FIS 13-266
Additional Information

Commission to Review Retiree Health Care For Employees Hired after July 1, 2013

Meetings held Oct-Nov 2013
& Final Report

State of New Hampshire

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

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November 19, 2013

Her Excellency, Governor Margaret Wood Hassan
State House
Concord, NH 03301

RE: Retiree Cost Containment Commission

Dear Governor Hassan:

As Chair of the Cost Containment Commission to Review Retiree Health Care Benefits for Employees Hired after July 1, 2013, I am pleased to submit the enclosed final report to you.

Chapter 144:33, Laws of 2013, established this Commission to study the question whether the State of New Hampshire should continue to offer retiree health benefits to new hires. This question is important to the state as an employer that competes to recruit and retain a quality workforce. It is also an extremely important question relevant to the state's financial health.

Governmental Accounting Standards Board (GASB) Statement No. 45 requires the state to determine on an actuarial basis and to disclose in its financial statements the cost of retiree health benefits and obligations for other post employment benefits (OPEB). In the last several months, the Department of Administrative Services working with the state's actuary, The Segal Company, conducted this actuarial analysis as of December 31, 2012 for inclusion in the state's FY 2013 Comprehensive Annual Financial Report and determined that the state's unfunded actuarial accrued liability totals $1.9 billion. Segal also conducted a thirty year projection of this unfunded actuarial accrued liability and estimated the state's OPEB liability to be $6.8 billion by 2042.

I am very pleased to report that the Commission continued to work with Segal to understand this long term liability and discovered that the $6.8 billion 30-year projection needed to be refined to reflect changes made to retiree health benefit eligibility laws, most recently as 2011. Under the current law, a Group I employee hired after July 1, 2011 is not eligible for retiree health benefits unless the individual has 20 years of state service and is age 65. Not only does the current retiree health benefit eligibility law require a significant period of state service, but a long-serving employee has to be age 65, the age when the individual is also eligible for Medicare, to receive retiree health benefits. This eligibility law has very positive financial benefits to the state since employees hired since its passage will only be eligible to receive a Medicare wrap retiree health benefit that we refer to as a Medicomp plan; significantly, the cost of the Medicomp plan is 1/3 the cost of the retiree health benefit that is available to today's retirees who are under the age 65 and not Medicare eligible. The Commission's work with Segal to incorporate the eligibility law changes refined the 30-year projection of the state's OPEB liability from $6.8 billion to $5.8 billion, a reduction of $1 billion. We encourage more analysis to see if changes already passed into law don't further reduce this liability.

Unfortunately, the establishing law provided very little time for the Commission to complete its study from the point commission members were named to serve to November 15th, the termination of the Commission. I am pleased the members met seven times in that condensed timeframe and identified a significant number of possible solutions to consider going forward. The Commission acknowledges in its report that it was only able to partially study the many issues it identified and therefore suggests issues for a successor commission to study. The Commission's report specifically recommends that any future commission should be provided the time and financial resources to adequately and fairly study the many important issues that should be considered when deciding whether to continue to offer newly hired employees the existing retiree health benefit or other alternative retiree health benefit support. In addition to attaching the report, I have attached the minutes of the Commission's meetings as well as the information and data that the Commission considered.

Please contact me if you have any questions.

Sincerely,

Linda M. Hodgdon

Linda M. Hodgdon

cc: Fiscal Committee members
Commission members

Commission to Review Retiree Health Care Benefits
For Employees Hired after July 1, 2013

FINAL REPORT

Background

Chapter 144:33, Laws of 2013, created RSA 21-I: 36-b and provided, "there is established a commission to review retiree health care benefits for employees hired after July 1, 2013 in light of the implementation of the Patient Protection and Affordable Care Act (ACA) and recommend a cohesive plan outlining cost effective health plan models effective for such new employees." The Commission is required to report its findings and recommendations to the Governor and the Fiscal Committee of the General Court by November 15, 2013.

The Commission had limited time and resources to fulfill its charge and met seven times over a period of seven weeks to review the current retiree health care plan model and to consider cost effective health plan models for new employees. The Commission reviewed data provided by the Department of Administrative Services (DAS) regarding retiree health benefits costs, the current retiree health care model and enrollment counts, conferenced with state contracted actuaries who conduct the actuarial valuation of the state's long term Other Post Employment Benefits (OPEB) liability, heard from a representative of the Department of Insurance about the ACA and the Marketplace exchange that is offering new health insurance products to New Hampshire citizens, and considered financial vehicles available that people may use to pre-fund future retiree health care costs. For purposes of its analysis, the Commission assumed that the law authorizing retiree health benefits for state employees would change no earlier than the end of the upcoming legislative session, or July 1, 2014. A summary of the Commission's work follows.

A. Health Care Public Policy

In 1985, the New Hampshire legislature passed a series of laws relative to employee and retiree health benefits and their administration. RSA 21-I: 26 articulates the purpose and policy that is the public rationale for providing retiree health insurance coverage for state employees and their spouses:

> "21-I: 26 Purpose and Policy. – This subdivision is to provide permanent group life insurance and group hospitalization, hospital medical care, surgical care and other medical and surgical benefits for New Hampshire state employees and their families, and retired state employees and their spouses. In view of the accepted value of group insurance to the well-being and efficiency of employees on the part of small and large private employers and the other 5 New England states in obtaining benefits of this type of insurance for their employees, the state of New Hampshire implements this subdivision in order that the state shall compare favorably to the standards now commonly accepted by private employers and the state employees in the other 5 New England states by making available to state employees and their families and retired state employees and

their spouses permanent group life insurance and group hospitalization, hospital medical care, surgical care and other medical and surgical insurance benefits."

Much has changed in the twenty-eight years since passage of RSA 21-I:26. From a public policy and legislative perspective, the 2010 passage of the ACA changed the health insurance landscape in many ways, most notably offering people a new way to access and purchase health insurance. The New Hampshire Health Insurance Marketplace (Marketplace) is an online exchange where retirees under the age of 65 may purchase health insurance. In fact, by going through the Marketplace, an individual, depending on his or her income, may be eligible for a subsidy or be directed to apply for Medicaid. While the Marketplace does not offer options to retirees over the age of 65 and others who are Medicare eligible, there are many options in the general market for purchasing health care coverage that is supplemental to Medicare, commonly referred to as a "Medicomp Wrap" benefit.

B. The State Employee Workforce

Against this backdrop of a health insurance Marketplace that provides individuals with access to health insurance options, the Commission looked at today's state employee workforce. Based on the 2012 State of New Hampshire, Division of Personnel Annual Report, the average full-time state employee has twelve years of service, is 47 years old and earns $46,559 in annual wages. From an employee recruitment perspective, over 80% of state employee positions require at least a high school degree and more than 50% require a postsecondary degree. More than 40% of state employee job applicants are between the ages of 41-50. From an employee retention perspective, 52% of the employees leaving state service had less than ten years of service. State employees today have more income earning potential and career mobility. Given the legislatively authorized retirement eligibility changes described later in this report, the number of newly hired workers that will remain in employ until retirement is likely to be significantly different than one would project for the current workforce.

C. The Cost of Retiree Health Benefits

The State of New Hampshire has long provided retiree health benefits to employees who meet age and years of state service eligibility requirements. Even though the State receives from its federal partners on a per employee basis approximately $10 million per year for post employment retiree health benefits, the state has never pre-funded the cost of retiree health benefits during the employee's active service. The use of this federal revenue is unrestricted and the state routinely reallocates these funds to other funding needs in the budget.

Rather than pre-funding retiree health care costs, the state pays for the retiree benefit when the employee retires and incurs medical costs, a funding method referred to as "pay-go". Further, in 2004, the state became self insured and annually adjusts the premiums, or working rates, to cover medical claims and modest administrative costs. The legislature's decision to move from fully insured to self insured was made primarily to lower the state's health care inflation trend for active and retiree health care costs. Notably, this decision has successfully achieved the desired outcomes. Today the active and retiree health plans consistently experience health care inflation trends that are significantly below the national average.

Effective July 1, 2007, governmental accounting rules applicable to the State of New Hampshire changed. Governmental Accounting Standards Board (GASB) Statement No. 45 requires the state to determine on an actuarial basis and disclose in its financial statements the cost of retiree health benefits and obligations for other post employment benefits (OPEB), just as it does for its pension plans. This had been established practice in the private sector that now is applied to governments as well. Most recently, the state conducted this OPEB actuarial valuation as of December 31, 2012, and although in FY 2013 the State paid nearly $50 million in retiree health benefits (with an additional $20 million in expenditures funded by certain plan participants and other revenue sources), this expenditure fell short of the actuarially calculated Annual Required Contribution (ARC) of approximately $132.3 million, that would be necessary to begin pre-funding the benefit. GASB requires New Hampshire to amortize the unfunded actuarial accrued liability over a period not to exceed thirty years and this unfunded actuarial accrued liability as of December 31, 2012 totals $1.9 billion. Thus the state's longstanding policy to provide retiree health care benefits on a "pay-go" basis results in a cost shift to the future.

Although the current OPEB liability represents the state's obligations to current employees and retirees, the state could implement a change that will impact new employees. The state could significantly reduce its ARC by setting aside funds in an OPEB trust to help pay for future retiree health care costs which may one day benefit new employees. In fact, in 2013, the New Hampshire legislature passed a law amending RSA 6:12-c and creating an OPEB trust, (Chapter 144:141, Laws of 2013), but did not provide funding for the trust. The $10 million per year in federal revenue referenced above could be placed into the OPEB trust to begin to reduce the state's long term unfunded liability, thereby applying the money to the purpose for which it was intended.

As the magnitude of the state's OPEB liability has come to light and been considered, the state has passed a series of laws to limit the state's liability and to study alternatives to offering retiree health benefits to its employees. The state's actuary originally estimated the OPEB liability to be $6.8 billion by 2042. As this Commission worked with the actuary to project the changes to the State's OPEB liability if retiree health benefits were not offered to new hires, it came to light that the actuary needed to refine its 30 year OPEB projection to take into account the changes to retiree health benefit eligibility described herein. This refined projection resulted in a reduction of the estimate of the state's OPEB liability as of 2042 from $6.8 billion to $5.8 billion.

D. Statutory Changes to Retiree Health Benefits Eligibility Laws

The State of New Hampshire has made significant statutory changes to eligibility laws that help to limit its liability for future retiree health benefit costs. For many years, Group I employees, the largest group of state employees, were required to have ten (10) years of service in order to be eligible for retiree health benefits provided that they received their pensions on a periodic basis rather than in a lump sum, and except for those having thirty (30) years of service, further required the retiree to be at least 60 years old in order to receive retiree health benefits.

These eligibility standards apply to 60% of the current state employee workforce who were hired when they were in place.

The state changed this eligibility standard in 2003, so that an employee hired on or after July 1, 2003 is required to have twenty (20) years of service in order to qualify for retiree health benefits, and except for those having thirty (30) years of service, continued to require the retiree to be at least 60 years old in order to receive retiree health benefits. Close to 40% of the current state employee workforce was hired under these new eligibility standards and will not be eligible to receive retiree health benefits until 2023.

In 2011, the state further restricted the eligibility for retiree health benefits for individuals hired after July 1, 2011 by eliminating the exception for those having thirty (30) years of service, and requiring the individual to have twenty (20) years of service and to be at least age 65 to receive retiree health benefits. This was an important change because retirees in this group will be Medicare eligible, presuming no changes to the age of Medicare eligibility occur, and the state share of the cost of retiree health benefits for someone who is Medicare eligible is one-third the cost of retiree health benefits for the non-Medicare eligible retiree. By 2031, the average state employee newly retiring will receive a retiree health benefit referred to as "Medicomp Wrap" that is supplemental to Medicare.

Group II employees have different eligibility rules for retiree health benefits due to the nature of their careers. For example, these employees do not earn or accrue a Social Security benefit during their Group II career, nor does the State make payments on behalf of these workers toward Social Security. Group II employees hired before July 1, 2010, do not have a minimum state service requirement and are eligible for retiree health benefits upon retirement from the state. In 2010, the state passed a law requiring Group II employees hired on or after July 1, 2010 to have twenty (20) years of state service in order to be eligible for retiree health benefits. In 2011, the law changed again so that Group II employees hired after July 1, 2011, must now have twenty (20) years of state service and be at least 52.5 years old to be eligible for retiree health benefits.

Prior to July 1, 2009, the state paid the full premium for all eligible retirees and their spouses. For the non-Medicare eligible retiree health benefit that the state provides, the retiree and the spouse must now each contribute 12.5% of the premium cost in order to obtain coverage. For the Medicare eligible retiree, the state pays the full cost of the Medicomp wrap coverage, which costs one-third of the amount of the non-Medicare plan, for the retiree and the spouse. In addition, a retiree's dependents may access benefits if the retiree self-pays for dependent coverage.

From an OPEB liability perspective, the 2011 statutory changes to the eligibility requirements for retiree health benefits will reduce the state's long term OPEB obligations. Those eligibility requirements have not been factored into the state's recent OPEB liability calculations, in part because relatively few people have been hired since the new eligibility laws were put into place. It is very important to understand the effects of these statutory changes. A determination whether the changes resulted in the State's intended effect should be made so that the state does not make further changes to benefits that may not be necessary. This Commission

has worked with the State's actuary to review the question of the long-term impact of statutory eligibility changes to retiree eligibility, but further study is required.

The State of New Hampshire's 2012 Comprehensive Annual Financial Report reflects an OPEB liability of $1.9 billion for Fiscal Year ending 2013. Working with the state's actuary, the Commission studied what the effect to OPEB liability would be if the state did not offer a retiree health benefits to new hires beginning July 1, 2014. This analysis showed that for the first ten years following the policy change to discontinue offering retiree health benefits to new hires the actuarial accrued liability drops modestly, mostly because the retiree health costs during those years are for people who are already receiving the benefit. After a ten year period, however, the actuarial accrued liability begins to reduce more significantly such that after a period of thirty years, the state's OPEB liability drops from $5.7 billion to $2.3 billion.

E. Retiree Health Benefits Alternatives and Considerations

Given the changing demographics of the state employee workforce, the availability of new funding vehicles for retiree health care coverage, the availability of new group health insurance products and the OPEB liability that the current pay-go practice has accumulated, it is clear that further research is needed. The options and alternatives presented below are not prioritized and they are not recommendations. They are simply options that this Commission partially studied and believes that successor commissions should study further.

Whether the state maintains the status quo benefit for new hires or pursues changes to the benefit, some specific alternatives that should be further researched include:

1. Funding future retiree health benefits for new hires throughout their career to ensure OPEB liability does not grow with respect to this benefit for this portion of the state employee workforce.

2. Eliminating the statutory requirement for the state to provide retiree health benefits for new hires and instead provide funding, in an amount to be determined each biennium, to assist the future retiree in funding health care coverage, deductibles, co-pays, or portions thereof.

3. Maintaining the State of New Hampshire's ability to compete with other employers with respect to recruitment and retention of a quality state employee workforce.

    a. Study the factors that make the state an effective recruiter and allow it to retain its employees.
    b. Study the effect of changes to eligibility requirements for retiree health benefits on recruitment and retention given that a new hire with limited or no access to retiree health benefits could be working along side an employee who because of date of hire and years of service may have access to retiree health benefits.
    c. Study the unique recruitment and retention issues that apply to Group II employees.

4. Research options such as a VEBA, HRA or Section 115 trust. Employers, employee representatives, such as unions, and individual accounts are all options that may provide tax sheltered savings alternatives to funding retiree health benefits.

5. Research further changes to eligibility laws. Among the options that should be considered are:

    a. Increasing eligibility to require more years of state service for Group I and Group II employees

    b. Providing retiree health benefits only to the state retiree and make spousal coverage only at the expense of the retiree, as is dependent coverage now.

    c. Tying the age of retiree health benefit eligibility to the "age of Medicare eligibility", rather than to a specific age. This would result in an automatic change in the age of retiree health benefit eligibility in the event of future changes to age of Medicare eligibility and would maintain the contraction of the state's retiree health program to one that only offers the Medicomp wrap coverage.

    d. Matching spousal coverage eligibility requirements to the same age as is required for the employee/retiree, i.e. age 65 or 52.5 or age of Medicare eligibility.

6. Continue to study the impact of the changes to retiree eligibility on the state's OPEB liability and report on recommendations to contain those costs including some or all of the $10 million in federal funds being directed to the OPEB trust.

7. Provide any future Commissions with the time and the financial resources to adequately and fairly study the above topics so that it can make soundly formed recommendations for legislative changes.

8. Whether the state should discontinue offering the current retiree health benefit to new employees.

In conclusion, before any future Commission spends time and resources on the above suggestions, make sure there is a clear understanding of the changes to retiree health benefit eligibility already made, particularly in light of the state's interest in and ability to recruit and retain a quality state employee workforce.

Respectfully Submitted,

The undersigned hereby submit this Final Report of the Commission to Review Retiree Health Care Benefits for Employees Hired after July 1, 2013 on this 15th day of November 2013.

Linda M. Hodgdon, Chair
Commissioner, Department of Administrative Services

Stephen Arnold
NH State Director, New England Police Benevolent Association

John Beardmore, Public Member
Commissioner, Department of Revenue,

Diana Lacey
President, New Hampshire State Employees Association

Catherine Provencher, Public Member
Treasurer, State of New Hampshire

Lisa Shapiro, PhD, Public Member

October 3, 2013
Meeting

144:33 New Section; State Employees Group Insurance; Commission Established; Cost Containment Options; Retiree Health Plan for New Employees. Amend RSA 21-I by inserting after section 36-a the following new section:

21-I:36-b Commission Established; Cost Containment Options; Retiree Health Plan for New Employees. There is established a commission to review retiree health care benefits for employees hired after July 1, 2013 in light of the implementation of the Patient Protection and Affordable Care Act and recommend a cohesive plan outlining cost effective health plan models effective for such new employees.

I. The members of the commission shall be:

(a) The commissioner of administrative services, or designee.

(b) The president of the State Employees' Association of New Hampshire, or designee.

(c) The president of the New Hampshire Troopers Association, or designee.

(d) The president of the New England Police Benevolent Association, or designee.

(e) The president of Teamsters Local 633, or designee.

(f) Four members of the public, each of whom shall be a person who in the last 10 years was not a member of a labor union, appointed by the governor.

II. The commissioner of the department of administrative services shall be the chairperson and shall call the first meeting as soon as practicable after the effective date of this section. Five members shall constitute a quorum.

III. The commission shall report its findings and recommendations to the governor and the fiscal committee of the general court by November 15, 2013.

Commission to Review Retiree Health Care Benefits
For Employees Hired after July 1, 2013

10/3/13

Present:
Linda Hodgdon, Commissioner,Department of Administrative Services (DAS), Chair
Lisa Shapiro, Public Member
John Beardmore, Commissioner, Department of Revenue, Public Member
Diana Lacey, President, State Employees Association
Kevin Foley, Teamsters Local 633
Stephen Arnold, New England Police Benevolent Association

Absent:
Catherine Provencher, Treasurer, Public Member
Public Member to be named by Governor
Seth Cooper, NH Troopers Association

Meeting
Commissioner Hodgdon began the meeting by distributing two handouts: (1) a presentation on Retiree Health Costs, and (2) a handout containing Summaries of Benefits for Retirees <65 years old for medical coverage (POS and PPO), Summaries of Benefits for Retirees > 65 years old for medical coverage, and a prescription drug coverage plan description.

A review of the presentation on Retiree Health Costs generated a series of questions and recommendations from Commission members for information for the Commission to review.

Slide #1: Laws of 2013, Chapter 144:33. The Commission's statutory charge is to review retiree health benefits for employees hired after July 1, 2013. The Commission is required to report its findings and recommendations to the Governor and Fiscal Committee by November 15, 2013.

- Discussion: Committee has no more than 6 weeks to complete its work

Slide #2: Retirees- Plan by Age Bracket. This slide shows the aging of the state retiree health program participants.

- There are over 4800 people over the age of 70 in the retiree health program.
- There are 1800 retirees over the age of 80
- People are living longer and are receiving benefits from the retiree health plan far longer than ever was anticipated when the plan was established.

Slide #3: Total Retiree Health Costs from FY 10- FY 12.

- The Commission commented on the pattern of high expenditures in one year followed by a reduction in expenditures in the next year
  - FY 09-10 ($74.1 m/$70.4 m.)
  - FY 11-12 ($76.2 m./ $73.5 m.)
- Changes in expenditures reflect changes in enrollment, retiree contribution to premiums, and plan design changes made to the retiree health plan effective 7/1/11

Slide #4: Employees by Age Distribution. This slide demonstrates the "silver tsunami". In 2002, the largest number of employees was in the age range 46-50. Ten years later in 2012, the largest number of employees is in the age range 51-55.

Slide # 5: Cadillac Tax. State's actuary projects $1.4 million Cadillac Tax related to retirees <65 beginning in 2018 and increasing yearly. The Cadillac Tax related to active employees is expected to be $14 million in 2018. DAS is assessing the effect of the negotiated active health benefit plan design changes on the reduced liability and the newly estimated Cadillac Tax.

Slide #6: Other Post Employment Benefits (OPEB). GASB 45 requires the state to recognize OPEB costs in periods of employee service.

- The state projects future OPEB costs, discounts them back to present value and allocates them to periods of employee service.
- NH is on a pay- as- you- go basis.

Slide #7: OPEB

- OPEB liability for the state is $1.857 billion as of 12/31/12

Discussion

- NH is in a high medical cost region. There may be federal law changes that address geographic and demographic differences on components of the thresholds triggering the Cadillac Tax.
- The state has been diverting in the budget approximately $10 million per year received from the federal government as unrestricted funds for retiree health costs related to state employees funded by federal dollars to non retiree health needs. If these funds were set aside to fund the state's OPEB costs, they would significantly reduce the state's OPEB liability. This Commission's recommendations could help on this issue.
- The state could make plan design changes to reduce short and long term retiree health costs.
- By changing the law and no longer making retiree health benefits a possibility for new hires, the state would be taking a first step in addressing a liability that it cannot afford.

- New hires would not rely on state funded retiree health benefits and there are opportunities to educate new hires about ways to fund their own retiree health costs, especially with the Affordable Care Act now in place.
- The State cannot pay into VEBAS (Voluntary Employee Benefits)directly. The state can pay employees and employees can contribute to their own accounts for retiree health costs.
- Unions are experiencing difficulties negotiating contracts for longer than 2 year periods because of unknown impacts of the ACA.

The Commission members requested further information:

- 2012 OPEB report
- FY 13 Retiree Health Expenditures broken down by < 65 and >65
- Laws on eligibility for retiree health benefits
- How would OPEB liability change if new hires were not eligible for retiree health benefits
- What are HRAs? Are we able to offer one group of employees a retiree health benefit different than the benefit and value of benefit offered to another group? What are the OPEB implications?
- How do agencies pay the working rate for retirees?

Next Meeting: 10/17/13 for 1.5 hours. Weekly meetings thereafter up until report's due date.

DEPARTMENT OF Administrative Services

NEW HAMPSHIRE

Commission to Review Retiree Health Care Benefits for Employees Hired after July 1, 2013

Retiree Health Costs

Linda M. Hodgdon
Commissioner
Department of Administrative Services
October 3, 2013

DEPARTMENT OF Administrative Services

NEW HAMPSHIRE

Laws 2013, Chapter 144:33 (HB2)

144:33 New Section; State Employees Group Insurance; Commission Established; Cost Containment Options; Retiree Health Plan for New Employees. Amend RSA 21-I by inserting after section 36-a the following new section:

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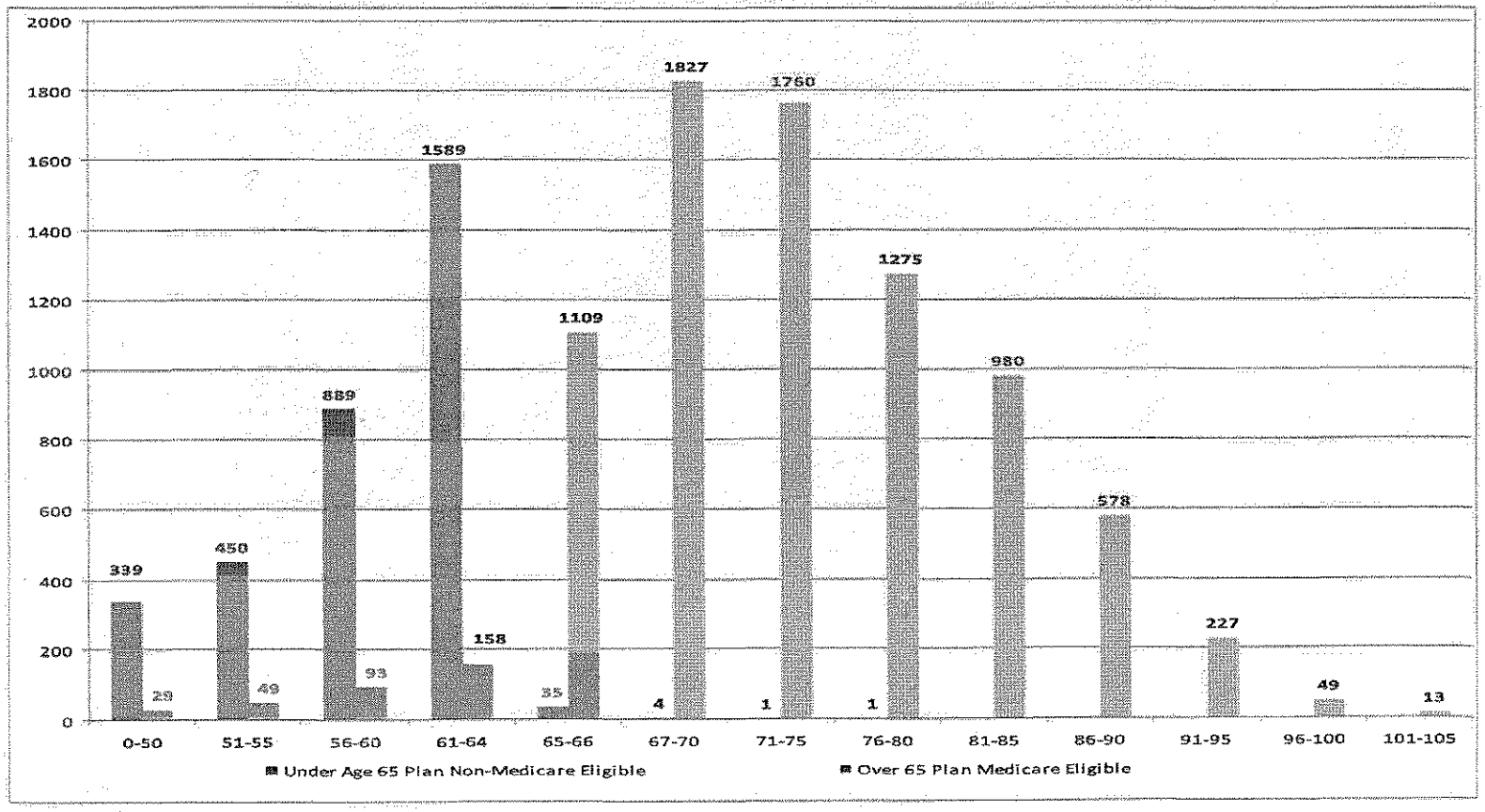
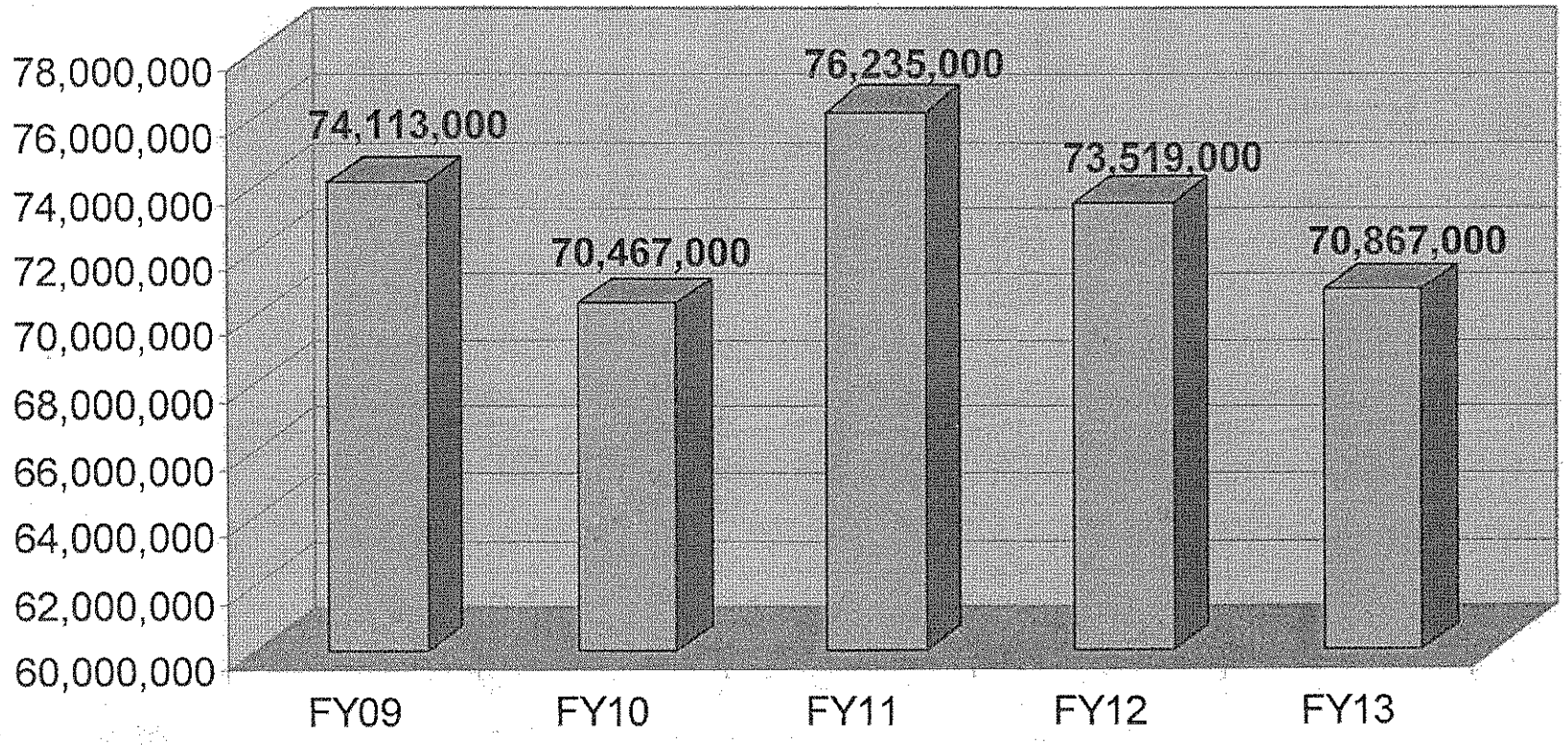
Retirees – Plan By Age Bracket



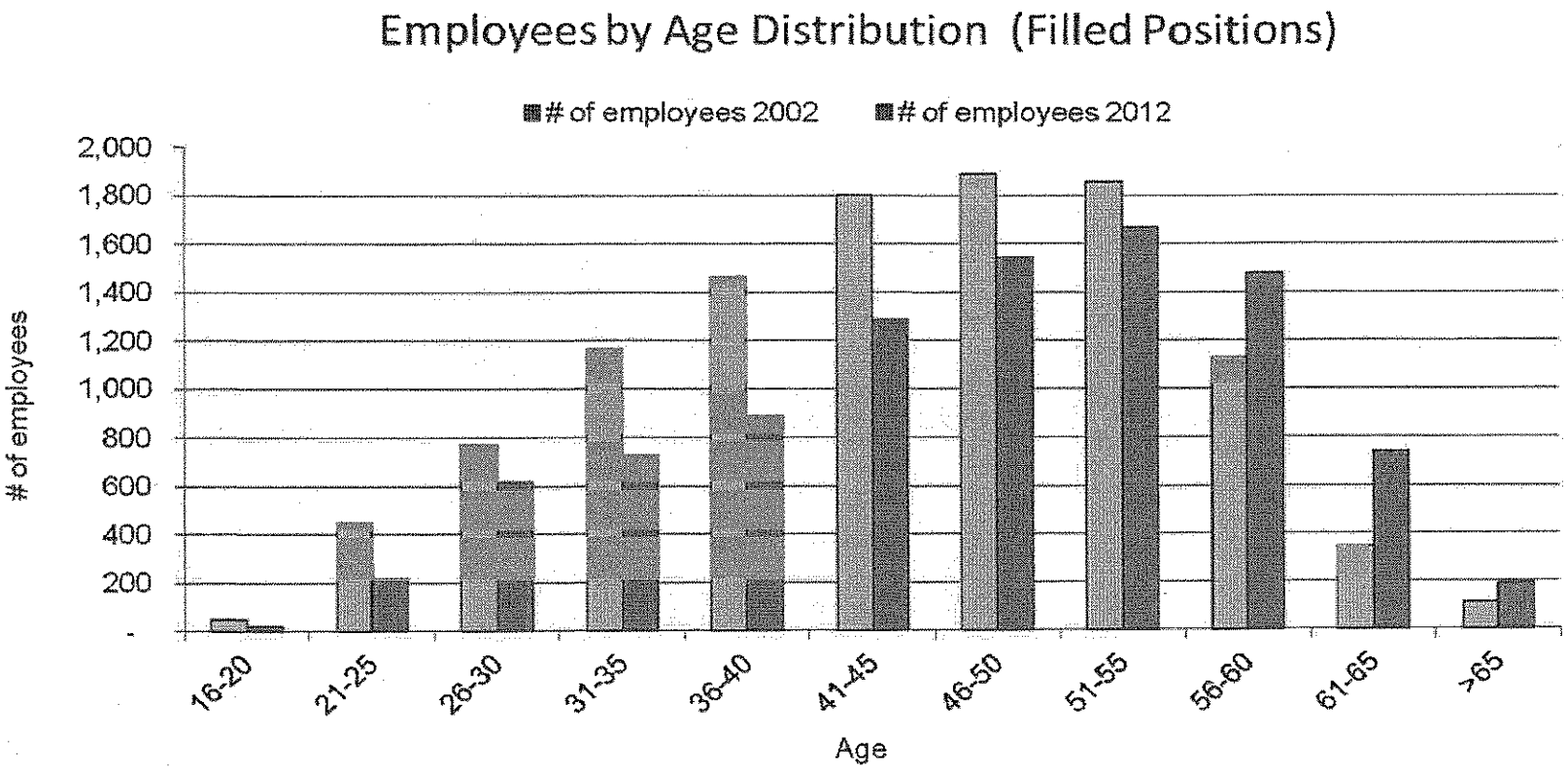
Source: Anthem, March 2013

Total Retiree Health Costs From FY10 through FY13



Source: State of NH, CAFR, FY09-FY12

In 2002, the largest employee age group was age 46-50. In 2012, the largest employee age group was age 51-55.



Source: Governor's Executive Budget Summary, 2013

Cadillac Tax

- Projected by Segal based on current plan design to be $1.4m in 2018 and increasing yearly for Retirees <65. Source: OPEB Valuation Report as of 12/31/12
- Projected by Segal based on current law and plan design to be $14m in 2018 and increasing yearly for active employees.
- We are assessing the impact of the proposed health benefit plan changes on the Cadillac Tax

Other Post-Employment Benefits (OPEB)

- **OPEB** – Other Postemployment Benefits other than pensions. For the State of NH, this includes medical and prescription drug coverage provided to eligible retirees.
- **GASB 45** – Governmental Accounting Standards Board Statement No. 45 *Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions.* State of NH was required to adopt and implement this standard in FY 2008. Even though RSA 21-I:30 stipulates that benefits provided are "*within the limit of the funds appropriated at each legislative session*", the GASB standard considers this to be a *"substantive plan"* which is the plan as generally understood by the employer and plan members.
- State of NH currently only finances OPEB on a *pay-as-you-go* basis where only the cash paid for OPEB are reported in fund financial statements in a given year. GASB 45 does not mandate the pre-funding of future OPEB.
- GASB 45 requires the State to recognize the *cost* of OPEB in periods when the related employee services are received. This requires the State to project future OPEB payments, discount them back to present value, and allocate them to periods of employee service. The State has retained Segal to provide these necessary actuarial services and calculate the State's Unfunded Actuarial Accrued Liability (UAAL) for future OPEB.
- In order for assets set aside to fund future benefits to be considered contributions to the OPEB plan, those assets or contributions must be made to trust or equivalent arrangement for the sole purpose of providing OPEB.

OPEB

The State's annual OPEB cost, the percentage of annual OPEB cost contributed to the plan, and the net OPEB obligation for fiscal year 2013, 2012 and 2011 were as follows (dollar amounts in thousands):

Fiscal Year Ended	Annual OPEB Cost	Actual Contributions (pay-as-you-go)	Percentages Contributed	Net OPEB Obligation
6/30/2013	$ 137,812	$ 51,332	37.25%	$ 765,669
6/30/2012	$ 171,912	$ 50,997	29.66%	$ 679,219
6/30/2011	$ 162,120	$ 54,418	33.57%	$ 558,304

As of December 31, 2012, the date of the most recent actuarial valuation, the actuarial accrued liability (AAL) for benefits was $1,857 million, with no actuarial value of assets, resulting in an unfunded actuarial accrued liability (UAAL) of $1,857 million.

Source: State of New Hampshire's Comprehensive Annual Financial Report for Fiscal Year 2013.

BlueChoice® New England

Anthem

State of NH Summary of Benefits

Retirees Under Age 65 Retirees Residing in New England (POS)

(Effective 01/01/2012)

This is only a brief summary of your coverage. Benefits apply when care is medically necessary. Services are covered up to the Maximum Allowable Benefit (MAB). Network providers agree to accept the MAB as payment in full. However, if you receive services from a non-network provider, under Self Referred benefits, it is your responsibility to pay the difference between the MAB and the provider's charge.

Service Received	Your Share of the Cost	
	In-Network Benefits	Out-Of-Network Benefits
Preventive Care • Immunization (including travel), lead screening, PSA (prostate screening)	No charge	Covered up to MAB
• Routine physical exam and well baby care • Routine hearing screening *(through age 18)* *See "Other Services" for additional Preventive Care information*	No charge	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 Some self referred benefits are subject to precertification requirements. Refer to your Benefit Booklet for details. Call 1-800-531-4450 to precertify.
Office Visit • Medical exam, family planning, and office surgery	$10 PCP/$30 Specialist Copay	
Other Outpatient Care • Allergy treatments and injection	$10 Copay	
• High Cost Radiology (CTA CAT, MRI, MRA, SPECT, PET)	$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 (as a bed patient in an acute care hospital) • Semi-private room and board • Physician in-hospital care, surgery, delivery, anesthesia, lab, X-ray, CT scan, MRI, medical supplies, medication and physical, occupational and speech therapy		
Skilled Nursing Facility and Rehabilitation Facility Care (Limited to 100 days combined maximum per member per calendar year) θ		
Durable Medical Equipment (DME) and External Prosthetic Devices (unlimited)		
Other Services • Routine vision exam – birth through age 18 *(one exam every year)* • Routine vision exam – age 19 and over *(one exam every two years)*	$10 Copay	
• Short term rehabilitative therapy-Physical, occupational, cardiac speech *(unlimited in-network; $3,000 per calendar year out-of network for all therapies combined)* θ	Subject to deductible	
• Chiropractic visit *(20 visit maximum per calendar year)*	$10 Copay	
• Infertility diagnosis and treatment • Treatment for surgical and non-surgical TMJ *(excluding appliances and orthodontic treatment)*	$30 copay	
• Hearing aids – birth to age 18 • Nutritional Counseling – *(if billed as an office visit, services will be subject to an office visit co-pay, 3 visits per member per calendar year, unlimited for diabetes or organic disease)* • OB/GYN care (performed by an OB/GYN provider) - Well women exam (1 per year) - Maternity care (routine prenatal, delivery and postpartum)	No Charge Subject to deductible	
• Mammogram and Pap smear	No charge	Covered to MAB
Emergency Room (ER) or Urgent Care Center Visit • ER/Urgent Care physician fee, medical supplies, etc.	No charge	Same as Network benefits
• ER charge (the copayment is waived if you are admitted) • Urgent Care Center charge	$150 per visit $50 per visit	$150 per visit
Ambulance *(medically necessary emergency transport only)*	Subject to deductible	Deductible and Coinsurance

θ Any combination of benefits from either column count toward this maximum.

∩ Services are covered up to the MAB. Out of network providers may bill you for amounts that exceed the

For these services, ALL care must be authorized in advance by Anthem Behavioral Health (ABH) at 1-800-228-5975. You will pay less if you utilize a network provider.

	Network Benefits	Out-of-Network Benefits^
Mental Health (MH) • Outpatient services - Individual Therapy - Group Therapy - Intensive Outpatient Treatment Program (IOP)	$10 Copay	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 Some self referred benefits are subject to precertification requirements. Refer to your Benefit Booklet for details. Call 1-800-531-4450 to precertify.
• Inpatient services - Inpatient - Partial Hospitalization Program (PHP)	Subject to deductible	
Substance Abuse (SA) • Outpatient services - Individual Therapy - Group Therapy - Intensive Outpatient Treatment Program (IOP)	$10 Copay	
• Inpatient services - Inpatient (*Including medical detoxification & SA rehabilitation)* - Partial Hospitalization Program (PHP)	Subject to deductible	

Prescription Drugs

Prescription drug benefits are administered by Caremark. For assistance with prescription drug benefit inquiries, call:

- Local Government Center: 1-800-527-5001 or Caremark: 1-888-726-1630

Maximums (For covered medical costs)

	Network Benefits	Out-of-Network Benefits^
• Individual Out-Of Pocket Maximum	$1000 per person per calendar year	$2000 per person per calendar year
• Family Out-of-Pocket Maximum	$2000 per family per calendar year	$4000 per family per calendar year
• Life Time Benefit Maximum	Unlimited	Unlimited

Other

- Health Education Reimbursement: N/A
- Fitness Equipment Reimbursement or Health Club Benefit: N/A
- Eyewear benefits: N/A

Exclusions and Limitations

The services listed below are not covered by this plan. Please review your Benefit Booklet for complete details on exclusions and limitations.

Services Not Covered

•Any service that is not medically necessary • Any service required by a third party (court ordered services are covered if all of the other terms of the plan are met) • Claims for services received more than 12 months ago • Complementary and Alternative Therapies/ Medicine • Cosmetic surgery • Custodial or convalescent care • Educational testing and therapy • Experimental and/or investigational services • Hospitalization for conditions that are not covered • Human organ transplants other than those listed in the Benefit Booklet as covered benefits • Mental health services which do not usually result in favorable modification through short-term therapy • Miscellaneous devices, materials, and supplies, including, but not limited to, breast pump, hearing aids (except for children under 19) , dentures and support devices for the feet and corrective shoes • Permanent dental restoration, orthognathic and most oral surgery • Personal comfort items • Radial keratotomy or other surgery to correct vision • Routine podiatry • Services covered by government programs to the extent permitted by law • Services for work-related illness or injury • Sex changes • Eye glasses and contact lenses (except after cataract surgery)

Anthem Blue Cross and Blue Shield has the right to recover its costs for care of:

• Injuries which are the responsibility of other parties • Services for which another insurance carrier or Medicare is primary • Services related to illegal conduct

This is only a brief summary of your coverage.

This summary of benefits is not a contract. It is a general description of the benefits and exclusions of this plan. Complete information about all benefits, limitations and exclusions is in the Benefit Booklet, which is available upon request. If you need further information, call Customer Service at 1-800-933-8415.

∩ Services are covered up to the MAB. Out of network providers may bill you for amounts that exceed the MAB.

† BlueChoice New England is administered by Anthem Blue Cross and Blue Shield.

Preferred Blue®

Anthem.

State of NH Summary of Benefits
Retirees Under Age 65 Retirees Residing Outside of New England (PPO)
(Effective 01/01/2012)

This is only a brief summary of your coverage. Benefits apply when care is medically necessary. Services are covered up to the Maximum Allowable Benefit (MAB). Network providers agree to accept the MAB as payment in full. However, if you receive services from a non-network provider, under Self Referred benefits, it is your responsibility to pay the difference between the MAB and the provider's charge.

Service Received	Your Share of the Cost	
	In-Network Benefits	Out-Of-Network Benefits
Preventive Care • Immunization (including travel), lead screening, PSA (prostate screening)	No charge	Covered up to MAB
• Routine physical exam and well baby care • Routine hearing screening *(through age 18)* *See "Other Services" for additional Preventive Care information*	No charge	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 Some self referred benefits are subject to precertification requirements. Refer to your Benefit Booklet for details. Call 1-800-531-4450 to precertify.
Office Visit • Medical exam, family planning, and office surgery	$10 PCP/$30 Specialist Copay	
Other Outpatient Care • Allergy treatments and injection	$10 Copay	
• High Cost Radiology (CTA CAT, MRI, MRA, SPECT, PET)	$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 (as a bed patient in an acute care hospital) • Semi-private room and board • Physician in-hospital care, surgery, delivery, anesthesia, lab, X-ray, CT scan, MRI, medical supplies, medication and physical, occupational and speech therapy		
Skilled Nursing Facility and Rehabilitation Facility Care (Limited to 100 days combined maximum per member per calendar year)☐		
Durable Medical Equipment (DME) and External Prosthetic Devices (unlimited)		
Other Services • Routine vision exam – birth through age 18 *(one exam every year)* • Routine vision exam – age 19 and over *(one exam every two years)*	$10 Copay	
• Short term rehabilitative therapy-Physical, occupational, cardiac speech (*unlimited in-network; $3,000 per calendar year out-of network for all therapies combined)* ☐	Subject to deductible	
• Chiropractic visit *(20 visit maximum per calendar year)*	$10 Copay	
• Infertility diagnosis and treatment • Treatment for surgical and non-surgical TMJ *(excluding appliances and orthodontic treatment)*	$30 copay	
• Hearing aids – birth to age 18 • Nutritional Counseling – *(if billed as an office visit, services will be subject to an office visit co-pay, 3 visits per member per calendar year, unlimited for diabetes or organic disease)* • OB/GYN care (performed by an OB/GYN provider) - Well women exam (1 per year) - Maternity care (routine prenatal, delivery and postpartum)	No Charge Subject to deductible	
• Mammogram and Pap smear	No charge	Covered to MAB
Emergency Room (ER) or Urgent Care Center Visit • ER/Urgent Care physician fee, medical supplies, etc.	No charge	Same as Network benefits
• ER charge (the copayment is waived if you are admitted) • Urgent Care Center charge	$150 per visit $50 per visit	$150 per visit
Ambulance *(medically necessary emergency transport only)*	Subject to deductible	Deductible and Coinsurance

☐ Any combination of benefits from either column count toward this maximum.

☐ Services are covered up to the MAB. Out of network providers may bill you for amounts that exceed the MAB.

For these services, ALL care must be authorized in advance by Anthem Behavioral Health (ABH) at 1-800-228-5975. You will pay less if you utilize a network provider.

	Network Benefits	Out-of-Network Benefits
Mental Health (MH) • Outpatient services - Individual Therapy - Group Therapy - Intensive Outpatient Treatment Program (IOP)	$10 Copay	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 Some self referred benefits are subject to precertification requirements. Refer to your Benefit Booklet for details. Call 1-800-531-4450 to precertify.
• Inpatient services - Inpatient - Partial Hospitalization Program (PHP)	Subject to deductible	
Substance Abuse (SA) • Outpatient services - Individual Therapy - Group Therapy - Intensive Outpatient Treatment Program (IOP)	$10 Copay	
• Inpatient services - Inpatient (*Including medical detoxification & SA rehabilitation)* - Partial Hospitalization Program (PHP)	Subject to deductible	

Prescription Drugs

Prescription drug benefits are administered by Caremark. For assistance with prescription drug benefit inquiries, call:

- Local Government Center: 1-800-527-5001 or Caremark: 1-888-726-1630

Maximums (For covered medical costs)

	Network Benefits	Out-of-Network Benefits
• Individual Out-Of Pocket Maximum	$1000 per person per calendar year	$2000 per person per calendar year
• Family Out-of-Pocket Maximum	$2000 per family per calendar year	$4000 per family per calendar year
• Life Time Benefit Maximum	Unlimited	Unlimited

Other

- Health Education Reimbursement: N/A
- Fitness Equipment Reimbursement or Health Club Benefit: N/A
- Eyewear benefits: N/A

Exclusions and Limitations

The services listed below are not covered by this plan. Please review your Benefit Booklet for complete details on exclusions and limitations.

Services Not Covered

•Any service that is not medically necessary • Any service required by a third party (court ordered services are covered if all of the other terms of the plan are met) • Claims for services received more than 12 months ago • Complementary and Alternative Therapies/ Medicine • Cosmetic surgery • Custodial or convalescent care • Educational testing and therapy • Experimental and/or investigational services • Hospitalization for conditions that are not covered • Human organ transplants other than those listed in the Benefit Booklet as covered benefits • Mental health services which do not usually result in favorable modification through short-term therapy • Miscellaneous devices, materials, and supplies, including, but not limited to, breast pump, hearing aids (except for children under 19) , dentures and support devices for the feet and corrective shoes • Permanent dental restoration, orthognathic and most oral surgery • Personal comfort items • Radial keratotomy or other surgery to correct vision • Routine podiatry • Services covered by government programs to the extent permitted by law • Services for work-related illness or injury • Sex changes • Eye glasses and contact lenses (except after cataract surgery)

Anthem Blue Cross and Blue Shield has the right to recover its costs for care of:

• Injuries which are the responsibility of other parties • Services for which another insurance carrier or Medicare is primary • Services related to illegal conduct

This is only a brief summary of your coverage.

This summary of benefits is not a contract. It is a general description of the benefits and exclusions of this plan. Complete information about all benefits, limitations and exclusions is in the Benefit Booklet, which is available upon request. If you need further information, call Customer Service at 1-800-933-8415.

☐ Services are covered up to the MAB. Out of network providers may bill you for amounts that exceed the MAB.

† BlueChoice New England is administered by Anthem Blue Cross and Blue Shield.

Anthem.

Outline of Coverage
State of New Hampshire Retiree Over 65

Medicare Complementary Coverage
The State of New Hampshire requires every insurance company selling health insurance to an individual covered by Medicare to provide the following information.

Medicare Benefits may be changed by Federal Law.

Inpatient Hospital Benefits	Medicare A Pays	Medicomp Three Pays	You Pay
First 60 days of Medicare benefit period	Full cost after $1,184 Benefit Period Deductible	Deductible $1,184	**No Balance**
Next 30 days (61st through 90th days)	Full cost except for coinsurance of $296 per day	Coinsurance $296 per day	**No Balance**
Next 60 days of one-time lifetime reserve days (91st through 150th days)	Full cost except for coinsurance of $592 per day	Coinsurance $592 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	**Remember:** 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 $148.00 per day	Coinsurance $148.00 per day	**No Balance**
After 100 days of continuous confinement	Nothing	Nothing	Full Cost
Medical Service Benefits	**Medicare 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 $147 annual deductible	20% of Medicare approved charges	$147 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**

*Please refer to Medicare Handbook for psychiatric maximums and exceptions
** Balances are eligible for consideration under the Major Medical portion of this plan. Please see "Additional Benefits" on Page 2 of this Outline.

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 describers in detail those services and supplies not covered by Medicomp.**

Anthem Blue Cross and Blue Shield Customer Service

3000 Goffs Falls Road
Manchester, NH 03111-0001
1-800-225-2666

Retirees

Your Personal Prescription Benefit Program

	RETAIL PHARMACY	MAIL SERVICE PHARMACY
	For immediate or short-term medication needs*	For maintenance or long-term medication needs*
YOU WILL PAY	• **$10** for each generic medication • **$20** for each preferred brand-name medication** • **$35** for each non-preferred brand-name medication**	• **$1** for each generic medication • **$40** for each preferred brand-name medication** • **$70** for each non-preferred brand-name medication**
	• **$0** for contraceptives, devices and emergency contraception	
MAXIMUM OUT-OF-POCKET	**$500** per individual per calendar year **$1,000** per family per calendar year	
DAY SUPPLY LIMIT	Up to a **31**-day supply	Up to a **90**-day supply
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
TOBACCO CESSATION	Your plan covers prescription medication and some over-the-counter products designed to eliminate tobacco use. Coverage is available through your retail and mail service benefit subject to the cost sharing components and dispensing limitations of your plan. To be eligible for the coverage you must be age 18 or older. Contact Customer Care or log on to www.caremark.com to find out more about which prescription medications and over-the-counter products are covered under your plan.	
PRIOR AUTHORIZATION REQUIRED	Acne Therapy, Amevive, Antiemetic Agents, Apokyn, Botox and Myobloc for Non-Cosmetic Purposes Only, Celebrex, Misc. Dermatologicals, Erectile Dysfunction, Erythroid Stimulants, Growth Hormones, Hypnotic Agents, Interferons, Migraine Agents, Multiple Sclerosis Therapy, Myeloid Stimulants, Platelet Proliferation Stimulants, Provigil, Rheumatoid Arthritis Therapy, Xolair, Wellbutrin and its generics.	

*Your plan may have coverage limits, be subject to dispensing limitations and may not cover certain medications. Please contact CVS Caremark at 1-888-726-1630 or log on to www.caremark.com for the most up-to-date plan information.
**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 the generic.
***Your plan requires that maintenance or long-term medications be filled through the CVS Caremark Mail Service Pharmacy once you exceed the refill limit per prescription. Your plan also includes the Mail-Order Opt-Out Program. For more information, please call CVS Caremark toll-free at 1-888-726-1630 to talk with a Customer Care Representative about the opt-out program.

Where to Fill Your Prescription

Choosing where to fill your prescription depends on whether you are ordering a short-term or long-term medication:

Short-term medications are generally taken for a limited amount of time and have a limited amount of refills, such as an antibiotic. You can fill prescriptions for these medications at any pharmacy in the CVS Caremark retail network.

- Choose from more than 64,000 network pharmacies nationwide, including over 20,000 independent community pharmacies
- Find a participating pharmacy at www.caremark.com

Tip: To avoid filling out claims paperwork, bring your Prescription Card with you when you pick up your prescription, and use a pharmacy in the CVS Caremark retail network. Additional Prescription Cards may be obtained by calling Customer Care toll-free at 1-888-726-1630.

Long-term medications are taken regularly for chronic conditions, such as high blood pressure, asthma, diabetes or high cholesterol. You will generally save money by using mail service for these prescriptions. Choose **one** of four easy ways to start using the CVS Caremark Mail Service Pharmacy:

1. Fill out and send in a mail service order form – use the one included in this welcome kit or print one at www.caremark.com
2. Use the FastStart® tool found on www.caremark.com
3. Call FastStart® toll-free at 1-800-875-0867
4. Ask your doctor to call in the prescription through the toll-free FastStart® physician number at 1-800-378-5697

Customer Care

If you have questions about your prescriptions or benefits, you can contact Customer Care 24 hours a day, seven days a week, toll-free at **1-888-726-1630** or by e-mail at **customerservice@caremark.com.** For Telecommunication Device assistance, please call toll-free **1-800-863-5488. Caremark.com** is also available to help you manage your prescription drug benefits. By registering online, you can order mail service refills, check order status, price medications, and much more.

Your feedback is important as it helps us improve our service. Please contact us with any questions or concerns at 1-888-726-1630.
Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

To contact LGC HealthTrust, please call toll-free at **1-800-527-5001** between the hours of 8:30 a.m. and 4:30 p.m. (EST) Monday through Friday or visit **www.nhlgc.org**. LGC HealthTrust's Enrollee Services Representatives are available for issues or concerns with enrollment or eligibility, and any other prescription benefit-related inquiry. For further information or questions, you may also e-mail Enrollee Services at **enrolleeservices@nhlgc.org**.

Getting Your Prescription Filled at a Retail Pharmacy

CVS Caremark Participating Retail Pharmacies
Participating retail pharmacies can easily access information about your prescription benefit plan and the appropriate payment. You will not need to file any additional paperwork when you use a pharmacy in the CVS Caremark retail network. If you use a pharmacy outside the CVS Caremark retail network, you will pay more for your prescription(s) in most cases. Non-participating retail pharmacies will ask you to pay 100 percent of the prescription price. Then, you will need to submit a paper claim form along with the original prescription receipt(s) for reimbursement of covered expenses.

Day Supply Limit
You can get up to a 31-day supply of medication each time you have a prescription filled at a participating retail pharmacy. Ask your doctor to write a prescription for up to a 31-day supply, when clinically appropriate.

Refill Limit
You may obtain one initial fill plus two refills for maintenance or long-term medications at a retail pharmacy. It will then be necessary for you to utilize CVS Caremark Mail Service Pharmacy for additional supplies. Otherwise, you will be responsible for 100 percent of the cost of the medication when filled at a retail pharmacy. To determine if your prescription medication is classified as maintenance or long-term, please call Customer Care at 1-888-726-1630.

Getting Your Prescription Filled through the CVS Caremark Mail Service Pharmacy

CVS Caremark operates five mail service pharmacies across the United States to provide quick service to plan participants wherever they live. To ensure your safety, our mail service pharmacies are staffed by registered pharmacists. Just like your neighborhood pharmacist, our pharmacists check each prescription to make sure it is filled correctly. In addition, your prescription history is reviewed to identify any possible problems with new medications you may be prescribed.

Day Supply Limit
You can get up to a 90-day supply of medication when you get a prescription filled through the CVS Caremark Mail Service Pharmacy. Ask your doctor to write a prescription for up to a 90-day supply plus three refills for up to one year when clinically appropriate. **Please Note:** *By law, CVS Caremark must fill your prescription for the exact quantity of medication prescribed by your doctor, up to the 90-day supply limit.*

Payment Options
While checks and money orders are accepted, the preferred method of payment is by credit card. For credit card payments, simply include your VISA®, Discover®, MasterCard®, American Express®, Health Reimbursement or Flexible Spending Account debit card number and expiration date in the space provided on the mail service order form.

Convenient Home Delivery
Please allow 7-10 days for delivery from the time your order is placed. Refills are delivered within seven days following CVS Caremark's receipt of your refill request by phone or online. Your package will include a new mail service order form and an invoice, if applicable. You will also receive the same type of information about your prescribed medication that you would receive from a retail pharmacy.

Other Important Plan Information

Drug List
Your plan is subject to a list of prescription drugs that are preferred by the plan because of their safety, clinical effectiveness and ability to help control prescription drug costs. The drug list is updated on a regular basis. Log on to www.caremark.com or call Customer Care at 1-888-726-1630 to access the most current drug list for your plan.

Mail Order Opt-Out Program
Your plan includes the Mail Order Opt-Out Program. This program can be used for plan participants who feel that using mail service would create undue hardship. The Mail Order Opt-Out Program gives you the choice of filling your maintenance or long-term prescriptions through the CVS Caremark Mail Service Pharmacy or at a retail pharmacy location. If you think filling your maintenance or long-term prescriptions through mail service will create a hardship for you, please call CVS Caremark toll-free at 1-888-726-1630 to talk with a Customer Care Representative about the opt-out program. Please note: You may only receive up to a 31-day supply at a retail pharmacy location and you will be subject to the retail copayment. Even if you elect to opt-out now, you can still choose to use mail service at any time.

Brand-Name Medications Requiring Use of a Generic First
You can save money by using safe, effective generic medications when possible. Your plan requires using an alternative generic medication for certain brand-name medications first unless you have tried a generic. Brand-name medications will be covered under your plan if your prescription history shows you have tried an alternative generic. Please call CVS Caremark toll-free at 1-888-726-1630 to talk with a Customer Care Representative about your plan and options available if you must take the brand-name medication because of a medical condition or allergy.

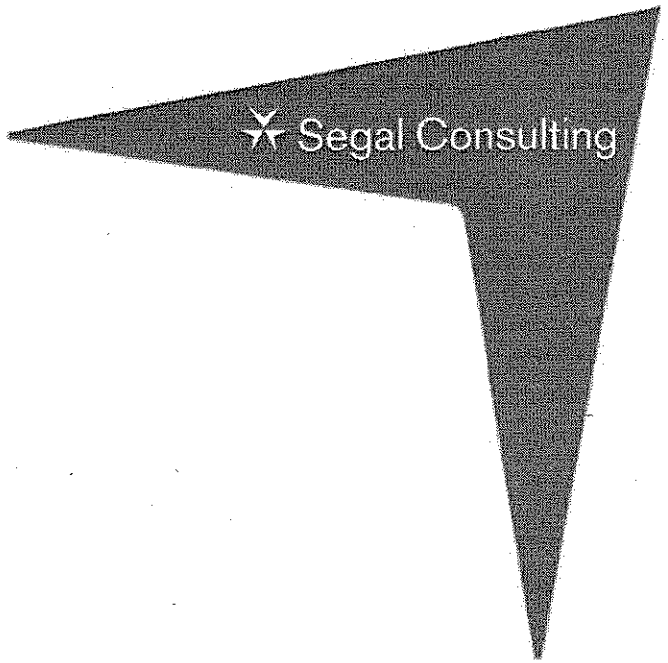
Quantity Limits
Your plan includes quantity limits for some medications limiting the amount of medication for which your plan will pay. Please call CVS Caremark toll-free at 1-888-726-1630 to talk with a Customer Care Representative about the limits and options available if your doctor determines additional quantities are clinically appropriate.

Prior Authorization
Some medications may require approval before the prescription can be filled. Your retail pharmacist will give you or your doctor a toll-free number to call in order to obtain approval. The CVS Caremark Mail Service Pharmacy will contact your doctor directly for approval.

Specialty Medications
Specialty medications are used for the treatment of chronic and/or genetic conditions, such as multiple sclerosis, rheumatoid arthritis or hepatitis C, and are often injected or infused. All specialty medications will be provided by CVS Caremark's Specialty Pharmacy. CVS Caremark's Specialty Pharmacy is a mail order facility dedicated to dispensing specialty medications. Questions? Call CVS Caremark Specialty Pharmacy toll-free at 1-800-237-2767.

State of New Hampshire

Actuarial Valuation and Review of Other Postemployment Benefits (OPEB) as of December 31, 2012 in accordance with GASB Statements No. 43 and No. 45



Segal Consulting
116 Huntington Avenue 8th Floor Boston, MA 02116-5744
T 617.424.7300 www.segalco.com

September 27, 2013

Ms. Catherine A. Keane
Administrator of Risk and Benefits
Department of Administrative Services
25 Capitol Street
Concord, NH 03301

Dear Ms. Keane:

We are pleased to submit this Actuarial Valuation and Review of Other Postemployment Benefits (OPEB) as of December 31, 2012 under Governmental Accounting Standards Board Statements Number 43 and 45. The report summarizes the actuarial data used in the valuation, discloses the Net OPEB obligation (NOO) as of June 30, 2013, establishes the Annual Required Contribution (ARC) for fiscal year 2013, and analyzes the preceding year's experience. This report was based on the census data provided by the State and the terms of the Plan. The actuarial calculations were completed under the supervision of Kathleen A. Riley, FSA, MAAA, EA, Senior Vice President and Actuary and Daniel J. Rhodes, ASA, FCA, MAAA, Vice President and Consulting Actuary.

This actuarial valuation has been completed in accordance with generally accepted actuarial principles and practices. To the best of our knowledge, the information supplied in this actuarial valuation is complete and accurate. Further, in our opinion, the assumptions used in this valuation and described in Exhibit II are reasonably related to the experience of and the expectations for the Plan. The actuarial projections are based on these assumptions and the plan of benefits as summarized in Exhibit III.

Sincerely,
Segal Consulting, a Member of The Segal Group, Inc.

By:
Kathleen A. Riley, FSA, MAAA, EA
Senior Vice President and Actuary

Daniel J. Rhodes, ASA, FCA, MAAA
Vice President and Consulting Actuary

cc: Andrew D. Sherman
Stephen L. Kuhn

7860698v5/05855.075

SECTION 1

INTRODUCTION

SECTION 2

VALUATION RESULTS

SECTION 3

VALUATION DETAILS

SECTION 4

SUPPORTING INFORMATION

SECTION 5

APPENDIX

PURPOSE

This report presents the results of our actuarial valuation of State of New Hampshire (the "Employer") postemployment welfare benefit plan as of December 31, 2012. The results are in accordance with the Governmental Accounting Standards, which prescribe an accrual methodology for accumulating the value of other postemployment benefits (OPEB) over participants' active working lifetimes. The accounting standard supplements cash accounting, under which the expense for postemployment benefits is equal to benefit and administrative costs paid on behalf of retirees and their dependents (*i.e.*, a pay-as-you-go basis).

HIGHLIGHTS OF THE VALUATION

During the fiscal year ending June 30, 2013, we project the State will pay claims and expenses (net of the New Hampshire Retirement System subsidy and retiree contributions) on behalf of retired employees of about $49,919,000. This amount is less than the annual "cost" (the "Annual Required Contribution" or ARC) of approximately $132,331,000

The GASB statements provide the method for selecting the investment return assumption (discount rate). If the benefits are funded, the discount rate should be based on the estimated long-term investment yield on the investments expected to be used to finance the payment of benefits. If financing continues to be pay-as-you-go, the discount rate should be based on the expected yield on the assets of the employer. Because the benefits are not being funded, we have used a 4.50% discount rate (referred to as the pay-as-you-go interest rate). For illustrative purposes, we have also shown what the obligations would be on a fully funded basis, assuming an interest rate of 7.75%.

To determine the amortization payment on the unfunded actuarial accrued liability (UAAL), an amortization period and amortization method must be selected. We have used a 30-year open amortization of the UAAL (the maximum permitted by the GASB statements), with payments increasing at 3.75% per year. In the prior valuation, payments were calculated to increase 4.5% per year. The GASB statements allow for either an open or closed amortization period. In open amortization, the period is reset to the initial value every year and the UAAL is reamortized, while under a closed amortization, the remaining period decreases and the UAAL is eventually "paid off."

To be considered a funded plan, the "contribution in relation to the ARC" must equal the ARC. For example, if the ARC is $93,562,000, and the employer pays claims and expenses to retirees of $49,919,000, then an additional contribution of the difference, or approximately $43,643,000 will need to be added to an OPEB trust fund during the fiscal year ending June 30, 2013.

On page 9, we show a funding schedule using the funded discount rate and a closed amortization beginning July 1, 2013. If the State were to start funding OPEB benefits, the "Additional Funding" amounts shown in this chart are the expected amounts the State would have to contribute to an OPEB trust in future years (beyond the projected net retiree claims and expenses) to fully fund the OPEB obligation in 30 years.

If benefits are funded in the future, assets set aside to fund OPEB liabilities must be held in a trust or equivalent arrangement, through which assets are accumulated and benefits are paid as they come due. Employer contributions

to the plan are irrevocable, plan assets are dedicated to providing benefits to retirees and their spouses in accordance with the terms of the plan, and plan assets are legally protected from creditors of the employer.

Page 10 shows a projection of the Annual Required Contribution. Please note that the projections on both pages 9 and 10 are based on a closed group projection. A closed group projection does not reflect new hires. The normal cost for each year after the valuation date has been increased by the ultimate medical cost trend rate of 5%. The actuarial accrued liability has been increased by benefits earned, less benefit payments, plus an adjustment for interest. Therefore, the changes adopted in the past few years to retirement eligibility and to retiree medical eligibility are reflected for only the affected individuals as of December 31, 2012. The normal cost and actuarial accrued liability will increase less than shown on these charts as future valuations reflect the larger portion of the active population that is affected by these changes.

GASB guidelines prohibit the offset of OPEB obligations by the future value of Medicare Part D subsidies. Therefore, these calculations do not include an estimate for retiree prescription drug plan federal subsidies that the Employer may be eligible to receive for plan years beginning in 2006.

Employer decisions regarding plan design, cost sharing between the Employer and its retirees, actuarial cost method, amortization techniques, and integration with Medicare are just some of the decisions that affect the magnitude of OPEB obligations. We are available to assist you with any investigation of such options you may wish to undertake.

This valuation does not include the potential impact of any future changes due to the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act (HCERA) of 2010 other than the excise tax on high cost health plans beginning in 2018 (reflected with this valuation) and those previously adopted as of the valuation date.

KEY VALUATION RESULTS

A summary of significant valuation results follows:

- The **unfunded actuarial accrued liability (UAAL)** as of December 31, 2012 is $1,140,302,000 (funded) and $1,856,714,000 (pay-as-you-go). Going forward, net unfunded plan obligations will be expected to change due to normal plan operations, which consist of continuing accruals for active members, plus interest on the total actuarial accrued liability, less expected benefit payments and contributions. Future valuations will analyze the difference between actual and expected unfunded actuarial accrued liabilities.
  - As of December 31, 2012, the ratio of assets to the AAL (the funded ratio) is 0%.
- The **Annual Required Contribution (ARC) is** $93,562,000 (funded) and $132,331,000 (pay-as-you-go) this year. The ARC is expected to remain relatively level as a percentage of payroll, as long as the ARC is fully funded each year. If the ARC is not fully funded, it may be expected to increase as a percentage of payroll over time.
- As noted above, **projected benefit payments** for the year ended June 30, 2013 are $49,919,000. The GASB 45 disclosure charts in Section 3 should reflect the actual benefit payments as the "contribution in relation to the ARC."

Plan obligations had been expected to increase due to normal plan operations, which consist of continuing accruals for active members, plus interest on the total obligation, less expected benefit payments. The smaller than expected increase was the net result of the following:

- An **actuarial experience gain** decreased obligations. This was the net result of gains and losses due to demographic changes, changes in Group code for a number of employees, the addition of new employees with a lower level of benefits, and other miscellaneous changes.
- **Valuation assumption changes** decreased obligations. This was the net result of a *decrease* in obligations due to valuation-year per capita health costs that did not increase as much as expected and changes to the future trend on per capita health costs, partially offset by an *increase* in obligations due to incorporating the changes in the demographic assumption shown in the NHRS Experience Study for the period July 1, 2005 – June 30, 2010. The medical and prescription drug per capita health costs for the prior and current valuations are shown on the following page. The complete set of assumptions is shown in Exhibit II.
- The addition of the **PPACA excise tax on high cost health plans** in this valuation increased obligations. Reflecting this tax in the valuation resulted in a 1.4% increase in the actuarial accrued liability and a 2.8% increase in normal cost.

The per capita health costs for retirees and spouses at selected ages used in the prior and current valuations are shown below:

Per Capita Health Costs for 2012*

	Medical				Prescription Drug			
	Retiree		Spouse		Retiree		Spouse	
Age	Male	Female	Male	Female	Male	Female	Male	Female
45	$4,933	$6,189	$3,060	$4,620	$1,303	$1,634	$808	$1,220
50	5,855	6,670	4,090	5,355	1,546	1,761	1,080	1,414
55	6,954	7,180	5,472	6,199	1,836	1,896	1,445	1,637
60	8,258	7,739	7,327	7,190	2,180	2,043	1,935	1,899
64	9,467	8,206	9,244	8,086	2,424	2,101	2,366	2,070
65	1,751	1,488	1,751	1,488	2,508	2,132	2,508	2,132
70	2,029	1,604	2,029	1,604	2,907	2,298	2,907	2,298
75	2,187	1,726	2,187	1,726	3,133	2,473	3,133	2,473

Per Capita Health Costs for 2013

	Medical				Prescription Drug			
	Retiree		Spouse		Retiree		Spouse	
Age	Male	Female	Male	Female	Male	Female	Male	Female
45	$4,673	$5,863	$2,897	$4,375	$1,138	$1,429	$706	$1,066
50	5,546	6,317	3,874	5,073	1,352	1,540	944	1,237
55	6,587	6,801	5,184	5,872	1,606	1,658	1,264	1,431
60	7,823	7,330	6,940	6,810	1,907	1,787	1,692	1,660
64	8,975	7,776	8,761	7,665	2,188	1,896	2,136	1,868
65	1,693	1,439	1,693	1,439	2,265	1,925	2,265	1,925
70	1,962	1,551	1,962	1,551	2,625	2,074	2,625	2,074
75	2,114	1,669	2,114	1,669	2,829	2,233	2,829	2,233

** Reflects changes effective January 1, 2012.*

A reconciliation of changes in obligations on both the funded and pay-as-you-go basis is shown on the following page.

RECONCILIATION OF CHANGES IN OPEB UAAL

	Pre- funded (7.75% interest rate)	Pay-as-you-go (4.5% interest rate)
Unfunded actuarial accrued liability as of December 31, 2010	$1,342,000,000	$2,258,000,000
Change in UAAL attributable to:		
Benefits earned net of benefits paid, NHRS subsidy and retiree contributions	$183,000,000	$264,000,000
Actuarial experience gain	-218,000,000	-395,000,000
Changes in demographic assumptions	98,000,000	160,000,000
Changes in per capita costs and trends	-281,000,000	-457,000,000
Reflection of PPACA excise tax	16,000,000	27,000,000
Total change in unfunded actuarial accrued liability	-$202,000,000	-$401,000,000
Unfunded actuarial accrued liability as of December 31, 2012	$1,140,000,000	$1,857,000,000

ACCOUNTING REQUIREMENTS

The Governmental Accounting Standards Board (GASB) issued Statement Number 43 -- *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans,* and Statement Number 45 – *Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions.* Under these statements, all state and local governmental entities that provide other post employment benefits (OPEB) are required to report the cost of these benefits on their financial statements.

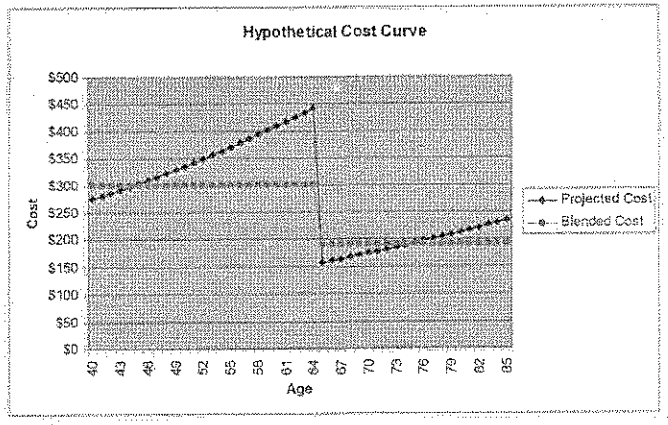
The statements cover postemployment benefits of health, prescription drug, dental, vision and life insurance coverage for retirees; long-term care coverage, life insurance and death benefits that are *not* offered as part of a pension plan; and long-term disability insurance for employees. These benefits, referred to as OPEB, are typically financed on a pay-as-you-go basis. The new standard introduces an accrual-basis accounting requirement; thereby recognizing the employer cost of postemployment benefits over an employee's career. The standards also introduce a consistent accounting requirement for both pension and non-pension benefits.

The total cost of providing postemployment benefits is projected, taking into account assumptions about demographics, turnover, mortality, disability, retirement, health care trends, and other actuarial assumptions. This amount is then discounted to determine the actuarial present value of the total projected benefits (APB). The actuarial accrued liability (AAL) is the portion of the present value of the total projected benefits allocated to years of employment prior to the measurement date. The unfunded actuarial accrued liability (UAAL) is the difference between the AAL and actuarial value of assets in the Plan.

Once the UAAL is determined, the Annual Required Contribution (ARC) is determined as the normal cost (the APB allocated to the current year of service) and the amortization of the UAAL. This ARC is compared to actual contributions made and any difference is reported as the net OPEB obligation (NOO). In addition, required supplementary information (RSI) must be reported, including historical information about the UAAL and the progress in funding the Plan.

The benefits valued in this report are limited to those described in Exhibit III of Section 4.

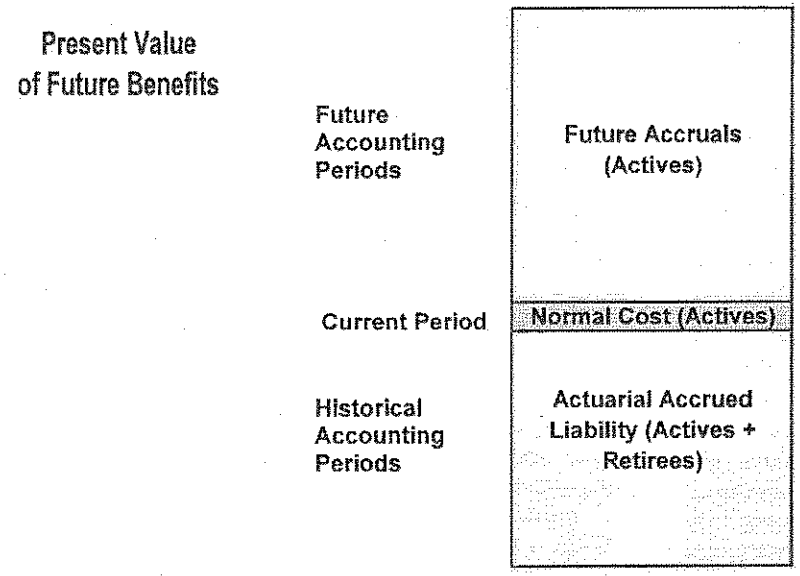
The following graph illustrates why a significant accounting obligation may exist even though the retiree contributes most or all of the blended premium cost of the plan. The average cost for retirees is likely to exceed the average cost for the whole group, leading to an implicit subsidy for these retirees. The accounting standard requires the employer to identify and account for this implicit subsidy as well as any explicit subsidies the employer may provide.



This graph shows how the actuarial present value of the total projected benefits (APB) is broken down and allocated to various accounting periods.

The exact breakdown depends on the actuarial cost method and amortization methods selected by the employer.

GASB 43/45 Measurement



Normal Cost
+
30 Years Amortization of Unfunded Actuarial Accrued Liability
Annual Required Contribution (ARC)

Net OPEB Obligation = $ARC_1 + ARC_2 + ARC_3 + ...$
$- Contribution_1 - Contribution_2 - Contribution_3 - .....$

Actuarial computations under GASB statements are for purposes of fulfilling certain welfare plan accounting requirements. The calculations shown in this report have been made on a basis consistent with our understanding of GASB. Determinations for purposes other than meeting the financial accounting requirements of GASB may differ significantly from the results reported here.

Calculations are based on the benefits provided under the terms of the substantive plan in effect at the time of the valuation and on the pattern of sharing costs between the employer and plan members. The projection of benefits does not incorporate the potential effect of legal or contractual funding limitations on the pattern of cost sharing between the employer and plan members in the future.

Actuarial calculations reflect a long-term perspective, and the methods and assumptions use techniques designed to reduce short term volatility in accrued liabilities and the actuarial value of assets, if any.

The calculation of an accounting obligation does not, in and of itself, imply that there is any legal liability to provide the benefits valued, nor is there any implication that the Employer is required to implement a funding policy to satisfy the projected expense.

Actuarial valuations involve estimates of the value of reported amounts and assumptions about the probability of events far into the future, and the actuarially determined amounts are subject to continual revision as actual results are compared to past expectations and new estimates are made about the future.

SECTION 2: Valuation Results for the State of New Hampshire December 31, 2012 Measurement Under GASB 43 and 45

The key valuation results for the current and prior years are shown on a funded basis and a pay-as-you-go basis.

SUMMARY OF VALUATION RESULTS

	Funded (7.75% interest rate)	Pay-as-you-go (4.5% interest rate)
Actuarial Accrued Liability – Gross		
1. Current retirees, beneficiaries and dependents	$760,711,614	$1,058,805,367
2. Current active employees	566,232,013	1,045,732,096
3. Total as of December 31, 2012: (1) + (2)	$1,326,943,627	$2,104,537,463
NHRS Subsidy		
4. Current retirees, beneficiaries and dependents	$116,435,379	$150,719,546
5. Current active employees	17,045,715	26,195,384
6. Total as of December 31, 2012: (4) + (5)	$133,481,094	$176,914,930
Retiree Contributions		
7. Current retirees, beneficiaries and dependents	$23,685,760	$27,779,591
8. Current active employees	29,474,407	43,128,700
9. Total as of December 31, 2012: (7) + (8)	$53,160,167	$70,908,291
Actuarial Accrued Liability – Net		
10. Current retirees, beneficiaries and dependents: (1) – (4) – (7)	$620,590,475	$880,306,229
11. Current active employees: (2) – (5) – (8)	519,711,891	976,408,013
12. Total as of December 31, 2012: (10) + (11)	$1,140,302,366	$1,856,714,242
Annual Required Contribution for Fiscal Year Ending June 30, 2013		
13. Normal cost as of December 31, 2012	$31,175,631	$63,760,421
14. Amortization of the unfunded actuarial liability (30 years, increasing 3.75% per year)	62,385,874	68,570,737
15. Total Annual Required Contribution (ARC): (13) + (14)	$93,561,505	$132,331,158
16. Projected net benefit payments for fiscal year ending June 30, 2013	$49,918,785	$49,918,785

FUNDING SCHEDULE

30 Years Closed (7.75% interest rate)

Fiscal Year Ended June 30	(1) Gross Benefit Payments	(2) Retiree Contributions	(3) NHRS Subsidy	(4) Projected Benefit Payments (1) – (2) – (3)	(5) Normal Cost	(6) Amortization of UAAL	(7) Total Funding Requirement (5) + (6)	(8) Additional Funding (7) – (4)	As of December 31 after Fiscal Year End (9) Assets	(10) AAL	(11) UAAL (10) – (9)
2013	$68,207,299	$4,651,280	$13,637,233	$49,918,786	$31,175,631	$62,385,874	$93,561,505	$43,642,719	$47,025,029	$1,208,480,050	$1,161,455,020
2014	72,262,990	4,829,434	13,584,940	53,848,616	32,734,412	64,725,344	97,459,756	43,611,140	97,660,473	1,279,386,699	1,181,726,226
2015	76,495,763	4,924,401	13,479,379	58,091,983	34,371,133	67,152,544	101,523,677	43,431,694	152,026,809	1,352,979,952	1,200,953,143
2016	81,001,944	5,026,531	13,349,008	62,626,405	36,089,689	69,670,764	105,760,453	43,134,048	210,285,824	1,429,242,587	1,218,956,763
2017	85,803,130	5,135,108	13,186,919	67,481,103	37,894,174	72,283,418	110,177,592	42,696,489	272,588,442	1,508,128,971	1,235,540,529
2018	91,784,021	5,278,343	13,013,034	73,492,644	39,788,883	74,994,046	114,782,929	41,290,285	338,204,328	1,588,693,163	1,250,488,836
2019	98,022,614	5,434,490	12,834,657	79,753,467	41,778,327	77,806,323	119,584,650	39,831,183	407,333,263	1,670,898,670	1,263,565,407
2020	103,750,743	5,587,741	12,663,033	85,499,969	43,867,243	80,724,060	124,591,303	39,091,334	481,022,503	1,755,534,054	1,274,511,552
2021	109,776,840	5,753,362	12,474,084	91,549,394	46,060,605	83,751,212	129,811,817	38,262,423	559,529,508	1,842,573,774	1,283,044,266
2022	115,617,992	5,860,533	12,229,921	97,527,538	48,363,635	86,891,882	135,255,517	37,727,979	643,544,942	1,932,399,136	1,288,854,194
2023	121,540,716	5,940,938	11,928,494	103,671,284	50,781,817	90,150,328	140,932,145	37,260,861	733,568,253	2,025,171,669	1,291,603,415
2024	127,834,857	6,153,756	11,587,172	110,093,929	53,320,908	93,530,965	146,851,873	36,757,944	830,026,478	2,120,949,543	1,290,923,065
2025	134,226,600	6,461,443	11,211,783	116,553,374	55,986,953	97,038,376	153,025,329	36,471,955	933,652,062	2,220,062,814	1,286,410,753
2026	140,937,930	6,784,516	10,807,828	123,345,586	58,786,301	100,677,315	159,463,616	36,118,030	1,044,927,274	2,322,555,053	1,277,627,779
2027	147,984,827	7,123,741	10,386,727	130,474,359	61,725,616	104,452,714	166,178,330	35,703,971	1,164,380,166	2,428,476,299	1,264,096,133
2028	155,384,068	7,479,928	9,943,298	137,960,842	64,811,897	108,369,691	173,181,588	35,220,746	1,292,569,983	2,537,865,224	1,245,295,241
2029	163,153,271	7,853,925	9,491,557	145,807,789	68,052,492	112,433,554	180,486,046	34,678,257	1,430,109,979	2,650,768,446	1,220,658,468
2030	171,310,935	8,246,621	9,040,950	154,023,364	71,455,116	116,649,812	188,104,928	34,081,564	1,577,666,388	2,767,235,714	1,189,569,326
2031	179,876,482	8,658,952	8,577,480	162,640,050	75,027,872	121,024,180	196,052,052	33,412,002	1,735,936,965	2,887,294,360	1,151,357,395
2032	188,870,306	9,091,900	8,108,037	171,670,369	78,779,266	125,562,587	204,341,853	32,671,484	1,905,675,604	3,010,969,509	1,105,293,906
2033	198,313,821	9,546,495	7,644,829	181,122,497	82,718,229	130,271,184	212,989,413	31,866,916	2,087,702,065	3,138,289,048	1,050,586,983
2034	208,229,512	10,023,819	7,184,649	191,021,044	86,854,141	135,156,353	222,010,494	30,989,450	2,282,890,107	3,269,266,610	986,376,504
2035	218,640,988	10,525,010	6,729,452	201,386,526	91,196,848	140,224,716	231,421,564	30,035,038	2,492,176,843	3,403,905,394	911,728,551
2036	229,573,037	11,051,261	6,288,932	212,232,844	95,756,690	145,483,143	241,239,833	29,006,989	2,716,575,579	3,542,205,006	825,629,427
2037	241,051,689	11,603,824	5,866,878	223,580,987	100,544,524	150,938,761	251,483,285	27,902,298	2,957,174,913	3,684,154,106	726,979,193
2038	253,104,274	12,184,015	5,455,033	235,465,226	105,571,751	156,598,965	262,170,716	26,705,490	3,215,131,134	3,829,715,830	614,584,696
2039	265,759,487	12,793,216	5,058,779	247,907,492	110,850,338	162,471,426	273,321,764	25,414,272	3,491,687,675	3,978,839,723	487,152,048
2040	279,047,462	13,432,877	4,688,446	260,926,139	116,392,855	168,564,104	284,956,959	24,030,820	3,788,186,679	4,131,465,188	343,278,510
2041	292,999,835	14,104,521	4,337,230	274,558,084	122,212,498	174,885,258	297,097,756	22,539,672	4,106,057,643	4,287,501,371	181,443,455
2042	307,649,826	14,809,747	4,004,442	288,835,637	128,323,123	181,443,455	309,766,578	20,930,941	4,446,830,199	4,446,830,199	-

Note: The projection of normal cost and actuarial accrued liability are based on a closed group projection. Therefore, the retirement and the retiree medical eligibility changes are reflected for only the affected individuals as of December 31, 2012.

PROJECTION OF THE ANNUAL REQUIRED CONTRIBUTION

30 Years Open (4.5% interest rate)

								As of December 31 after Fiscal Year End		
Fiscal Year Ended June 30	(1) Gross Benefit Payments	(2) Retiree Contributions	(3) NHRS Subsidy	(4) Projected Benefit Payments (1) – (2) – (3)	(5) Normal Cost	(6) Amortization of UAAL	(7) ARC (5) + (6)	(8) Assets	(9) AAL	(10) UAAL (9) – (8)
2013	$68,207,299	$4,651,280	$13,637,233	$49,918,786	$63,760,421	$68,570,737	$132,331,158	$0	$1,954,730,892	$1,954,730,892
2014	72,262,990	4,829,434	13,584,940	53,848,616	66,948,442	72,190,612	139,139,054	-	2,056,383,100	2,056,383,100
2015	76,495,763	4,924,401	13,479,379	58,091,983	70,295,864	75,944,752	146,240,616	-	2,161,673,395	2,161,673,395
2016	81,001,944	5,026,531	13,349,008	62,626,405	73,810,657	79,833,252	153,643,909	-	2,270,636,241	2,270,636,241
2017	85,803,130	5,135,108	13,186,919	67,481,103	77,501,190	83,857,384	161,358,574	-	2,383,285,863	2,383,285,863
2018	91,784,021	5,278,343	13,013,034	73,492,644	81,376,249	88,017,673	169,393,922	-	2,498,772,094	2,498,772,094
2019	98,022,614	5,434,490	12,834,657	79,753,467	85,445,062	92,282,721	177,727,783	-	2,617,164,555	2,617,164,555
2020	103,750,743	5,587,741	12,663,033	85,499,969	89,717,315	96,655,100	186,372,415	-	2,739,344,087	2,739,344,087
2021	109,776,840	5,753,362	12,474,084	91,549,394	94,203,181	101,167,340	195,370,521	-	2,865,387,778	2,865,387,778
2022	115,617,992	5,860,533	12,229,921	97,527,538	98,913,340	105,822,288	204,735,628	-	2,995,778,391	2,995,778,391
2023	121,540,716	5,940,938	11,928,494	103,671,284	103,859,007	110,637,774	214,496,781	-	3,130,784,589	3,130,784,589
2024	127,834,857	6,153,756	11,587,172	110,093,929	109,051,957	115,623,718	224,675,675	-	3,270,581,034	3,270,581,034
2025	134,226,600	6,461,443	11,211,783	116,553,374	114,504,555	120,786,573	235,291,128	-	3,415,616,165	3,415,616,165
2026	140,937,930	6,784,516	10,807,828	123,345,586	120,229,783	126,142,898	246,372,681	-	3,566,062,878	3,566,062,878
2027	147,984,827	7,123,741	10,386,727	130,474,359	126,241,272	131,699,080	257,940,352	-	3,722,112,132	3,722,112,132
2028	155,384,068	7,479,928	9,943,298	137,960,842	132,553,335	137,462,170	270,015,505	-	3,883,956,333	3,883,956,333
2029	163,153,271	7,853,925	9,491,557	145,807,789	139,181,002	143,439,276	282,620,278	-	4,051,809,376	4,051,809,376
2030	171,310,935	8,246,621	9,040,950	154,023,364	146,140,052	149,638,294	295,778,346	-	4,225,902,737	4,225,902,737
2031	179,876,482	8,658,952	8,577,480	162,640,050	153,447,055	156,067,776	309,514,831	-	4,406,461,681	4,406,461,681
2032	188,870,306	9,091,900	8,108,037	171,670,369	161,119,408	162,736,039	323,855,447	-	4,593,726,702	4,593,726,702
2033	198,313,821	9,546,495	7,644,829	181,122,497	169,175,378	169,651,967	338,827,345	-	4,787,959,664	4,787,959,664
2034	208,229,512	10,023,819	7,184,649	191,021,044	177,634,147	176,825,228	354,459,375	-	4,989,428,542	4,989,428,542
2035	218,640,988	10,525,010	6,729,452	201,386,526	186,515,854	184,265,721	370,781,575	-	5,198,412,974	5,198,412,974
2036	229,573,037	11,051,261	6,288,932	212,232,844	195,841,647	191,983,773	387,825,420	-	5,415,212,757	5,415,212,757
2037	241,051,689	11,603,824	5,866,878	223,580,987	205,633,729	199,990,455	405,624,184	-	5,640,142,447	5,640,142,447
2038	253,104,274	12,184,015	5,455,033	235,465,226	215,915,416	208,297,385	424,212,801	-	5,873,519,306	5,873,519,306
2039	265,759,487	12,793,216	5,058,779	247,907,492	226,711,187	216,916,279	443,627,466	-	6,115,677,536	6,115,677,536
2040	279,047,462	13,432,877	4,688,446	260,926,139	238,046,746	225,859,479	463,906,225	-	6,366,974,059	6,366,974,059
2041	292,999,835	14,104,521	4,337,230	274,558,084	249,949,083	235,140,168	485,089,251	-	6,627,771,486	6,627,771,486
2042	307,649,826	14,809,747	4,004,442	288,835,637	262,446,538	244,771,738	507,218,276	-	6,898,444,594	6,898,444,594

Note: The projection of normal cost and actuarial accrued liability are based on a closed group projection. Therefore, the retirement and the retiree medical eligibility changes are reflected for only the affected individuals as of December 31, 2012

September 27, 2013

ACTUARIAL CERTIFICATION

This is to certify that Segal Consulting, a Member of The Segal Group, Inc. has conducted an actuarial valuation of certain benefit obligations of the State of New Hampshire's other postemployment benefit programs as of December 31, 2012, in accordance with generally accepted actuarial principles and practices. The actuarial calculations presented in this report have been made on a basis consistent with our understanding of GASB Statements 43 and 45 for the determination of the liability for postemployment benefits other than pensions.

The actuarial valuation is based on the plan of benefits verified by the State and reliance on participant, claims and expense data provided by the State or from vendors employed by the State. Segal Consulting does not audit the data provided. The accuracy and comprehensiveness of the data is the responsibility of those supplying the data. Segal, however, does review the data for reasonableness and consistency.

The actuarial computations made are for purposes of fulfilling plan accounting requirements. Determinations for purposes other than meeting financial accounting requirements may be significantly different from the results reported here. Accordingly, additional determinations may be needed for other purposes, such as judging benefit security at termination of the plan, or determining short-term cash flow requirements.

To the best of our knowledge, this report is complete and accurate and in our opinion presents the information necessary to comply with GASB Statements Number 43 and 45 with respect to the benefit obligations addressed. The signing actuaries are members of the Society of Actuaries, the American Academy of Actuaries, and other professional actuarial organizations and collectively meet their "General Qualification Standards for Statements of Actuarial Opinions" to render the actuarial opinion contained herein. Further, in our opinion, the assumptions as approved by the State are reasonably related to the experience and expectations of the postemployment benefit programs.

Kathleen A. Riley, FSA, MAAA, EA
Senior Vice President and Actuary

Daniel J. Rhodes, ASA, FCA, MAAA
Vice President and Consulting Actuary

CHART 1

Required Supplementary Information – Schedule of Employer Contributions

Plan Year Ended June 30	Annual OPEB Cost	Actual Contributions	Percentage Contributed
2008	$207,142,322	$50,332,000	24.30%
2009	195,442,213	57,011,000	29.17%
2010	208,150,852	52,790,000	25.36%
2011	162,119,767	54,418,000	33.57%
2012	171,911,651	50,997,000	29.66%
2013	137,811,620	51,332,000	37.25%

This schedule of funding progress presents multi-year trend information about whether the actuarial value of plan assets is increasing or decreasing over time relative to the actuarial accrued liability for benefits.

CHART 2

Required Supplementary Information – Schedule of Funding Progress

Actuarial Valuation Date	Actuarial Value of Assets (a)	Actuarial Accrued Liability (AAL) (b)	Unfunded AAL (UAAL) (b) - (a)	Funded Ratio (a) / (b)	Covered Payroll (c)	UAAL as a Percentage of Covered Payroll [(b) - (a) / (c)]
12/31/2006	$0	$2,559,477,420	$2,559,477,420	0%	$558,400,000	458.36%
6/30/2008	0	2,470,484,690	2,470,484,690	0%	602,644,000	409.94%
12/31/2010	0	2,257,820,367	2,257,820,367	0%	597,800,000	377.69%
12/31/2012	0	1,856,714,242	1,856,714,242	0%	518,663,650	357.98%

CHART 3

Required Supplementary Information – Net OPEB Obligation/(Asset) (NOO/NOA)

Fiscal Year Ended June 30	Annual Required Contribution (a)	Interest on Existing NOO (b)	ARC Adjustment (c)	Annual OPEB Cost (a) + (b) + (c) (d)	Actual Contribution Amount (e)	Net Increase in NOO (d) - (e) (f)	NOO as of Following Date (g)
2008	$207,142,322	$0	$0	$207,142,322	$50,332,000	$156,810,322	$156,810,322
2009	193,729,073	7,056,464	(5,343,324)	195,442,213	57,011,000	138,431,213	295,241,535
2010	204,948,075	13,192,314	(9,989,537)	208,150,852	52,790,000	155,360,852	450,602,387
2011	156,862,740	20,277,107	(15,020,080)	162,119,767	54,418,000	107,701,767	558,304,154
2012	165,398,102	25,123,687	(18,610,138)	171,911,651	50,997,000	120,914,651	679,218,805
2013	132,331,158	30,564,846	(25,084,384)	137,811,620	51,332,000	86,479,620	765,698,425

CHART 4

Summary of Required Supplementary Information

Valuation date	December 31, 2012
Actuarial cost method	Projected Unit Credit
Amortization method	Level percent of pay, open
Remaining amortization period	30 years
Asset valuation method	Market value
Actuarial assumptions:	
Investment rate of return	4.5%, pay-as-you-go scenario
Inflation rate	3.75%
Projected salary increases	3.75%
Medical cost trend rate under age 65	6.00% decreasing at 0.25% for 4 years to an ultimate level of 5.00%
Medical cost trend rate age 65 and over	5.00%
Drug cost trend rate	6.00% decreasing at 0.25% for 4 years to an ultimate level of 5.00%
Plan membership:	
Current retirees, beneficiaries, and dependents*	11,259
Current active participants	10,584
Total	21,843

* *Includes 72 retirees eligible for retiree medical benefits in the future.*

This exhibit summarizes the participant data used for the current and prior valuations.

EXHIBIT I

Summary of Participant Data

	January 1, 2013	January 1, 2011
Active employees covered for medical benefits		
Number of employees		
Male	4,855	5,968
Female	5,729	5,546
Total	10,584	11,514
Average age	48.4	47.8
Average service	12.2	11.5
Average age at hire	36.2	36.3
Retired employees, spouses and beneficiaries covered for medical benefits		
Number of individuals	11,259*	10,636
Average age	70.1	69.5

** Includes 72 retirees eligible for retiree medical benefits in the future.*

EXHIBIT II

Actuarial Assumptions and Actuarial Cost Method

Data:	Detailed census data, claims information, and summary plan descriptions for postemployment welfare benefits were provided by the State.
Actuarial Cost Method:	Projected Unit Credit
Per Capita Cost Development:	
Medical	Per capita claims costs were based on actual retiree paid claim experience furnished by Anthem for the period July 1, 2011, through June 30, 2013. Claims were separated by year and plan (under-65 vs. 65-and-over), adjusted for plan changes during the experience period, and then total claims were divided by the number of adult members to yield a per capita claims cost. Per capita claims for each plan year were then combined by taking a weighted average. The weights used in this average account for a number of factors including each plan year's volatility of claims experience and distance to the valuation year. Actuarial factors were then applied to the weighted average cost to estimate individual retiree and spouse costs by age and by gender.
Prescription Drug	Per capita costs were based on actual retiree paid claim experience furnished by LGC/CVS Caremark for the period July 1, 2011, through June 30, 2013. Claims were separated by year, adjusted for plan changes and changes in financial terms during the experience period, and then adjusted as described above to yield a combined weighted average per capita claims cost.
Administrative Expenses	Administrative expenses were based on vendor contractual rates and fees as well as a pro-rated share of other Fund 60 expenses.

Measurement Date: December 31, 2012

Discount Rate: 7.75% funding and 4.5% pay-as-you-go

Postretirement Mortality Rates:

Healthy RP-2000 Healthy Annuitant Mortality Table projected to 2020, with a margin of 15% for men and 17% for women

Disabled 80% of the PBGC Disabled Mortality Tables

These mortality tables were determined to contain provision appropriate to reasonably reflect future mortality improvement.

Termination Rates before Retirement:

	Group I - Rate per year (%)			
	Mortality*		Disability**	
Age	Male	Female	Male	Female
20	0.00	0.01	0.02	0.00
25	0.04	0.02	0.02	0.01
30	0.04	0.02	0.02	0.02
35	0.05	0.03	0.03	0.02
40	0.08	0.04	0.08	0.05
45	0.12	0.06	0.15	0.09
50	0.18	0.08	0.25	0.19
55	0.25	0.13	0.43	0.35
60	0.35	0.20	1.16	0.58

* *98% are assumed to be ordinary death and 2% are assumed to be accidental death.*
** *50% are assumed to be ordinary disability and 50% are assumed to be accidental disability.*

Termination Rates before Retirement (cont):

Group II Police - Rate per year (%)

	Mortality*		Disability	
Age	Male	Female	Ordinary	Accidental
20	0.02	0.00	0.04	0.02
25	0.02	0.01	0.04	0.02
30	0.03	0.02	0.04	0.02
35	0.05	0.03	0.08	0.05
40	0.07	0.04	0.18	0.12
45	0.09	0.06	0.32	0.21
50	0.11	0.09	0.50	0.34
55	0.19	0.17	0.75	0.50
60	0.37	0.34	0.00	0.00

* *50% are assumed to be ordinary death and 50% are assumed to be accidental death.*

Group II Fire - Rate per year (%)

	Mortality*		Disability	
Age	Male	Female	Ordinary	Accidental
20	0.02	0.00	0.04	0.02
25	0.02	0.00	0.04	0.02
30	0.02	0.02	0.05	0.02
35	0.04	0.02	0.06	0.02
40	0.04	0.02	0.11	0.08
45	0.06	0.04	0.23	0.08
50	0.08	0.12	0.54	0.33
55	0.12	0.12	1.21	0.33
60	0.24	0.22	3.00	0.33

* *50% are assumed to be ordinary death and 50% are assumed to be accidental death.*

Withdrawal Rates:		Rate per year (%)				
		Group I		Group II - Police		
Age	Years of Service	Male	Female	Male	Female	Group II - Fire
	0	30.00	30.00	30.00	40.00	8.00
	1	22.00	22.00	15.00	17.00	6.00
	2	16.00	16.00	9.00	14.00	4.50
	3	12.00	12.00	6.00	11.00	3.00
	4	8.00	8.00	4.00	9.00	2.00
25	5+	5.00	8.00	4.00	4.00	1.50
30		5.00	8.00	4.00	4.00	1.50
35		5.00	5.60	4.00	4.00	1.50
40		5.00	5.60	4.00	4.00	1.50
45		5.00	5.60	4.00	4.00	1.50
50		5.00	4.40	4.00	4.00	1.50
55		5.00	4.00	4.00	4.00	1.50
60		5.00	4.00	4.00	4.00	1.50

Retirement Rates:

	Rate per year (%) Group I - Hired prior to July 1, 2011					
	Male			Female		
Ages	Normal	Early	Early Rule X	Normal	Early	Early Rule X
45	--	--	1.0	--	--	1.0
46	--	--	1.0	--	--	1.0
47	--	--	1.0	--	--	1.5
48	--	--	1.0	--	--	1.5
49	--	--	1.0	--	--	1.0
50	--	1.0	1.5	--	1.0	2.0
51	--	1.0	3.0	--	1.0	2.5
52	--	1.0	3.0	--	1.0	2.0
53	--	1.0	4.0	--	1.0	3.5
54	--	1.0	4.5	--	1.5	5.5
55	--	2.0	8.0	--	2.5	10.0
56	--	2.5	10.0	--	3.5	6.0
57	--	2.5	11.0	--	3.0	13.0
58	--	3.5	11.0	--	4.0	15.0
59	--	5.0	18.0	--	5.5	15.0
60	12.0	--	--	12.0	--	--
61	12.0	--	--	12.0	--	--
62	17.0	--	--	15.0	--	--
63	16.0	--	--	15.0	--	--
64	15.0	--	--	15.0	--	--
65	15.0	--	--	20.0	--	--
66	25.0	--	--	20.0	--	--
67	20.0	--	--	20.0	--	--
68	20.0	--	--	16.0	--	--
69	20.0	--	--	17.0	--	--
70	100.0	--	--	100.0	--	--

Retirement Rates (cont.):

Group I - Hired on or after July 1, 2011

	Male		Female	
Ages	Normal	Early	Normal	Early
60	--	12.0	--	12.0
61	--	12.0	--	12.0
62	--	17.0	--	15.0
63	--	16.0	--	15.0
64	--	15.0	--	15.0
65	46.0	--	45.0	--
66	46.0	--	45.0	--
67	20.0	--	20.0	--
68	20.0	--	16.0	--
69	20.0	--	17.0	--
70	100.0	--	100.0	--

Retirement Rates (cont.):

Group II - Hired prior to July 1, 2011 and vested as of January 1, 2012

Ages	Police	Fire
45	25.0	15.0
46	25.0	12.0
47	25.0	12.0
48	25.0	12.0
49	25.0	12.0
50	25.0	15.0
51	25.0	15.0
52	25.0	15.0
53	30.0	25.0
54	30.0	20.0
55	30.0	30.0
56	25.0	30.0
57	25.0	25.0
58	30.0	25.0
59	25.0	25.0
60	25.0	25.0
61	20.0	40.0
62	20.0	30.0
63	25.0	30.0
64	25.0	30.0
65	100.0	100.0

Retirement Rates (cont.):

Group II - Hired on or after July 1, 2011 or
Hired prior to July 1, 2011 and not vested as of January 1, 2012

Police

Ages	Age 46 with 21 years	Age 47 with 22 years	Age 48 with 23 years	Age 49 with 24 years	Age 50 with 25 years
45	--	--	--	--	--
46	28.0	--	--	--	--
47	28.0	35.0	--	--	--
48	28.0	35.0	35.0	--	--
49	28.0	30.0	35.0	40.0	--
50	28.0	30.0	35.0	40.0	50.0
51	28.0	30.0	35.0	40.0	50.0
52	28.0	30.0	35.0	40.0	50.0
53	30.0	30.0	35.0	35.0	35.0
54	30.0	30.0	35.0	35.0	35.0
55	30.0	30.0	30.0	35.0	35.0
56	25.0	25.0	25.0	25.0	25.0
57	25.0	25.0	25.0	25.0	25.0
58	30.0	30.0	30.0	30.0	30.0
59	25.0	25.0	25.0	25.0	25.0
60	25.0	25.0	25.0	25.0	25.0
61	20.0	20.0	20.0	20.0	20.0
62	20.0	20.0	20.0	20.0	20.0
63	25.0	25.0	25.0	25.0	25.0
64	25.0	25.0	25.0	25.0	25.0
65	25.0	25.0	25.0	25.0	25.0
66	100.0	100.0	100.0	100.0	100.0

Retirement Rates (cont.):

Group II - Hired on or after July 1, 2011 or Hired prior to July 1, 2011 and not vested as of January 1, 2012

Firefighters

Ages	Age 46 with 21 years	Age 47 with 22 years	Age 48 with 23 years	Age 49 with 24 years	Age 50 with 25 years
45	--	--	--	--	--
46	15.0	--	--	--	--
47	15.0	17.0	--	--	--
48	15.0	17.0	21.0	--	--
49	15.0	17.0	21.0	25.0	--
50	15.0	18.0	21.0	25.0	32.0
51	15.0	18.0	21.0	25.0	32.0
52	15.0	18.0	21.0	25.0	32.0
53	25.0	25.0	25.0	25.0	25.0
54	20.0	20.0	20.0	20.0	20.0
55	30.0	30.0	30.0	30.0	30.0
56	30.0	30.0	30.0	30.0	30.0
57	25.0	25.0	25.0	25.0	25.0
58	25.0	25.0	25.0	25.0	25.0
59	25.0	25.0	25.0	25.0	25.0
60	25.0	25.0	25.0	25.0	25.0
61	40.0	40.0	40.0	40.0	40.0
62	30.0	30.0	30.0	30.0	30.0
63	30.0	30.0	30.0	30.0	30.0
64	30.0	30.0	30.0	30.0	30.0
65	100.0	100.0	100.0	100.0	100.0

Dependents:

Demographic data was available for spouses of current retirees. For current future retirees, husbands were assumed to be three years older than their wives. For future retirees who elect to continue their health coverage at retirement, 75% were assumed to have an eligible spouse. In both groups, 100% of eligible spouses are assumed to receive postretirement medical benefits.

Per Capita Health Costs:

2013 medical and prescription drug claims costs are shown in the table below for retirees and for spouses at selected ages. These costs are net of such items as deductibles, copays and coinsurance amounts.

	Medical				Prescription Drug			
	Retiree		Spouse		Retiree		Spouse	
Age	Male	Female	Male	Female	Male	Female	Male	Female
45	$4,673	$5,863	$2,897	$4,375	$1,138	$1,429	$706	$1,066
50	5,546	6,317	3,874	5,073	1,352	1,540	944	1,237
55	6,587	6,801	5,184	5,872	1,606	1,658	1,264	1,431
60	7,823	7,330	6,940	6,810	1,907	1,787	1,692	1,660
64	8,975	7,776	8,761	7,665	2,188	1,896	2,136	1,868
65	1,693	1,439	1,693	1,439	2,265	1,925	2,265	1,925
70	1,962	1,551	1,962	1,551	2,625	2,074	2,625	2,074
75	2,114	1,669	2,114	1,669	2,829	2,233	2,829	2,233

Health Care Cost Trend Rates: Health care trend measures the anticipated overall rate at which health plan costs are expected to increase in future years. The rates shown below are "net" and are applied to the net per capita costs shown above. The trend shown for a particular plan year is the rate that must be applied to that year's cost to yield the next year's projected cost.

Year Ending December 31	Pre-65 Medical	Post-65 Medical	Prescription Drug
2013	6.00%	5.00%	6.00%
2014	5.75%	5.00%	5.75%
2015	5.50%	5.00%	5.50%
2016	5.25%	5.00%	5.25%
2017 & later	5.00%	5.00%	5.00%

NHRS Retiree Medical Subsidy: Based on information received from the New Hampshire Retirement System, the postretirement subsidy is assumed to continue without future increases indefinitely.

Retiree Contribution Increase Rate: The contribution of 12.5% of working rates per retiree or spouse under the age of 65 is assumed to increase with medical trend.

Participation and Coverage Election: 100% of active employees with coverage are assumed to elect retiree coverage.

Plan Design: Development of plan liabilities was based on the substantive plan of benefits in effect as described in Exhibit III.

Administrative Expenses: An administrative expense load of $261 per non-Medicare-eligible retiree and $242 per Medicare-eligible retiree increasing at 4.0% per year was added to projected incurred claim costs in developing the benefit obligations.

Annual Maximum Benefits: No increase in the annual maximum benefit levels was assumed.

Lifetime Maximum Benefits: No information was available regarding accumulations toward lifetime maximum benefits and no such accumulations were assumed.

Missing Participant Data: A missing census item for a given participant was assumed to equal the average value of that item over all other participants of the same status for whom the item is known.

Health Care Reform Assumption:

This valuation does not include the potential impact of any future changes due to the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act (HCERA) of 2010 other than the excise tax on high cost health plans beginning in 2018 (reflected with this valuation) and those previously adopted as of the valuation date. The addition of the excise tax in this valuation resulted in a 1.4% increase in the actuarial accrued liability and a 2.8% increase in the normal cost.

Assumption Changes Since Prior Valuation:

Per capita health costs and administrative expenses were recalculated based on more recent data.

The medical and drug trends were updated to better reflect experience and future expectations.

The demographic assumptions were changed as a result of the NHRS Experience Study for the period July 1, 2005 – June 30, 2010 completed by Gabriel Roeder Smith & Company.

EXHIBIT III

Summary of Plan

This exhibit summarizes the major benefit provisions as included in the valuation. To the best of our knowledge, the summary represents the substantive plans as of the measurement date. It is not intended to be, nor should it be interpreted as, a complete statement of all benefit provisions.

Eligibility:

The following groups of retirees receiving a pension from the New Hampshire Retirement System are eligible for postretirement medical benefits:

Group I:

- Retirees whose service began before July 1, 2003, with at least 10 years of State creditable service, are eligible at age 60.
- Retirees whose service began on or after July 1, 2003 and before July 1, 2011, with at least 20 years of State creditable service, are eligible at age 60.
- Retirees whose service began before July 1, 2011, with at least 30 years of State creditable service, are eligible at any age.
- Retirees whose service began on or after July 1, 2011 with at least 20 years of State creditable service, are eligible at age 65.
- Vested Deferred Retirees and Early Service Retirees who satisfy the above criteria and collect their pensions before age 60 (or 65, if applicable), are eligible at age 60 (or 65, if applicable).

Group II:

- Retirees whose service began before July 1, 2010 are eligible at retirement.
- Retirees whose service began on or after July 1, 2010 and before July 1, 2011, with at least 20 years of State creditable service, are eligible at retirement.
- Retirees whose service began after July 1, 2011 with at least 20 years of State creditable service, are eligible at age 52.5.
- Vested Deferred Retirees who are in vested status before January 1, 2012 are eligible when 20 years of service would have been completed and they are at least age 45.

- Vested Deferred Retirees whose service began after July 1, 2011 with at least 20 years of State creditable service are eligible when 25 years of service would have been completed and they are at least age 50.
- Vested Deferred Retirees hired before July 1, 2011 who have not attained vested status before January 1, 2012 are eligible at retirement subject to the following transition rules:

Creditable Service on January 1, 2012	Minimum Years of Service	Minimum Age Attained
Less than 4 years	24	49
At least 4 but less than 6 years	23	48
At least 6 but less than 8 years	22	47
At least 8 but less than 10 years	21	46

Disability: Retirees on Ordinary (non-job-related) or Accidental (job-related) Disability Retirement are eligible at any age.

Ordinary Death: Surviving spouse is eligible if eligible for ordinary death retirement benefits and, for Group I, if the employee had 10 years of State creditable service and was hired before July 1, 2003 or 20 years of State creditable service if hired on or after July 1, 2003 and for Group II, if the employee had 10 years of State creditable service and was hired before July 1, 2010 or 20 years of State creditable service if hired on or after July 1, 2010.

Accidental Death: Surviving spouse and minor children are eligible.

Post-Retirement Death: Surviving spouse is eligible.

Benefit Types:

Medical coverage is self-funded and was administered by Anthem. Retirees not yet eligible for Medicare participate in a Network Open Access Point of Service (POS) or a Preferred Provider Organization (PPO) plan depending on their geographic location. Retirees eligible for Medicare participate in an indemnity plan that coordinates with Medicare.

Prescription drug coverage is self-funded and administered by LGC/CVS Caremark.

The monthly working rates for retiree medical coverage, effective January 1, 2013, are as follows:

	Individual	2-person	Family
Retiree Under Age 65	$873.96	$1,747.92	$2,365.26
Retiree Age 65 and Older	$323.91	N/A	N/A

Duration of Coverage: Lifetime.

Dependent Benefits: Medical and Prescription Drugs.

Dependent Coverage: Benefits are payable to a spouse for their lifetime, regardless of when the retiree dies.

Retiree Contributions: The retiree health insurance premium contribution required for postretirement medical coverage is 12.5% of the working rate per month per retiree or spouse under the age of 65.

NHRS Subsidy: The State receives a postretirement medical subsidy from the New Hampshire Retirement System for retirees that meet the following criteria (in addition to the eligibility requirements described earlier in this section):

Group I: Employees who retired on or before July 1, 2004.

Group II: Employees who were active or retired as of June 30, 2000, or active as of June 30, 2005, and subsequently retired on Accidental Disability Retirement.

The current monthly subsidy amounts, are as follows:

	One person	Two person
Retiree Under Age 65	$375.56	$751.12
Retiree Age 65 and Older	$236.84	$473.68

As a result of the 2011 legislative changes, these subsidies will not increase in the future.

In addition, there is a group of 4 retirees whose subsidy amount is equal to 100% of the premium.

Benefit Descriptions:

Medical for Retirees Under Age 65 (effective January 1, 2012)	**In-Network**	**Out-Of-Network**
Annual Deductible	$500 individual / $1,000 family	$650 individual / $1,300 family
Coinsurance	100%	80%
Physician's Office Visit	$10 copay ($30 for specialists)	Coinsurance & deductible
Emergency Room	$150 copay	$150 copay
Hospital	Coinsurance & deductible	Coinsurance & deductible
Maximum Out-Of-Pocket Expense	$1,850 individual / $3,700 family	$1,850 individual / $3,700 family

Medical for Retirees Age 65 and Older (effective January 1, 2012)	
Annual Deductible	Medicare Part B deductible
Coinsurance	100% after deductible (if applicable)

Prescription Drug (effective January 1, 2012)	
Retail	$10 generic / $20 preferred brand / $35 non-preferred brand
Mail Order	$1 generic / $40 preferred brand / $70 non-preferred brand
Maximum Out-Of-Pocket Expense	$500 individual / $1,000 family

Plan Changes since Prior Valuation: None.

AGENCY RESULTS – PAY-AS-YOU-GO (4.5%)

Actuarial Accrued Liability (AAL) and Annual Required Contribution	GROUP I			
	General Government			
	All Other	Safety	DOT General	DOT Highway
Actuarial Accrued Liability – Gross				
1. Current retirees, beneficiaries and dependents	$514,225,228	$35,432,829	$3,348,551	$167,232,121
2. Current active employees	548,309,467	51,482,086	1,329,607	140,600,473
3. Total as of December 31, 2012: (1) + (2)	$1,062,534,695	$86,914,915	$4,678,158	$307,832,594
NHRS Subsidy				
4. Current retirees, beneficiaries and dependents	$51,366,028	$2,590,983	$603,834	$25,265,565
5. Current active employees	0	0	0	0
6. Total as of December 31, 2012: (4) + (5)	$51,366,028	$2,590,983	$603,834	$25,265,565
Retiree Contributions				
7. Current retirees, beneficiaries and dependents	$9,612,713	$836,883	$23,272	$4,138,499
8. Current active employees	16,876,627	1,726,271	58,171	6,618,558
9. Total as of December 31, 2012: (7) + (8)	$26,489,340	$2,563,154	$81,443	$10,757,057
Actuarial Accrued Liability – Net				
10. Current retirees, beneficiaries and dependents: (1) – (4) – (7)	$453,246,485	$32,004,962	$2,721,445	$137,828,058
11. Current active employees: (2) – (5) – (8)	531,432,842	49,755,816	1,271,436	133,981,914
12. Total as of December 31, 2012: (10) + (11)	$984,679,327	$81,760,778	$3,992,881	$271,809,972
Annual Required Contribution for Fiscal Year Ending June 30, 2013				
13. Normal cost as of December 31, 2012	$32,678,660	$3,477,917	$76,049	$7,549,381
14. Amortization of the unfunded actuarial liability (30 years, increasing 3.75% per year)	36,365,416	3,019,526	147,462	10,038,276
15. Total Annual Required Contribution (ARC): (13) + (14)	$69,044,076	$6,497,443	$223,511	$17,587,657
16. Projected net benefit payments for fiscal year ending June 30, 2013	$28,253,289	$1,899,506	$181,783	$7,758,423

Actuarial Accrued Liability (AAL) and Annual Required Contribution	Group I (continued)					
	Business Type Activities				Component Units	
	Liquor Group I	Lottery	Racing & Gaming	Turnpike	CCSNH	Retirement System
Actuarial Accrued Liability – Gross						
1. Current retirees, beneficiaries and dependents	$37,727,654	$6,024,637	$2,596,586	$19,329,186	$53,713,525	$3,896,625
2. Current active employees	20,147,254	4,232,918	1,342,137	16,932,249	48,668,017	4,090,567
3. Total as of December 31, 2012: (1) + (2)	$57,874,908	$10,257,555	$3,938,723	$36,261,435	$102,381,542	$7,987,192
NHRS Subsidy						
4. Current retirees, beneficiaries and dependents	$5,275,145	$383,327	$136,628	$2,534,642	$5,001,472	$290,222
5. Current active employees	0	0	0	0	0	0
6. Total as of December 31, 2012: (4) + (5)	$5,275,145	$383,327	$136,628	$2,534,642	$5,001,472	$290,222
Retiree Contributions						
7. Current retirees, beneficiaries and dependents	$1,052,450	$113,511	$51,032	$351,596	$804,571	$61,248
8. Current active employees	746,920	139,185	37,580	565,349	1,321,441	125,385
9. Total as of December 31, 2012: (7) + (8)	$1,799,370	$252,696	$88,612	$916,945	$2,126,012	$186,633
Actuarial Accrued Liability – Net						
10. Current retirees, beneficiaries and dependents: (1) – (4) – (7)	$31,400,058	$5,527,799	$2,408,926	$16,442,948	$47,907,482	$3,545,155
11. Current active employees: (2) – (5) – (8)	19,400,335	4,093,733	1,304,557	16,366,900	47,346,576	3,965,182
12. Total as of December 31, 2012: (10) + (11)	$50,800,393	$9,621,532	$3,713,483	$32,809,848	$95,254,058	$7,510,337
Annual Required Contribution for Fiscal Year Ending June 30, 2013						
13. Normal cost as of December 31, 2012	$1,227,761	$224,087	$67,932	$998,228	$3,288,625	$269,870
14. Amortization of the unfunded actuarial liability (30 years, increasing 3.75% per year)	1,876,121	355,335	137,143	1,211,708	3,517,849	277,366
15. Total Annual Required Contribution (ARC): (13) + (14)	$3,103,882	$579,422	$205,075	$2,209,936	$6,806,474	$547,236
16. Projected net benefit payments for fiscal year ending June 30, 2013	$1,811,887	$329,245	$165,064	$1,093,408	$3,002,753	$206,911

Actuarial Accrued Liability (AAL) and Annual Required Contribution	GROUP II						
	Safety-Fire	Safety-Police	Fish & Game	Police Standards and Training	Liquor Group II	All Other – Fire	All Other - Police
Actuarial Accrued Liability – Gross							
1. Current retirees, beneficiaries and dependents	$3,526,797	$87,233,215	$11,247,554	$1,933,847	$5,419,747	$6,939,208	$98,978,057
2. Current active employees	3,559,285	58,545,588	9,108,677	1,050,176	2,495,770	7,368,448	126,469,377
3. Total as of December 31, 2012: (1) + (2)	$7,086,082	$145,778,803	$20,356,231	$2,984,023	$7,915,517	$14,307,656	$225,447,434
NHRS Subsidy							
4. Current retirees, beneficiaries and dependents	$780,881	$27,217,073	$3,710,181	$549,652	$1,856,662	$1,140,682	$22,016,569
5. Current active employees	387,972	6,380,233	1,369,581	56,605	274,732	1,267,342	16,458,919
6. Total as of December 31, 2012: (4) + (5)	$1,168,853	$33,597,306	$5,079,762	$606,257	$2,131,394	$2,408,024	$38,475,488
Retiree Contributions							
7. Current retirees, beneficiaries and dependents	$141,454	$4,377,792	$468,438	$76,319	$245,936	$393,287	$5,030,590
8. Current active employees	208,654	4,431,345	737,701	71,206	184,078	556,110	8,724,119
9. Total as of December 31, 2012: (7) + (8)	$350,108	$8,809,137	$1,206,139	$147,525	$430,014	$949,397	$13,754,709
Actuarial Accrued Liability – Net							
10. Current retirees, beneficiaries and dependents: (1) – (4) – (7)	$2,604,462	$55,638,351	$7,068,934	$1,307,877	$3,317,150	$5,405,239	$71,930,898
11. Current active employees: (2) – (5) – (8)	2,962,659	47,734,009	7,001,396	922,364	2,036,959	5,544,996	101,286,339
12. Total as of December 31, 2012: (10) + (11)	$5,567,121	$103,372,360	$14,070,330	$2,230,241	$5,354,109	$10,950,235	$173,217,237
Annual Required Contribution for Fiscal Year Ending June 30, 2013							
13. Normal cost as of December 31, 2012	$264,696	$4,253,630	$574,508	$93,127	$223,176	$494,716	$7,998,058
14. Amortization of the unfunded actuarial liability (30 years, increasing 3.75% per year)	205,601	3,817,668	519,635	82,366	197,734	404,406	6,397,125
15. Total Annual Required Contribution (ARC): (13) + (14)	$470,297	$8,071,298	$1,094,143	$175,493	$420,910	$899,122	$14,395,183
16. Projected net benefit payments for fiscal year ending June 30, 2013	$128,191	$1,774,752	$275,721	$57,112	$112,194	$214,223	$2,654,323

Actuarial Accrued Liability (AAL) and Annual Required Contribution	TOTALS		
	Group I Total	Group II Total	Grand Total
Actuarial Accrued Liability – Gross			
1. Current retirees, beneficiaries and dependents	$843,526,942	$215,278,425	$1,058,805,367
2. Current active employees	837,134,775	208,597,321	1,045,732,096
3. Total as of December 31, 2012: (1) + (2)	$1,680,661,717	$423,875,746	$2,104,537,463
NHRS Subsidy			
4. Current retirees, beneficiaries and dependents	$93,447,846	$57,271,700	$150,719,546
5. Current active employees	0	26,195,384	26,195,384
6. Total as of December 31, 2012: (4) + (5)	$93,447,846	$83,467,084	$176,914,930
Retiree Contributions			
7. Current retirees, beneficiaries and dependents	$17,045,775	$10,733,816	$27,779,591
8. Current active employees	28,215,487	14,913,213	43,128,700
9. Total as of December 31, 2012: (7) + (8)	$45,261,262	$25,647,029	$70,908,291
Actuarial Accrued Liability – Net			
10. Current retirees, beneficiaries and dependents: (1) – (4) – (7)	$733,033,318	$147,272,911	$880,306,229
11. Current active employees: (2) – (5) – (8)	808,919,291	167,488,722	976,408,013
12. Total as of December 31, 2012: (10) + (11)	$1,541,952,609	$314,761,633	$1,856,714,242
Annual Required Contribution for Fiscal Year Ending June 30, 2013			
13. Normal cost as of December 31, 2012	$49,858,510	$13,901,911	$63,760,421
14. Amortization of the unfunded actuarial liability (30 years, increasing 3.75% per year)	56,946,202	11,624,535	68,570,737
15. Total Annual Required Contribution (ARC): (13) + (14)	$106,804,712	$25,526,446	$132,331,158
16. Projected net benefit payments for fiscal year ending June 30, 2013	$44,702,269	$5,216,516	$49,918,785

SUMMARY OF PARTICIPANT DATA BY DEPARTMENT

GROUP I	General Government		
	All Other	Safety	DOT General and Highway
Active employees covered for medical benefits			
Number of employees	6,182	655	1,332
Average age	49.5	46.9	47.1
Average service	12.6	11.0	13.7
Average age at hire	36.9	35.9	33.4
Retired employees, spouses and beneficiaries covered for medical benefits			
Number of individuals	6,034	384	1,877
Average age	71.3	69.5	70.8

	Business Activities			Component Units	
	Liquor Group I	Lottery and Racing & Gaming	Turnpike	CCSNH	Retirement System
Active employees covered for medical benefits					
Number of employees	267	57	187	747	60
Average age	47.5	50.4	52.6	50.9	48.3
Average service	10.7	13.9	12.3	9.4	10.0
Average age at hire	36.8	36.5	40.3	41.5	38.3
Retired employees, spouses and beneficiaries covered for medical benefits					
Number of individuals	407	103	242	638	43
Average age	71.0	72.3	72.8	71.3	69.3

GROUP II	Safety-Fire	Safety-Police	Fish & Game	Liquor Group II	All Other – Fire	Police Standards & Training and All Other – Police
Active employees covered for medical benefits						
Number of employees	21	312	43	18	43	660
Average age	45.7	39.2	38.0	39.1	40.1	44.7
Average service	11.3	10.4	12.1	8.1	11.1	11.6
Average age at hire	34.3	28.8	26.0	31.1	28.9	33.1
Retired employees, spouses and beneficiaries covered for medical benefits						
Number of individuals	26	619	93	43	46	704
Average age	62.1	62.9	66.3	65.4	62.1	62.4

Note: Because of the small number of participants in the DOT General, Racing & Charitable Gaming, and Police Standards & Training groups, we have combined their demographic information with DOT Highway, Lottery, and All Other – Police, respectively.

TOTALS	Group I Total	Group II Total	Grand Total
Active employees covered for medical benefits			
Number of employees	9,487	1,097	10,584
Average age	49.1	42.6	48.4
Average service	12.4	11.2	12.2
Average age at hire	36.7	31.4	36.2
Retired employees, spouses and beneficiaries covered for medical benefits			
Number of individuals	9,728	1,531	11,259
Average age	71.2	62.9	70.1

October 17, 2013
Meeting

Retiree Cost Containment Commission

10/17/13

- Review of Distributed Materials
  - OPEB Report
  - Retiree Eligibility
  - Retiree Costs FY 10-13
  - Retiree Revenue Flow
  - Notes from 10/3/13 Meeting

- Today's Handouts
  - Chart: Changes in Benefits Payments if New Hires Are Not Included in Retiree Benefit
  - Chart: Current Retirees and their eligibility
  - Budget Manual Instructions FY 14/15: Page 28

- Discussion About Retiree Health Alternatives
  - HRAs
  - VEBAs
  - Other

- Drafting the Commission's Report: The components?
  - Problem Statement: Why did HB 2 establish the commission?
  - Background: demographics, expenditures, OPEB
  - Solutions Considered
  - Recommendations
  - Appendix: Metrics

- Next Meeting: 10/24/13, 2-3:30pm
  - Segal resource to discuss OPEB
  - HRA expert
  - Other

Commission to Review Retiree Health Care
For Employees Hired after July 1, 2013

10/17/13

Present:
Linda Hodgdon, Commissioner of Department of Administrative Services, Chair
Lisa Shapiro, PhD, Public Member
Catherine Provencher, State Treasurer, Public Member
John Beardmore, Commissioner, Department of Revenue, Public Member
Diana Lacey, President, State Employees Association
Stephen Arnold, New England Police Benevolent Association

Absent:
Seth Cooper, NH Troopers Association
Kevin Foley, Teamsters Local 633
Public Member to be named by Governor

Meeting
Commissioner Hodgdon reviewed the documents emailed out to Commission members:

- Other Post Employment Benefit (OPEB) Valuation Report as of 12/31/12
- Diagram of Retiree Revenue Flow
- Chart: Retiree Health Costs, <65 and >65 FYs 10-14
- Chart: Retiree Eligibility Law Changes
- Notes from 10/3/13 Meeting

Commissioner Hodgdon then distributed the following documents:

- Budget Manual Instructions FY 14-15
    - Instructs agencies to budget 10.5% in Class 042 Post Retirement to reimburse the general fund with federal funds available for employees whose positions are funded in whole or part by federal funds.
    - These federal funds are available as long as retiree health benefits are funded for federally funded positions.
    - When Class 042 funds are pooled statewide, they total approximately $10 million. However, the funds are unrestricted and used for purposes other than prefunding the state's OPEB liability.
    - If the 10.5% were placed in a trust, we could allow these funds to build with interest.
    - HB 2 (Laws of 2013) established an OPEB trust that authorizes the Treasurer to invest the funds until they reach $10 million at which point the Treasurer would seek legislative authority to establish a board

- If these federal funds were dedicated to retiree health benefits, the state would be able to reduce its OPEB liability and/or consider alternative funding methods for retiree health care for new hires.

- Chart: History of Retiree Eligibility

- Review of Chart produced by Segal actuaries Kathleen Reilly and Daniel Rhodes to adjust OPEB valuation calculations to determine effect of not offering retiree health benefits to new hires after 12/31/12 (date of OPEB valuation)
  - Chart shows that the State's accrued actuarial liability would drop by approximately 2/3 from $6.8 billion to $2.3 billion by 2042.
  - After discussion, the Commission asked that the Segal actuaries be available by telephone for the next Commission meeting to discuss the chart

The Commission then discussed future topics to consider.

- Department of Insurance presentation on the Affordable Care Act and Health Care Reform (meeting after next)
- VEBA's
  - Every payroll, funds deposited into a retiree medical trust. After a certain period of time, the funds are shifted into HRA or FSA.
  - State cannot give money to a union but can give money for retirement to employees.
  - State cannot treat highly compensated individuals differently. It can treat Groups I and II differently.
  - There are private VEBAs. The SEA and the firefighters have paid to create a VEBA but it is cost prohibitive unless there is a large group. Participation could include political subdivisions
  - Cassie Keane and Diana Lacey to bring materials on VEBAs to next commission meeting.
- HRA's
  - Stephen Arnold will invite Deb Clayton to speak with the group. She can provide an overview of HRAs and HSAs.
- Drafting the Report: the Commission brainstormed about report's contents.
  - It is good to identify the various solutions considered. This allows future groups to build on Commission's work.
  - We can start to write the report while Commission meetings are still taking place. This allows us to meet the Commission deadline, 11/15/13.
  - Discussion about how to present the issue the Commission is studying: a problem, a situation, a mission statement.
  - Retiree Health unfunded liability is double the unfunded liability of the pensions.

- Concerns about causing harm to retirees. Legislative changes have resulted in no COLAs for pensions.
- This commission does not want to see removal of retiree health to current employees.
- Rating agencies want to see states taking action to address their unfunded liabilities.
- The treasurer will ask her counterparts in other states about the actions they are taking.

Next Meeting: Segal, HRA's, VEBA's (there is a presentation from a few years ago)

Meeting on 10/31/13: Department of Insurance and Other state's approaches

State of New Hampshire - December 31, 2012 Measurement Under GASB 43 and 45

30-year Projection of Net Benefit Payments, Normal Cost, and Actuarial Accrued Liability (AAL)

Fiscal Year Ending Jun 30,	From Valuation Report			Assuming No New Hires		
	Benefit Payments	Normal Cost	AAL at Mid-Year	Benefit Payments	Normal Cost	AAL at Mid-Year
2013	49,918,786	63,760,421	1,954,730,892	49,918,786	63,760,421	1,954,730,892
2014	53,848,616	66,948,442	2,056,383,100	53,848,616	61,515,387	2,050,705,558
2015	58,091,983	70,295,864	2,161,673,395	58,091,983	59,239,946	2,144,186,929
2016	62,626,405	73,810,657	2,270,636,241	62,626,405	57,052,374	2,234,850,478
2017	67,481,103	77,501,190	2,383,285,863	67,481,103	54,788,948	2,322,155,448
2018	73,492,644	81,376,249	2,498,772,094	73,492,644	52,532,257	2,404,748,839
2019	79,753,467	85,445,062	2,617,164,555	79,753,467	50,313,402	2,482,197,669
2020	85,499,969	89,717,315	2,739,344,087	85,499,969	47,980,996	2,554,689,237
2021	91,549,394	94,203,181	2,865,387,778	91,549,394	45,557,830	2,621,589,068
2022	97,527,538	98,913,340	2,995,778,391	97,527,538	43,181,682	2,682,769,157
2023	103,671,284	103,859,007	3,130,784,589	103,671,284	41,093,407	2,738,099,887
2024	110,093,929	109,051,957	3,270,581,034	110,093,929	39,020,150	2,787,042,283
2025	116,553,374	114,504,555	3,415,616,165	116,421,294	36,806,287	2,829,261,504
2026	123,345,586	120,229,783	3,566,062,878	122,754,106	34,603,005	2,864,460,371
2027	130,474,359	126,241,272	3,722,112,132	129,280,121	32,171,630	2,891,882,714
2028	137,960,842	132,553,335	3,883,956,333	135,352,799	29,537,275	2,911,440,214
2029	145,807,789	139,181,002	4,051,809,376	140,948,191	26,959,578	2,923,336,923
2030	154,023,364	146,140,052	4,225,902,737	147,230,084	24,496,897	2,926,630,904
2031	162,640,050	153,447,055	4,406,461,681	153,636,167	22,031,905	2,920,802,841
2032	171,670,369	161,119,408	4,593,726,702	159,435,483	19,795,431	2,906,315,114
2033	181,122,497	169,175,378	4,787,959,664	165,184,746	17,616,442	2,882,890,417
2034	191,021,044	177,634,147	4,989,428,542	170,355,014	15,712,332	2,851,018,883
2035	201,386,526	186,515,854	5,198,412,974	174,319,459	13,962,262	2,811,741,462
2036	212,232,844	195,841,647	5,415,212,757	177,569,227	12,403,616	2,765,671,764
2037	223,580,987	205,633,729	5,640,142,447	180,423,454	10,825,676	2,712,897,316
2038	235,465,226	215,915,416	5,873,519,306	182,875,972	9,391,271	2,653,686,182
2039	247,907,492	226,711,187	6,115,677,536	184,972,568	8,095,281	2,588,265,296
2040	260,926,139	238,046,746	6,366,974,059	186,816,636	6,909,239	2,516,734,004
2041	274,558,084	249,949,083	6,627,771,486	188,172,937	5,876,942	2,439,487,719
2042	288,835,637	262,446,538	6,898,444,594	188,970,797	4,947,040	2,356,959,841

Note: The projections of the normal cost and AAL from the valuation report are estimates based on standard actuarial techniques to roll forward liabilities. These projections assume a constant workforce eligibile for retiree medical benefits. However, the retirement and retiree medical changes are reflected for only the affected individuals as of December 31, 2012. The projected amounts will grow slightly slower than shown above, as the plan changes are fully reflected over time.

The projections of normal cost and AAL for the "No New Hires" scenario are for the closed group of employees in the valuation as of December 31, 2012.

GROUP I SERVICE RETIREMENT: RETIREE HEALTH BENEFITS ELIGIBILITY CHART

STATE EMPLOYEE RETIREE HEALTH BENEFITS ELIGIBILITY REQUIREMENTS Administered by Department of Administrative Services (DAS)			GENERAL NHRS SERVICE RETIREMENT REQUIREMENTS Administered by New Hampshire Retirement System[1]
State of New Hampshire Hire Date	STATE Creditable Service[2] Requirements	Minimum Age Eligible to Enroll in Retiree Health Benefit Plan	NHRS Minimum Age and Creditable Service[3] Requirements for Group I State Employees Service Retirement
Prior to July 1, 2003	10 years	Age 60 **See** RSA 21-I:30, VI(a)(1) and IX **OR** Age at service retirement if 30 years of STATE creditable service upon retirement **See** RSA 21-I:30, VI(b)	**If service commenced prior to July 1, 2011,** at age 60 with no minimum service requirement **See** RSA 100-A:5, I(a) **OR** **If service commenced prior to July 1, 2011 and meets requirements of RSA 100-A:10, I(a),** then after age 50, but before age 60, minimum 10 years of creditable service also required[4] **See** RSA 100-A:5, I(c) **OR** **If service commenced prior to July 1, 2011 and meets requirements of RSA 100-A:10, I(a),** then at age when creditable service plus age equals at least 70 years, minimum 20 years of creditable service also required[5] **See** RSA 100-A:5, I(c)
On or after July 1, 2003 but before July 1, 2011	20 years	Age 60 **See** RSA 21-I:30, VI(a)(1) and IX **OR** Age at service retirement if 30 years of STATE creditable service **See** RSA 21-I:30, VI(b)	
On or after July 1, 2011	20 years	Age 65 **See** RSA 21-I:30, VI(a)(2) and XI	**If service commenced after July 1, 2011,** at age 65 with no minimum service requirement **See** RSA 100-A:5, I(a) & (b) **OR** At age 60 with 30 years of creditable service[6] **See** RSA 100-A:5, I(a) & (b)

[1] Statements in this column are for informational purposes only as NHRS administers retirement laws. Questions related to retirement requirements must be addressed to NHRS representatives. Applicable laws and the information provided herein are subject to change.
[2] Creditable Service under this column must be earned while employed by the State.
[3] "Creditable Service" is defined by RSA 100-A:1, XVI and RSA 100-A:4 and calculated by the New Hampshire Retirement System (NHRS)
[4] Election will result in reduced retirement allowance
[5] Election will result in reduced retirement allowance (e.g. Group I member age 48 with 22 years of creditable service is eligible (48 + 22 = 70)
[6] Election will result in reduced retirement allowance

GROUP II SERVICE RETIREMENT: RETIREE HEALTH BENEFITS ELIGIBILITY CHART

STATE EMPLOYEE RETIREE HEALTH BENEFITS ELIGIBILITY REQUIREMENTS Administered by Department of Administrative Services			GENERAL NHRS SERVICE RETIREMENT REQUIREMENTS Administered by the New Hampshire Retirement System[1]
State of New Hampshire Hire Date	**STATE Creditable Service[2] Requirements**	**Minimum Age Eligible to Enroll in Retiree Health Benefit Plan**	**NHRS Minimum Age and Creditable Service[3] Requirements for Group II State Employee Service Retirement See RSA 100-A:5,II**
Prior to July 1, 2010	No minimum **STATE** creditable service requirement **See** RSA 21-I:30, VII(a)	Eligible upon service retirement from the State	**If vested[4] before 1/1/12:** Minimum age 45 and has completed 20 years of NHRS required creditable service. **See** RSA 100-A:5, II (a) **OR** **If not vested before 1/1/12:** Minimum age/creditable service requirements are on a sliding scale based on years of creditable service as of 1/1/2012, as outlined in RSA 100-A:5, II(d). **See** RSA 100-A:5, II(a): **OR** At age 60 with no minimum NHRS creditable service requirement **See** RSA 100-A:5, II (a)
On or after July 1, 2010 but before July 1, 2011	20 years **STATE** creditable service **See** RSA 21-I:30, VII(a)	Eligible upon service retirement from the State	
On or after July 1, 2011	20 years **STATE** creditable service **See** RSA 21-I:30, VII(a)	52.5 **See** RSA 21-I:30, XI	**If NHRS service began on or after July 1, 2011:** Minimum age 52.5 and has completed 25 years of NHRS required creditable service. **OR** At age 50 with 25 years of NHRS required creditable service[5]. **See** RSA 100-A:5, II (a) and (b)(3) **OR** At age 60 with no minimum NHRS creditable service requirement **See** RSA 100-A:5, II (a)

[1] Statements in this column are for informational purposes only as NHRS administers retirement laws. Questions related to retirement requirements must be addressed to NHRS representatives. Applicable laws and the information provided herein are subject to change.
[2] Creditable Service under this column must be earned while employed by the State.
[3] "Creditable Service" is defined by RSA 100-A:1, XVI and RSA 100-A:4 and calculated by the New Hampshire Retirement System (NHRS)
[4] "Vested" for NHRS purposes means a member has attained ten years of NHRS creditable service. **See** RSA 100-A:10, II
[5] Election will result in reduced retirement allowance

Breakdown of Active Employee Counts by Eligibility Rule
As of 12/31/12

Group 1:

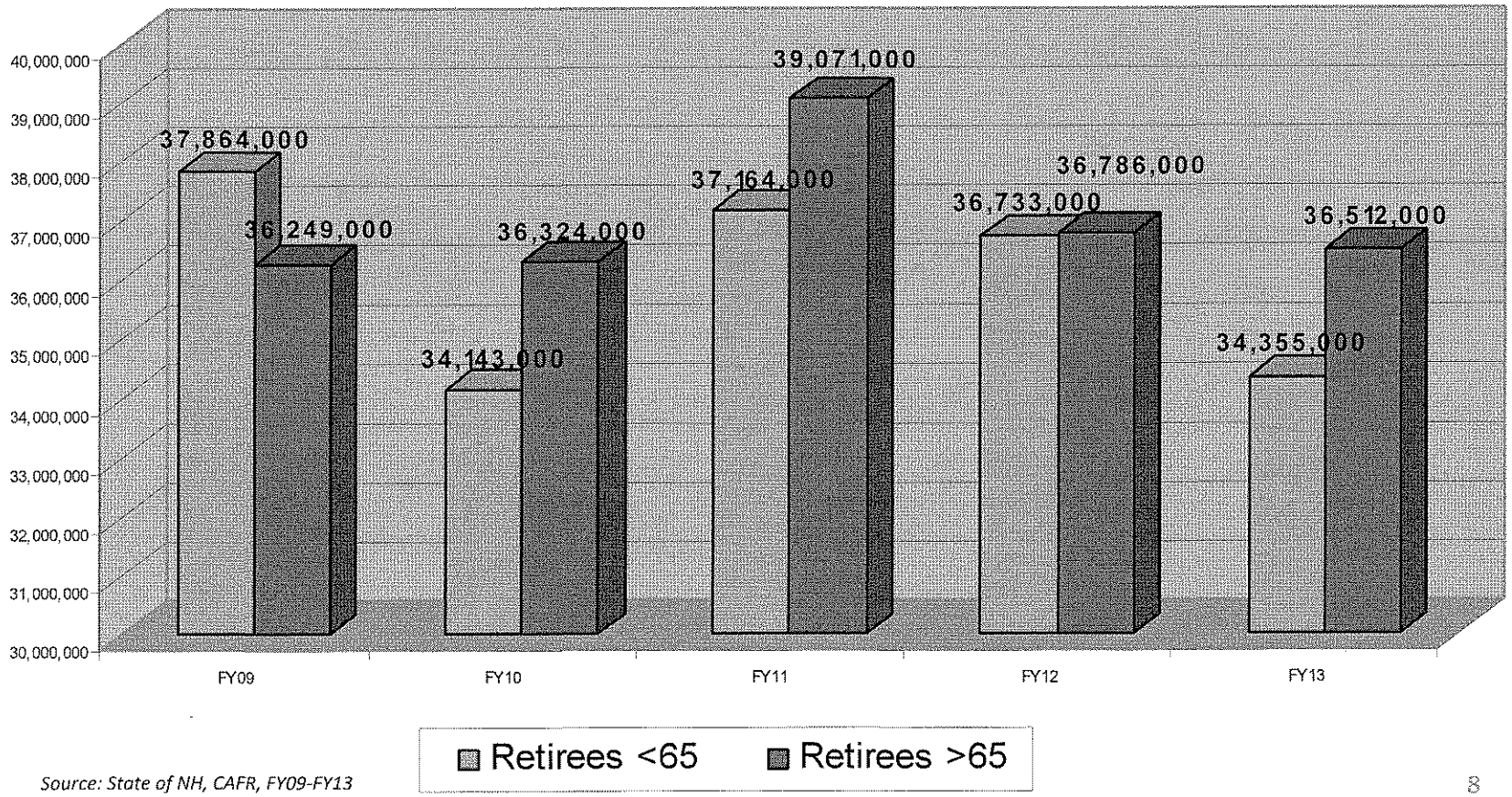
- 5,161 hired prior to July 1, 2003
  - Eligible at age 60 with 10 years of service or any age with 30 years of service
- 3,641 hired on or after July 1, 2003 and prior to July 1, 2011
  - Eligible at age 60 with 20 years of service, or any age with 30 years of service
- 685 hired on or after July 1, 2011
  - Eligible at age 65 with 20 years of service

Group 2:

- 969 hired prior to July 1, 2010
  - Eligible at retirement from NHRS
- 28 hired on or after July 1, 2010, and prior to July 1, 2011
  - Eligible at retirement from NHRS with 20 years of STATE service
- 100 hired on or after July 1, 2011
  - Eligible at age 52.5 with 20 years of STATE service (need 25 years of creditable service to retire)

Source: Segal, 2012 OPEB report

Under 65 and Over 65
Retiree Health Costs From FY10 through FY13



Source: State of NH, CAFR, FY09-FY13

Retiree Enrollment History

		Number of Retirees Under 65 Plans**							Retirees Over 65**		Total**	
		RETIREE ONLY OR SPOUSE ONLY PLAN	RETIREE & SPOUSE PLAN	RETIREE & ONE CHILD PLAN	RETIREE, SPOUSE & CHILD PLAN	RETIREE & MANY CHILDREN PLAN	Total (not including specials):	FY increase/decrease (July - June)		FY inc/dec (July - June)	Total Retirees	FY inc/dec (July - June)
	Jul-10						**2,378**		7,378		9,756	
FY11	Jun-11	1,461	981	2	25	-	**2,469**	3.83%	7,240	-1.87%	9,709	-0.48%
	July 11 *	1,511	1,019	2	28	-	**2,560**		7,308		9,868	
FY12	Jun-12	1,540	914	1	24	2	**2,481**	0.49%	7,673	5.98%	10,154	4.58%
	Jul-12	1,544	900	2	24	3	**2,473**		7,724		10,197	
FY13	Jun-13	1,527	818	3	22	3	**2,373**	-4.35%	8,070	5.17%	10,443	2.85%

** July 1, 2011 retiree only and retiree & spouse plans started paying 12.5% premium contribution.*

*** Plan counts do not include Specials and Legislators*

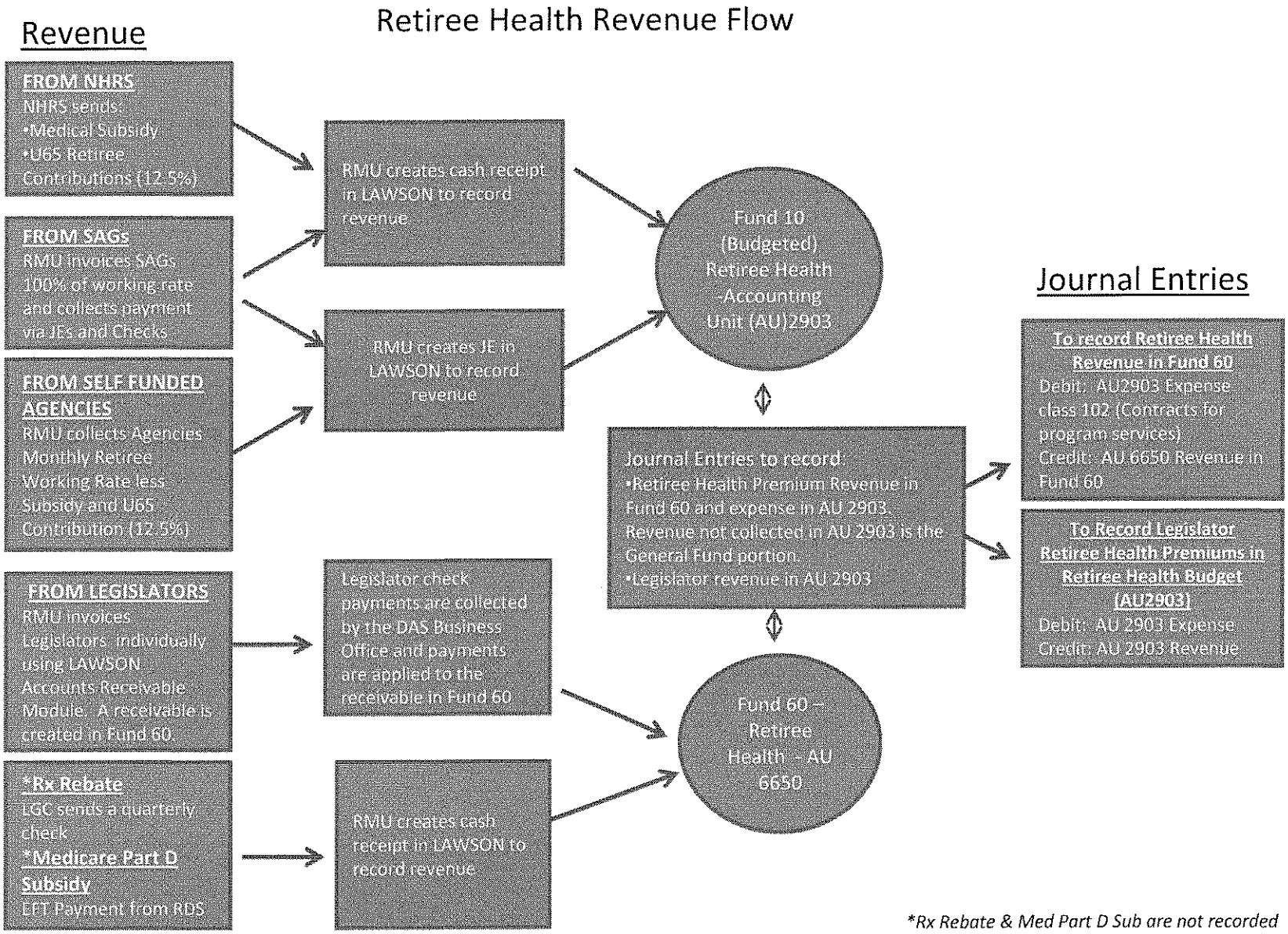
Under 65 Retiree Increase/decrease in tier enrollment (July - June)			
	RETIREE ONLY OR SPOUSE ONLY PLAN	RETIREE & SPOUSE or RETIREE & 1 DEPENDANT PLAN	RETIREE, SPOUSE, & DEPENEDANT OR RETIREE & DEPENDANTS PLAN
FY12	5.407%	-6.918%	4.000%
FY13	-0.844%	-10.273%	-3.846%

Special and Legislator Retiree Enrollment

	Specials Under 65						Specials/Legislators Over 65			
	RETIREE ONLY OR SPOUSE ONLY PLAN	RETIREE & SPOUSE PLAN	RETIREE, SPOUSE & CHILD PLAN	RETIREE & MANY CHILDREN PLAN	Total Specials Retirees U65	FY increase/decrease (July - June)	Special Ret O65	FY inc/dec (July - June)	Legislator Ret O65	FY inc/dec (July - June)
Jul-10	20				20		78		40	
FY11 Jun-11	12	6	1	-	19	-5.00%	79	1.28%	50	25.00%
July 11 *	12	7	1	-	20		78		50	
FY12 Jun-12	15	3	1	-	19	0.00%	86	8.86%	59	18.00%
Jul-12	14	3	-	1	18		89		59	
FY13 Jun-13	10	1		1	12	-36.84%	97	12.79%	60	1.69%

	SUBSCRIBER ONLY	Subscriber plus one	Subscriber plus many
FY12	25.00%	-50.00%	0.00%
FY13	-33.33%	-66.67%	0.00%

Retiree Health Revenue Flow



**Rx Rebate & Med Part D Sub are not recorded in Retiree Health Budget (AU 2903)*

October 24, 2013
Meeting

Commission to Review Retiree Health Care B
For Employees Hired after July 1, 2013

10/24/13

- Segal Review of Other Post Employment Benefit Projections Revised for No New Hires
  - On telephone: Segal Actuaries Kathleen Reilly and Daniel Rhodes
  - Q&A
- National Association of State Retirement Administrators (NASRA) article: Spotlight on Retiree Health Care Benefits for State Employees in 2013, June 18, 2013.
- Review of History of Retiree Health Funding Alternatives
  - HB 1645(Chapter 300:13, Laws of 2008): Commission to Propose a Retiree Health Care Benefits Funding Model (December 2, 2009)
  - Senate Joint Resolution 2 (Chapter 379, Laws of 2010)
  - RSA 21-I:30(a)
  - 2011-2013 Collective Bargaining Agreement between the State of New Hampshire and the State Employees Association: Section 19.8.3 (a)
  - Segal Draft Memo dated July 30, 2010: Retiree Health Care Prefunding Options (includes VEBAs)
  - Segal Chart: Retiree Medical Funding (presented on September 1, 2010)
- Establishing a Process to draft Commission Report (due November 15, 2013)
- Next Meeting: October 31, 2013
  - Department of Insurance Presentation: Health Care Reform and the ACA
  - HRA Presentation (possible)
- Other

Commission to Review Retiree Health Care
For Employees Hired after July 1, 2013

10/24/13
FINAL

Present:
Linda Hodgdon, Commissioner, Department of Administrative Services, Chair
Lisa Shapiro, PhD, Public Member
Catherine Provencher, State Treasurer, Public Member
John Beardmore, Commissioner, Department of Revenue, Public Member
Diana Lacey, President, State Employees Association

Absent:
Seth Cooper, NH Troopers Association
Kevin Foley, Teamsters Local 633
Stephen Arnold, New England Police Benevolent Association
Public Member to be named by Governor

Meeting

- The Commission approved the minutes of the 10/17/13 meeting, as amended.

Adjusted OPEB Chart: This topic resulted in a lengthy discussion but the commission did not make any decisions based on any of the discussion points.

- Kathleen Riley and Daniel Rhodes, Actuaries from the Segal Company, joined the Commission meeting by telephone to discuss the chart presented at the 10/17/13 meeting. This chart adjusts the OPEB valuation calculations to determine the effect of not offering retiree health benefits to new hires after 12/31/12 (date of OPEB valuation).
- Chart is broken down into two sides;
    - The left side represents the ongoing cost of the plan showing benefit payments, normal cost and accrued actuarial liability as reflected in the 2012 OPEB valuation report.
    - The right side assumes no new hires and adjusts accordingly benefit payments, normal cost and accrued actuarial liability as reflected in the 2012 OPEB valuation report.
- Chart's reflection of eligibility rules
    - Gross approximation
    - Always a distribution of those eligible under the "old" rules and the "new rules"
    - Some later hires reflect new eligibility rules
    - Based on 2012 claims that are trended forward
        - Takes into account if there is a surplus
        - CY 2014 working rates included in trend

        - The difference between budgeted working rates and updated CY working rates is that the CY working rates are based on updated claims data.
- For the first ten years, both charts are pretty much the same. This is because in those ten years, new hires would not retire.
- After the first ten years:
    - the trend increases
    - assumes as employees leave, they are replaced (assumes same number of active employees in the same demographic)
    - difference between the left and right side are the new hires that come in and then ultimately retire.
- The Actuarial Accrued Liability (AAL) analysis: what would happen to the AAL on the left if no new hires assumed
    - Does not change at first
    - Going forward, both numbers grow, but the "No New Hires" side growns less quickly
    - When you get to 2028, the "No New Hires" side has an unfunded liability of $1 billion less. This difference increases the further out you go.
        - Closed groups increase for awhile and then decrease
    - The current AAL of $2 billion has a long tail and grows to $6.8b.
- Question: What would the normal cost be if we started funding retiree health care for new hires?
    - What would we have to put in savings now for new hires?
    - Very small contribution at first since the normal cost is larger the older you are
        - normal cost for new hires, presumed to be younger, are lower than the average normal cost
        - As new hires age, their normal cost increases
    - Partial funding would lower the discount rate and in turn lower the unfunded liability.
- Employer could discontinue offering retiree health care and instead make a contribution to a private trust for an employee's health care upon retirement
    - If no future benefits, then no associated OPEB costs.
    - Terms of trust are critical: if they create a state liability, then there is an associated OPEB cost whether an HRA or VEBA.
    - If we had a VEBA to fund current retiree health plan and its future costs, then the state would still have future liability or OPEB costs
    - If we do away with the plan, then we just have the costs of an HRA, no OPEB
- Regarding the ACA:
    - Segal estimated cost of plan in place for 2018.
    - We do not know if pre-medicare retirees will have less expensive options at the healthcare exchange.
    - The state has a richer <65 year old retiree health plan than is available on the exchange.

- The current estimate of the ACA Cadillac Tax for <65 retiree health is $1.4 million in 2018

- Before calling in, Segal ran some numbers to model what projected OPEB costs would look like if all current GROUP I employees were subject to the 2011 eligibility rules for retiree health
  - Lowers the OPEB liability by 1/3
  - Normal Cost grows at 3.6% instead of 5%
  - Estimate is rough. For example, assumes people leave uniformly
    - Concern that number is understated
- If no new hires, then the next valuation would get reset. All things being equal, in 30 years the OPEB liability would start coming down.
- Question: If state changed how it provided support for retiree health from current plan to a specific dollar amount, what would happen?
  - Change would be factored in for current employees
  - Would not factor in for new employees until they were hired.
- Question: Why not take 2011 changes into account, projecting them in the best possible way?
  - The OPEB liability goes in the State's CAFR
  - We have historical employee turnover data
  - The OPEB valuation's main purpose is to provide the GASB information
  - Normal cost is 1/3 less; not the same to AAL
  - Segal would need to redo the formulas to get a better sense of the impact of the eligibility changes ; this projection would be very complex and would have a cost associated with it
  - If we focused only on the benefit payment, and worked through the employees who could get retiree medical after ten years of service and then move on to those who require 20 years of service, what would happen?
    - It wouldn't drop by a 1/3. We still pay out on 10 year people until as a group they are retired and die and then move on to 20 year people
    - The right side of the chart is not an illustration of the current plan, it is an illustration of the what would occur if we closed the door to new hires.
- We use the NHRS assumptions about retirees: age of retirement and service. NHRS has data to support its assumptions.
- If all people retired upon eligibility, it would increase the state's liability. However, employees are not retiring upon eligibility.
  - Many current employees choose to continue working
  - There are employees today who are in their 50's who are eligible to retire and receive retiree health care.
  - There are many variables that employees consider when retiring such as whether there is a working spouse, college tuition payments, other retirement resources, home equity. Many people are working a little longer.

- No assumption that state is paying normal cost, just the benefit payments. Benefit payments are lower than total expenditures because there are other revenues such as contributions to premium and rebates that are not reflected.

Article: Spotlight on Retiree Health Care Benefits for State Employees in 2013(June 18, 2013, National Association of State Retirement Administrators)

- Article was presented to a national group in June, 2013.
- Figure 3 is significant because it shows the Unfunded AAL by state on a per capita basis
  - NH has 12th highest per capita UAAL
  - Figure 4 assigns a per capita value for NH at $1,700 per person
- The question this commission needs to consider is whether NH can continue to make promises to its future hires to provide retiree health care when we cannot afford to make those promises.

Handouts: History of Alternatives to Retiree Health Care Funding

- Commissioner Hodgdon provided several handouts that the Commission reviewed:
  - Final report of the Commission to Propose a Retiree Health Benefits Funding Model, HB 1645, Chapter 300:13 (Laws of 2008)
  - Senate Joint Resolution 2 (Laws of 2010)
  - Segal memo dated 7/30/10 on Retiree Health Prefunding Options
  - RSA 21-I:30, I-a
  - Excerpt from 2011-2013 Collective Bargaining Agreement between the state and the SEA: Section 19.8.3.
  - Segal Chart on Retiree Medical Funding (Presented on September 1, 2010)
- The SEA created 3 private medical trusts
  - They are expensive to fund so they need significant participation to start them up
  - There is a trust coalition that jointly selects the plan and administrators
  - Created at a time when GASB OPEB requirement was not enacted
  - No money has gone into the trust
- The state cannot give money to a union to put into a trust. The state can give employees money to put into a trust.

Next Meeting:

- Dept of Insurance: presentation on the ACA
- HRAs (Steve Arnold)
- VEBA Trust (Diana Lacey)

Brainstorming about Drafting the Report

- Need to focus on the Commission's original mission: should the state fund retiree health for new hires
- We do not want to create barriers for current workforce
- We should attach appendices to report
- Sections of Report
    - Background
    - Solutions considered
    - Other Issues: trusts etc.
    - Appendices
- What can commission members agree on?
- Final Report should incorporate the Joint Senate Resolution
    - This is a different time with different solutions
    - ACA was not in place when Joint Senate Resolution passed

Breakdown of Active Employee Counts by Eligibility Rule
As of 12/31/12

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- 3,641 hired on or after July 1, 2003 and prior to July 1, 2011
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- 685 hired on or after July 1, 2011
  - Eligible at age 65 with 20 years of service

Group 2:

- 969 hired prior to July 1, 2010
  - Eligible at retirement from NHRS
- 28 hired on or after July 1, 2010, and prior to July 1, 2011
  - Eligible at retirement from NHRS with 20 years of STATE service
- 100 hired on or after July 1, 2011
  - Eligible at age 52.5 with 20 years of STATE service (need 25 years of creditable service to retire)

Source: Segal, 2012 OPEB report

Commission to Review the Retiree Health Care B
For Employees Hired after July 1, 2013

10/24/2013

RSA 21-I:30, I-a. Nothing in this section shall prohibit the state or state employees from making contributions to post-retirement medical savings plans for such employees, if authorized by a collective bargaining agreement, but only for a term of such agreement.

2011-2013 Collective Bargaining Agreement between the State of New Hampshire and the SEA

19.8.3. **Additional Health Benefit Advisory Committee Duties:** The Committee shall develop recommendations for the parties to secure alternative funding and provide for future retiree health expenses as described in NH RSA 21:I:30.

CHAPTER 379

SJR 2 – FINAL VERSION

2010 SESSION

10-2872

10/05

SENATE JOINT RESOLUTION *2*

A RESOLUTION endorsing the establishment of a statewide retiree medical trust for public employee health care reimbursement benefits after retirement.

SPONSORS: Sen. Janeway, Dist 7; Sen. Cilley, Dist 6; Sen. Downing, Dist 22; Rep. Benn, Graf 9; Rep. McEachern, Rock 16; Rep. Reagan, Rock 1; Rep. Harding, Graf 11; Rep. Hawkins, Hills 18

COMMITTEE: Executive Departments and Administration

ANALYSIS

This joint resolution endorses the establishment of a statewide retiree medical trust to provide a funding source for reimbursement of post-retirement medical expenses of state, county, and municipal employees.

10-2872

10/05

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Ten

A RESOLUTION endorsing the establishment of a statewide retiree medical trust for public employee health care reimbursement benefits after retirement.

Be it Enacted by the Senate and House of Representatives in General Court convened:

Whereas, the legislature, in 2007, 355, established the commission to make recommendations to ensure the long-term viability of the New Hampshire retirement system; and

Whereas, the commission met and subsequently filed its report on January 2, 2008; and

Whereas, certain recommendations from the report of the commission were included in

2008, 300, relative to administration of the New Hampshire retirement system and benefits for members; and

Whereas, the legislature, in 2008, 355:13, established a commission to propose a retiree health care benefits funding model (hereinafter retiree health commission); and

Whereas, the retiree health commission met and studied alternative approaches to retiree health care funding; and

Whereas, the retiree health commission recommended the establishment of a retiree medical trust, according to applicable state and federal law, to provide a funding source for reimbursement of post-retirement medical expenses of state, county, and municipal employees; now, therefore, be it

Resolved by the Senate and House of Representatives in General Court convened:

That the general court hereby endorses the implementation of a retiree medical trust, to be established by public employee associations and/or unions, according to applicable state and federal law and regulations, to provide medical expense reimbursement benefits after retirement to retirees of local, county, and state governments, provided such retiree medical trust meets the following criteria:

I. Participation in such a trust is elective by option of an employee group, which includes an employee bargaining unit or other rational employee classification. The employee group will have the option to join the trust, and to select the employee contribution level. If an employee group decides to join the trust, then every employee in that group shall participate in the trust.

II. Contributions to such a trust are made during active employment for benefit payments after retirement, so that the trust is pre-funded and not pay-as-you-go funded. Employee and/or employer contributions shall be transferred to the trust by employers during the active working lives of employees, in the fixed amount negotiated in a collective bargaining agreement or set forth in an employer resolution or other written document for non-bargained employees.

III. The trust provides to participating retirees reimbursement payments toward the costs, in whole or in part, of health insurance premiums and miscellaneous medical expenses.

IV. All contributions to the trust are based on a defined contribution level set forth in a collective bargaining agreement, memorandum of understanding, or other written agreement to which a participating employer is signatory. There shall be no defined vested benefits.

V. Funding for the trust is negotiated and may include the following:

(a) From regular payroll. Each bargaining unit or other employee classification will decide the level of its employee contributions. The level of employee contributions will be uniform

for all members of the association bargaining unit or employee classification.

(b) From transfer of sick leave and vacation leave. Each bargaining unit or other employee classification may provide that accumulated sick and/or vacation leave which is payable upon retirement be transferable to the trust on retirement.

(c) From participating employers. Contributions may be accepted from the local, county, and state governmental employers, as negotiated by the parties. These contributions may be either in a lump sum, or a regular monthly or annual contribution.

VI. The trust is structured to provide optimal tax advantages, which under current federal law include:

(a) Pretax contributions. All contributions made to the trust are not taxable income to the employee, even though they may be employee contributions.

(b) Tax free earnings. The earnings of the trust are exempt from tax, which enables higher benefits to retirees.

(c) Non-taxable distributions. Benefit payments from the trust to retirees are not taxable income to retirees.

VII. The trust is administered by a board of trustees, who are appointed or elected according to rules set by the sponsoring organizations.

VIII. The benefit plan and trust shall be designed so that participating employers avoid Governmental Accounting Standards Board (GASB) reporting obligations as a "defined benefit" plan. It is structured as a defined contribution plan.

Approved: August 23, 2010

Commission to Propose a Retiree Health Care Benefits Funding Model

HB 1645, Chapter 300:13

FINAL REPORT

Commission to Propose a Retiree Health Care Benefits Funding Model

Committee Membership

Senator Harold Janeway, Chairman
Representative Benn - Vice Chair

Legislative Appointees:
Senator Cilley Representative Reagan Representative Leishman

Non Legislative Appointees:

Chairperson of the New Hampshire Retirement System Board of Trustees

Lisa K. Shapiro, PhD

Representatives of Group I Retirement System

Gary Smith
Rhonda Wesolowski

Representative of Group II Retirement System

David Lang
Jon Stewart

Representatives of municipal and school employers in the retirement system

Allen B. Damren - School employer, Assistant Superintendent SAU 6
Steve Fournier - Municipal employer, North Hampton Town Administrator

Six Public members with recognized expertise in finance, financial management, health care finance, health care delivery, or the governance and oversight of large endowments or public funds

David Jensen – Health Care Consultant, retired CEO of Anthem Blue Cross Blue Shield
Newton Kershaw Jr. – Attorney, Devine Millimet & Branch Attorneys at Law
Roland Lamy Jr. – Helms & Company Principal and Senior Consultant
Patrick Miller – Research Associate Professor, NH Institute for Health Policy & Practice at UNH
Lawrence Weissbrot – Director of Actuarial and Research, Northeast Delta Dental
Michael Wilson – CFO, NH Charitable Foundation

December 22, 2009

Governor John Lynch
Office of the Governor
State House, Room 208
Concord, NH 03301

Dear Governor Lynch:

I am pleased to report to you on behalf of the Commission established under 2008 House Bill 1645 to study and recommend to the General Court the detailed design for a preferential tax vehicle for employees who do and do not qualify for the existing medical subsidy, to make contributions that would provide funds for post-employment medical expenses.

The Commission, made up of 18 members, held its first meeting on August 13, 2008 and its 15th and last meeting on October 15, 2009, In addition to the five members of the legislature, there were four employee members representing Groups I and II, two municipal and school employers, the Chair of the NHRS Board of Trustees, and six public members with relevant experience. (See attachment 1) I appreciate the time and effort that the members put into the assignment and their willingness at the end to join in a unanimous endorsement of our proposal.

Given the nature of our proposal for a state-wide Retiree Medical Trust established by public employee associations, no further legislation is necessary. However, we recommend that the legislature endorse the concept of a state-wide Retiree Medical Trust and authorize the implementation of such a trust established by public employee associations. LSR 2872 has been filed as the vehicle to accomplish that objective.

Legal structure of the Trust. The Trust will be a legally separate entity from the State of New Hampshire, from the participating employers and from the participating employee associations. The Trust is controlled and administered by a Board of Trustees, composed of persons elected or appointed by the participating Associations. The Trust alone will be responsible for debts and obligations of the Trust, and participating employers will be entitled to a copy of the Trust Agreement. The Board of Trustees will design the Plan, and retain an administrator for recordkeeping and claims payments.

The Trust will be regulated by federal tax and employee benefits law, under which the Trustees are charged with fiduciary responsibility to administer the Plan for the "exclusive benefit" of the participating employees. If the Trustees fail to do so, they are subject to civil and criminal penalties. All contributions and earnings into the Plan can be spent only on benefits and administrative expenses. It would violate federal law if the

assets ever were paid to the employee associations, the Trustees, or the participating employers.

Achieves Principles of HB1645. This model meets eight of the nine principles set forth in HB 1645; inclusion of the fifth listed principle (additional voluntary employee contributions) would prevent obtaining optimal tax advantages, which is the second principle set forth by the Benefits Subcommittee. The Commission decided that the tax advantages were far more important and, accordingly, the Commission has decided to remove voluntary employee contributions from the list of desirable features.

Further Goals of HB 876. Appendix A of the HB 876 Report also indicated a preference for a plan that allowed certain possibilities related to bonding, integration with the new Trust under RSA 21-I-30, moving subsidy eligible employees into the new plan, and analysis of other overcall cost savings measures. Since unfunded liabilities are not an issue under our proposal, bonding, a dubious proposition at best, was not considered. Due to the extraordinary tax, accounting and regulatory complexities related to these matters, the Commission did not believe it could explore the integration possibilities in a responsible manner in any reasonable time frame. The trust concept endorsed herein does not preclude the possibility of some integration in the future.

Effective Date. The Trust could be fully operational for a July 1, 2010 start date; and bargaining units can negotiate their contribution into the Trust immediately.

Advisor to Commission. The Retiree Health Commission worked with the Saichek Law Firm, APC, a law firm with offices in California and Washington D.C., which has already assisted in the establishment of nearly thirty retiree health trusts for public sector employees. A representative list is attached. See also, www.saicheklawfirm.com or www.retireemedicaltrust.com.

Sincerely,

Senator Harold Janeway, Chair

Cc: Senate President Larsen
House Speaker Norelli
Senator Cilley, Chair Senate Executive Departments and Administration
Senator D'Allesandro, Chair Senate Finance
Representative Irwin, Chair House Executive Departments and Administration
Representative Smith, Chair House Finance
Senate Clerk
House Clerk
State Library

RECOMMENDATIONS

2010 SESSION

10-2872.1
10/05

SENATE BILL *[bill number]*

AN ACT relative to establishment of a retiree medical trust for post-employment public employee health care funding.

SPONSORS: [sponsors]

COMMITTEE: [committee]

ANALYSIS

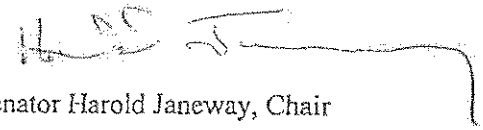
This bill endorses the implementation of, and establishes criteria for, a statewide retiree medical trust for post-employment public employee health care funding.

This bill is a request of the commission to propose a retiree health care benefits funding model established in 2008, 300:13.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

The Commission unanimously recommends that the legislature endorse the concept of a statewide Retiree Medical Trust by adopting the legislation incorporated in this report.

Respectfully submitted,



Senator Harold Janeway, Chair

Report Date: December 22, 2009

cc: Senate President Larsen
House Speaker Norelli
Senator Cilley, Chair Senate Executive Departments and Administration
Senator D'Allesandro, Chair Senate Finance
Representative Irwin, Chair House Executive Departments and Administration
Representative Smith, Chair House Finance
Senate Clerk
House Clerk
State Library

Attachment 1

Legislative Duties of the Commission
HB 1645, 2008 Chapter 300:13

The commission shall study and recommend to the general court by December 1, 2009, the detailed design for a preferential tax vehicle for employees who do and do not qualify for the existing medical subsidy, to make contributions that would provide funds for post-employment medical expenses.

Among the duties, the commission shall:

(a) Analyze the models in use by other states.
(b) Collect information from experts in the field.
(c) Consider different vehicles for such a plan including governmental trusts, Voluntary Employee Benefit Associations (VEBAs), 401(h) trusts, and Health Savings Accounts.
(d) Consider and analyze the appropriate and effective use of bonding by the state in order to provide an affordable medical subsidy.
(e) Consider the following principles, in designing a recommended plan that:
- (1) Allows for member and employer contributions.
- (2) Utilizes tax advantaged contributions, earnings, and benefit distributions.
- (3) Includes pre-funding for cost-effectiveness, security, and to satisfy the Governmental Accounting Standards Board and the Internal Revenue Service.
- (4) Permits employer contributions through negotiated matches for currently active members.
- (5) Permits additional voluntary member contributions.
- (6) Is administratively efficient.
- (7) Is available and integrated with other benefits.
- (8) Allows unused sick and vacation leave to be contributed toward the medical subsidy.
- (9) Is viable long term.

(f) Additionally, in designing a recommended plan, consider the following possibilities:
- (1) Bonding to assist in the establishment of the trust and/or the transfer of medical subsidy eligible active members and/or retirees to the new health care funding model.
- (2) Integrating the new trust with the existing subsidy-eligible state employees and the benefits provided by RSA 21-I:30.
- (3) Moving all subsidy-eligible retirees into the new plan, bringing the current 401(h) subtrust funding with them, if permitted.
- (4) Analyzing alternative retiree health care insurance programs for political subdivision retirees and Medicare retirees that would reduce the overall costs of medical care.

(g) Seek technical assistance as necessary from the New Hampshire retirement system and from other independent financial, investment, actuarial, and retirement experts.

Attachment B

SAICHEK LAW FIRM APC

SAN DIEGO
SEATTLE
WASHINGTON, D.C.

2445 FIFTH AVENUE, SUITE 332
SAN DIEGO, CALIFORNIA 92101
TEL: 619.232.8700 · 877.551.4174
FAX: 619.232.8706

MEMORANDUM

REPRESENTATIVE LIST OF RETIREE MEDICAL TRUST CLIENTS

- Beverly Hills Police Officers' Association Supplemental Benefit Trust
- Central Valley Retiree Medical Trust (established by the Stanislaus Deputy Sheriffs Assn)
- Health Professionals and Allied Employees, AFT/AFL-CIO Retiree Medical Trust (New Jersey)
- North State Public Safety Retiree Medical Trust
- Northern California Firefighters Retiree Medical Trust
- Pasadena Fire Fighters' Association Benefit Trust
- PORAC Retiree Medical Trust (established by the Peace Officers Research Association of California)
- Portland Police Association Benefit Trust
- Public Safety Employees Benefit Trust
- Redwood Empire Public Safety Medical Trust
- Southern California Public Safety Retiree Medical Trust
- Stockton Regional Retiree Medical
- Washington State Council of Fire Fighters Employee Benefit Trust

General Court
New Query

Statutory and Study Committees - Committee Details

Result List | Prev Record | Next Record

COMMISSION TO PROPOSE A RETIREE HEALTH CARE BENEFITS FUNDING MODEL : *relative to administration of the New Hampshire retirement system and benefits for members.*

General Info.

Committee Reports: HB1645 Report - ATTACHED

Year:	2008	Bill Number:	HB1645	Effective Date:	6/30/2008
Chapter Law:	300:13	RSA Chapter:	*None*	Report Filed:	Yes
Comm. Status:	Archived Chaptered Study Committee			Final Report Due:	12/1/2009
Amending Bills:	*None*				

Committee Members

Bernard Benn - House	John Reagan - House
Peter Leishman - House	Jacalyn Cilley - Senate
Harold Janeway - Senate	Lisa Shapiro - Chapter
Gary Smith - Governor	Rhonda Wesolowski - Governor
Jon Stewart - Governor	David Lang - Governor
Steve Fournier - Governor	Allen Damren - Governor
Lawrence Weissbrot - Governor	Roland Lamy, Jr - Governor
Patrick Miller - Governor	Michael Wilson - Governor
David Jensen - Governor	Newton H Kershaw, Jr - Governor

Meeting Dates

Date/Time	*Meeting Location*

Show Previous Meetings

Committee Detail:

Members elect chair; 1st mtg called by 1st named Rep; 1st mtg held w/in 30 days of eff date; 10 members = quorum; Interim Rpt due 12/1/08 & Final Rpt due 12/1/09 to hse spkr, sen pres, hse & sen clk, chair of hse & sen ed&a & fin comms, gov, st lib.; Interim Report filed, 12/4/08; Final Report filed 12/24/2009.

SEGAL

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DRAFT - MEMORANDUM

To: Brenda Johnson
Department of Administrative Services, State of New Hampshire

From: Stuart Wohl
Daniel Rhodes

Date: July 30, 2010

Re: Retiree Health Care Prefunding Options

As requested, we have prepared information regarding various vehicles the State may wish to consider for prefunding retiree health care benefits. In the attached exhibit, we have summarized the key features of five such vehicles:

- Voluntary Employees' Beneficiary Association Trust (VEBA)
- Employer general asset account
- Governmental Trust Fund (under IRC Section 115)
- Health Reimbursement Arrangement (HRA)
- Health Savings Account (HSA)

In addition, we have compiled a list of questions to help guide the State in its consideration of these options. Certain of these can also be used in discussions at the HBAC regarding the section of the new collective bargaining agreement that discussed retiree medical prefunding.

1. What are the State's goals for reviewing its current retiree medical plan? How do these goals fit into a framework of "total compensation" for State employees?
2. Are other changes in the retiree medical plan being considered for the new future, such as benefit changes or additional retiree premium cost sharing?
3. Is the intent to provide a defined contribution approach to retiree medical benefits, versus the defined benefit approach currently in place?

4. What will be the purpose(s) of these funds?
    i. Offsetting a portion of the State's costs?
    ii. Reimbursing retiree cost sharing such as copayments, deductibles, etc., under the State's plan?
    iii. Paying Medicare premiums (Part B)?
    iv. Providing funds for retirees to purchase alternative coverage?
    v. Providing funds for retirees to use for non-covered health services?
5. Does the State want to allocate funds to retirees individually (through real or notional "accounts") or to fund the retiree medical program as a whole?
6. What will be the source of the funds?
7. Are some or all of the contributions employee-funded? If so:
    i. Will employee contributions be required or optional?
    ii. Can the contribution amount vary by employee?
    iii. Will employees in different unions contribute different amounts? What are the future collective bargaining implications?
    iv. How will non-collectively bargained employees fit in?
8. Who will administer the funds?
9. How will the funds be invested?

We also anticipate that the attached exhibit and these questions (and/or answers to these questions) can become part of the feasibility study noted in the Collective Bargaining Agreement.

We look forward to discussing further with you at your earliest convenience.

cc: Monica Ciolfi
Eric Remillard
Jason Dexter
Andrew Sherman

Retiree Medical Funding

Pre-Funding Vehicle	Description	Contributions	Investment of Assets	Plan Design Issues	GASB 45 Impact
Voluntary Employees' Beneficiary Association Trust (VEBA)	Independent entity established for the benefit of a voluntary membership of active and retired employees and their beneficiaries.	Employer-funded (employee contributions would be after-tax). May be subject to VEBA maximum contribution limits.	Trust document would spell out investment policy. Requires a private qualification letter from the IRS to be tax-exempt.	Subject to requirements of IRC 501(c)(9).	Would likely qualify as "plan assets" under GASB 45. Investment in higher-yielding assets would lead to decrease in OPEB costs.
Employer General Asset Account	Ledger account for employer to set aside and track assets for retiree benefit prefunding.	Employer-funded (employee contributions would be after-tax). No special tax treatment of contributions.	Employer may be limited in how general asset accounts can be invested (e.g., limited to short-term, low-yield investments).	N/A	Assets not restricted to plan purposes, and thus would not qualify as "plan assets" under GASB 45. A pay-as-you-go discount rate would still apply.
Health Care Trust Fund (IRC Section 115)	Governmental trust dedicated to essential governmental functions, including prefunding OPEB.	Employer-funded (employee contributions would be after-tax). Contributions are unlimited.	Trust document would spell out investment policy. Investment earnings are not taxed.	Subject to requirements of IRC 115 and any applicable state law.	Would likely qualify as "plan assets" under GASB 45, depending on how trust is structured under state law. Investment in higher-yielding assets would lead to decrease in OPEB costs.
Health Reimbursement Arrangement (HRA)	Employer-sponsored real or notional accounts used to pay for qualified medical expenses for actives and/or retirees.	Employer-funded only. Contributions are before-tax.	Accounts can be notional or funded with real dollars. If funded, accounts must be held in trust and subject to specific requirements.	Used to reimburse medical expenses under IRC 213(d) and/or retiree medical premiums.	If funded, may be considered a "defined contribution" plan under GASB 45. Annual OPEB expense would equal required contributions under the plan. May result in significant decrease in OPEB costs.
Health Savings Account (HSA)	Individual- or employer sponsored accounts to pay for qualified medical expenses in conjunction with a high-deductible health plan.	Employer- or employee-funded (but contributions are limited). Medicare-eligible employees cannot contribute.	Accounts must be held in trust and subject to specific requirements. Account balances can rollover into another HSA.	Must be paired with a high deductible health plan. Penalty for non-qualified distributions.	May be considered a "defined contribution" plan under GASB 45. Annual OPEB expense would equal required contributions under the plan. May result in significant decrease in OPEB costs.

Retiree Medical Funding *(Presented on September 1, 2010)*

Pre-Funding Vehicle	Description	Contributions	Investment of Assets	Plan Design Issues	GASB 45 Impact
Voluntary Employees' Beneficiary Association Trust (VEBA)	Independent entity established for the benefit of a voluntary membership of active and retired employees and their beneficiaries.	Employer-funded (employee contributions would be after-tax). May be subject to VEBA maximum contribution limits.	Trust document would spell out investment policy. Requires a private qualification letter from the IRS to be tax-exempt.	Subject to requirements of IRC 501(c)(9).	Would likely qualify as "plan assets" under GASB 45. Investment in higher-yielding assets would lead to decrease in OPEB costs.
Employer General Asset Account	Ledger account for employer to set aside and track assets for retiree benefit prefunding.	Employer-funded (employee contributions would be after-tax). No special tax treatment of contributions.	Employer may be limited in how general asset accounts can be invested (e.g., limited to short-term, low-yield investments).	N/A	Assets not restricted to plan purposes, and thus would not qualify as "plan assets" under GASB 45. A pay-as-you-go discount rate would still apply.
Health Care Trust Fund (IRC Section 115)	Governmental trust dedicated to essential governmental functions, including prefunding OPEB.	Employer-funded (employee contributions would be after-tax). Contributions are unlimited.	Trust document would spell out investment policy. Investment earnings are not taxed.	Subject to requirements of IRC 115 and any applicable state law.	Would likely qualify as "plan assets" under GASB 45, depending on how trust is structured under state law. Investment in higher-yielding assets would lead to decrease in OPEB costs.
Health Reimbursement Arrangement (HRA)	Employer-sponsored real or notional accounts used to pay for qualified medical expenses for actives and/or retirees.	Employer-funded only. Contributions are before-tax.	Accounts can be notional or funded with real dollars. If funded, accounts must be held in trust and subject to specific requirements.	Used to reimburse medical expenses under IRC 213(d) and/or retiree medical premiums.	If funded, may be considered a "defined contribution" plan under GASB 45. Annual OPEB expense would equal required contributions under the plan. May result in significant decrease in OPEB costs.
Health Savings Account (HSA)	Individual- or employer sponsored accounts to pay for qualified medical expenses in conjunction with a high-deductible health plan.	Employer- or employee-funded (but contributions are limited). Medicare-eligible employees cannot contribute.	Accounts must be held in trust and subject to specific requirements. Account balances can rollover into another HSA.	Must be paired with a high deductible health plan. Penalty for non-qualified distributions.	May be considered a "defined contribution" plan under GASB 45. Annual OPEB expense would equal required contributions under the plan. May result in significant decrease in OPEB costs.

Retiree Medical Funding *(Presented on September 1, 2010)*

Pre-Funding Vehicle	Description	Contributions	Investment of Assets	Plan Design Issues	GASB 45 Impact
HRA within a VEBA Trust	Individual accounts for each retiree, funded over period of active employment, with assets held in a qualified VEBA trust. All requirements above for VEBAs and HRAs apply.	HRA contributions must come from employer money only. For union-represented employees, contribution amounts and formulas can be part of a collective bargaining agreement.	Assets would be controlled by Trustees, and held for the sole benefit of plan participants. Assets cannot revert to the employer and are protected from employer's creditors.	Formula for determining contributions will need to be developed (and possibly spelled out in CBA). Will formula allow for current retirees and/or those nearing retirement to accumulate meaningful assets? IRC 105 nondiscrimination rules apply.	See above comments for VEBAs and HRAs

Retiree Health Care Benefits for State Employees in 2013

Joshua Franzel and Alex Brown

June 18, 2013

Most state government employees in the United States have a portion of their compensation deferred until they retire. Types of this compensation typically include annuity payments, more commonly known as defined benefit pension plans. Some public workers also participate in primary or supplemental defined contribution retirement savings plans, and many workers have access to an assortment of other retirement-related benefits, including public employer provided health care.

The term "other post-employment benefits" (OPEB) refers to a range of employer-provided benefits, other than pensions, that are available to public employees once they retire. Usually the largest portion of OPEB benefits is retiree health insurance, which most states provide to retired employees, should the employees meet certain criteria.[1] Although a sizable majority of state workers have access to retiree health insurance,[2] similar to pensions,[3] the two benefit categories differ significantly in regard to their protected status, costs, short and long term financing, and benefits offered.

This brief uses recent data samples to highlight characteristics of health benefits states offer to their retired workforce while exploring how the health benefit differs from pension benefits available to this same group. In addition to these distinctions, this brief considers the underlying OPEB finances, approaches states take to paying for retiree health care, and the range of policy and program changes made to retiree health benefits by states since the recent 18-month recession ended in 2009.[4]

Our review reveals that 1) state government units offering retiree health care benefits have declined in number during the past decade; 2) retiree health care obligations are concentrated in a minority of states; specifically, of all state retiree health care unfunded liabilities, 80 percent are attributable to 12 states; 3) on a per capita basis, retiree health care obligations vary widely among states; and 4) states are utilizing a variety of methods designed to shift a greater portion of the cost of providing retiree health care to employees and retirees.

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[1] Given that the predominant OPEB benefit is retiree health care, this brief will treat the terms "OPEB" and "retiree health care" interchangeably.
[2] Table 42. Health-related benefits: Access, State and local government workers, National Compensation Survey, March 2012. Bureau of Labor Statistics. U.S. Department of Labor. <http://www.bls.gov/ncs/ebs/benefits/2012/ownership/govt/table39a.pdf>
[3] Table 2. Retirement benefits: Access, participation, and take-up rates, State and local government workers, National Compensation Survey, March 2012. Bureau of Labor Statistics. U.S. Department of Labor. <http://www.bls.gov/ncs/ebs/benefits/2012/ownership/govt/table02a.pdf>
[4] Business Cycle Dating Committee. National Bureau of Economic Research. <http://www.nber.org/cycles/sept2010.pdf>

CENTER FOR STATE & LOCAL GOVERNMENT EXCELLENCE

NASRA

Joshua Franzel, PhD, is the vice president of research at the Center for State and Local Government Excellence.

Alex Brown is the research manager at the National Association of State Retirement Administrators.

The authors would like to thank SLGE and NASRA staff for their review of this paper.

Overarching Legal Issues

Pensions for state employees are protected, to varying degrees, by state constitutions, statutes, or other edicts.[5] To the extent that health insurance for state retirees has the same standard of protection, it is usually due to being an element of a negotiated labor agreement. Some cities and counties have contractual agreements for medical benefits with their employees, but generally no such statewide guarantees exist.[6] This lesser legal protection means that health insurance benefits can often be modified to a greater degree than pension benefits.

Health Insurance Costs, Overall

The overall U.S. health insurance market saw annual cost increases of about 5 percent between 2008 and 2011.[7] These increases were lower than the four years prior (2004-2007) when yearly cost increases averaged 7.2 percent.[8] Also, in recent years, 2008-2012, consumer prices for medical care have annually increased at a lower rate, 3.4 percent, than they did between 2003 and 2007, when they experienced annual increases of 4.2 percent.[9]

For public employers, health care as a portion of overall employee wage and benefit compensation has increased from 10 percent in 2004 to 12 percent of total compensation in 2012.

For the four years 2008 to 2011, wage and salary earners of all sectors saw their costs for health insurance increase from the previous year by an average of 7.4 percent, relative to average annual increases of 4.8 percent from 2004 to 2007. Retirees of all sectors experienced average annual cost increases of 7.5 percent between 2004 and 2007 and 2.6 percent between 2008 and 2011.[10]

State and local government employers have seen their costs for providing employee health care increase annually by an average of 4.4 percent from 2004 to 2012, with rates increases generally lowering from 8.7 percent in 2005 to 2.4 percent in 2012.[11] These increases are similar to those found for employers of all sectors. Also, for public employers, health care as a portion of overall employee wage and benefit compensation has increased from 10 percent in 2004 to 12 percent of total compensation in 2012 (by comparison, the percentage of wages and salaries as a portion of public employee wage and benefit compensation fell from 69 percent to 65 percent over the same time period).[12]

State Retiree Health Insurance: Provision and Access

Eligibility for a pension benefit in most states is based on age and/or length of service and a minimum amount of creditable service known as a vesting period.

Eligibility requirements for government-provided retiree health insurance are much more diverse and usually more stringent. Some states simply tie eligibility for health insurance to eligibility for a pension benefit. Other states require employees to vest in order to be eligible for health insurance, and some in this category provide benefits on a tiered system calculated based on an employee's length of tenure in the system.[13]

An additional characteristic of state-provided retiree health care is that the benefit is linked to the age of the plan participant, with benefit levels typically changing once a retiree reaches the age of eligibility for Medicare (currently age 65). While pension benefits generally provide a guaranteed, level benefit for an individual's entire retirement, state-provided retiree health benefits usually become secondary to Medicare, once the retiree has reached the age of eligibility for the program.

Eligibility and access to retiree health care differ significantly from that of pensions due to the differences in legal protections discussed earlier.

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[5] Klausner, Robert D. State Constitutional Protections for Public Sector Retirement Benefits. Presented at the 2013 NASRA NCTR Joint Legislative Conference, February 25, 2013, Washington, D.C.

[6] Klausner, Robert D. State and Local Government Retirement Law: A Guide for Lawyers, Trustees and Plan Administrators 2012 ed. Thomson West; pg 488.

[7] Table 3 National Health Expenditures; Levels and Annual Percent Change, by Source of Funds: Selected Calendar Years 1960-2011. Centers for Medicare & Medicaid Services. U.S. Department of Health & Human Services. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf>

[8] Ibid.

[9] Author calculations of: Bureau of Labor Statistics. U.S. Department of Labor. Consumer Price Indexes (All Urban Consumers). <http://www.bls.gov/cpi/home.htm>

[10] Author calculations of: Bureau of Labor Statistics. U.S. Department of Labor. Consumer Expenditure Survey. <http://www.bls.gov/cex/>

[11] Author calculations of: Bureau of Labor Statistics. U.S. Department of Labor. Employer Cost for Employee Compensation. <http://www.bls.gov/data/#wages>

[12] Ibid.

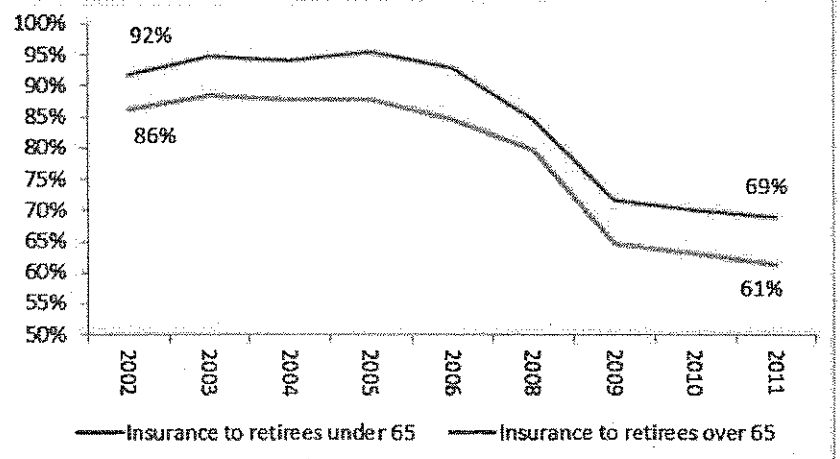
[13] Kearney, C., et al. At a Crossroads: The Financing and Future of Health Benefits for State and Local Government Retirees. Center for State and Local Government Excellence. <http://slge.org/wp-content/uploads/2011/12/At_a_Crossroads.pdf>

As can be seen in Figure 1, 2006 marked the beginning of a recent shift in state government units[14] offering health care to retirees, both under and over the age of 65.

Between 2002 and 2006, the percentage of state government units offering health care to retirees under age 65 ranged between 92 percent in 2002 and 96 percent in 2005; but in recent years (2011) the rate dipped to 69 percent.

For retirees over 65, the percentage of state government units offering health care was between 86 percent in 2002 and 88 percent in 2005, dipping to 61 percent in 2011.[15]

Figure 1: Percent of State Government Units Offering Insurance to Retirees (Medical Expenditure Panel Survey – US HHS)



Meanwhile, the level of access to health insurance for retirees of all ages has remained relatively stable and, in fact, has actually increased. In 2009,[16] 82 percent of 82 percent of state workers had access to retiree health benefits before turning 65, with 79 percent having access when they were 65 or older. In 2012,[17] the percentages were 86 percent and 83 percent, respectively.

State Retiree Health Insurance: Finances

Unlike retiree health care, pensions for state employees are generally financed in a manner similar to one another, with little variation among states. Retirement systems collect contributions from both employees and employers, which are invested to grow the fund, pay the plan's administrative costs, and provide formulaic benefits for the remaining life of an individual retiree or their survivor.

Retiree health insurance coverage varies significantly in financing from state-to-state and calculations of benefits are not typically formulaic like they are for pensions. Many states fund retiree health benefits on a pay-as-you-go basis, meaning benefits are paid from the annual operating budget. Other states choose to prefund benefits, setting up trusts or other fiscal arrangements for retiree health care whose assets may be invested and grown to pay future benefits.[18] The number of states setting assets aside has grown in recent years, as has the overall value of retiree health care assets themselves.

In a review of state-administered OPEB plan finances reported between 2009-2011, 18 states had set aside assets to prefund retiree health benefits. In a similar review of finances reported between 2011-2012, the number of states that had set aside assets grew to 25.[19]

State government retirees receiving health care coverage often contribute towards the cost of their benefits. In most cases, beneficiaries are responsible for paying a portion of plan premiums, making copayments for medical services, and

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[14] "sample is drawn at the governmental unit level, which is defined as all sites under a single controlling governmental entity:" Quote comes from MEPS-IC Sample Size web page. <http://meps.ahrq.gov/mepsweb/survey_comp/ic_sample_size.jsp>

[15] From Medical Expenditure Panel Survey. Agency for Healthcare Research and Quality. U.S. Department of Health & Human Services. <http://meps.ahrq.gov/mepsweb/data_stats/MEPSnetIC.jsp>

[16] Table 37. Health-related benefits: Access, State and local government workers, National Compensation Survey, March 2009. Bureau of Labor Statistics. U.S. Department of Labor. <http://www.bls.gov/ncs/ebs/benefits/2009/ownership/govt/table39a.pdf>

[17] Table 42. Health-related benefits: Access, State and local government workers, National Compensation Survey, March 2012. Bureau of Labor Statistics. U.S. Department of Labor. <http://www.bls.gov/ncs/ebs/benefits/2012/ownership/govt/table39a.pdf>

[18] Kearney, C., et al. At a Crossroads: The Financing and Future of Health Benefits for State and Local Government Retirees. Center for State and Local Government Excellence. <http://slge.org/wp-content/uploads/2011/12/At_a_Crossroads.pdf>

[19] 2009-2011 data was collected from state comprehensive annual financial reports for use in the article "Understanding Finances and Changes in Retiree Health Care" by Franzel and Brown (published by the Government Finance Review, 2012)." Data reported in this article was collected in early 2013 following the same data collection methodology as an update.

paying a deductible. Similar to pension benefits, which often require employee contributions to the pension system during service years, some states are requiring individuals employed by a state government to make contributions towards their health benefits as periodic in-service payroll deductions.[20]

Previous reports have offered and discussed unfunded liabilities, annual required contributions (ARC), and other measures, collected from state comprehensive annual financial reports (CAFR), associated with state retiree healthcare programs, both in the aggregate and by individual state.[21]

Table 1 offers recent data on liabilities for retiree health care by state. There is wide variation in unfunded liabilities across the states. "The substantial variation in unfunded liabilities is a function of the size of the state workforce, the generosity of the retiree health plan, the portion of the total cost of the health program paid for by the state, and what type of employees are included in the plan."[22] In the aggregate, unfunded liabilities for the states is about $425 billion, or approximately 2.7 percent of combined state GDP.[23]

Using the data provided in Table 1 we can draw some conclusions about the range among states with regard to OPEB liabilities. Figure 2 breaks out OPEB liability by state and shows some of the variation in total liabilities carried. In fact, the data show that a large portion of overall OPEB obligations are held by a handful of states. The median state OPEB liability is $2.1 billion. Values above the median represent approximately 96 percent of all state OPEB liability, with values below the median representing approximately 4 percent of the total.[24]

Table 1: Retiree health care liabilities by state, 2010-2012[25]

State	Unfunded Liabilities (millions)	Unfunded Actuarial Accrued Liability - Per Capita[26]	Date of Report	State	Unfunded Liabilities (millions)	Unfunded Actuarial Accrued Liability - Per Capita	Date of Report
AL	$3,261	$676	2012	MT	$337	$335	2012
AK	$4,039	$5,522	2012	NE*	$0	$0	2012
AZ	$257	$39	2012	NV	$947	$343	2011
AR	$1,953	$662	2012	NH	$2,258	$1,710	2012
CA	$63,840	$1,678	2012	NJ	$18,078	$2,039	2012
CO	$1,429	$275	2011	NM	$3,347	$1,605	2011
CT	$17,905	$4,987	2012	NY	$59,668	$3,049	2012
DE	$5,641	$6,151	2012	NC	$29,610	$3,036	2012
FL	$4,903	$254	2012	ND	$54	$77	2012
GA	$4,312	$435	2012	OH	$18,211	$1,577	2011
HI	$11,706	$8,408	2012	OK	$359	$94	2008**
ID	$24	$15	2012	OR	$161	$41	2011
IL	$33,295	$2,586	2011	PA	$12,907	$1,011	2012
IN	$(7)	$(1)	2012	RI	$775	$738	2012
IA	$378	$123	2012	SC	$9,145	$1,936	2011
KS	$283	$98	2012	SD	$66	$79	2012
KY	$2,679	$612	2012	TN	$1,476	$229	2012
LA	$4,862	$1,057	2012	TX	$20,823	$799	2012
ME	$1,180	$888	2012	UT	$375	$131	2012
MD	$9,371	$1,592	2012	VT	$998	$1,594	2012
MA	$16,299	$2,452	2012	VA	$1,849	$226	2012
MI	$14,251	$1,442	2012	WA	$3,492	$506	2012
MN	$799	$149	2012	WV	$6,987	$3,766	2011
MS	$665	$223	2012	WI	$953	$166	2012
MO	$1,511	$251	2012	WY	$219	$380	2012

*Note: NE carries an OPEB liability that is described as immaterial for purposes of reporting [27]

**2008 is the latest year that published data is available for Oklahoma OPEB liabilities[28]

[20] National Conference of State Legislatures researchers tracking changes to public employee retirement benefits have noted that certain states have passed recent legislation requiring some employee groups to begin making contributions, while employed, to offset the costs of health care for retirees (see NCSL Enacted State Pension Legislation, http://www.ncsl.org/issues-research/labor/pension-and-retirement-legislative-summaries-and-r.aspx).

[21] See: Clark and Morrill - The Crisis in State and Local Government Retiree Health Benefit Plans: Myths and Realities (published by the Center for State and Local Government Excellence, 2009); Prunty - U.S. States' OPEB Liabilities and Funding Strategies Vary Widely (published by Standard & Poors, 2009); The Widening Gap: The Great Recession's Impact on State Pension and Retiree Health Care Costs (published by Pew Center on the States, 2011); Franzel and Brown - Understanding Finances and Changes in Retiree Health Care (published by the Government Finance Review, 2012).

[22] Clark, R and M. Morrill. The Crisis in State and Local Government Retiree Health Benefit Plans: Myths and Realities. Center for State and Local Government Excellence; pg. 5. < http://slge.org/wp-content/uploads/2012/01/NC-State-Brief1-UPDATED_The-Crisis_Nov-09.pdf>

[23] Author calculations using latest available state GDP data from the U.S. Bureau of Economic Analysis. <http://www.bea.gov/iTable/iTable.cfm?ReqID=99&step=1#reqid=99&step=4&isuri=1&9901=1200&9902=1&9903=200&9990=99>

[24] Author calculations using data provided in Table 1.

[25] The data offered in this table reflects the most recent comprehensive annual financial report OPEB figures available at the time this piece was drafted. For most of the states, the amounts offered are associated with the retiree health care of general state employees (the focus of this brief). Some states offer amounts that may include other state employees. To compile the data of this table the authors used the data collection methodology previously used by R. Clark and M. Morrill of NCSU (see: 'The Crisis in State and Local Government Retiree Health Benefit Plans: Myths and Realities', Center for State and Local Government Excellence, 2009) and later used during for the research and writing of '*Understanding Finances and Changes in Retiree Health Care,*' Government Finance Review, 2012 by J. Franzel and A. Brown.

[26] Per capita calculations use 2012 population estimates from the U.S. Census Bureau. <http://quickfacts.census.gov/qfd/index.html>

[27] Standard & Poor's, "U.S. States' OPEB Liabilities and Funding Strategies Vary Widely," June 3, 2009. <http://www.naic.org/documents/committees_e_rating_agency_101118_hearing_doc4.pdf>

[28] There is no separate OPEB trust for retirees in Oklahoma; the assets of the health plans for active employees and retirees are combined.

State Retiree Health Insurance: Finances (cont.)

Another way to compare OPEB liability by state is to compare the relative size of liabilities by measuring them on a per capita basis. When population is factored in, as it is in Figure 3, we find that the chart reinforces the data presented in Figure 2. The values above the $1,000 per capita indicator represent 51 percent of the population, with 49 percent residing below the $1,000 line.[29]

Figure 2: UAAL By State[30]

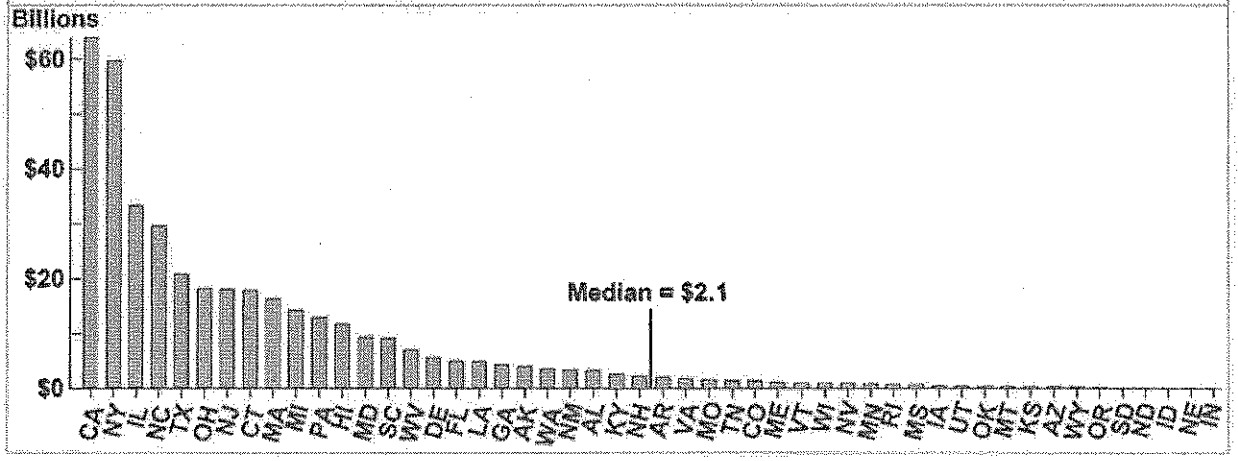
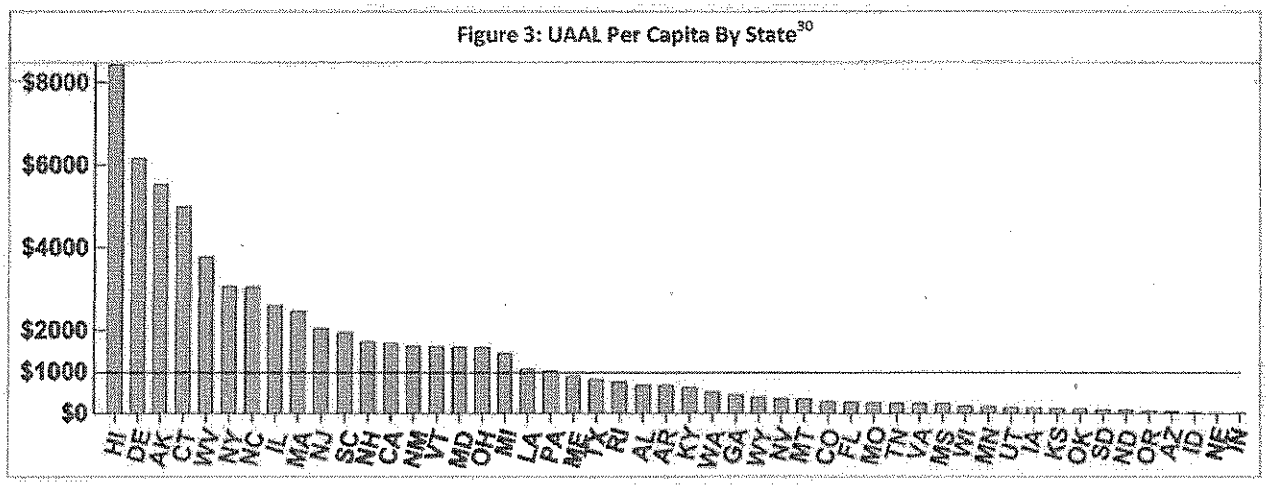


Figure 3: UAAL Per Capita By State[30]



[29] Author calculations using data provided in Table I.

[30] For a 2006-2008 data chart see Kearney, C., et al. At a Crossroads: The Financing and Future of Health Benefits for State and Local Government Retirees. Center for State and Local Government Excellence. <http://slge.org/wp-content/uploads/2011/12/At_a_Crossroads.pdf>

State Governments Making Changes to Retiree Health Care Coverage

Given overall continued increases in health insurance costs, liabilities (Table 1) related to the past and current offering of retiree health insurance by state governments, and improving, yet still vulnerable, underlying state revenues,[31] changes have and continue to be made to retiree health insurance benefits.

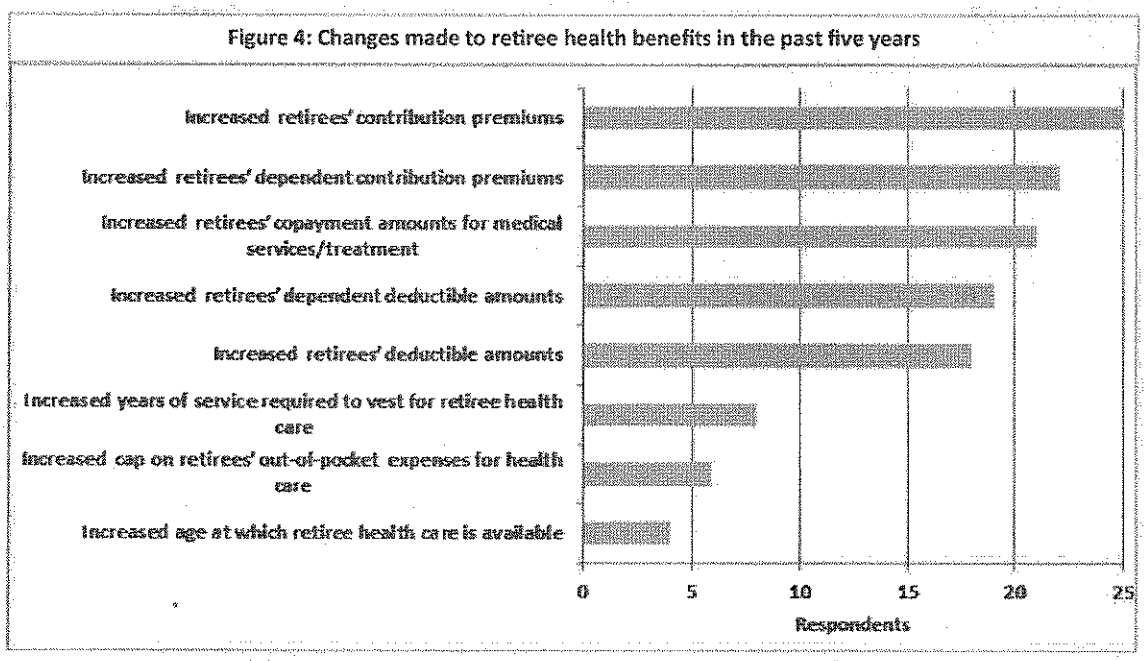
Since 2011,[32] the Center for State and Local Government Excellence, National Association of State Personnel Executives, and International Public Management Association for Human Resources have surveyed state and local human resource executives across the United States asking about a range of topics related to the public workforce, including changes to retiree health care coverage.[33]

In 2011, 65 percent of state government respondents reported that over the past year, their government had made changes to the health benefits offered to employees and retirees. In 2012, 61 percent, and in 2013, 66 percent, of state respondents indicated that their governments had made such changes.

More specifically, in 2011, 31 percent of state government respondents answered that more health care costs were shifted from the employer to retirees in the form of higher premiums, copayments, and/or deductibles, among other approaches. Since 2011, fewer respondents have noted this type of change: 12 percent in 2012 and 13 percent in 2013.

A 2013 National Association of State Retirement Administrators (NASRA) survey[34] provides a further breakdown of the types of changes to retiree health care being pursued by state governments. According to the survey findings (see Figure 4), altering the cost-sharing arrangement by increasing premiums or deductible amounts for beneficiaries and/or their dependents, and increasing copayment amounts have been the most common methods of reform.[35] Other changes implemented by some states include increasing the age of eligibility and/or years of service required to vest in the health care plan, and increasing the cap on retirees' out-of-pocket expenses.

Figure 4: Changes made to retiree health benefits in the past five years



[31] The Fiscal Survey of States. National Governors Association and National Association of State Budget Officers. <http://www.nasbo.org/sites/default/files/Fall percent202012 percent20Fiscal percent20Survey.pdf>

[32] 2011 was the first year the three organizations included questions about retiree health care. SLGE, NASPE, IPMA-HR. State and Local Government Workforce: 2011 Realities. <http://slge.org/wp-content/uploads/2011/12/S-L-Govt-Workforce_2011-Realities_11-220.pdf>; SLGE, NASPE, IPMA-HR. State and Local Government Workforce: 2012 Trends. <http://slge.org/wp-content/uploads/2012/04/S-L-Govt-Workforce-2012_12-195_web.pdf>; SLGE, IPMA-HR. State and Local Government Workforce: 2013 Trends. <http://slge.org/wp-content/uploads/2013/05/Workforce-Trends-2013_13-3541.pdf>

[33] Note the 2013 survey was administered by SLGE and IPMA-HR.

[34] The survey was conducted in March 2013, with questions sent to 51 directors (50 states and one university system) of public employee retirement systems whose members are primarily employees of state government. The questions were based on an earlier surveys conducted by The Center for State and Local Government Excellence (City/County Government Retiree Health Care Survey, 2008) and International City/County Management Association (Local Government Employee Health Insurance Programs, 2011); 38 responses were received from 37 states.

[35] Respondents were allowed to cite more than one change made to their retiree health care benefit.

Conclusion

Pensions and retiree health care differ in the way they are financed and the benefits provided. Where they share similarities is in the unprecedented levels of attention both are receiving from policymakers, media, and the general public, and the changes that are being implemented to manage and lessen their costs.

As discussions continue and proposed policy and program changes are advanced it is important to recognize the unique ways in which these two different benefits are structured, financed, and administered.

The data points identified in this brief show that health benefits for public retirees are being offered by fewer state government units with participating retired public employees likely receiving less and/or paying a larger portion of the cost of the benefit. These two trends will likely continue to change the landscape of state employee retiree health care moving forward.

CENTER FOR STATE & LOCAL GOVERNMENT EXCELLENCE

NASRA

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October 31, 2013
Meeting

Commission to Review Retiree Health Care
For Employees Hired after July 1, 2013

AGENDA

10/31/13

- Review and Approve Minutes from 10/24/13 meeting
- Health Care Reform, the ACA and Retirees: Mike Wilkey, Director Compliance and Consumer Services, NH Department of Insurance
- Segal Review of Other Post Employment Benefit Projections Revised for No New Hires (3pm)
    - On telephone: Segal Actuaries Kathleen Reilly and Daniel Rhodes
    - New chart for review and comparison to p. 11 of OPEB Chart (Handouts)
    - Q&A
- Establishing a Process to Draft Commission Report (due November 15, 2013)
- Next Meeting: November 7, 2013
    - HRA Presentation (possible)
    - Review of Report Drafts
    - Other
- Future Meetings
    - Thursday November 14, 2013
    - Do we want to add a November 15, 2013 meeting (report due date)?
- Other

Commission to Review Retiree Health Care
For Employees Hired after July 1, 2013

10/31/13

Present:
Linda Hodgdon, Commissioner, Department of Administrative Services, Chair
Lisa Shapiro, PhD, Public Member
Catherine Provencher, State Treasurer, Public Member
Stephen Arnold, New England Police Benevolent Association

Absent:
John Beardmore, Commissioner, Department of Revenue, Public Member
Seth Cooper, NH Troopers Association
Kevin Foley, Teamsters Local 633
Diana Lacey, President, State Employees Association
Public Member to be named by Governor

- Review of Minutes from 10/24/13

Meeting

Mike Wilkey, Director Compliance and Consumer Services, NH Department of Insurance (DOI) presented on the Affordable Care Act, the health care exchanges in NH and their relevance to Retirees.

Handouts: New Hampshire Market Place 2014 and NH Marketplace Standard Plans

The following supplements the handouts:
- Focus on INDIVIDUAL marketplace and on 2014-2016.
- Exchange is a web portal to see a range of benefit plans for possible purchase.
- The exchange is the only point of access to tax credits and subsidies.
- Anthem: Anthem submits partnership application through DOI, it is reviewed by DOI and then DOI makes a recommendation to federal government to certify.
- A multistate plan goes to OMB, not CMS
- Despite implementation issues, the website is expected to send real time feeds to enroll people in a health plan.
- System will send individuals to Medicaid or private insurance as appropriate.
- They are building a NH specific piece and it will advise people of other programs to assist a family.
- There are individual annual penalties, administered by the IRS.
- ACA goal is to get everyone covered.
- When a person fills out the application, fills out income, it filters against the IRS data, which then may result in the need to submit documentation to prove income.

- Carrier perspective: need stability of risk pool. Need all people, not just those who know they need health care.

Minimal Essential coverage and HRAs:

- Includes HRAs. DOI has requested information on retiree coverage. If an employer offers an HRA, it's a group offer usually in conjunction with a group plan. If employer drops the group plan but keeps the HRA, the HRA is a minimal essential coverage. This means someone who gets the HRA is eligible for tax credit or subsidies.
- Premium reimbursement accounts, an HRA equivalent, are minimal essential coverage, per guidance from CMS. It gets complicated as to what qualifies as minimal essential coverage, when, where.

Q: So if future retirees are no longer covered, and are sent to exchange, could we couple it with an HRA because they wouldn't be eligible for a subsidy?
A: Need to figure out how the employee is better off- with subsidy or not; with HRA or not.

- Designed so that if employer wants to give a subsidy, it negates the federal subsidy. The critical view is what the money is (income or subsidy for medical)

Q: Why are they doing this?
A: They want to encourage employers to help retirees with co pays or co insurance and are trying to discourage premium payments.

- If a Group I employee is hired today, the state at age 65 and with 20 years of service, provides a Medicare wrap. Current employees are not eligible for subsidy.
- Group 2: retiree health benefit eligibility is age 52.5 and 25 years of service.
- For retirees, the subsidy only applies to those who are under age 65. Impact of ACA is primarily for under age 65 and also for only Group II that has a lower benefits eligibility age requirement.

Q: What is problem we are trying to solve? Current eligibility for a new hires provides for retiree health benefits to those who fail to meet of age 65 and 20 years of service. ACA does not help those that are Medicare eligible. If not eligible for retiree medical benefits, then there is no OPEB impact.

- Flaw on exchange: No dependent child eligibility under a plan. Technically only an adult can purchase coverage. This is a logistical challenge. Child is one under 26.

Ball park number for someone age 41 or 42 in a silver plan is $400 pmpm or about $480 per month. Adjusts up or down.

Handout: NH Marketplace Standard Plans

- Deductibles are high.
- NH has the 3rd most expensive health care in country. From an actuarial perspective, couldn't meet ACA without the coinsurance.
- Subsidy can be up to 89% of the $480, sliding scale based on income level.
- All plans are from Anthem. These products are also available through a health insurance producer. They would be more than 20% more expensive on non exchange setting.

Q: Some individuals had been told they can keep the insurance they have? Insurance carriers do not want to administer two different plan designs. Carriers discontinued entire blocks of products. They accelerated their processes to improve their bottom lines. ACA/Obamacare is getting blamed- no law to prevent a carrier to leave the marketplace. Anthem switched the product from HMO to carrier license. So someone with an individual policy through Anthem will have to renew through the exchange; more expensive off the exchange.

- Anthem is a narrow network under HMO filing on exchange. All products sold on the exchange are statewide technically, but they do not include all 26 hospitals and all practitioners. There is concern that Anthem is the only product offered on exchange.

Is the State of NH going to be forced to open doors to bring in other companies and products? DOI working with CMS to bring another carrier in at an accelerated timeframe; however, the company pulled out because they didn't have enough time to be ready. The carrier is likely to come back a year from now and has submitted an informational filing.

- DOI is working on 2015 planning already even though not through 2013.

- By 2016, there has to be a for profit and not for profit plan offering in the state. So we are assured at least another carrier will offer products on the exchange.

- Some companies said they would offer options in 2015 but this is in the small market, not the individual market. Federally facilitated exchange makes it more difficult and would have to get state legislation.

- It is unknown what will happen to subsidy level beyond 2016. Levels will remain constant for first two years. Enables the person to go on exchange and buy some sort of protection for family. There are trade offs.

- Exchange plans: Co pays and deductibles are high. Max Out of Pocket is $6250 for health benefits and $6250 for drug plan. All preventive services and all women's care are no co pay or deductible.
- NH has the highest level of deductibles and co insurance in the country.

What will people do? It is always a personal decision. Some may forego insurance in the first year and pay the penalty. Knowledge of what is available is important. Hospitals will maintain uninsured risk pool.

- There is reason for optimism. It will get easier and many elements will improve. Competition could change this. The bugs will get fixed. There are positive features such as no preexisting conditions. Many people have not gone to the hospital with preexisting conditions. Paying $6250 may be better than paying even more.

- The world is changing and NH will have to catch up. Specialization is in future and providers will be known by specialty. The trend and movement is towards quality measures. If a provider is more than a standard deviation on downside, then the provider will not be in network. Quality and Cost will drive.

- If people are 65 or older, and cannot get insurance on exchange and state didn't offer retiree health benefits, then they could purchase insurance in existing insurance market. State could put funding toward premium or something else.

- If person were under age 65, between ages 50-65, and state did not offer retiree heath plan, the person would have to purchase on the exchange in order to avoid the penalty. If State offers retiree coverage, we know that our current assessed Cadillac Tax for the < 65 retiree group is $1.4 m.

- If we put amounts aside for people under age 65 to defray cost, then they could not get subsidy if eligible. We need to study if an HRA disqualifies one from receiving the subsidy. HRAS are usually for things not covered by the plan: co pays and deductible.

- Joint team with CMS, CCIO, and DOL is very busy and further guidance to come.

- Commission reserves the right to call Mike Wilkey to help when writing the report.

Danny Rhodes and Katherine Riley (KR), Segal

- Walk through new assumptions. Last week, talked about a rough estimate for just Group I. They ran everyone through new eligibility rules for those hired after July 1, 2011.
- Segal did a Group II analysis after last week's call and the normal cost reduced by 1/3, the same as for Group I.

- Segal recalculated the exhibit. Took normal cost (NC) (Column 5) to grow at 5% originally, goal was to get the normal cost down by 1/3. Changed from 5% to 3.6 % and gets us to lower number.

- They then looked at benefit payments. Takes longer for changes to work through the years because current retirees are subject to older eligibility rules. Don't see change until later and many years out. By 30 years, 10% lower. 2023 starts to drop. 2042 10% lower.

Q: Segal assumed NC grows 5% per year and employees are replaced with similarly situated employees. Why assume reduced rate of cost? Idea is that drops 1/3 over many years. What do we have to change to do this?
A: Reflects the fact age of retirement is 65 in Group I and 52.5 in Group II. The difference is not a 1/3 initially but it is at the end of the schedule. They solved for the increase.

- This is a better way of not overstating the problem. Problem doesn't come back a 1/3 less because needs to trickle down.

- Refine Get No New Hire chart: drop in latest numbers into the no new hire chart. Want this chart to be an attachment to Commission report. This will help inform the reader to understand what we are talking about....

- Will change the label of chart. Reflects more accurate prediction of new eligibility rules with age and service requirements.

Q: We have run a scenario to reflect new rules. Is it apples to apples?
Benefit column 4 would change in time. Issue is NC for no new hires.
A: Today, better estimate to reflect new hire eligibility. The analysis is still rough, but benefits and NC reduce uniformly.

- Benefit payments should be lower. Adjustments made are macro adjustments. Need to fine tune middle years so they make sense.

KR: We need numbers that make sense. Three or four year projection can swing by several million and then it builds.

- Commission is trying to focus on scenarios for future. Nothing exact but need common set of assumptions. Hopefully will get chart soon and we will email it out.

Drafting the Report

Cathy Provencher handed out a one page document with her thoughts about how the Commission might go about writing the report. The Commission reviewed the Handout and brainstormed about the report.

Components of the Report

- Mission statement of the Commission
- Background: OPEB expenditures
- Solutions considered
- Recommendations: provide a pathway of what should be done in future, including actuarial report.
- Appendix: metrics.

Upcoming Meetings

- November 7th
- Nov 14th
- Nov 15th?

New Hampshire Health Insurance Marketplace 2014

Cost Containment Commission

New Hampshire Insurance Department
October 31, 2013

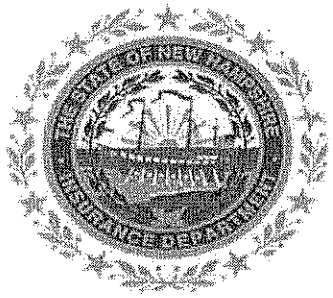
What is The New Hampshire Health Insurance Marketplace?

- Online Exchange where individuals and small businesses are able to purchase health and dental insurance.
- Federally Facilitated Exchange where there exists a Plan Partnership with the State of NH.
- Low and moderate-income individuals using the Marketplace will be able to obtain **payment assistance** to help them buy health insurance.
  - Some may also get **reductions** on deductibles and other cost-sharing.
  - People can also use the Marketplace to **enroll in Medicaid**.

2

The Individual Mandate

- Beginning in 2014, every individual must have health insurance that meets the **Minimum Essential Coverage** requirements or pay a penalty.
- Administered and enforced by IRS
- Penalty amount:
  - 2014: $95 per household member (up to $285) or 1% of income (whichever is higher).
  - 2015: $325 per household member (up to $975) or 2% of income (whichever is higher).
  - 2016: $695 per household member (up to $2095) or 2.5% of income (whichever is higher).
  - After 2016 – cost of living adjustments
- Goals of the ACA:
  - Get everyone covered
  - Improve stability of insurance risk pool



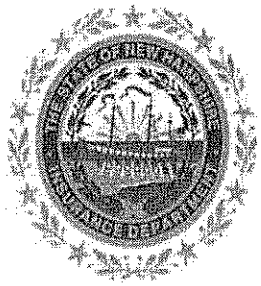
3

Minimum Essential Coverage

- Qualifying Employer-sponsored coverage (including retiree plans)
- Coverage purchased in the individual market
- Medicare Part A coverage and Medicare Advantage
- Most Medicaid coverage
- Children's health Insurance Program (CHIP)
- Certain types of veterans health coverage administered by the Veterans Administration
- TRICARE
- Coverage provided to Peace Corps volunteers
- Coverage under the Nonappropriated Fund Health Benefit Program
- HRA's (in certain instances)

New Hampshire Health Insurance Marketplace (Focus for Discussion: Health Coverage)

- New Hampshire's Health Insurance Marketplace:
  - Operated by the federal government (CMS/CCIIO)
  - Under NH's partnership model, the state will operate some specific functions that are related to traditional state roles
- Insurance Market outside the Exchange still remains (limited carriers in individual marketplace)



5

Essential Health Benefits

The ACA requires coverage of services in 10 categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity & newborn care
5. Mental health and substance abuse disorder services, incl. behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services
8. Laboratory services
9. Preventative and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

Metal Levels

- Metal levels are a way to help consumers understand the relationship between premium levels and cost sharing.
- Plan levels of coverage vary depending on the metal level:

Levels of Coverage	Plan pays on Average	Enrollees Pay on Average*
Bronze	60%	40%
Silver	70%	30%
Gold	80%	20%
Platinum (1)	90%	10%

- All plans cover the same services (EHBs).

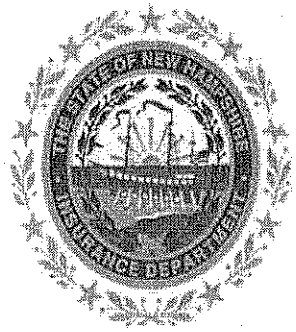
*amount based on average cost of an individual; may not be the same for every enrolled person.
(1) Not offered in 2014 in New Hampshire

Other Notables

- Guarantee Issue
- No Pre-Existing Conditions
- High Risk Pool no longer in existence
- 2014 Allowable Rating Factors:
  - Age (specified scale) at 3:1
  - Tobacco Use at 1.5:1
  - Membership Tier
    - **Member Developed Rates**
  - Geographic Rating – single area for NH
- Open Enrollment
  - 2014 October 1, 2013 – March 31, 2014
  - 2015 October 15, 2014 – December 7, 2014

Subsidy Availability to Individuals

- Substantial subsidies are available through the Marketplace for those at 100%-400% of federal poverty (FPL).
  - Individuals: $11,490 - $45,960
  - Family of 4: $23,550 - $94,200
  - http://kff.org/interactive/subsidy-calculator/
- Those under 100% FPL are **not** eligible for subsidies; the ACA presumed they would be covered by Medicaid.
- **THE CHASM**: Without the Medicaid expansion, those who aren't currently eligible for Medicaid will have **no** access to coverage or subsidies. (100 – 138% FPL)



2014 Health Coverage Offerings

- One Carrier
- Narrow Network
- 11 Plans (includes 1 Catastrophic Plan for individuals < age 30)
- Limited Open Enrollment Period (Special enrollment permitted)
- Out of Pocket Maximums $6,250 Health, $6,250 Rx (only one OOP maximum 2015)
- Multi State Plan (1), a for-profit by :

10

Medicaid Expansion Status

New Hampshire will make a decision this fall on whether to expand Medicaid.

Special Legislative Sessions have been called

With or without expansion, the NH Department of Health and Human Services will continue to administer the state's Medicaid program.

- Eligibility determinations
- Customer services

Medicaid Expansion Commission:
http://www.dhhs.nh.gov/sme/index.htm

What is happening in the delivery system?

- Investment in Community Health Centers
- Increased use of mid-level providers (NPs, PAs), health coaches, and community health workers
- Telemedicine
- Hospitalists
- Urgent care centers and walk in clinics
- Accountable Care Organizations and medical homes
- Hospital services provided in non-traditional settings
- Incentives exist for restructuring the delivery system with a lower cost structure
- Centers of Care
- Improved and Expanded Quality Measures

Calender Year 2014 NH Marketplace (Exchange) Individual "Standard" Plans *Note 1 FINAL October 24, 2013

Plan ID/ Form Schedule #	96751NH0330002	96751NH0150010	96751NH0150006	96751NH0330001 2nd lowest priced Silver Plan	96751NH0150008	96751NH0150001	96751NH0150002	96751NH0150009	96751NH0150004	96751NH0150005	96751NH0150011
Plan Name	Anthem Blue Cross and Blue Shield Gold DirectAccess, a Multi-State Plan	Anthem Gold DirectAccess - ccaf	Anthem Silver DirectAccess w/HSA - cbdo	Anthem BC & BS Silver DirectAccess, a Multi-State Plan	Anthem Silver DirectAccess - cbcm	Anthem Bronze DirectAccess w/HSA - cacc	Anthem Bronze DirectAccess w/HSA - ccax	Anthem Bronze DirectAccess - cabr	Anthem Bronze DirectAccess - caaa	Anthem Bronze DirectAccess w/Child Dental - cdaa	Anthem Catastrophic DirectAccess *Note 2
Plan Variation Name	Standard Gold On Exchange Plan	Standard Gold On Exchange Plan	Standard Silver On Exchange Plan	Standard Silver On Exchange Plan	Standard Silver On Exchange Plan	Standard Bronze On Exchange Plan	Standard Bronze On Exchange Plan	Standard Bronze On Exchange Plan	Standard Bronze On Exchange Plan	Standard Bronze On Exchange Plan	Standard Catastrophic On Exchange Plan
Metal Level	Gold	Gold	Silver	Silver	Silver	Bronze	Bronze	Bronze	Bronze	Bronze	Catastrophic
Deductible Individual/Family	$1,000/$2,000	$1,000/$2,000	$2,500/$5,000	$1,500/$3,000	$3,250/$6,500	$3,500/$7,000	$5,500/$11,000	$4,300/$8,600	$5,750/$11,500	$5,750/$11,500	$6,350/$12,700
Coinsurance	10%	10%	10%	30%	0%	25%	0%	20%	10%	10%	0%
Max Out of Pocket Individual/Family *Note 4	$3,500/$7,000	$3,500/$7,000	$4,000/$8,000	$6,000/$12,000	$5,000/$10,000	$6,350/$12,700	$6,350/$12,700	$6,350/$12,700	$6,350/$12,700	$6,350/$12,700	$6,350/$12,700
Preventive Care	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
PCP Visits (not wellness)	$30 Copay Unlimited visits	$30 Copay Unlimited visits	Subject to ded. & coinsurance	$35 Copay first 2 visits; all other visits thereafter subject to ded. & coinsurance	$40 Copay first 3 visits; all other visits thereafter subject to deductible	Subject to ded. & coinsurance	Subject to deductible	$35 Copay first 2 visits; all other visits thereafter subject to ded. & coinsurance	$40 Copay first 2 visits; all other visits thereafter subject to ded. & coinsurance	$40 Copay first 2 visits; all other visits thereafter subject to ded. & coinsurance	$40 Copay first 3 visits; all other visits thereafter subject to deductible
Specialist Visits	Subject to ded. & coinsurance	Subject to ded. & coinsurance	Subject to ded. & coinsurance	Subject to ded. & coinsurance	Subject to deductible	Subject to ded. & coinsurance	Subject to deductible	Subject to ded. & coinsurance	Subject to ded. & coinsurance	Subject to ded. & coinsurance	Subject to deductible
Urgent Care	$50 Copay then subject to ded. & coinsurance	$50 Copay then subject to ded. & coinsurance	$50 Copay then subject to ded. & coinsurance	$50 Copay then subject to ded. & coinsurance	$50 Copay then subject to deductible	$50 Copay then subject to ded. & coinsurance	$50 Copay then subject to deductible	$50 Copay then subject to ded. & coinsurance	$50 Copay then subject to ded. & coinsurance	$50 Copay then subject to ded. & coinsurance	Subject to deductible
Outpatient Facility/Surgical Center	Subject to ded. & coinsurance	Subject to ded. & coinsurance	Subject to ded. & coinsurance	Subject to ded. & coinsurance	Subject to deductible	Subject to ded. & coinsurance	Subject to deductible	Subject to ded. & coinsurance	Subject to ded. & coinsurance	Subject to ded. & coinsurance	Subject to deductible
Emergency Room	$200 Copay then subject to ded. & coinsurance	$200 Copay then subject to ded. & coinsurance	$200 Copay then subject to ded. & coinsurance	$200 Copay then subject to ded. & coinsurance	$200 Copay then subject to deductible	$200 Copay then subject to ded. & coinsurance	$200 Copay then subject to deductible	$200 Copay then subject to ded. & coinsurance	$200 Copay then subject to ded. & coinsurance	$200 Copay then subject to ded. & coinsurance	Subject to deductible
Inpatient Hospital Services	$500 Copay then subject to ded. & coinsurance	$500 Copay then subject to ded. & coinsurance	Subject to ded. & coinsurance	$500 Copay then subject to ded. & coinsurance	$500 Copay then subject to deductible	$500 Copay then subject to ded. & coinsurance	$500 Copay then subject to deductible	$500 Copay then subject to ded. & coinsurance	$500 Copay then subject to ded. & coinsurance	$500 Copay then subject to ded. & coinsurance	Subject to deductible
Retail Pharmacy (Tiers 1-4) *Note 3 (Non-Formulary is not covered)	Tier 1: $15 Copay Tier 2: $40 Copay Tiers 3 & 4: Subject to ded. & coin.	Tier 1: $15 Copay Tier 2: $40 Copay Tiers 3 & 4: Subject to ded. & coin.	All Tiers subject to ded. & coinsurance	Tier 1: $15 Copay Tier 2: $40 Copay Tiers 3 & 4: Subject to ded. & coin.	Tier 1: $15 Copay Tier 2: $40 Copay Tiers 3 & 4: Subject to ded. & coin.	All Tiers subject to ded. & coinsurance	All Tiers subject to deductible	All Tiers subject to ded. & coinsurance	All Tiers subject to ded. & coinsurance	All Tiers subject to ded. & coinsurance	No Charge (All Tiers)
Durable Medical Equipment	Subject to ded. & coinsurance	Subject to ded. & coinsurance	Subject to ded. & coinsurance	Subject to ded. & coinsurance	Subject to deductible	Subject to ded. & coinsurance	Subject to deductible	Subject to ded. & coinsurance	Subject to ded. & coinsurance	Subject to ded. & coinsurance	Subject to deductible
Chiropractic	Subject to ded. & coinsurance	Subject to ded. & coinsurance	Subject to ded. & coinsurance	Subject to ded. & coinsurance	Subject to deductible	Subject to ded. & coinsurance	Subject to deductible	Subject to ded. & coinsurance	Subject to ded. & coinsurance	Subject to ded. & coinsurance	Subject to deductible
Pediatric Dental Benefits	Yes	No	No	No	No	No	No	No	No	Yes	No

*Note 1 In addition to the "Standard" plans illustrated here, Native Americans can purchase Zero cost sharing plans and other individuals may qualify, based on their income level, to purchase plans with lesser cost sharing amounts.

*Note 2 Catastrophic plan is only available to those under the age of 30 or who get a "hardship exemption"

*Note 3 Retail Pharmacy Tiers-- Tier 1 = Generic, Tier 2 = Preferred, Tier 3 = Non-Preferred, and Tier 4 = Specialty Drugs

*Note 4 Max Out of Pocket - Individual/Family: All copays, deductibles and coinsurances are applied towards the Max Out Of Pocket limits

Calender Year 2014 NH Marketplace (Exchange) Individual Dental Plans Updated Oct 16, 2013

Plan ID/ Form Schedule #	57601NH0400001	57601NH0400052	57601NH0420001	57601NH0420052	87701NH0100001	87701NH0090001	87701NH0080001	87701NH0070001
Company Name	Anthem Ind Pediatric Dental	Anthem Ind Pediatric Dental Enhanced	Anthem Ind Dental Family	Anthem Ind Dental Family Enhanced	Delta Dental Pediatric Low Plan	Delta Dental Pediatric High Plan	Delta Dental Family Low Plan	Delta Dental Family High Plan
Form Schedule Item #	4 & 10	5 & 11	8 & 14	9 & 15	1	1	1	1
Plan Variation Name	Low	High	High	High	Low	High	Low	High
Deductible-Individual (age 19 & over)	none	none	$50	$50	$150	$50	$150	$50
SERFF Tracking Number	ANTV-129035381	ANTV-129035381	ANTV-129035381	ANTV-129035381	NEDD-129100519	NEDD-129100498	NEDD-129100395	NEDD-129100525
Issuer Actuarial Value	70.00%	85.00%	85.00%	85.00%	71.50%	86.30%	71.50%	86.30%
Pediatric Preventive Services	90%	100%	90%	100%	100%	100%	100%	100%
Pediatric Basic Services	60%	80%	60%	80%	60%	80%	60%	80%
Pediatric Major Services	50%	50%	50%	50%	50%	50%	50%	50%
Pediatric Necessary Ortho Care	50%	50%	50%	50%	50%	50%	50%	50%
Waiting Period for Necessary Child Ortho Care	12 months	12 months	12 months	12 month	24 months	24 months	24 months	24 months
Pediatric Cosmetic Ortho Care Lifetime Max	n/a	n/a	$1,000	$1,000	n/a	n/a	n/a	n/a
Max Pediatric Out of Pocket (1 child/2 or more)	$700/$1,400	$700/$1,400	$700/$1,400	$700/$1,400	$700/$1,400	$700/$1,400	$700/$1,400	$700/$1,400
Office Visit Copay	n/a	n/a	n/a	n/a	$30	$15	$30	$15
Age 19 & over Preventive Services	n/a	n/a	100%	100%	n/a	n/a	100%	100%
Age 19 & over Basic Services	n/a	n/a	50%	80%	n/a	n/a	50%	80%
Age 19 & over Major Services	n/a	n/a	30%	50%	n/a	n/a	50%	50%
Age 19 & over Ortho Care	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Benefit Maximum - age 19 and over	n/a	n/a	$750 per covered adult	$1,000 per covered adult	n/a	n/a	$1,000 per covered adult	$1,000 per covered adult
Waiting Period for age 19 & over Basic Restorative	n/a	n/a	6 months	6 months	n/a	n/a	3 months	3 months
Waiting Period for age 19 & over Major Services	n/a	n/a	12 months	12 months	n/a	n/a	6 months	6 months

Service percentages are based on Participating Dentists

Percentages for non-Participating Dentists will be different, if coverage is provided (Anthem provided out of network benefits/Delta Dental does not offer out of network benefits including Deltas's Premier Network)

Read certificate, outline of coverage and policy very carefully before receiving services

Delta Dental's network is their "Preferred" network only and does not include their "Premier" Dentists. This is a significanly reduced provider network for Delta.

Medical plans embedded with Dental carry a Medical & Dental combined Out of Pocket Max. Stand alone Dental plans carry the "Essential Health Benefit" Pediatric Out of Pocket Max of $700/$1,400

Retiree Health Cost Containment Report Thoughts
Prepared by Provencher 10-31-13

Background:

The State has provided retiree health benefits to eligible employees meeting certain criteria for many years. The cost of this benefit has never been funded by the State while the employee was working but rather is paid as the retiree incurs medical costs. The result is significant intergenerational inequity, the liability for which as of December 31, 2012 totaled $1.85 billion. It is important to note, however, that the statutory changes in recent years effecting eligibility requirements have not been factored into that number and the effects could be material. It will be very important to understand those effects so as not to make further changes to benefits that may not be necessary or conversely to determine whether the statutory changes made had their intended effect. During fiscal year 2014 the State expended over $70 million to cover the current cost of medical benefits provided to its eligible retirees.

Solutions Considered

1. Eliminate retiree health benefits altogether for new employees.

2. Increase eligibility to require 30 years of service.

3. Provide benefit only to the retiree; remove spousal and dependent benefit.

4. Fund a portion of a benefit account for future retirees, for example a VEBA arrangement. Look closely at how this might function with the legal VEBA structure already established by SEA.

5. Tie the age of the benefit to Medicare eligibility rather to age 65 in the event the Medicare eligible age increases. IN other words, make the program a Medicare wrap rather than a State-paid retiree health plan.

6. Review vested deferred eligibly requirements. There appears to be inconsistency in age eligibility with those employees required to have 20 years of service.

Commission's Charge

The Commission's charge requires it to recommend a cohesive plan outlining cost effective alternatives for new employees in light of ACA. This charge requires much more study and actual experience to understand the effects of the ACA. The Commission suggests changes be made to retiree health benefits for new employees notwithstanding any possible impact of the ACA. The State cannot afford to wait for actual experience with the ACA to act.

SUPPLEMENTAL PROJECTION OF THE ANNUAL REQUIRED CONTRIBUTION

30 Years Open (4.5% interest rate)

								As of December 31 after Fiscal Year End		
Fiscal Year Ended June 30	(1) Gross Benefit Payments	(2) Retiree Contributions	(3) NHRS Subsidy	(4) Projected Benefit Payments (1) – (2) – (3)	(5) Normal Cost	(6) Amortization of UAAL	(7) ARC (5) + (6)	(8) Assets	(9) AAL	(10) UAAL (9) – (8)
2013	$68,207,299	$4,651,280	$13,637,233	$49,918,786	$63,760,421	$68,570,737	$132,331,158	$0	$1,954,730,892	$1,954,730,892
2014	72,262,990	4,829,434	13,584,940	53,848,616	66,055,796	72,190,612	138,246,408	-	2,055,450,285	2,055,450,285
2015	76,495,763	4,924,401	13,479,379	58,091,983	68,433,805	75,910,302	144,344,107	-	2,158,752,752	2,158,752,752
2016	81,001,944	5,026,531	13,349,008	62,626,405	70,897,422	79,725,389	150,622,811	-	2,264,539,838	2,264,539,838
2017	85,803,130	5,135,108	13,186,919	67,481,103	73,449,729	83,632,236	157,081,965	-	2,372,681,345	2,372,681,345
2018	91,784,021	5,278,343	13,013,034	73,492,644	76,093,919	87,626,035	163,719,954	-	2,482,170,338	2,482,170,338
2019	98,022,614	5,434,490	12,834,657	79,753,467	78,833,300	91,669,598	170,502,898	-	2,592,906,429	2,592,906,429
2020	103,750,743	5,587,741	12,663,033	85,499,969	81,671,299	95,759,218	177,430,517	-	2,705,586,259	2,705,586,259
2021	109,776,840	5,753,362	12,474,084	91,549,394	84,611,466	99,920,622	184,532,088	-	2,820,087,505	2,820,087,505
2022	115,617,992	5,860,533	12,229,921	97,527,538	87,657,479	104,149,294	191,806,773	-	2,936,677,231	2,936,677,231
2023	121,540,716	5,940,938	11,928,494	103,671,284	90,813,148	108,455,095	199,268,243	-	3,055,390,954	3,055,390,954
2024	127,195,683	6,122,987	11,587,172	109,485,523	94,082,421	112,839,339	206,921,760	-	3,176,787,305	3,176,787,305
2025	132,884,334	6,396,829	11,211,783	115,275,722	97,469,388	117,322,655	214,792,043	-	3,301,135,115	3,301,135,115
2026	138,823,861	6,682,748	10,807,828	121,333,285	100,978,286	121,914,972	222,893,258	-	3,428,415,222	3,428,415,222
2027	145,025,130	6,981,266	10,386,727	127,657,137	104,613,505	126,615,583	231,229,088	-	3,558,613,311	3,558,613,311
2028	151,499,466	7,292,930	9,943,298	134,263,239	108,379,591	131,423,958	239,803,549	-	3,691,702,498	3,691,702,498
2029	158,258,673	7,618,307	9,491,557	141,148,809	112,281,256	136,339,105	248,620,361	-	3,827,662,518	3,827,662,518
2030	165,315,052	7,957,989	9,040,950	148,316,113	116,323,381	141,360,276	257,683,657	-	3,966,474,927	3,966,474,927
2031	172,681,423	8,312,594	8,577,480	155,791,349	120,511,023	146,486,788	266,997,811	-	4,108,098,358	4,108,098,358
2032	180,371,142	8,682,765	8,108,037	163,580,341	124,849,420	151,717,116	276,566,536	-	4,252,488,972	4,252,488,972
2033	188,398,130	9,069,170	7,644,829	171,684,131	129,343,999	157,049,638	286,393,637	-	4,399,605,538	4,399,605,538
2034	196,776,889	9,472,509	7,184,649	180,119,731	134,000,383	162,482,834	296,483,217	-	4,549,393,068	4,549,393,068
2035	205,522,529	9,893,509	6,729,452	188,899,567	138,824,397	168,014,671	306,839,068	-	4,701,787,203	4,701,787,203
2036	214,650,790	10,332,929	6,288,932	198,028,929	143,822,075	173,642,774	317,464,849	-	4,856,721,465	4,856,721,465
2037	224,178,071	10,791,556	5,866,878	207,519,636	148,999,670	179,364,686	328,364,356	-	5,014,120,566	5,014,120,566
2038	234,121,453	11,270,214	5,455,033	217,396,207	154,363,658	185,177,628	339,541,286	-	5,173,886,978	5,173,886,978
2039	244,498,728	11,769,759	5,058,779	227,670,190	159,920,750	191,077,998	350,998,748	-	5,335,913,727	5,335,913,727
2040	255,328,428	12,291,082	4,688,446	238,348,899	165,677,897	197,061,845	362,739,742	-	5,500,088,646	5,500,088,646
2041	266,629,850	12,835,114	4,337,230	249,457,506	171,642,301	203,125,026	374,767,327	-	5,666,275,746	5,666,275,746
2042	278,423,093	13,402,821	4,004,442	261,015,829	177,821,424	209,262,520	387,083,944	-	5,834,320,001	5,834,320,001

Note: To estimate the impact of the eligibility rule changes over time, we have assumed normal cost will grow at 3.6% per year (and be 32% lower than previously projected in our prior exhibit by 2042), and that benefit payments will ultimately be 10% lower than previously projected in our prior exhibit.

BRIEF OVERVIEW OF SEA/SEIU LOCAL 1984 RETIREMENT MEDICAL TRUST'S VOLUNTARY EMPLOYEE BENEFIT ACCOUNT

This information is subject to change pending formal adoption by the Trustees. Additionally, the future claims procedure is anticipated to change to describe online access to accounts and claim submittal procedures.

DEFINITIONS (excerpts)

1.1 "Active Service" means service as defined in Section 2.2 herein, after the Employee's Effective Date, provided however that an Employee may receive Active Service Units from contributions made to another similar Trust, if so provided in a joinder agreement signed by this Trust. An **"Active Service Unit'** means a monthly Contribution of $10.00 to the Trust on behalf of an Employee. Note that an Employee may earn more than one Active Service Unit in a month.

1.2 "Beneficiary" means an Eligible Retiree, his or her lawful spouse, and the Eligible Retiree's Children; and an Eligible Retiree's Surviving Spouse and Surviving Children. A "**Regular Beneficiary**" is a person who has become eligible for monthly benefits under Section 2.1(a). A "**Limited Beneficiary**" is a person who has become eligible for benefits from an Employee Account under Section 2.1(b).

1.3 "Board of Trustees" or **"Trustees"** means the duly selected board which administers the Plan and Trust, pursuant to the Trust Agreement.

1.4 "Child(ren)" means a child as defined in Code Section 152(f)(1), of the Employee or Eligible Retiree, who is required to be covered by a group health plan under Section 2714(a) of the Public Health Services Act (42 USC Section 300gg-14(a)). **"Surviving Child(ren)"** means an individual who met the definition of Child or Children in the foregoing sentence at the time of the Eligible Retiree's death and who continues to meet those requirements. Child or Surviving Child shall also include a child of any age who is legally Child(ren) upon the Eligible Retiree (or was legally Child(ren) upon the Eligible Retiree at the time of the Eligible Retiree's death) for support and maintenance for so long as the child is determined to be totally disabled by the Social Security Administration.

1.5 "Code" means the Internal Revenue Code, as amended.

1.6 "Collective Bargaining Agreement" or **"CBA"** means a written agreement between an Employer and a Local that requires mandatory contributions to a retiree medical trust on behalf of each Employee in the bargaining unit covered by the CBA, and subsequent amendments or successor agreements. The term CBA shall also include a Special Agreement that requires mandatory contributions on each employee in an objective employment classification of an Employer during the period that the employer is also making contributions to the Trust on the employees in the bargaining unit of the same Employer. If there are two CBAs from one employer (or a CBA and a Special Agreement), the contribution rate must be the one set in the CBA that covers non-management employees.

1.7 "Contribution" means a mandatory contribution for every employee in a defined class in the bargaining unit represented by a Local, and made at the level of $10.00 up to $XXX.00, in increments of $10.00 there between. A contribution must be made without any election on the part of an individual employee (except for contributions made pursuant to continuation requirements of federal law under IRC Sec. 4980B). Any elective contributions (other than under 4980B) will be returned within thirty (30) days of discovery that the contribution was made by individual election, and Active Service granted based on an elective contribution will be rescinded..

1.8 "Covered Expense" means payment for the following:

(a) Premium or contribution payment on behalf of a Beneficiary to a health, dental, or vision insurance plan, for coverage in effect while the Beneficiary is eligible for benefits under this Plan, for the type of medical expenses excludible from gross income under Code Section 105(b);

(b) Medical expense, as defined in Code Section 213(d) (i.e., costs for the diagnosis, cure, mitigation, treatment, or prevention of disease or injury), including insulin but excluding all other non-prescribed drugs, incurred by the Beneficiary while the Beneficiary is eligible for benefits under this Plan and which has not been claimed by the Beneficiary as a deduction on his or her personal tax return; and

(c) Premium payment for long-term care insurance qualified under Code Section 7702, for coverage in effect while the Beneficiary is eligible for benefits under the Plan, but for no other expenses associated with the costs of long-term care.

1.9 "Effective Date" for an Employee means the date that contributions for that Employee's Local are required and made to the Trust, as approved by the Trustees.

1.10 "Eligible Retiree" means an Employee who is entitled to benefits under Section 2.1 of the Plan.

1.11 "Employee" means any individual employed as a permanent employee on or after that Employee's effective date, who is a member of a Local that represents public sector employees; and on whom the required contributions are made to the Trust Fund pursuant to a Collective Bargaining Agreement or Special Agreement, as defined herein, for all periods of Active Service after the Effective Date.

1.12 "Employee Account" means the individual bookkeeping account maintained by the Trust in the name of an Employee, which reflects certain contributions made to the Trust as set forth in Section 3.5.

1.13 "**Employer**" or "**Participating Employer**" means an employer that contributes to this Plan pursuant to a CBA.

1.14 "ERISA" means the federal Employee Retirement Income Security Act, 29, USC 1001 et seq.

1.15 "Local" means a lawful labor organization that is a member Local in SEA/SEIU 1984 that represents Employees, and is party to a Collective Bargaining Agreement with a participating employer; or any rational class of individuals employed by a participating employer that is the subject of a Special Agreement as defined herein, provided that such labor organization or class of employees has been accepted for participation by the Board of Trustees.

1.16 "Medicare Eligibility Age" means for an Employee who is eligible to enroll in Medicare, the age set by the federal government at which an Employee is eligible to receive Medicare benefits (even if the person does not apply for such benefits).

1.17 "Modify" means to adjust, including increase or decrease.

1.18 "Permanent" means either a part-time or a full-time employee filling a regular, permanent, exempt, or nonexempt budgeted position, as defined in the applicable CBA.

1.19 "Plan" means this separate written document, together with any amendments duly adopted by the Trustees.

1.19 "Same-Sex Spouse[1]" means the spouse of an Employee or Eligible Retiree that is the same sex as the Employee or Eligible Retiree, and who has been recognized as legally married by the State of New Hampshire, or other state.

1.20 "Special Agreement" means a written agreement between a participating employer and the Trustees, and any supplement, amendment, continuation, or renewal thereof that obligates the entity to make contributions to the Trust Fund for employees, for the purpose of providing employee welfare benefits to the employees covered by said agreement, and their beneficiaries. The contribution under the Special Agreement must be at the same level as that in the CBA of the same employer.

1.21 "Surviving Spouse" means the lawful spouse, as defined in the Internal Revenue Code, who was in that status at least twelve (12) months on the date of the Eligible Retiree's death. The Surviving Spouse of an Employee who has satisfied all the requirements of Section 2.1, except the Employee dies prior to separation from service, shall also be considered a Surviving Spouse. To the extent allowed by federal law without jeopardizing the tax advantages of this Plan, the Plan will also cover a Same-Sex Spouse, as set forth in this Plan and recognizing that this may impose taxation on the employee who has a Same-Sex Spouse.

1.22 "Trust" or **"Trust Fund"** means the SEA/SEIU Retiree Medical Trust created by the Trust Agreement and all property and money held by such entity, including all contract rights and records. Trust Office means 207 North Main St. Concord, NH.

1.23 "Trust Agreement" or **"Agreement"** means the Trust Agreement governing the SEA/SEIU Retiree Medical Trust, effective November 1, 2010, and any amendments thereto.

1.24 "Unit Multiplier" or "UM" means the variable amount periodically set by the Trustees, based on demographic and financial factors, and used in the determination of the monthly benefit level of an Eligible Retiree, as set forth in section 3.3(a). The Trustees may adjust the UM from time to time.

BENEFITS (excerpts)

3.2 Commencement of Benefits. Benefits for Beneficiaries shall commence as set forth in this Section 3.2.

(a) Retiree. A Regular Beneficiary shall be entitled to benefit payments upon meeting the eligibility requirements of Section 2.1(a) and having contributions made to this Trust, or a prior similar trust, on the Employee's behalf for a minimum of ten years. A Limited Beneficiary shall be entitled to benefit payments upon meeting the eligibility requirements of Section 2.1(b).

3.3 Benefit Levels for Regular Beneficiaries. An Employee, who becomes an Eligible Retiree under Section 2.1(a), shall be a Regular Beneficiary and entitled to monthly reimbursement of Covered Expenses in an amount not to exceed the Beneficiary's benefit level, calculated pursuant to this section.

(a) Eligible Retiree. The maximum monthly benefit level for an Eligible Retiree shall be determined according to the following methodology:

(1) Determine the number of Active Service Units, and

(2) Multiply the number of Active Service Units by the Unit Multiplier in effect on the date that contributions to the Plan terminate for the Retiree, subject to subsection 3.3(b) hereof.

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(3) Reduction at Medicare Eligibility Age. This maximum monthly benefit level shall be reduced by 50% the month after the Eligible Retiree is eligible to receive Medicare benefits (regardless of whether he/she applies for Medicare).

Modifications. The Trustees reserve the right and power to modify the Unit Multiplier from time to time, and the new Unit Multiplier may apply to current and/or future Beneficiaries, as determined by the Trustees. The applicable Unit Multiplier and the designation of Beneficiaries to whom it is applicable will be set forth in Appendix A hereto, which is by this reference incorporated herein.

3.4 Termination of Benefits

(a) Eligible Retirees. An Eligible Retiree's monthly benefit coverage as a Regular Beneficiary under the Plan shall terminate on the earliest of the following dates:

(1) Return to employment with a Participating Employer; provided however that upon subsequent cessation of all employment with participating employers, benefit payments shall resume.

(2) Date of the Retiree's death, provided however that claims for Covered Expenses, which are properly and timely submitted on behalf of the deceased Retiree after death, will be paid for the months through and including the month in which the Retiree died, at the rate of the monthly benefit level for that Retiree.

(b) Upon the death of the Retiree, any funds contributed by that retiree, or by the employer on his/her behalf, not yet disbursed as a monthly benefit shall be converted to a Limited Beneficiary account and may be used by Surviving Spouse, Surviving Same-sex Spouse or Surviving Children for the reimbursement of qualified medical expenses.

3.5 Benefits from Employee Accounts

(a) Employee Account. An Employee, who becomes an Eligible Retiree under Section 2.1(b) hereof as a Limited Beneficiary, and his or her Beneficiaries, are entitled to reimbursement of Covered Expenses from his or her Employee Account. The balance in the Employee Account shall include the following:

(1) Transfer of accrued leave, annually or upon retirement, only as required pursuant to a non-elective requirement for such transfer in his or her CBA. Accrued leave shall include only the type of leave that the Internal Revenue Service allows for conversion to retiree medical benefits on a non-taxable basis (e.g., sick leave, vacation leave).

(2) Employee contributions from salary.

(3) Employer contributions, on the condition that the Employee terminates from the employer at the retirement age as defined in the retirement system of his or her employer, or if laid off prior to retirement?

(4) Earnings and/or losses, minus a proportionate share of expenses, will be applied to the Account, on the condition that the Employee terminates from the employer at the retirement age as defined in the retirement system of his or her employer. At retirement, earnings and/or losses will be posted at the actual rate of return experienced by the Trust during the period that the employee was earning Active Service.

(b) Benefit Level from Employee Account. There shall be no maximum amount on a claim against the Employee Account, so long as all claims are for reimbursement of Covered Expenses, i.e., the monthly Unit Multiplier calculation does not apply to Employee Accounts.

(c) Commencement and Termination of Benefits from Employee Account. Reimbursement from the Employee Account may commence after and during separation from service with all participating employers, and will terminate when the Account balance reaches zero. If the Eligible Retiree returns to employment with a participating employer, eligibility for this benefit shall be suspended until termination of such employment.

(d)

3.6 Benefit Claim Procedure

(a) To make a claim for Plan benefits, Beneficiaries must present proof of payment of Covered Expenses, on a form approved by the Trustees, to the Trust Office at:

SEA/SEIU Local 1984 Retiree Medical Trust
XXXXXXXXXXXXXXXXXXXXX (insert vendor information)

Prior to issuing payment, the Trust Office shall review such proof and determine whether to grant or deny coverage under the Plan.

(b) If the Trust Office grants coverage, payment will be made to the Beneficiary. If the Trust Office denies coverage, the Beneficiary may appeal the denial of coverage or any other adverse benefit determination of the Trustees.

(c) Proof of payment of a covered expense shall include, but not be limited to, canceled checks drawn to the name of the medical insurance provider or receipt for payment from the medical insurance provider, subject to verification as determined by the Trustees in their sole discretion.

(d) In order to be paid, a claim for Plan benefits must be submitted within thirty (30) days after end of the Plan year in which the expense was incurred.

(e) Subject to subsection (f), below, unless specifically provided by law, the Trustees shall not make any payments on behalf of or distributions to any person entitled to any benefits except to a Beneficiary personally or pursuant to a Qualified Medical Child Support Order under federal law.

(f) If a Beneficiary is deemed to be incompetent by a lawful judicial or quasi-judicial forum, or reasonably deemed to be incompetent by the Trustees, then any payment due may be paid to such person and in such manner as the Trustees, in their sole discretion, consider to be in the best interest of the Beneficiary, (unless the judicial forum has appointed a party as the Beneficiary's representative, in which case the Trustees will make payment to that party). The Trustees shall not be under any duty to oversee the application of funds so paid, provided due care was exercised in the selection of the person to whom funds were paid, and the receipt of the person to whom funds were paid shall be full acquittance to the Trustees. The Trustees shall not be liable to any person for a determination made in good faith that a Beneficiary is incompetent.

November 7, 2013
Meeting

Commission to Review Retiree Health Care
For Employees Hired after July 1, 2013

AGENDA

11/7/13

- HRAs and HSAs: Michael Bachand, Benefit Strategies
- 115 Trusts (Handout)
- Review of Further Revised Other Post Employment Benefit Projections Taking Into Account No New Hires (Handout)
- Review of Draft Commission Report (due November 15, 2013)
    - Comments, Concerns, Corrections
    - Other subject matter to add
        - Recommendations
        - Other
    - Appendix: What exhibits do we want to include?
- Next Meeting: November 14, 2013
- Do we need a meeting on November 15, 2013?
- Other

Commission to Review Retiree Health Care
For Employees Hired after July 1, 2013

11/7/13

Present:
Linda Hodgdon, Commissioner, Department of Administrative Services, Chair
Lisa Shapiro, PhD, Public Member
Catherine Provencher, State Treasurer, Public Member
Stephen Arnold, New England Police Benevolent Association
John Beardmore, Commissioner, Department of Revenue, Public Member
Diana Lacey, President, State Employees Association

Absent:
Seth Cooper, NH Troopers Association
Kevin Foley, Teamsters Local 633
Public Member to be named by Governor

Meeting

Health Reimbursement Arrangements (HRAs) Health Savings Accounts (HSAs) Presentation- Michael Bachand from Benefits Strategies, LLC, Manchester, NH, distributed handouts and presented on HRAs and HSAs. Some highlights were:

- HRAs
  - Are notional accounts, that are generally annual promises to pay
  - Employer funded to be used by employees for out of pocket expenses under a health plan (deductibles, co pays, coinsurance)
  - Can generate employer and employee savings
  - Nondiscriminatory
- HSAs
  - Tax advantaged health savings account; distributions are tax free for eligible (health care) expenses. Distributions for ineligible expenses are taxable.
  - Personal asset that is portable and inheritable
  - Must be aligned with a high deducible health plan; minimum deductible is $1250
  - Medicare enrollees are not eligible to make contributions to an HSA
  - Contributions can be made by anyone: employer, employee, third party
  - Nondiscriminatory

Voluntary Employee Benefit Accounts (VEBAs)- Diana Lacey

- Diana Lacey discussed the VEBA account that the SEA established in partnership with the NEA and the firefighters.
- The VEBA is a private trust with multiple employers
- The employee earns shares during employment
- Employer can make contribution in lieu of retiree health benefit

- Can be current employees or future employees
- Can discriminate and be set up differently for different classes of employees

Draft Report Discussion

- Current draft emphasizes OPEB liability
- Interest in discussing the changing state worker and employment opportunities. Younger employees do not tend to stay with a single employer
- Diana to forward suggested changes to Commission members.

Next Meetings:

- November 13, 2013 10 am
- November 14, 2013 2 pm
- November 15, 2013 if necessary

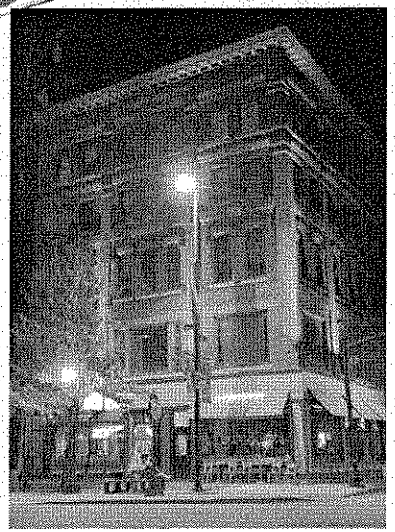
Final Report is due on 11/15/13.

NH Cost Containment Commission

Health Reimbursement Arrangement (HRA) and

Health Savings Accounts (HSA)

benefit strategies LLC



About Benefit Strategies, LLC

Benefit Strategies, LLC was originally founded in 1989 by Paul Smith with a vision of offering high quality Flexible Spending Account administrative services to small and mid-sized companies in New England. Hands-on education of benefit brokers, employers and employees coupled with reliable customer service and a reasonable fee structure has led to Benefit Strategies' success.

- COBRA
- Commuter Choice (Parking & Transit)
- Flexible Spending Account (FSA)
- Health Reimbursement Arrangement (HRA)
- Health Savings Account (HSA)
- Leave of Absence
- Retiree/Direct Billing
- Tuition Reimbursement
- Wellness Benefit Validation / Incentive Rewards Plans

What Sets Us Apart?

- **All Employees are HIPAA Trained and Certified**
- **Dedicated Implementation Specialist and Dedicated Account Manager**
- **Awards**
  - **1Cloud-** Service Excellence, Evangelist of the Year, Leadership, Partner of the Year
  - **Initiative for a Competitive Inner City, top 100-** #66 in 2012 #82 in 2011
  - **INC 5000-** #2,587 in 2011, #2,915 in 2010, #4,418 in 2007
- **Technology Certifications**
  - WISP / 201 CMR 17.00
  - SSAE 16
- **Direct feed integration** – Participant or Provider
  - Anthem BCBS NH, BCBS MA, BCBS RI, Harvard Pilgrim Health Care, Neighborhood Health Plan, Tufts Health Plan
- **Mobile Technology**
- **SaaS (software as a service)**
- **Call Center Technology**
- **Call Center- first call resolution**

Health Reimbursement Arrangement (HRA) Overview

- **What is an HRA?**

  HRAs are employer-funded health reimbursement arrangements. An employer sets aside a specific amount of dollars on an annual basis to reimburse employees for out-of-pocket expenses incurred under the health plan, such as deductible expenses. HRAs can generate significant savings in overall health benefits for employers and employees.

- **What is a Deductible?**

  A deductible is the amount of money you need to pay before the health plan begins to pay for expenses subject to the deductible under the health plan.

- **What is a High Deductible Plan?**

  A High Deductible Plan is a health plan with lower premiums and higher deductibles. Most commonly referred to as HDHP – High Deductible Health Plan. Enrolling in a High Deductible Health Plan coupled with an HRA provides two major advantages to employees:

  1. Lower premiums
  2. Employer funds to help offset out-of-pocket expenses under the health plan

HRA *Flexible* Plan Designs

- Employers may pay a portion of the deductible (i.e. first or second 50% of the deductible) or the entire deductible amount. If on a file feed some carriers have restrictions to what portion can be reimbursed through the HRA.
- Allowable expenses include medical deductibles, copayments, coinsurance, or all code 213 expenses (only if Minimum Value is Required with the HDHP)
- For two-person or family plans, a per member maximum MAY be imposed to require more than one family member to meet deductible expenses in order for the plan to pay.

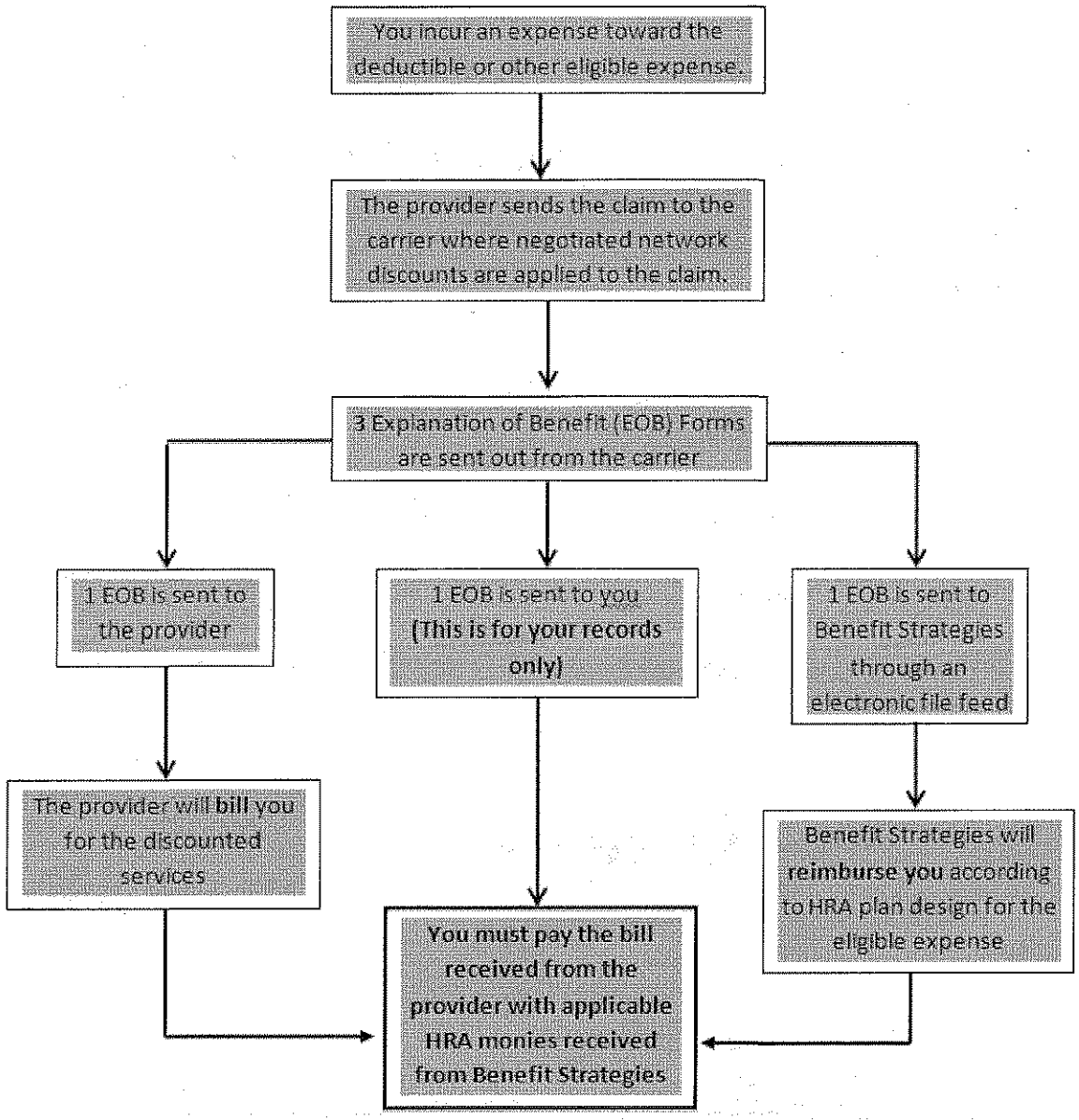
HRA
Participant Pay or Provider Pay?

- HRA plans have the option of reimbursing expenses directly to the Participant or to the Provider. (This will vary by Administrator)
- Provider pay should only be offered if the HRA plan design involves first dollar pay. This is intended to keep employee confusion to a minimum.
- Direct Payment issued to the member's provider eliminates the need for the participant to receive the funds and subsequently provide separate payment to the provider of services.
- Provider Pay creates the perception of a more seamless approach to the addition of a high deductible plan when employees are not used to having out of pocket expenses.
- Any plan that chooses to makes payments for the purchase of health care services by hospitals and ambulatory surgical centers must pay a surcharge. The regulations state that payments made by TPA's to providers regardless of amount are subject to the current tax rate of 1.87%. This is only for services that are incurred at Massachusetts hospitals and ambulatory surgical centers.
- Please refer to Provider Pay FAQ for more detail.

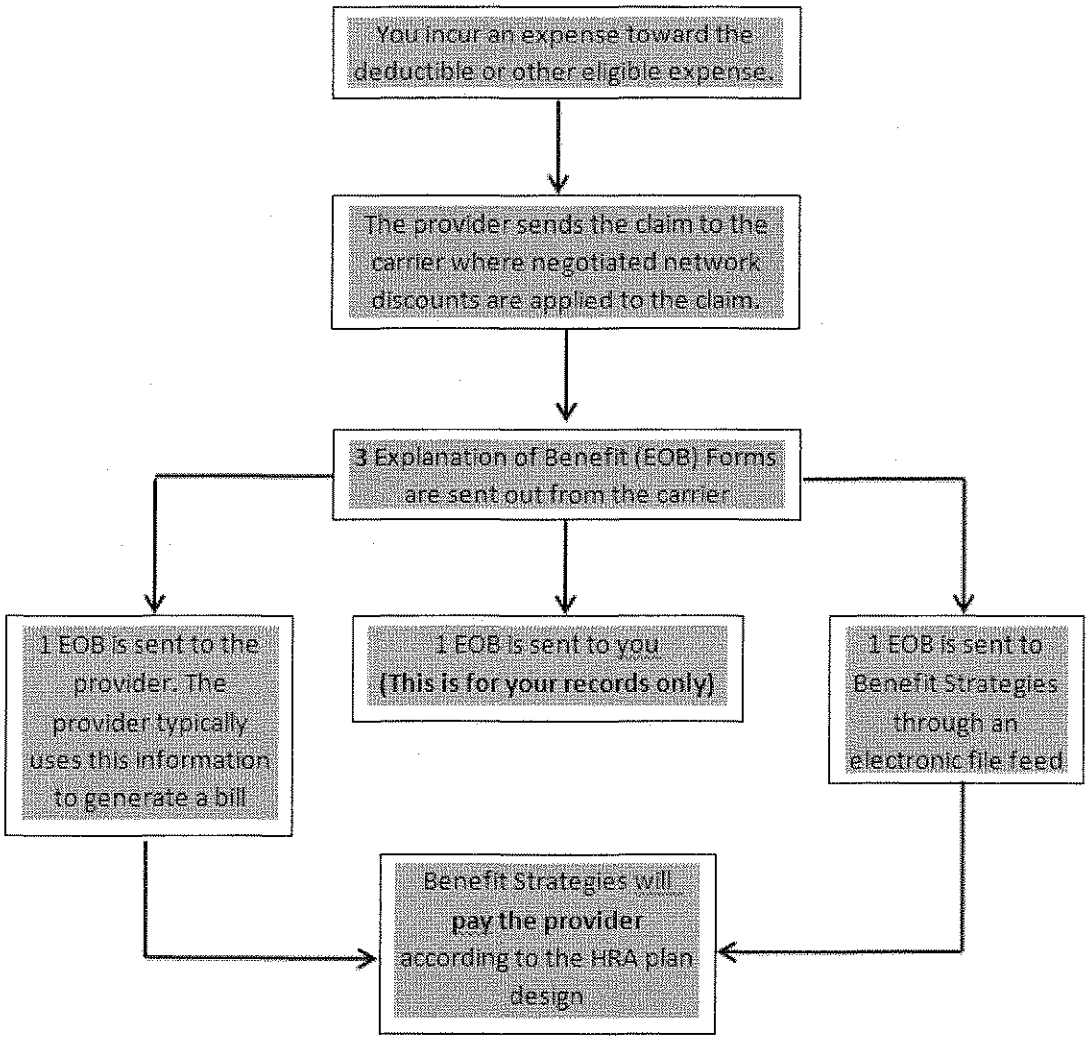
HRA
Why NOT the debit card?

- The Debit Card can be a good option for very basic fully funded first dollar pay HRA plan designs only.
- Debit Card Technology does not yet allow us to confirm that ALL transactions in a doctor's office or medical facility ARE in line with the plan deductible or covered co-pays or co-insurance.
- Deductible amounts are typically NOT available at the date of service, since the provider has not yet sent the claim to the carrier.

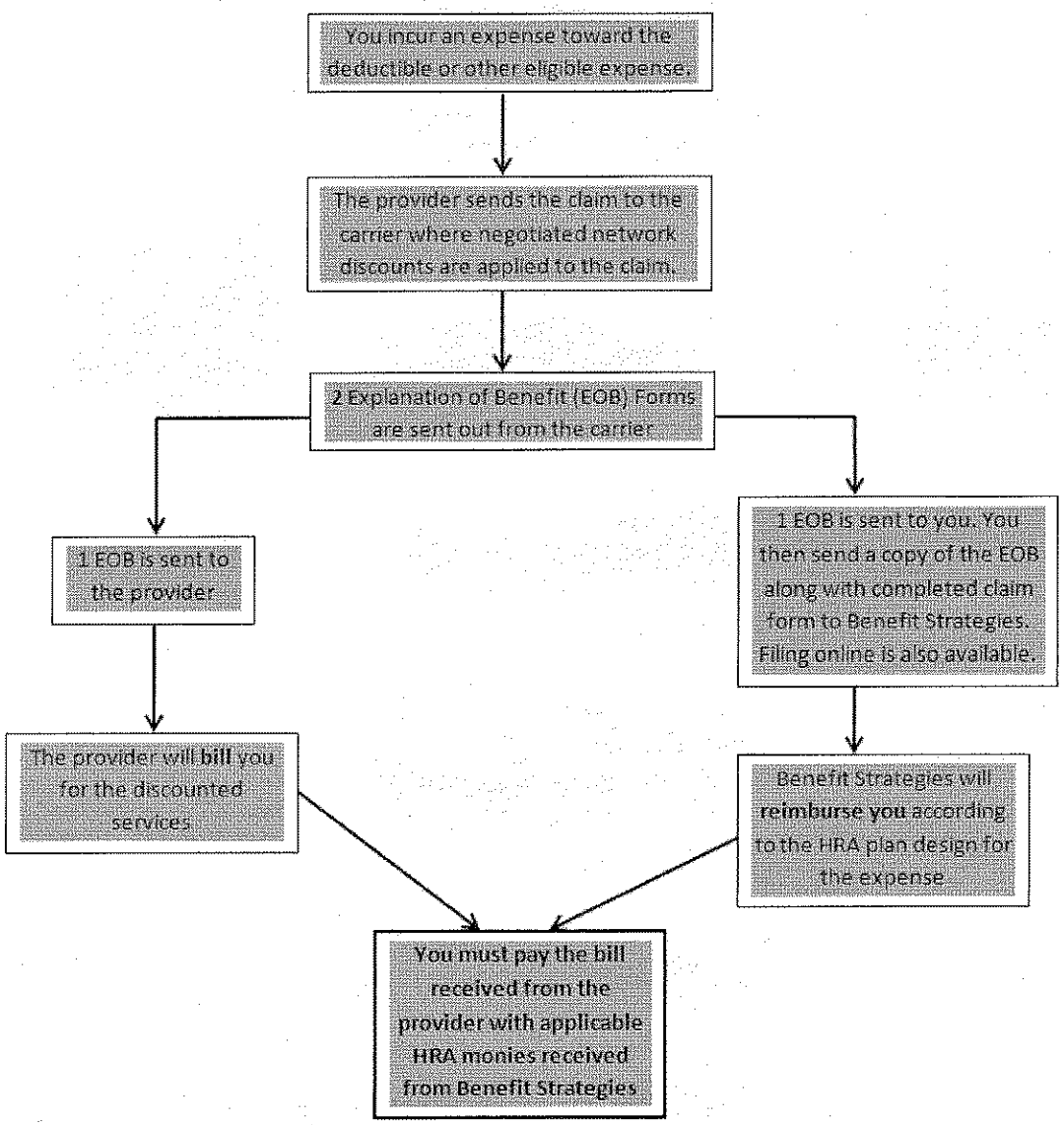
Carrier Feed Process Overview – Participant Pay



Carrier Feed Process Overview – Provider Pay



Participant Paper or Online Claim Filing Process



HRA Automated Feed Services Overview

Plan Description	Works with Feed?	Works with Provider Pay?	Works with Debit Card?	Notes:
Simple - plan pays 100% of only deductible expenses:	Yes.	Yes.	No.	
Simple - plan pays deductible expenses coupled with co-insurance* or co-pays*:	Yes.	Yes, but most providers will collect co-pays at time of service, causing a credit at their office.	No.	*Additional IT development fees may apply.
Plan pays a portion of deductible expenses:	Yes.	Yes.*	No.	*Works best when HRA pays first portion of the deductible.
Plan pays all or a portion of a certain expense type (i.e. ER copays only, MRIs only, etc.)*	Yes.	Yes.**	No.	*Additional IT development fees may apply. Need to be for services easily identifiable by service type codes only. **Works best when HRA pays first portion of the deductible.

Health Savings Accounts (HSA) Overview

- A Health Savings Account (HSA) is a tax-advantaged medical savings account available to taxpayers in the United States who are enrolled in an HSA-qualified High Deductible Health Plan(HDHP).
- The HSA account is a personal financial asset. The account is inheritable so a beneficiary must be appointed.
- Distributions for eligible expenses are tax-free.
- Distributions can be made to the individuals bank account via Direct Deposit or paid for with a debit card (if available from plan sponsor).
- Tax-free distributions can continue to be used for eligible expenses, even if no longer eligible to make additional contributions.
- HSA funds used for ineligible expenses are subject to tax. Under age 65 will incur 20% tax penalty. This is self administered when filing tax returns.
- Contribution amounts can be changed at anytime during the year.
- Offers Triple Tax Advantage tax free contributions, tax free earnings, tax free distributions for qualified expenses.

HSA Contributions Eligibility

- You must be enrolled in a HSA-qualified HDHP.
- You must not be covered under any other plan that is not an HSA qualified HDHP, including a Health FSA.* If married, your spouse must not be covered under a Health FSA
- You must not be enrolled in Medicare.
- You cannot be claimed as a dependent on another person's tax return.

*Enrollment in a Limited Purpose FSA, allowing dental and vision expenses only, is permitted.

2014 HSA Yearly Contribution Maximums

	Contribution Limits	Deductible Minimum	Out-of-Pocket Expense Limit
Single Coverage	$3,300	$1,250	$6,350
Family Coverage	$6,550	$2,500	$12,700

An additional $1,000 catch-up contribution may be made for an account holder who is at least age fifty-five (55) or older and not enrolled in Medicare.

Tax Savings Example

	Before Enrolling In An HSA	After Enrolling In An HSA
Annual Earnings	$36,000	$36,000
Annual HSA contribution amount	$0	-$1,500
Taxable Income	$36,000	$34,500
Approximate Taxes Paid Average Federal, State, FICA Taxes = 27.65%	-$9,954	-$9,539
Annual tax savings/increase in spendable income by making HSA contributions:	$0	$415

Investment Information

- Participants can accumulate balances, similar to a 401(k) or IRA
- Participants can invest the contributions to accelerate growth.
- Typically once there is an accrued balance of $2,100 in HSA, investment options are available to the participants in increments of $100.00. (this can vary by Plan and Administrator)

Eligible Expenses for Qualified Distributions

- Medically necessary medical, dental, vision and hearing expenses not otherwise reimbursed
- COBRA premiums
- Insurance premiums you pay while receiving unemployment compensation
- Long Term Care insurance premiums
- Retiree insurance premiums

HSA vs. HRA

	HSA	HRA
Ownership	Employee	Employer
Contributions Made By	Employee , employer, or other	Employer
Contribution Changes	Can change as needed at any point	Determined Annual by Employer
Interest-earning or investment options?	Yes	No
Roll over balances?	Yes	Determined by Employer
Portable?	Yes	Only available through COBRA and could be an additional premium fee.

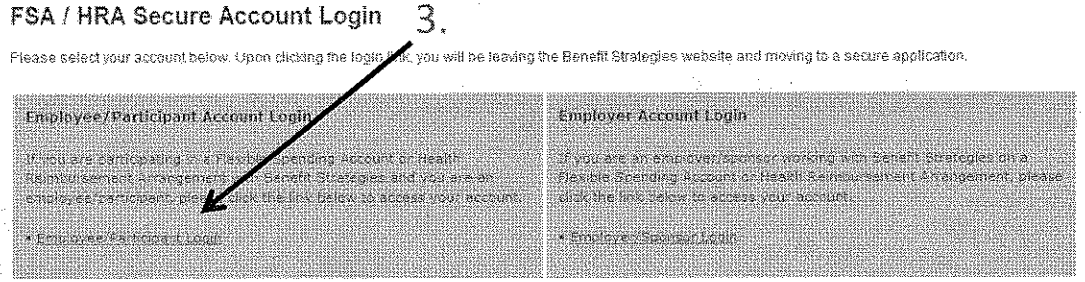
Refer to FSA/HRA/HSA handout for more details

Recap of IRS Modifications

- All HRAs should be designed as integrated HRAs. Stand-alone HRAs are no longer permitted. This means that you cannot have an HRA that is not attached directly to a group medical insurance plan.
- Health Reimbursement Arrangements (HRA) cannot impose a waiting period in excess of 90 days. Suggested to not have longer then a 1st of the month following 60 day waiting period. HRA needs to meet the Minimum Value Requirement in order to reimburse for 213 expenses.
- Health FSAs offered as part of a cafeteria plan must be designed as excepted benefits: 1) employer must provide group health (medical) coverage (insurance) and 2) employer contributions to the health FSAs must be at or below $500 or not more than a 100% match of employee contributions.
- Health Care Flexible Spending Accounts now have the option of allowing participants to roll over up to $500 of unused funds at the end of the plan year. Cant couple an Employer contribution and the roll over option.
- Employers may no longer reimburse employees for individual health insurance coverage on a pre-tax basis unless the employer is participating in a SHOP (Small Business Health Options Program). This means that Premium Reimbursement Accounts are no longer permitted.

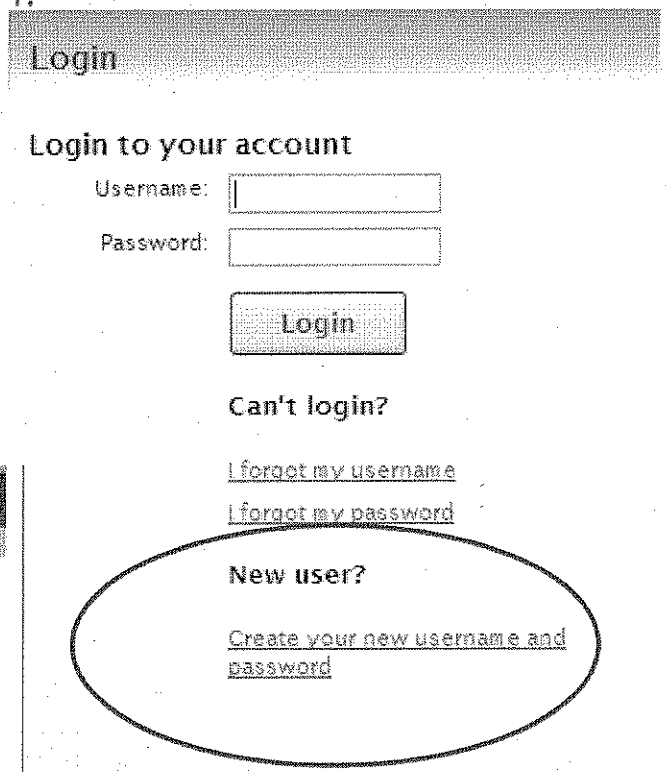
Online Access

1. Go to: www.benstrat.com

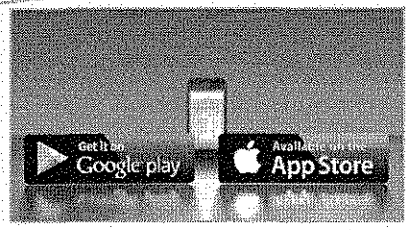


Benefit Strategies, LLC is your go-to resource for secure participant account information!

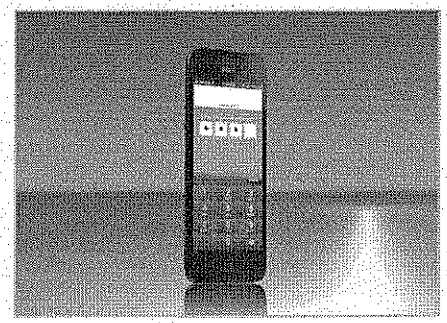
4.

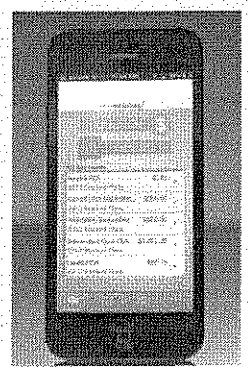


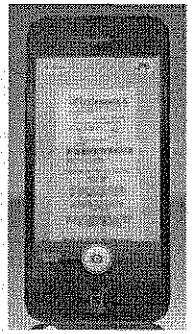
Mobile Technology



- **Use the Benefit Strategies mobile application to manage your HAS/HRA!**
  - Easy 4 Digit Pin Access
  - Account balance
  - Transaction history
  - Request distributions
  - Expense Tracker
  - Receipt upload with camera
  - Convenient customer service contact information
  - Upgraded Tablet version







Our Service Model

Trust Loyalty Commitment

We would like our clients and participants to know our employees are trustworthy and loyal to our jobs. We are fully committed to solving their problems and answering their questions.

Think Like the Customer

We are all customers in our daily lives so we fully understand that our customers deserve to be treated as we would like to be treated.

Tender Loving Care

Our customers trust us to handle their questions and concerns efficiently with consideration, compassion and concern as we strive for "One Call Resolution".

Call Statistics

2012	Total Calls	Answered	IVR	IVR %	Abandoned	ABR %	Avg. Handling	Avg. Wait
COBRA	20,105	19,348	278	1.38%	100	0.50%	0:04:11	0:00:07
Flex	162,736	122,706	37,171	22.84%	285	0.18%	0:03:36	0:00:04
GIC	23,161	17,444	5,074	21.91%	60	0.26%	0:04:07	0:00:04
HRA	6,844	6,459	275	4.02%	12	0.18%	0:03:59	0:00:04
Tuition	2,502	2,152	178	7.11%	55	2.20%	0:05:02	0:00:10
Operator	6,705	6,502	132	1.97%	49	0.73%	0:03:51	0:00:04
TOTALS	**222,053**	**174,611**	**43,108**	**19.41%**	**561**	**0.25%**	**0:04:08**	**0:00:05**

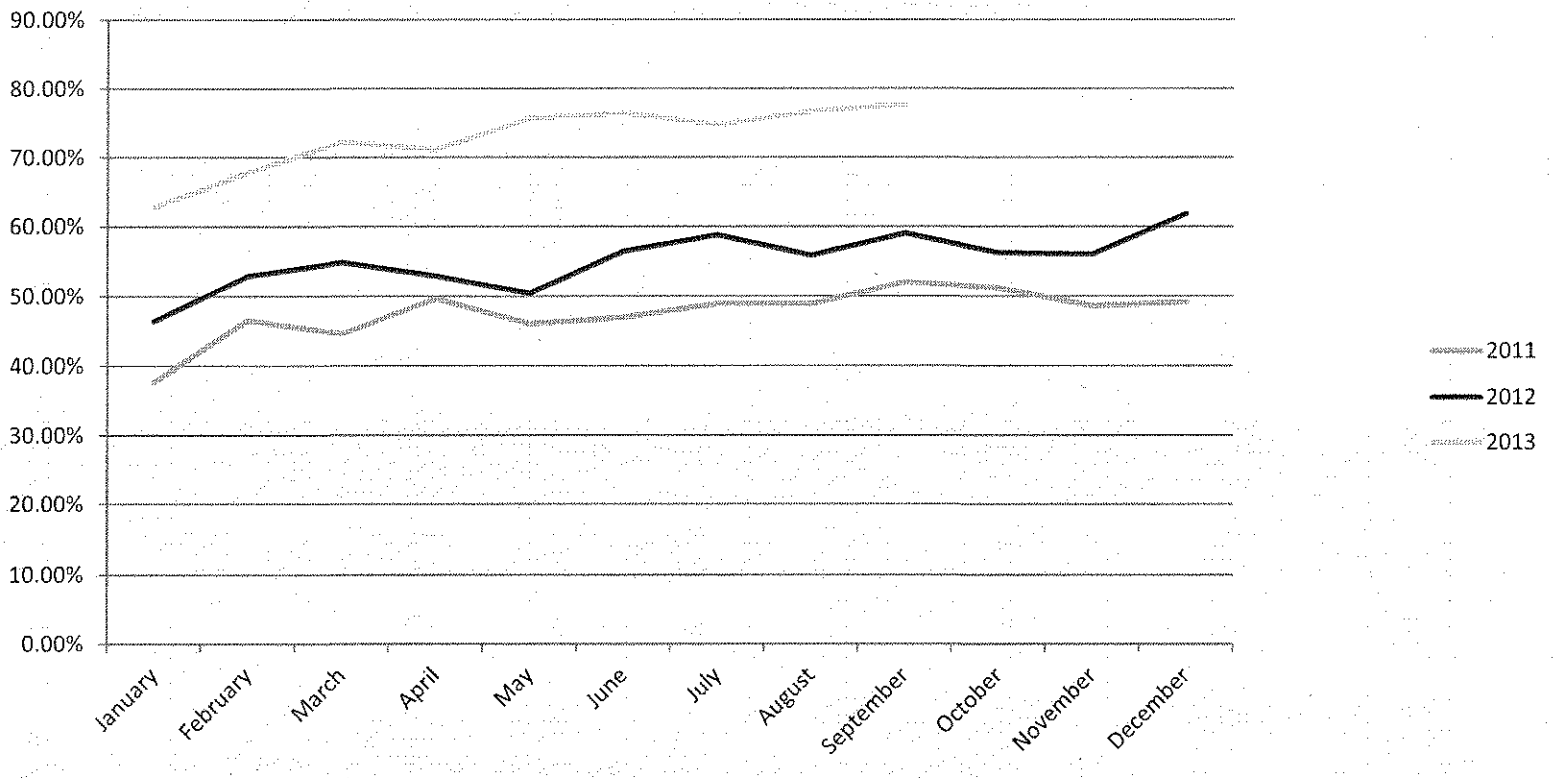
2013	Total Calls	Answered	IVR	IVR %	Abandoned	ABR %	Avg. Handling	Avg. Wait
COBRA	16553	15788	519	3.14%	47	3.03%	0:04:28	0:00:08
Flex	87213	58309	27419	31.44%	161	0.19%	0:03:06	0:00:04
GIC	21997	13200	8170	37.14%	51	0.23%	0:03:39	0:00:04
HRA	7691	7141	429	5.58%	14	0.18%	0:03:32	0:00:04
Tuition	2002	1758	138	6.89%	13	0.65%	0:04:55	0:00:08
Operator	6243	5846	315	5.05%	42	0.67%	0:03:53	0:00:05
TOTALS	**141,699**	**102,042**	**36,990**	**26.10%**	**328**	**0.23%**	**0:03:56**	**0:00:05**

2011, 2012, 2013 Call Stat Averages

IVR Percentage: 21.02%
ABR Percentage: 0.24%

Average Handling: 4.04 minutes
Average Wait : 6 seconds
First Call Resolution: 94.49%

Percentage Utilization of Self Service



2011 Average Self Service Usage: 47.54%
2012 Average Self Service Usage: 55.15%
2013 Average Self Service Usage: 72.88%

Contact Us With Any Questions!

1-888-401-FLEX (3539)

Customer Relations Team available:
Monday – Thursday 8:00 AM – 6:00 PM ET
Friday 8:00 AM – 5:00 PM ET
(automated system available at all times)

info@benstrat.com

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PO Box 1300
Manchester, NH 03105-1300

Fax: 603-647-4668

Requirements/Features	Health Savings Accounts (HSA)	Health Reimbursement Accounts (HRA)	Healthcare Flexible Spending Account (Healthcare FSA)
High Level Overview:	Employer offers a Qualified High Deductible Health Plan from an insurance carrier. Employee opens up a Health Savings Account (HSA) with a financial institution. Employer and/or employee make tax-favored contributions to the Health Savings Accounts. Contributions can only be made while the employee is enrolled in the qualified High Deductible Health Plan.	Typically, employer offers a medical plan from an insurance carrier with higher deductibles or large copayments. Employer establishes Health Reimbursement Arrangement (HRA) in order to pay a portion of the employee's out-of-pocket exposure under the medical plan.	Healthcare FSA is a stand-alone product allowing employees to pay for out-of-pocket medical, dental and vision expenses on a pre-tax basis. (FYI: There is also a Dependent Care FSA option, which allows for pre-tax dollars to pay for expenses incurred to provide care for an eligible dependent.)
Linked Plan Design	Must be linked to an IRS-qualified High Deductible Health Plan (HDHP). IRS sets limits for the HDHP that is going to be used with a Health Savings Account: 2014 Minimum Deductibles: $1,250 Single; $2,500 Family 2014 Maximum Out-of-Pocket: $6,350 Single; $12,700 Family NOTE: For HSA compatible plan design, there is not a 2-Person coverage tier. All expenses, including prescription drugs, are subject to the medical plan deductible. Once the IRS established minimum deductible has been met, Rx co-pays can be put in place on the medical plan. Exceptions: preventive care covered at 100% and not subject to deductible; certain preventive care RX can be covered at 100% and not subject to deductible.	HRAs must be linked to a health care plan; standalone HRAs are no longer permitted. HRAs are typically linked to a plan with higher employee out-of-pocket exposure.	Employees offered FSA must be offered health insurance as well.

Requirements/Features	Health Savings Accounts (HSA)	Health Reimbursement Accounts (HRA)	Healthcare Flexible Spending Account (Healthcare FSA)
Unspent Funds at End of Plan Year	Rolled over to next year; funds always belong to the employee; funds can earn interest and be invested.	Employer determines rollover rules: Rollover all, a portion or none of the unused funds.	Reverts to employer to offset expenses for offering plan. IRS prohibits employer from returning unspent funds to the employee. New for 2014: Employers can opt to allow participants to rollover up to $500 to next plan year, IF employer does not contribute to FSA AND the optional grace period has not been put on plan.
Funding	Employee, employer, others, in any combination, can make contributions to the HSA; IRS specifies annual maximum contribution limits: 2014 Single Coverage: $3,300 2014 Family Coverage: $6,550 NOTE: Maximum is based on total contributions from all sources	Notional accounts solely funded with employer dollars.	Employee and/or employer; IRS specifies annual employee maximum election amount: 2013 Healthcare FSA Maximum Employee Election Amount: $2,500 An employer may also make contributions to the FSA up to $500, over and above employee election amount.
Portability	Fully portable	Not portable after termination, but is a COBRA qualified plan	Not portable after termination, but is a COBRA qualified plan
Taxation of Contributions	Employee contributions can be pre-tax; Employer contributions are 100% tax free	Employer contributions are 100% tax free	Employee contributions can be pre-tax; Employer contributions are 100% tax free
Taxation of Withdrawals	Withdrawals for Qualified Expenses are not taxable; Withdrawals for Non-Qualified Expenses are treated as taxable income and if under age-65 a 20% tax penalty also applies.	Payments for eligible expenses made with HRA funds are not taxable.	Payments for eligible expenses made with FSA funds are not taxable.

Requirements/Features	Health Savings Accounts (HSA)	Health Reimbursement Accounts (HRA)	Healthcare Flexible Spending Account (Healthcare FSA)
Compatibility With Other Types of Health Plans	To make or receive HSA contributions: cannot be enrolled in a non-qualified high deductible health plan as subscriber or spouse or dependent; cannot be enrolled in a full Healthcare FSA; if married, spouse cannot be enrolled in a full Healthcare FSA. Enrollment in a Limited Purpose FSA (dental and vision expenses only) is permitted. HSAs can be offered with HRAs as long as the HRA does not reimburse until the minimum HSA deductible has been met.	If offered with an HSA, HRA cannot begin reimbursing until the HSA minimum deductible has been met.	If employee or the employee's spouse is enrolled in an HSA, FSA enrollment is not permitted. However, enrollment in a Limited Purpose (dental and vision expenses only) FSA is permitted.
Value To Employer	Employees participating more in healthcare purchasing decisions, which can lead to reduced claims volume as they learn to become more efficient health care consumers; Employer FICA savings; Employer can purchase a lower cost deductible plan as long it meets the criteria for a Qualified High Deductible Health Plan	Employer flexibility in HRA plan design and no restrictions on medical plan the HRA is linked to; HRA "account" is notional, with funds only paid out when claim is processed; unused funds belong to the employer; Employer can purchase a lower cost deductible plan and use some of the savings to off-set the increased employee out-of-pocket exposure by paying a portion of HRA eligible expenses.	Inexpensive benefit to offer and is popular with employees; Employer FICA savings; helps to "soften" the out-of-pocket exposure under a medical plan as employees have a mechanism to pay for the exposure with pre-tax dollars.
Value to Employee	The employee owns the funds in the HSA, even after termination of employment; Pre-tax savings on contributions; Savings roll over each year; HSA funds can be used to pay retiree medical expenses including Medicare premiums	Employees have the premium advantage of a high deductible health plan but without the full out-of-pocket exposure	Pre-tax savings on contributions; Full election amount available on first day of the plan year ("interest free loan"); ability to pay for out-of-pocket expenses with pre-tax dollars

Requirements/Features	Health Savings Accounts (HSA)	Health Reimbursement Accounts (HRA)	Healthcare Flexible Spending Account (Healthcare FSA)
Cautions	If employee has large expense early in plan year, or high prescription costs, and they are without funds in the HSA to pay for these expenses, employee dissatisfaction is high; HSA funds can't be spent on a child unless the child qualifies as a tax dependent (even if the child is their covered dependent on the linked qualified high deductible health plan); Some employees may not be eligible for HSA contributions; Can be difficult for employees to shop wisely for healthcare as pricing information is not readily available.	Reimbursing too much of the employee's out-of-pocket exposure reduces or eliminates the consumerism aspect that leads to lower claims volume. Employer has to offer HRA through COBRA.	Employers with high turnover rates should carefully consider eligibility and maximum contribution as full amount of election is available on first day of plan year and employer cannot require a terminated employee to pay back funds spent prior to termination. Employer has to offer FSA through COBRA.
Business Type	Sole proprietors, partners in a partnership, members of a LLC can only make after-tax contributions to an HSA outside of work, and cannot accept the employer contributions the business may make. The above also applies to More-than-2%-owners in a Subchapter S Corps, as well as their spouse, parents, children and grandchildren.	In general, sole proprietors, partners in a partnership, members of a LLC are not eligible to participate in their company's plan on a tax favored basis. The individual should consult with their tax attorney regarding HRA eligibility based on their specific business set-up. The above also applies to More-than-2%-owners in a Subchapter S Corps, as well as their spouse, parents, children and grandchildren.	Sole proprietors, partners in a partnership, members of a LLC are ineligible to participate in a cafeteria plan and thus ineligible to participate in an FSA. The above also applies to More-than-2%-owners in a Subchapter S Corps, as well as their spouse, parents, children and grandchildren.

VEBA IRC § 501(c)(9) and IRC § 115 Trusts

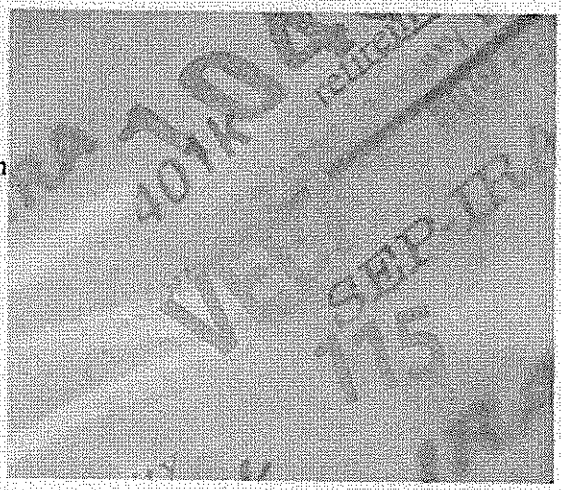
TRUST COMPARISON

Many governmental plan sponsors have set up medical reimbursement plans, defined by the IRS as health reimbursement arrangements (HRAs), using a VEBA (voluntary employees' beneficiary association - authorized by IRC Section 501(c)(9)) trust or a IRC Section 115 integral part governmental trust.

Many HRA programs are called VEBAs simply because VEBA is a simple, memorable term, and the IRS did not coin the "HRA" phrase until 2002. Many plan sponsors have been operating medical reimbursement programs through VEBAs for governmental employers for many years prior to 2002.

You will find the word "VEBA" many times interchanged with "HRA". You should be aware, however, that VEBAs are also used to hold assets for self-insured medical plans, dental plans, severance pay plans and other benefits.

HRAs offered through VEBA trusts typically offer the same tax benefits as HRAs offered through Section 115 integral part trusts. It should be noted that custom VEBAs are subject to additional discrimination rules under IRC Section 505 and are generally more expensive to set up. The IRC 505 discrimination rules are not applicable to HRAs offered through Section 115 trusts.



HRAs offered through Section 115 trusts can provide discriminatory contributions if the benefits are limited to insurance premiums, because Section 105(h) discrimination testing does not apply to HRAs that are restricted to paying only insurance premiums. Discriminatory contributions to VEBAs offering HRAs may result in the VEBA losing its tax-exempt status under 501(c)(9).

	VEBA	115
A health reimbursement arrangement (HRA) can be offered by governmental employers within a VEBA or other tax-exempt trust.	Formed pursuant to specific provisions of Section 501(c)(9) of the Internal Revenue Code (IRC) which sets forth the requirements and limitations relating to the trust's tax exemption.	A trust that is exempt from taxation under Section 115 of the IRC set up to benefit from the same tax exempt status of the governmental employer who establishes and adopts the trust. The legal guidance for the requirements and limitations for a 115 trust is based upon a collection of IRC provisions, Treasury regulations, and IRS private letter rulings.
What is the tax treatment on trust income?	Trust earnings accumulate on a tax-exempt basis.	Trust earnings accumulate on a tax-exempt basis.

TRUST COMPARISON

	VEBA	115
Is IRS approval required or recommended?	Yes. An IRS 501(c)(9) determination letter is required and must be obtained within 15 months after the Trust documents have been executed. VEBA trusts are typically limited to three contiguous states.	IRS approval is not required. However, an IRS private letter ruling (PLR) is recommended for a prototype plan document used by multiple employers. The documents used by all other employers will be substantially similar in order to ensure that each employer may be confident their program complies with the IRS guidelines for tax-exemption.
Does IRS approval apply to all adopting governmental employers?	Yes, if it is a multi-employer VEBA.	While the IRS does not permit its PLR to be relied upon by anyone other than the particular employer for whom the PLR is obtained, tax-exemption under 115 is less stringent and complex than for 501(c)(9), and thus reliance on IRS approval is less critical. Usually, in a multiple employer arrangement, all employers' 115 documents are substantially similar to the documents for which a PLR is obtained, giving assurance to other adopting employers that their program meets the IRS guidelines for compliance.
What non-discrimination rules apply?	Subject to the non-discrimination rules for HRA plans under IRC §105(h). In addition, 501(c)(9) has its own set of non-discrimination rules under IRC §505, which are generally satisfied by compliance with the non-discrimination rules applicable to HRAs.	Subject to the non-discrimination rules for HRA plans under IRC §105(h).
What are the consequences of violating non-discrimination rules?	Violation of the non-discrimination rules by any participating employer in a multiple-employer trust will disqualify the tax exemption for all participating employers. Violation of the non-discrimination rules will also cause the HRA payments to be taxable for highly compensated employees of the violating employer.	Violation of the non-discrimination rules by any participating employer has no effect on the tax exemption of the trust under IRC §115. Violation of the HRA non-discrimination rules will cause the HRA payments to be taxable for highly compensated employees of the violating employer.
Is the trust expensive to create?	VEBA trusts are generally fairly expensive to create as the plan sponsor must prepare and submit IRS Form 1024 along with a pro forma budget and plan and trust documents to the IRS for approval as a 501(c)(9) organization. The IRS issues a letter of determination if the plan qualifies as a VEBA.	Generally setting up 115 trusts are less expensive than a VEBA trust because the effort to seek and receive the IRS letter of determination approval is not necessary.

State of New Hampshire - December 31, 2012 Measurement Under GASB 43 and 45

30-year Projection of Net Benefit Payments, Normal Cost, and Actuarial Accrued Liability (AAL)

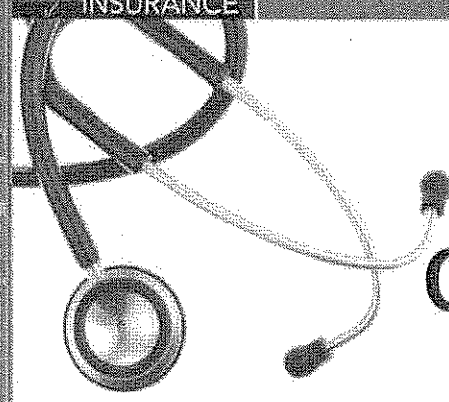
Fiscal Year Ending Jun 30.	From Valuation Report, Modified			Assuming No New Hires		
	Benefit Payments	Normal Cost	AAL at Mid-Year	Benefit Payments	Normal Cost	AAL at Mid-Year
2013	$49,918,786	$63,760,421	$1,954,730,892	$49,918,786	$63,760,421	$1,954,730,892
2014	53,848,616	66,055,796	2,055,450,285	53,848,616	61,515,387	2,050,705,558
2015	58,091,983	68,433,805	2,158,752,752	58,091,983	59,239,946	2,144,186,929
2016	62,626,405	70,897,422	2,264,539,838	62,626,405	57,052,374	2,234,850,478
2017	67,481,103	73,449,729	2,372,681,345	67,481,103	54,788,948	2,322,155,448
2018	73,492,644	76,093,919	2,482,170,338	73,492,644	52,532,257	2,404,748,839
2019	79,753,467	78,833,300	2,592,906,429	79,753,467	50,313,402	2,482,197,669
2020	85,499,969	81,671,299	2,705,586,259	85,499,969	47,980,996	2,554,689,237
2021	91,549,394	84,611,466	2,820,087,505	91,549,394	45,557,830	2,621,589,068
2022	97,527,538	87,657,479	2,936,677,231	97,527,538	43,181,682	2,682,769,157
2023	103,671,284	90,813,148	3,055,390,954	103,671,284	41,093,407	2,738,099,887
2024	110,093,929	94,082,421	3,176,151,522	110,093,929	39,020,150	2,787,042,283
2025	116,425,609	97,469,388	3,299,269,090	116,421,294	36,806,287	2,829,261,504
2026	122,943,126	100,978,286	3,424,782,941	122,754,106	34,603,005	2,864,460,371
2027	129,770,054	104,613,505	3,552,609,580	129,280,121	32,171,630	2,891,882,714
2028	136,925,513	108,379,591	3,682,646,523	135,352,799	29,537,275	2,911,440,214
2029	144,254,796	112,281,256	3,814,953,267	140,948,191	26,959,578	2,923,336,923
2030	151,903,528	116,323,381	3,949,444,911	147,230,084	24,496,897	2,926,630,904
2031	160,071,787	120,511,023	4,085,828,934	153,636,167	22,031,905	2,920,802,841
2032	168,614,136	124,849,420	4,223,957,108	159,435,483	19,795,431	2,906,315,114
2033	175,459,477	129,343,999	4,365,844,503	165,184,746	17,616,442	2,882,890,417
2034	184,480,256	134,000,383	4,509,556,038	170,355,014	15,712,332	2,851,018,883
2035	193,686,235	138,824,397	4,655,155,439	174,319,459	13,962,262	2,811,741,462
2036	203,491,973	143,822,075	4,802,282,390	177,569,227	12,403,616	2,765,671,764
2037	212,108,594	148,999,670	4,952,436,272	180,423,454	10,825,676	2,712,897,316
2038	221,010,010	154,363,658	5,105,650,466	182,875,972	9,391,271	2,653,686,182
2039	230,199,853	159,920,750	5,261,963,074	184,972,568	8,095,281	2,588,265,296
2040	241,005,045	165,677,897	5,420,034,542	186,816,636	6,909,239	2,516,734,004
2041	250,851,982	171,642,301	5,581,161,979	188,172,937	5,876,942	2,439,487,719
2042	261,015,829	177,821,424	5,745,376,114	188,970,797	4,947,040	2,356,959,841

Note: The projections of the normal cost and AAL from the valuation report are estimates based on standard actuarial techniques to roll forward liabilities. We have modified the projections from the valuation report to estimate the impact of the eligibility rule changes over time. We have assumed normal cost will grow at 3.6% per year (5.0% long-term trend, less 1.4% to reflect eligibility rules for new hires), and ultimately be 32% lower than previously projected in our valuation report exhibits. We have assumed benefit payments will be 10% lower in 30 years than previously projected in those exhibits. The projections of normal cost and AAL for the "No New Hires" scenario are for the closed group of employees in the valuation as of December 31, 2012.

benefit strategies

Provider Pay FAQ

Provider Pay Plan Design Best Practice:	• Provider pay should only be offered if the HRA plan design involves first dollar pay. This is intended to keep employee confusion to a minimum. • Provider pay can only currently be offered in an "all claims" fashion. Employers and consumers cannot "special request" some claims be paid to provider and some be paid to a participant.
Provider Pay Convenience Points:	• Direct Payment issued to the member's provider eliminates the need for the participant to have to cash a check and subsequently provide separate payment to the provider of services. • Provider Pay eliminates the need for participant to reconcile EOBs and payments they have made to their provider. • Provider Pay eliminates provider collection notices from being generated. • Provider Pay creates the perception of a more seamless approach to the addition of a high deductible plan when employees are not used to having out of pocket expenses.
Provider Pay Challenges:	• Carriers may not always have complete information in their system for the provider, causing an incomplete check to be cut. ***Our system is designed that if we receive incomplete data from the carrier, we pay the participant directly for that transaction.*** This is infrequent, but does occur periodically. • With plans that don't have a first dollar pay design, employees may be confused about why they owe funds to a provider if their deductible liability is met with a portion of a claim. This would result in a partial payment being made to provider and a bill being generated by the provider. • Carrier adjustments are challenging to manage, because if a payment is made to the provider and then a carrier correction is processed, the provider now has a credit on file. The credit can either be released by the provider back to the participant, or we have found that some providers will apply credits to other balances due on file, which complicates reconciliation. We have also had the experience that some providers take a VERY long time to send money back, unless they are notified by the employee. The end result is customer dissatisfaction. • Lack of exposure to medical activity greatly reduces employee involvement. Their knowledge related to their medical expenses or plans may be more limited as a result of not being involved. This could cause confusion and frustration. • Provider may apply payment incorrectly in their system, which causes a problem for the employee. This can happen with any payment from participant or TPA, of course, but our experience has been that third party checks are more frequently applied incorrectly. • Some service providers require payment at the time of the visit. When this has happened, the result is that the employee has paid the deductible portion and then needs to be reimbursed. Pulling a provider pay check and having the money re-issued to the participant is not a general practice and is a rare corrective action. If the provider check is issued AND the employee has paid the deductible, the employee is now tasked to obtain a credit from their service provider, not Benefit Strategies.
If our employees don't currently have Provider Pay, what are the steps to implement Provider Pay? When is the best time to do this?	*Implementing Provider Pay at Renewal:* • When the client renews their medical plan, the date that the new plan(year) is effective is the date that provider pay will be enabled. Prior plan year's claims, as well as, current year's claims will be paid to provider. *Implementing Provider Pay mid-Plan Year:* • When a client wants to implement Provider Pay in the middle of their medical plan year, Benefit Strategies will work with the employer to choose a date to start paying the provider. We recommend that consumers check their account on line for transactions that are recent to understand when they see provider pay has officially commenced with the carrier and Benefit Strategies. Consumers may also call Benefit Strategies and inquire the same. • Consumers should be advised NOT to pay providers if they are having plan related services. They should wait to get an invoice to pay the provider and be sure their transaction has gone through the carrier network adjustments, as well.
MA Surcharge	The Massachusetts Uncompensated Care Pool is a fund created by the state of Massachusetts to finance health care for the low income and uninsured within that state. The tax is levied upon all health care services rendered at a hospital or ambulatory surgical center in Massachusetts. Any individual or entity that makes payments for the purchase of health care services by hospitals and ambulatory surgical centers must pay the surcharge. The regulations state that payments made by TPA's to providers regardless of amount are subject to the current tax rate of 1.87%. Benefit Strategies has registered with the MA Division of Health Care. Benefit Strategies will start calculating the necessary payments for all clients with an HRA using the pay provider method. We will bill those clients for this fee on a monthly basis. Once funds are received, Benefit Strategies will issue payments to the MA Division of Health Care.



The ABCs of the ACA

BY ERIKA COHEN

The Affordable Care Act (ACA), or "Obamacare," has become the staging ground for a vicious political war, with claims, depending on what side you are on, that it will save a failing health care system or destroy it. The full impact won't be known for a few years, but it is expected to be seismic, changing how individuals, and eventually small businesses, buy health coverage. And yes, the exchange will offer plans that are more affordable than the individual market it replaces.

Each state has its own exchange, or marketplace, through the Act. New Hampshire currently has only one provider on its exchange, Anthem Blue Cross Blue Shield, though Harvard Pilgrim has said it will enter the marketplace in 2015. Anthem's 11 plans promise premium reductions of about 25 percent with deductibles ranging from $1,000 to $11,500. Per federal guidelines, the plans offer preventative and emergency services along with maternity, prescriptions drugs and newborn coverage. Enrollment opened in October. Those without insurance have until Dec. 15 to enroll for coverage to begin in January 2014.

The ABCs of the ACA

The most immediate effect of the law will be felt by those who either buy individual policies (5 percent) or are uninsured (11 percent). The majority of NH residents—61 percent, according to The Henry J. Kaiser Family Foundation—receive insurance through their employer. And while Anthem does not expect many small businesses to sign on for 2014, policy analysts say that will likely happen down the road. Steve Norton, executive director of the NH Center for Public Policy Studies in Concord, says, in the short term, the exchange offers individuals health plans cheaper. In the long-term, these plans will limit the network patients can see, Norton says, adding that will direct people to lower cost options. The question, he says, is whether it will result in higher quality.

There are three main groups of people most likely to purchase insurance on the exchange: those with individual coverage, the uninsured and small businesses with fewer than 25 people and average annual wages of $50,000 or less that would receive tax credits through the exchange's SHOP plans (plans especially for small business on the exchange). Some of the uninsured include those with pre-existing conditions who were previously denied coverage—something the ACA forbids insurers from doing. The NH Insurance Department reports that about 40,000 people now have individual health plans and 110,000 receive coverage from a small employer. Subsidies will be available for people making less than 400 percent of the federal poverty level to reduce their premiums. (See chart for rates)

Open enrollment for coverage in 2014 ends March 31. People who do not have health insurance in 2014 will be charged a penalty unless they meet one of the exemption requirements, such as those who cannot afford the exchange premiums even with a subsidy. Come 2015, businesses with more than 50 employees will be charged an "employer shared responsibility payment," which has also been coined as "Pay or Play," if at least one employee gets a lower-cost premium through the exchange.

The network of health care providers that patients can access using a health plan on the exchange is currently limited to 16 of the state's 26 acute care hospitals. Anthem officials say limiting the network was crucial to lowering costs. That network includes 74 percent of primary care providers and 85 percent of specialists. "By offering more value to a subset of the hospitals across the state, we were able to get to a lower price point," says Bob Noonan, vice president of provider engagement and contracting.

ACA Time Line

2013

Oct. 1
Health insurance exchange opened for enrollment. Anthem is the only company offering plans on NH's exchange

Dec.15
Deadline to enroll on the exchange for coverage beginning Jan. 1, 2014

2014

Individuals must have health insurance or pay a penalty, unless they qualify for an exemption (such as low income or incarceration)

March 31
Deadline to enroll for coverage in 2014

2015

Employers with more than 50 employees who don't offer adequate coverage will be charged a shared responsibility payment.

2016

Employers with up to 100 employees can access group health insurance through the SHOP plans on the exchange.

How many people access the marketplace in part depends on Medicaid expansion, says Lisa Kaplan Howe, the policy director of NH Voices for Health. Medicaid expansion is up in the air in NH. If it does happen, adults making up to 138 percent of the federal poverty limit (FPL) would be covered by Medicaid. If that expansion does not happen, those making 100 percent to 138 percent of the FPL would qualify for subsidies on the exchange. Those making less than 100 percent of FPL would likely have trouble affording exchange premiums, as the law assumes they would be covered by Medicaid.

The New Network

Just as Anthem was able to offer lower premiums by offering a limited network, a new product by Elliot Health System, Harvard Pilgrim, and Dartmouth-Hitchcock takes this concept even further. Called Elevate Health, it will be offered to employer groups off the exchange. Elevate Health

includes five hospitals and their affiliated physician groups along with Derry Medical Center and Southern NH Internal Medicine. It promises premium reductions of 10 percent over Harvard Pilgrim's similar full-network plans. Dr. James Weinstein, CEO and president of Dartmouth-Hitchcock health system, says Elevate Health, which focuses on care coordination, offers a system based on three aspects not currently available in tandem: value not volume, populations and people not market share, and quality not quantity.

Weinstein says they approached a "select number" of hospitals and health systems, and not everybody was interested. "We hope to grow the network because we think it will be the best product on the market," Weinstein says. The system provides payments based on specific quality measures and includes care coordination to guide patients to better health access and quality outcomes.

Norton says these limited networks are common nationally and that NH is behind the times. And he says they do reduce costs. "What often happened was you exclude the higher cost, lower quality providers from the networks." Norton says one reason NH was slower to adopt limited networks is the trend is more prevalent in areas that have hospitals competing in a geographic area and NH only has three such communities (Portsmouth, Manchester and Nashua).

NH Health Care Exchange Costs

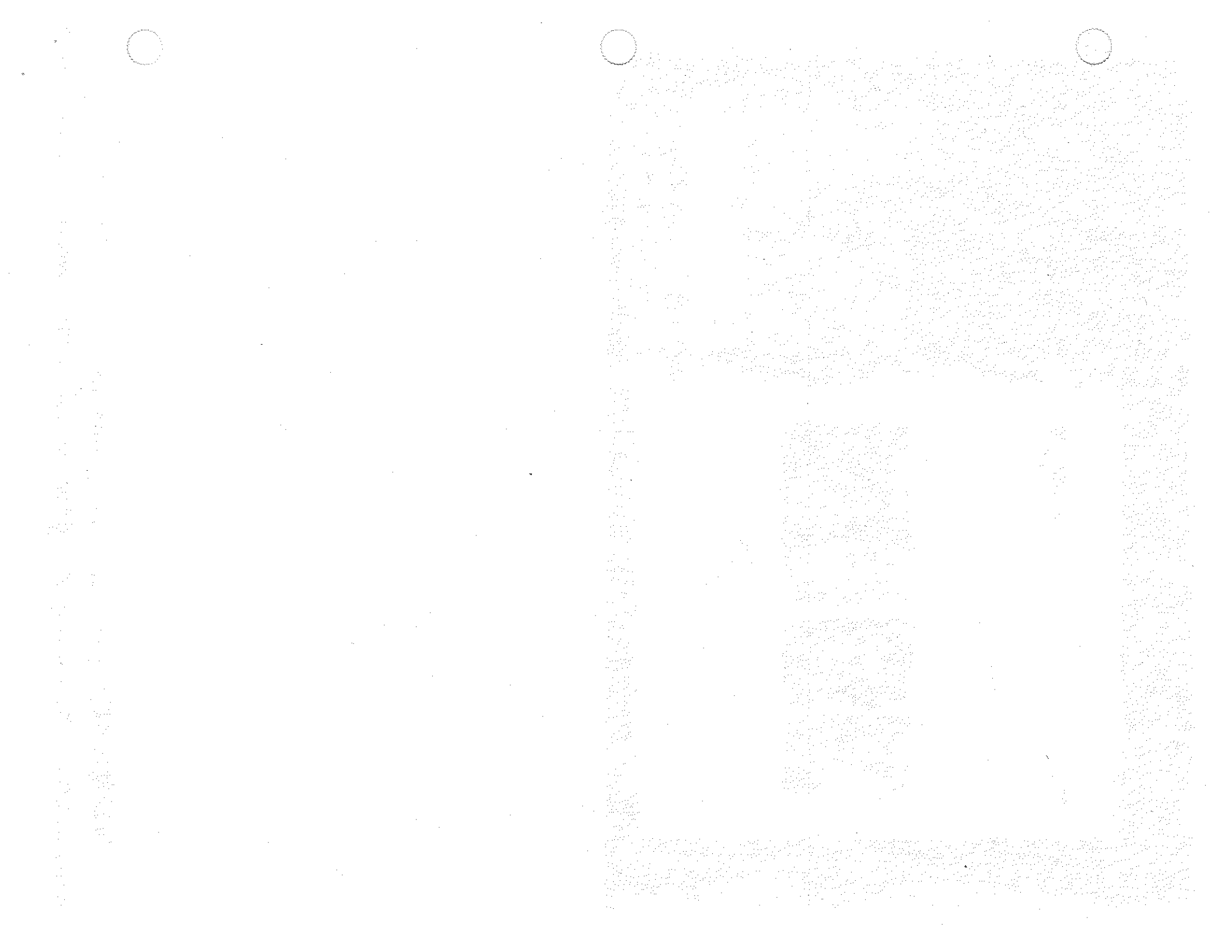
Plans	21-year-old	40-year-old	40-year-old making 300% poverty	60-year-old	60-year-old making 300% poverty	Weighted Average Premium
Bronze (Covers 60 percent. Deductible=$5,750)	$177	$227	$210	$482	$140	$282
Silver (Covers 70 percent. Deductible=$2,500)	$226	$288	$272	$612	$271	$359
Gold (Covers 80 percent. Deductible=$1,000)	$268	$342	$326	$727	$385	$366

Note: There is no premium reduction for 21-year-olds.

Source: U.S. Department of Health and Human Services, Anthem

Projections

Anthem is uncertain how many people will sign on, but the company has been visiting chambers of commerce, rotary clubs, and other community groups to let people know their options. Anthem says there have been several enrollment projections bandied about, with the lowest at 20,000 in NH. There are currently 30,000 people with Anthem's individual coverage. Paula Rogers, a lobbyist for Anthem, says there are 50,000 people eligible for the exchange if the Medicaid expansion is delayed further. And Maria Proulx, Anthem's senior legal counsel, says right now "there is no real shopping to SHOP. I see that being rather quiet" as businesses will carefully weigh the benefits to their employees against costs to determine the value proposition, and that takes time. ■



November 13, 2013
Meeting

Commission to Review Retiree Health Care
For Employees Hired after July 1, 2013

AGENDA

11/13/13

- Review of Commission Report Draft(s)
- Vote on Report Contents
- Next Meeting: November 14, 2013
- Future Meeting: November 15, 2013?
- Other

Commission to Review Retiree Health Care
For Employees Hired after July 1, 2013

11/13/13

Present:
Linda Hodgdon, Commissioner, Department of Administrative Services, Chair
Lisa Shapiro, PhD, Public Member
Catherine Provencher, State Treasurer, Public Member
Stephen Arnold, New England Police Benevolent Association
John Beardmore, Commissioner, Department of Revenue, Public Member
Diana Lacey, President, State Employees Association

Absent:
Seth Cooper, NH Troopers Association
Kevin Foley, Teamsters Local 633
Public Member to be named by Governor

Meeting

Draft Report Discussion

The Commission met and compared two different drafts of the report and made recommended changes. At next meeting, Commission will try and finalize the report.

Motion by Cathy Provencher to vote to approve the revised report contingent on the changes approved by the Commission in today's meeting and subject to final approval. Motion seconded and passed unanimously.

Next Meetings:

- November 14, 2013 2 pm
- November 15, 2013 if necessary

Final Report is due on 11/15/13.

November 14, 2013
Meeting

Commission to Review Retiree Health Care
For Employees Hired after July 1, 2013

AGENDA

11/14/13

- Approval of Minutes from 10/31/13; 11/7/13 and 11/13/13
- Review of Commission Report Draft
- Finalize Report
- Vote on Report
- Next Meeting: November 15, 2013?

The State Employees' Association
of New Hampshire, Inc.
Service Employees International Union, Local 1984
CTW, CLC

November 14, 2013

Linda Hodgdon, Commissioner
Department of Administrative Services
State House Annex
Capitol Street
Concord, NH 03301

RE: Cost Containment Commission—New State Employee Retiree Health Benefits

Dear Commissioner:

The attached excerpts of the SEA/SEIU Local 1984 Retirement Medical Trust's Voluntary Employee Benefit Account (VEBA) are being provided to the Commission for information purposes only. Our organization made a deep commitment and financial investment into creating this trust after Senate Joint Resolution 2 was adopted in 2008. In more recent years, through the Collective Bargaining Agreement between the State of New Hampshire and this organization, we have successfully pursued an amendment to RSA 21-I with respect to this subject matter as well. The combination of which do provide a viable option for the employer and employees to save for future retiree health care costs. Further, it is a viable option to assist current employees with saving money for them to pay for the employee's share of their future retiree health care costs as well.

It is important to note that the Association believes that utilization of this option can be done in a way that not only assists state employees, present and future, with paying for a portion of their retiree health care costs, we believe it is a vehicle that, with careful contract negotiation and budget development, will assist the state in reducing its OPEB liability gradually and intentionally, and yet will also assist both the state and employees with ensuring that comparable, reasonable compensation and preparation for future retiree healthcare is achieved in a balanced way throughout the state employee workforce.

We look forward to our continued working relationship on this issue.

Sincerely,

Diana Lacey

Diana Lacey
President
SEA/SEIU Local 1984

207 North Main Street
Concord, NH 03301

Telephone (603) 271-3411
Fax (603) 271-3500

BRIEF OVERVIEW OF SEA/SEIU LOCAL 1984 RETIREMENT MEDICAL TRUST'S VOLUNTARY EMPLOYEE BENEFIT ACCOUNT

This information is subject to change pending formal adoption by the Trustees. Additionally, the future claims procedure is anticipated to change to describe online access to accounts and claim submittal procedures.

DEFINITIONS (excerpts)

1.1 **"Active Service"** means service as defined in Section 2.2 herein, after the Employee's Effective Date, provided however that an Employee may receive Active Service Units from contributions made to another similar Trust, if so provided in a joinder agreement signed by this Trust. An **"Active Service Unit'** means a monthly Contribution of $10.00 to the Trust on behalf of an Employee. Note that an Employee may earn more than one Active Service Unit in a month.

1.2 **"Beneficiary"** means an Eligible Retiree, his or her lawful spouse, and the Eligible Retiree's Children; and an Eligible Retiree's Surviving Spouse and Surviving Children. A "**Regular Beneficiary**" is a person who has become eligible for monthly benefits under Section 2.1(a). A "**Limited Beneficiary**" is a person who has become eligible for benefits from an Employee Account under Section 2.1(b).

1.3 **"Board of Trustees"** or **"Trustees"** means the duly selected board which administers the Plan and Trust, pursuant to the Trust Agreement.

1.4 **"Collective Bargaining Agreement"** or **"CBA"** means a written agreement between an Employer and a Local that requires mandatory contributions to a retiree medical trust on behalf of each Employee in the bargaining unit covered by the CBA, and subsequent amendments or successor agreements. The term CBA shall also include a Special Agreement that requires mandatory contributions on each employee in an objective employment classification of an Employer during the period that the employer is also making contributions to the Trust on the employees in the bargaining unit of the same Employer. If there are two CBAs from one employer (or a CBA and a Special Agreement), the contribution rate must be the one set in the CBA that covers non-management employees.

1.5 **"Covered Expense"** means payment for the following:

(a) Premium or contribution payment on behalf of a Beneficiary to a health, dental, or vision insurance plan, for coverage in effect while the Beneficiary is eligible for benefits under this Plan, for the type of medical expenses excludible from gross income under Code Section 105(b);

(b) Medical expense, as defined in Code Section 213(d) (i.e., costs for the diagnosis, cure, mitigation, treatment, or prevention of disease or injury), including insulin but excluding all other non-prescribed drugs, incurred by the Beneficiary while the Beneficiary is eligible for benefits under this Plan and which has not been claimed by the Beneficiary as a deduction on his or her personal tax return; and

(c) Premium payment for long-term care insurance qualified under Code Section 7702, for coverage in effect while the Beneficiary is eligible for benefits under the Plan, but for no other expenses associated with the costs of long-term care.

1.6 **"Employee Account"** means the individual bookkeeping account maintained by the Trust in the name of an Employee, which reflects certain contributions made to the Trust as set forth in Section 3.5.

1.7 **"Employer"** or **"Participating Employer"** means an employer that contributes to this Plan pursuant to a CBA.

1.8 **"ERISA"** means the federal Employee Retirement Income Security Act, 29, USC 1001 et seq.

1.9 **"Local"** means a lawful labor organization that is a member Local in SEA/SEIU 1984 that represents Employees, and is party to a Collective Bargaining Agreement with a participating employer; or any rational class of individuals employed by a participating employer that is the subject of a Special Agreement as defined herein, provided that such labor organization or class of employees has been accepted for participation by the Board of Trustees.

1.10 **"Medicare Eligibility Age"** means for an Employee who is eligible to enroll in Medicare, the age set by the federal government at which an Employee is eligible to receive Medicare benefits (even if the person does not apply for such benefits).

1.19 **"Special Agreement"** means a written agreement between a participating employer and the Trustees, and any supplement, amendment, continuation, or renewal thereof that obligates the entity to make contributions to the Trust Fund for employees, for the purpose of providing employee welfare benefits to the employees covered by said agreement, and their beneficiaries. The contribution under the Special Agreement must be at the same level as that in the CBA of the same employer.

1.20 **"Trust"** or **"Trust Fund"** means the SEA/SEIU Retiree Medical Trust created by the Trust Agreement and all property and money held by such entity, including all contract rights and records. Trust Office means 207 North Main St. Concord, NH.

1.21 **"Trust Agreement"** or **"Agreement"** means the Trust Agreement governing the SEA/SEIU Retiree Medical Trust, effective November 1, 2010, and any amendments thereto.

1.22 **"Unit Multiplier" or "UM"** means the variable amount periodically set by the Trustees, based on demographic and financial factors, and used in the determination of the monthly benefit level of an Eligible Retiree, as set forth in section 3.3(a). The Trustees may adjust the UM from time to time.

BENEFITS (excerpts)

3.2 **Commencement of Benefits.** Benefits for Beneficiaries shall commence as set forth in this Section 3.2.

(a) Retiree. A Regular Beneficiary shall be entitled to benefit payments upon meeting the eligibility requirements of Section 2.1(a) and having contributions made to this Trust, or a prior similar trust, on the Employee's behalf for a minimum of ten years. A Limited Beneficiary shall be entitled to benefit payments upon meeting the eligibility requirements of Section 2.1(b).

3.3 **Benefit Levels for Regular Beneficiaries.** An Employee, who becomes an Eligible Retiree under Section 2.1(a), shall be a Regular Beneficiary and entitled to monthly reimbursement of Covered Expenses in an amount not to exceed the Beneficiary's benefit level, calculated pursuant to this section.

(a) Eligible Retiree. The maximum monthly benefit level for an Eligible Retiree shall be determined according to the following methodology:

(1) Determine the number of Active Service Units, and

(2) Multiply the number of Active Service Units by the Unit Multiplier in effect on the date that contributions to the Plan terminate for the Retiree, subject to subsection 3.3(b) hereof.

(3) Reduction at Medicare Eligibility Age. This maximum monthly benefit level shall be reduced by 50% the month after the Eligible Retiree is eligible to receive Medicare benefits (regardless of whether he/she applies for Medicare).

Modifications. The Trustees reserve the right and power to modify the Unit Multiplier from time to time, and the new Unit Multiplier may apply to current and/or future Beneficiaries, as determined by the Trustees. The applicable Unit Multiplier and the designation of Beneficiaries to whom it is applicable will be set forth in Appendix A hereto, which is by this reference incorporated herein.

3.4 Termination of Benefits

(a) Eligible Retirees. An Eligible Retiree's monthly benefit coverage as a Regular Beneficiary under the Plan shall terminate on the earliest of the following dates:

(1) Return to employment with a Participating Employer; provided however that upon subsequent cessation of all employment with participating employers, benefit payments shall resume.

(2) Date of the Retiree's death, provided however that claims for Covered Expenses, which are properly and timely submitted on behalf of the deceased Retiree after death, will be paid for the months through and including the month in which the Retiree died, at the rate of the monthly benefit level for that Retiree.

(b) Upon the death of the Retiree, any funds contributed by that retiree, or by the employer on his/her behalf, not yet disbursed as a monthly benefit shall be converted to a Limited Beneficiary account and may be used by Surviving Spouse, Surviving Same-sex Spouse or Surviving Children for the reimbursement of qualified medical expenses.

3.5 Benefits from Employee Accounts

(a) Employee Account. An Employee, who becomes an Eligible Retiree under Section 2.1(b) hereof as a Limited Beneficiary, and his or her Beneficiaries, are entitled to reimbursement of Covered Expenses from his or her Employee Account. The balance in the Employee Account shall include the following:

(1) Transfer of accrued leave, annually or upon retirement, only as required pursuant to a non-elective requirement for such transfer in his or her CBA. Accrued leave shall include only the type of leave that the Internal Revenue Service allows for conversion to retiree medical benefits on a non-taxable basis (e.g., sick leave, vacation leave).

(2) Employee contributions from salary.

(3) Employer contributions, on the condition that the Employee terminates from the employer at the retirement age as defined in the retirement system of his or her employer, or if laid off prior to retirement.

(4) Earnings and/or losses, minus a proportionate share of expenses, will be applied to the Account, on the condition that the Employee terminates from the employer at the retirement age as defined in the retirement system of his or her employer. At retirement, earnings and/or losses will be posted at the actual rate of return experienced by the Trust during the period that the employee was earning Active Service.

(b) Benefit Level from Employee Account. There shall be no maximum amount on a claim against the Employee Account, so long as all claims are for reimbursement of Covered Expenses, i.e., the monthly Unit Multiplier calculation does not apply to Employee Accounts.

(c) Commencement and Termination of Benefits from Employee Account. Reimbursement from the Employee Account may commence after and during separation from service with all participating employers, and will terminate when the Account balance reaches zero. If the Eligible Retiree returns to employment with a participating employer, eligibility for this benefit shall be suspended until termination of such employment.

3.6 Benefit Claim Procedure

(a) To make a claim for Plan benefits, Beneficiaries must present proof of payment of Covered Expenses, on a form approved by the Trustees, to the Trust Office at:

SEA/SEIU Local 1984 Retiree Medical Trust
XXXXXXXXXXXXXXXXXXXXX (insert vendor information)

Prior to issuing payment, the Trust Office shall review such proof and determine whether to grant or deny coverage under the Plan.

(b) If the Trust Office grants coverage, payment will be made to the Beneficiary. If the Trust Office denies coverage, the Beneficiary may appeal the denial of coverage or any other adverse benefit determination of the Trustees.

(c) Proof of payment of a covered expense shall include, but not be limited to, canceled checks drawn to the name of the medical insurance provider or receipt for payment from the medical insurance provider, subject to verification as determined by the Trustees in their sole discretion.

(d) In order to be paid, a claim for Plan benefits must be submitted within thirty (30) days after end of the Plan year in which the expense was incurred.

(e) Subject to subsection (f), below, unless specifically provided by law, the Trustees shall not make any payments on behalf of or distributions to any person entitled to any benefits except to a Beneficiary personally or pursuant to a Qualified Medical Child Support Order under federal law.

(f) If a Beneficiary is deemed to be incompetent by a lawful judicial or quasi-judicial forum, or reasonably deemed to be incompetent by the Trustees, then any payment due may be paid to such person and in such manner as the Trustees, in their sole discretion, consider to be in the best interest of the Beneficiary, (unless the judicial forum has appointed a party as the Beneficiary's representative, in which case the Trustees will make payment to that party). The Trustees shall not be under any duty to oversee the application of funds so paid, provided due care was exercised in the selection of the person to whom funds were paid, and the receipt of the person to whom funds were paid shall be full acquittance to the Trustees. The Trustees shall not be liable to any person for a determination made in good faith that a Beneficiary is incompetent.