INTRODUCTION AND BACKGROUND

Bolton Offutt Donovan, Inc. (BOD) was retained by the Baltimore Efficiency and Economy Foundation, Inc. (BEEF) to conduct a review and evaluation of the health care benefits provided by the City of Baltimore (City) to its employees and retirees. BEEF listed three specific areas to be addressed as follows:

1. How does the City's health care benefits package for employees and for retirees compare (in terms of the benefit types, benefit levels and costs to employer and employee/retiree) to the benefits packages of other public and private employers, and in particular with those offered by Anne Arundel, Baltimore, Montgomery and Prince George's Counties in Maryland, with other large employers in the Baltimore-Washington region and with Washington, DC and the City of Philadelphia?
2. How does a comparison of overall compensation with those other public and private employers differ from and/or change the importance of the comparison of health care benefits?
3. If Baltimore City's employee or retiree benefits (especially health care benefits) deviate significantly (in types, levels or costs) from those entities with which Baltimore's benefits are compared, what are the specific major elements or components of Baltimore City's benefits package that cause the deviation?

STUDY PROCEDURE

A number of activities were undertaken by BOD to conduct the study and form conclusions and recommendations. Those activities included the following:

- Health Benefits Survey – a comprehensive survey document (included as Addendum A) was prepared and sent to a number of cities, counties and private employers over the signature of Jesse E. Hoskins, City Personnel Director. Surveys were sent to the following:
    - City of Boston, MA
    - City of Richmond, VA
    - City of Philadelphia, PA
    - City of Pittsburg, PA
    - City of St. Louis, MO
    - City of Cleveland, OH
    - District of Columbia
    - Baltimore County, Maryland
    - Montgomery County, Maryland
    - Prince George's County, Maryland
    - Baltimore Gas & Electric Company
    - Black & Decker US Inc.
    - Bell Atlantic Corporation
    - Johns Hopkins Health Systems
    - Potomac Electric Power Company

BOD conducted follow up contacts by telephone and e-mail to get as many surveys completed as possible. We received full or partial responses from the following:

- City of Boston, MA
- City of Richmond, VA
- City of Philadelphia, PA
- City of St. Louis, MO
- District of Columbia
- Baltimore County, Maryland
- Montgomery County, Maryland
- Prince George's County, Maryland
- Johns Hopkins Health Systems

It should be noted at this time that the School System employees in the City are presently included under the City plans and administration. This is not always the case with the survey group. A number of entities have separate plans and administration of school systems benefits. We attempted to get separate school systems information where this situation occurred. The following survey respondents maintain separate school system benefits:

- City of Richmond, VA
- City of Philadelphia, PA
- City of St. Louis, MO
- District of Columbia
- Baltimore County, Maryland
- Montgomery County, Maryland

- Prince George's County, Maryland

Baltimore County, Maryland was the only separate school system that responded to the survey with meaningful data. While we would have liked more responses to the survey, we feel we have sufficient information to address the issues raised by BEEF.

- Compensation Survey – The public sector survey group was also asked to respond to a separate compensation survey (included as Addendum B). This survey sought information on benchmark jobs specific to public sector employers. The purpose of the compensation survey was to determine if differences in compensation might correlate to differences in health benefit levels and costs. The following entities responded to the compensation survey in whole or in part:

  - City of Boston, MA
  - City of Richmond, VA
  - City of Philadelphia, PA
  - City of St. Louis, MO
  - District of Columbia
  - Baltimore County, Maryland
  - Montgomery County, Maryland

  The Compensation Survey was not intended to be a stand alone analysis of the City's compensation practices. Its goal was to shed light, if possible, on any benefits differences among public sector employers. As noted in the Compensation section of this report, the linkage between benefit levels and pay practices is well established in the public sector. Our purpose was not to support or criticize that linkage but to allow the reader to recognize differences if they

exist. It should also be kept in mind that we compare direct compensation only. Other benefits such as retirement, annual leave and other time off would have to examined as well to come to a meaningful conclusion on linkage.

- Information/Data Gathering – Data requests were prepared for the City and its vendors and consultants involved with health care coverages. Questions and clarification issues were directed to City personnel for explanation and discussion. City personnel were cooperative and responsive throughout the process. We have relied on the City and its vendors to supply data and information for this study. We have further relied on the accuracy of those data in preparing this report. We have not independently verified information.
- BOD Experience – BOD has extensive public sector experience as part of its ongoing consulting practice. This experience was used along with other activities mentioned to form the basis for conclusions and recommendations.
- Senior Management Questionnaire – A questionnaire for City senior management personnel was prepared by BOD and distributed by the Director of Personnel. The questionnaire (included as Addendum 3) was designed to gauge management perceptions on the adequacy and cost of health benefits. It was not a critical part of the Study and did not impact overall conclusions or recommendations. Fifteen questionnaires were distributed and six responses were received.

REPORT ORGANIZATION

The report is organized to deal with the three areas of study indicated by BEEF and listed previously. The first section will address the survey of other

employers and how they compare with the City's plans and practices. Besides the survey information, this section will draw on BOD's experience in its public and private sector benefits practice. Other published survey information was also used to round out the picture of City benefits' practices versus other employers. BOD's comments, conclusions and recommendations are included in each section as well as accumulated in an executive summary.

The second section reviews and comments on the compensation information gathered from other public sector employers. The purpose of gathering compensation information was to determine if there might be some correlation between levels of benefits provided and costs charged to employees vis a vis compensation levels. Public sector officials in general have often maintained that high benefit levels make up for lower compensation levels. The compensation survey done as part of this study is meant to address that issue on a summary level basis.

While we recognize the issue and its historic validity, we do not support maintaining its application. Compensation inadequacies or shortfalls should be addressed specifically. Benefit issues likewise should be addressed specifically. It is impossible to adjust either compensation or benefits on an ongoing basis to completely cover lower or higher levels in one or the other.

EXECUTIVE SUMMARY

OBSERVATIONS AND CONCLUSIONS

- The City pays too much for most of its healthcare because it pays too high a share of the cost for actives and retirees and because its most popular health plan lacks meaningful cost control mechanisms. Paying significantly less will require some fundamental changes to plan structure and employee/retiree cost sharing. It will not require a reduction in what is covered.

- The City in partnership with its bargaining units needs to make some fundamental changes in plan design and employee cost to successfully manage this excellent plan of coverage over time.
- The City's healthcare benefits program is an excellent one. It compares very favorably with the Survey Group and our experience with employers in general, when one compares benefits covered.
- The City's payments on behalf of employees, dependents and retirees exceed the Survey Group and would be considered high in most measurement groups.
- The City's non-HMO healthcare costs are too high. We attribute this to the majority of employees being in an unmanaged plan design and lack of meaningful copays.
- The City's prescription drug plan lacks any meaningful employee incentive to share or control cost.
- Liberal access to and the low cost of retiree health coverage has resulted in the City carrying a significant financial burden that can only grow over time.
- The City lags behind its comparison group from a compensation standpoint.
- The City's and the School System's decision to separate benefits and benefits purchasing is not a good benefits decision.
- The City's indemnity health plan should be phased out.
- A Healthcare Flexible Spending Account should be considered if other changes to employee cost sharing are made.
- The City offers too many plans. They are confusing to understand and administratively cumbersome.

- The City has become the "Plan of Choice" by virtue of the 63.4% of employees enrolling dependents. While the public sector is historically higher than the private sector, the City should have an objective of lowering this number.
- The City lags behind its peer group in prescription drug plan and cost management.
- The City's fixed costs for healthcare are not out of line.
- The City's high retiree cost is driven by the high number of retirees, not the cost per retiree.
- Access to coverage by City retirees is liberal and the cost paid by the City is significant.

RECOMMENDATION AND COST IMPACT

There are a number of recommendations throughout our report. The major ones are summarized here with potential savings identified where they could be objectively measured. We recognize the collective bargaining process in the City and respect it. We do not expect the recommendations to be done outside that process. Potential savings are stated as annual amounts but the reader must recognize that the process to achieve them would require some fundamental changes and some time. Our suggestion would be for the City and its bargaining groups to set a timetable for change and move in the direction of these recommendations.

- Partner with collectively bargained groups to address the fundamental changes needed to keep this plan of benefits financially viable.
- Partner with the School System to continue a joint purchase arrangement even with separate management control.
- Eliminate the indemnity health plan.

- Evolve the PPO plan into a more managed Point of Service plan. Potential annual savings $8-$11 million.
- Bring retiree cost sharing into line with other demonstrated practice. Potential annual savings $7.5 million.
- Introduce a PPO office copay of $5. Potential annual savings $1-$2 million.
- Introduce drug plan cost sharing changes. Potential annual savings $9.3 million.
- Reduce the number of health plans offered.
- Address the issue of high dependent participation.
- Begin collecting group specific (actives, under age – 65 retirees and over age 65 retirees) claims experience so ongoing cost can be adjusted to the groups actual experience.
- Address the relative lag in compensation directly as a compensation issue. As indicated earlier, this topic needs to include pension, leave and other benefits as well.

ANOTHER ISSUE

One major issue, not directly identified in the scope of work, emerged as the study progressed. That issue is the decision of the Baltimore City Public School System (BPS) with concurrence by the City to set up their own plan of benefits separate from the City. BPS would negotiate with vendors, hire consultants, administer plans, change benefits and do all the other things a separate employer would do to maintain a benefits program. Currently, BPS benefits are under the aegis of the City.

While not indicated as a specific study area, we feel it is appropriate to address because the overall thrust of this effort is to help the City save money

while maintaining superior benefits. We believe the City and the BPS will better achieve these objectives by remaining together as a purchaser of benefits.

It is true that a number of political subdivisions maintain separate benefits programs for city/county/state personnel and school system personnel. We contend that these arrangements are not benefits driven. A number of political subdivisions we deal with have studied the issue of consolidated purchase. The results of those studies have uniformly been positive in favor of consolidated purchase but not always implemented. Baltimore County and Baltimore County Schools implemented a joint purchase arrangement several years ago. Harford County and Harford County Public Schools recently announced a joint purchase arrangement.

The City provided BOD with a summary of the recommendations from a 1999 consultant's report done for BPS. Among other things, the report recommended that BPS sponsor a health and welfare benefits program independent of the City. Reasons cited in the recommendation were:

- Financial terms, performance guarantees and other key contractual terms with medical and prescription drug vendors, as well as other health and welfare plan vendors, through direct vendor negotiations.
- Benefit levels and employee/retiree cost sharing.
- Cash flow between BPS and each of the health and welfare benefit plan vendors.
- Rate setting for the self-funded medical and prescription drug plans and reserve levels for those plans.

We believe these goals are achievable within the joint purchase arrangement. We see no compelling benefits reason to separate the two groups and dilute the purchasing leverage inherent with the larger group.

Although we feel strongly about the opinion stated above, we understand that a great deal of planning and structuring has gone into the future separation of BPS benefits from the City. We recommend that both groups participate in joint solicitation of carriers, vendors, administrators, etc. to preserve as much leverage as possible in achieving fixed price advantages, volume discounts and administrative savings.

SECTION I

This section of the report deals with the City's healthcare benefits in relation to benefits plans provided by other employers, principally in the public sector. As noted in the introduction, this was the first area of concentration for BEEF's initiative.

In order to answer BEEF's first question one needs to look beyond just a comparison of health issues covered by an employer's plan design. Most medium to large employers, including the City, offer coverage on an excellent range of potential health issues that could negatively impact employees, retirees and their dependents. It would be rare to find large gaps in coverage. Other issues that need to be addressed to fully answer the question include:

- Overall cost – Is the City paying more or less than other employers.
- Management costs – Do amounts paid to vendors, carriers, administrators etc. match up with other employers.
- Participant cost – How do employees, retirees and dependents share in the cost of benefits. There are two ways to share cost. The first has to do with access cost (sometimes referred to as premium) that one must pay in order to have coverage. The second is event specific cost such as co-pays, deductibles, co-insurance etc. that occur when one has a covered health event.
- Healthcare cost management activity – Has the City pursued healthcare cost management techniques to the extent other employers have.
- Plan access issues and results – Does the City's access to coverage rules and resulting enrollment patterns negatively impact overall cost.

HEALTH BENEFIT PLAN DESIGN COMPARISON

Exhibit I is the summary of plan design and cost issues comparing the City with the responding survey group. Only public sector responses are shown since only incomplete data were received from private sector employers.

The first issue to address is level of benefits without regard to cost which will be dealt with separately. The following conclusions and observations emerge from the comparison of benefit levels:

- The City provides an excellent array of benefits to its active and retired workforce.
- The level of benefits (things covered) matches favorably with the Survey Group as well as our experience in the private sector.
- There are no major gaps in coverage in the City's plans.
- One issue that could be considered a gap to address is the $225,000 maximum in the indemnity plan and CareFirst PPO (except for teachers and para-professionals). No other jurisdiction shows a plan maximum this low. Unlimited or $1 million is most common.
- Boston is the only other city to offer an indemnity plan. The City should evaluate the ongoing viability of this plan. Indemnity plans are the least managed and most expensive way to deliver health care benefits. As can be seen from the Survey, most employers have phased them out. Our recommendation is to phase it out over a relatively short period of time (1-2 years). The PPO plan offered by the City effectively matches benefits and has a wide network of providers.
- The CareFirst indemnity plan contains a $50 hospital admission deductible for the year's first admission. This is obsolete and more

of a nuisance than anything else. It should be increased or eliminated if this plan is not phased out.

- The City does not offer a Healthcare Flexible Spending Account (HFSA) which would allow participants to pay for eligible, not-covered expenses and out-of-pocket expenses such as co-pays and deductibles. At the present time there is little out of pocket expense for participants. One of our recommendations is to involve participants more in sharing costs. That would make a HFSA more meaningful.
- The City offers too many plans (nine). We understand the collective bargaining process in the City and respect the integrity of that process. However, the City's goal should be to reduce the number of plan offerings for the following reasons:
  - Lower confusion and improve communication.
  - Reduce carrier, administrator fixed cost expense.
  - Reducing the number of options should not reduce network (number and types of doctors) because much overlap already occurs.
  - Consolidating participation will increase leverage with carriers.
  - The number of options makes it difficult for participants to evaluate their needs and make informed choices.
  - The comparison charts given to employees are well done but exhaustive. They are difficult to get through and lead to the problem cited above.

- Opt Outs – Although not reflected in Exhibit I, we understand from the City that certain collectively bargained groups receive opt out payments if they waive medical coverage. Many employers in the public and private sectors use opt out payments to reduce plan participation. One of the City's problems is high participation of dependents. The City should consider an overall opt out strategy as it deals with this participation issue. It is also our understanding that employees who waive medical coverage still receive prescription drug coverage. We believe this practice to be expensive and unnecessary.
- Collective bargaining agreements – We were not given copies of collective bargaining agreements since our task did not address comparing them to other employers. We do recommend however that the City review those agreements to determine if carrier or vendor specific language is used. If that is the case, we recommend the City adopt a goal of removing that language so they have more latitude in the healthcare marketplace.
- All of the survey respondents offer very good prescription drug plans as does the City. The striking difference in benefits is the more aggressive cost management/cost savings posture adopted by the survey respondents (as compared to the City) in creating copays, generic and formulary incentives. The City has seen its prescription drug costs increase at a rapid rate over the last few years. It should adopt a more aggressive posture to control these costs. We have specific recommendations in separate prescription drug sections.

OVERALL COSTS AND MANAGEMENT COSTS

One of the critical questions in this effort can be simply stated as:

Does the City of Baltimore pay too much for its healthcare coverage?

The answer is yes, in our opinion, but the answer is more complex than the question. When we say the City is paying too much we do not mean they are being charged too much or that the care received is overpriced. We believe the City pays too much because they use an expensive delivery system – the PPO – and they do not ask employees to share as much cost as other employers. Therefore, we believe the City pays more than it should for health care benefits. To fully understand this, one must separate the various components of cost to understand the answer. The components we examined are:

- Fixed Costs or Management Costs – amounts paid to vendors for services on healthcare plans
- Non-HMO Costs – plans that are self-insured by the City
- HMO Costs – fixed rate plans purchased by the City
- Funding Arrangement Costs – how the cash is handled between the City and vendors in self-insured arrangements
- Trend Factors – carrier estimates for increasing costs relative to the marketplace

In examining these cost items and coming to our conclusions, we evaluated the Survey Group responses and used our experience as practitioners in the healthcare marketplace. While the cost information from the Survey Group was helpful, it was sometimes incomplete and was not easily verifiable. The best and most complete survey response came from Baltimore County Government and Baltimore County Public Schools. We will concentrate

on that comparison in reviewing cost items. We feel it is the most on-point comparison because of commonality of carriers and geography.

FIXED COSTS / MANAGEMENT COSTS

CareFirst Blue Cross Blue Shield (CFBCBS) is the largest City vendor as well as the largest County (Government plus Schools) vendor. We compared like services (administrative fees, utilization review fees and network access fees) and adjusted for cash flow (interest credits) between the two entities. The per employee per month costs are:

	Under 65	+65
City	21.71	13.51
County	21.43	12.80

Our conclusion is that given the City's size (40,000 employees/retirees versus 24,000 for the County), it should be getting a slightly better deal, not slightly worse. If the City could achieve the same fixed cost profile, it would save $225,000 per year.

We believe the City is a more complex customer for CFBCBS to administer. The City has 55 different group numbers versus 40 for County entities. Total fixed costs were $8.6 million for 1999 which represents less than 3% of total expenditures. The City should challenge their vendors to suggest ways to simplify administration and lower fixed costs. While we think the City could be somewhat better, these costs are not way out of line.

NON-HMO AND HMO COSTS

The true cost of the City's healthcare benefits (or any large employer) will be the cost of care consumed by eligible participants. Again, we compare the

City enrollment and experience to Baltimore County. It should be noted that we do not assume the County is doing everything right or has the best "deal" available. Their geographic proximity, commonality of vendors and verifiable information make them the appropriate comparison group for this effort.

The following summarizes the enrollment in plans for active employees and non-Medicare retirees. Medicare eligible retirees (over 65) will be considered in a following section.

City	Traditional	2,400	7.0%
	PPO	21,800	63.6%
	HMO	10,100	29.4%
County (Incl. Schools)	Traditional	200	1.0%
	PPO	3,800	18.5%
	Point of Service	13,550	65.9%
	HMO	3,000	14.6%

We will refer back to these enrollment patterns in subsequent sections of this report.

Based on the above enrollment, cost of care on a per member (employees and dependents) per month basis, including drug, is as follows:

	Non-HMO	HMO	Composite
City	$257	$132	$220
County	180	149	176
City Variance	+42%	-11%	+25%

This is a significant difference which gets at the crux of our opinion that the City pays too much for its healthcare benefits. The reason is that care in the non-HMO setting is costing the City too much. The obvious question is why and whether the dogged pursuit of the answer is meaningful to the City.

It certainly is meaningful. If the City could match the practice demonstrated by the County, it could achieve a savings in the $25-$30 million range. Savings of that magnitude are most likely unrealistic because some factors, which the City cannot influence, can partially explain the significant variance in non-HMO cost. We do think that savings in the $8-$11 million range are achievable over time by making some fundamental changes in approach.

In order to understand the cost variance and the potential for savings, one first needs to examine possible reasons for the variance. Based on our experience in evaluating healthcare costs, we looked to the following areas for answer:

- Dependent Participation – a high percent of employees with dependents covered can be a cost increase factor. In this case, however, the City has 63.4% of employees covering dependents. The County has 63.7%. Both are high. We will address this issue further at another point.

- Percent of Non-Medicare Retirees Covered – Retirees comprise 30% of the City group, while in the County it is 19%. We feel this can have an impact on costs. Health conditions may factor into early retirement decisions. Retirees also have more time to engage the healthcare delivery system. We think the number of retirees is a cost factor. We do not think age is a big factor –see next bullet point.

- Relative Demographics Rate Factors – non-HMO – one suspicion is that a higher percent of retirees means a higher age demographic. We employed age based relative risk factors used by insurance carriers to determine a group's risk profile (1.00 would be an average group). We compared the City and County populations with the following result:

City	1.354
County	1.322

Our conclusion is that age plays a small role in explaining the variance.

- Plan Management – managed care concepts have received much publicity and scrutiny over the past several years. A trend that has emerged is that plans in a more managed environment produce lower costs than those not in that environment. The City has many more employees in a less managed environment than the County. In the City, 64% of employees are in the PPO. The County has 66% of its employees in the more managed Point of Service environment. The City needs to develop a strategy to change this pattern. Specifically, the PPO needs to evolve to a

Point of Service type arrangement with the financial and utilization controls that come with those arrangements.

- Office Copays – City PPO plan has no office copays while the County has $5 (Schools) and $10 (Government).
- Higher Cost Hospitals – While we did not look at hospital specific usage, we assume the City is faced with higher hospital costs on average.
- Selection – The City PPO plan is likely to be experiencing some anti-selection due to its HMO penetration, i.e. younger, healthier employees going to the HMO.

The following is our estimate of the components making up the cost variance of 42% and the areas of potential savings

Category	Estimated Variance	Savings Potential
Age	2-3%	
Retiree Use	4-5%	
Plan Less Managed	7-10%	$8-11 million
Selection	5-7%	
Office Copay	1-2%	$1-$2 million
High Cost Hospitals	5-8%	
Sub total	24-35%	
Other Unexplained	18- 7%	
Savings Potential		$9-$13 million

OVER 65 RETIREES

No discussion of overall costs would be complete without looking at retirees on Medicare. The previous discussion dealt with non-Medicare retirees and actives. As with the previous group, we have compared the City and County costs on a per member per month basis as follows:

CFBCBS Medicare supplement plus drug.

	County Schools	County Government	City
Medicare	$81.01	$112.75 (e)	$98.64
Drug	101.44	84.91	90.60
Total	$182.45	$197.66	$189.24

The medical benefits in the comparison are comparable. The drug benefits differ as follows:

City	$5 copay mandatory generic Note: a "single source" brand has $5 copay
County Government	$50 deductible; 80% generic/70% brand paid by plan
County Schools	No deductible; 80% - paid by plan

Before drawing conclusions on this information, we must look at enrollment information as well.

	County Schools	County Government	City
Active Employees	10,650	6,225	23,850
Pre-Medicare Retirees	2,000	1,975	10,450
Medicare Retirees	3,900	2,025	17,100
Total	16,550	10,225	51,400
% Retiree	35.5%	39%	53.5%
% Medicare Retiree	23.5%	20%	33%
Ratio Retiree to Active	.55:1	.64:1	1.155:1

County Schools and County Government Combined. .59:1

Based on the preceding retiree cost information, we draw the following observations and conclusions:

- Cost per member is not out of line with the County's cost.
- Benefit for drugs is very rich in comparison to the County and the Survey Group.
- Drug utilization by the retiree group is comparable to the County despite the higher benefit.
- The real culprit in retiree cost is the number of retirees covered and how they share the cost.
- The City retiree to active ratio is about twice what it is for the County.

Another way to look at the cost of supporting the large number of retirees is to look at what cost per active is attributable to retiree benefits.

- For each active employee, the additional cost attributable to retirees is:

City	$2,625
County	$1,335

- The City provides a valuable and expensive benefit to its retires. The City pays a disproportionate share of the cost compared to the County and the Survey Group.
  - County Schools cost sharing is by year of service:

10-19 Years	30%
20-29 Years	55%
30+ Years	70%
Weighted average is	55%

In other words, an employee with 15 years of service would get 30% of the cost paid by the County Schools. Someone with 25 years gets 55% paid and so on.

- County Government generally pays:

Pre-Medicare	
10-19 Years	42.5%
20-29 Years	64%
30+ Years	85%
Medicare	
75% regardless of service	
Weighted average approximately 72%	

- City pays an average of 77.5% of medical and all of drug for a weighted average of approximately 83.5% of retiree cost.

- If the City could reduce its cost sharing from 83.5% to 75%, the annual savings would be approximately $7.5 million.

PRESCRIPTION DRUGS

The area of prescription drugs is an important one in the overall cost picture. The rise in drug cost and utilization has been well documented in the popular press and in the City's past experience and projected budget. Previous areas of this report have dealt with drug costs as a component of overall costs. It is important to focus specifically on the drug issue in light of the survey and offer suggestions on future cost management.

The inescapable conclusion reached when reviewing the City's drug approach in light of the Survey Group is that the City's plan is very rich and offers little hope of stemming a rising tide of increased cost. Prescription drug coverage in the City is essentially free since its cost is not used in determining

employee cost sharing. Combining this with relatively low copays (mostly $5) and lack of incentives to use generics or formularies yields a plan design at the mercy of the marketplace. The survey respondents have adopted a more aggressive posture in dealing with rising drug costs via copays, incentives and employee contributions. Our experience in the private sector shows them to be even more aggressive.

The City must get a handle on prescription drug costs. Besides working with their Pharmacy Benefits Manager to understand costs and utilization, the City should take steps to share more of the cost with the consumer of the benefit. We realize there is a collective bargaining process that must be followed. We suggest that the City and its bargaining groups collectively come to grips with the problem and agree to solutions that will protect the substance of an important benefit and lead to its financial stability.

We have three areas of potential changes that can have significant impact on prescription drug costs. The changes, which might appear drastic, would bring the City in line with the Survey Group.

1. Currently maintenance drugs can be filled at retail pharmacies for one copay. Change this to require a 3x copay for 90 day maintenance drugs. A corresponding change would be to charge 2x copay for a 90 day mail order supply. Estimated annual savings is $1 million.

2. Currently the plan charges a $5 copay for 98.4% of drugs dispensed (the rest are multi-source brand drugs where the employee should pay the difference plus the $5). Costs to the City per fill for 1999 were:

Generic	$16
Multi Source Brand	$50

Single Source Brand	$77

This means employees pay about 25% of generic drug costs ($5/$21) but only 6% ($5/$82) of single source brand drugs. If the City went to a $10 copay for single source brand drugs the annual savings would be approximately $3.5 million for 2001 or $4.8 million if done with #1 above.

3. If retirees are to get free drug coverage, their copay should be higher. If the City went to a $20 copay for single source drugs, annual savings would be an additional $4.5 million.

COST TRENDS AND FUNDING ARRANGEMENTS

These are two elements that impact the City's costs to varying degrees. While they were not direct comparison items with the Survey Group, they merit discussion under the heading of how the City can better manage its healthcare purchase with the objective of saving money.

Cost trends are factors carriers or vendors use to predict the future inflation and utilization. In coming up with anticipated future costs they will use a prior period's experience, adjust it for enrollment or plan changes and apply trend factors. While the majority of the City's healthcare expense is self-insured, trend factors are still important because they are used to set the budget. The following trend factors were reported by vendors:

CFBCBS:	1997-98	+7.2% per member
	1998-99	+3.1%
	two years	+5.4% annualized
Express Scripts Drug:	1998-99	+16% per member

HMOs:	1998-99	+7.5% on average

In our opinion, these are in line with marketplace practice

Funding arrangements determine how the carrier or vendor handles the customer's money until the time it is used to pay claims or expenses. The HMOs are fixed rate arrangements where the City pays negotiated costs for each period. For CFBCBS, the City pays an expected rate each month for its enrollment. There is an annual reconciliation at the end of the contract period with surpluses or deficits paid or called. The last two contract years have averaged a $4 million surplus to the City.

The other classic funding arrangement involves a banking arrangement where the carrier can draw on the employer's funds as claims come due. The employer pays fixed costs on a regular basis. Either funding arrangement has cash flow implication (interest credited on funds held, interest earned on funds in the bank etc.) The City should satisfy itself that its funding arrangement works best for it.

PARTICIPANT COST

This section looks at how City employees, dependents and retirees share in the cost of healthcare benefits. It was stated earlier that the list of things covered by the City stacks up favorably with the Survey Group and employers in general. This is to be expected because few, if any, large employers have real gaps in healthcare coverage.

The City gets way out ahead of the Survey Group and other employers when one factors in how much the City pays and how little employees and retirees pay. As indicated earlier, there are two ways for employees and retirees to share cost:

- Premium or access cost – the amount one pays to have coverage available
- Event cost – the amount, if any, one pays for a specific health care event

Excluding the Traditional Plan (which we recommend phasing out), the City requires the lowest percent premium or access cost of the Survey Group. Our experience in the private sector indicates they require even more contributions from employees.

Carrying this over to event costs shows that the City continues to be out in front of the Survey Group by requiring modest payments for services. The most striking example of this is the lack of an office copay for the CFBCBS PPO. This is almost unheard of in plans today. In another section of this report we address overall cost issues and estimate a potential savings of $1-2 million dollars annually by introduction of $5 copay. Private sector employers have been much more aggressive in this area. Copays of $10 and $20 are common.

The City needs to partner with its bargaining units to address these cost issues. A gradual increase in participant cost over time will be preferable to drastic action in face of serious financial need.

The areas of prescription drugs and retiree costs certainly merit mention under the heading of participant cost. They are focal points with high sensitivity and high potential for savings. As such, they are addressed specifically elsewhere in the report.

PLAN ACCESS ISSUES

Plan access has to do with how participants get covered by the City plans and how that impacts ongoing cost. One needs to deal with actives and retirees separately.

Active employees and dependents achieve covered status by being in an eligible class, actively enrolling in a plan and paying required cost, if any, by salary reduction. As indicated earlier, the City requires a modest contribution (in some cases none at all) for access to coverage. They stand out from the Survey Group in this respect.

An area for concentration by the City is that of dependent participation. Currently, 63.4% of employees enroll one or more dependents. Baltimore County is similarly high at 63.7%. This is a concern because many public and private sector employers have adopted strategies to get employees and dependents out of their plans. These strategies involve opt-out credits and/or higher premium requirements for employees and dependents. Their goal is to make another employer's plan more attractive (i.e. lower cost) and have the employee go to that plan as a dependent.

With dependent participation so high, we believe the City has become the "employer of choice" in dual wage earner households. This results in the City paying more than its share for healthcare coverage. The best evidence of this is the simple test of healthcare costs per employee. According to the City enrollment and cost records, the cost per employee is approaching $5,000 on an annual basis. In its most recent survey, the U.S. Chamber of Commerce reported a national average of $3,523 per employee for non-manufacturing employers.

We do not have an easy solution for this issue. The City needs to realize the high cost of being the employer of choice for healthcare. The plans are excellent and they cost little to get them.

Other sections of this report looked at pre-Medicare retirees and Medicare retirees from cost and participation standpoints. We made the following conclusions:

- The culprit in the Medicare retiree cost was not the per retiree cost but the number of retirees
- The City has 1.155 health plan retirees for every 1 active employee versus .59 to 1 in Baltimore County

The City reported to us that anyone drawing a retirement benefit from the City is eligible for retiree medical with the standard payment by the City regardless of years of service. While we have not seen the actual language outlining this practice, we have concerns about its ongoing cost impact. Once again, we realize that this may have been the subject of bargaining. That notwithstanding, we have the following concerns:

- Such liberal access, along with a rich plan design (particularly drugs), can create a future cost spiral that will be difficult to contain.
- The presumably unmeasured liability for this future promise most likely is significant. The private sector has had to disclose this liability via Financial Accounting Statement 106. To date no such disclosure is required of the public sector, but that could change.
- The City should prioritize a thorough review of retiree access and cost sharing. Staggered cost sharing based on year of service should be considered.
- The City should immediately begin collecting claims experience information by three groupings – actives, pre-Medicare retirees and Medicare retirees. These are three distinct groups that are going to generate different experience patterns over time. The City should develop an overall contribution philosophy and then have each of these groups pay according to the experience they generate. Only in this way can the City first understand the cost consequences of each group and then share the burden on an equitable basis.

SENIOR MANAGEMENT QUESTIONNAIRE

As indicated in the introduction, the Questionnaire was used to gauge management perceptions with regard to health benefits and compensation. It was not a critical element of the overall study and did not impact conclusions and recommendations. Six responses to the Questionnaire were received. While we do not consider this to be a solid sample (15 sent out), the following perceptions and judgments emerged:

- It is felt that employees perceive the health benefits package to be good to excellent.
- The linkage to perceived low pay is well established. One respondent indicated that employees understand that benefits are very good "...because pay raises have been minimal in the past".
- It is felt that employees generally understand their benefits.
- It is felt that employees could bear more of the cost of benefits.
- It is felt that health benefits are up to date with plenty of choice.

SECTION II

COMPENSATION SURVEY FINDINGS

As indicated in an earlier section, part of the overall study process was to conduct a summary level compensation survey of public sector employers. The purpose of the Compensation Survey was to determine where the City stood vis a vis other employers and see what light, if any, that might shed on benefits levels.

There has been a historic linkage in the public sector between compensation and benefit levels. The private sector also recognizes a linkage between compensation and benefits but not to the extent of public sector

employers. It was the City's suggestion that a Compensation Survey be done in conjunction with the health benefits survey so that this linkage could be understood and examined.

Compensation surveys were sent to 10 public sector employers. With the City's assistance, 27 benchmark jobs were selected for analysis. These jobs, selected from the City and Public Schools, have approximately 12,400 incumbents. The survey provided the job title and a position description for each job to assist respondents in correctly matching their jobs to those City jobs in the survey. Respondents were asked to give the number of incumbents in those jobs, the current average salary actually paid to incumbents, and the salary scale minimum and maximum. Seven jurisdictions responded in whole or in part to the Compensation Survey. Exhibit 2, BEEF Compensation Survey Detail, summarizes those responses.

A summary of the Compensation Survey results is shown on Exhibit 3, BEEF Compensation Survey Results. That Exhibit shows:

- Current Actual Salaries – Average salary actually paid to incumbents for the same job for Baltimore City and the Survey Respondent Group. Overtime is not included in this statistic. Data are weighted by the number of incumbent employees reported by each employer, so that high incumbent jobs make up their proportionate share of the calculated averages.

  The City's actual salaries are then compared to the weighted averages of the Survey Group as a percentage. A percentage over 100% for a particular job means that Baltimore City's incumbents earn more than the Survey Group's incumbents in that job; a percentage under 100% means that Baltimore City's incumbents earn less than the Survey Group. One must be careful drawing

conclusions from this comparison because the age and longevity of the incumbent group will explain some of the differences.

- Salary Scale Minimum – Minimum salaries reported by Baltimore City and the average minimums reported by the Survey Group. The City's actual salaries are then compared to those of the Survey Group.
- Salary Scale Maximum – Same as above except that salary scale maximums are compared. The number of years' experience to reach the salary scale maximum varies among respondents. This statistic represents the highest amount that an employee in that job can earn, including any available longevity.

CONCLUSIONS BASED ON COMPENSATION SURVEY:

- Overall, the City's actual salaries are 96% of those of the Survey Group (this is the employee-weighted number). On an aggregate basis for these benchmark jobs, Baltimore City's employees earn 4% less than their counterparts in the Survey Group.
- The most telling comparisons are the minimum and maximum scales. The City's minimum salary scales are 90% of the Survey Group, a deficit of 10%. The City's maximum salary scales are 85% of the Survey Group, a deficit of 15%. Baltimore City's salary scales are significantly below those of the Survey Group.
- For some jobs, like *Classroom Teacher,* Baltimore City pays incumbents more than the survey group average, but Baltimore City's salary scale minimum and maximum are below those of the Survey Group. This pattern appears to indicate that Baltimore City has longer service incumbents than the Survey Group.

- Confirming evidence of this salary scale deficit is found in the numbers of jobs above and below the survey group average of 100%. For actual salaries, incumbents in 10 Baltimore City jobs are actually paid at or above 100% of the survey average. For salary scales, however, only 4 Baltimore City jobs have salary scale minimums at or above 100% of the survey group average minimums, and only 2 jobs have salary scale maximums at or above 100% of the Survey Group maximums.
- Because Baltimore City's salary scales are lower than those of the survey group, an employee will earn less during a career in Baltimore City than he/she would, on average, working at some other employers in the Survey Group.

In short, Baltimore City's salaries are lower than those of other public sector employers in this survey. However, it is nearly impossible to draw a meaningful comparison between Baltimore City's lagging compensation and its relative position as a provider of health benefits. One cannot develop an accurate algorithm to adjust the value or level of benefits based on compensation shortfalls or excesses.