgeted Expense (enrollment x premium equivalent)	**$68,408,200**	**$69,490,400**	**$69,882,400**	**$72,967,400**	**$80,953,300**	**$90,407,200**
Retiree Health Benefit Account Surplus to be used in FY2016/2017			*$1,600,000*	*$4,000,000*		
Total Projected Budget Need			***$71,482,400***	***$76,967,400***		

In 2015, the financial sustainability challenges faced by the Retiree Health Benefit Plan became even more pronounced. During the Governor, House and Senate phases of the Fiscal Year (FY) 2016/2017 budget process, the Plan budget had a $5.6 million funding deficit. In June 2015, the State's Department of Administrative Services (DAS), working with Segal Consulting (Segal), its health benefits consultant, determined that the Plan was further in debt because prescription drug expenses had risen 5% above the projected increase level. This increase added $4 million to the $5.6 million projected Plan deficit. At about this same time, the State was notified by Express Scripts, the Plan's Pharmacy Benefits Manager, that a federal subsidy paid to the State for Medicare-eligible retirees would be reduced by $1 million. Suddenly, the Plan—and the State—faced a $10.6 million deficit for the FY 2016/2017 budget.

In July 2015, DAS began working with the Fiscal Committee of the General Court to address the $10.6 million deficit in the Retiree Health Benefit Plan budget. (Pursuant to RSA 21-I:30, the Fiscal Committee must approve all changes to retiree premium cost share amounts and to design changes related to the Plan.) Between July and November 2015, at five separate meetings of the Fiscal Committee, DAS provided the Committee with information to assist with making decisions to reduce the $10.6 million deficit. Ultimately, the Fiscal Committee used the following approaches to reduce the deficit:

- Applied a $5.6 million previously-existing surplus in the Retiree Health Benefits account.
- Transferred funds from within the DAS budget.
- Increased the monthly retiree premium cost share amount paid by non-Medicare retirees (described below).
- Increased copays and out-of-pocket maximums for prescription drugs paid by non-Medicare and Medicare retirees.

Throughout the 2015 Fiscal Committee process, the Fiscal Committee asked DAS to work with Segal to study options to make the Plan financially sustainable for the long term (hence this Long Term Study). DAS began this work in late 2015 and continued working with Segal through May, 2016. In May 2016, Retiree Health Benefits legislation that would have authorized funding to continue the Long Term Study did not pass. This forced DAS to discontinue work on the Long Term Study. Instead, DAS turned its attention to working with the Fiscal Committee to obtain authority to continue the Long Term Study and to identify a source of funds to pay for it. In July 2016, the Fiscal Committee approved the use of retiree health reserve funds to pay for the Long Term Study. DAS then resumed work on the Study with Segal.

As the FY 2018/2019 budget process gets underway, DAS projects the need for an additional $25.4 million ($16.1 million from General Funds, $9.3 million from Other Funds) during FY 2018/2019 to provide Retiree Health Benefits at the same level as currently provided to retirees. This $25.4 million takes into account projected increases in medical and prescription drug costs and an estimated 4% annual enrollment increase of Medicare retirees. The State legislature must determine whether to fund this increase in whole or in part and/or whether to change the Plan's premium cost share amounts for retirees, change plan design and/or change laws related to governing the Plan (*e.g.*, introduce a premium cost share for Medicare retirees or offer access to a Private Medicare Exchange with a defined contribution to an HRA).

Current Retiree Medical Plan Overview

The State provides comprehensive Retiree Health Benefits to its retirees and their spouses. Non-Medicare retirees and spouses are required to pay the 2017 premium cost share of $176.74 per month. Medicare retirees and spouses do not currently pay a premium cost share. The summary of benefits for the Non-Medicare Retiree Plan and Medicare Retiree Plan are included in the *Appendix E* of this draft report. The State's retiree plan designs are briefly described below:

- **Non-Medicare Medical Coverage:** For in-network services, retirees are responsible for copayments for physician office visits and emergency room visits. Retirees must pay a deductible for outpatient and inpatient hospital services, to a maximum out-of-pocket cost of $1,000 per person per year.

- **Medicare Medical Coverage:** The State's Medicare retirees have almost 100% of their medical expenses covered, with the exception of being responsible for the Medicare Part B deductible for Part B services. The plan does not provide coverage for any services that are not covered by Medicare.
- **Non-Medicare and Medicare Prescription Drug Coverage:** The State provides a three-tier copayment plan; retirees pay less for generics versus brand drugs and less for mail order versus retail drugs to a maximum out-of-pocket cost of $750 per person per year. The State provides coverage for certain prescriptions that are not covered by Medicare (*e.g.*, lifestyle drugs).

Coverage for Other New Hampshire Residents

For individuals in the State of New Hampshire that do not have access to subsidized retiree medical coverage from the State Plan, coverage would need to be attained in the individual market.

For non-Medicare residents seeking medical and prescription drug coverage in retirement, individual coverage can be attained through New Hampshire's Federally Facilitated Health Insurance Marketplace (*i.e.*, the Public Exchange). In the State of New Hampshire, residents would have access to up to 34 plans from four carriers ranging in value from Bronze (60% actuarial value of coverage) to Platinum (90% actuarial value of coverage). Certain individuals may qualify for federal subsidies to offset premiums and/or enhance benefits based on income level. In addition, residents that make up to 138% of the Federal Poverty Level would have access to coverage through Medicaid. In order to secure similar coverage to the plan provided to State non-Medicare retirees, an individual would need to purchase a Platinum plan. Premium cost varies by age, but in the State of New Hampshire, there are two Platinum plans offered, with approximate 2017 premiums of $873 and $938 for a 62-year-old. Although similar coverage levels can be achieved through the plan design of these plans, it is likely that the individual would have access to a more restrictive (or narrow) network of doctors and hospitals than the network currently offered by the State Non-Medicare Retiree Plan.

For Medicare-eligible residents seeking medical coverage in retirement, individual Medicare Supplement and Medicare Advantage plans (in certain areas) would be available. These plans would range in value and premium, and would provide coverage in addition to Medicare Part A and Part B. Residents would be able to replicate medical coverage available through the State by purchasing Medicare Supplement Plan F, which essentially provides 100% coverage for all medical services, including the Medicare Part B deductible (not currently provided by the State Medicare Retiree Plan). Premiums for this coverage would vary by age, gender, and location, but as an example, a 75-year-old male in Concord, NH would be able to enroll in a Supplement Plan F offered by Humana for approximately $276 per month for 2017 and a 75-year-old female would pay approximately $248 per month.

While Medicare medical plan coverage can be almost duplicated, residents would not be able to secure coverage for prescription drug benefits that is as comprehensive as the State Medicare Retiree Plan, largely due to the $750 out-of-pocket maximum offered by the State Plan as well as the unique structure of individual market Medicare Part D plans. Although there are plans that offer comparable, or lower, copayments for prescription drug coverage during the initial coverage level of Medicare Part D, cost share structure changes when a participant reaches the

"Doughnut Hole". Some plans do continue with a copay structure during this phase of coverage, but this tends to only be for generic drugs. In addition, there is no out-of-pocket maximum in individual Part D plans. While members that reach the catastrophic level of Part D coverage are only responsible for up to 5% of the cost of their drugs, this out-of-pocket cost could become expensive for the highest utilizers. Part D plans in the State of New Hampshire range in price from approximately $15 to $145 per month, with an average premium of approximately $50 per month.

A Brief History of the Retiree Health Benefit Plan

Establishing and Funding the Plan

In 1963, the State of New Hampshire established the Retiree Health Benefit Plan. Chapter 327, Laws of 1963, enacted RSA 101:56 stated:

> ***101-A:6 Group Hospitalization, Hospital Medical Care, Surgical Care and Other Medical and Surgical Benefits.*** *The state shall pay a fixed cost of three dollars per month per state employee and retired employee towards the present group hospitalization, hospital medical care, surgical care and other medical and surgical benefits towards a group plan offering benefits as good or better than the present plans. The state employees and the retired employees shall pay for the balance of the premium on payrolls deductions.*

Chapter 327:2 (Laws of 1963) appropriated to the then-Board of Trustees of the State Employees' Retirement System (today called the New Hampshire Retirement System) for FY 1964 and 1965, $232,800 in funds from various sources. A review of legislative history for subsequent years shows only specific amounts of budget appropriations in support of the Retiree Health Benefit Plan.

In 1976, the law for the first time stated that Retiree Health Benefits funding is limited to the funds appropriated by the legislature. Chapter 51, Laws of 1976, established RSA 101-A:6. It states that the Retiree Health Benefit Plan is funded "within the limits of the funds appropriated at each biennial session and providing any change in plan or vendor is approved by the fiscal committee of the general court prior to its adoption."

Today, RSA 21-I:30 states that the State will provide Retiree Health Benefits "within the limits of the funds appropriated at each legislative session."

Changes to Retiree Health Benefits – Eligibility Laws

After the Retiree Health Benefit Plan was established in 1963, participation in the Plan grew substantially. Growth in participation added to the financial burden of the Plan on the State's finances. To help alleviate some of this increasing burden, the State changed the law governing Plan eligibility in 2003 and 2011 for Group I, and in 2010 and 2011 for Group II.

Plan eligibility for Group I State employees (employees other than police and firefighters) is currently as follows:

- **Employees hired before July 1, 2003** must have at least 10 years of State service and be at least age 60 (special rules are available that permit long-term employees to enroll before age 60).
- **Employees hired on or after July 1, 2003 but before July 1, 2011** must have at least 20 years of State service and be at least age 60 (special rules are available that permit long-term employees to enroll before age 60).
- **Employees hired on or after July 1, 2011** must have at least 20 years of State service and be at least age 65 (the special rules for long-term employees were repealed and the retiree can no longer designate coverage to a non-spouse).

Increasing the enrollment age to 65 for employees hired on or after July 1, 2011 and repealing special eligibility rules for long-term employees are expected to reduce the number of future Group I retirees eligible for State Retiree Health Benefits before they become eligible for Medicare coverage.

For Group II State employees (police and firefighters), before changes were made in 2010, eligibility for Plan coverage was linked to eligibility for a pension through the New Hampshire Retirement System (NHRS).

- Employees were eligible for a pension under the NHRS if they were at least age 45 with at least 20 years of creditable service with participating employers.
- Creditable service could be earned through a combination of municipal and State service.
- To be eligible for coverage under the Plan, a Group II employee needed to retire while employed by the State. This meant a Group II employee could, for example, work 19 years for a municipality but work his or her final year for the State and be eligible for Plan coverage at retirement.

Currently, Group II employees hired on or after July 1, 2010 must have at least 20 years of creditable service **as a State employee** to be eligible for the Plan. Employees hired on or after July 1, 2011 must also be at least age 52½ to enroll in the Plan.

Group I and Group II Retiree Health Benefits eligibility rules for accidental death or disability, and ordinary death or disability, have remained mostly the same.

- There is no minimum age or service requirement for accidental death or disability.
- There is no minimum age requirement to be eligible for ordinary death or disability. However, employees must have at least 10 years of creditable service to be eligible for an ordinary death or disability pension.
- Prior to July 1, 2003, the individual only needed to demonstrate eligibility for the ordinary death or disability pension to be eligible for Retiree Health Benefits.

- Additional Retiree Health Benefits Retiree Health Benefits eligibility rules under an ordinary death pension include:
  - Group I employees hired after July 1, 2003 need at least 20 years of service in order for their surviving spouse to be eligible for Retiree Health Benefits.
  - Group II employees hired after July 1, 2010 need at least 20 years of creditable service in order for their surviving spouse to be eligible for Retiree Health Benefits.

Changes to Retiree Health Benefits – Plan Design

To help mitigate rising health costs, the State made plan design changes to the retiree medical and prescription drug benefits over the last few years, as summarized below:

- **Effective July 1, 2009**, Non-Medicare Retiree Plan medical changes:

	Prior to July 1, 2009	Effective July 1, 2009
In-Network: Office Visit Copayment	$10 Primary Care / $10 Specialist	$10 Primary Care / $20 Specialist
Emergency/Urgent Care Copayment	$10	$50
In Network: Maximum Out-of-Pocket	None	$500 individual / $1,000 family
Out-of-Network: Maximum Out-of-Pocket	$900 individual / $2,700 family	$1,500 individual / $3,000 family

- **Effective July 1, 2009**, Non-Medicare and Medicare Retiree prescription drug plans changed to a three-tier flat dollar copayment design:

	Prior to July 1, 2009		Effective July 1, 2009
	Non-Medicare Retirees	Medicare Retirees	ALL Retirees (Non-Medicare and Medicare)
Retail Pharmacy (*31-day supply*)			
Annual Deductible	$50	$100	None
Copayments	20%	20%	$5 generic $10 preferred brand $15 non-preferred brand
Annual Maximum Out-of-Pocket	$500	$80	$500 individual/$1,000 family (combined with mail-order)
Annual Maximum Benefit	$2,000	None	None
Mail Order Pharmacy *(90-day supply)*			
Copayments	$4	$4	$10 generic $20 preferred brand $30 non-preferred brand
Annual Maximum Out-of-Pocket	None	None	$500 individual/$1,000 family (combined with retail)

- **Effective October 1, 2010**, the Non-Medicare and Medicare Retiree prescription drug plan changed as follows:
  - Decreased mail order generic copayment to $1 (from $10)
  - Implemented mandatory mail order for maintenance drugs (required after three fills at retail)
  - Implemented directed generic, which means mandatory use of generic equivalents unless the prescribing physician orders "Dispense as Written"
  - Implemented exclusive specialty pharmacy, which required the use of the mail order pharmacy for certain high-cost specialty drugs
  - Added coverage for smoking cessation drugs.
- **Effective January 1, 2011**, non-Medicare and Medicare retirees were allowed to opt-out of participating in mandatory mail order.
- **Effective January 1, 2012**, Non-Medicare Retiree Plan medical changes:
  - Specialist office visit copayment increased to $30 (from $20)
  - Emergency Room copayment increased from $50 to $150 (urgent care copayment remained at $50)
  - Implemented a $150 copayment for advanced imaging services
  - Increased the out-of-network deductible to $650 individual/$1,350 family (from $150 individual/$450 family)
- **Effective January 1, 2012**, Medicare retirees became responsible for paying the annual Medicare deductible for Part B services ($162 for 2012).
- **Effective January 1, 2012**, the Non-Medicare and Medicare Retiree prescription drug plan changed as follows:

	Prior to January 1, 2012	Effective January 1, 2012
Retail Pharmacy (*31-day supply*)		
Generic Copayment	$5	$10
Preferred Brand Copayment	$10	$20
Non-Preferred Brand Copayment	$15	$35
Mail Order Pharmacy *(90-day supply)*		
Generic Copayment	$1	$1
Preferred Brand Copayment	$20	$40
Non-Preferred Brand Copayment	$30	$70
Annual Maximum Out-of-Pocket (retail and mail order combined)	$500 individual / $1,000 family	No Change

- **Effective January 1, 2015**, the State changed the Medicare Retirees prescription drug plan to an Employer Group Waiver Plan (EGWP). An EGWP is a Medicare Part D plan that must follow CMS requirements. It is available to group plans like the State Plan. The EGWP allows the State to mirror its plan design while maximizing federal revenue to take advantage of the Medicare subsidies and funding only available to Part D plans.

- **Effective January 1, 2016**, the Non-Medicare and Medicare Retiree prescription drug plans changed as follows:

	Prior to January 1, 2016	Effective January 1, 2016
Retail Pharmacy (*31-day supply*)		
Generic Copayment	$10	$10
Preferred Brand Copayment	$20	$25
Non-Preferred Brand Copayment	$35	$40
Mail Order Pharmacy *(90-day supply)*		
Generic Copayment	$1	$10
Preferred Brand Copayment	$40	$50
Non-Preferred Brand Copayment	$70	$80
Annual Maximum Out-of-Pocket (retail and mail order combined)	$500 individual / $1,000 family	$750 individual / $1,500 family

Changes to Retiree Health Benefits – Premium Cost Share

In addition to implementing plan design changes to address retiree health budgeting challenges, the State introduced a retiree premium cost share for the Non-Medicare Retiree Plan in 2009. The Medicare Retiree Plan does not have a premium cost share.

The Non-Medicare Retiree Plan premium cost shares changed as follows:

- **Effective July 1, 2009**, a premium cost share of $65 per month was introduced.
- **Effective July 1, 2011**, the premium cost share was changed from a flat dollar amount to 12.5% of the plan's premium rate. During 2011, this percentage represented $113.80 for each retiree and spouse per month.
- **Effective January 1, 2016**, the premium cost share was increase to 17.5% of the plan's premium. This percentage equates to $159.94 and $176.74 per month for each retiree and spouse in 2016 and 2017, respectively.

Retirees Testify to the Promise of Having Retiree Health Benefits

Retirees have testified before the State legislature that they were promised Retiree Health Benefits when they were hired and that this promise was reiterated when they applied for retirement benefits. In addition, retirees have produced an excerpt of retirement literature that indicates they will receive Retiree Health Benefits. In their testimony, retirees maintain that they did not know that these benefits were dependent on and limited to the funds appropriated by the State legislature. Some retirees testified that had they known that retiree health was not a guaranteed benefit, they may have made different employment decisions earlier in their careers because they cannot afford to absorb more health care costs given their pension amounts. At least one retiree has consistently suggested that further changes to the Retiree Health Benefit Plan would be unnecessary if the State were to address tort reform in order to lower health care costs throughout the healthcare system.

Retiree Health Accounting Requirements

The Governmental Accounting Standards Board (GASB) sets standards for financial reporting for governmental employers and benefit plans (like pension plans and retiree health benefit plans) to promote consistency and transparency in financial reporting. GASB refers to retiree health benefit plans as Other Post-Employment Benefits (OPEB) plans.

The State of New Hampshire is required to follow the GASB reporting requirements for OPEB. In 2004, the GASB issued Statement No. 45 (GASB 45)—Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions. Under this Statement, all state and local governmental entities that provide other postemployment benefits must report the cost of these benefits on their annual financial statements. The State's retiree medical and prescription drug coverage is covered under GASB 45.

Prior to GASB 45, these benefits were typically financed on a "pay-as-you-go" basis. This means that they were accounted for only as the cost of providing the benefits arose. The future costs of these benefits did not have to be reported as a current financial liability on the financial statements. The GASB 45 standard required accrual-basis accounting for OPEB benefits. Accrual-basis accounting means that employers must recognize and show on their financial statements the employer cost of postemployment benefits that are credited to employees while they are working. This change made the accounting requirements for non-pension benefits such as medical and prescription drugs similar to the requirements for pension benefits.

The total employer cost of providing OPEB benefits is projected by taking into account certain actuarial assumptions, including those about demographics (turnover, mortality, disability, retirement) and health care cost trend (*i.e.*, inflation factor). The total employer cost is then actuarially "discounted" to determine the actuarial present value of the total projected benefits (APB). The higher the discount rate, the lower the OPEB liability. The lower the discount rate, the higher the OPEB liability.

Since this OPEB liability represents the present value of all future promised benefits, it can be used (as it is in this draft report) as a proxy for the long-term financial impact of changes. The OPEB liability referred to in this draft report reflects the Actuarial Accrued Liability (AAL). The AAL is the present value of the total projected benefits allocated to years of employment, up to the date of valuation. For plans like the State's, where no assets are currently dedicated to paying OPEB benefits, the AAL is equal to the **unfunded** AAL (or UAAL). The State authorized creation of a trust in 2013 to fund the OPEB liability, but the State has not funded the trust at this point.

State's OPEB Liability Statistics

Although this section of the draft report is technical in nature, it is necessary to illustrate that the State of New Hampshire's current unfunded AAL as of the most recent valuation (performed as of December 31, 2014) is $2,138,000,000 at the pay-as-you-go actuarial discount rate of 4.5%. This discount rate is much lower than the 7.25% rate used for the New Hampshire Retirement System, which is a partially funded plan (meaning a set amount of assets and future contributions have been designated for the sole purpose of paying the cost of all retirement benefits).

Of this $2,138,000,000 liability, over 80% is for projected benefits provided under the Medicare Retiree Plan. As a result, the majority of the financial impact scenarios shown in this draft report focus on changes that would impact Medicare retirees (*i.e.*, Participants in the Medicare Retiree Plan). Also, more than half (approximately 55%) of the $2,138,000,000 liability is for active employees (or future retirees) who are not currently receiving retiree medical and prescription drug benefits.

In terms of the effect on the State's balance sheet, GASB 45 allows liability recognition gradually, over time, and only required disclosure of the full liability in the footnotes of the financial statement. The portion of the UAAL recognized on the balance sheet (referred to as the "Net OPEB Obligation"), was just under $1 billion as of June 30, 2015.

Upcoming OPEB Accounting Changes

The upcoming impact of GASB Statement No. 75 (GASB 75) on OPEB accounting will bring renewed prominence to the State's long-term financial liability for Retiree Health Benefits—specifically, its OPEB liability. GASB 75 will replace GASB 45 and will be effective with the State's June 30, 2018 Comprehensive Annual Financial Report (CAFR).

These are the most significant changes affecting the State's financial reporting for OPEB, based on Statement No.75:

- GASB 75 requires the entire unfunded OPEB liability to be reported on the State's balance sheet. GASB 45 allows for gradual recognition as noted above. **As a result of GASB 75 requirements, the OPEB liability reported on the State's balance sheet (based on the most recent valuation) will approximately double—from the GASB 45 "Net OPEB Obligation" of approximately $1 billion (a portion of the $2 billion), to the GASB 75 "Net OPEB Liability" of the entire $2 billion.**
- The discount rate used to calculate the OPEB liability under GASB 75 must be based on a municipal bond index. Using this index, the discount rate will likely be lower than the discount rate used to calculate the liability under GASB 45. The lower discount rate will result in an even higher OPEB liability.
- In addition, under GASB 45, many of the changes that occur between valuations, such as changes in actuarial assumptions, plan experience, and benefit design changes, could be recognized in the State's income and expense statement over 30 years. Under GASB 75, these changes must be recognized immediately or over a much shorter time. As a result, the annual expense for OPEB (known under GASB 45 as the "Annual OPEB Cost") will vary much more dramatically from year to year than it does currently. This will result in substantially increased volatility in the State's income and expense statement.

OPEB Liability Modeled in this Report

Financial modeling for the options described in this draft report was developed using specific levels of retiree premium cost share amounts and defined contribution amounts (for HRA contributions). However, many of these amounts can be increased or decreased and/or combined with other changes to generate additional options that could be modeled to measure their potential impact. Certain options are modeled assuming that they apply to all retiree groups. However, the State could consider certain options for certain groups but not for others (*e.g.*, the elimination of prescription drug coverage only for employees not eligible for retirement within the next five or more years).

The State's GASB actuarial valuation as of December 31, 2014 (including its underlying data and assumptions) was used as the basis for all liability impact calculations in this draft report. These liabilities were projected to January 1, 2017, which are presented as the current plan baseline in all charts throughout the report.

Please refer to *Appendix C* for discussion of assumptions important information about the actuarial valuation.

Means Testing

During the 2016 State legislative session, several retiree health bills were introduced. As these bills were debated, some legislators expressed concern about State retirees who were living on fixed incomes and were facing the financial pressure of paying for the cost of retiree health care. In response to these concerns, several legislators expressed interest in the possibility of applying means testing to determine each retiree's ability to pay for additional costs associated with retiree health care plan design and premium cost share changes.

DAS has raised concerns about using means testing, for the following reasons:

- The State does not have access to each retiree's total household income or other financial information which is needed to accurately determine their ability to contribute to the cost of health care. The State only has retiree monthly pension payment information. Pension amounts could be based on a combination of years of service with State and municipalities (versus service only with the State). With this limitation on access to household financial information, if means testing were applied, some retirees with a higher State pension and no other income sources could pay more than retirees who have a lower State pension and have other income sources that are much greater than retirees who receive a higher State pension.
- DAS does not have the staffing resources and/or systems capacity needed to implement the means-testing process, including setting standards, determining eligibility, and administering the application and appeals processes. In 2016, DAS collaborated with the Department of Health and Human Services (DHHS) to explore whether its eligibility staff and computer systems could accommodate a means testing eligibility process for State retirees. DAS learned that this support would cost approximately $1 million to implement, taking into account additional staffing and training, computer system modifications, and establishing rules, procedures and an appeals process. Additionally, there would be ongoing staffing and maintenance costs to consider. In order to access this DHHS support, DAS would have to direct funding from health care to support a means testing process.

- Further, if retiree monthly pension payments were the sole determinant used in means testing, one possible outcome would be that retirees with the fewest years of State service would receive the greatest subsidy because their pension payments are lowest.

Considering DAS's inability to administer a means-testing approach, and the lack of access to household income data, DAS suggested during the legislative process two alternatives to means testing that might be more fair:

1. Consider each retiree's years of State service
2. Grandfather current retirees, based on their age.

These alternatives are included in this draft report.

If the grandfathering alternative is selected, it must not use a future retirement date to determine grandfathering eligibility. A future retirement date could cause a significant spike in retirements from the State's active employee workforce.

The State's pensions by age is summarized in *Appendix F*.

Other States and Retiree Health Benefits

The State's short-term financial and long-term OPEB liabilities challenges are not specific to the State of New Hampshire Retiree Health Plan. Other states face the same or similar challenges regarding providing health benefits to their retired employees.

A report on retiree health spending for all fifty states was issued by The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation in early 2016. It includes data as of 2013. This report can be used to see how the State of New Hampshire compares to its peers and can be found at: http://www.pewtrusts.org/en/research-and-analysis/reports/2016/05/state-retiree-health-plan-spending.

Appendix D of this report includes a survey with a smaller sample size of states, but has more current information (as of May 2016) on the measures states have taken to address their retiree health programs' financial liabilities.

Regarding Private Medicare Exchanges with defined contributions to an HRA, Louisiana, Nevada, Ohio, and Rhode Island have implemented this benefit approach for some or all of their Medicare retirees. While interest is growing regarding this approach, there is a still a limited number of states that have implemented a Private Medicare Exchange with defined contribution to an HRA.

Options Considered

This section describes options the State may want to consider to address budgeting concerns and reduce its unfunded liability for the cost of retiree medical and prescription drug coverage.

For each option, this section:

- Provides education to understand key concepts of a particular option
- Describes the potential impact on retirees
- Describes the potential impact on the State
- Provides financial modeling to illustrate the estimated impact on ten-year cash flows. Cash flow exhibits include the expected State costs associated with benefits provided to retirees.
- Provides financial modeling to illustrate the estimated impact on projected GASB/OPEB long-term liability for coverage offered to retirees.

The estimated potential cash flows and liability reductions described in this section are intended to illustrate orders of magnitude of projected savings and liability reductions associated with implementing changes to the retiree health plan. As a result, the estimated cash flow liabilities and savings should not be used to set State budget levels in the short term (*e.g.*, FY 2018/2019). For State budgeting purposes, the estimated impact of the options described in this draft report would need to be modeled independently (*i.e.*, outside of this draft report).

The options described in this draft report are not recommendations for action; they are provided solely to help the Governor and State Legislature consider the steps that could be taken to manage the State's retiree health program costs and, in turn, reduce the State's short-term expenses and unfunded long-term financial liability. If the State were to implement any of these options, the State may choose to implement them individually or in various combinations with one another. Any options under consideration would need to be reviewed, debated and voted on by the State Legislature and, if passed by the legislature, signed by the Governor into law before they could be implemented.

Option 1 – Private Medicare Exchange with a Defined Contribution to an HRA

The State could consider replacing the current Medicare retiree medical and prescription drug coverage with a Private Medicare Exchange. To assist with understanding the option of introducing a Private Medicare Exchange, it is helpful to first briefly describe the function of Health Care Exchanges and their history. In addition, a description of Health Reimbursement Arrangements is also provided, as these are typically offered in conjunction with a Private Medicare Exchange.

Background on Health Care Exchanges

Health Care "Exchanges" have been operating in the Medicare market for a number of years. The passage of the Affordable Care Act (ACA) brought the concept of Exchanges to greater public prominence. Health Care Exchanges were established for the general public by the ACA. Public Exchanges have been providing health care coverage options since January 2014.Public Exchanges are run by individual states, by the federal government, or as partnerships (Partnership Marketplace), with the federal government and the applicable state each retaining certain administrative functions. The New Hampshire Public Exchange is run as a Partnership Marketplace.

An Exchange is typically delivered as a website that is similar to a retail website—except, of course, it sells health insurance coverage instead of consumer goods or services. An Exchange includes decision-support tools to help individuals understand the coverage options it provides and to help them make an informed health care coverage purchasing decision.

Any individual who is not Medicare eligible can purchase coverage through a Public Exchange and choose from different levels of coverage from various insurers. The Public Exchanges are primarily a way of providing health care coverage for those who were previously uninsured and for lower-income individuals who may be eligible for a federal premium assistance tax credit in the Public Exchange. Public Exchanges do not include Medicare supplemental coverage options.

Under the ACA, individuals in small groups can purchase coverage in the Public Exchanges through the Small Business Health Options Program (SHOP) Exchange. However, states have not yet opened the SHOP Exchange to participation for individuals of large groups (more than 100 employees), like the State Health Plan.

Background on Private Health Care Exchanges

A Private Health Care Exchange is also a marketplace through which individuals can evaluate the differences among available health care plan options and/or insurers and purchase health insurance. However, Private Exchanges are owned and operated by private-sector companies or non-profit organizations.

Private Exchanges operate in three main markets—those for:

- Part-time employees, retired pre-65 employees and recipients of continued coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA);
- Medicare-eligible individuals; and

- Active employees.

Although Private Exchange options exist for non-Medicare retirees, they currently largely rely on coverage available through the Public Exchange marketplace. The Public Exchange marketplace is highly volatile for the following reasons:

- Insurance carriers can and do enter and leave the Public Exchanges annually
- Premium rates for coverage in the Exchanges have been increasing much faster than anticipated
- There is uncertainty about changes that will be made to the Affordable Care Act itself (which established the Public Exchanges) and how those changes may affect the Public Exchanges.

Therefore, providing health care coverage to non-Medicare retirees through a third-party administrator (TPA) as the State does today (rather than a Private Exchange) is the most stable approach to providing benefits for this group. Options that address cost reduction opportunities for non-Medicare retiree coverage are addressed later in this draft report.

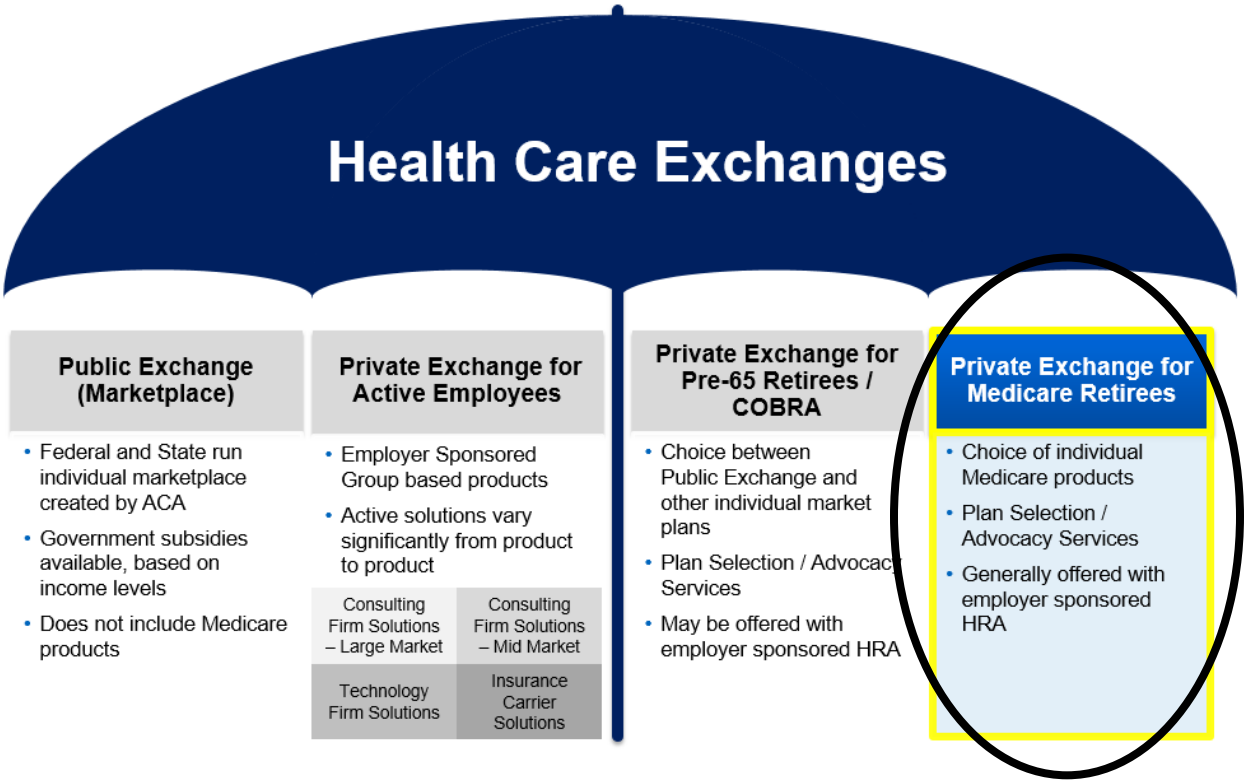
The Private Medicare Exchange market is the longest-existing type of health care Exchange. It came into existence long before the passage of the Affordable Care Act. The Private Medicare Exchange market has gained popularity because of the cost savings it offers plan sponsors faced with increasing retiree health care costs and OPEB liabilities. Plan sponsors realize cost savings by transitioning from providing a group health benefit plan to a defined contribution plan. The Private Medicare Exchange's popularity also arises from the potential savings opportunities it provides for retirees. Further, Private Medicare Exchanges provide professional and personalized service to retirees to help them identify their unique personal healthcare needs and to choose plan coverage accordingly.

The cost of insurance in the individual Medicare market, including the plans available through a Private Medicare Exchange is often competitive, when compared to the cost of employer-sponsored Medicare coverage. The reasons include the large number of individuals in the Medicare risk pool and the large increase in the number of "baby boomer" retirees. In recent years, as baby boomers have aged into and continue to age into Medicare eligibility, the overall average age of individuals who are enrolled in Private Medicare Exchange plans has decreased. These younger individuals have fewer—and generally less costly—health issues, which keeps the health care cost down. In turn, this has slowed the growth in the average cost of Private Medicare Exchange plans. Also, the larger number of individuals in the Medicare risk pool results in more stable year-over-year increases than most other group plans. Other factors influencing competitive premiums for Private Medicare coverage include carrier competition and pricing efficiencies.

Due to the stability and cost-effective nature of the Medicare insurance market and the State's financial liability associated with Medicare retirees, part of our review of the State's retiree health plan focuses on the Private Exchange plans offered to Medicare-eligible individuals.

The Health Care Exchange marketplace, including Public and Private Exchange options, is illustrated in Figure 1 below.

FIGURE 1: HEALTH CARE EXCHANGE COMPARISON



Private Medicare Exchanges – How They Work

Private Medicare Exchanges offer individual health care plans for Medicare-eligible individuals. Their main function is to provide decision support through call centers and web-based tools to help individuals evaluate and enroll in Medicare products such as Medicare supplement plans, Medicare Advantage plans and Medicare Prescription Drug Plans—all insurance products that are also available without a Private Medicare Exchange and the customer service it provides.

Plan sponsors that offer their Medicare-eligible retirees health care coverage under a Private Medicare Exchange transition these Medicare retirees from group medical plan coverage to coverage available in the individual Medicare market. Retirees must each purchase their own coverage, choosing from the options offered in their geographic location under the Private Medicare Exchange.

To help retirees purchase coverage under a plan offered through an Exchange, plan sponsors make an annual deposit to a Health Reimbursement Arrangement (HRA) in each retiree's name. Retirees can then be reimbursed from their HRA to help pay for the cost of coverage. The Exchange vendor is generally in charge of managing the balances and reimbursements for each retiree's HRA account.

Health Reimbursement Arrangements (HRAs) – How They Work

A Health Reimbursement Arrangement (HRA) is an IRS-approved, employer-funded, tax-advantaged employer health benefit plan. It allows employees or retirees to be reimbursed tax-

free for individual health insurance premiums and eligible out-of-pocket medical expenses (*e.g.*, deductibles, copays, coinsurance). Employers contribute to their retirees' HRAs each year. The employer, the State in this instance, decides whether any money remaining in retirees' HRAs at the end of each calendar year rolls over to the following calendar year or is forfeited. For retirees, this reimbursement arrangement can be advantageous because they can choose a low-cost or no-cost health care plan (assuming it meets their health care needs) and have money remaining in their HRA to pay out-of-pocket health care expenses when they need care.

Each HRA account, while maintained in the applicable retiree's name, is "notional." This means that the account is not actually funded until the retiree files a claim for reimbursement. Each HRA account is also owned and maintained by the State—a retiree does not have a claim to the value of his or her account. If a retiree or spouse dies or is terminated from coverage, the account balance reverts to the State.

In a Private Exchange scenario, the State would have a number of options to consider to structure HRA accounts. The two most significant issues for the State to consider in deciding on a structure are the following:

1. **HRA Account Usage:** The State must decide whether the account would be used by retirees to only pay for their premium cost share or to pay for their cost share and for out-of-pocket expenses (*e.g.*, deductibles, coinsurance, copayments). Allowing reimbursement of out-of-pocket costs would give retirees greater flexibility in the way they use the HRA account. For example, retirees could choose a less expensive plan and use any remaining HRA account money to pay out-of-pocket costs.

   All modeling in this draft report related to the use of HRA accounts assumes the State would allow retirees to use their HRA accounts for reimbursement of their premium cost share and out-of-pocket costs.

2. **HRA Account Roll Over:** The State must decide whether any existing balance remaining in the account at the end of each year would roll over to the next year, or if the retiree would lose his/her remaining account balance at the end of each year. Allowing funds to roll over gives retirees more flexibility in plan choice—they can choose a plan with a premium cost share that is less than their HRA account balance knowing that money would be available in their HRA account to pay out-of-pocket expenses in future years if/when care is needed.

   All modeling in this draft report related to the use of HRA accounts assumes the State would allow annual HRA account rollovers.

Option 1A – Private Medicare Exchange with a Defined Contribution to an HRA, Flat Dollar Amount

This option would introduce a Private Medicare Exchange and a State sponsored HRA. The State's contribution to this HRA would be the same flat dollar amount for all Medicare participants. It would not increase each year.

Impact on Retirees

For retirees currently covered under the State's Medicare Retiree Health Plan, moving to a Private Medicare Exchange would mean that retirees would need to choose from among a number of plans. The number of plan choices and the plan rates would vary, depending on where retirees live (in- or-out-of-state), their age and their gender.

As noted earlier, Private Medicare Exchanges support retirees with online decision-support tools and decision-making counseling by phone to lessen the burden of choosing a plan. The Exchange vendor would take the time necessary on the phone with a retiree (or someone acting on their behalf) to guide them through their health plan options, including asking a series of questions relating to their travel patterns, current use of medical and prescription drug services, and general demographic information. Once retirees choose a plan, the Exchange would offer advocacy services. These services include assistance with any medical or prescription drug claims issues with their insurance carrier or care access issues with medical providers.

Currently, Medicare retirees do not pay a monthly premium for State-sponsored medical and prescription drug coverage; they do pay prescription drug copays and a Medicare Part B deductible ($183 for calendar year 2017) when they receive services. Medicare retirees are also responsible for the Medicare Part B monthly premium. This premium generally ranges between $109 and $134 (most pay $109). Retirees would continue to be responsible for this premium under a Private Medicare Exchange.

Under the Private Medicare Exchange, if the State were to implement an HRA, retirees would need to pay their plan's monthly premium rate from their pocket. They would then be reimbursed through their HRA for all or a part of the premium rate (depending on the amount in their HRA and the premium rate of their selected plan). Some Private Medicare Exchange vendors have solutions to mitigate the impact retirees of paying the monthly premium up front (*e.g.*, auto-reimbursement). Generally, though, retirees would need to submit paperwork to have their out-of-pocket expenses reimbursed.

The actual cost of health care coverage—and the amount each Medicare retiree pays when they need care—depends on the plan each retiree chooses. With a wider array of potentially cost-effective health care plan options, and an HRA provided by the State, retirees who choose the most cost-effective plan that meets their health care needs may pay less out-of-pocket (for coverage and care/services) than they do now. With the HRA, retirees may elect to "buy-up." This means they would purchase coverage that has a higher premium for them. If they do, they would pay less out-of-pocket to receive care or services when needed. As an alternative, retirees can "buy-down." This means they would purchase coverage that has a lower premium for them. If they do, they would pay more out-of-pocket to receive care or services when needed. As a general rule, the higher the plan premium an individual pays, the lower the out-of-pocket costs (*i.e.*, copays, deductibles and coinsurance) the individual pays when he/she receives care.

Based on the illustrative HRA contribution modeled in this draft report (*i.e.*, $4,500 annual contribution based on the 2017 Medicare premium rate), the majority of Medicare retirees are projected to have the option to choose coverage under a Private Medicare Exchange with total out-of-pocket costs that are comparable to or less than their current out-of-pocket costs. It is also projected that some retirees would have a remaining HRA account balance that would roll over

to the following year. Details about the impact on Medicare retirees transitioning to a Private Medicare Exchange are shown in *Appendix B*.

While the majority of retirees are projected to have similar or lower total out-of-pocket costs in a Private Medicare Exchange compared with the coverage they have now, some individuals would pay more out-of-pocket. Generally, individuals with the largest projected increase in out-of-pocket costs would be those who are older, get sick more often and who have chronic health conditions—particularly those with the highest use of prescription drugs. For a small percentage of retirees with the highest prescription drug use, this potential out-of-pocket cost increase could be in the thousands of dollars.

Many Private Medicare Exchange vendors have optional catastrophic protection programs designed to protect retirees from substantial financial losses in the event of very large pharmacy expenses. Generally, these protection programs are offered as an additional HRA account. The account could be funded by the State at an additional cost. Alternatively, the State could allocate a small portion of its HRA defined contribution to the catastrophic protection program. Even with catastrophic protection, it is projected that some of the State's highest-utilizing Medicare retirees would pay more out-of-pocket under a Private Medicare Exchange than they do today (see *Appendix B* for impact on a 75 year-old in New Hampshire at various utilization levels), if the State were to fund retiree HRA accounts at the $4,500 annual contribution modeled in this report.

If the State provides the same HRA contribution to retirees every year (with no annual increases), the burden of health care cost inflation would be on retirees. The number of individuals expected to pay more out-of-pocket under a Private Medicare Exchange arrangement than they do today would rise over time. The next section discusses alternatives to this approach and how they would impact retirees.

Impact on the State

If the State were to adopt a Private Medicare Exchange, retirees would use State-provided HRA contributions to purchase coverage in the individual Medicare marketplace and potentially offset any out-of-pocket costs (*e.g.*, deductibles, copayments, coinsurance) in their selected plans with any dollars remaining in their HRA after they pay their premium cost share.

By discontinuing the current Medicare plan and offering a Private Medicare Exchange instead, the State would eliminate its cost for third-party plan administration related to the current plan. The transition would require a significant investment of the State's staff resources and time in the short term. A transition of this kind requires a procurement process to choose a Private Medicare Exchange vendor. This transition would also need to include adequate time to educate Medicare participants on the new plan structure. This process is expected to take at least 18 months.

Transitioning to a Private Medicare Exchange would also require a robust communications campaign to educate retirees about the transition, help them understand their new health plan options and ensure they understand the need to elect new health care coverage, including how and when to make a coverage election. This campaign would likely include print and online communications, video, and in-person and telephone town hall meetings to reach all retirees who would be impacted by the change.

Most Private Medicare Exchange vendors provide some level of communications support to aid in the transition. However, if that level of support is not up to the State's standards, the State may decide to purchase additional communications assistance from employee benefits communications experts to support its retirees at the level it believes is necessary. The cost of the additional communications depends on the communication support the State wishes to provide above the level provided by the Exchange vendor. Getting this added support may require an additional procurement process to select qualified employee benefits communications experts.

Even with an HRA contribution equal to the 2017 total premium (approximately $4,500 for the year) for the State's retiree health care plan, and the cost of developing a robust and effective communications campaign, the State could see a significant reduction in its long-term liability for the cost of retiree health care and improve its cash flow by moving to a Private Medicare Exchange. If the HRA contribution is set at the 2017 premium level for the State's Medicare retiree plan, it is projected that the majority of retirees would have the opportunity to pay less out-of-pocket than they pay today under the current plan. (See *Appendix B* for a review of the financial impact on retirees.)

Through the use of an HRA defined contribution arrangement, the State would have control over the increases it incurs for the cost of retiree health care coverage, regardless of actual health care cost increases. This control would come from the State setting a flat-dollar annual contribution amount to retirees' HRAs. Since the State's Medicare retiree population is expected to continue to grow, even with a flat dollar defined contribution approach, the State's retiree health budget would need to grow at the same rate as the population growth to maintain the flat dollar amount. If the State's retiree health budget does not increase with the population growth, the defined contribution to an HRA would need to be decreased per retiree to operate within the budget.

Due to the 18-month timeline associated with procurement and implementation of this type of program, and the plan design decisions that would need to be made by the State before implementation begins (*e.g.*, subsidy amount, rollover provision), it is unlikely that this type of approach could address any budget shortfall that may exist in the FY 2018/2019 budget.

As noted above, administration, advocacy support services, and limited communications assistance, is generally provided at relatively little or no cost to the plan sponsor—the Exchange is compensated by the commissions that exist in the premiums for the individual market plans. (Note that if current retirees are not moved to the Exchange, the State would likely be required to pay for some of the services provided by the Exchange. In addition, if a catastrophic protection benefit is provided, the State may be required to pay additional administrative fees). Moving to a Private Medicare Exchange would benefit the State's finances in the short-term.

However, the Medicare rules surrounding commissions and non-solicitation of Medicare participants can create certain contracting issues that make a transition from one Exchange vendor to another a challenge. These rules may make it difficult for a new Private Medicare Exchange vendor to provide advocacy services to Medicare retirees that have already enrolled in individual market plans through another Private Medicare Exchange. As a result, employers have tended to remain with the Exchange vendor initially selected. This places great importance on the Exchange vendor selection process, ongoing management of the contract, and addressing any State procurement rules that may hinder a long-term relationship with an Exchange vendor.

Alternative HRA Contribution Options Under a Private Medicare Exchange

While the State can provide an HRA contribution to retirees that does not increase each year, it may want to consider implementing tiered contributions (*e.g.*, based on years of service) and/or an annually-indexed increase for the HRA contribution.

Option 1B – Private Medicare Exchange with a Defined Contribution to an HRA, Tiered Contributions Based on Years of Service

Rather than provide the same HRA contribution to all retirees, the State could provide greater contributions to retirees who have more years of service. By implementing HRA contributions based on years of service, the State can create a program that rewards longer-service retirees and supports employee retention. This approach could also reduce the total HRA contributions the State makes because future retirees with fewer years of service at retirement could receive lower HRA contributions.

However, if HRA contributions are based on years of service, the State must accurately collect and maintain years-of-service data for the retiree health plan. It is anticipated that this effort would be considerable. The reason is that the State's past data collection practices did not include tracking years of creditable State service at retirement for all current retirees. Tracking this would require a manual audit of DAS and the New Hampshire Retirement System (NHRS) records pertaining to years of creditable State service.

In addition, the introduction of a tiered contribution would be a departure from current practice. Currently, all retirees (regardless of years of service) are treated equally in retirement. The tiered-contribution approach would reward retirees with more State service at the expense of retirees with less State service, even though retirees with less state service meet the Retiree Health Plan eligibility requirements.

Finally, this approach would require the administration of multiple HRA contribution amounts. While this is manageable, it would increase the State's administrative burden associated with the program and would need to be clearly and carefully explained in employee communications.

Option 1C – Private Medicare Exchange with a Defined Contribution to an HRA, Indexed Contributions

By indexing HRA contributions under a Private Medicare Exchange program (*i.e.*, an annual increase in the contribution amount tied to a selected measure of inflation), the State could provide a level of inflation protection to retirees. This could help ease some of the concerns that retirees may have about the transition to an Exchange and future out-of-pocket expenses.

Depending on the inflation measure used to index (that is, to increase or decrease) the State's HRA contribution, the State's OPEB liability reduction could be much smaller than the reduction that could be achieved using a flat HRA contribution amount for all retirees that does not change from year to year. The State would need to determine an indexing measure to use (*e.g.*, Consumer Price Index, Medicare trend), including any minimum or maximum contribution increase levels (*i.e.*, annual floors or ceilings). It would also need to explain to retirees that it retains the right to reduce or eliminate indexing if future budgetary needs require it to do so.

Impact on Projected Ten-Year Benefit Payments

In developing scenarios for the implementation of a defined contribution to an HRA in conjunction with a Private Medicare Exchange, the contribution amount was set at the current premium level for the Medicare Retiree Plan. This equates to an HRA contribution of roughly $4,500 per participant per year. This was the amount modeled in this option. This contribution was assumed to be provided to retirees, spouses, and surviving spouses.

In addition, modeling was conducted to assess the impact of tiering the HRA contribution based on years of service with the State, as a way to recognize the contribution of longer-service employees. In the tiering scenario, current retirees and future retirees with at least 30 years of service received the $4,500 HRA contribution. However, the contribution was reduced to $3,900 for those who retire with 20 – 29 years of service, and to $2,700 for those who retire with 10 – 19 years of service. The HRA contribution was modeled with and without 5% indexing, to account for future increases in premium costs.

Over a ten-year period, under the modeled defined contribution HRA approaches, the State may be able to save 25% – 30% on a cash basis (*i.e.,* the amount that the State would be projected to pay for retiree benefits over ten years). Introducing an indexing feature could lower the overall savings to 13% for this period. Savings in the first few years would be modest, as contributions are set equal to the State's current contribution amounts. Savings, or more precisely, cost avoidance, would continue to grow over time (under all approaches), as the State's contribution is projected to grow at a rate that is below health care cost trend.

COMPARISON OF 10-YEAR CASH FLOW SAVINGS
By Various Types of HRA Contributions

The chart below compares the cost savings over a 10-year period of implementing three different kinds of HRA contributions: Flat Defined, Tiered Defined based on years of service, and Tiered and Indexed Defined.

Further savings could be achieved by the State if the starting contribution and/or projected indexed amounts are reduced.

	Medicare Retiree and Spouse Counts	Non-Medicare Retiree Counts	Current Plan Baseline	Option 1A Flat Defined Contribution	Option 1B Tiered Defined Contribution Based on Years of Service	Option 1C Tiered and Indexed Defined Contribution
FY 2018	9,512	3,146	$63,000,000	$63,000,000	$63,000,000	$63,000,000
FY 2019	9,809	3,056	70,100,000	65,100,000	64,700,000	67,500,000
FY 2020	10,075	2,993	77,200,000	62,800,000	61,700,000	70,000,000
FY 2021	10,286	2,968	85,000,000	65,800,000	64,500,000	75,500,000
FY 2022	10,490	2,916	92,900,000	68,500,000	67,000,000	81,100,000
FY 2023	10,706	2,830	100,800,000	70,900,000	69,200,000	86,500,000
FY 2024	10,878	2,759	108,900,000	73,300,000	71,500,000	92,200,000
FY 2025	11,031	2,671	116,900,000	75,400,000	73,400,000	97,800,000
FY 2026	11,179	2,568	124,700,000	77,300,000	75,000,000	103,300,000
FY 2027	11,289	2,479	132,600,000	79,100,000	76,700,000	109,000,000
10-Year Total			**$972,100,000**	**$701,200,000**	**$686,700,000**	**$845,900,000**
$ Difference			**N/A**	**-$270,900,000**	**-$285,400,000**	**-$126,200,000**
% Difference			**N/A**	**-27.9%**	**-29.4%**	**-13.0%**

Key:

- **Current Plan Baseline:** Projected benefit payments (based on the December 31, 2014 OPEB valuation) assuming no changes are made to the existing retiree health care program.
- **Option 1A – Flat Defined Contribution:** Flat Defined Contribution to HRAs is $4,500 per year for all Medicare retirees, without indexed increases to offset health care trend
- **Option 1B – Tiered Defined Contribution Based on Years of Service:** Tiered Defined Contributions to HRAs of $4,500 for all current Medicare retirees and actives with 30 or more years of service at retirement, $3,900 for actives with 20 to 29 years of service at retirement, and $2,700 for actives with 10 to 19 years of service at retirement. Indexed increases are not applied to the defined contribution amounts.
- **Option 1C – Tiered and Indexed Defined Contribution:** Tiered Defined Contribution structure detailed in the option above, with a 5% annual index to the contribution amount.

IMPORTANT NOTE: The estimated cash flows (*i.e.*, expected State costs associated with benefits provided to retirees) and savings included in this draft report are intended to illustrate the orders of magnitude of the projected savings associated with implementing the changes to the retiree health plan. As these estimates are based on the State's December 31, 2014 OPEB valuation which is more long-term focused, the estimated cash flow and savings should not be used as a basis for setting State budget levels in the short term (*e.g.*, FY 2018/2019).

Please refer to the section titled "Important Information About Actuarial Valuations" in *Appendix C: Assumptions and Caveats*, for a discussion about financial assumptions in this draft report.

Impact on OPEB Liability

The introduction of a defined contribution to an HRA can have a significant impact on the State's financial liability for its Retiree Health Benefits program. The lower overall cost of a Flat Defined Contribution is largely due to the elimination of inflation (*i.e.*, health care cost trend) in the valuation; the contribution has been set in line with current costs. This is so that the risk and expense of all future cost increases are assumed by current and future Medicare retirees.

While the introduction of a Tiered Defined Contribution based on service may be attractive for a variety of reasons, it does not drive a large reduction in overall liability compared with the Flat Defined Contribution. The reason for this is that the majority of retirees are assumed to receive the highest contribution due to years of service or being current retirees. The Tiered and Indexed Defined Contribution introduces a health care cost trend component (*i.e.*, inflation factor) to the defined contribution amounts. This reduces the financial liability savings opportunity by over 30%. However, since the indexed 5% increase is set at a level below the composite health care cost trend currently assumed in the valuation (or the current plan baseline, where the State is assumed to take no action), the State would still realize financial liability savings under this approach.

COMPARISON OF JANUARY 1, 2017 OPEB LIABILITY By Member Group

The chart below compares the liability reduction, by member group, of implementing three different kinds of HRA contributions as of January 1, 2017: Flat Defined, Tiered Defined based on years of service, and Tiered and Indexed Defined.

	Member Counts	Current Plan Baseline	Option 1A Flat Defined Contribution	Option 1B Tiered Defined Contribution Based on Years of Service	Option 1C Tiered and Indexed Defined Contribution
Medicare Retirees and Spouses	8,570	$555,300,000	$265,500,000	$265,500,000	$440,500,000
Non-Medicare Retirees and Spouses	3,038	425,500,000	210,400,000	210,400,000	363,700,000
Actives Eligible for OPEB Now	1,559	324,400,000	151,800,000	139,400,000	247,300,000
Actives Eligible for OPEB Within 5 Years	1,111	251,400,000	117,100,000	108,700,000	193,000,000
Actives Eligible for OPEB Within 6 to 10 Years	1,281	255,300,000	119,400,000	114,400,000	204,600,000
All Other Actives	6,584	413,100,000	175,500,000	170,900,000	338,300,000
Vested Deferred Retirees	494	49,600,000	19,800,000	16,700,000	34,000,000
Total	**22,637**	**$2,274,600,000**	**$1,059,500,000**	**$1,026,000,000**	**$1,821,400,000**
$ Difference from Current Plan Baseline		**N/A**	**-$1,215,100,000**	**-$1,248,600,000**	**-$453,200,000**
% Difference from Current Plan Baseline		**N/A**	**-53.4%**	**-54.9%**	**-19.9%**

Key:

- **Current Plan Baseline**: Projected liability as of January 1, 2017 assuming no changes are made to the existing retiree health care program.

Option 1 – Private Medicare Exchange with a Defined Contribution to an HRA

- **Option 1A – Flat Defined Contribution:** Flat Defined Contribution to HRAs of $4,500 per year for all Medicare retirees and spouses, without indexed increases to offset health care cost trend
- **Option 1B – Tiered Defined Contribution Based on Years of Service:** Tiered Defined Contributions to HRAs of $4,500 for all current Medicare retirees and actives with 30 or more years of service at retirement, $3,900 for actives with 20 to 29 years of service at retirement, and $2,700 for actives with 10 to 19 years of service at retirement. Indexed increases are not applied to the defined contribution amounts.
- **Option 1C – Tiered and Indexed Defined Contribution:** Tiered Defined Contribution structure detailed in the option above, with a 5% annual index to the contribution amount.

Option 2 – Medicare Retiree Premium Cost Share

State Medicare retirees do not currently pay a monthly premium cost share to participate in the Medicare Retiree Plan. This places a significant financial burden on the State to pay the great majority of the costs associated with the Plan. As the cost of medical care and prescription drugs continues to rise at rates greater than inflation, many plan sponsors (including public employers) have implemented a monthly retiree premium cost share for all retirees, regardless of Medicare eligibility. Doing so in New Hampshire would require a change in State law. If New Hampshire law changed to require a Medicare premium costs chase, DAS would then collect the premium cost share from Medicare retiree's pension checks or invoice Medicare retirees. DAS estimates the need for a part-time accountant position in order to carry out the billing responsibilities associated with the collection of a premium cost share from retirees.

Option 2A – Medicare Retiree Premium Cost Share, Flat Dollar

Impact on Retirees

Unlike the Private Medicare Exchange approach where some Medicare retirees would pay less than others depending on the medical plan they choose and their use of medical services and prescription drugs, requiring all Medicare retirees to pay a monthly premium cost share would spread premium cost sharing equally across all Medicare retirees. Sharing the cost equally would avoid having the sickest Medicare retirees paying the most for the cost of having coverage.

This option could be employed while keeping the current plan design rather than discontinuing the current plan and moving to a Private Medicare Exchange. Keeping the current plan design would avoid potentially disrupting retiree's health care provider relationships and requiring retirees to understand, choose and use new health care coverage. Nevertheless, depending on future cost increases and State funding levels, it may still be necessary to change plan design or increase the amount retirees pay—whether as a flat rate or a percentage of premium.

As previously noted, Medicare retirees currently pay the Medicare Part B premium (most retirees pay $109 per month). The premium cost share would be in addition to the Part B premium.

Impact on the State

Since introducing a monthly Medicare retiree premium cost share may not require changes to the current medical and/or prescription drug plan designs or require the procurement of a new vendor, it can be implemented relatively quickly. This assumes that legislation authorizing the premium cost share is passed. As a result, introducing a monthly Medicare retiree premium cost share could be used to address short-term budgetary shortfalls and the State's long-term OPEB liability.

However, if the premium cost share is set as a flat dollar amount rather than as a percentage of monthly premium, the State would bear the full health care cost trend risk. For the State to avoid bearing all of the health care cost trend risk, legislators would need to intervene annually to increase the premium cost share since, over time, the flat dollar amount would represent a decreasingly smaller percentage of the full premium.

Although simple in concept, this approach has its risks and administrative burdens. First, the State would need to allocate resources and set up administrative procedures to invoice and

collect funds from retirees. This may be challenging for the State, particularly in situations where retirees do not receive a large enough monthly pension benefit to pay the premium cost share (not enough money could be withheld directly from pension checks). In addition, the State would be required to terminate from the Plan any non-paying retirees.

Additional Medicare Retiree Premium Cost Share Options

Rather than implementing a flat dollar retiree premium cost share for all State Medicare retirees, the State could exempt (*i.e.*, "grandfather") a group of current retirees from paying for coverage and/or create a percentage premium cost share for retirees that increases with health care cost trend.

Option 2B – Medicare Retiree Premium Cost Share, Flat Dollar with Grandfathering

Impact on Retirees

By grandfathering a certain group of current retirees from paying for Medicare Retiree Plan coverage, the State could protect a portion of its current retiree population from paying a retiree premium cost share. However, non-grandfathered participants could pay substantially more for health care coverage than they would if there was no grandfathering—premium cost share amounts for the non-grandfathered group would need to be proportionately higher to make up for grandfathered retirees not paying a premium cost share.

Impact on the State

Grandfathering a certain group of current retirees from paying for Medicare Retiree Plan coverage would have a limited impact on the State's long-term health care costs. This could effectively be seen as an alternative to "means testing" (*i.e.*, charging different amounts to different retirees, based on income levels) since older retirees tend to have the lowest pensions.

In reviewing the demographics of the State's retiree population, it appears that the majority of retirees with the smallest pensions are those over age 75 (representing approximately 5,500 retirees). As a result, age 75 has been used as the cutoff to illustrate the impact of this grandfathering provision, as shown in the modeling for this option.

Although this provision would have a limited impact on the State's long-term budget, short-term savings would be reduced. An alternative to reducing short-term savings would be for non-grandfathered retirees to make up the amount not paid by grandfathered retirees. In addition, the State must determine the appropriate age at which to grandfather retirees. As with any grandfathering provision, determining the age at which retirees would be required to pay a premium cost share can be challenging. The lower the age selected for the grandfathering cut-off, the greater the financial burden on the non-grandfathered (who would be required to contribute toward the cost of coverage.

Requiring Medicare retiree contributions may be challenging for the State. This is especially true in situations where retirees don't receive a large enough monthly pension benefit to pay their premium cost share (not enough money could be withheld directly from pension checks). In addition, the State would be required to terminate from the Plan any non-paying retirees.

Option 2C – Medicare Retiree Premium Cost Share, Percentage of Cost

Implementing a premium cost share for the Medicare Retiree Plan based on a percentage of the premium cost means that premium cost share increases would be based on a set percentage of the total cost that retirees pay for coverage.

Impact on Retirees

Implementing a premium cost share for Medicare retirees based on a percentage of the premium cost would place additional financial burden on retirees who, generally, have limited incomes. This could result in some retirees losing coverage under the Plan over time because they cannot afford the increasing premium cost share. In comparison to a flat retiree premium cost share, the burden on Medicare retirees of a premium cost share based on a percentage of the premium cost would be greater. The reason is that premium cost share amounts would adjust automatically as the cost of medical care and prescription drugs changes. Over the long term, this cost is projected to increase.

Impact on the State

Implementing a premium cost share for Medicare retirees based on a percentage of the premium cost would provide some inflation protection for the State—retirees and the State would share a portion of the overall increase in premium rather than the full increase being borne by the State. In addition, this approach may not require annual maintenance and review of the premium cost share amount by the Fiscal Committee, given that the premium cost share amount would be tied to a percentage of the premium (similar to the way in which the non-Medicare plan works today). The exception to this would be if the State needs to increase the premium costs share percentage or change plan design to operate the plan within the funds appropriated by the legislature.

Today, approximately 350 Medicare retirees do not receive a pension or do not receive a large enough pension to cover their full premium cost share. Therefore, DAS would require additional staff resources or funding to secure billing and collection services for these individuals. Additionally, because DAS must terminate benefits for retirees who do not pay their premium cost share, these terminations would require additional customer service support.

Impact on Projected Ten-Year Benefit Payments

In reviewing the introduction of a retiree premium cost share, costs were modeled with and without annual indexing. For retiree premium cost share scenarios where the amounts are not indexed, short-term savings are generally larger than long-term savings, as the contribution amount loses value in relation to the premium over time. When an indexing approach is introduced, savings are more consistent year over year, as the retiree premium cost share remains intact. Grandfathering scenarios reduce shorter-term savings but do not result in a significant reduction in long-term savings.

COMPARISON OF 10-YEAR CASH FLOW SAVINGS, By Flat Dollar vs. Percentage Medicare Retiree Premium Cost Share

The chart below compares the cost savings over a 10-year period of implementing five different Medicare Retiree Premium Cost Share Options: Flat Dollar, Flat Dollar excluding retirees currently age 75 or older, Percentage premium cost share, Percentage premium cost share excluding retirees currently age 75 or older, and Tiered based on years of service.

	Medicare Retiree and Spouse Counts	Non-Medicare Retiree Counts	Current Plan Baseline	Option 2A Flat Dollar Medicare Retiree Premium Cost Share	Option 2B Flat Dollar Medicare Retiree Premium Cost Share, Grandfathering Retirees Age 75+	Option 2C Percentage Medicare Retiree Premium Cost Share	Option 2D Percentage Medicare Retiree Premium Cost Share, Grandfathering Retirees Age 75+	Option 2E Tiered Percentage Medicare Retiree Premium Cost Share
FY 2018	9,512	3,146	$63,000,000	$57,300,000	$59,200,000	$56,400,000	$58,350,000	$59,400,000
FY 2019	9,809	3,056	70,100,000	58,300,000	61,600,000	55,600,000	59,300,000	66,000,000
FY 2020	10,075	2,993	77,200,000	65,100,000	68,000,000	61,500,000	64,900,000	72,700,000
FY 2021	10,286	2,968	85,000,000	72,700,000	75,100,000	68,000,000	71,200,000	80,000,000
FY 2022	10,490	2,916	92,900,000	80,300,000	82,400,000	74,600,000	77,500,000	87,300,000
FY 2023	10,706	2,830	100,800,000	87,900,000	89,700,000	81,100,000	83,700,000	94,600,000
FY 2024	10,878	2,759	108,900,000	95,800,000	97,300,000	87,700,000	90,100,000	102,100,000
FY 2025	11,031	2,671	116,900,000	103,600,000	104,900,000	94,300,000	96,400,000	109,500,000
FY 2026	11,179	2,568	124,700,000	111,300,000	112,300,000	100,600,000	102,500,000	116,700,000
FY 2027	11,289	2,479	132,600,000	119,100,000	119,900,000	107,000,000	108,600,000	124,000,000
10-Year Total			**$972,100,000**	**$851,400,000**	**$870,400,000**	**$786,800,000**	**$812,550,000**	**$912,300,000**
$ Difference			**N/A**	**-$120,700,000**	**-$101,700,000**	**-$185,300,000**	**-$159,550,000**	**-$59,800,000**
% Difference			**N/A**	**-12.4%**	**-10.5%**	**-19.1%**	**-16.4%**	**-6.2%**

Key:

- **Current Plan Baseline:** Projected benefit payments (based on the December 31, 2014 OPEB valuation) assuming no changes are made to the existing retiree health care program.
- **Option 2A – Flat Dollar Medicare Retiree Premium Cost Share:** Retiree premium cost share of $100 per month for all Medicare retirees/spouses. This amount does not increase with health care cost trend.
- **Option 2B – Flat Dollar Medicare Retiree Premium Cost Share, Grandfathering Retirees Age 75+:** Same $100 premium cost share as above, but retirees currently age 75 or older do not pay a premium cost share. Retirees currently under age 75, retirees turning 75 in the future, and future retirees (*i.e.*, current active employees), would be required to pay a contribution at all ages.
- **Option 2C – Percentage Medicare Retiree Premium Cost Share:** Retiree premium cost share of $100 per month indexed annually at levels equal to the annual health care cost trend assumed in the December 31, 2014 valuation.

- **Option 2D – Percentage Medicare Retiree Premium Cost Share, Grandfathering Retirees Age 75+:** Percentage Retiree Premium cost share, but retirees currently age 75 or older do not pay a premium cost share. Retirees currently under age 75, retirees turning 75 in the future, and future retirees (*i.e.*, current active employees) would be required to pay a contribution at all ages.
- **Option 2E – Tiered Percentage Medicare Retiree Premium Cost Share:** Retiree premium cost share tiered based on years of service at retirement. Current Medicare retirees and actives with 30 or more years of service at retirement pay $25 per month, actives with 20 to 29 years of service at retirement pay $50 per month, and actives with 10 to 19 years of service at retirement pay $75 per month. These amounts are assumed to increase annually with health care cost trend assumed in the December 31, 2014 valuation.

IMPORTANT NOTE: The estimated cash flows (*i.e.*, expected State costs associated with benefits provided to retirees) and savings included in this draft report are intended to illustrate the orders of magnitude of the projected savings associated with implementing the changes to the retiree health plan. As these estimates are based on the State's December 31, 2014 OPEB valuation which is more long-term focused, the estimated cash flow and savings should not be used as a basis for setting State budget levels in the short term (*e.g.*, FY2018-2019 budget).

Please refer to the section titled "Important Information About Actuarial Valuations" in *Appendix C: Assumptions and Caveats*, for a discussion about financial assumptions in this draft report.

Impact on OPEB Liability

Simply introducing a flat dollar amount retiree premium cost share for Medicare retirees would only modestly reduce the State's OPEB liability (7% – 9% reduction, depending on grandfathering provision); the premium cost share amount would lose value over time if it is set at a flat dollar amount.

Introducing indexing for this retiree premium cost share (*i.e.*, setting the retiree premium cost share as a percentage of the premium) would increase the State's savings opportunity (18% - 22% savings, depending on grandfathering provision). A premium cost share of $100 is modeled in the Flat Dollar Retiree Premium cost share. This represents a Medicare retiree premium cost share equal to about 28% of the calendar year 2017 Medicare Retiree Plan premium.

A tiered contribution approach set at a percentage of premium can achieve OPEB liability savings comparable to a larger flat retiree premium cost share amount. The reason is that the increasing value of the contribution would achieve additional savings over time.

COMPARISON OF JANUARY 1, 2017 OPEB LIABILITY
By Member Group

The chart below compares the liability reduction, by member group, of implementing five different kinds Medicare Retiree Premium Cost Share Options as of January 1, 2017: Flat Dollar, Flat Dollar excluding retirees currently age 75 or older, Percentage premium cost share, Percentage premium cost share excluding retirees currently age 75 or older, and Tiered based on years of service.

	Member Counts	Current Plan Baseline	Option 2A Flat Dollar Medicare Retiree Premium Cost Share	Option 2B Flat Dollar Medicare Retiree Premium Cost Share, Excluding Retirees Age 75+	Option 2C Percentage Medicare Retiree Premium Cost Share	Option 2D Percentage Medicare Retiree Premium Cost Share, Excluding Retirees Age 75+	Option 2E Tiered Percentage Medicare Retiree Premium Cost Share
Medicare Retirees and Spouses	8,570	$555,300,000	$469,100,000	$505,300,000	$407,000,000	$469,300,000	$518,300,000
Non-Medicare Retirees and Spouses	3,038	425,500,000	386,500,000	386,500,000	335,400,000	335,400,000	403,000,000
Actives Eligible for OPEB Now	1,559	324,400,000	294,700,000	294,700,000	255,100,000	255,100,000	294,500,000
Actives Eligible for OPEB Within 5 Years	1,111	251,400,000	234,000,000	234,000,000	202,600,000	202,600,000	227,300,000
Actives Eligible for OPEB 5 to 10 Years	1,281	255,300,000	242,600,000	242,600,000	210,300,000	210,300,000	234,600,000
All Other Actives	6,584	413,100,000	398,800,000	398,800,000	341,600,000	341,600,000	383,300,000
Vested Deferred Retirees	494	49,600,000	46,100,000	46,100,000	39,100,000	39,100,000	43,100,000
Total	**22,637**	**$2,274,600,000**	**$2,071,800,000**	**$2,108,000,000**	**$1,791,100,000**	**$1,853,400,000**	**$2,104,100,000**
$ Difference from Current Plan Baseline		**N/A**	**-$202,800,000**	**-$166,600,000**	**-$483,500,000**	**-$421,200,000**	**-$170,500,000**
% Difference from Current Plan Baseline		**N/A**	**-8.9%**	**-7.3%**	**-21.3%**	**-18.5%**	**-7.5%**

Key:

- **Current Plan Baseline:** Projected liability as of January 1, 2017 assuming no changes are made to the existing retiree health care program.
- **Option 2A – Flat Dollar Medicare Retiree Premium Cost Share:** Retiree premium cost share of $100 per month for all Medicare retirees/spouses. This amount does not increase with health care cost trend.
- **Option 2B – Flat Dollar Medicare Retiree Premium Cost Share, Grandfathering Retirees Age 75+:** Same $100 premium cost share as above, but retirees currently age 75 or older do not pay a premium cost share. Retirees currently under age 75, retirees turning 75 in the future, and future retirees (*i.e.*, current active employees) would be required to pay a contribution at all ages.
- **Option 2C – Percentage Medicare Retiree Premium Cost Share:** Retiree premium cost share of $100 per month indexed annually at levels equal to the annual health care cost trend assumed in the December 31, 2014 valuation.
- **Option 2D – Percentage Medicare Retiree Premium Cost Share, Grandfathering Retirees Age 75+:** Percentage Retiree Premium cost share, but retirees currently age 75 or older do not pay a premium cost share. Retirees currently under age 75, retirees turning 75 in the future, and future retirees (*i.e.*, current active employees) would be required to pay a contribution at all ages.

- **Option 2E – Tiered Percentage Medicare Retiree Premium Cost Share:** Retiree premium cost share tiered based on years of service at retirement. Current Medicare retirees and future Medicare retirees with 30 or more years of service at retirement pay $25 per month, future Medicare retirees with 20 to 29 years of service at retirement pay $50 per month, and future Medicare retirees with 10 to 19 years of service at retirement pay $75 per month. These amounts are assumed to increase annually with health care cost trend assumed in the December 31, 2014 valuation.

Option 3 – Eliminate Medicare Retiree Prescription Drug Program in 2020

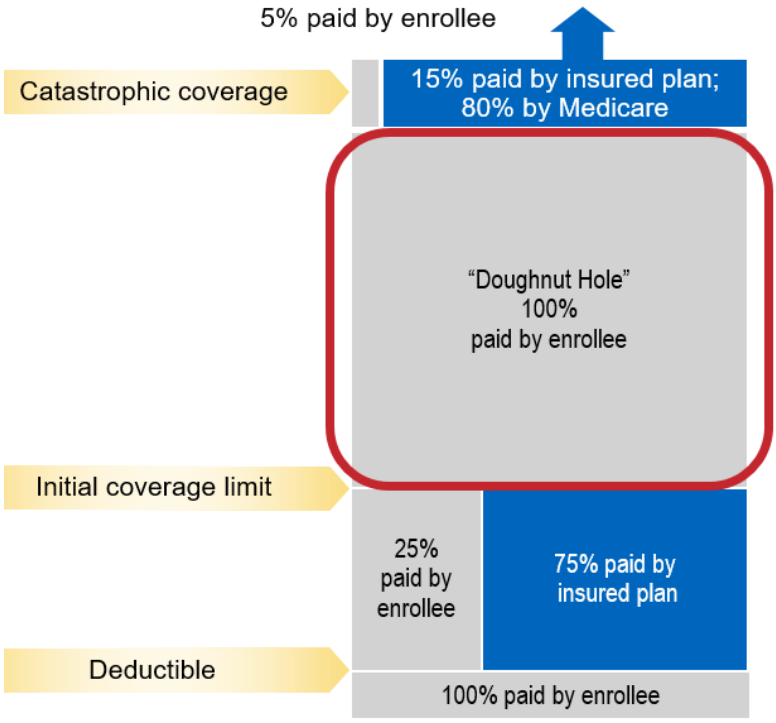
Why Should This Be Considered?

The State may want to consider an option to discontinue prescription drug coverage for Medicare eligible retirees. If the State were to discontinue this coverage, Medicare retirees could shop in the individual market that now offers an array of Medicare Part D prescription drug plans. Assuming that the ACA or its successor law maintains key provisions that by 2020 limit Medicare retirees' out-of-pocket costs for prescriptions, the elimination of prescription drug coverage in the State's Retiree Health Benefit Plan is a potentially attractive option to control State expenditures. If the State eliminates prescription drug coverage, then State retirees purchasing coverage in the individual market would experience the same out-of-pocket expenses as other Medicare eligible individuals who do not have group Retiree Health Benefits coverage.

A Brief History of Medicare Prescription Drug Coverage

Medicare did not always offer prescription drug coverage. As part of the Medicare Modernization Act enacted in 2003, Medicare was expanded to include prescription drug coverage, through the creation of Medicare Part D. Medicare Part D plans are offered by private insurance companies that are reimbursed by the federal government. The creation of this program introduced a standard prescription drug plan that included what is known as the "Doughnut Hole." Participants in the initial roll-out of Medicare Part D were subject to this Doughnut Hole after reaching a certain cost threshold. While in the "Doughnut Hole," they paid 100% of the cost of their prescription drugs. Figure 2 below represents the initial Standard Medicare Part D plan.

FIGURE 2: INITIAL STANDARD MEDICARE PRESCRIPTION DRUG BENEFIT



With the introduction of the Affordable Care Act (ACA) in 2010, Medicare Part D was updated and additional benefits were provided. One additional benefit was the gradual closing of the Doughnut Hole. The first portion of the Doughnut Hole closure came through funding from pharmaceutical manufacturers. As part of the ACA, pharmaceutical manufacturers were required to provide a 50% discount on the cost of brand-name drugs purchased within the Doughnut Hole.

Unless changes to the ACA occur, the remainder of the Doughnut Hole will gradually close until it reaches a 25% member-cost-share in 2020. Figures 3, 4 and 5 below represent:

1. The 2020 standard Medicare Part D plan (Figure 3), and
2. The generic (Figure 4) and brand-name (Figure 5) drug cost sharing schedules that illustrate the Doughnut Hole closing between 2010 and 2020.

FIGURE 3: STANDARD MEDICARE PRESCRIPTION DRUG BENEFIT, 2020

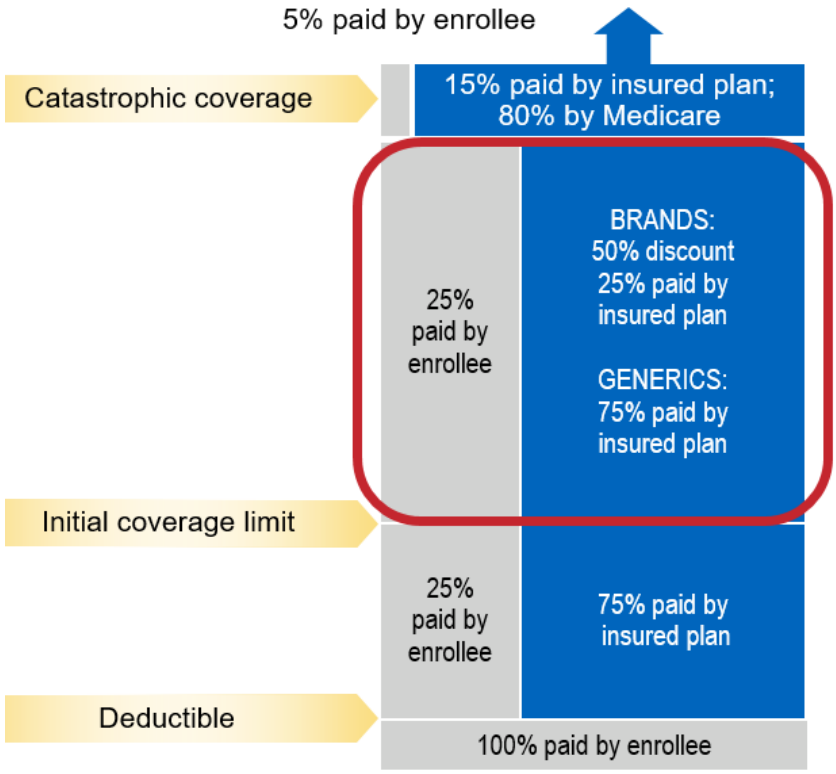


FIGURE 4: COST SHARING FOR GENERIC DRUGS IN THE MEDICARE PART D COVERAGE GAP, 2010 – 2020

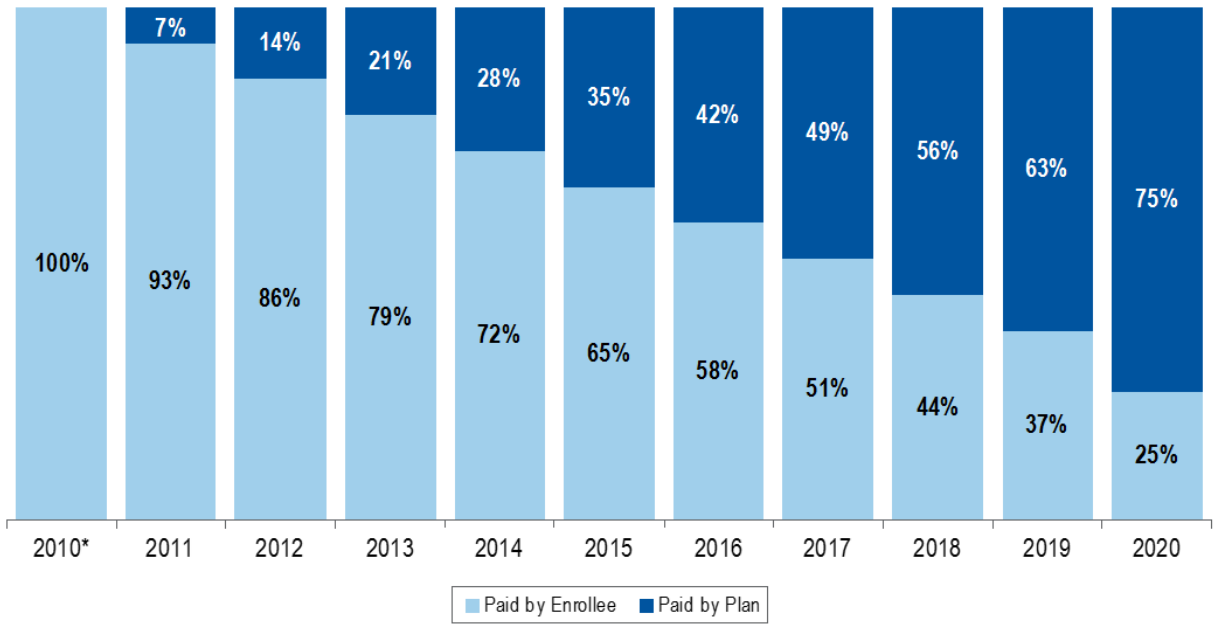
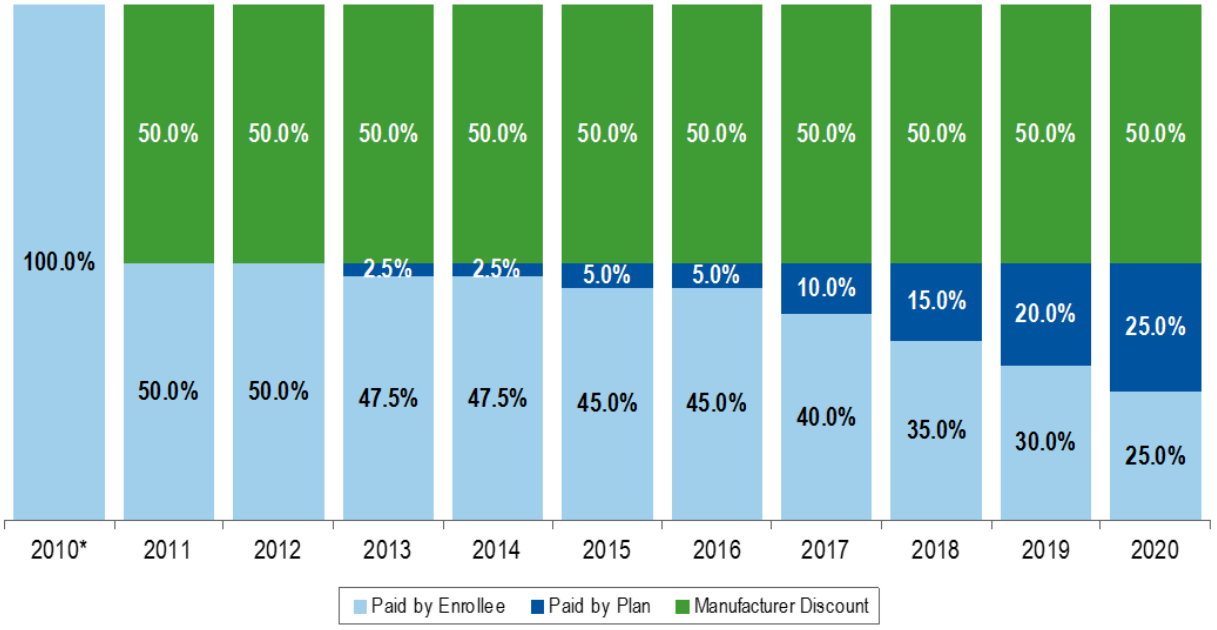


FIGURE 5: COST SHARING FOR BRAND NAME DRUGS IN THE MEDICARE PART D COVERAGE GAP, 2010 – 2020



There is now a set of prescription drug plans available in the individual prescription drug insurance market that provide comprehensive prescription drug coverage. These plans currently (2017) range in price for Medicare-eligible individuals in New Hampshire from approximately $15 to $145 per month, with an average premium of approximately $50. With the Doughnut Hole closure level to be reached in 2020, some plan sponsors are considering eliminating prescription drug coverage for retirees in 2020.

Option 3A – Eliminate Medicare Retiree Prescription Drug Program in 2020 (no Defined Contribution to HRA)

Impact on Retirees

Eliminating Medicare retiree prescription drug coverage would represent a significant change in the way Medicare retirees would receive prescription drug benefits. Today, State Medicare-eligible retirees do not pay a premium for prescription drug coverage, although they do pay prescription drug copayments up to an out-of-pocket maximum. Eliminating the prescription drug plan would require retirees to purchase prescription drug coverage independently in the individual market. They would need to pay 100% of the premium and out-of-pocket drug costs according to the prescription drug plan they choose.

Although individual marketplace Medicare Part D plans are relatively comprehensive, they are generally not as rich as the prescription drug benefit offered currently by the State. In addition, there are certain drugs covered by the State (*e.g.*, lifestyle drugs) that would not be covered by individual market plans. As a result, eliminating State-provided prescription drug coverage would result in an increase in out-of-pocket costs for all Medicare retirees. Retirees with high prescription drug use would see the greatest out-of-pocket cost increases.

Retirees would have to navigate the individual marketplace on their own through any number of access points, including brokers, the Medicare.gov website, or individual carrier websites. As consumers in the individual market, retirees may find the number of options confusing and may feel burdened by the additional responsibility to choose the plan that best meets their needs. Many plans have more restrictive formularies than the State's current prescription drug coverage. This means that some retirees may need to work with their doctors to change their current medications if those current medications are not on their new prescription drug plan's formulary. (A formulary is a list of drugs covered by a prescription drug plan.). This makes each retiree's decision to choose the right plan complicated.

Today, retirees receive a considerable level of customer support from the State of New Hampshire as they navigate their benefits with Express Scripts, the State's Pharmacy Benefit Manager. Because the State would not have a contract with the retirees' insurance carrier for prescription drugs, the State cannot provide this assistance to retirees. This would be a big change for retirees.

Although there are resources available to assist retirees in making a prescription drug plan choice, it is unlikely that the State would be able to implement the level of support offered through a Private Medicare Exchange if only the prescription drug program is eliminated and retirees must purchase coverage in the individual insurance marketplace.

Impact on the State

By eliminating the Medicare retiree prescription drug benefit, the State would realize significant savings by reducing its OPEB liability and increasing its cash flow. Roughly half of its OPEB liability would be eliminated. Starting in 2020, eliminating the Medicare retiree prescription drug benefit would reduce by roughly 60% year-to-year cash payments associated with paying benefits for Medicare eligible participants. However, since the change would not take effect until 2020, it would not help close any State budget shortfalls for the next two fiscal years.

In deciding whether to eliminate the Medicare retiree prescription drug program, the State should consider the potential impact on its medical claims budget. If the prescription drug plan is eliminated, it could result in a reduction in the rate at which retirees fill and take their prescriptions (typically referred to as "prescription drug compliance"). Since reduced prescription drug compliance can lead to the need for additional medical care (*e.g.*, hospital stays, doctor visits), the State could see higher medical costs relative to market trend.

In addition, it is very possible that the State's retiree customer service staff would receive an increased number of calls and walk-in visits from retirees struggling to manage their prescription drug benefits. Unfortunately, State staff would have to refer these retirees to the customer service department of their prescription drug plan's insurance carrier or the HRA administrator, if an HRA is provided.

Option 3B: Eliminate Medicare Retiree Prescription Drug Program in 2020 and Provide Defined Contribution to HRA (to purchase individual prescription drug coverage)

If the State were to eliminate Medicare Retiree prescription drug coverage, it could contribute money to an HRA for each Medicare retiree as a way to help retirees pay for the cost of purchasing individual Medicare Part D coverage and/or associated out-of-pocket prescription drug costs. The HRA would work as described above in Option 1. Although providing defined contributions to an HRA for Medicare retirees to purchase prescription drug coverage would limit some of the State savings associated with eliminating prescription drug coverage for Medicare retirees, it would likely reduce some of the negative reactions retirees could have if prescription drug coverage is eliminated.

The State could structure the HRA contribution as a flat dollar amount, use a tiered approach based on age or years of service, or index the HRA contribution annually. The associated considerations and impact on the State and retirees relating to the different HRA options are discussed in the "Option 1 – Private Medicare Exchange with Defined Contribution to an HRA" section of this draft report. The HRA contribution ultimately provided would depend on the State's savings goals versus the overall impact on Medicare retirees. Details about the retiree impact are in *Appendix B*.

Impact on Retirees

The principle benefit of an HRA for retirees is to reduce their out-of-pocket prescription drug costs. Retirees would pay their monthly benefit premium and other related costs for prescription drug from their own pockets. They would then submit their out-of-pocket costs to the HRA vendor for reimbursement. Although the State would provide the necessary education to navigate this benefit, some retirees would find this complicated.

Today, retirees receive a considerable level of customer support from the State of New Hampshire as they navigate their benefits with Express Scripts, the State's Pharmacy Benefit Manager. Because the State would not have a contract with the retirees' insurance carrier for prescription drugs, the State would not be able to provide assistance to retirees. This would be a big change for retirees.

This portion of the program could potentially be administered by a Private Medicare Exchange, which would provide administrative and advocacy support as described under Option 1. However, some vendors may not be willing to provide the services and others may charge significant fees relating to implementation costs, HRA administration and/or communications. This is due to the compensation structure of a Private Medicare Exchange. A Private Medicare Exchange is funded mainly through commissions in individual market plans from medical premiums (commissions from prescription drug premiums represent a very small portion of the overall revenue generated by a Private Medicare Exchange). If a Private Medicare Exchange is not used, retirees would have limited support as they shop for a prescription drug plan in the individual market.

Impact on the State

For the State to provide Retirees with an HRA for prescription drug coverage, it would be necessary to procure for an HRA vendor. This would result in third-party administrative costs. If administrative services related to HRA contributions are not paired with a Private Medicare Exchange, prescription drug coverage may be more complicated to administer, since neither the State nor the HRA administrator would be involved in retirees' benefit elections. Also, as noted above, the defined contributions to an HRA would reduce the savings associated with eliminating prescription drug coverage for Medicare retirees.

Impact on Projected Ten-Year Benefit Payments

Elimination of Medicare retiree prescription drug coverage would reduce projected ten-year cash flow by approximately 38%. This savings opportunity would be reduced if the State were to introduce defined contributions to an HRA. However, since this change would not be implemented until 2020 at the earliest, there would be no impact on projected short-term cash flow for the State.

COMPARISON OF 10-YEAR CASH FLOW SAVINGS By Medicare Prescription Drug Plan Elimination Without and With an HRA Contribution

The chart below compares the cost savings over a 10-year period of eliminating the Medicare Prescription Drug Plan versus eliminating the Plan and providing retirees with a defined contribution to an HRA.

	Medicare Retiree and Spouse Counts	Non-Medicare Retiree Counts	Current Plan Baseline	Option 3A Eliminate Medicare Rx Plan in 2020	Option 3B Eliminate Medicare Rx Plan in 2020 with Defined Contribution to HRA
FY 2018	9,512	3,146	$63,000,000	$63,000,000	$63,000,000
FY 2019	9,809	3,056	70,100,000	70,100,000	70,100,000
FY 2020	10,075	2,993	77,200,000	59,200,000	64,100,000
FY 2021	10,286	2,968	85,000,000	47,000,000	52,100,000
FY 2022	10,490	2,916	92,900,000	50,800,000	56,000,000
FY 2023	10,706	2,830	100,800,000	54,400,000	59,800,000
FY 2024	10,878	2,759	108,900,000	58,200,000	63,700,000
FY 2025	11,031	2,671	116,900,000	61,900,000	67,500,000
FY 2026	11,179	2,568	124,700,000	65,400,000	71,100,000
FY 2027	11,289	2,479	132,600,000	69,100,000	74,900,000
10-Year Total			**$972,100,000**	**$599,100,000**	**$642,300,000**
$ Difference			**N/A**	**-$373,000,000**	**-$329,800,000**
% Difference			**N/A**	**-38.4%**	**-33.9%**

Key:

- **Current Plan Baseline:** Projected benefit payments (based on the December 31, 2014 OPEB valuation) assuming no changes are made to the existing retiree health care program.
- **Option 3A – Eliminate Medicare Retiree Rx Plan in 2020:** Eliminate the Medicare Prescription Drug benefit beginning in 2020.
- **Option 3B – Eliminate Medicare Retiree Rx Plan in 2020 with Defined Contribution to HRA:** Eliminate the Medicare Prescription Drug benefit beginning in 2020, with the State providing retirees with a $50 monthly defined contribution to an HRA. This defined contribution amount is not assumed to increase with health care cost trend.

IMPORTANT NOTE: The estimated cash flows (*i.e.*, expected State costs associated with benefits provided to retirees) and savings included in this draft report are intended to illustrate the orders of magnitude of the projected savings associated with implementing the changes to the retiree health plan. As these estimates are based on the State's December 31, 2014 OPEB valuation which is more long-term focused, the estimated cash flow and savings should not be used as a basis for setting State budget levels in the short term (*e.g.*, FY2018-2019 budget).

Please refer to the section titled "Important Information About Actuarial Valuations" in *Appendix C: Assumptions and Caveats*, for a discussion about financial assumptions in this draft report.

Impact on OPEB Liability

By eliminating the prescription drug benefit for Medicare retirees beginning in 2020, the State has the potential to eliminate almost 50% of the current OPEB liability for the retiree health program. By introducing a small defined contribution to an HRA of $50 per month, the savings opportunity for the State is reduced but still provides a liability reduction of over 45%. Overall reduction in OPEB liability would depend on the amount of the HRA defined contribution. The State could also choose to index the HRA contribution, as discussed in "Option 1C – Private Medicare Exchange with a Defined Contribution to an HRA, Indexed Contributions," but this would reduce savings further.

COMPARISON OF JANUARY 1, 2017 OPEB LIABILITY
By Member Group

The chart below compares the liability reduction, by member group, of eliminating the Medicare Prescription Drug Plan versus eliminating the Plan and providing retirees with a defined contribution to an HRA.

	Member Counts	Current Plan Baseline	Option 3A Eliminate Medicare Rx Plan in 2020	Option 3B Eliminate Medicare Rx Plan in 2020 with Defined Contribution to HRA
Medicare Retirees and Spouses	8,570	$555,300,000	$252,900,000	$286,200,000
Non-Medicare Retirees and Spouses	3,038	425,500,000	216,500,000	232,400,000
Actives Eligible for OPEB Now	1,559	324,400,000	158,400,000	172,600,000
Actives Eligible for OPEB Within 5 Years	1,111	251,400,000	129,900,000	138,000,000
Actives Eligible for OPEB 5 to 10 Years	1,281	255,300,000	142,600,000	148,800,000
All Other Actives	6,584	413,100,000	233,400,000	240,500,000
Vested Deferred Retirees	494	49,600,000	23,400,000	25,200,000
Total	**22,637**	**$2,274,600,000**	**$1,157,100,000**	**$1,243,700,000**
$ Difference from Current Plan Baseline		**N/A**	**-$1,117,500,000**	**-$1,030,900,000**
% Difference from Current Plan Baseline		**N/A**	**-49.1%**	**-45.3%**

Key:

- **Current Plan Baseline:** Projected liability as of January 1, 2017 assuming no changes are made to the existing retiree health care program.
- **Option 3A – Eliminate Medicare Retiree Rx Plan in 2020:** Eliminate the Medicare Prescription Drug benefit beginning in 2020.
- **Option 3B – Eliminate Medicare Retiree Rx Plan in 2020 with Defined Contribution to HRA:** Eliminate the Medicare Prescription Drug benefit beginning in 2020, with the State providing retirees with a $50 monthly defined contribution to an HRA. This defined contribution amount is not assumed to increase with health care cost trend.

Option 4 – Eliminate Retiree Health Benefits for Certain Participants

Option 4A – Eliminate of Retiree Health Benefit for New Hires

As discussed in the Introduction section of this report, the State has changed retiree health care coverage eligibility rules to require retirees to have more years of service and be older to be eligible. However, this is still an "open program"—that is, all new hires are eligible to enroll for coverage when they retire if they meet the service and age requirements. The State could choose to eliminate Retiree Health Benefits for new hires.

Impact on Retirees

If the State eliminated Retiree Health Benefits for new hires, affected future retirees would need to buy health care coverage in the individual insurance marketplace if they wished to have medical and prescription drug coverage. As an alternative, they could participate in the State's plan provided they pay 100% of the premium cost of the State's plan. The State would need to consider the adverse selection risks associated with this alternative, and how that might raise total costs of the program. (In this context, "adverse selection risks" refers to the likelihood that individuals with greater and costlier health care needs would choose retiree health plan coverage.) Issues related to Medicare retirees purchasing individual health care coverage are discussed on the preceding pages. No current employees or retirees would be impacted by this change.

Impact on the State

If the State eliminated Retiree Health Benefits for new hires, there would be limited short-term impact on the State's obligation to pay Retiree Health Benefits and on its OPEB liability. Based on current eligibility requirements for retiree medical plan participation, it would take 20 years before the State's payments for retiree health care benefits are reduced if today's new hires are not eligible for Retiree Health Benefits. On the other hand, the State should consider that eliminating Retiree Health Benefits for new hires could hinder its ability to attract new employees.

However, closing the Plan to new hires would help reduce the growth of retiree health care costs over time, while having no impact on the health benefits for current retirees and current State employees. Fewer employers are providing health care benefits to retirees than in the past (*e.g.*, The University System of New Hampshire discontinued Retiree Health Benefits for non-union faculty and staff hired on or after July 1, 1994 and union faculty and staff hired on or after July 1, 1995).

Option 4B – Eliminate Retiree Health Benefits for Spouses of Future Retirees

The State currently provides Retiree Health Benefits to the spouses of retirees (and, in a similar way, it provides active health care coverage to the spouses of active employees). The cost of covering the spouses of future retirees represents almost 25% of the State's December 31, 2014 retiree health care liability—75% of future retirees are projected to cover a spouse during retirement. The State could choose to eliminate Retiree Health Benefits for the spouses of future retirees.

Impact on Retirees

If the State eliminated Retiree Health Benefits for the spouses of future retirees, health care benefits for future retirees would stay the same. However, future retirees who planned to cover their spouses may see this change as a significant cut in benefits. For active employees who are further away from retirement, eliminating Retiree Health Benefits for the spouses of future retirees could result in employment retention issues of valued State employees. Another possibility is that employees currently eligible for Retiree Health but who have delayed retirement may decide to retiree in order for their spouses to be eligible for health benefits. This could lead to difficulties retaining key current employees and challenges attracting future employees.

Impact on the State

By eliminating health benefits for spouses of future retirees, the State could see a reduction of almost 25% in its OPEB liability. The State could also see a reduction in the amount it spends on retiree benefits in the long term. Since this change would only affect future retirees, it would not help reduce the State's short-term cash flow. However, it would likely help the retiree health care Plan to be seen by retirees as more equitable, since all retirees would receive the same benefit (*i.e.*, employee-only coverage), regardless of marital status.

For the purpose of evaluating the financial impact of this option, the financial modeling assumes a future retiree is one that retirees on or after January 1, 2018. It is recommended that, to avoid a mass retiree exodus, the State set this date based on hire date or that the State grandfather active employees already eligible for retiree health coverage.

As the State considers the option of eliminated Retiree Health Benefits for the spouses of new hires, note the following reasons as to why eliminating spouse coverage for current retirees was not explored as an option:

- Eliminating coverage for spouses of members who are in the current Retiree Plans was seen as a dramatic change for those that decided to retire understanding they would have spousal retiree coverage.
- As previously noted, the State has had difficulties with data collection. These difficulties extend to collecting data to determine which retiree health care plan participants are retirees and which are the spouses of retirees—especially for Medicare retirees. DAS can work with the New Hampshire Retirement System (NHRS) to audit and correct data issues.

Impact on Projected Ten-Year Benefit Payments

When looking at eliminating Retiree Health Benefits for new hires, the State would see no impact over ten years. The reason is that new hires do not become eligible to retire for at least 20 years from their date of hire. As illustrated in Figure 6, it would take significantly longer than ten years for the State to realize material savings if it eliminates retiree health coverage for new hires.

From a ten-year cash flow perspective, savings from eliminating benefits for the spouses of future retirees is relatively low. This is due to the fact that coverage would continue for the spouses of current retirees who are in the program, so savings would take time to materialize.

COMPARISON OF 10-YEAR CASH FLOW SAVINGS By Eliminating Retiree Coverage for The Spouses of Future Retirees vs. Eliminating Retiree Coverage for New Hires

The chart below compares the cost savings over a 10-year period of eliminating retiree health care coverage for new hires versus eliminating retiree health care coverage for the spouses of future retirees.

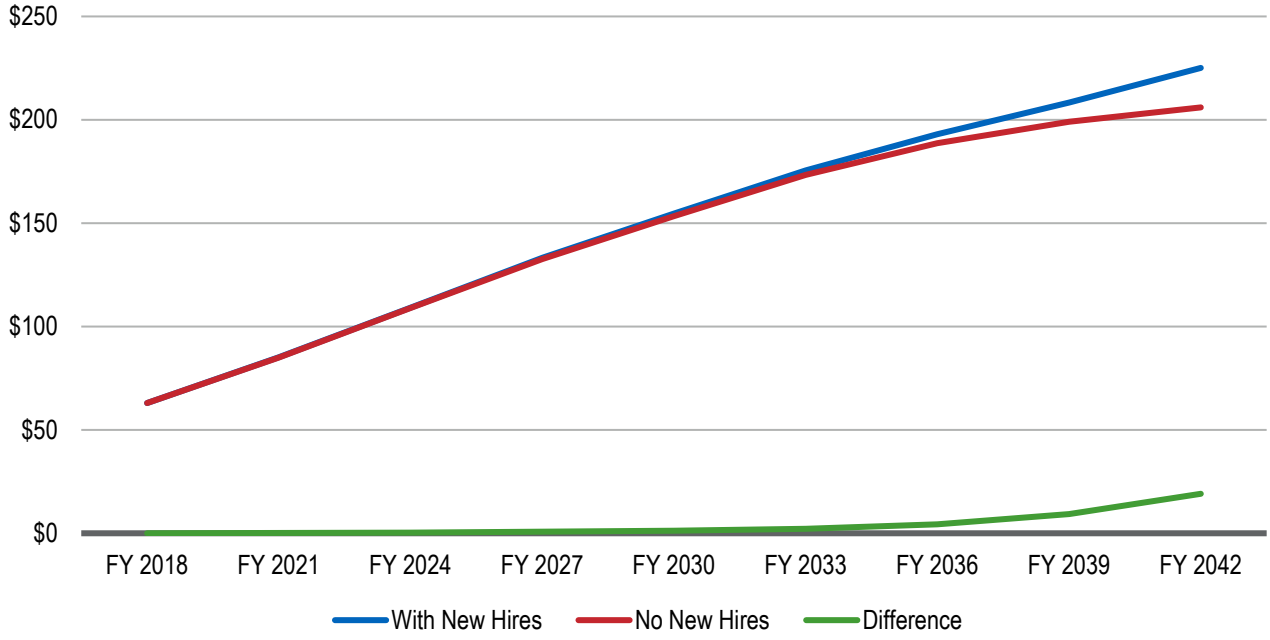
	Medicare Retiree and Spouse Counts	Non-Medicare Retiree Counts	Current Plan Baseline	Option 4A Eliminate Retiree Health Benefits for New Hires	Option 4B Eliminate Retiree Health Benefits for Spouses of Future Retirees
FY 2018	9,512	3,146	$63,000,000	$63,000,000	$62,550,000
FY 2019	9,809	3,056	70,100,000	70,100,000	68,300,000
FY 2020	10,075	2,993	77,200,000	77,200,000	74,400,000
FY 2021	10,286	2,968	85,000,000	85,000,000	81,000,000
FY 2022	10,490	2,916	92,900,000	92,900,000	87,800,000
FY 2023	10,706	2,830	100,800,000	100,800,000	94,400,000
FY 2024	10,878	2,759	108,900,000	108,900,000	101,200,000
FY 2025	11,031	2,671	116,900,000	116,900,000	107,800,000
FY 2026	11,179	2,568	124,700,000	124,700,000	114,300,000
FY 2027	11,289	2,479	132,600,000	132,600,000	120,700,000
10-Year Total			**$972,100,000**	**$972,100,000**	**$912,450,000**
$ Difference			**N/A**	**$0***	**-$59,650,000**
% Difference			**N/A**	**0.0%**	**-6.1%**

Key:

- **Current Plan Baseline:** Projected benefit payments (based on the December 31, 2014 OPEB valuation) assuming no changes are made to the existing retiree health care program.
- **Option 4A – Eliminate Retiree Health Benefits for New Hires:** Eliminates Retiree Health Benefits (both non-Medicare and Medicare) for employees hired on or after January 1, 2018.
- **Option 4B – Eliminate Retiree Health Benefits for Spouses of Future Retirees:** Eliminates subsidized retiree health coverage eligibility for spouses of retirees with retirement dates on or after January 1, 2018.

* No impact in 10 years because new hires require a minimum of 20 years of service to be eligible for Retiree Health Benefits.

FIGURE 6: PROJECTED CASH FLOW IMPACT OF ELIMINATING RETIREE COVERAGE FOR NEW HIRES (Numbers in $Millions)



IMPORTANT NOTE: The estimated cash flows (*i.e.*, expected State costs associated with benefits provided to retirees) and savings included in this draft report are intended to illustrate the orders of magnitude of the projected savings associated with implementing the changes to the retiree health plan. As these estimates are based on the State's December 31, 2014 OPEB valuation which is more long-term focused, the estimated cash flow and savings should not be used as a basis for setting State budget levels in the short term (*e.g.*, FY2018/2019 biennium).

Please refer to the section titled "Important Information About Actuarial Valuations" in *Appendix C: Assumptions and Caveats*, for a discussion about financial assumptions in this draft report.

Impact on OPEB Liability

Eliminating subsidized coverage for spouses of those retiring on or after January 1, 2018 could provide meaningful OPEB liability savings, as it is assumed that 75% of future retirees will cover a spouse at the time of retirement.

Eliminating retiree coverage for new hires would not result in an OPEB liability reduction in the short-term because the impact is calculated based on the current active employee population employed and retirees currently enrolled in the State's retiree health care program. Eliminating retiree coverage for new hires would have an impact on longer-term OPEB liability and future cash flow. Since the OPEB liability is based on the current active and retiree participants, it would take years for new hires to have appreciably reduce the OPEB liability. The impact and timeline of the cash flow impact is detailed in Figure 6, above.

COMPARISON OF JANUARY 1, 2017 OPEB LIABILITY
By Member Group

The chart below compares the liability reduction, by member group, of eliminating retiree health care coverage for new hires versus eliminating retiree health care coverage for the spouses of future retirees.

	Member Counts	Current Plan Baseline	Option 4A Eliminate Retiree Health Benefits for New Hires	Option 4B Eliminate Retiree Health Benefits for Spouses of Future Retirees
Medicare Retirees and Spouses	8,570	$555,300,000	$555,300,000	$555,300,000
Non-Medicare Retirees and Spouses	3,038	425,500,000	425,500,000	425,500,000
Actives Eligible for OPEB Now	1,559	324,400,000	324,400,000	185,600,000
Actives Eligible for OPEB Within 5 Years	1,111	251,400,000	251,400,000	145,000,000
Actives Eligible for OPEB 5 to 10 Years	1,281	255,300,000	255,300,000	146,800,000
All Other Actives	6,584	413,100,000	413,100,000	235,700,000
Vested Deferred Retirees	494	49,600,000	49,600,000	49,600,000
Total	**22,637**	**$2,274,600,000**	**$2,274,600,000**	**$1,743,500,000**
$ Difference from Current Plan Baseline		**N/A**	**$0[2]**	**-$531,100,000**
% Difference from Current Plan Baseline		**N/A**	**0.0%**	**-23.3%**

Key:

- **Current Plan Baseline:** Projected liability as of January 1, 2017 assuming no changes are made to the existing retiree health care program.
- **Option 4A – Eliminate Retiree Health Benefits for New Hires:** Eliminates Retiree Health Benefits (both non-Medicare and Medicare) for all new hires on or after January 1, 2018.
- **Option 4B – Eliminate Retiree Health Benefits for Spouses of Future Retirees:** Eliminates subsidized retiree health coverage eligibility for spouses of retirees with retirement dates on or after January 1, 2018.

[2] No immediate impact on OPEB liability as it is based on current active and retiree participants and not future employees (*i.e.*, new hires).

Option 5 – Replace the Current Medicare Retiree Plan with a Group Medicare Advantage Plan

What is a Medicare Advantage Plan?

Medicare Advantage plans are private health care plans offered by insurance companies to participants looking for health care coverage in the Medicare marketplace. These plans (formally known as Medicare + Choice) were created as part of the Medicare Modernization Act enacted in 2003. Medicare Advantage plans replace health care coverage offered through Medicare Parts A and B, (if prescription drugs are part of the Medicare Advantage plan, the plan would also cover Part D). They also often provide additional benefits such as vision and hearing care. These plans are fully insured, generally require the payment of deductibles before the plan pays benefits, and require coinsurance and/or copayments at the time of care. Insurance companies that provide these plans receive a per-person ("capitated") payment from the Centers for Medicaid and Medicare Services (CMS) to subsidize the cost of coverage. This capitated payment varies by county, the health of the members covered by the insurance company within that county, and the overall quality of care provided by the insurance company.

Insurance companies that provide Medicare Advantage plans manage all of the claims, risk adjustment and clinical programs that are included as part of their plan. Insurance companies are incentivized to manage risk, maximize CMS funding through risk adjustment strategies and minimize claim cost through medical management strategies—all while maintaining a high level of member satisfaction. The better the insurance companies are with this management process, the greater the payment they receive from CMS. Higher payments to the insurance companies are filtered to plan participants in the form of lower insurance premiums and/or a higher level of benefits.

Medicare Advantage plans are available on an individual or group basis. They can be structured as Health Maintenance Organizations (HMOs) or Preferred Provider Organizations (PPOs). In the group insurance marketplace, if 51% of a PPO group's membership lives in the network service area of the Medicare Advantage plan, the product may be offered on a "Passive" PPO basis. This means that the plan may offer the same level of benefits regardless of whether a participant uses an in-network or out-of-network provider, as long as that provider accepts Medicare. The result is that members can use all Medicare providers and receive the same level of benefits whether or not the provider is in the network. For individual insurance market plans, and for groups that do not meet the 51% threshold, members must visit in-network providers to receive the highest level of benefits the plan offers.

Over the past few years, many employers have implemented a national group Passive PPO Medicare Advantage plan. In such situations, benefits provided by the Passive PPO Medicare Advantage plan are at least as good as the plan the employer offered before switching to a Medicare Advantage plan. And, in making the switch, the employer is able to achieve significant savings (in some cases, over 25%). These savings result from the insurance company's ability to manage claims and receive the highest possible subsidy offered by CMS. Insurance company's often implement robust care management programs (including house calls from clinicians, disease management programs and wellness programs) so they can receive the highest reimbursement available from the Federal government. This ultimately lowers the Medicare Advantage plan premium for participants.

The above approach was reviewed by the State of New Hampshire in early 2016 as a way to reduce short-term and long-term retiree health care costs.

Why Implementing a Group Medicare Advantage Plan is Not a Viable Option for the State at this Time

In moving to a retiree health care program that offers only Medicare Advantage plans, the State would be able to keep much of its current retiree health care plan design as is. Due to federal rules for Medicare Advantage plans, the State would likely be able to continue offering coverage through virtually all current Medicare providers (*e.g.*, hospitals, physicians), rather than offer a plan with the limited provider networks that typically come with the Medicare Advantage plans available in the individual Medicare plan marketplace. This would allow the State to implement a Medicare Advantage plan with limited provider disruption to retirees—meaning the vast majority of retirees could continue seeing their current providers and receive the highest level of benefits offered by the plan.

While moving to a Medicare Advantage plan has been cost effective for many employers, there is currently limited provider network development and vendor competition for Medicare Advantage plans in New Hampshire. This limited availability and provider participation has resulted in low overall adoption and enrollment rates in these plans in New Hampshire (less than 10% of the Medicare-eligible population in New Hampshire is enrolled in Medicare Advantage plans). As a result, savings opportunities and vendor choice are limited.

At the start of this retiree study, the State reviewed the opportunity to switch to Medicare Advantage plans. Savings were estimated to be about 7.5% when compared to 2016 Medicare retiree premiums. Medicare premiums represent approximately half of the total retiree health budget, which would result in an overall savings opportunity of 3% – 4%. Since the time of this estimate, the Centers for Medicare and Medicaid Services updated the reimbursement process for group Medicare Advantage plans; this is expected to raise premiums in the Medicare marketplace. As a result, estimated savings are expected to be lower than the initial estimate (or potentially eliminated altogether) and would not be enough to justify this change at this time or to close any potential short-term budget gap. In addition, moving to a Medicare Advantage program would require the State to procure for a vendor, which would take at least 18 months to implement.

If there are future changes in the market (*e.g.*, additional carrier/member participation in the State, changes to group Medicare Advantage funding), Medicare Advantage could be an option for the State.

Impact on Projected Ten-Year Benefit Payments

COMPARISON OF 10-YEAR CASH FLOW SAVINGS
By Eliminating the Current Medicare Retiree Health Care Plan and Replacing it with a Medicare Advantage Program

The chart below compares the cost savings over a 10-year period of eliminating the current Medicare retiree health care plan and replacing it with a Medicare Advantage plan. Note that ten-year cash flow savings would be relatively small if this change was made. The reason is that, in the early years, expected claims payments for the State's retiree population are more heavily weighted towards non-Medicare claims, which would not be impacted under this scenario, and the fact that the savings opportunity for Medicare retirees overall is not that significant. In addition, savings below are based on the initial 2016 estimate provided. Due to changes in reimbursement levels from CMS (discussed previously), actual achieved savings would likely be smaller.

	Medicare Retiree and Spouse Counts	Non-Medicare Retiree Counts	Current Plan Baseline	Option 5 Group Medicare Advantage Program
FY 2018	9,512	3,146	$63,000,000	$61,400,000
FY 2019	9,809	3,056	70,100,000	66,600,000
FY 2020	10,075	2,993	77,200,000	73,400,000
FY 2021	10,286	2,968	85,000,000	80,900,000
FY 2022	10,490	2,916	92,900,000	88,400,000
FY 2023	10,706	2,830	100,800,000	95,900,000
FY 2024	10,878	2,759	108,900,000	103,500,000
FY 2025	11,031	2,671	116,900,000	111,100,000
FY 2026	11,179	2,568	124,700,000	118,500,000
FY 2027	11,289	2,479	132,600,000	125,900,000
10-Year Total			**$972,100,000**	**$925,600,000**
$ Difference			**N/A**	**-$46,500,000**
% Difference			**N/A**	**-4.8%**

Key:

- **Current Plan Baseline:** Projected benefit payments (based on the December 31, 2014 OPEB valuation) assuming no changes are made to the existing retiree health care program.
- **Option 5 – Group Medicare Advantage Program:** Moving all current and future Medicare Retiree Health Care Plan participants to a group Medicare Advantage program.

IMPORTANT NOTE: The estimated cash flows (*i.e.*, expected State costs associated with benefits provided to retirees) and savings included in this draft report are intended to illustrate the orders of magnitude of the projected savings associated with implementing the changes to the retiree health plan. As these estimates are based on the State's December 31, 2014 OPEB valuation which is more long-term focused, the estimated cash flow and savings should not be used as a basis for setting State budget levels in the short term (*e.g.*, FY2018-2019 biennium).

Please refer to the section titled "Important Information About Actuarial Valuations" in *Appendix C: Assumptions and Caveats*, for a discussion about financial assumptions in this draft report.

Impact on OPEB Liability

As discussed above, savings that would result from the implementation of a Medicare Advantage program are limited because of the limited presence of Medicare Advantage programs/networks in New Hampshire.

COMPARISON OF JANUARY 1, 2017 OPEB LIABILITY by Member Group

The chart below compares the liability reduction, by member group, of eliminating Medicare retiree health care coverage and replacing it with a Medicare Advantage program. Savings below are based on the initial 2016 estimate provided. Due to changes in reimbursement levels from CMS (discussed previously), actual achieved savings would likely be smaller.

	Member Counts	Current Plan Baseline	Option 5 Group Medicare Advantage Plan
Medicare Retirees and Spouses	8,570	$555,300,000	$513,500,000
Non-Medicare Retirees and Spouses	3,038	425,500,000	401,100,000
Actives Eligible for OPEB Now	1,559	324,400,000	304,800,000
Actives Eligible for OPEB Within 5 Years	1,111	251,400,000	237,500,000
Actives Eligible for OPEB 5 to 10 Years	1,281	255,300,000	242,100,000
All Other Actives	6,584	413,100,000	391,200,000
Vested Deferred Retirees	494	49,600,000	46,600,000
Total	**22,637**	**$2,274,600,000**	**$2,136,800,000**
$ Difference from Current Plan Baseline		**N/A**	**-$137,800,000**
% Difference from Current Plan Baseline		**N/A**	**-6.1%**

Key:

- **Current Plan Baseline:** Projected liability as of January 1, 2017 assuming no changes are made to the existing retiree health care program.
- **Option 5 – Group Medicare Advantage Program:** Moving all current and future Medicare Retiree Health Care Plan participants to a group Medicare Advantage program.

Option 6 – Defined Dollar Amount for the Non-Medicare Retiree Plan

While options described on the previous pages generally focus on Medicare retirees, the State could also opt to pay a defined dollar amount toward the cost of health care coverage for non-Medicare retirees. In doing so, the State would adjust the premium share it provides towards the cost of non-Medicare retiree medical and prescription drug coverage from a percentage contribution (currently 82.5%) to a flat dollar amount. This defined dollar amount would no longer change as the costs for medical and prescription drugs change each year.

Due to the volatility of premium rates and carrier participation in the Public Exchange market (as discussed previously in this draft report) and the fact that Private Exchange offerings for non-Medicare participants rely on the rates and plan options in the Public Exchange, continuing to offer the non-Medicare plan while changing to a defined dollar amount is the main option for the State to protect against plan cost inflation. Plan design changes (*e.g.*, increasing deductibles, copayments and/or out-of-pocket maximum amounts) are also an option; however, these are typically more short-term in nature and will not be discussed in this long-term-focused report.

Impact on Retirees

Using a defined dollar amount approach, all future Plan premium cost increases would be paid by non-Medicare retirees. The State's portion of the annual premium would remain fixed at the same amount. Currently, the State and the non-Medicare retirees share in the premium increases as the premium cost share amounts are determined by a percentage of the overall premium cost. Over time, as the cost continues to increase for the non-Medicare retiree, they may find that the cost of the benefit outweighs the value of the benefit they are receiving. This could result in more of non-Medicare retirees opting out of State-provided health care coverage to seek coverage elsewhere (*e.g.*, the Public Marketplace).

For certain early retirees, who are no longer able to work due to illness or other disability, this plan is seen as a safety net. The State should consider the fact that this plan would become very expensive over time under the defined dollar amount approach for these retirees. The charts below compare the projected increase in retiree premium share under a flat defined dollar approach versus the current percentage-of-premium approach used today.

CURRENT PERCENTAGE-OF-PREMIUM SHARE APPROACH
Year-Over-Year Impact

Year	Premium Amount*	State Premium Share	Retiree Premium Share	Retiree Premium Share % Increase
2017	$1,010	$833	$177	N/A
2018	$1,081	$892	$189	7%
2019	$1,156	$954	$202	7%
2020	$1,237	$1,021	$216	7%
2021	$1,324	$1,092	$232	7%
2022	$1,417	$1,169	$248	7%
2023	$1,516	$1,251	$265	7%
2024	$1,622	$1,338	$284	7%
2025	$1,735	$1,431	$304	7%

DEFINED DOLLAR AMOUNT APPROACH
Year-Over-Year Impact

Year	Premium Amount*	State Premium Share	Retiree Premium Share	Retiree Premium Share % Increase
2017	$1,010	$833	$177	N/A
2018	$1,081	$833	$248	40%
2019	$1,156	$833	$323	30%
2020	$1,237	$833	$404	25%
2021	$1,324	$833	$491	22%
2022	$1,417	$833	$584	19%
2023	$1,516	$833	$683	17%
2024	$1,622	$833	$789	16%
2025	$1,735	$833	$902	14%

Impact on the State

If the State adopted a defined dollar amount approach for non-Medicare retirees, the State would have some inflation protection against the cost of rising health care costs. The protection would come from shifting all future health care premium cost increases to non-Medicare retirees. This would result in a reduction in its OPEB liability. It would also generate short-term cash savings. Note that since the State would continue offering group medical coverage to non-Medicare retirees, the State would still bear the risk and be responsible for paying any claims for retirees that exceed projected premium rates.

The potential risk to the State of this approach is that non-Medicare retirees that remain covered under the State's plan would be individuals who use health care services the most (those who are

* Assumed to increase by 7% annually.

most ill and/or have chronic health conditions). This could result in the State paying more for claims on a per-retiree basis than market trend would indicate. Over time, this approach could increase employee retention by discouraging early retirement if the non-Medicare retirees who remain covered under the Plan cannot find attractive alternative health care coverage in the individual insurance market.

Impact on Projected Ten-Year Benefit Payments

COMPARISON OF 10-YEAR CASH FLOW SAVINGS
By Transitioning to a Defined Dollar Amount for Non-Medicare Retirees

The chart below compares the cost savings over a 10-year period of fixing the State's premium share to a Defined Dollar Amount, requiring non-Medicare retirees to pay 100% of the cost of future projected increases in health care coverage.

Savings from this approach are projected to be greater than 10% of total projected costs. The impact on retirees would increase year over year, as additional costs are shifted to retirees due to projected health care cost trend.

Savings assume that the State sets the Defined Dollar Amount at their current 2017 funding level. The state could choose to set this amount as a maximum contribution (*e.g.*, twice current State funding), but this would reduce the potential savings opportunity of this approach.

	Medicare Retiree and Spouse Counts	Non-Medicare Retiree Counts	Current Plan Baseline	Option 6 Defined Dollar Amount for Non-Medicare Retiree Plan
FY 2018	9,512	3,146	$63,000,000	$62,550,000
FY 2019	9,809	3,056	70,100,000	67,100,000
FY 2020	10,075	2,993	77,200,000	72,000,000
FY 2021	10,286	2,968	85,000,000	77,400,000
FY 2022	10,490	2,916	92,900,000	82,900,000
FY 2023	10,706	2,830	100,800,000	88,700,000
FY 2024	10,878	2,759	108,900,000	94,600,000
FY 2025	11,031	2,671	116,900,000	100,600,000
FY 2026	11,179	2,568	124,700,000	106,600,000
FY 2027	11,289	2,479	132,600,000	112,700,000
10-Year Total			**$972,100,000**	**$865,150,000**
$ Difference			**N/A**	**-$106,950,000**
% Difference			**N/A**	**-11.0%**

Key:

- **Current Plan Baseline:** Projected benefit payments (based on the December 31, 2014 OPEB valuation) assuming no changes are made to the existing retiree health care program.
- **Option 6 – Defined Dollar Amount for the Non-Medicare Retiree Plan:** Sets a monthly defined dollar amount (at the current funding levels) that the State would pay for non-Medicare retirees and the retiree is responsible for the remaining monthly premium.

IMPORTANT NOTE: The estimated cash flows (*i.e.*, expected State costs associated with benefits provided to retirees) and savings included in this draft report are intended to illustrate the orders of magnitude of the projected savings associated with implementing the changes to the retiree health plan. As these estimates are based on the State's December 31, 2014 OPEB valuation which is more long-term focused, the estimated cash flow and savings should not be used as a basis for setting State budget levels in the short term (*e.g.*, FY2018 – 2019 biennium).

Please refer to the section titled "Important Information About Actuarial Valuations" in *Appendix C: Assumptions and Caveats*, for a discussion about financial assumptions in this draft report.

Impact on OPEB Liability

COMPARISON OF JANUARY 1, 2017 OPEB LIABILITY
By Member Group

The chart below compares the liability reduction, by member group, of fixing the State's premium share to a Defined Dollar Amount, requiring non-Medicare retirees to pay 100% of future projected increases in the cost of health care coverage

This change in premium share structure for non-Medicare retirees represents a significant cost shift to these retirees. However, Non-Medicare Retiree Plan costs are projected to represent less than 20% of the State's OPEB liability. As a result, OPEB liability savings are projected to be lower than the percentage of cash savings over a 10-year period.

Savings assume that the State sets the Defined Dollar Amount at their current 2017 funding level. The state could choose to set this amount as a maximum contribution (*e.g.*, twice current State funding), but this would reduce the potential savings opportunity of this approach.

	Member Counts	Current Plan Baseline	Option 6 Defined Dollar Amount for Non-Medicare Retiree Plan
Medicare Retirees and Spouses	8,570	$555,300,000	$555,300,000
Non-Medicare Retirees and Spouses	3,038	425,500,000	394,300,000
Actives Eligible for OPEB Now	1,559	324,400,000	307,500,000
Actives Eligible for OPEB Within 5 Years	1,111	251,400,000	225,800,000
Actives Eligible for OPEB 5 to 10 Years	1,281	255,300,000	215,300,000
All Other Actives	6,584	413,100,000	325,600,000
Vested Deferred Retirees	494	49,600,000	47,100,000
Total	**22,637**	**$2,274,600,000**	**$2,070,900,000**
$ Difference from Current Plan Baseline		**N/A**	**-$203,700,000**
% Difference from Current Plan Baseline		**N/A**	**-9.0%**

Key:

- **Current Plan Baseline:** Projected liability as of January 1, 2017 assuming no changes are made to the existing retiree health care program.
- **Option 6 – Defined Dollar Amount for the Non-Medicare Retiree Plan:** Sets a monthly defined dollar amount (at the current funding levels) that the State would pay for non-Medicare retirees and the retiree is responsible for the remaining monthly premium.

Appendix A: Definition of Terms

- **Adverse Selection:** A phenomenon that occurs in the health insurance market where healthier individuals in the risk pool drop coverage as premiums increase. The resulting impact is that premium rates based on past utilization will not be sufficient to pay the claims of remaining members.
- **Catastrophic Protection HRA:** A separate HRA account that is set up to reimburse claims for Medicare retiree prescription drug claims in the "Catastrophic" portion of Medicare Part D. A retiree is typically required to pay up to 5% of all costs at the catastrophic level with no out-of-pocket limit. Once a retiree reaches this threshold, the retiree would pay for costs out-of-pocket and then submit claims for HRA.
- **CMS:** The Centers for Medicare & Medicaid Services, CMS, is part of the Department of Health and Human Services (HHS). CMS oversees the operation of a number of government insurance programs, including Medicare.
- **Current Plan Baseline:** Current plan baseline represents the projected liability as of January 1, 2017 for the current retiree plans (non-Medicare and Medicare) offered by the State. These baseline figures are developed and projected using standard actuarial techniques and are based on the December 31, 2014 GASB valuation report. Liabilities were adjusted to reflect the January 1, 2016 prescription drug and non-Medicare retiree contribution changes, and
- **Defined Contribution:** In this report, defined contribution represents a set annual contribution, during retirement, by the State to an HRA account. This is not related to a Defined Contribution retirement plan (*e.g.*, 401(k), 403(b)), where an employer may fund a retirement plan account during active service.
- **Defined Dollar Amount:** A fixed dollar premium share amount provided by the State. To participate in a State sponsored plan, a retiree would pay the difference between the premium amount and the State's Defined Dollar Amount.
- **Formulary:** A list of drugs covered by the prescription drug plan
- **Group I Retiree**: Retired employee of the State representing all job classifications besides police and firefighters.
- **Group II Retiree:** Retired employee of the State working for a police or fire department
- **Government Accounting Standards Board (GASB):** Established in 1984, the GASB is the independent, private-sector organization that establishes accounting and financial reporting standards for U.S. state and local governments that follow Generally Accepted Accounting Principles.
- **Health Reimbursement Arrangement (HRA):** An HRA is an employer-funded, tax-advantaged employer health benefit plan. It allows employees or retirees to be reimbursed tax-free for individual health insurance premiums and eligible out-of-pocket medical expenses (*e.g.*, deductibles, copays, coinsurance).
- **Long Term / Short Term:** In this report, Long Term refers to all future costs of the retiree medical plan and Short Term represents the next biennium (*i.e.*, the next two years)

- **Medicare Advantage:** Medicare Advantage plans are private health care plans offered by insurance companies to participants looking for health care coverage in the Medicare marketplace. These plans (formally known as Medicare + Choice) were created as part of the Medicare Modernization Act enacted in 2003. Medicare Advantage plans replace health care coverage offered through Medicare Parts A and B, (if prescription drugs are part of the Medicare Advantage plan, the plan would also cover Part D). They also often provide additional benefits such as vision and hearing care.
- **Medicare Retiree Plan:** The self-funded plan currently offered to Medicare eligible retirees of the State. This consists of a medical plan design offered through Anthem Blue Cross Blue Shield that integrates with Medicare and a prescription drug plan administered by Express Scripts. Details about this plan are included in *Appendix E.*
- **Non-Medicare Retiree Plan:** The self-funded plan currently offered to retirees of the State not eligible for Medicare. This consists of a medical and prescription drug plan administered by Anthem Blue Cross Blue Shield and Express Scripts, respectively. Details about this plan are included in *Appendix E.*
- **Other Post-Employment Benefits (OPEB):** A term defined by the Government Account Standards Board to represent non-pension benefits offered to retirees. For the State, this includes the medical and prescription drug benefits offered to retirees.
- **OPEB Liability:** This is the present value of all future promised other post-employment benefits. The total employer cost of providing OPEB benefits is projected by taking into account certain actuarial assumptions, including those about demographics (*e.g.*, turnover, mortality, disability, retirement) and health care cost trend (*i.e.*, inflation factor). The total employer cost is then actuarially "discounted" to determine the actuarial present value of the total projected benefits
- **Percentile:** A percentile indicates the value below which a given percentage of individuals in a data set fall. For example, the 75th percentile is the value below which 75% of the individuals in a data set fall.
- **Premium Rate:** This may refer to either the State Plans' self-funded projected premium equivalent rates or the fully insured premium rates one could purchase in the individual market.
- **Private Medicare Exchange:** Private Medicare Exchanges offer individual health care plans for Medicare-eligible individuals. Their main function is to provide decision support through call centers and web-based tools to help individuals evaluate and enroll in Medicare products such as Medicare supplement plans, Medicare Advantage plans and Medicare Prescription Drug Plans—all insurance products that are also available without a Private Medicare Exchange and the customer service it provides. An employer contribution to an HRA is typically provided to assist with premium and out-of-pockets.
- **Public Exchange:** An online marketplace for individual health insurance products operated by states and/or the federal government. The Public Exchanges (now known as "Marketplaces") were created as part of the Affordable Care Act. Coverage is available for those that are not eligible for Medicare or Medicaid (with certain exceptions).

Appendix B: Retiree Impact of Moving to Individual Market

Whether retirees are moved to the individual insurance marketplace under a Private Medicare Exchange or because the State's current Medicare retiree prescription drug plan is eliminated, it is important to consider how it will affect the amount retirees pay for the cost of health care.

The following review accounts for all health care costs to retirees, including premium cost shares, deductibles, copayments and coinsurance payments offset by any subsidy (*e.g.*, through an HRA contribution) that may be provided by the State.

Assumptions

In developing this illustrative modeling, Segal created retiree profiles based on a 2014 Segal Medicare claims database of approximately 87,500 Medicare-eligible retirees. The costs were indexed using the following health care cost trends:

- Premiums: 5%
- Medical Costs: 5%
- Prescription Drug Utilization: 3%
- Prescription Drug Cost: 2% for generic drugs, 8% for brand-name drugs.

Using this database, Segal created retiree health care usage profiles from average utilization of medical and prescription drug services for members in the 25th percentile, 50th percentile, 75th percentile, 90th percentile and top percentile of costs. Retirees were assumed to select the plan that minimized their total out-of-pocket spend from a selection of the following plans:

- Humana Medicare Supplement Plan K, N, and F
- AARP Preferred and Saver PDP.

Premiums for these plans were based on the costs for an age 75 retiree, with the male and female rate averaged for individuals living in Concord, NH. Actual individual premiums will vary based on age, gender and where a retiree lives. Individual market Medicare Advantage plans may be available to retirees as well, but the impact was not considered in this illustrative modeling.

For the purposes of this analysis, no plan changes were assumed in any future projections.

The projections in this draft report are estimates of future costs and are based on information available to Segal at the time the projections were made. Segal has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, variables such as changes in the regulatory environment, local market pressure, health care cost trend and claims volatility. The accuracy and reliability of health projections decrease as the projection period increases.

The purpose of this analysis is to provide an illustration of potential impact of moving to a defined contribution approach with individual market plans. Actual retiree impact will depend on specific retiree utilization, plan availability, age, and gender.

Retiree Impact

Medicare Exchange

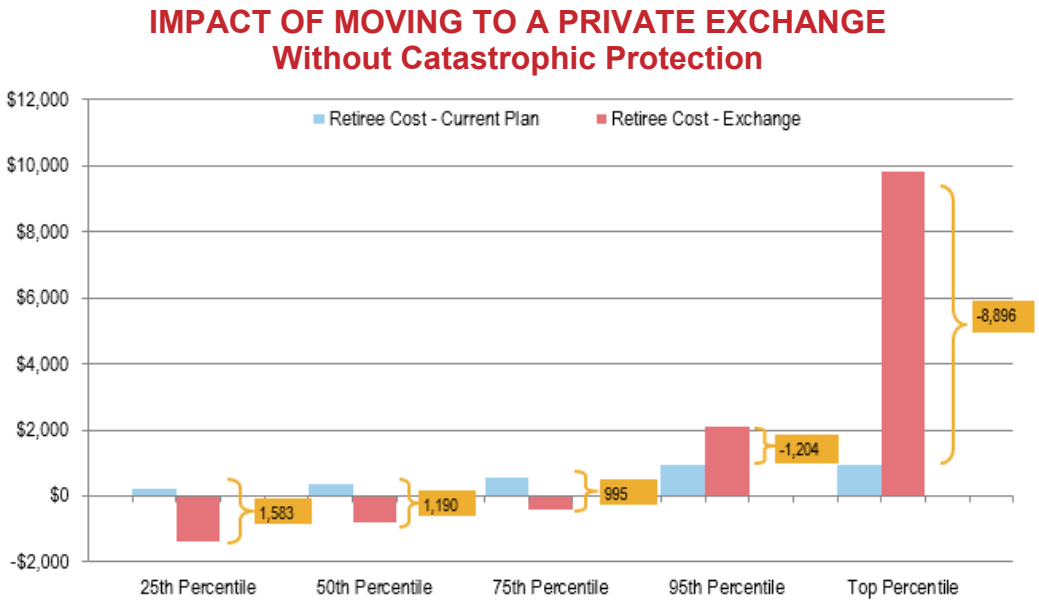
The following chart represents the total projected out-of-pocket costs that a retiree would pay under the current State Medicare Retiree Plan ("Current") versus the costs under the individual market plan that minimizes total out-of-pocket costs ("Exchange") for the various utilization profiles. The impact on retirees assumes that the State would provide a defined contribution of $4,500 to an HRA. The projected retiree impact is shown for both 2017 and 2020.

The costs and savings in Rows 5, 6, 7, and 8 assume that the State would not provide a Catastrophic Protection HRA. If the State were to provide this additional Catastrophic Protection HRA, the costs in Row 2c would be paid for by the State instead of the retiree. For retirees in the top percentile of costs, this Catastrophic Protection HRA would provide meaningful value, reducing the retiree's projected costs by almost $8,000 in 2017.

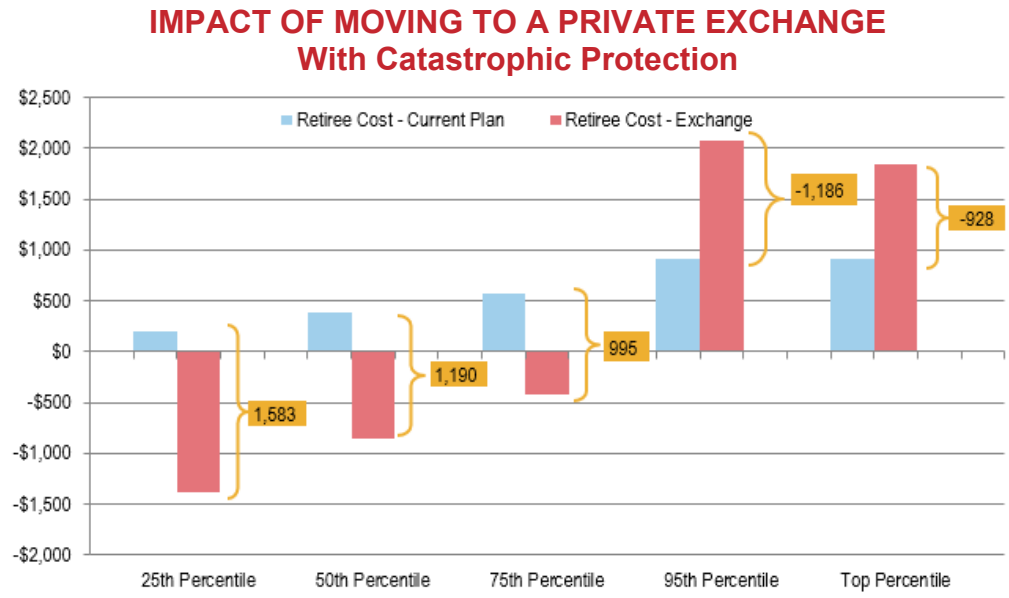
	25th Percentile		50th Percentile		75th Percentile		95th Percentile		Top Percentile	
	Current	Exchange	Current	Exchange	Current	Exchange	Current	Exchange	Current	Exchange
1. Plan Premiums										
a. Medical	$0	$1,689	$0	$1,689	$0	$1,689	$0	$3,147	$0	$3,147
b. Prescription Drug	0	391	0	391	0	391	0	391	0	391
c. Total	**$0**	**$2,080**	**$0**	**$2,080**	**$0**	**$2,080**	**$0**	**$3,538**	**$0**	**$3,538**
2. Estimated Retiree Out-of-Pocket Costs										
a. Medical	$166	$999	$166	$1,129	$166	$1,236	$166	$0	$166	$0
b. Prescription Drug	34	38	216	482	407	762	750	3,063	750	2,805
c. Catastrophic Coverage	0	0	0	0	0	0	0	18	0	7,968
d. Total	**$200**	**$1,037**	**$382**	**$1,611**	**$573**	**$1,997**	**$916**	**$3,081**	**$916**	**$10,773**
3. Total Gross Retiree Costs (Line 1 + Line 2)	**$200**	**$3,117**	**$382**	**$3,691**	**$573**	**$4,077**	**$916**	**$6,620**	**$916**	**$14,312**
4. The State Subsidy		$4,500		$4,500		$4,500		$4,500		$4,500
5. Total Net Retiree Costs/(HRA Growth) (Line 3 – Line 4)	$200	($1,383)	$382	($809)	$573	($423)	$916	$2,120	$916	$9,812
6. Retiree Savings/(Costs) – 2017		**$1,583**		**$1,190**		**$995**		**($1,204)**		**($8,896)**
7. Retiree Savings/(Costs) – 2020		**$1,095**		**$629**		**$375**		**($1,507)**		**($12,267)**
8. Retiree Savings/(Costs) – 2020 5% COLA		**$1,805**		**$1,338**		**$1,084**		**($798)**		**($11,558)**

In moving to a Medicare Exchange, based on the assumed State contribution to an HRA of $4,500 and the retiree utilization profiles created in this illustrative modeling, it is projected that as many as 90% of 75-year old Medicare retirees in New Hampshire could have the opportunity to be better off financially in the initial transition. For retirees that would see the largest overall increase in total out-of-pocket costs, the State could offer a Catastrophic Protection HRA (at an additional cost to the State) that would significantly lower, but not completely eliminate, the overall increase in the projected out-of-pocket costs for these high utilizing participants. The impact on New Hampshire Medicare Retirees would vary based on age, gender, actual utilization and plan selection.

The bar chart below summarizes the projected impact on retirees in 2017 (data included in the chart above) assuming the State did not provide a catastrophic protection HRA.



The bar chart below summarizes the projected impact on retirees in 2017 (data included in the chart above) assuming the State did provide a catastrophic protection HRA.



Elimination of Prescription Drug Plan in 2020

The following chart represents the total projected out-of-pocket costs that a retiree would pay under the current State Medicare Retiree Plan ("Current") versus the costs under the individual market prescription drug plan that minimizes total out-of-pocket costs ("No Rx") for the various utilization profiles. The impact on retirees assumes that the State would provide a defined contribution of $600 into an HRA. Retiree impact is shown for 2020.

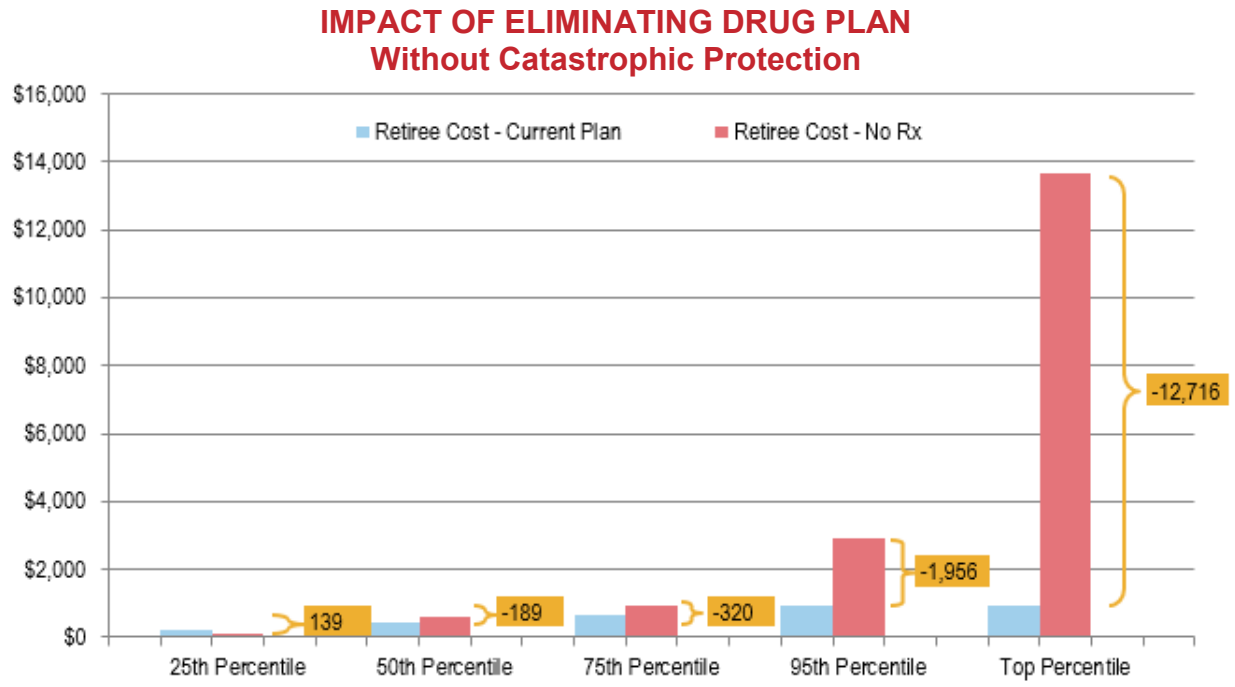
The costs and savings in Rows 5 and 6 do not assume that the State would provide a catastrophic protection HRA. If the State were to provide this additional HRA, the costs in Row 2c would be paid for by the State. For retirees in the top percentile of costs, this catastrophic HRA would provide meaningful value, reducing retiree costs by almost $11,000 in this projection.

	25th Percentile		50th Percentile		75th Percentile		95th Percentile		Top Percentile	
	Current	No Rx	Current	No Rx	Current	No Rx	Current	No Rx	Current	No Rx
1. Plan Premiums										
a. Medical	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
b. Prescription Drug	$0	$453	$0	$453	$0	$453	$0	$453	$0	$453
c. Total	**$0**	**$453**	**$0**	**$453**	**$0**	**$453**	**$0**	**$453**	**$0**	**$453**
2. Estimated Retiree Out-of-Pocket Costs										
a. Medical	$192	$192	$192	$192	$192	$192	$192	$192	$192	$192
b. Prescription Drug	$37	$44	$236	$572	$444	$911	$750	$2,837	$750	$2,637
c. Catastrophic Coverage	$0	$0	$0	$0	$0	$0	$0	$16	$0	$10,976
d. Total	**$229**	**$237**	**$428**	**$764**	**$637**	**$1,103**	**$942**	**$3,046**	**$942**	**$13,805**
3. Total Gross Retiree Costs (Line 1 + Line 2)	**$229**	**$689**	**$428**	**$1,217**	**$637**	**$1,556**	**$942**	**$3,498**	**$942**	**$14,258**
4. The Company Subsidy		$600		$600		$600		$600		$600
5. Total Net Retiree Costs/(HRA Growth) (Line 3 – Line 4)	$229	$89	$428	$617	$637	$956	$942	$2,898	$942	$13,658
6. Retiree Savings/(Costs) – 2020		**$139**		**($189)**		**($320)**		**($1,956)**		**($12,716)**

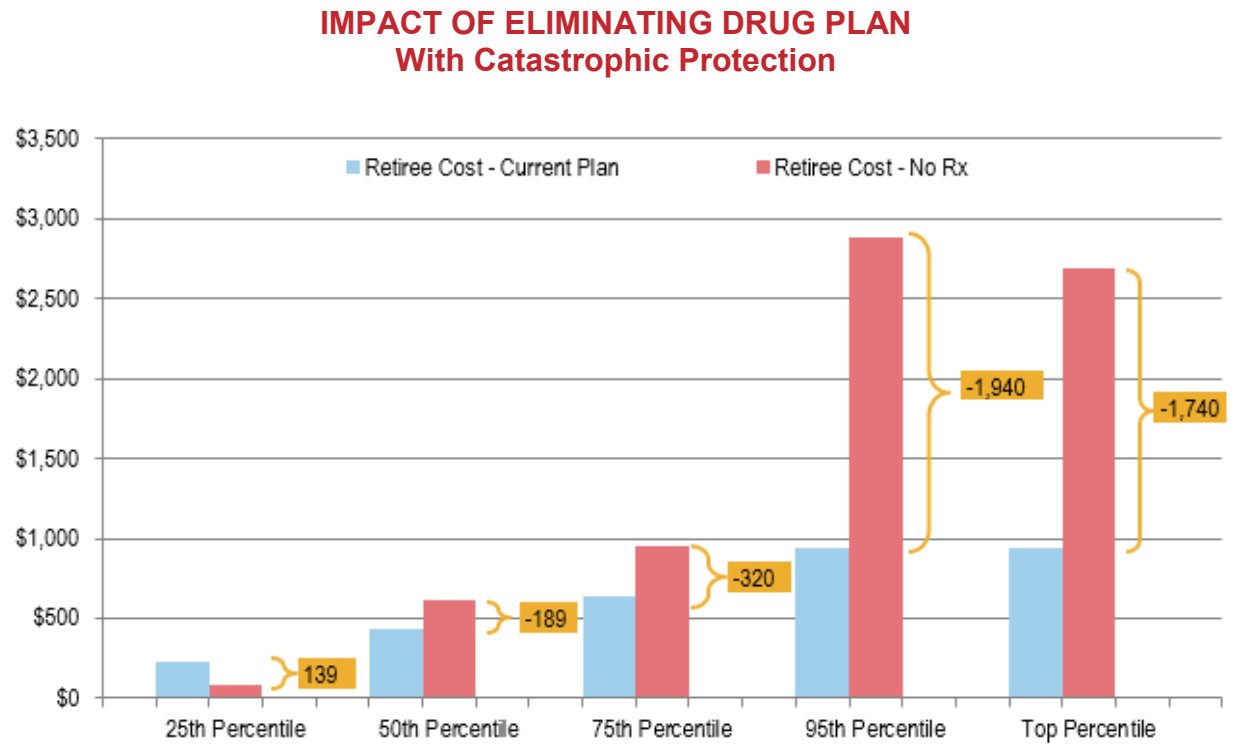
Unlike the Medicare Exchange scenario, where the majority of Medicare retirees are projected to do be better financially than they are under the current State Medicare Retiree Health Plan, eliminating prescription drug coverage is projected to increase costs for over 50% of Medicare retirees, even if the State provides a modest subsidy (through HRA contributions) of $600 per year. This percentage could be reduced if the State were to increase the level of HRA contribution, but the overall savings would be reduced as well.

As with the Medicare Exchange scenario, the total out-of-pocket cost increase in the individual market can be reduced through the implementation of a Catastrophic Protection HRA (at an additional cost to the State). However, this HRA this may be difficult to implement without the use of a Private Medicare Exchange vendor. Finally, the impact on New Hampshire Medicare Retirees would vary based on actual use and plan selection.

The bar chart below summarizes the projected impact on retirees in 2020 (data included in the chart above) assuming the State did not provide a catastrophic protection HRA.



The bar chart below summarizes the projected impact on retirees in 2020 (data included in the chart above) assuming the State did provide a catastrophic protection HRA.



Appendix C: Assumptions and Caveats

Caveats

The projections in this draft report are estimates of future costs and are based on information available to Segal Consulting at the time the projections were made. Segal has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, health care cost trend and claims volatility.

The accuracy and reliability of health projections decrease as the projection period increases.

All liability information and assumptions used to develop these figures are based on the Actuarial Valuation and Review of Other Postemployment Benefits (OPEB) as of December 31, 2014 in accordance with GASB Statements No. 43 and No. 45. This valuation report is dated October 9, 2015.

Important Information About Actuarial Valuations

An actuarial valuation is an estimate of future uncertain obligations of a postretirement health plan. As such, it will never forecast the precise future stream of benefit payments. It is an estimated forecast; the actual cost of the plan will be determined by the benefits and expenses paid, not by the actuarial valuation.

To prepare a valuation, Segal Consulting ("Segal") relies on a number of input items. These include:

- **Plan of benefits.** Plan provisions define the rules that will be used to determine benefit payments. These rules, or the interpretation of them, may change. Even where the rules appear precise, outside factors may change those rules. For example, a plan may provide health benefits to post-65 retirees that coordinate with Medicare. If so, changes in the Medicare law or administration may change the plan's costs without any change in the terms of the plan itself. It is important for the State of New Hampshire to keep Segal informed with respect to plan provisions and administrative procedures, and to review the plan summary included in our report to confirm that Segal has correctly interpreted the plan of benefits.
- **Participant data.** An actuarial valuation for a plan is based on data provided to the actuary by the plan. Segal does not audit such data for completeness or accuracy, other than reviewing it for obvious inconsistencies compared to prior data and other information that appears unreasonable. It is not necessary to have perfect data for an actuarial valuation; the valuation is an estimated forecast, not a prediction. Uncertainties in other factors are such that even perfect data does not produce a "perfect" result. Notwithstanding the above, it is important for Segal to receive the best possible data and to be informed about any known incomplete or inaccurate data.
- **Actuarial assumptions.** In preparing an actuarial valuation, Segal starts by developing a forecast of the benefits to be paid to existing plan participants for the rest of their lives and the lives of their beneficiaries. To determine the future costs of benefits, Segal collects claims, premium and enrollment data to establish a baseline cost for the valuation measurement. Segal then develops short- and long-term health care cost rates to project

increases in costs. This forecast also requires actuarial assumptions as to the probability of death, disability, withdrawal and retirement of each participant for each year, as well as forecasts of the plan's benefits for each of those events.

Forecasted benefits are then actuarially discounted to a present value, typically based on an estimate of the rate of return that will be achieved by the plan's assets, or if there are no assets, a rate of return on the assets of the employer. All of these factors are uncertain and unknowable. Thus, there will be a range of reasonable assumptions, and the results may vary materially based on which assumptions the actuary selects within that range. That is, there is no right answer (except with hindsight).

It is important for any user of an actuarial valuation to understand and accept this constraint. The actuarial model may use approximations and estimates that will have an immaterial impact on our results and will have no impact on the actual cost of the plan. In addition, the actuarial assumptions may change over time. While this can have a significant impact on the reported results, it does not mean that the previous assumptions or results were unreasonable or wrong.

Given the above, the user of Segal's actuarial valuation (or other actuarial calculations) needs to keep the following in mind:

- The actuarial valuation is prepared for use by the State of New Hampshire. It includes information for compliance with accounting standards. Segal is not responsible for the use or misuse of its report, particularly by any other party.
- An actuarial valuation is a measurement at a specific date—it is not a prediction of a plan's future financial condition. Accordingly, Segal did not perform an analysis of the potential range of financial measurements, except where otherwise noted.
- Sections of this draft report include actuarial results that are not rounded, but that does not imply precision.
- Critical events for a plan include, but are not limited to, decisions about changes in benefits and contributions. The basis for such decisions needs to consider many factors such as the risk of changes in plan enrollment, emerging claims experience and health care cost trend, not just the current valuation results.
- Segal does not provide investment, legal, accounting or tax advice. Segal's valuation is based on our understanding of applicable guidance in these areas and of the plan's provisions, but they may be subject to alternative interpretations. The State should look to their other advisors for expertise in these areas.
- While Segal maintains extensive quality assurance procedures, an actuarial valuation involves complex computer models and numerous inputs. In the event that an inaccuracy is discovered after presentation of Segal's valuation, Segal may revise that valuation or make an appropriate adjustment in the next valuation.
- Segal's draft report shall be deemed to be final and accepted by the State of New Hampshire upon delivery and review. The State of New Hampshire should notify Segal immediately of any questions or concerns about the final content.
- As Segal Consulting has no discretionary authority with respect to the management of the Plan, it is not a fiduciary in its capacity as actuaries and consultants with respect to the Plan.

Appendix D: Survey Data on Other State Retiree Health Plans

State Health Plans and Retiree Health
May 2016

Segal investigated what other state health plans are offering in respect to retiree health benefits. The focus of the review was to see what other state health plans have done or are planning to do to assist in managing retiree plan costs.

Utilizing Segal's experience with state health plans, Segal team leads were surveyed to provide information on the plans to which Segal consults. Information on both the non-Medicare and Medicare retiree programs for the following state health plans are included in this report:

Alabama[1]	Alaska	Colorado
Connecticut	Delaware	Hawaii
Kansas	Maryland	Massachusetts[2]
New Mexico	North Carolina	Pennsylvania[3]
Rhode Island	Wisconsin	

The results of Segal's review are illustrated in the attached exhibits and are separated into three categories:

1. Medical Benefits (*Exhibit 1*).
2. Prescription Drug Benefits (*Exhibit 2*).
3. Eligibility and Contribution Strategies (*Exhibit 3*).

Within each category, the status of each plan component is identified by one of the following: "Yes" (*i.e.*, part of the current plan), "Under Consideration", and "No" (*i.e.*, not part of the current plan).

As some of the provided information is not public and may be considered confidential by the state plans, this report indicates the total number of states that fall into each status (*i.e.*, yes, under consideration, no) and does not identify the specific state plans.

In addition to the exhibits attached, we note the following key observations for the non-Medicare and Medicare retiree plans.

Non-Medicare Retiree Plan Observations

- One (1) state is considering transferring non-Medicare retirees to a public exchange.
- No states have transferred or are considering transferring non-Medicare retirees to a private exchange.

[1] Alabama: Public Education Employees' Health Insurance Plan (PEEHIP)
[2] Massachusetts: Group Insurance Commission (GIC)
[3] Pennsylvania: Public School Employees Retirement System (PSERS)

- Two (2) states offer a high deductible plan with a Health Savings Account (HSA) and three (3) states are considering this option.
- Eight (8) states offer different retiree contributions and three (3) states offer different plan designs based on retirement date and/or date of hire.
- Five (5) states offer different retiree contributions based on length of service.
- Three (3) states grandfathered current retirees when implementing contribution rate changes.
- One (1) state eliminated and two (2) states are considering eliminating providing coverage for working spouses.

Medicare Retiree Plan Observations

- One (1) state implemented a defined contribution plan and transferred its Medicare retirees to a private exchange.
- Two (2) states are considering paying Medicare Part A premiums (including any late enrollment penalties) for those not eligible for Part A for free.
- All 14 states implemented Medicare Part D prescription drug coverage, including: An Employer Group Waiver Plan (EGWP); a Prescription Drug Plan (PDP); or a Medicare Advantage Plan with Prescription Drugs (MAPD).
- One (1) state plans to remove prescription drug coverage in 2020 (or after), once the Medicare Part D "donut hole" is closed.
- Nine (9) states offer different retiree contributions and three (3) states offer different plan designs based on retirement date and/or date of hire.
- Five (5) states offer different retiree contributions based on length of service.
- Three (3) states grandfathered current retirees when implementing contribution rate changes.

EXHIBIT 1: STATE RETIREE HEALTH PLANS
Medical Benefit Information

	Non-Medicare			Medicare		
Medical Benefit	Yes	Under Consideration	No	Yes	Under Consideration	No
Offer a deductible plan with Health Reimbursement Account (HRA)	3	0	11			
Offer a high deductible plan with Health Savings Account (HSA)	2	3				
Transfer all retirees to a public exchange	0	1	13	0	0	14
Transfer all retirees to a private exchange	0	0	14	1	0	13
Offer a Medicare Advantage plan				6	4	4
Change the plan's Medicare coordination rules				3	0	11
State health plan pays Medicare Part A premiums (including any late enrollment penalties) for those not eligible for free Part A				0	2	12

EXHIBIT 2: STATE RETIREE HEALTH PLANS
Prescription Drug Benefit Information

	Medicare		
Prescription Drug Benefit	Yes	Under Consideration	No
Implement a Medicare Part D Prescription Drug Plan (PDP)	4	0	10
Implement an Employer Group Waiver Plan (EGWP)	10	1	3
Offer a Medicare Advantage with Prescription Drug Plan (MAPD)	6	4	4
Will remove prescription drug coverage in 2020 (or after) for Medicare retirees	1	0	13

EXHIBIT 3: STATE RETIREE HEALTH PLANS
Eligibility and Contribution Strategies

	Non-Medicare			Medicare		
Eligibility and Contribution Strategies	Yes	Under Consideration	No	Yes	Under Consideration	No
Implemented a defined contribution plan	0	0	14	1	0	13
Changed rules to be eligible for retiree coverage	2	1	11	4	1	9
Offers different plan designs based on retirement date and/or hire date	3	0	11	3	0	11
Offers different retiree contributions based on retirement date and/or hire date	8	0	6	9	0	5
Offers different retiree contributions based on length of service	5	1	8	5	1	8
Grandfathered contributions of current retirees	3	1	10	3	1	10
Does not provide coverage for spouses	0	0	14	0	0	14
Does not provide coverage for working spouses	1	2	11	1	1	12
Does not provide retiree coverage for those with access to coverage through active employment	0	1	13	1	1	12

Appendix E: Current Retiree Plan Designs

Non-Medicare Medical Plan Summary

Full details can be found at the following link:
https://das.nh.gov/hr/documents/benefits/Anthem%20Retirees%20Under%2065%20POS%20Summary%202016.pdf

	IN-NETWORK	OUT-OF-NETWORK
Preventive Care	No Charge	Covered up to Maximum Allowable Charge
Office Visit	$10 PCP / $30 Specialist Copay	Subject to deductible and coinsurance. Individual: $650 deductible per member per calendar year and 20% coinsurance up to $1350 per member Family: $1350 per family per calendar year and 20% coinsurance up to $2,650 per family per calendar year
High Cost Radiology	$150 Copay	
- Lab, X-ray and ultrasound **- Surgery in hospital outpatient department or ambulatory surgery center** **- outpatient facility fees**	$500 deductible per member, no more than $1,000 per family per calendar year	
Inpatient Care		
Skilled Nursing Facility and Rehabilitation Facility Care		
Durable Medical Equipment		
Short term rehabilitative therapy - Physical, occupational, cardiac speech		
Chiropractic visit	$10 Copay	
Behavioral Health Outpatient	$10 PCP Copay	
Behavioral Health Inpatient	Subject to deductible	
Emergency Room (ER) or Urgent Care Center Visit	$150 ER / $50 Urgent Care Copay	$150 per visit
Individual Out-of-Pocket Maximum	$1,000 per person per calendar year	$2,000 per person per calendar year
Family Out-of-Pocket Maximum	$2,000 per family per calendar year	$4,000 per family per calendar year

Non-Medicare Prescription Drug Plan Summary

Full details can be found at the following link:
https://das.nh.gov/hr/documents/Retiree%20Pharmacy%20RU65%201%201%202016.pdf

	RETAIL PHARMACY	MAIL ORDER PHARMACY
YOU WILL PAY	**$10** for each generic medication **$25** for each preferred brand-name medication **$40** for each non-preferred brand-name medication	**$10** for each generic medication **$50** for each preferred brand-name medication **$80** for each non-preferred brand-name medication
PREVENTIVE	**$0 Co-Pay** for certain preventive maintenance medications (some age and brand restrictions apply)	
MAXIMUM OUT-OF-POCKET	**$750** per individual per calendar year **$1,500** per family per calendar year	
DAY SUPPLY LIMIT	Up to a **31-day** supply	Up to a **90-day** supply
MANDATORY GENERIC	When a generic equivalent is available but the pharmacy dispenses the brand-name medication for any reason other than a doctor's "dispense as written" or equivalent instructions, you will pay the generic copayment plus the difference in cost between the brand-name and generic.	
REFILL LIMIT	One initial fill plus two refills for maintenance or long-term medications. For each additional fill, you will pay 100% of the prescription cost.	None

Medicare Medical Plan Summary

Full details can be found at the following link:
https://das.nh.gov/hr/documents/benefits/Anthem_Retiree_Over_65_Summary_2017.pdf

Inpatient Hospital Benefits	Medicare Part A Pays	Medicomp Three Pays	You Pay
First 60 days of Medicare benefit period	Full cost after $1,316 Benefit Period Deductible	Deductible $1,316	No Balance
Next 30 days (61st through 90th days)	Full cost except for coinsurance of $329 per day	Coinsurance $329 per day	No Balance
Next 60 days of one-time lifetime reserve days (91st through 150th days)	Full cost except for coinsurance of $658 per day	Coinsurance $658 per day	No Balance
After 150 days of continuous confinement	Nothing	90% of covered services Lifetime Maximum: 365 days	Remaining Balance
Skilled Nursing Facility Benefits	Skilled Nursing Facility confinement must follow a hospitalization, must be medically necessary. **Custodial care is not covered.**		
First 20 days of benefit period	Full cost	Nothing	No Balance
Next 80 days (21st through 100th days)	Full cost except for coinsurance of $164.50 per day	Coinsurance $164.50 per day	No Balance
After 100 days of continuous confinement	Nothing	Nothing	Full Cost
Medical Service Benefits	**Medicare Part B Pays**	**Medicomp Three Pays**	**You Pay**
Physician Services, Hospital Outpatient, Prosthetic Devices, Durable Medical Equipment, Immunosuppressive Drugs and Other Covered Services	80% of Medicare approved charges after $183 annual deductible	20% of Medicare approved charges	$183 deductible
Certain hospital outpatient services	Full cost except for the hospital outpatient copayment	Hospital outpatient copayment	No Balance
Specific Benefits	**Medicare Pays**	**Medicomp Three Pays**	**You Pay**
Blood (for New Hampshire residents NH Red Cross replaces blood free of charge but hospitals do charge for this administration)	Full cost after 3 pints	First 3 pints of blood for non-residents and applicable coinsurance for administrative charges	Nothing
Non-inpatient Psychiatric Services	80% of Medicare approved charges after psychiatric reduction, if applicable	Psychiatric reduction and 20% of Medicare approved charges	Remaining Balance
Additional Benefits	Major Medical, the second component of Medicomp Three, provides additional coverage for eligible balances remaining after Medicare and Medicomp have processed claims. Major Medical benefits are paid at 100% of the allowable charge.		
Exclusions and Limitations	Services and supplies not covered by Medicare or Medicomp include but are not limited to: dental services, routine foot care, prescriptions drugs, eye glasses and hearing aids: service and supplies which are not medically necessary; and charges in excess of Medicare allowed charges. It is important to read and understand Article vi of your Medicomp Three Medicare Complementary Contract which describes in detail those services and supplies not covered by Medicomp.		

Medicare Prescription Drug Plan Summary

Full details can be found at the following link:
https://das.nh.gov/hr/documents/Retiree%20EGWP%20Benefit%20Overview%20Jan%202016.pdf

	RETAIL PHARMACY	MAIL ORDER PHARMACY
YOU WILL PAY	**$10** for each generic medication **$25** for each preferred brand-name medication **$40** for each non-preferred brand-name medication	**$10** for each generic medication **$50** for each preferred brand-name medication **$80** for each non-preferred brand-name medication
MAXIMUM OUT-OF-POCKET	**$750** per individual per calendar year **$1,500** per family per calendar year	
DAY SUPPLY LIMIT	Up to a **31-day** supply	Up to a **90-day** supply
CATASTROPHIC COVERAGE STAGE (2017 Amounts)	If you have not met your member out-of-pocket maximum of $750, but your yearly out-of-pocket drug costs exceed $4,950, you will pay the greater of 5% coinsurance or $3.30 for generic drugs / $8.25 for brand drugs	

Appendix F: Pension Data by Age

KEY DATA POINTS OF PENSION BY AGE DATA: AGE 65 AND OLDER
Handouts from February 8, 2016 House Bill 1591 & 1592 Work Session

All Retirees Age 65 and Older (Group I & Group II)	
Average Pension:	**$17,250**
Average pension for retirees age 90 and older:	$9,900
Average pension for retirees age 80 and older:	$13,100
Average pension for retirees age 70 and older:	$15,400
Median Pension:	**$13,980**
Median pension for retirees age 90 and older:	$8,400
Median pension for retirees age 80 and older:	$10,000
Median pension for retirees age 70 and older:	$12,300

Longevity: Age 65 and Older

7% have less than 10 years of service
44% have 10 to 19 years of service
28% have 20 to 29 years of service
21% have 30 or more years of service

90% have an annual pension $34,000 or less
67% have an annual pension $20,000 or less
34% have an annual pension $10,000 or less

Longevity: Annual pension of $10,000 or less and age 65 and older

14% have less than 10 years of service
34% have 10-11 years of service
44% have 12-19 years of service
9% have 20 or more years of service

KEY DATA POINTS OF PENSION BY AGE DATA: UNDER AGE 65
Handouts from February 8, 2016 House Bill 1591 & 1592 Work Session

All Retirees Under Age 65 (Group I & Group II)	
Average Pension:	**$26,680**
Median Pension:	**$23,160**

Longevity: Under Age 65

6% have less than 10 years of service
28% have 10 to 19 years of service
36% have 20 to 29 years of service
30% have 30 or more years of service

90% have an annual pension $50,000 or less
73% have an annual pension $34,000 or less
44% have an annual pension $20,000 or less
14% have an annual pension $10,000 or less

Longevity: Annual pension of $10,000 or less and under age 65

8% have less than 10 years of service
31% have 10-11 years of service
50% have 12-19 years of service
11% have 20 or more years of service

Appendix G: Age Distribution of Actives and Retirees at the State

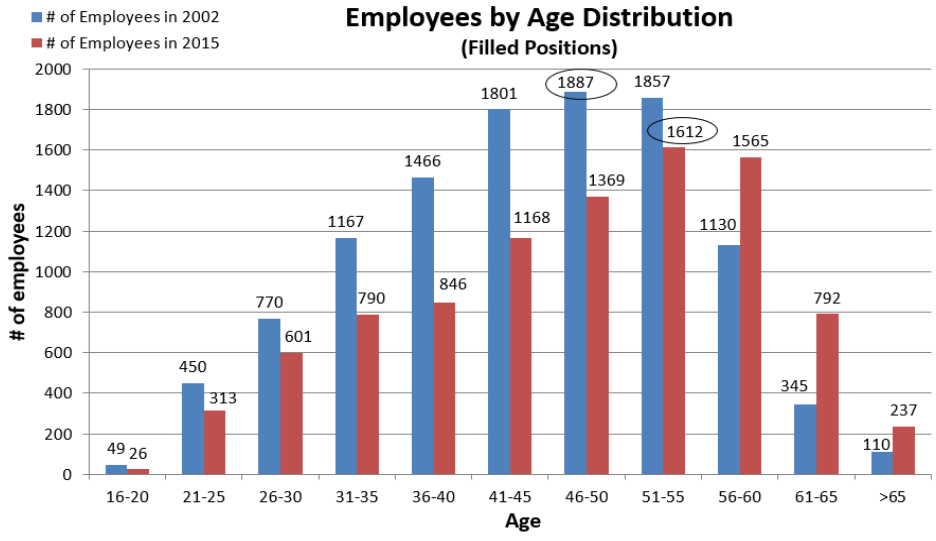
AGE DISTRIBUTION OF ACTIVE EMPLOYEES
December 2016

	Active Plans – Employees			
Age	**Male**	**Female**	**Total**	**% of Total**
0 – 50	2,528	2,694	5,222	53.2%
51 – 55	715	957	1,672	17.0%
56 – 60	701	931	1,632	16.6%
61	96	149	245	2.5%
62	105	138	243	2.5%
63	94	100	194	2.0%
64	73	94	167	1.7%
65	66	74	140	1.4%
66 – 70	120	134	254	2.6%
71 – 75	23	19	42	0.4%
76 – 80	5	2	7	0.1%
81 – 85	1	0	1	0.0%
Grand Total	**4,527**	**5,292**	**9,819**	**100.0%**

Source: Anthem December 2016 AEDW Warehouse

FIGURE 7: DISTRIUTION OF ACTIVE EMPLOYEES
2002 vs. 2015

In 2002, the largest employee age group was age 46-50.
In 2015, the largest employee age group was age 51-55.



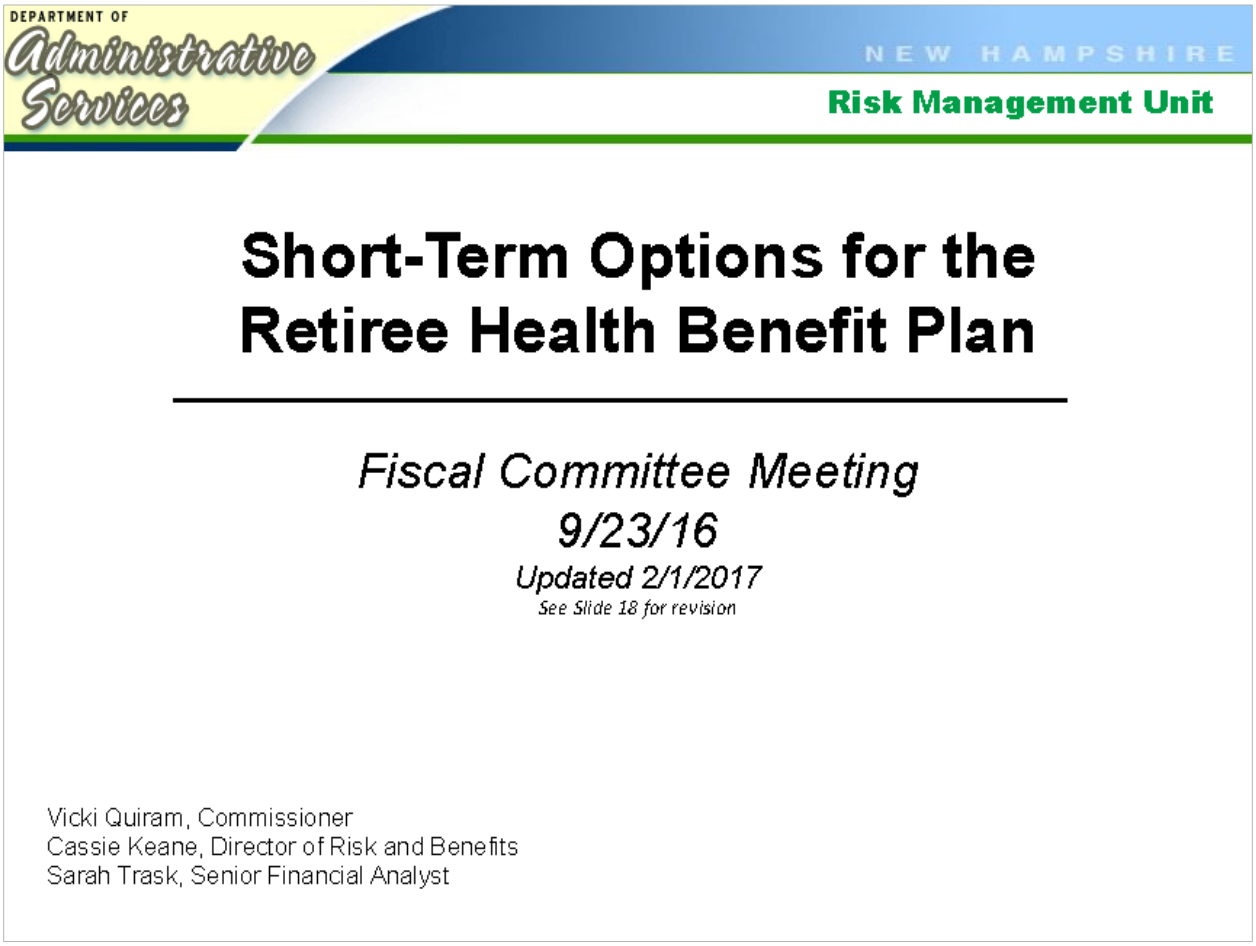
Division of Personnel 2015 Annual Report

AGE DISTRIBUTION OF RETIREES
December 2016

	Non-Medicare Plan				Medicare Plan			
	Total Member Count				Total Member Count			
Age	Male	Female	Count	% of Total	Male	Female	Count	% of Total
0 – 50	109	134	243	8.3%	8	15	23	0.2%
51 – 55	165	204	369	12.6%	8	31	39	0.4%
56 – 60	330	483	813	27.8%	39	66	105	1.1%
61	122	159	281	9.6%	5	18	23	0.2%
62	149	193	342	11.7%	14	27	41	0.4%
63	161	227	388	13.3%	16	23	39	0.4%
64	197	251	448	15.3%	20	22	42	0.5%
65	0	0	0	0.0%	237	301	538	5.8%
66 – 70	19	19	38	1.3%	1,310	1,612	2,922	31.4%
71 – 75	3	0	3	0.1%	1,000	1,226	2,226	23.9%
76 – 80	0	1	1	0.0%	640	773	1,413	15.2%
81 – 85	1	0	1	0.0%	412	553	965	10.4%
86 – 90	0	0	0	0.0%	214	376	590	6.3%
91 – 95	0	0	0	0.0%	90	183	273	2.9%
96 – 100	0	0	0	0.0%	11	39	50	0.5%
101 – 105	0	0	0	0.0%	-	9	9	0.1%
106 – 110	0	0	0	0.0%			0	0.0%
Grand Total	**1,256**	**1,671**	**2,927**	**100.0%**	**4,024**	**5,274**	**9,298**	**100.0%**

Source: Anthem December 2016 AEDW Warehouse

Appendix H: Short-Term Options for the Retiree Health - September 23, 2016 Fiscal Committee



DEPARTMENT OF Administrative Services

NEW HAMPSHIRE

Risk Management Unit

Today's Goals

- Review Short-Term Options to Mitigate the Increase in FY 18/19 Retiree Health Benefits Budget
- Focus on Calendar Year 2017 and the variety of currently available options:
  - < 65/Non-Medicare Premium Contribution
  - Medical Benefits: copays, deductibles and out-of-pocket expenses
  - Prescription Drug (RX) Benefits: copays, deductibles and out-of-pocket expenses
- Review example of how to achieve a savings goal

2

DEPARTMENT OF Administrative Services

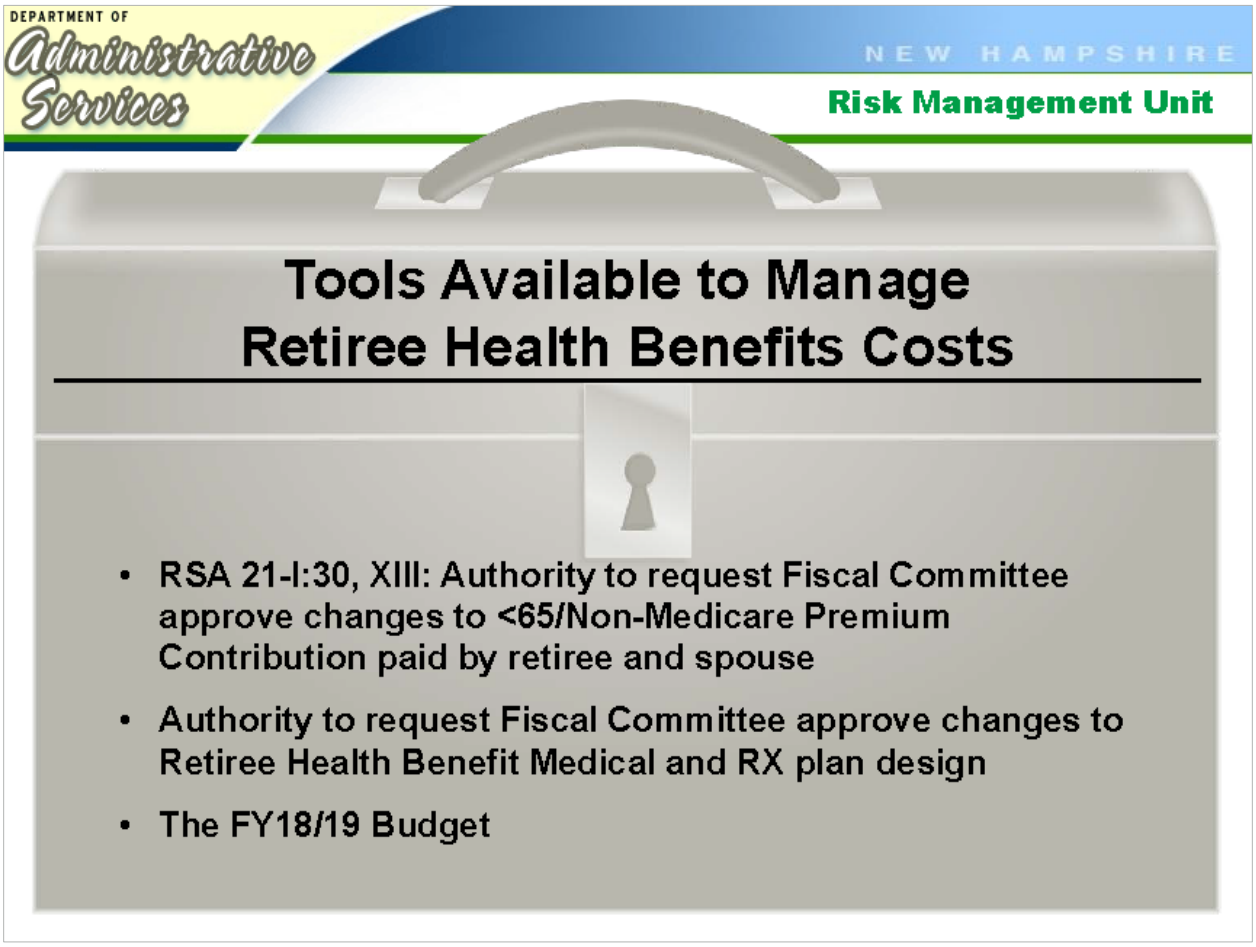
NEW HAMPSHIRE

Risk Management Unit

Retiree Health Long-Term Options

- Today's options do not include the Long-Term Study
- Examples of Long-Term Options
  - Defined Contribution
  - Eliminate Rx Medicare Part D EGWP ("Egg Whip" or Employer Group Waiver Program)
  - Eliminate Coverage for spouses based on hire date
  - Improve Retiree education on programs that save costs (Vitals SmartShopper (<65), Diabetes Prevention, Nutrition Counseling, Other)
  - Other

3


DEPARTMENT OF
Administrative Services
NEW HAMPSHIRE
Risk Management Unit
Tools Available to Manage Retiree Health Benefits Costs
• RSA 21-I:30, XIII: Authority to request Fiscal Committee approve changes to <65/Non-Medicare Premium Contribution paid by retiree and spouse
• Authority to request Fiscal Committee approve changes to Retiree Health Benefit Medical and RX plan design
• The FY18/19 Budget

DEPARTMENT OF Administrative Services

NEW HAMPSHIRE

Risk Management Unit

Retiree Health Benefits and the FY18/19 State Budget

	Current Budget/ Projected Need	Biennium Total	Available Tools
FY16 Budget	$69,832,000	$142,699,000	Surplus, reserves, increased premium contributions, and Rx changes
FY17 Budget	$72,867,000		
FY18	$81,708,000	$172,614,000	Increase Premium Contribution for <65/Non-Medicare Eligible, Rx and Medical changes, Budget
FY19	$90,906,000		
Biennium Difference		**$29,915,000**	

The current proposed FY18/19 Efficiency Budget includes an additional $18 million General Funds/$12 million Other Funds to meet the projected need.

5

DEPARTMENT OF Administrative Services

NEW HAMPSHIRE

Risk Management Unit

How Much Change in CY17?

- Goal: Best possible plan for retirees within Final FY18/19 budget allocation
- Projected Need – Budget = Required Plan Changes ($0 - $30m)
- Unknown variable: Final FY18/19 Retiree Health Budget

Example

	Biennium Year 1	Biennium Year 2
FY18/19 Projected Need	$81,708,000	$90,906,000
FY16/17 Budget	$69,832,000	$72,867,000
Increase per year	$11,876,000	$18,039,000

- *KEY: The Benefit of Time*
  - The earlier Premium Contribution and/or Medical and Rx Plan Design changes are implemented, the greater the State's cost savings across the biennium.
  - The earlier changes are made, the less severe they are on the retiree.

6

DEPARTMENT OF Administrative Services

NEW HAMPSHIRE

Risk Management Unit

Timing of Changes

- Premium Contribution changes for <65/Non-Medicare retirees can occur anytime during a calendar year with adequate time for DAS to implement those changes and for retirees to plan for increased monthly premium contribution payments.
- Medical and Rx Plan Design changes (member cost share: copayments, deductibles, coinsurance and maximum-out-of-pocket expenses) are implemented on a Calendar Year (January 1-December 31) basis.
  - Medicare rules require notice to Over 65/Medicare retirees. This year's deadline is no later than 10/14/16 to provide sufficient time to provide notice to retirees.

7

DEPARTMENT OF Administrative Services

NEW HAMPSHIRE

Risk Management Unit

Retiree Paid Premium Contributions

	Premium Contribution to the State	Premium Contribution to Medicare
Non-Medicare Eligible Retirees (<65)	17.5% ($159.94 in CY2016)	N/A
Medicare Eligible Retirees (>65)	None	Part B Monthly Premium* $104.90 - $121.80 (CY2016)

* The standard Medicare Part B Premium is $121.80 per month in CY16 and was $104.90 in CY15. Those who paid $104.90 in CY2015 through a deduction from their Social Security check still pay $104.90 in CY2016 based on laws that prohibit an increased deduction if the Social Security amount is not raised. Retirees may pay $121.80, $104.90, or an amount determined by their annual income if they are a high income beneficiary.

8

DEPARTMENT OF Administrative Services

NEW HAMPSHIRE

Risk Management Unit

Premium Contribution Amounts

- **RSA 21-I:30 The Fiscal Committee has the authority to approve changes to the Premium Contribution amounts paid by <65/Non-Medicare Retirees (3,100 people)**
  - 2016 Legislation to implement a premium contribution for Over 65/Medicare retirees (9,100 people) failed

- **<65/Non-Medicare Premium Contribution History:**
  - 7/1/2009: First premium contribution: $65/month
  - 7/1/2011: $65 per month increased to 12.5% of premium ($113.80)
  - 1/1/2016: 12.5% ($113.86 in 2015) increased to 17.5% of premium ($159.94 in 2016)

9

DEPARTMENT OF Administrative Services

NEW HAMPSHIRE

Risk Management Unit

<65/Non-Medicare Retirees

Premium Contribution Options

CY16 Monthly Premium and PC	$913.95 (Retiree current PC at 17.5% = $159.94)
Projected FY 18 Monthly Premium and PC	$1,006 (Retiree estimated PC at 17.5%= $176)
Projected FY 19 Monthly Premium and PC	$1,079 (Retiree estimated PC at 17.5%= $188)

PC as a percentage	Estimated Avg. monthly PC as a flat dollar amount	Estimated *Avg. increase in monthly PC as a dollar amount*	Estimated Total projected increase in PC revenue in 24 months	PC Revenue	Other Funds*	General Fund Revenue*	Total budget increase from FY16/17
17.5%	$182	*$22*	Current	-	$12M	$18M	$30M
18.5%	$190	*$30*	$746,400	$746K	$11.8M	$17.5M	$30M
20%	$210	*$50*	$1,866,400	$1.9M	$11.3M	$16.8M	$30M
25%	$260	*$100*	$5,599,400	$5.6M	$9.7M	$14.7M	$30M
27.5%	$286	*$126*	$7,466,200	$7.5M	$8.9M	$13.6M	$30M
30%	$315	*$155*	$9,332,400	$9.3M	$8.1M	$12.6M	$30M
35%	$360	*$200*	$13,065,500	$13M	$6.5M	$10.5M	$30M
37.5%	$390	*$230*	$14,932,000	$14.9M	$5.7M	$9.4M	$30M
40%	$420	*$260*	$16,798,500	$16.8M	$4.8M	$8.4M	$30M
45%	$470	*$310*	$20,531,600	$20.5M	$3.3M	$6.2M	$30M
50%	$520	*$360*	$24,264,900	$24.3M	$1.6M	$4.1M	$30M
58%	$605	*$445*	$30,237,800	$30M	-	-	$30M

For every 1% increase in the retiree premium contribution, approx. $750K more is collected in premium contribution revenue **over the FY18/19 biennium (assuming a flat under 65 enrollment), decreasing the general funds by $425K (57%) and self-funded agency funds by $325K (Other Funds) (43%).*

10

DEPARTMENT OF Administrative Services

NEW HAMPSHIRE

Risk Management Unit

<65/Non-Medicare Eligible Medical Plan Options
Office Visit Copayments

	Retiree <65 Medical Plan Design Alternatives	Savings Factor (% of Medical Claims)	Estimated Savings FY 2017 (six months)	FY 2018 (full year)	FY 2019 (full year)	Total (30 months)
	Increase Office Visit Copayments					
CURRENT	$10 for PCP and $30 for Specialist					
1A	Increase to $15 for PCP and maintain $30 for Specialist	0.45%	$61,000	$127,000	$133,000	$321,000
1B	Increase to $20 for PCP and $35 for Specialist	0.75%	$102,000	$211,000	$222,000	$535,000
1C	Increase to $20 for PCP and $40 for Specialist	0.85%	$115,000	$240,000	$252,000	$607,000

Actives Copayments: $15 PCP / $30 Specialist Office Visit

11

DEPARTMENT OF Administrative Services

NEW HAMPSHIRE

Risk Management Unit

<65/Non-Medicare Eligible Medical Plan Options

Deductible and Out-of-Pocket Maximum

(+ High Cost Radiology to Deductible)

	Retiree <65 Medical Plan Design Alternatives	Savings Factor (% of Medical Claims)	Estimated Savings FY 2017 (six months)	FY 2018 (full year)	FY 2019 (full year)	Total (30 months)
Deductible and Out-of-Pocket Maximum (OOPM) Changes Alternatives include changing High Cost Radiology to be subject to deductible (removing $150 copayment)						
CURRENT	In-Network: $500 individual / $1,000 family deductible and $1,000 individual / $2,000 family OOPM Out-of-Network: $650 individual / $1,350 family deductible and $2,000 individual / $4,000 family OOPM					
2	In-Network: $750 individual / $1,500 family deductible and $1,250 individual / $2,500 family OOPM Out-of-Network: $1,500 individual / $3,000 family deductible and $2,500 individual / $5,000 family OOPM	2.70%	$367,000	$761,000	$799,000	$1,927,000
3	In-Network: $1,000 individual / $2,000 family deductible and $1,500 individual / $3,000 family OOPM Out-of-Network: $2,000 individual / $4,000 family deductible and $3,000 individual / $6,000 family OOPM	4.90%	$666,000	$1,381,000	$1,450,000	$3,497,000
4	In-Network: $1,500 individual / $3,000 family deductible and $2,000 individual / $4,000 family OOPM Out-of-Network: $2,500 individual / $5,000 family deductible and $4,000 individual / $8,000 family OOPM	8.50%	$1,155,000	$2,396,000	$2,516,000	$6,067,000
5	In-Network: $2,000 individual / $4,000 family deductible and $2,500 individual / $5,000 family OOPM Out-of-Network: $2,500 individual / $5,000 family deductible and $4,000 individual / $8,000 family OOPM	11.30%	$1,535,000	$3,185,000	$3,344,000	$8,064,000

12

DEPARTMENT OF Administrative Services

NEW HAMPSHIRE

Risk Management Unit

<65/Non-Medicare Eligible Medical Plan Options

Deductible, Coinsurance and Out-of-Pocket Maximum

(+ High Cost Radiology to Deductible)

	Retiree <65 Medical Plan Design Alternatives	Savings Factor (% of Medical Claims)	Estimated Savings FY 2017 (six months)	FY 2018 (full year)	FY 2019 (full year)	Total (30 months)
CURRENT	In-Network: $500 individual / $1,000 family deductible and $1,000 individual / $2,000 family OOPM Out-of-Network: $650 individual / $1,350 family deductible and $2,000 individual / $4,000 family OOPM					
Deductible, Coinsurance, and Out-of-Pocket Maximum (OOPM) Changes Implement an in-network 10% coinsurance for services subject to the deductible Alternatives include changing High Cost Radiology to be subject to deductible (removing $150 copayment)						
6	In-Network: $750 individual / $1,500 family deductible and $2,250 individual / $4,500 family OOPM Out-of-Network: $1,500 individual / $3,000 family deductible and $3,500 individual / $7,000 family OOPM	6.10%	$829,000	$1,719,000	$1,805,000	$4,353,000
7	In-Network: $1,000 individual / $2,000 family deductible and $2,500 individual / $5,000 family OOPM Out-of-Network: $2,000 individual / $4,000 family deductible and $3,500 individual / $7,000 family OOPM	8.10%	$1,100,000	$2,283,000	$2,397,000	$5,780,000
8	In-Network: $2,000 individual / $4,000 family deductible and $3,500 individual / $7,000 family OOPM Out-of-Network: $2,500 individual / $5,000 family deductible and $4,000 individual / $8,000 family OOPM	13.70%	$1,861,000	$3,861,000	$4,054,000	$9,776,000

13

DEPARTMENT OF Administrative Services

NEW HAMPSHIRE

Risk Management Unit

>65/Medicare Eligible Medical Plan Design Options

Part A Deductible

	Retiree 65+ Medical Plan Design Alternatives	Savings Factor (% of Medical Claims)	Estimated Savings FY 2017 (six months)	FY 2018 (full year)	FY 2019 (full year)	Total (30 months)
CURRENT	Medicare Part A (Inpatient Hospital and Skilled Nursing Facility Benefits): Member pays nothing Medicare Part B (Physician Services, Hospital Outpatient, and Other Covered Services): Member pays $166 annual deductible					
1	Medicare Part A: Member pays $300 deductible Medicare Part B: Member pays $166 deductible (no change)	2.70%	$213,000	$436,000	$467,000	$1,116,000
1B	Medicare Part A: Member pays $350 deductible Medicare Part B: Member pays $166 deductible (no change)	3.25%	$257,000	$525,000	$563,000	$1,345,000
2	Medicare Part A: Member pays $500 deductible Medicare Part B: Member pays $166 deductible (no change)	5.25%	$415,000	$849,000	$909,000	$2,173,000
3	Medicare Part A: Member pays $750 deductible Medicare Part B: Member pays $166 deductible (no change)	8.00%	$632,000	$1,293,000	$1,385,000	$3,310,000
4	Medicare Part A: Member pays $1,288 deductible Medicare Part B: Member pays $166 deductible (no change)	13.70%	$1,083,000	$2,214,000	$2,372,000	$5,669,000

14

DEPARTMENT OF Administrative Services

NEW HAMPSHIRE

Risk Management Unit

>65/Medicare Eligible Medical Plan Design Options

Part A Deductible and/or Copayment Structure

	Retiree 65+ Medical Plan Design Alternatives	Savings Factor (% of Medical Claims)	Estimated Savings FY 2017 (six months)	FY 2018 (full year)	FY 2019 (full year)	Total (30 months)
CURRENT	Medicare Part A (Inpatient Hospital and Skilled Nursing Facility Benefits): Member pays nothing Medicare Part B (Physician Services, Hospital Outpatient, and Other Covered Services): Member pays $166 annual deductible					
5	Member pays $166 Part B deductible (no change) Implement $20 Office Visit Copayment Implement $50 Emergency Room Copayment	9.05%	$715,000	$1,463,000	$1,567,000	$3,745,000
5B	Member pays $166 Part B deductible (no change) Implement $20 Office Visit Copayment Implement $150 Emergency Room Copayment	9.75%	$771,000	$1,576,000	$1,688,000	$4,035,000
5C	Medicare Part A: Member pays $350 deductible Medicare Part B: Member pays $166 deductible (no change) Implement $20 Office Visit Copayment Implement $150 Emergency Room Copayment	13.00%	$1,028,000	$2,101,000	$2,251,000	$5,380,000

15

DEPARTMENT OF Administrative Services

NEW HAMPSHIRE

Risk Management Unit

All Retirees

RX Copay and Maximum Out-of-Pocket Options

Rx Plan Design Alternatives		Retiree Plan	Savings Factor (%of Rx Claims)	Estimated Savings FY 2017 (six months)	FY 2018 (full year)	FY 2019 (full year)	Total (30 months)
CURRENT	**Rx Copayments and Maximum Out-of-Pocket (MOOP)** *Current Plan Design (generic / preferred brand / non-preferred brand)* *Retail Copayments: $10 / $25 / $40* *Mail Copayments: $10 / $50 / $80* *MOOP: $750 individual / $1,500 family*			**Active Copayments & MOOP:** Retail $10/$25/$40; Mail $1/$40/$70 MOOP: $750 Individual/$1,500 Family			
1	Retail Copayments: $15 / $30 / $45 Mail Copayments: $15 / $60 / $90 MOOP: $750 individual / $1,500 family	Retiree <65 Plan	1.3%	$43,000	$101,000	$116,000	$260,000
		Retiree 65+ Plan	2.9%	$318,000	$738,000	$885,000	$1,941,000
		All Retirees	**2.5%**	**$361,000**	**$839,000**	**$1,001,000**	**$2,201,000**
2A	Retail Copayments: $15 / $30 / $45 Mail Copayments: $30 / $60 / $90 MOOP: $750 individual / $1,500 family	Retiree <65 Plan	2.9%	$93,000	$217,000	$251,000	$561,000
		Retiree 65+ Plan	5.1%	$567,000	$1,318,000	$1,582,000	$3,467,000
		All Retirees	**4.6%**	**$660,000**	**$1,535,000**	**$1,833,000**	**$4,026,000**
2B	Retail Copayments: $15 / $30 / $45 Mail Copayments: $30 / $60 / $90 MOOP: $1,000 individual / $2,000 family	Retiree <65 Plan	3.7%	$120,000	$277,000	$321,000	$718,000
		Retiree 65+ Plan	7.5%	$824,000	$1,914,000	$2,296,000	$5,034,000
		All Retirees	**6.6%**	**$944,000**	**$2,191,000**	**$2,617,000**	**$5,752,000**
3	Retail Copayments: $20 / $35 / $50 Mail Copayments: $20 / $70 / $100 MOOP: $1,000 individual / $2,000 family	Retiree <65 Plan	3.6%	$117,000	$273,000	$315,000	$705,000
		Retiree 65+ Plan	7.0%	$768,000	$1,785,000	$2,142,000	$4,695,000
		All Retirees	**6.2%**	**$885,000**	**$2,058,000**	**$2,457,000**	**$5,400,000**
4	Retail Copayments: $20 / $35 / $50 Mail Copayments: $40 / $70 / $100 MOOP: $1,000 individual / $2,000 family	Retiree <65 Plan	5.3%	$172,000	$399,000	$462,000	$1,033,000
		Retiree 65+ Plan	10.4%	$1,142,000	$2,653,000	$3,184,000	$6,979,000
		All Retirees	**9.2%**	**$1,314,000**	**$3,052,000**	**$3,646,000**	**$8,012,000**
5	Retail Copayments: $20 / $35 / $50 Mail Copayments: $20 / $70 / $150 MOOP: $1,250 individual / $2,500 family	Retiree <65 Plan	4.3%	$140,000	$324,000	$375,000	$839,000
		Retiree 65+ Plan	8.1%	$893,000	$2,075,000	$2,491,000	$5,459,000
		All Retirees	**7.2%**	**$1,033,000**	**$2,399,000**	**$2,866,000**	**$6,298,000**
6	Retail Copayments: $20 / $35 / $50 Mail Copayments: $40 / $70 / $150 MOOP: $1,250 individual / $2,500 family	Retiree <65 Plan	6.1%	$199,000	$462,000	$534,000	$1,195,000
		Retiree 65+ Plan	11.9%	$1,314,000	$3,053,000	$3,664,000	$8,031,000
		All Retirees	**10.6%**	**$1,513,000**	**$3,515,000**	**$4,198,000**	**$9,226,000**

16

DEPARTMENT OF Administrative Services

NEW HAMPSHIRE

Risk Management Unit

All Retirees: Introduce RX Deductible

Rx Plan Design Alternatives		Retiree Plan	Savings Factor (%of Rx Claims)	Estimated Savings FY 2017 (six months)	FY 2018 (full year)	FY 2019 (full year)	Total (30 months)
CURRENT	**Rx Copayments and Maximum Out-of-Pocket (MOOP)** *Current Plan Design (generic / preferred brand / non-preferred brand)* *Retail Copayments: $10 / $25 / $40 – Mail Copayments: $10 / $50 / $80 – MOOP: $750 individual / $1,500 family*						
Introduce an Annual Deductible - Maintain Current Copayments and MOOP and implement an annual deductible that applies prior to copayments							
7A	$25 Annual Deductible	Retiree <65 Plan	0.7%	$23,000	$46,000	$46,000	$115,000
		Retiree 65+ Plan	0.9%	$96,000	$200,000	$208,000	$504,000
		All Retirees	**0.7%**	**$119,000**	**$246,000**	**$254,000**	**$619,000**
7B	$50 Annual Deductible	Retiree <65 Plan	1.4%	$44,000	$88,000	$88,000	$220,000
		Retiree 65+ Plan	1.7%	$192,000	$399,000	$415,000	$1,006,000
		All Retirees	**1.5%**	**$236,000**	**$487,000**	**$503,000**	**$1,226,000**
7C	$75 Annual Deductible	Retiree <65 Plan	2.0%	$65,000	$130,000	$130,000	$325,000
		Retiree 65+ Plan	2.6%	$285,000	$593,000	$617,000	$1,495,000
		All Retirees	**2.2%**	**$350,000**	**$723,000**	**$747,000**	**$1,820,000**
7D	$100 Annual Deductible	Retiree <65 Plan	2.6%	$84,000	$168,000	$168,000	$420,000
		Retiree 65+ Plan	3.4%	$377,000	$784,000	$815,000	$1,976,000
		All Retirees	**2.9%**	**$461,000**	**$952,000**	**$983,000**	**$2,396,000**
7E	$125 Annual Deductible	Retiree <65 Plan	3.2%	$103,000	$211,000	$218,000	$532,000
		Retiree 65+ Plan	4.2%	$467,000	$995,000	$1,068,000	$2,530,000
		All Retirees	**3.6%**	**$570,000**	**$1,206,000**	**$1,286,000**	**$3,062,000**
7F	$150 Annual Deductible	Retiree <65 Plan	3.7%	$120,000	$246,000	$254,000	$620,000
		Retiree 65+ Plan	5.0%	$555,000	$1,182,000	$1,269,000	$3,006,000
		All Retirees	**4.3%**	**$675,000**	**$1,428,000**	**$1,523,000**	**$3,626,000**
7G	$175 Annual Deductible	Retiree <65 Plan	4.2%	$137,000	$281,000	$290,000	$708,000
		Retiree 65+ Plan	5.1%	$566,000	$1,206,000	$1,295,000	$3,067,000
		All Retirees	**4.5%**	**$703,000**	**$1,487,000**	**$1,585,000**	**$3,775,000**
7H	$200 Annual Deductible	Retiree <65 Plan	4.7%	$153,000	$313,000	$323,000	$789,000
		Retiree 65+ Plan	5.9%	$646,000	$1,376,000	$1,478,000	$3,500,000
		All Retirees	**5.1%**	**$799,000**	**$1,689,000**	**$1,801,000**	**$4,289,000**
7I	$225 Annual Deductible	Retiree <65 Plan	5.2%	$168,000	$344,000	$355,000	$867,000
		Retiree 65+ Plan	6.6%	$724,000	$1,542,000	$1,656,000	$3,922,000
		All Retirees	**5.7%**	**$892,000**	**$1,886,000**	**$2,011,000**	**$4,789,000**
7J	$250 Annual Deductible	Retiree <65 Plan	5.6%	$182,000	$373,000	$385,000	$940,000
		Retiree 65+ Plan	7.2%	$799,000	$1,702,000	$1,828,000	$4,329,000
		All Retirees	**6.3%**	**$981,000**	**$2,075,000**	**$2,213,000**	**$5,269,000**

17

DEPARTMENT OF Administrative Services

NEW HAMPSHIRE

Risk Management Unit

All Retirees: Miscellaneous RX Options

	Rx Plan Design Alternatives	Retiree Plan	Savings Factor (% of Rx Claims)	Estimated Savings FY 2017 (six months)	FY 2018 (full year)	FY 2019 (full year)	Total (30 months)
CURRENT	**Rx Copayments and Maximum Out-of-Pocket (MOOP)** *Current Plan Design (generic / preferred brand / non-preferred brand)* *Retail Copayments: $10 / $25 / $40* *Mail Copayments: $10 / $50 / $80* *MOOP: $750 individual / $1,500 family*						
Additional Rx Plan Options - Maintain Current Copayments and MOOP, except implement the changes noted below							
8	Specialty Coinsurance of 10% per script to maximum of $100 at retail and $200 at mail	Retiree <65 Plan	0.5%	$16,000	$32,000	$32,000	$80,000
		Retiree 65+ Plan	3.5%	$390,000	$907,000	$1,088,000	$2,385,000
		All Retirees	**2.8%**	**$406,000**	**$939,000**	**$1,120,000**	**$2,465,000**
9	Implement a closed formulary (non-preferred drugs not covered) and only provide coverage for Part D eligible drugs	**Retiree 65+ Plan**	11.1%	$1,229,000	$2,856,000	$3,427,000	$7,512,000
10	Only provide coverage for generic drugs while retiree is in the Part D coverage gap	**Retiree 65+ Plan**	13.5%	$1,485,000	$3,451,000	$4,141,000	$9,077,000

Updated 2/1/2017: In the 9/23/16 presentation, this slide included Option #11 that showed the potential savings associated with excluding coverage for drugs available Over-the-Counter (OTC). Upon further review, Option #11 has been deleted. Continued analysis determined that the vast majority of drugs included in the initial estimate required a prescription because they were for higher strengths, or dosage amounts, than are available OTC.

18

DEPARTMENT OF Administrative Services

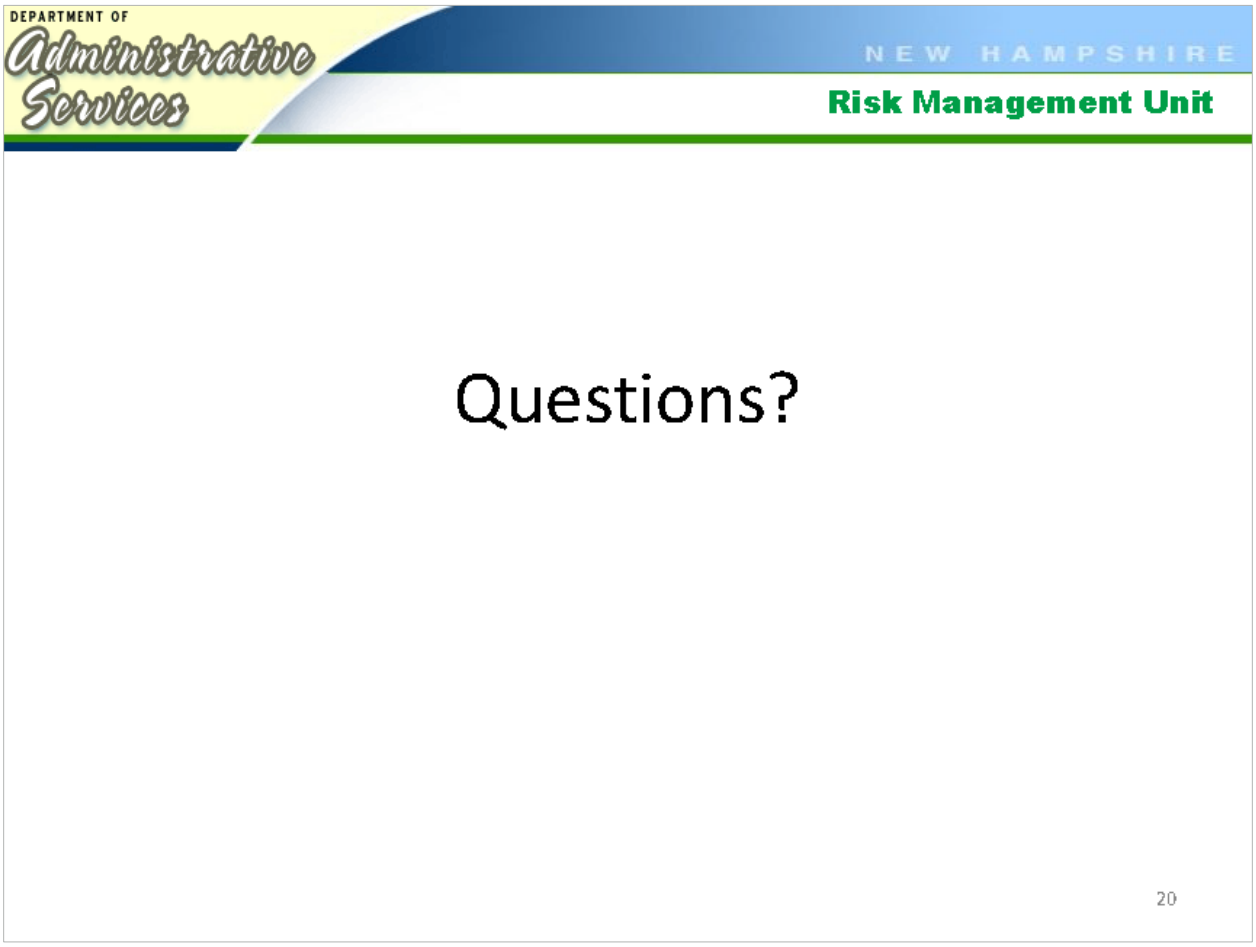
NEW HAMPSHIRE

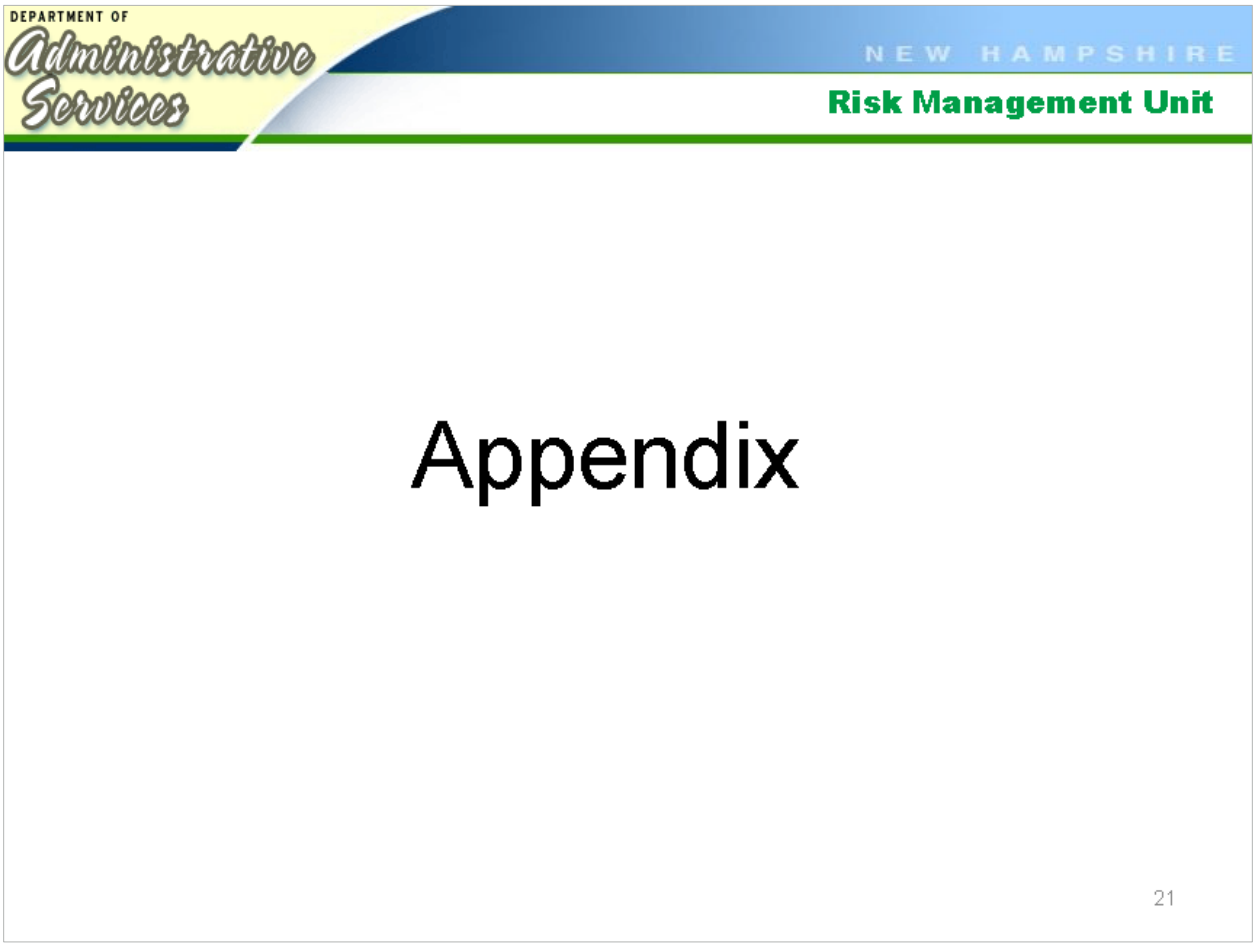
Risk Management Unit

Examples of Options to Save Approximately $5M

Reference Slide/#	OPTIONS	30-Month Savings
Slide 10	Increase Non-Medicare Eligible Premium Contribution (PC) to 25% effective 1/1/17	$5.6M
Slide 17, #7J	Implement a $250 Annual Deductible for the Rx Plan (All Retirees)	$5.3M
Slide 14, #4	Implement a Medicare Part A Deductible of $1,288	$5.7M
Slide 15, #5C	Implement a $350 Medicare Part A Deductible, $20 Office Visit Copayment, $150 ER Copayment	$5.4M
Slide 10; Slide 17, #7E; Slide 11, #1A	Increase Non-Medicare Eligible PC to 20%; Implement a $125 Annual Deductible for the Rx Plan; Non-Medicare Eligible Medical Copays to $15 for PCP and $30 Specialist	$1.9M+$3.1M+$300K = $5.3M

19


DEPARTMENT OF
Administrative Services
NEW HAMPSHIRE
Risk Management Unit
Questions?
20


DEPARTMENT OF
Administrative Services
NEW HAMPSHIRE
Risk Management Unit
Appendix
21

DEPARTMENT OF Administrative Services

NEW HAMPSHIRE

Risk Management Unit

Number of State of NH Retirees

- **<65/Non-Medicare Retirees (Under 65)**
  - January 2016 – 3,100
  - *Projected* Jan'18 (FY 18) - 3,100
  - *Projected* Jan'19 (FY19)- 3,100
- **>65/Medicare Retirees (Over 65)**
  - January 2016 – 8,975
  - *Projected* Jan'18 (FY 18) – 9,700
  - *Projected* Jan'19 (FY19)– 10,100

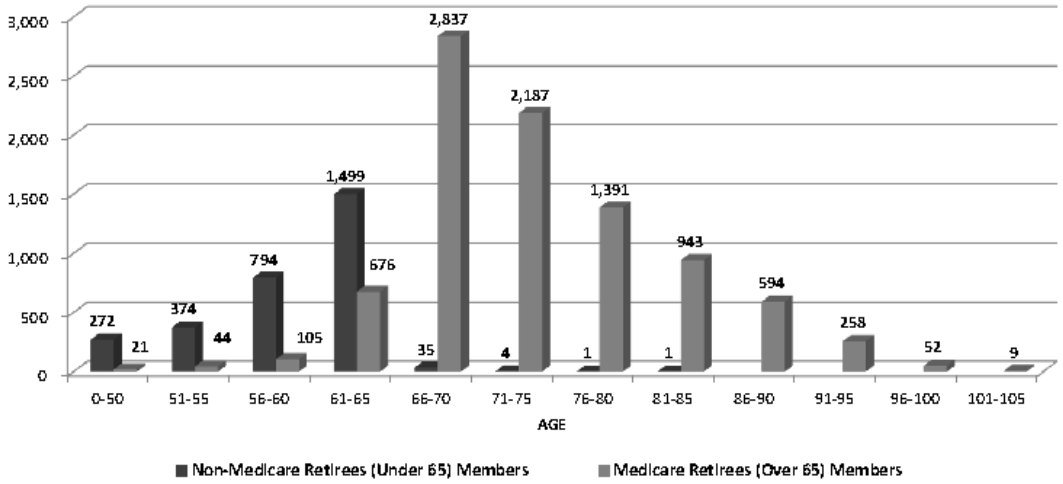
22

DEPARTMENT OF Administrative Services

NEW HAMPSHIRE

Risk Management Unit

Ages of State of NH Retirees



5,440 (45%) members over age 70	*1,857 (15%) members over age 80*	*319 (3%) members over age 90*

Source: Anthem - June 2016

23

DEPARTMENT OF Administrative Services

NEW HAMPSHIRE

Risk Management Unit

Retirees and Years of State Service Summary Chart

Years of Service	% of State Retirees
Less than 10 years	7%
10 to 19 years	40%
20 to 29 years	30%
30 years and greater	23%

Based on NHFIRST plan subscriber data and NHRS pension data as of February 2016

24

DEPARTMENT OF Administrative Services

NEW HAMPSHIRE

Risk Management Unit

Over 65 Retiree: Pension and Longevity*

- **All Retirees age 65 and Older (Group I & Group II)**
  - Average Pension: $17,250
  - Median Pension: $13,980
  - 90% have an annual pension $34,000 or less
  - 67% have an annual pension $20,000 or less
  - 34% have an annual pension $10,000 or less
- **State Service Longevity**
  - Longevity: Age 65 and Older
    - 7% have less than 10 years of service
    - 44% have 10 to 19 years of service
    - 28% have 20 to 29 years of service
    - 21% have 30 or more years of service
  - Longevity: 34% annual pension of $10,000 or less and age 65 and older
    - 14% have less than 10 years of service
    - 34% have 10-11 years of service
    - 44% have 12-19 years of service
    - 9% have 20 or more years of service

Based on NHFIRST plan subscriber data and NHRS pension data as of February 2016

25

DEPARTMENT OF Administrative Services

NEW HAMPSHIRE

Risk Management Unit

Under 65 Retiree: Pension and Longevity (Cont.)

- **All Retirees Under Age 65 (Group I & Group II)**
  - Average Pension: $26,680
  - Median Pension: $23,160
  - 90% have an annual pension $50,000 or less
  - 73% have an annual pension $34,000 or less
  - 44% have an annual pension $20,000 or less
  - 14% have an annual pension $10,000 or less
- **State Service Longevity**
  - **Longevity: Under Age 65**
    - 6% have less than 10 years of service
    - 28% have 10 to 19 years of service
    - 36% have 20 to 29 years of service
    - 30% have 30 or more years of service
  - **Longevity: 14% annual pension of $10,000 or less and under age 65**
    - 8% have less than 10 years of service
    - 31% have 10-11 years of service
    - 50% have 12-19 years of service
    - 11% have 20 or more years of service

**Based on NHRS pension data as of February 2016*

26