

Health and OPEB Funding Strategies:

2009 National Survey of Local Governments

Study by Cobalt Community Research

Analysis by Paul Zorn of Gabriel Roeder Smith & Company (GRS)

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Acknowledgements

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Executive Summary

In 2004, the Governmental Accounting Standards Board (GASB) issued Statement No. 45, “Accounting and Financial Reporting by Employers for Postemployment Benefits Other than Pensions (OPEB).” This statement created a national standard for the measurement and disclosure of OPEB liabilities, especially in the area of health care for retirees.

Local governments across the nation have been struggling with soaring health care costs for many years. The awareness of this new liability and the requirement to disclose it have created heightened concerns with the affordability of public sector health care.

This second year annual study provides detailed insight into the awareness of and response to GASB 45 and maps the strategies local governments have implemented and plan to implement to address health care costs. While several studies have examined OPEB issues for statewide retirement systems or for a limited sample of local governments, this study deliberately sampled a random cross-section of local governments across the United States.

Here are major questions this study seeks to answer:

- What strategies are local governments using to address their health costs?
- What do governments plan to do in the next two years?
- Who is aware of the GASB 45 requirements and has done the valuation?
- Which strategies are local governments using to reduce or fund their liabilities?

Executive Summary *Continued*

Three key findings emerge from the research:

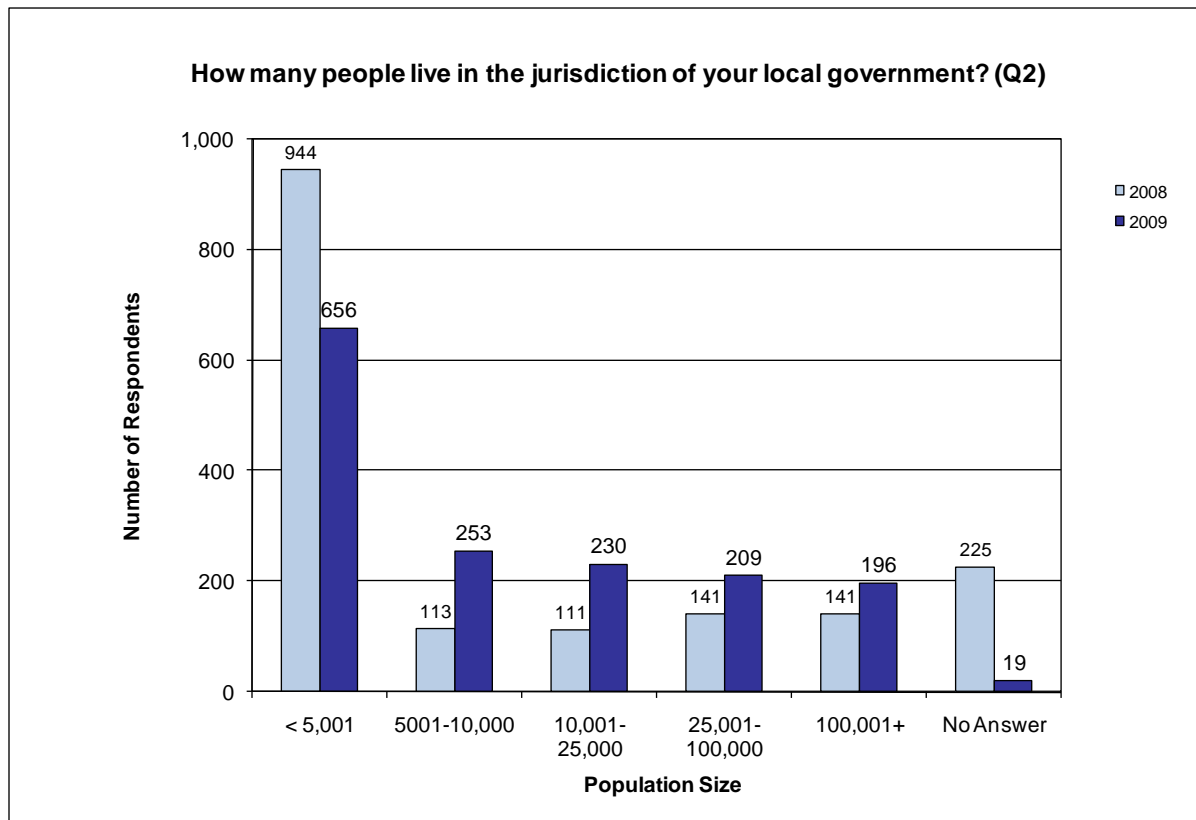
1. The economic environment is having a clear effect on revenue and employment expectations. Respondents from larger governments are more likely to expect revenues to decline.
 - Local governments expecting a decrease in revenue for 2010 rose from 16 to 49%
 - Local governments expecting a decrease in employment rose from 5 to 21%
 - Local governments expecting more consolidation/shared services rose from 10 to 26%.
2. 78% of the respondent local governments provide health care to their employees, and 30% provide health care to retirees. These percentages are larger than found in our prior study, due mainly to a greater representation of larger governments in our survey sample.
 - Of the governments that provide active employee health care, 67% pay between 81% and 100% of their active employees' health care premiums.
 - While a majority of local governments provide health care to employees, a significant number might consider a range of untapped cost-containment strategies to limit future expenses.
 - The most frequently used methods to control health care costs include: increasing deductibles and copays, increasing the employees' share of premium costs, implementing wellness programs, expanding use of generic drugs, implementing HSAs and HRAs, negotiating lower costs with current carriers, and educating employees/retirees to make better health care decisions.

Executive Summary *Continued*

3. Almost one-third (30%) of the 2009 survey respondents work for governments that provide retiree health care. Generally, governments serving larger populations are more likely to provide retiree health care. Of the governments that provide retiree health care, only about one-third pay between 81% and 100% of the retirees' health care premiums. In addition, about one-third pay none of the retirees' health care premiums.
- About 80% of the local governments that provide retiree health care are aware of the GASB 45 requirements, and 62% report that they have already calculated the liability or the calculation is in process.
 - For the 2009 survey respondents who have completed their OPEB valuation, 55% have OPEB liabilities of less than \$10 million. However, for 13%, the liability exceeds \$100 million.
 - Of the governments that have completed their OPEB valuations, 40% plan to fully or partially prefund the liability. Of these, 30% plan to establish formal trusts.
 - 52% of responding governments plan to continue a pay-as-you-go approach to funding retiree health costs.

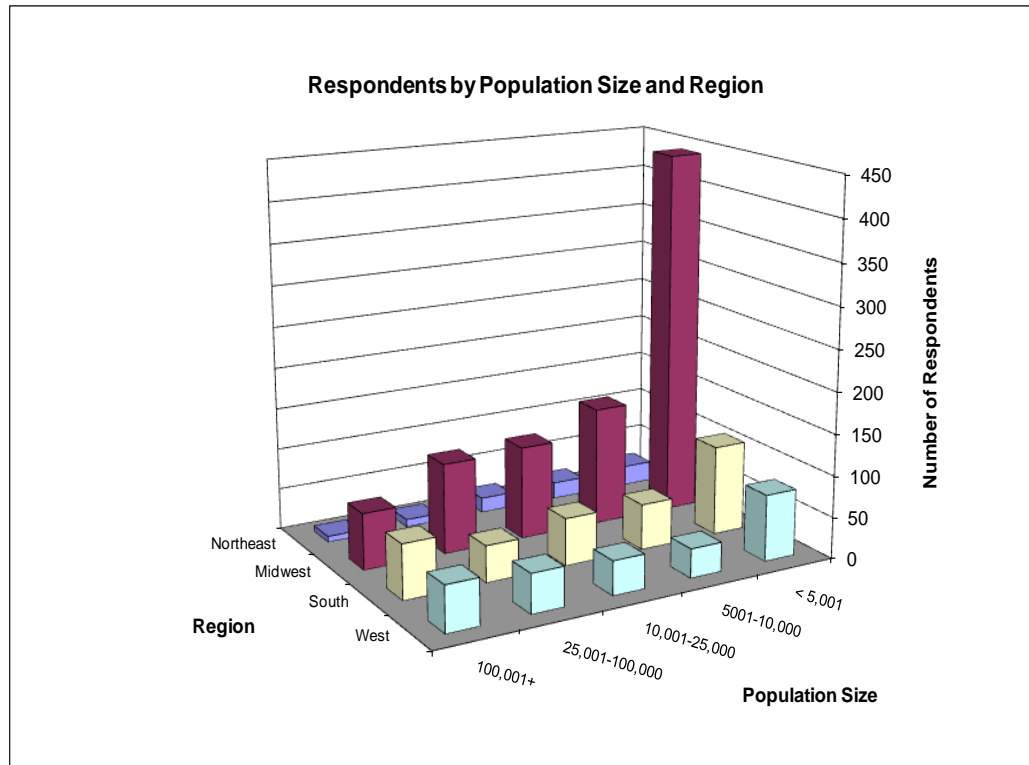
Section 1: Characteristics of the Respondents

As shown below, the 1,563 respondent governments serve a wide range of populations, but were mostly representative of smaller governments. Of the respondents, 656 (42% of the total) represent governments that serve populations of less than 5,000. Another 635 respondents (41% of the total) represent governments with populations of over 10,000. See page 48 in Section 7 for details on the survey respondents compare with other local governments in the U.S. Census. For 2009, a new population category was added for governments with more than 100,000 residents. The 2008 numbers below reflect the category for 25,001 or more. This means that larger governments have greater weight on the results of this study. (Note: numbers in parentheses after the chart title refer to the question number in the survey questionnaire.)

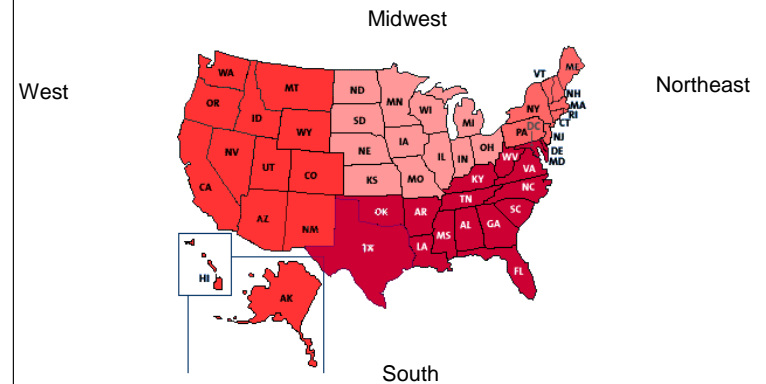


Section 1: Characteristics of the Respondents

The chart below shows the distribution of the respondents by population size and region. Many of the respondents represent smaller jurisdictions in the Midwest, based on the large number of township governments in that region. In addition, a relatively small number of respondents were from the Northeast, which correlates with the small number of governments overall in that region.

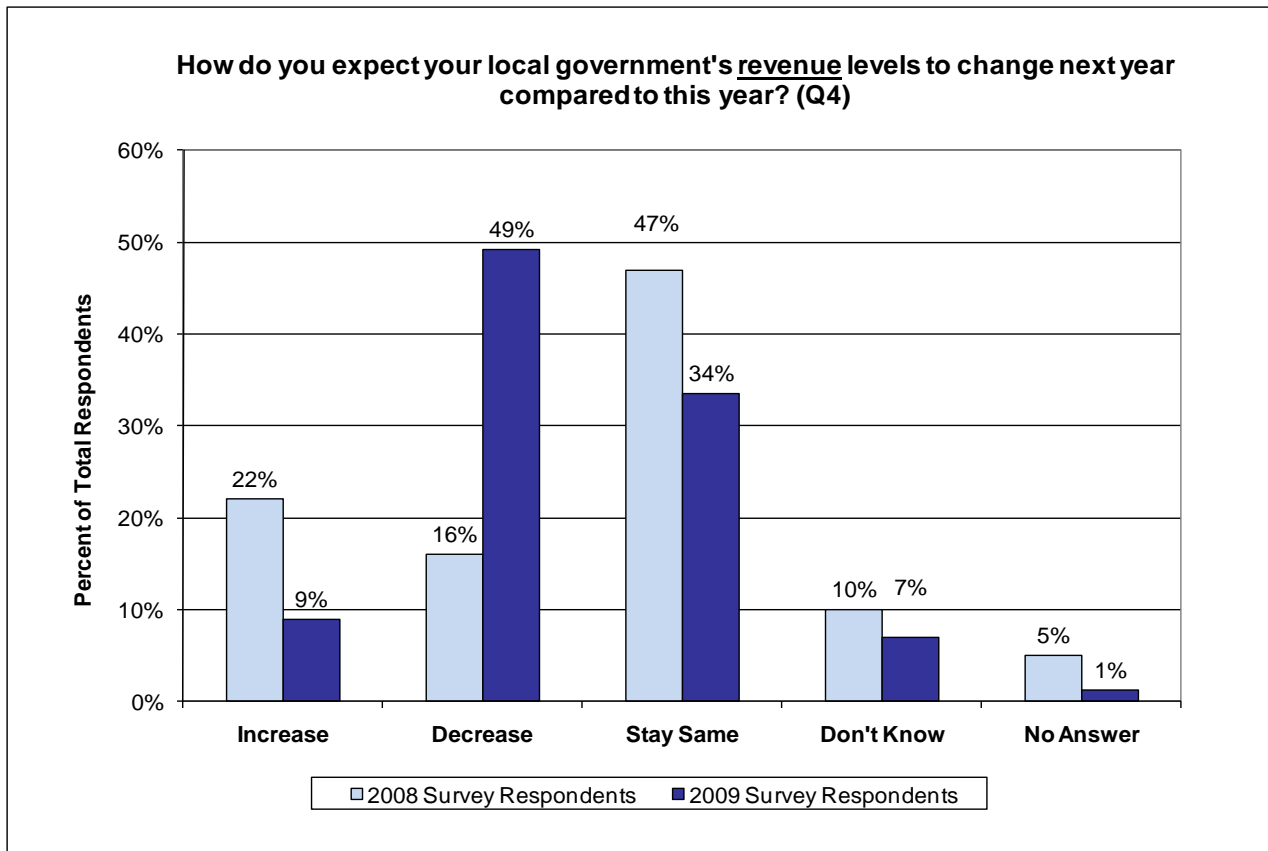


Census Bureau Regions



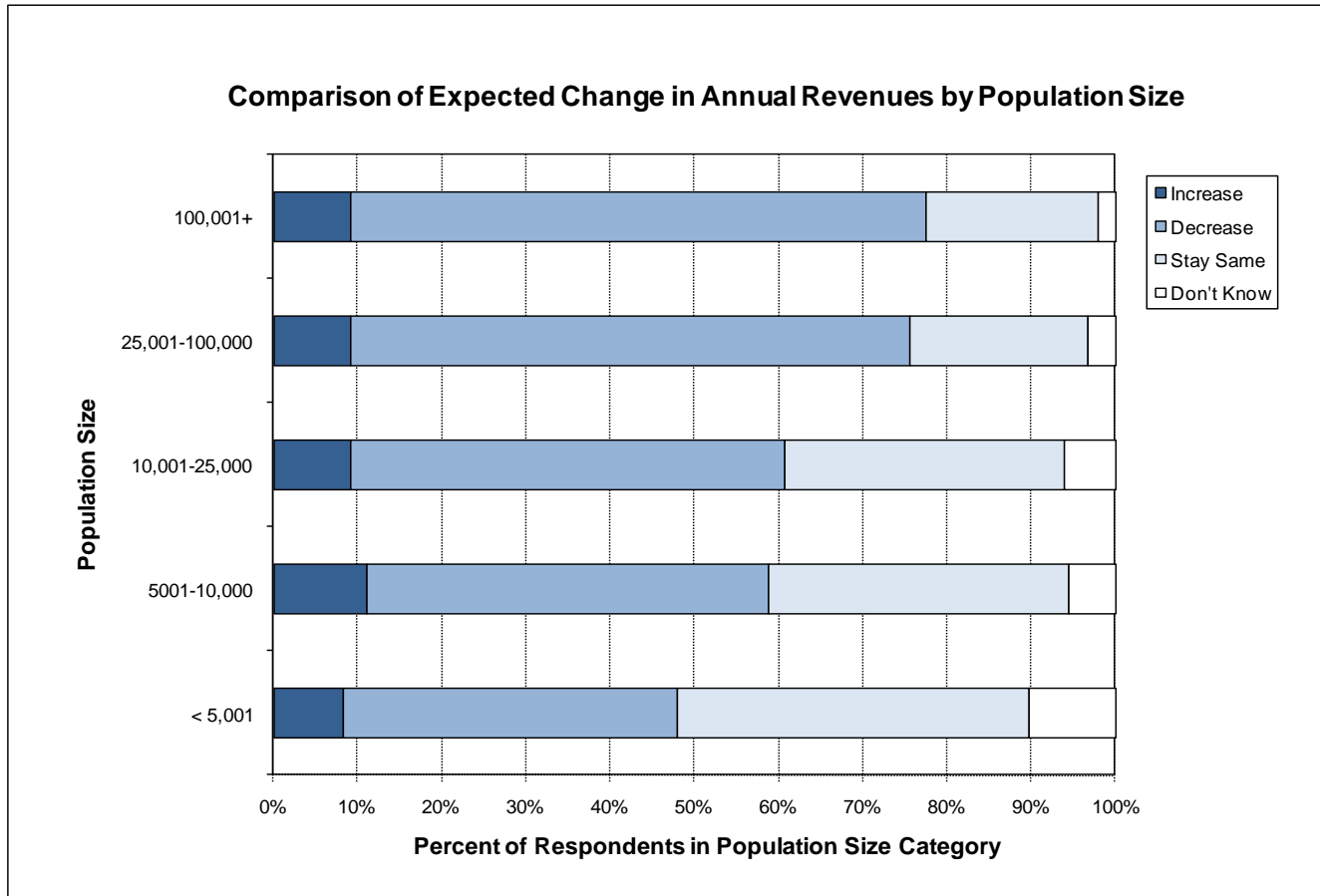
Section 2: Expected Revenue and Employment Changes

The chart below shows the distribution of respondents by expected changes in next year's level of revenues. As one would expect in the current economic environment, a large proportion (49%) of respondents expect revenues to decrease in the coming year. Interestingly, in last year's survey, 47% of the respondents expected revenues to stay the same, and only 16% expected revenues to decrease. The smallest units of government showed less change in their responses between 2008 and 2009.



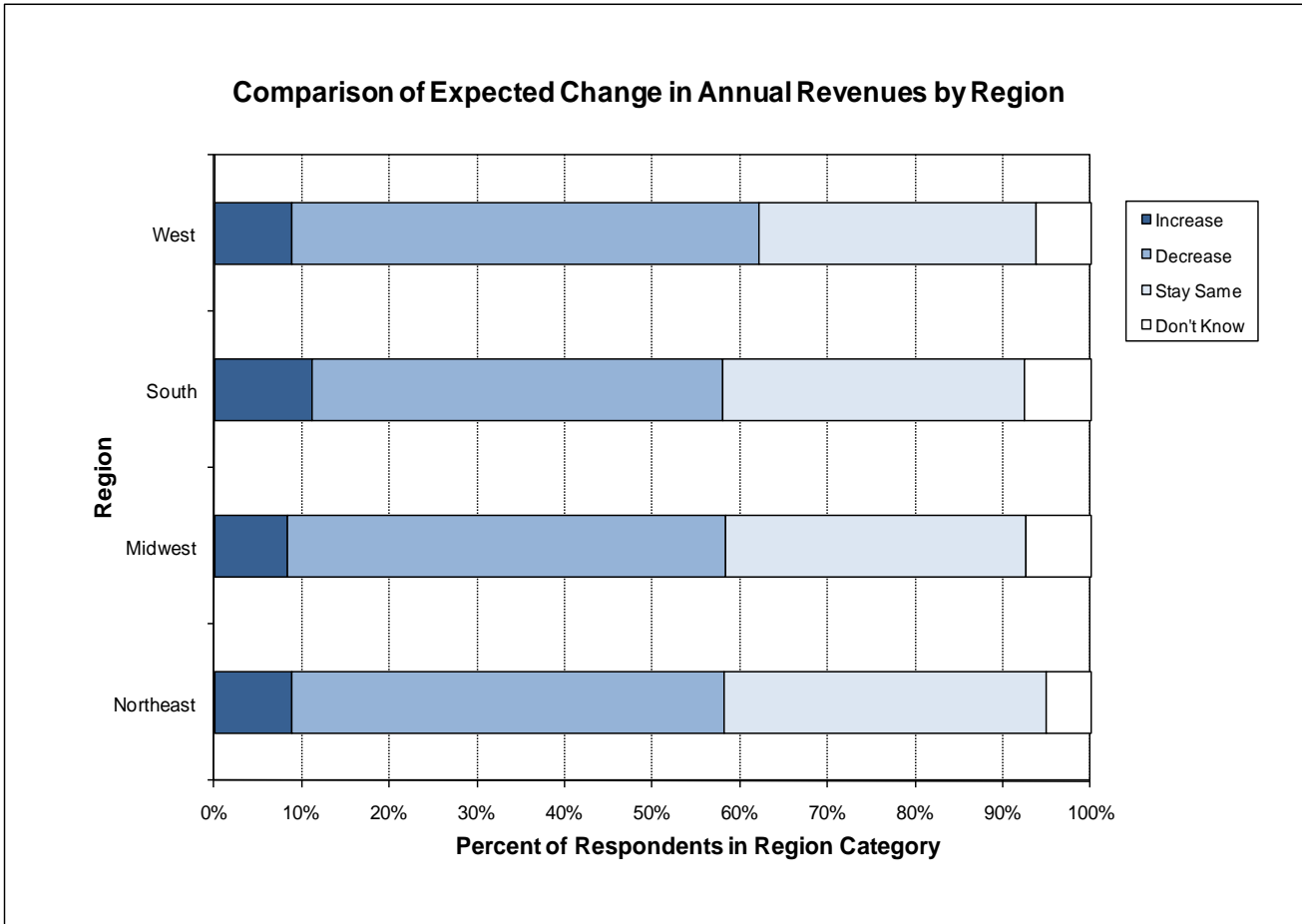
Section 2: Expected Revenue and Employment Changes

The next three charts show expected changes in revenues by different groups of respondents. The chart below shows that about 65% of the respondents with populations of more than 25,000 expect revenues to decrease next year, compared with about 40% of respondents with populations of 5,000 or less.



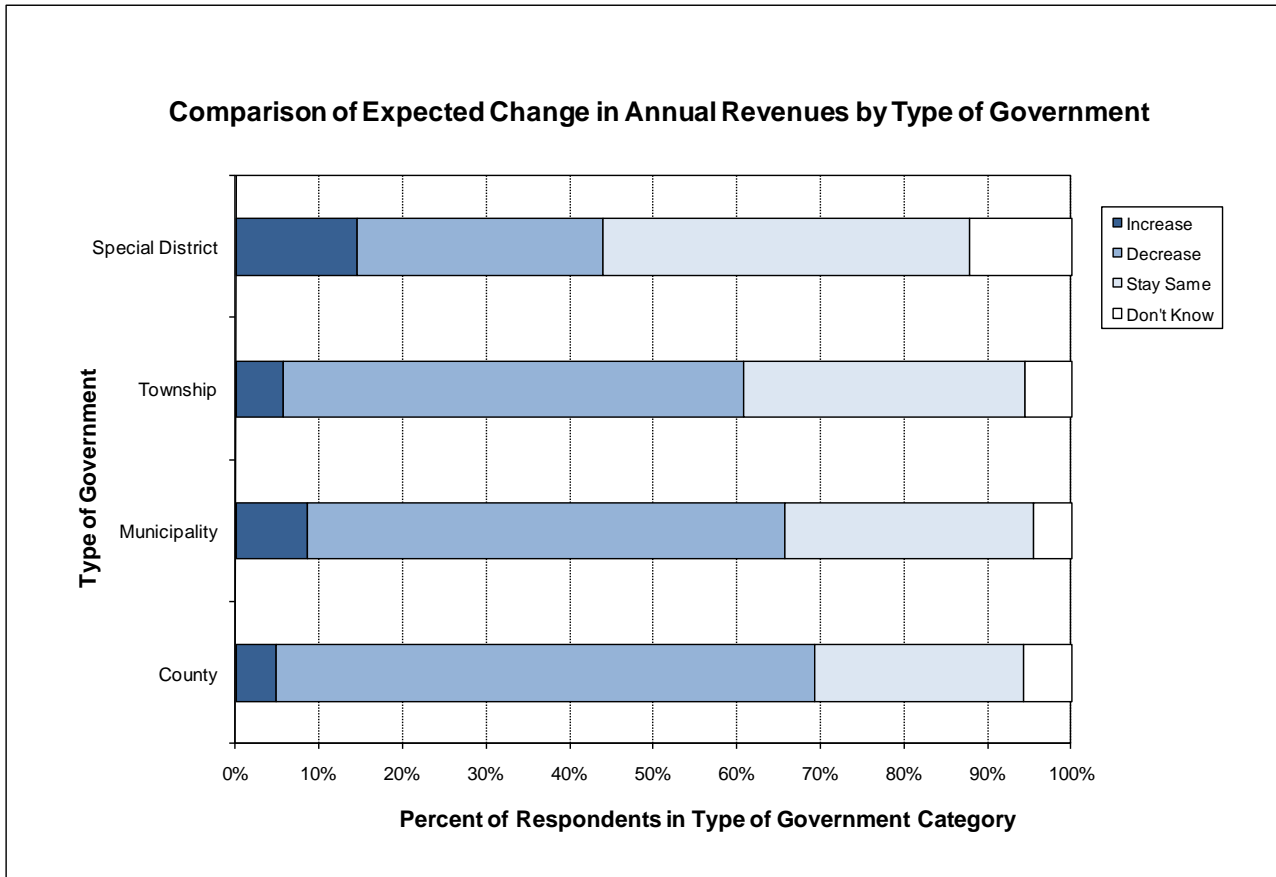
Section 2: Expected Revenue and Employment Changes

While larger governments appear more likely to expect revenues to decrease next year, there does not appear to be a relationship between expected revenue changes and geographic region. The chart below shows that about 50% of respondents in all four major geographic regions expect revenues to decrease next year, about 30% expect revenues to stay the same, and only 10% expect revenues to increase.



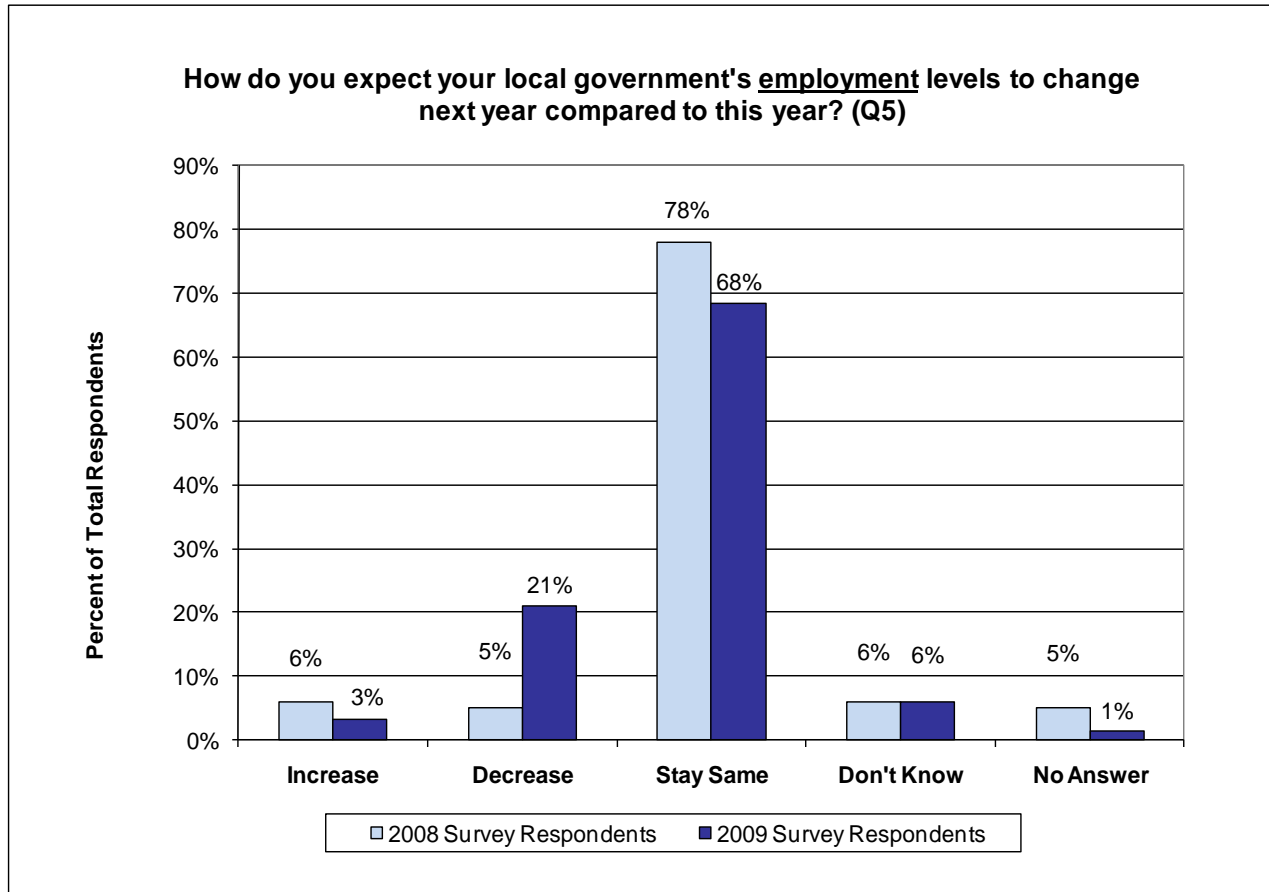
Section 2: Expected Revenue and Employment Changes

The chart below shows that respondents representing county, municipal, and township governments were more likely to expect revenues to decrease next year, compared with special districts. On average, over 50% of respondents from these governments expect revenues to decrease, compared with about 30% of respondents from special districts.



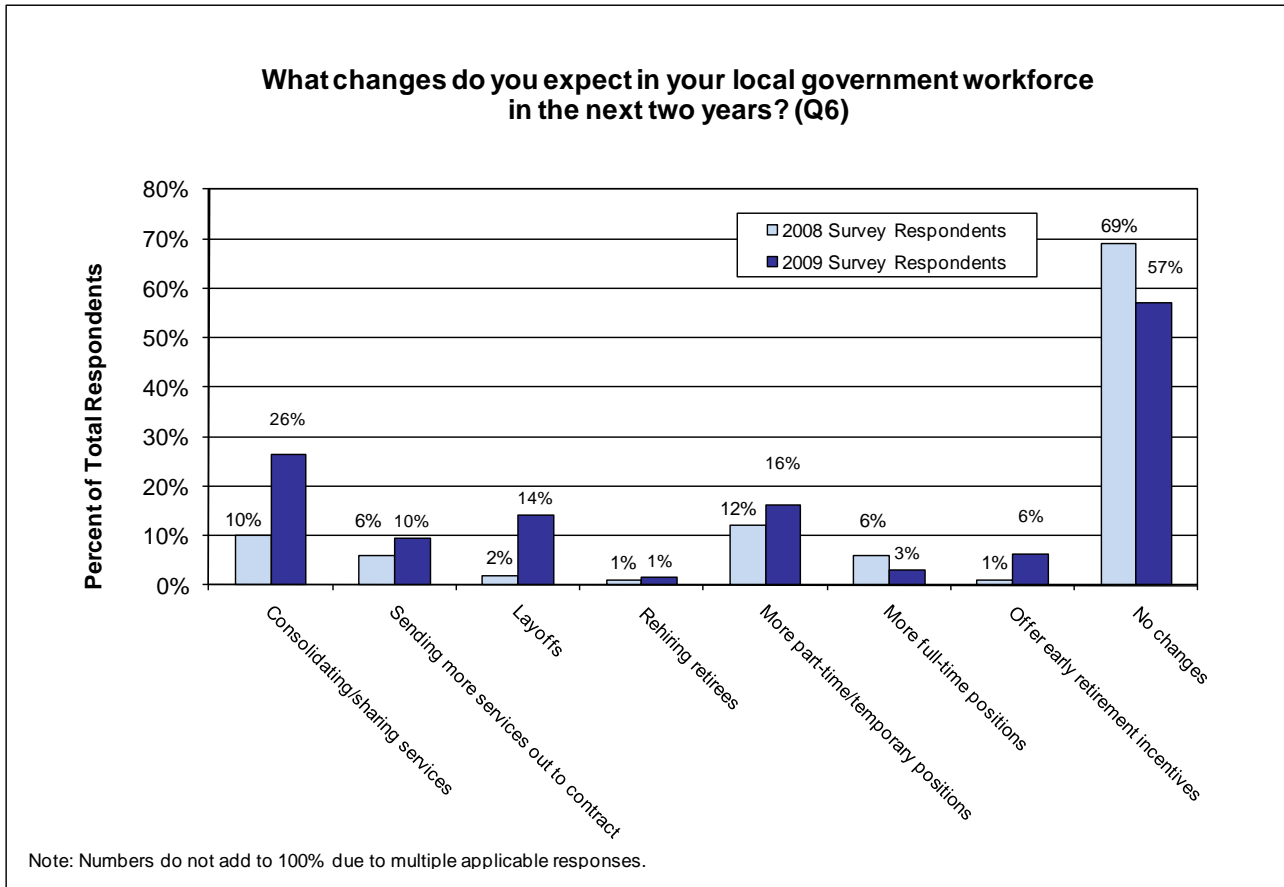
Section 2: Expected Revenue and Employment Changes

The chart below shows the distribution of respondents by the expected change in next year's level of government employment and indicates that the majority of respondents (68%) expect next year's employment levels to stay the same, compared with 78% in 2008. In addition, 21% of the 2009 respondents expect their local governments' employment to decrease next year, compared with only 5% in 2008.



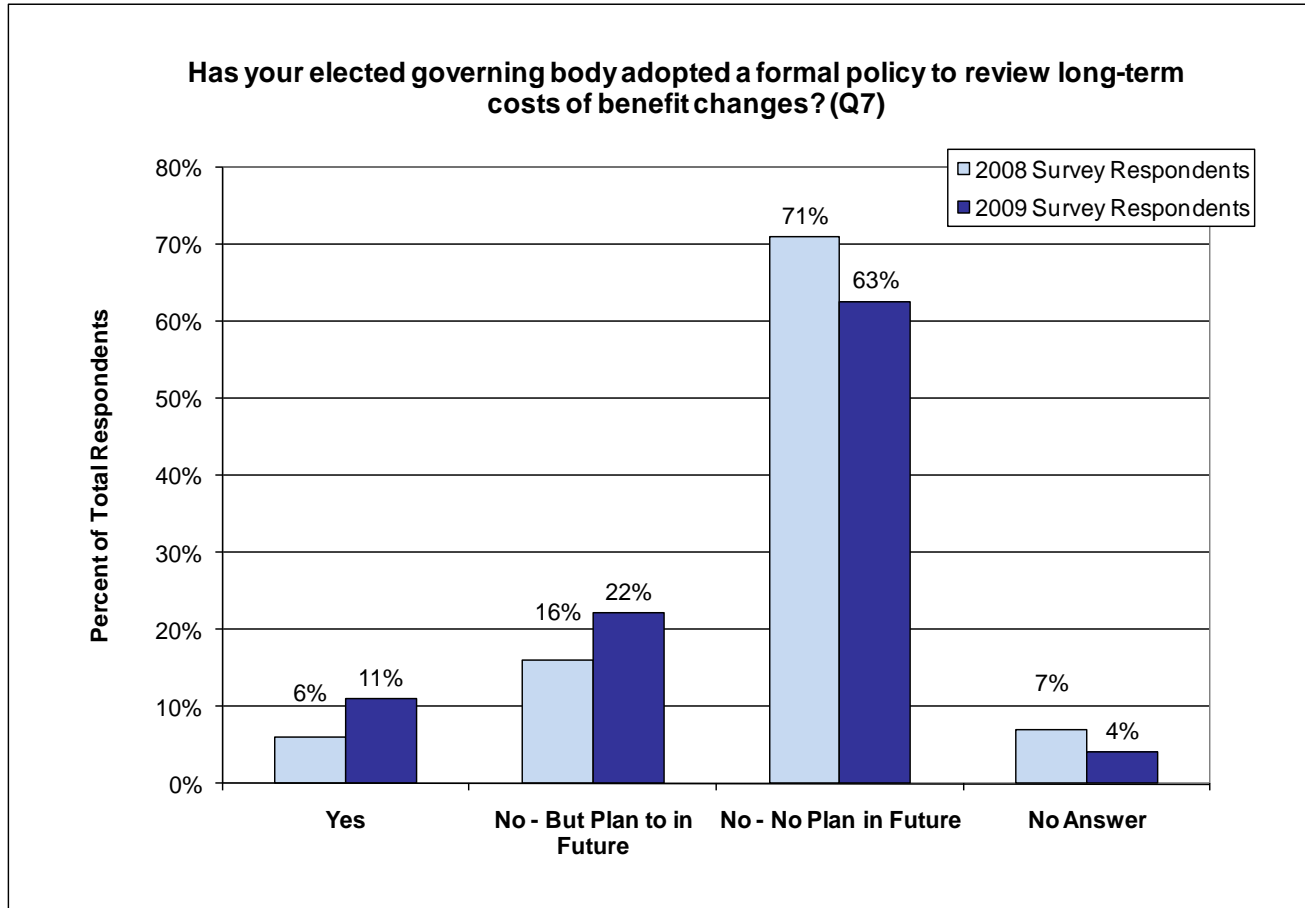
Section 2: Expected Revenue and Employment Changes

To the extent the governmental workforce is expected to change, the chart below shows that it will most likely involve the consolidation of public services, layoffs, and the greater use of part-time and temporary positions. The majority (57%) expect no change in the next two years, down from 69% of respondents in last year's survey. However, 26% expect to see consolidation and sharing of services, up from 10% in 2008. Additionally, 14% expect to see layoffs, up from 2% in 2008.



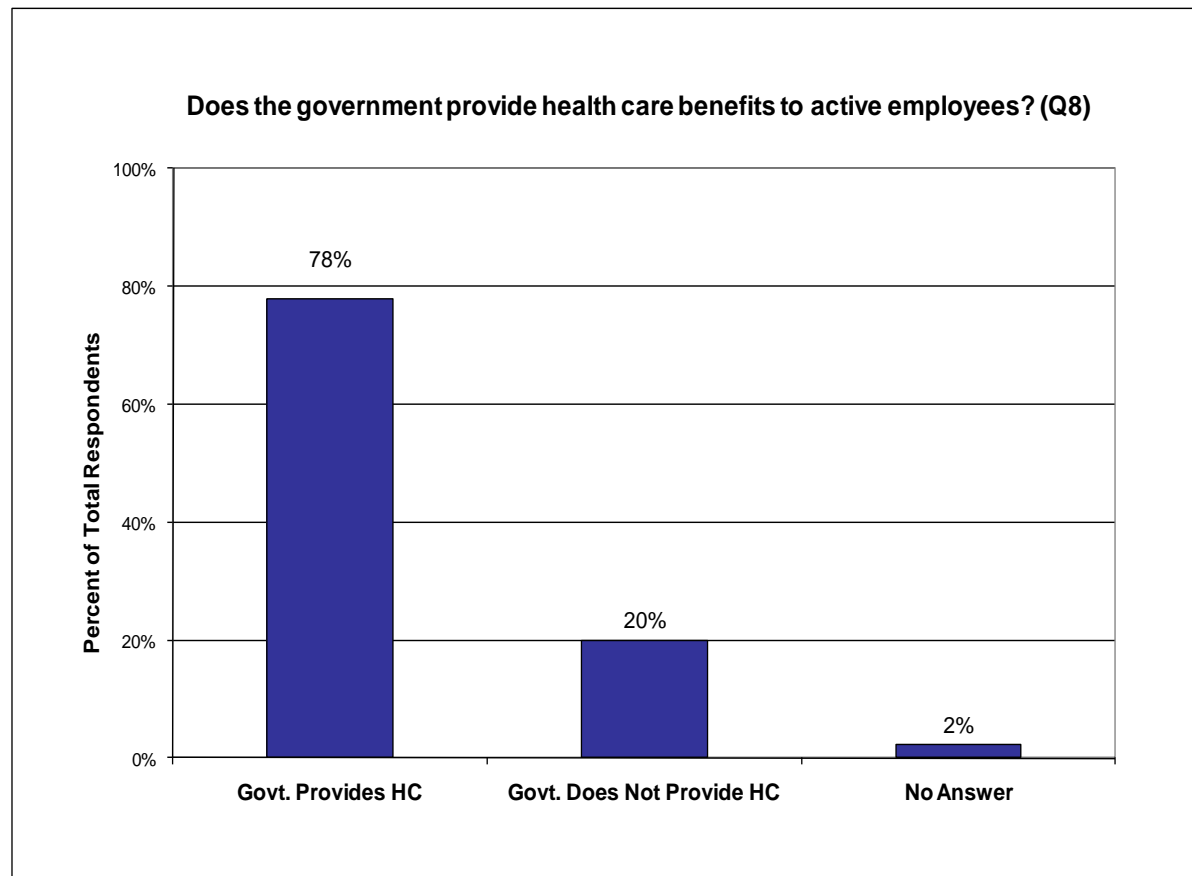
Section 2: Expected Revenue and Employment Changes

The chart below shows that while 11% of the respondents have adopted a formal policy to review long-term benefit costs and 22% have plans to do so in the future, the majority (63%) have not adopted a formal policy to review the long-term costs of benefit changes.



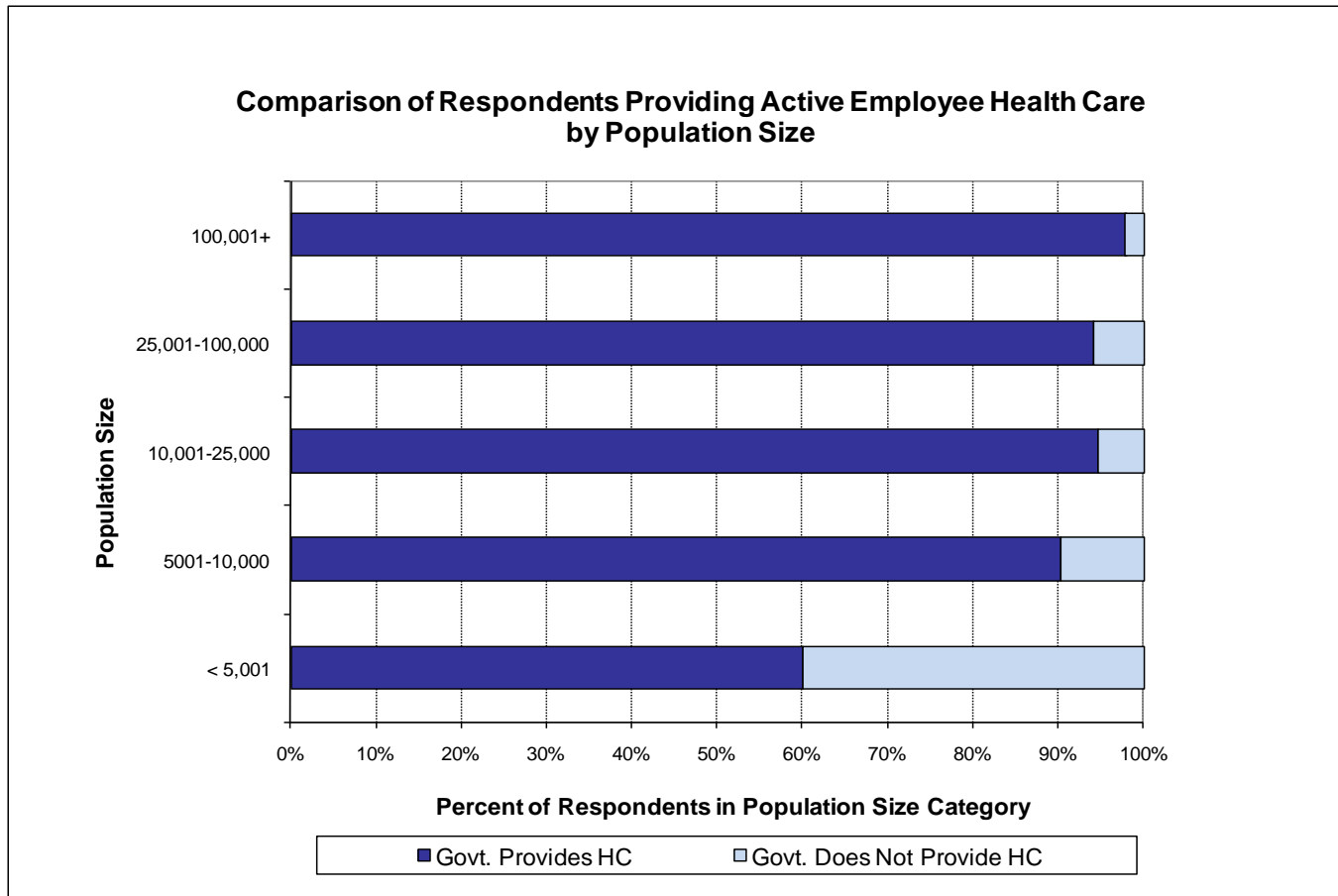
Section 3: Provision of Health Care to Active Employees

One focus of the survey was to gauge the extent to which local governments provide health care benefits. The chart below shows that 78% of the respondents indicated they provide health care benefits to active employees. This is up from 52% in last year's survey, and is partly due to the greater proportion of larger governments in the survey sample. The increase in healthcare coverage does show in all size categories, even those that were not affected by sampling changes. Note that not all governments that offer health care to active members also offer it to retirees.



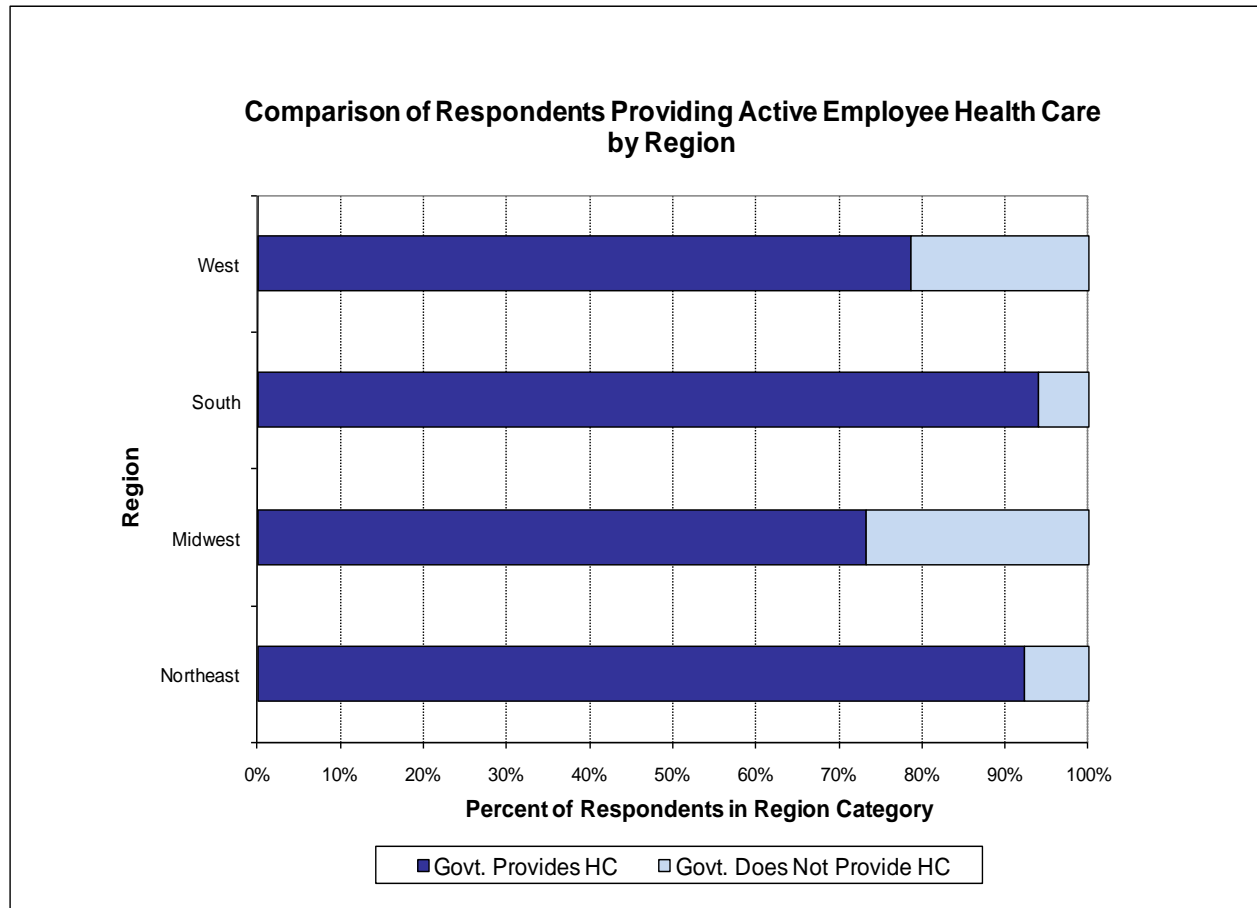
Section 3: Provision of Health Care to Active Employees

The chart below shows the extent to which different sized governments offer health care benefits to active employees. Interestingly, the vast majority (over 90%) of governments serving populations of more than 5,000 provide health care benefits to active employees. However, only about 60% of respondent governments serving populations of 5,000 or less provide health care to active employees. As discussed in Section 7, the survey sample excluded governments with populations of 1,500 or less.



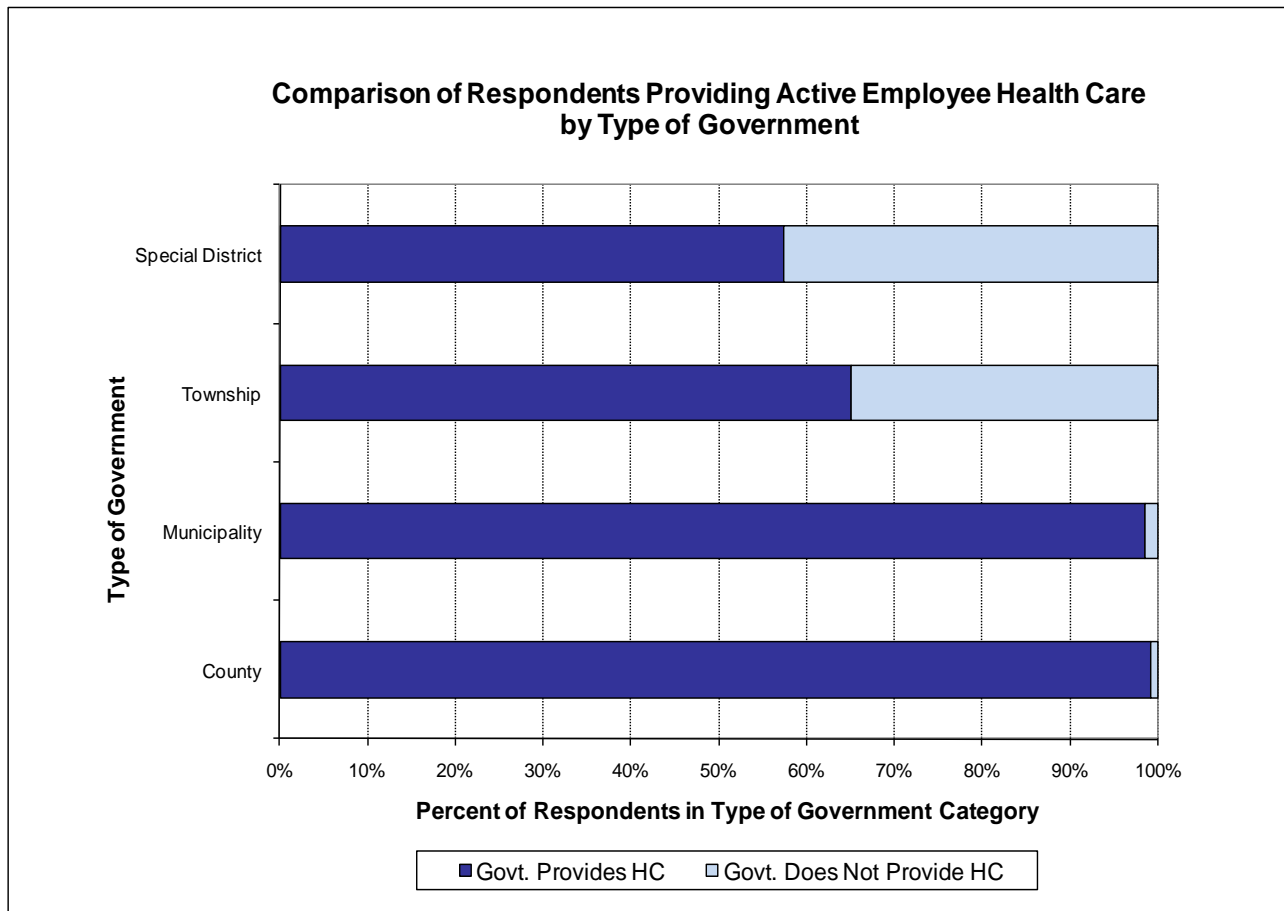
Section 3: Provision of Health Care to Active Employees

The chart below shows the extent to which the respondents' provision of active employee health care varies by major geographic region. Over 90% of respondents from the Northeast and South offer health care to active employees, compared with about 80% for Western respondents. The lower percentage of Midwest respondents offering health care to active employees (74%) may reflect the relatively large proportion of Midwest respondents representing small governments.



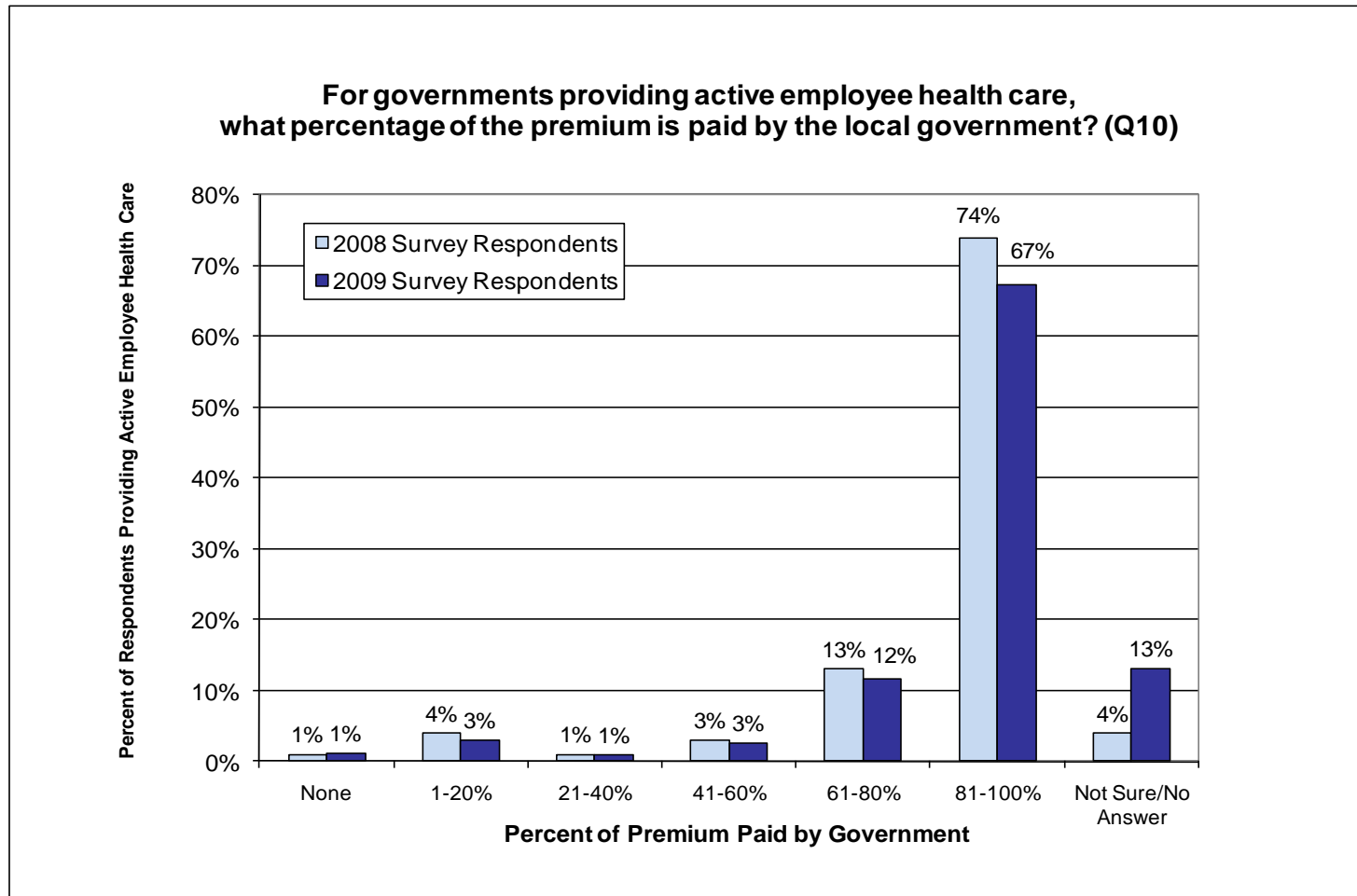
Section 3: Provision of Health Care to Active Employees

The chart below shows that the vast majority of respondents representing county and municipal governments (98%) provide health care to active employees. Smaller proportions of respondents from townships and special districts offer health care to active employees. However, readers should note that the respondents in these categories generally represent smaller governments. Consequently, care should be taken in extrapolating these results to municipalities, townships, and special districts as a whole.



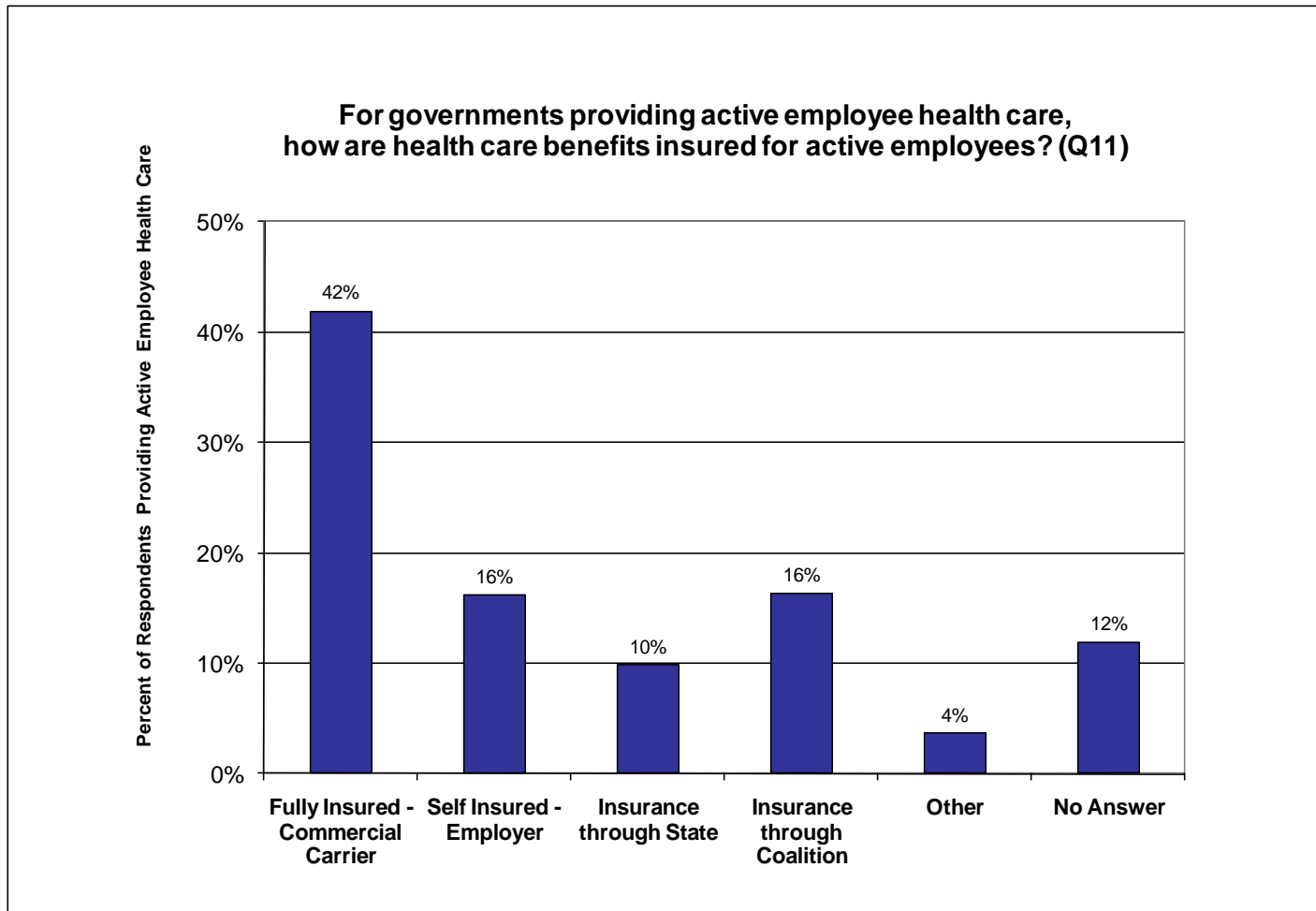
Section 3: Provision of Health Care to Active Employees

For the government respondents that provide health care to active employees, the chart below shows the percentage of the premium paid by the local government. The vast majority of these respondents (67%) pay between 81% and 100% of the premium. Most of the remaining respondents pay more than 60% of the premium.



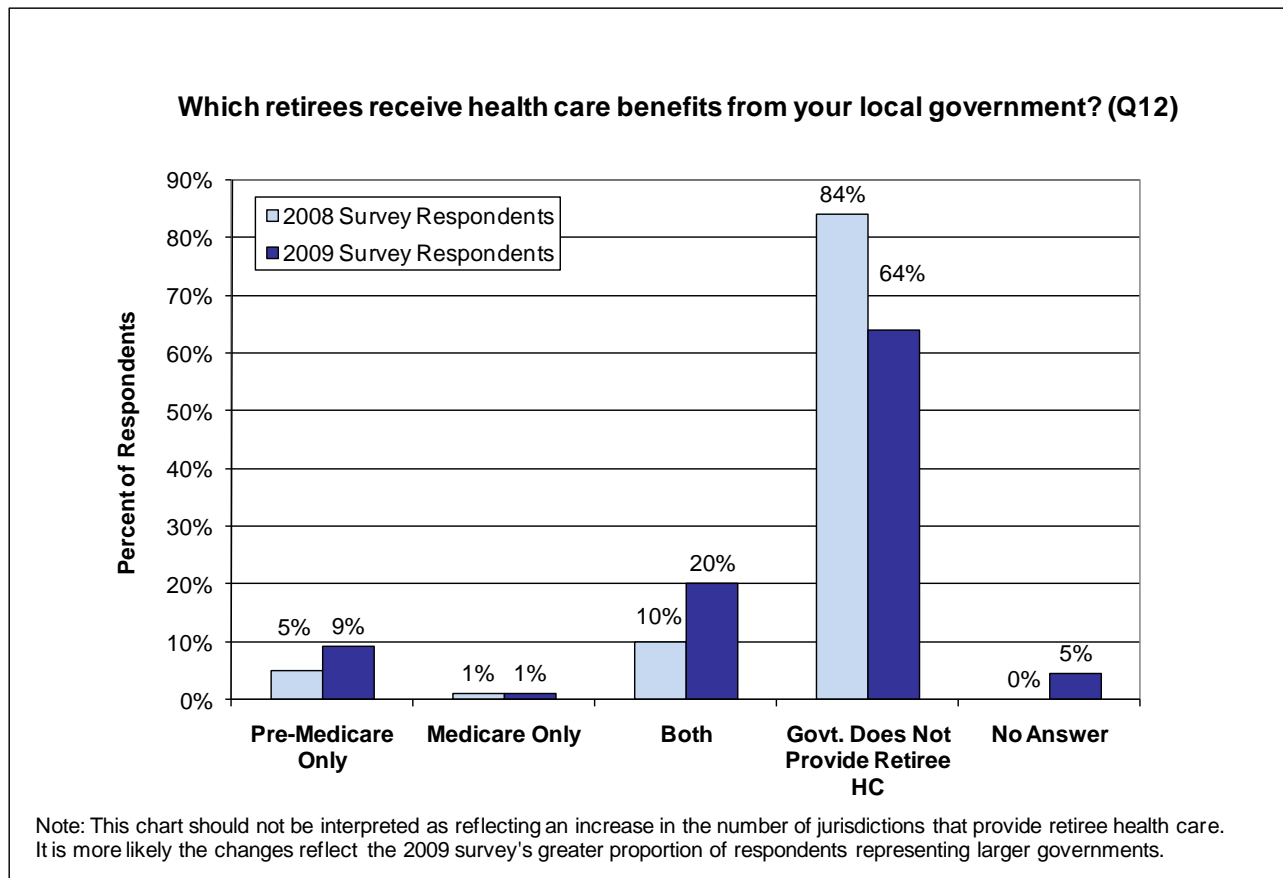
Section 3: Provision of Health Care to Active Employees

For the government respondents that provide health care to active employees, the chart below shows the means of insuring the benefits. Almost half (42%) are fully insured through a commercial carrier, 16% are self-insured, 10% obtain insurance through their state government, and 16% obtain it through a coalition.



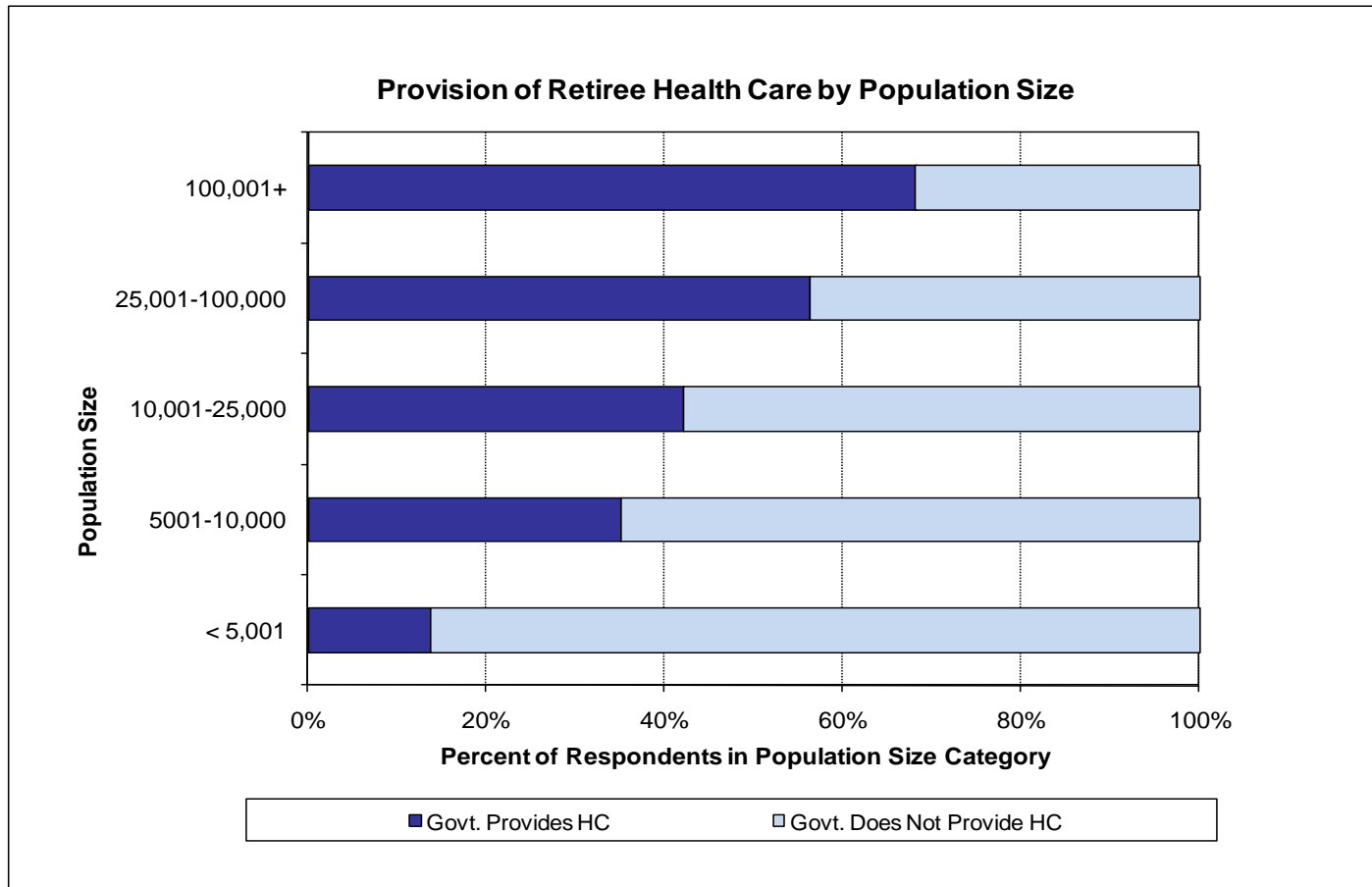
Section 4: Provision of Health Care to Retirees

Another surprising result of the study is the relatively small percentage of respondent governments that provide retiree health care. As shown in the chart below, more than 60% of the respondents do not provide retiree health care. Of the remaining 30% who do, 20% indicate they provide health care to both Medicare-eligible retirees and pre-Medicare eligible retirees. Another 9% provide retiree health care only to pre-Medicare eligible retirees, and 1% provide it only to Medicare-eligible retirees. Note that the increase in respondents providing retiree health care between 2008 and 2009 is likely due to changes in the survey sampling process. See Section 7 for further details.



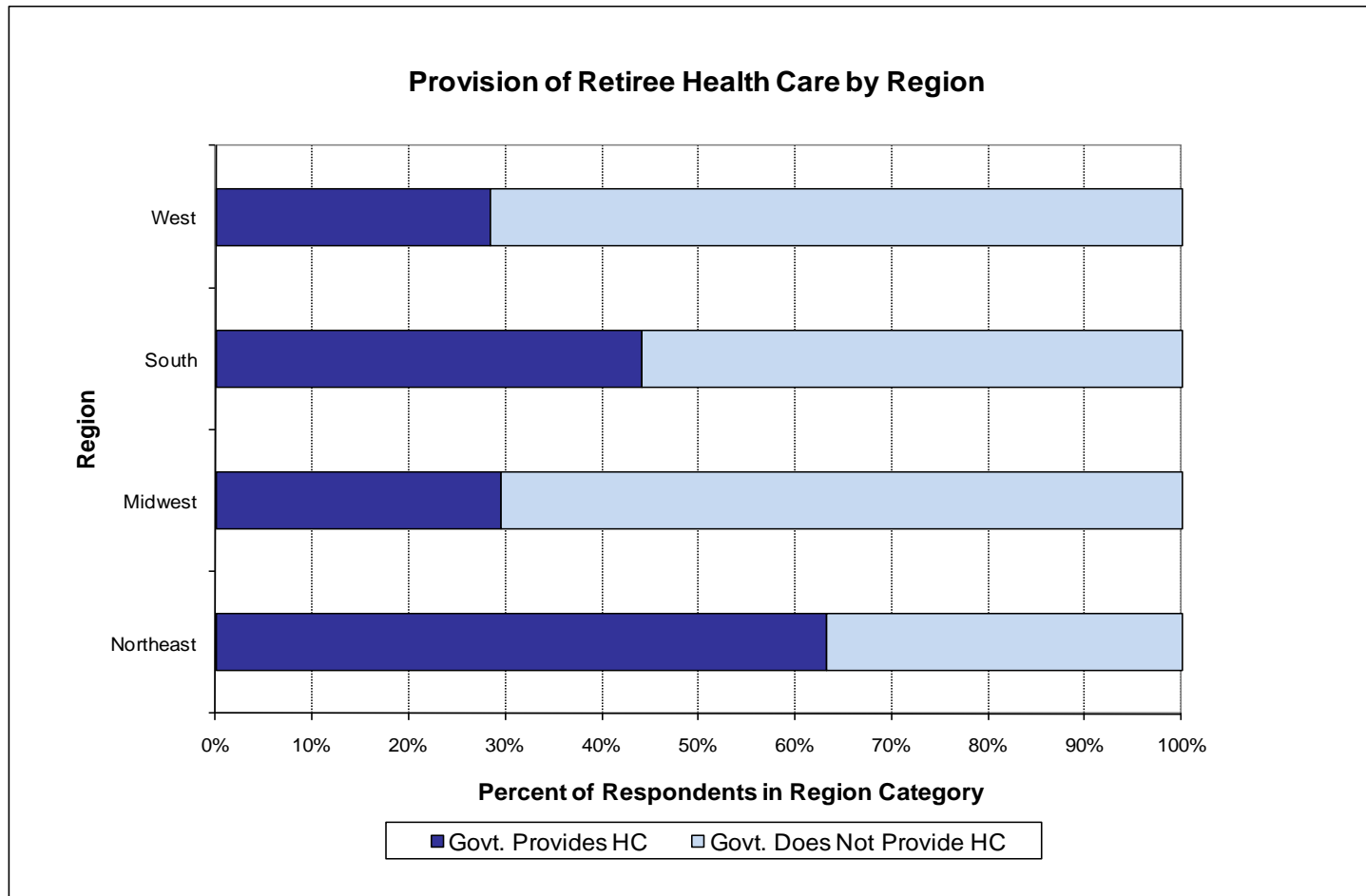
Section 4: Provision of Health Care to Retirees

The chart below shows a clear correlation between the size of the local government (measured by population) and the provision of retiree health care. Over two-thirds of the respondents from governments with populations of more than 100,000 provide retiree health care, compared with about 42% for governments with populations between 10,001 and 25,000 and 35% for governments with populations between 5,001 and 10,000. Only about 15% of the respondents representing governments with populations of 5,000 or less provide retiree health care.



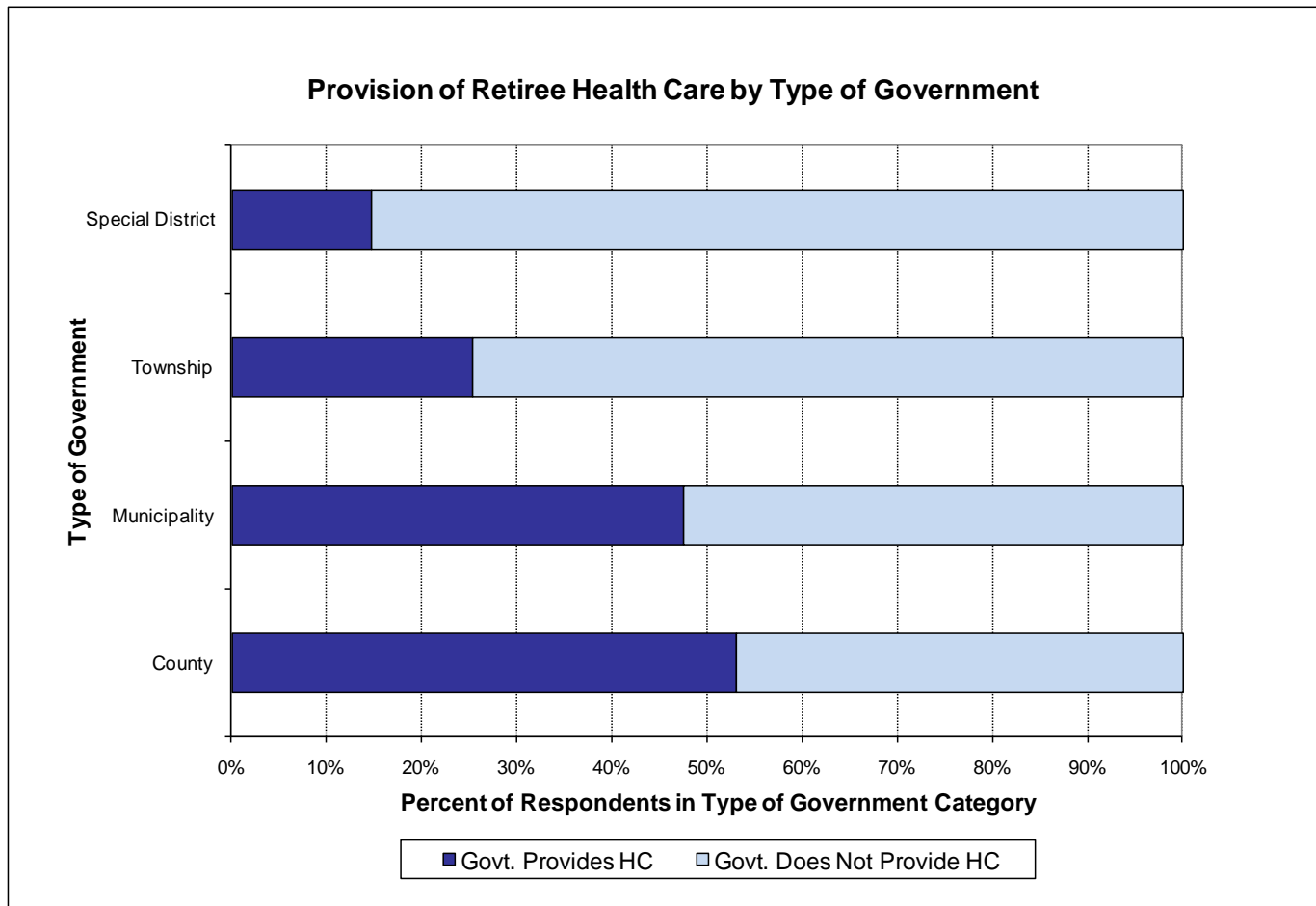
Section 4: Provision of Health Care to Retirees

The chart below shows that a larger percentage of respondents from the Northeast provide retiree health care (63%) than those from the other geographic regions. A smaller percentage of respondents from the West and Midwest provide retiree health care (28% and 29%, respectively). This may have less to do with geographic region than the fact that many of the respondents from the West and Midwest represent governments with populations of 5,000 or less.



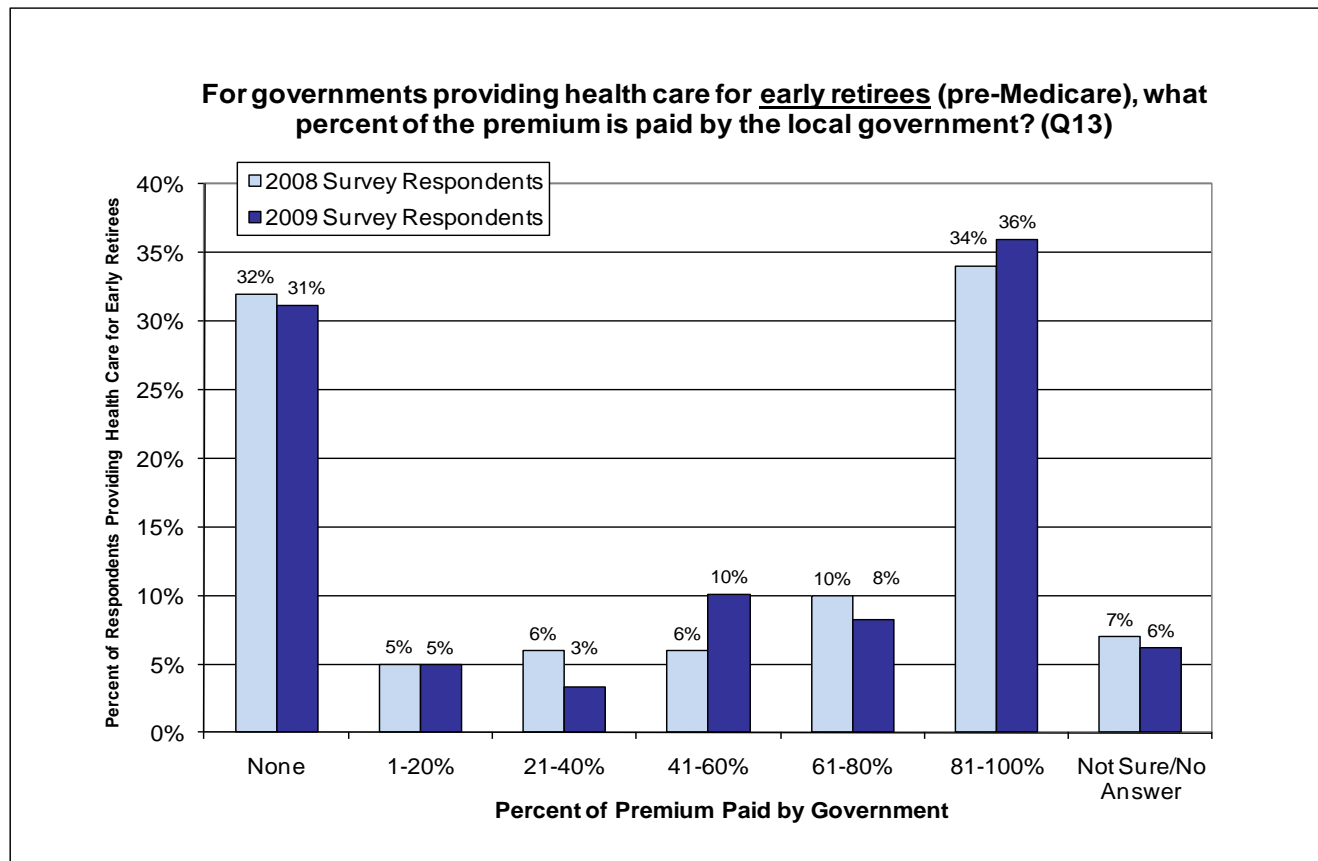
Section 4: Provision of Health Care to Retirees

As was the case with the provision of health care for active employees, county governments are also more likely to offer health care for retirees. The chart below shows, of the respondent county governments, 53% offer health care benefits for retirees. This compares with about 47% for municipalities, 25% for townships, and about 15% for special districts.



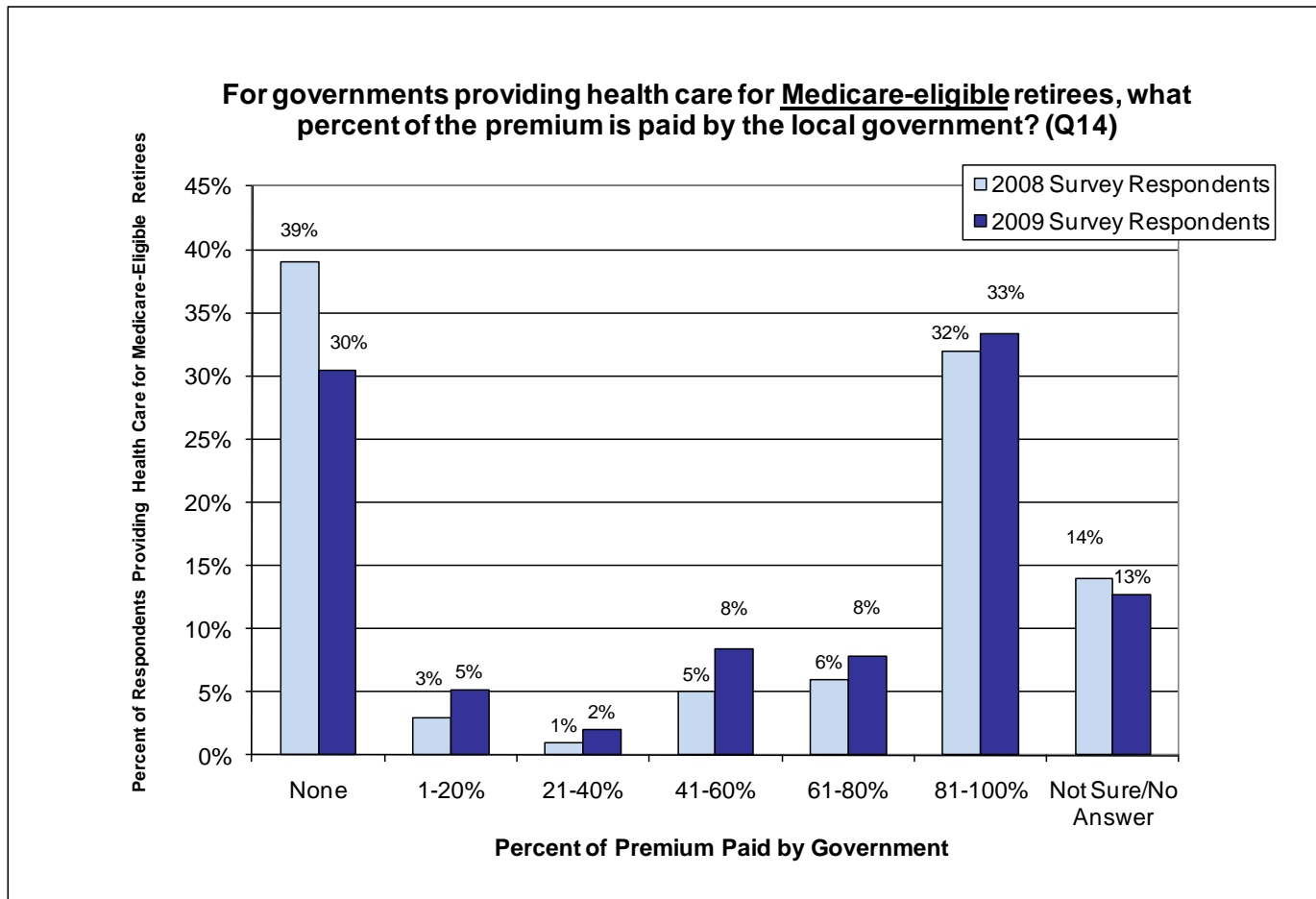
Section 4: Provision of Health Care to Retirees

The chart below shows that, of the respondents offering health care for pre-Medicare eligible retirees, 36% pay between 81% and 100% of the premium, 26% pay some lesser percent of the premium, and 31% pay none of the premium. It is likely that many of the respondent governments paying none of the premium were essentially offering retirees access to active member group health coverage. Thus, they were likely offering what the GASB describes as an “implicit rate subsidy” – that is access to health care coverage at a premium rate that blends active employee and retiree health care costs.



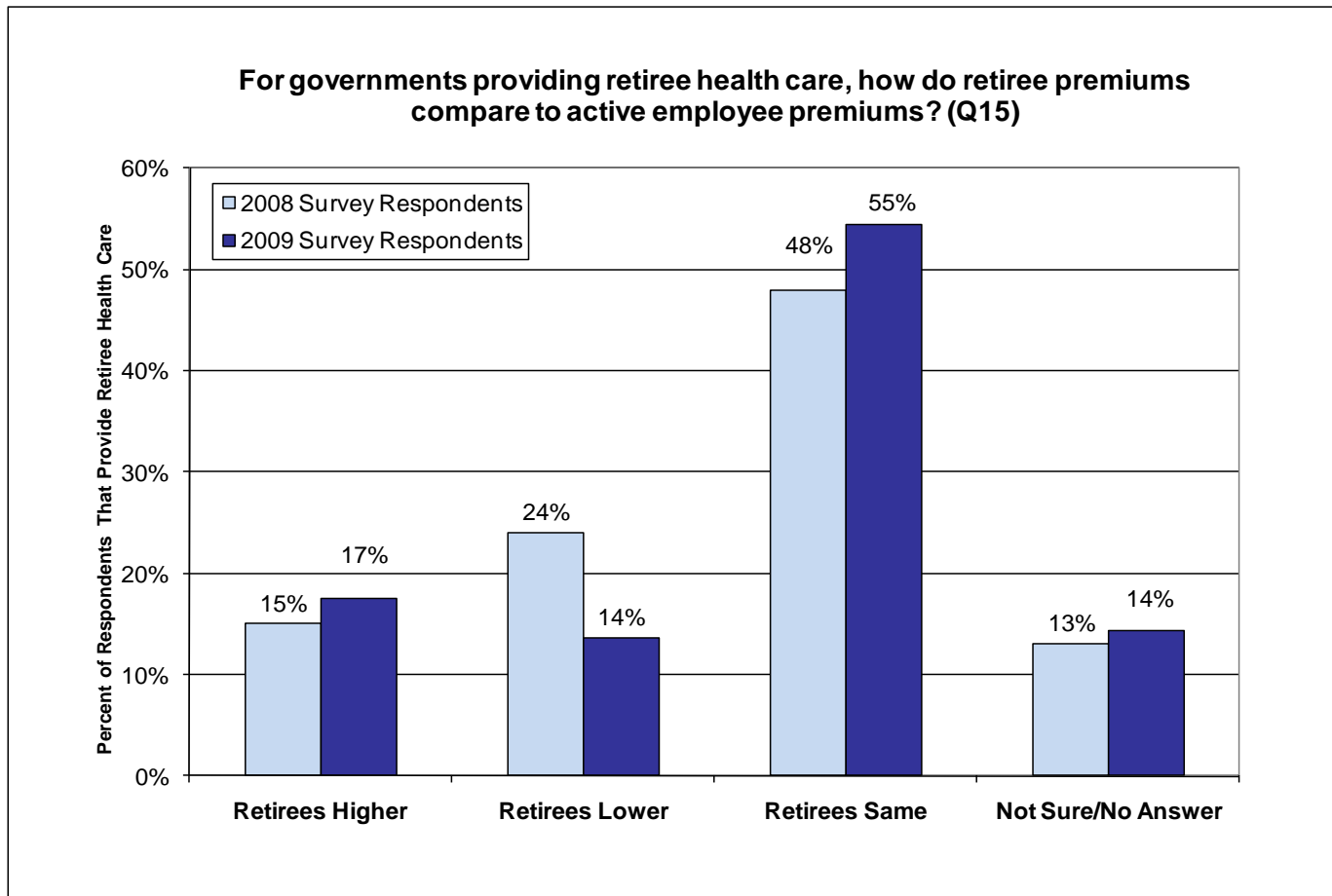
Section 4: Provision of Health Care to Retirees

The chart below shows that, of the respondents offering health care coverage to Medicare-eligible retirees, 33% pay between 81% and 100% of the premium, 23% pay some lower share of the premium, and 30% pay none of the premium. Since insurance companies provide a separate rate for Medicare-eligible retirees, there is little (if any) implicit rate subsidy in these situations.



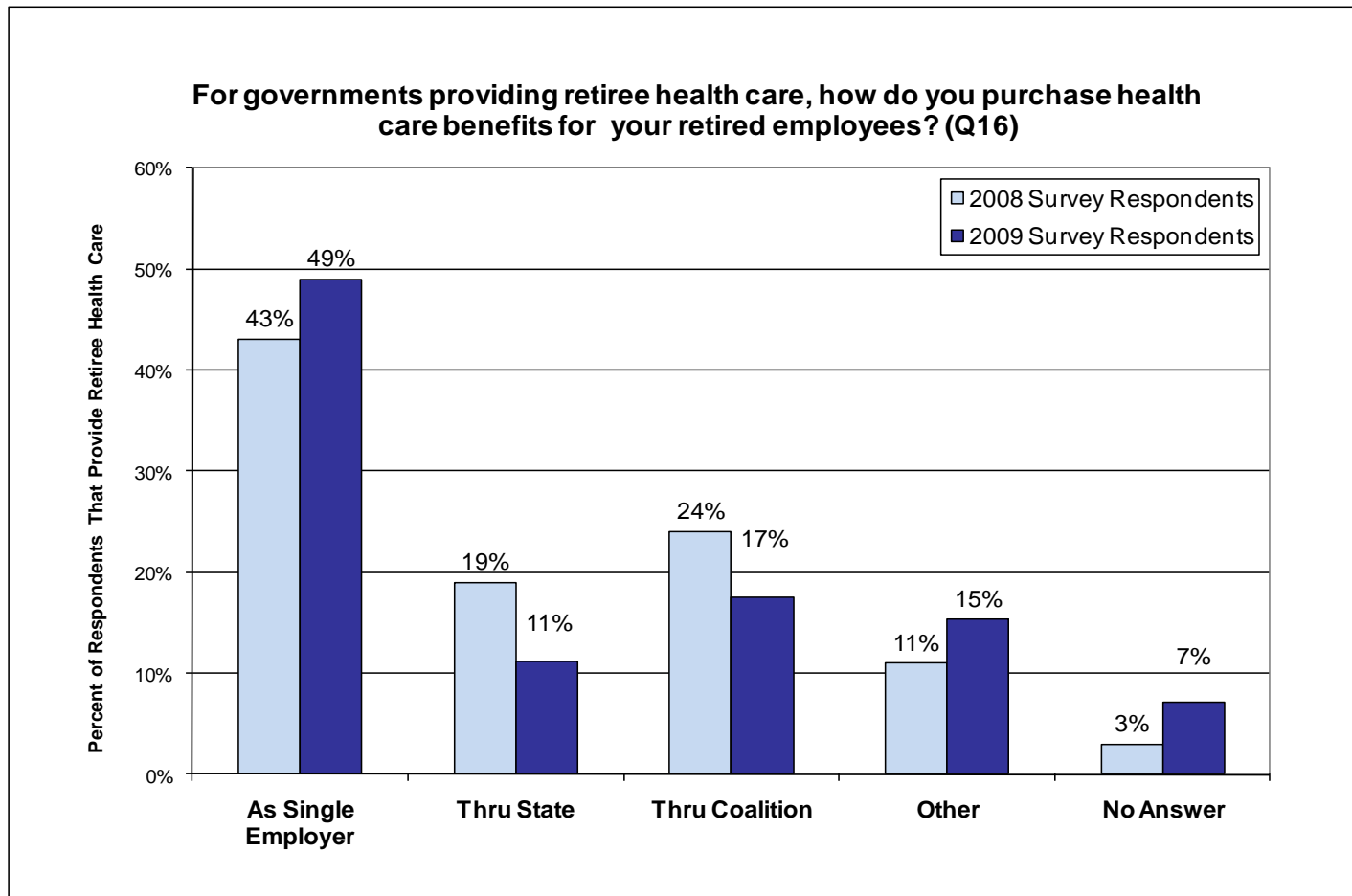
Section 4: Provision of Health Care to Retirees

The chart below shows that retiree health care premiums are the same as active member premiums for over half (55%) of the respondents that offer retiree health care. This supports the conclusion that many governments offering retiree health care do so using a premium rate that blends the costs of active and retired members. Retiree health care premiums are higher than active member premiums for 17% of the respondents and lower than active member premiums for 14% of the respondents.



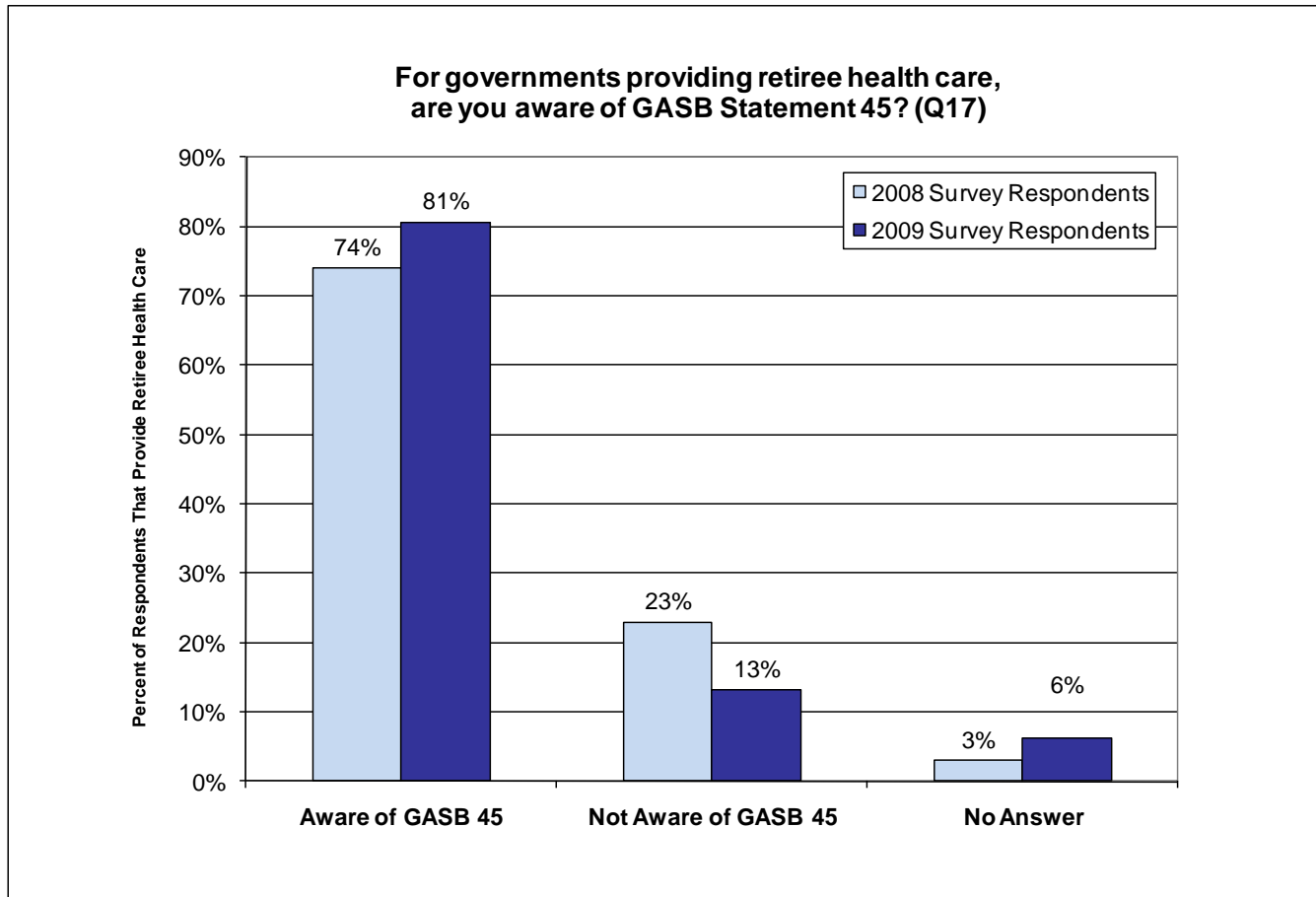
Section 4: Provision of Health Care to Retirees

Many of the respondents providing retiree health care purchased the care as a single employer, rather than through the state or a coalition. Of the respondents providing retiree health care, the chart below shows that 49% purchased it as a single employer, 11% purchased it through the state, 17% through a coalition, and 15% through some other arrangement.



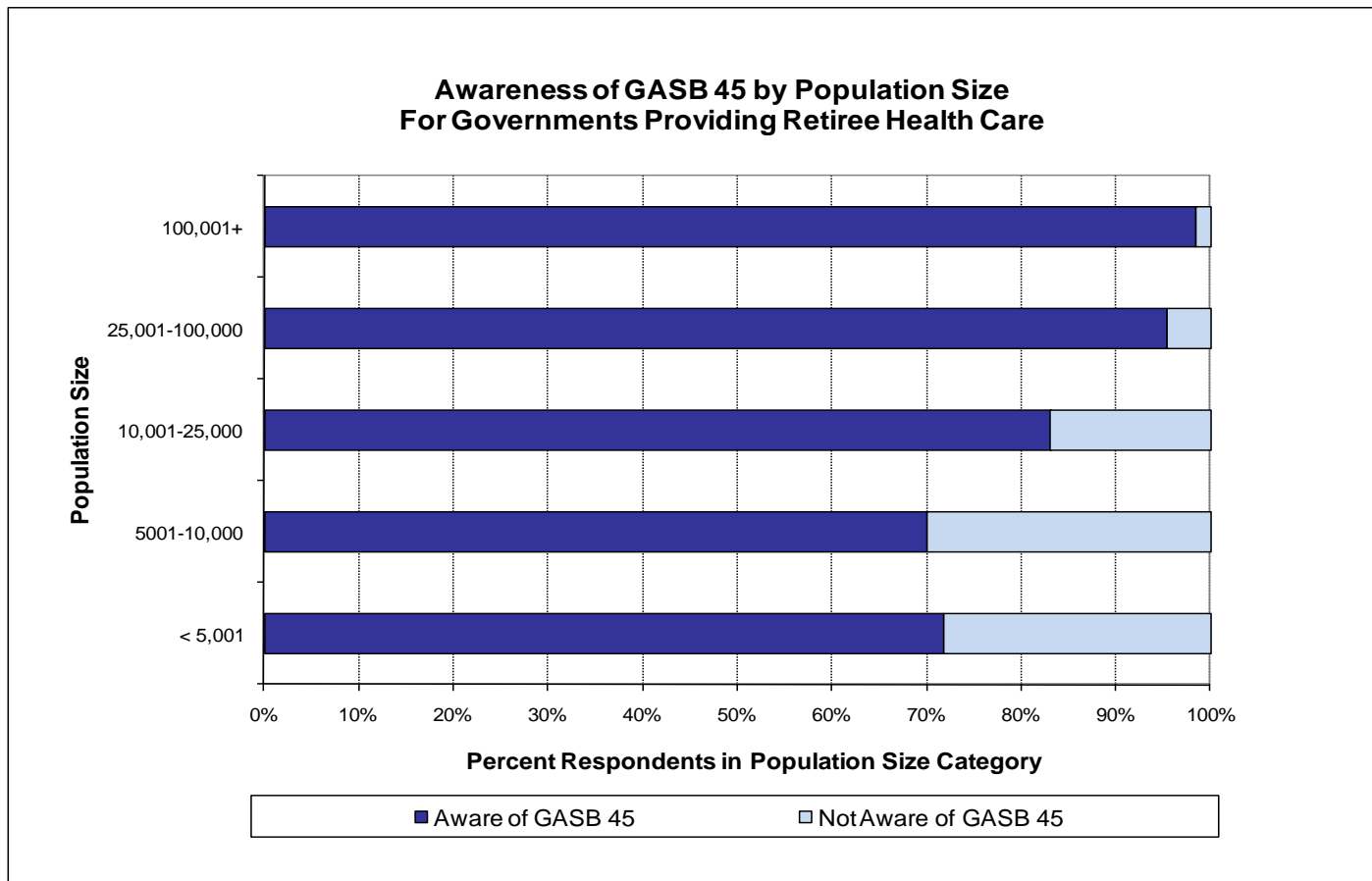
Section 5: Addressing GASB

Another goal of the survey was to determine the extent to which governments that provide retiree health care are aware of the related financial reporting requirements established by the Governmental Accounting Standards Board (GASB) in Statement No. 45. The chart below shows that, of the respondents providing retiree health care, the vast majority (81%) are aware of Statement 45. There was little improvement for local governments with fewer than 25,000 residents. Moreover, as the next slides show, many of the respondents that are not aware of Statement 45 represent smaller governments.



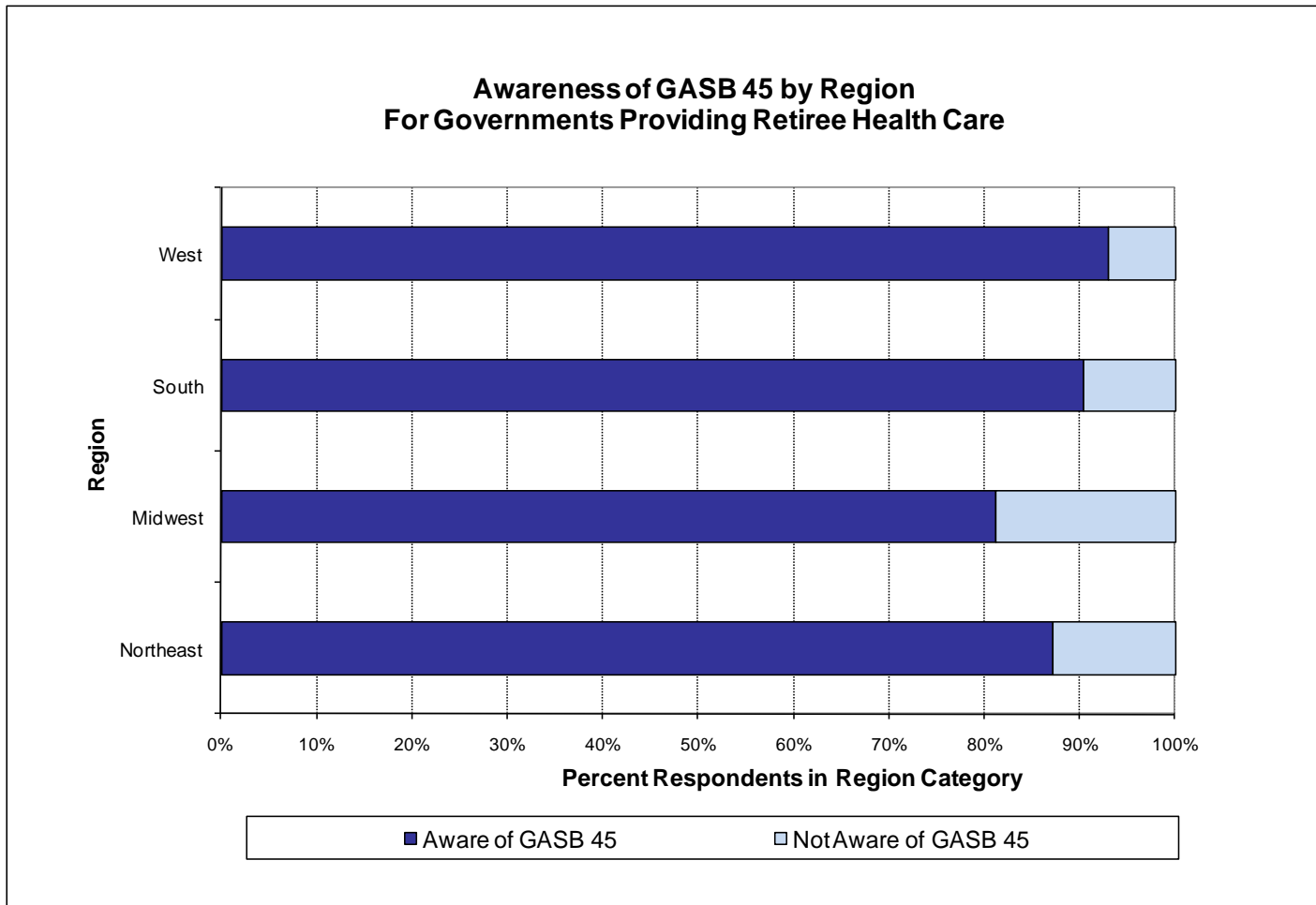
Section 5: Addressing GASB

The chart below compares respondents' awareness of GASB Statement 45 by size of jurisdiction. For respondents from governments with populations of more than 25,000, the vast majority (over 95%) are aware of Statement 45. Additionally, over 70% of the 2009 survey respondents from governments with populations of 10,000 or less are aware of Statement 45. The improvement for governments smaller than 5,000 residents compared to the 2008 survey is from the sampling change that filtered out communities with fewer than 1,500 residents.



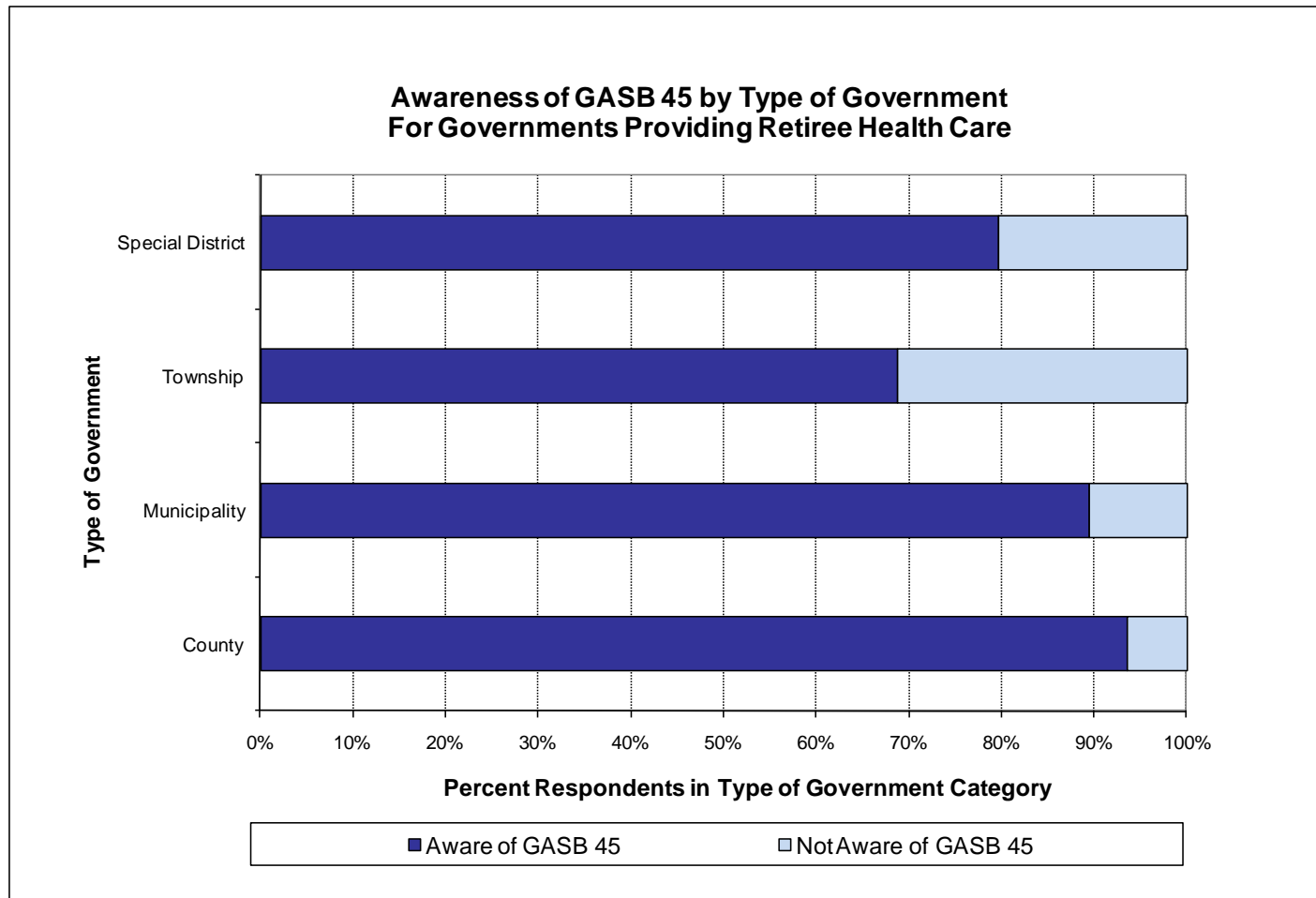
Section 5: Addressing GASB

The chart below shows that awareness of GASB Statement 45 does not vary much by major geographic region. Across all regions, between 80% and 95% of respondent governments offering retiree health care are aware of GASB Statement 45.



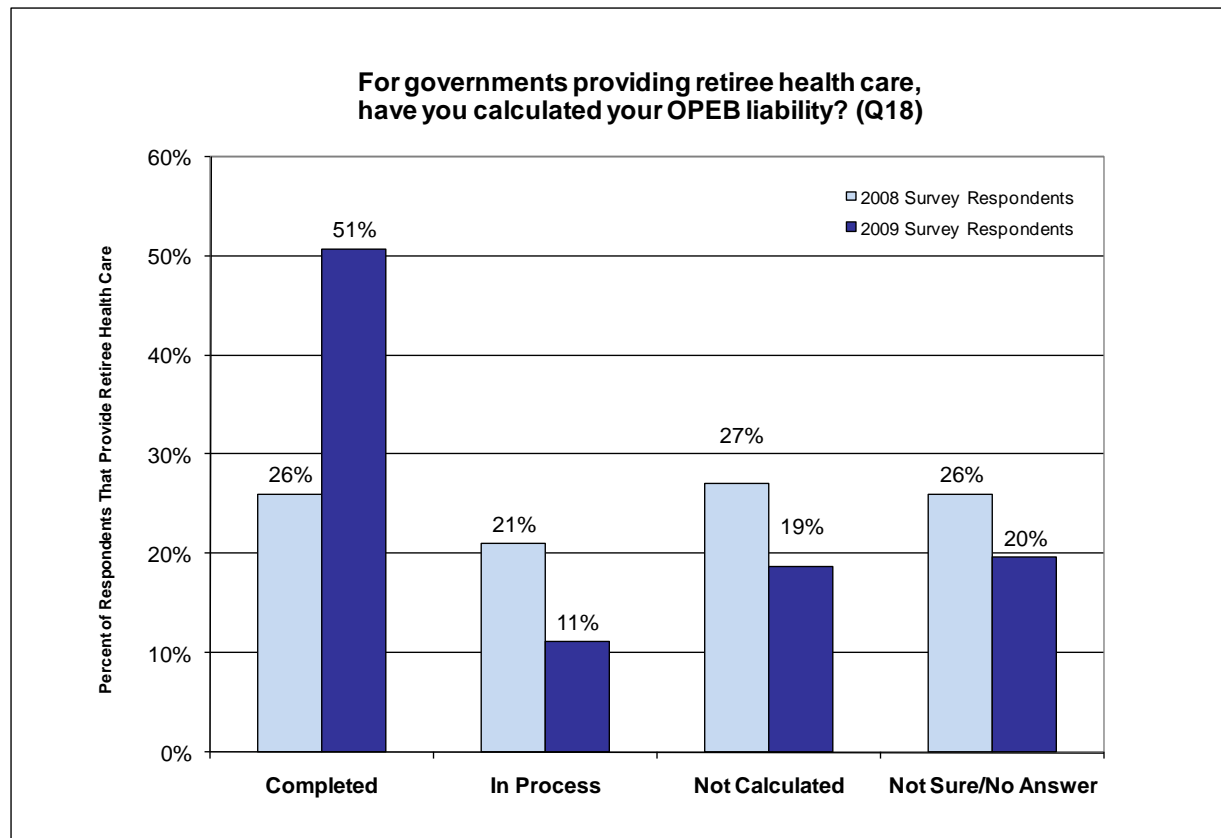
Section 5: Addressing GASB

The chart below shows that at least 90% of respondents from county and municipal governments that provide retiree health care are aware of Statement 45. However, less than 70% of respondents from townships are so aware.



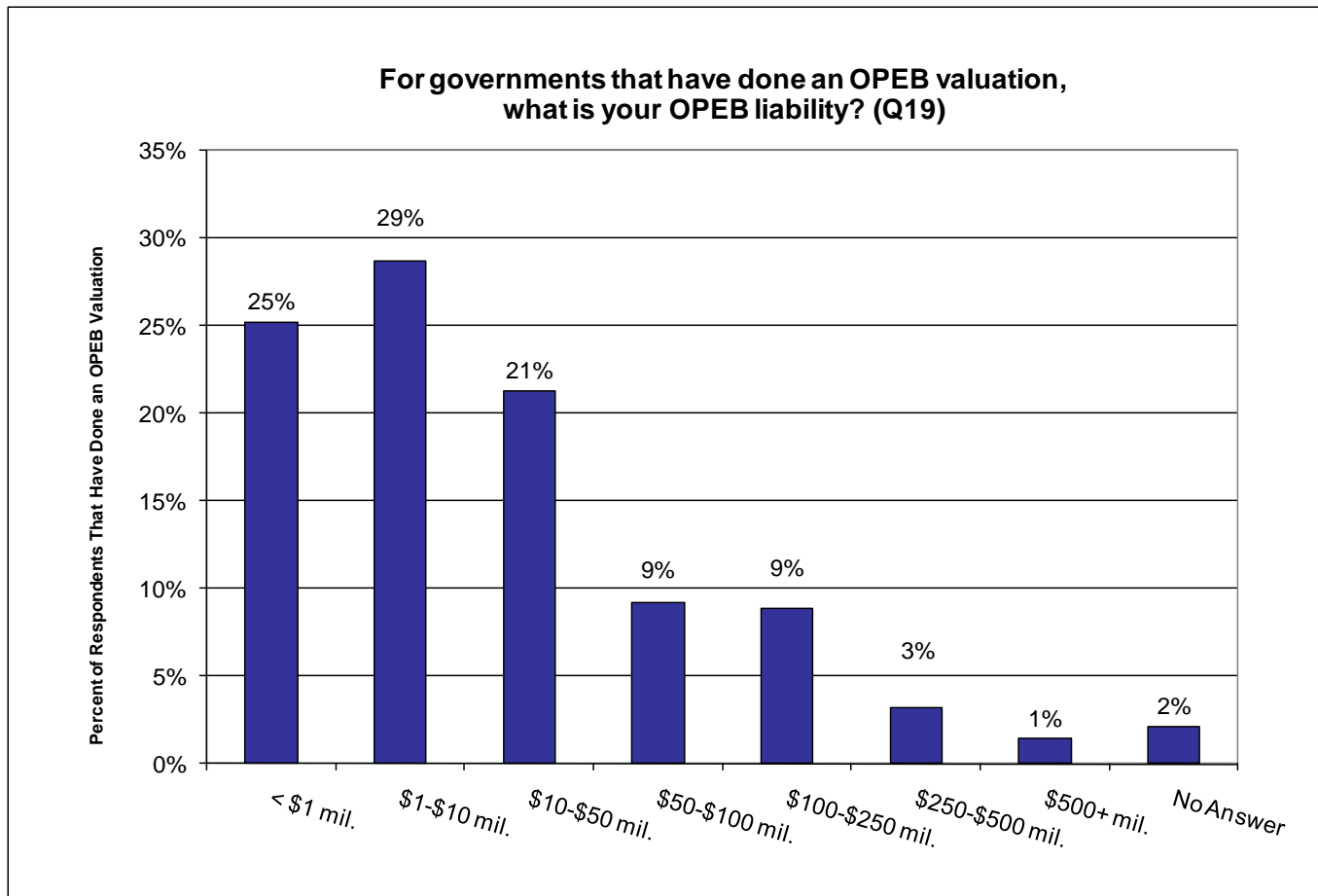
Section 5: Addressing GASB

Another focus of the survey was to examine the extent to which local governments that offer retiree health care have taken steps to calculate their related other postemployment benefit (OPEB) liability. The chart below shows that, of the respondents offering retiree health care, 51% have calculated their OPEB liability and another 11% are in the process of calculating it. Another 19% have not calculated it; however, these generally represent the “Phase 3” governments, who are required to report the OPEB calculations in their financial statements for periods beginning after December 15, 2008. A significant portion of the respondents (20%) providing retiree health care were not sure or did not respond to this question.



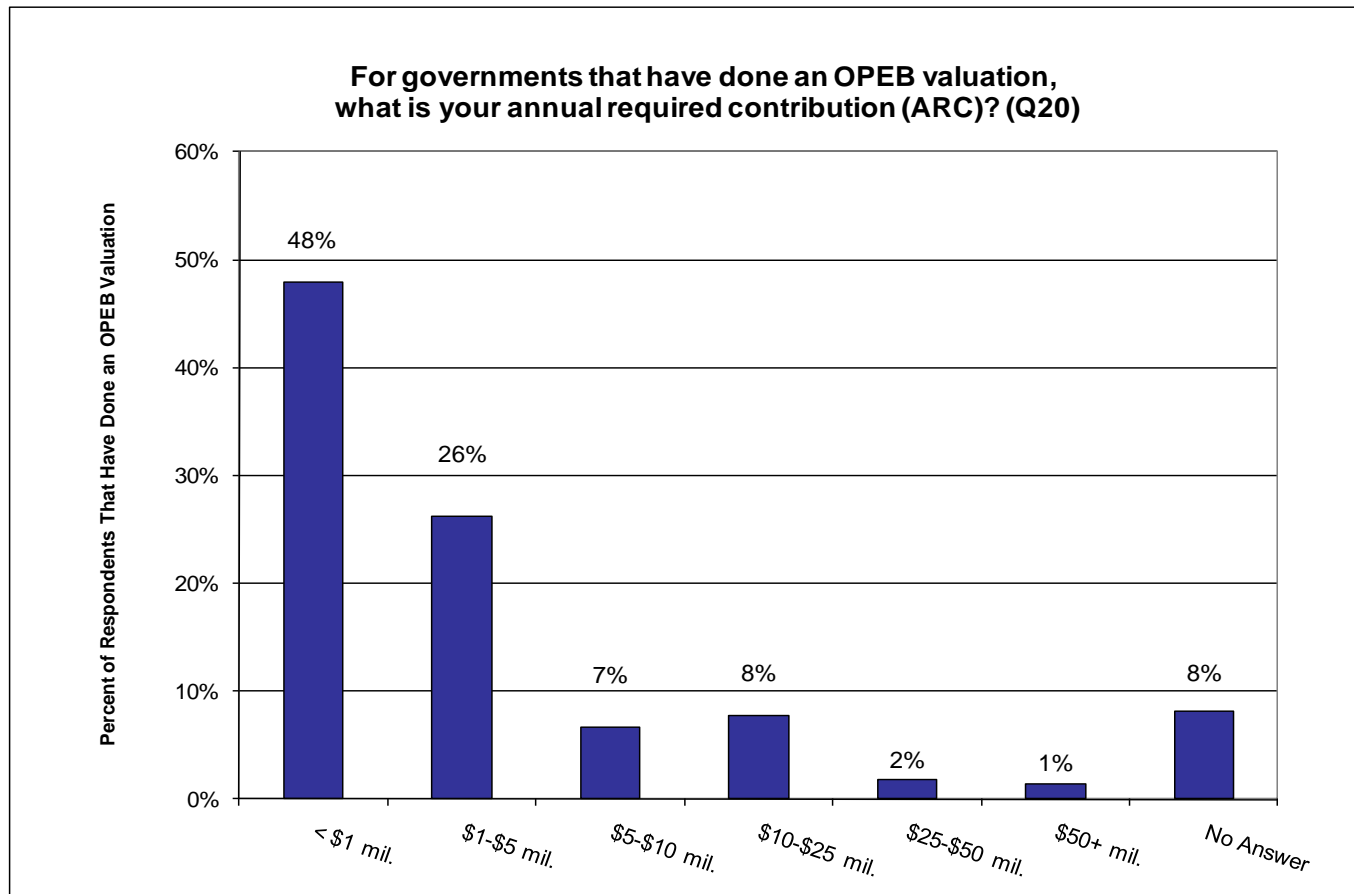
Section 5: Addressing GASB

Of the respondents that have calculated their OPEB liability, the chart below shows that the majority (54%) have liabilities of less than \$10 million. This reflects the fact that many of the respondents represent smaller local governments. However, 13% of the respondents that have done an OPEB valuation have liabilities of at least \$100 million.



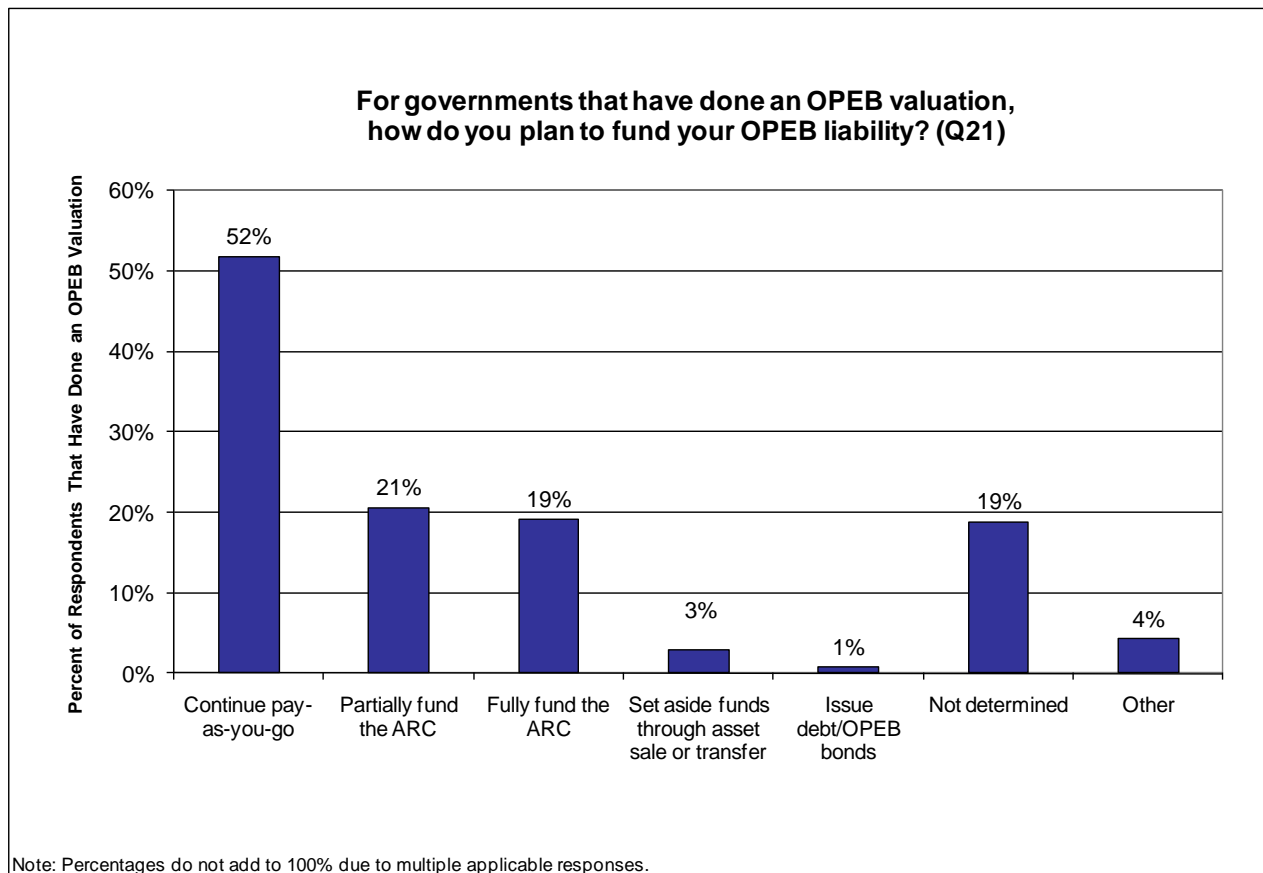
Section 5: Addressing GASB

The chart below shows that, for the majority of respondents (74%) that have calculated their OPEB liability, the annual required contribution (ARC) related to retiree health care benefits is \$5 million or less. Again, this reflects the fact that the respondents generally represent smaller governments.



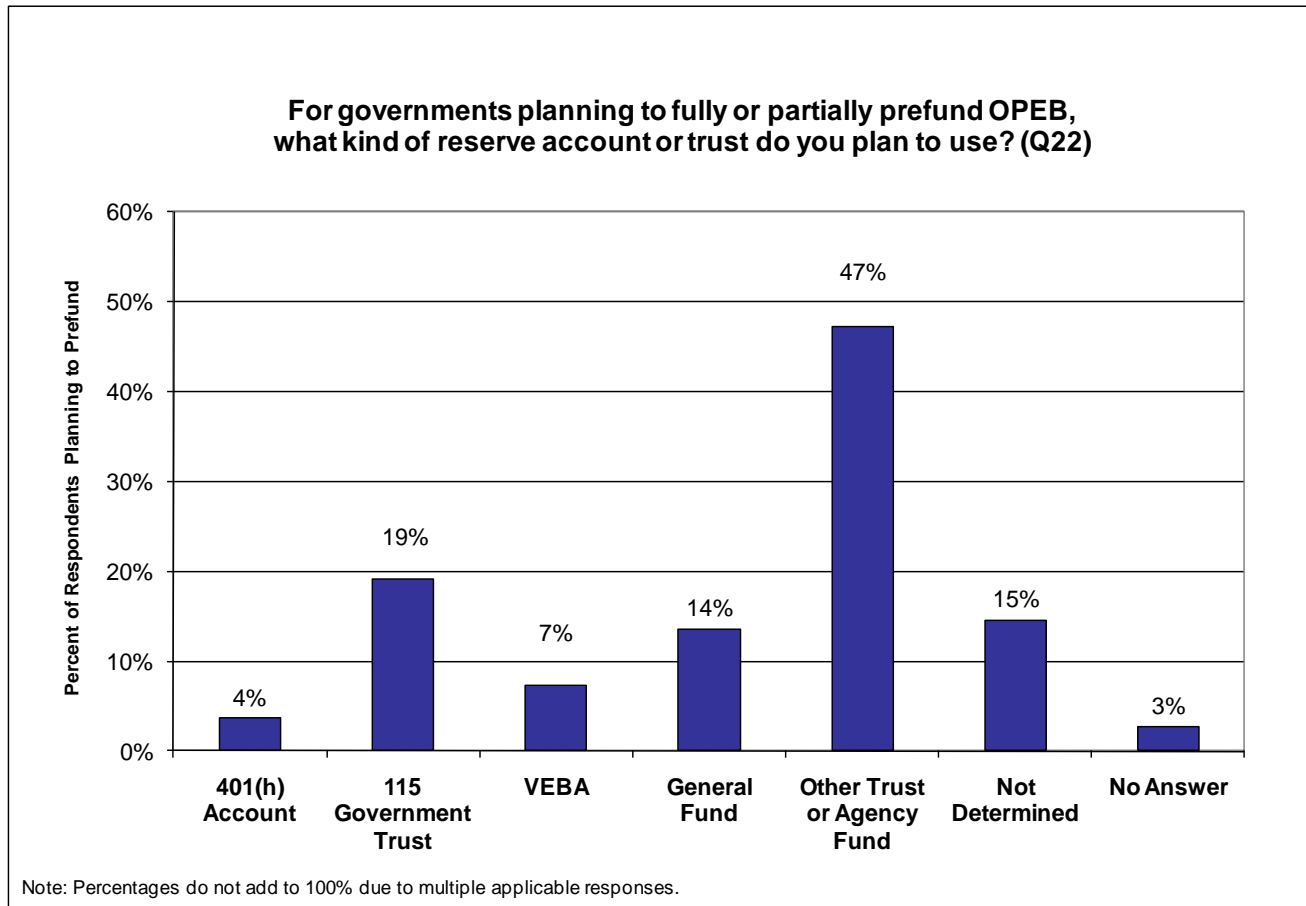
Section 5: Addressing GASB

For respondent governments that have actuarially valued their OPEB benefits, there are several approaches to financing the OPEB liability. The chart below shows that 52% indicated they would not pre-fund, but rather continue the pay-as-you-go approach. Only 19% indicated they would fully fund their annually required contribution (ARC), and another 21% indicated they would partially prefund the benefits. Another 19% indicated they had not yet determined their approach to funding. Interestingly, only one percent of the respondents indicated they plan to issue OPEB bonds to prefund the liability.



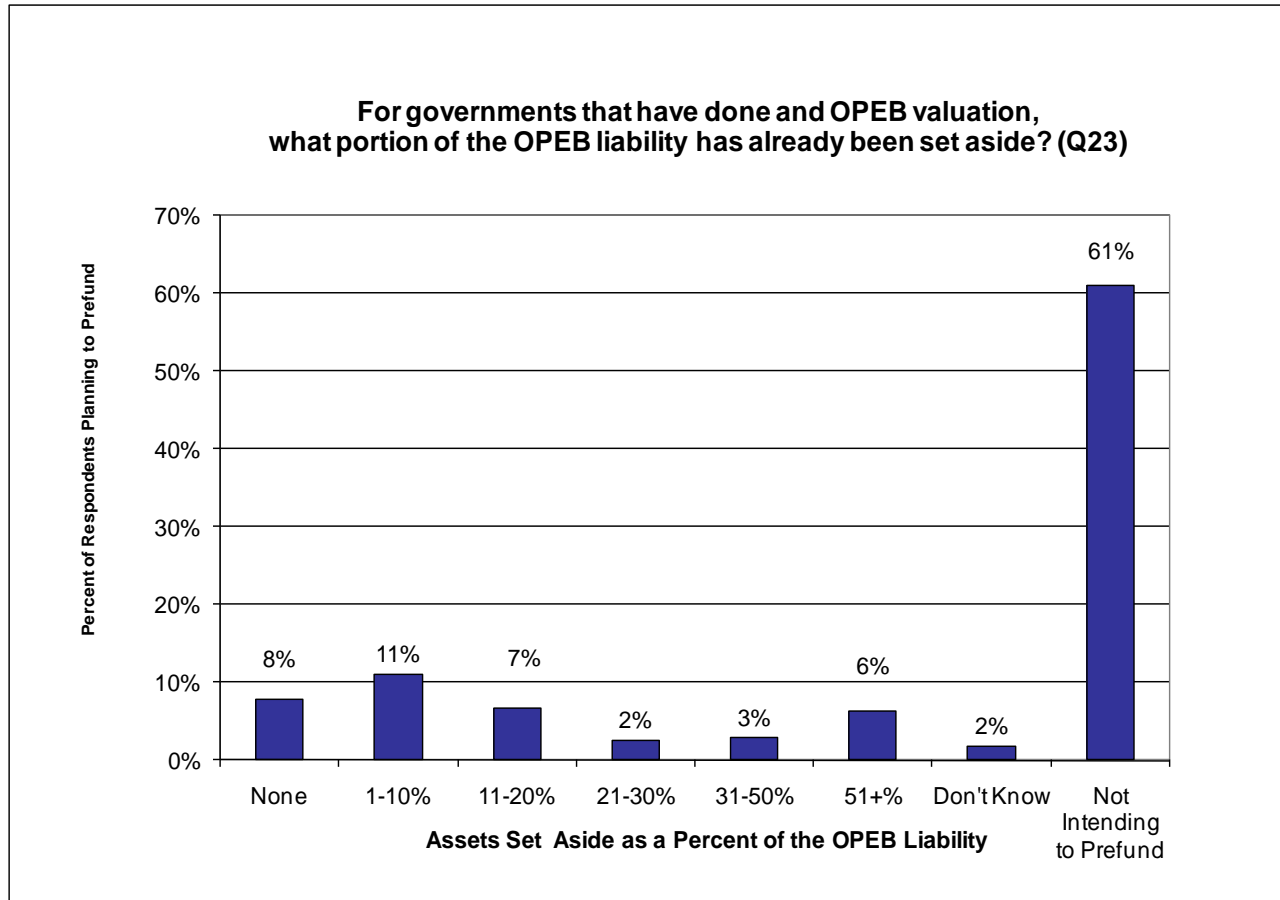
Section 5: Addressing GASB

As shown on the previous page, 40% of the respondents that provide retiree health care have decided to fully or partially prefund the OPEB liability. The chart below shows that of these, 47% expect to rely on the general fund or an agency fund as the funding vehicle. In addition, 30% are planning to put funds into a separate trust, established either as a voluntary employees' beneficiary association (VEBA), a governmental trust established under section 115 of the Internal Revenue Code, or a 401(h) account within the pension plan.



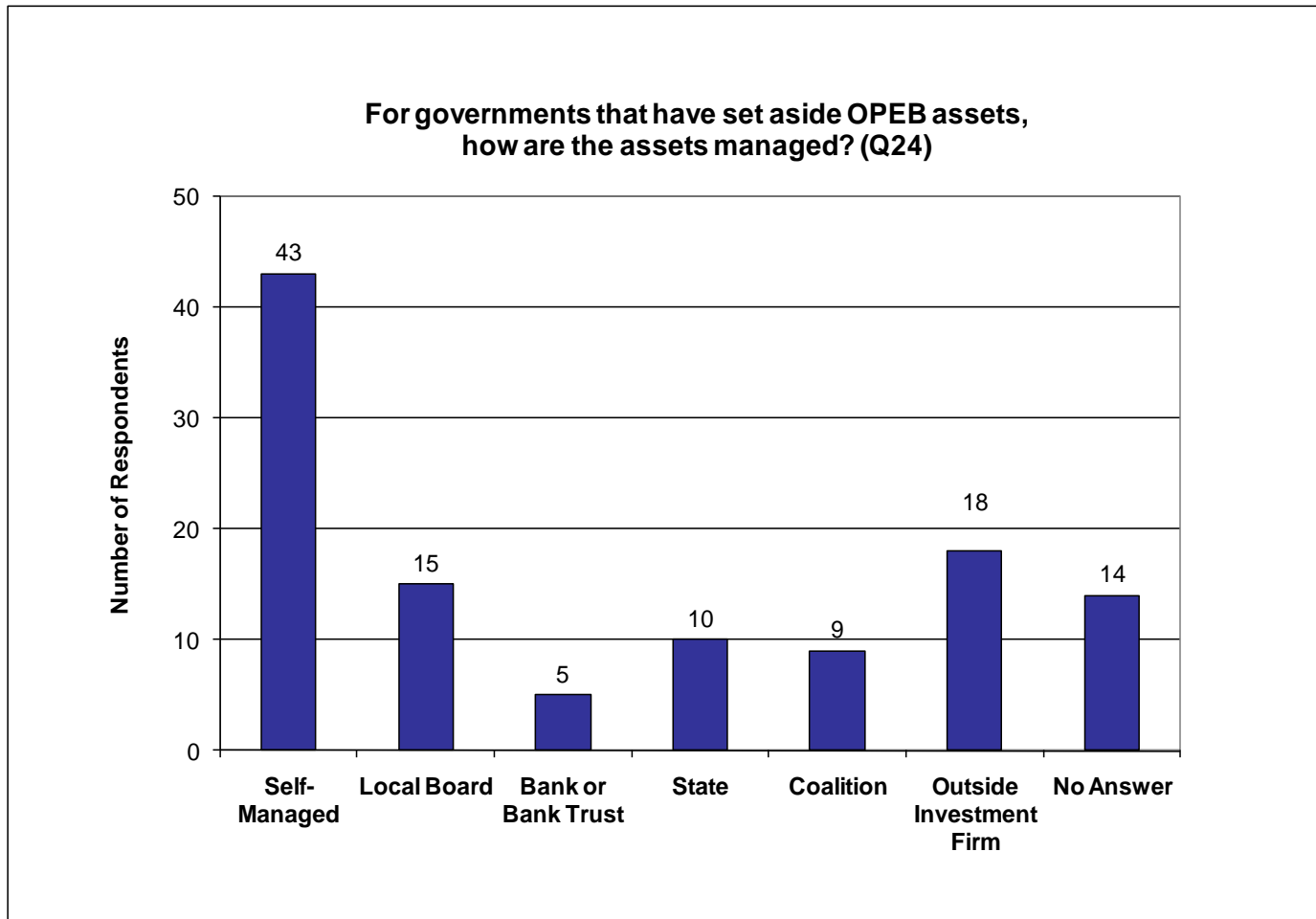
Section 5: Addressing GASB

With regard to setting aside assets to prefund the OPEB liability, of the respondents that have done an OPEB valuation, 29% indicated that they had set assets aside. The chart below shows that 11% reported accumulating less than 10% of the assets currently needed to fund the liability and 6% reported accumulating more than 50% of the assets needed to fund the liability. Over half (61%) of the respondents that have done an OPEB valuation do not intend to prefund the benefits.



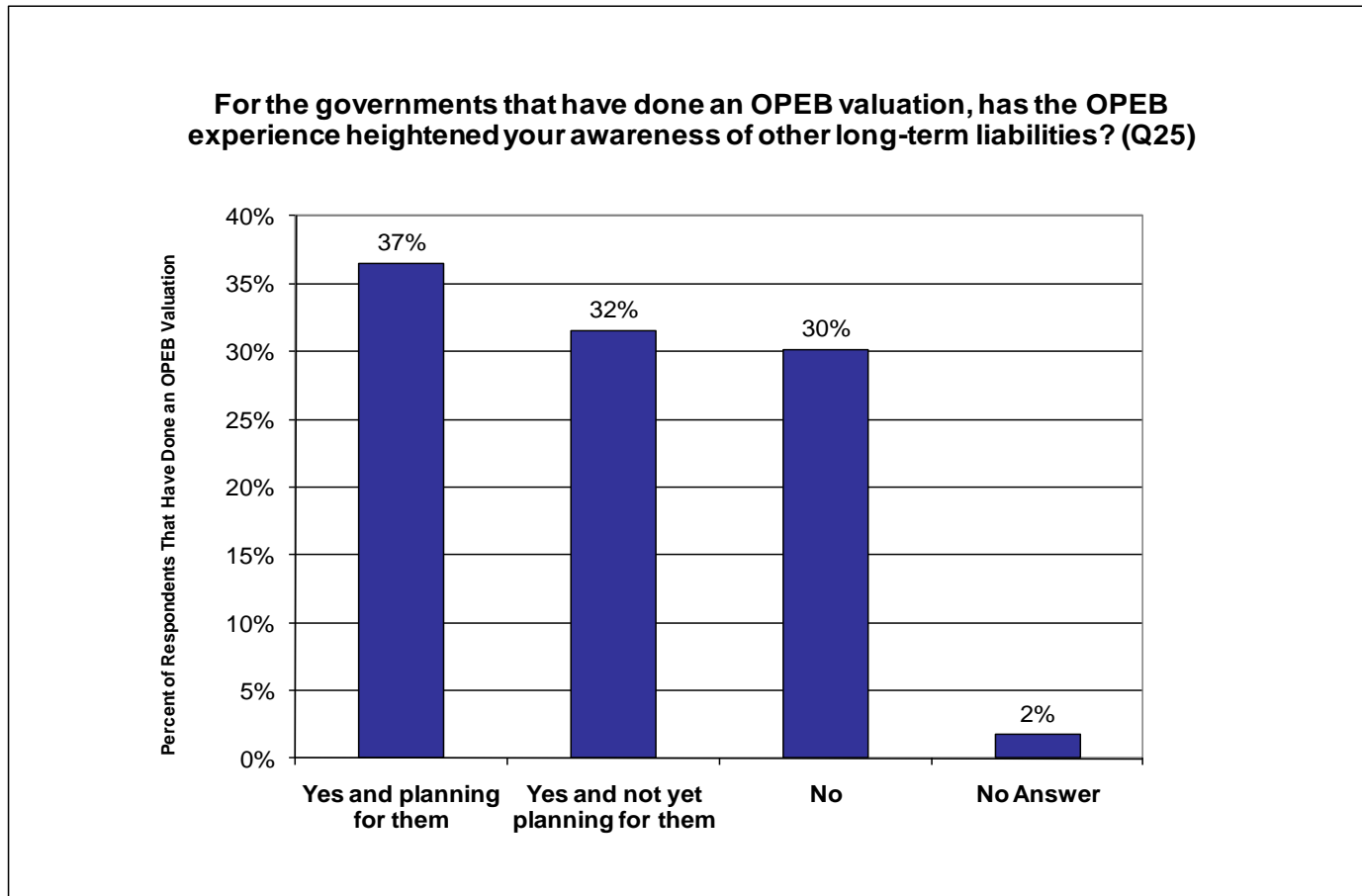
Section 5: Addressing GASB

For governments that have set aside OPEB assets, the chart below suggests that the assets are largely self-managed. However, the responses to this question were limited and so the results may not reflect general practice.



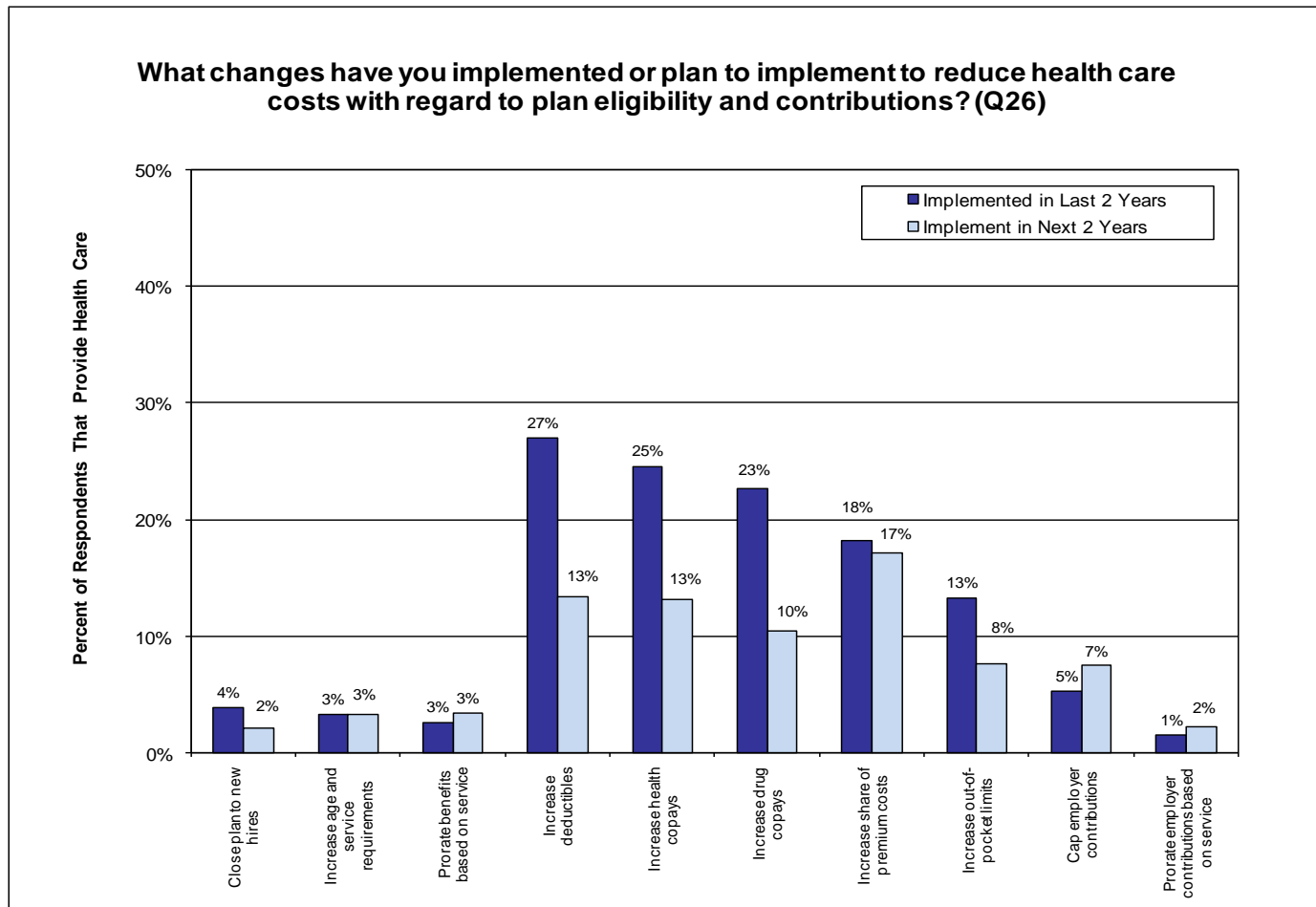
Section 5: Addressing GASB

The chart below shows the extent to which the respondents' experience with retiree health care and GASB's OPEB standards has heightened their awareness of other long-term liabilities. Of the respondents who have done an OPEB valuation, 37% indicated the experience has heightened their awareness of other long-term liabilities to the extent that they have begun planning for them. For another 32%, the experience has heightened awareness, but the governments have not yet begun planning for them. For another 30%, the experience has heightened awareness, but the governments have not yet begun planning for them. For another 2%, the experience has heightened awareness, but the governments have not yet begun planning for them.



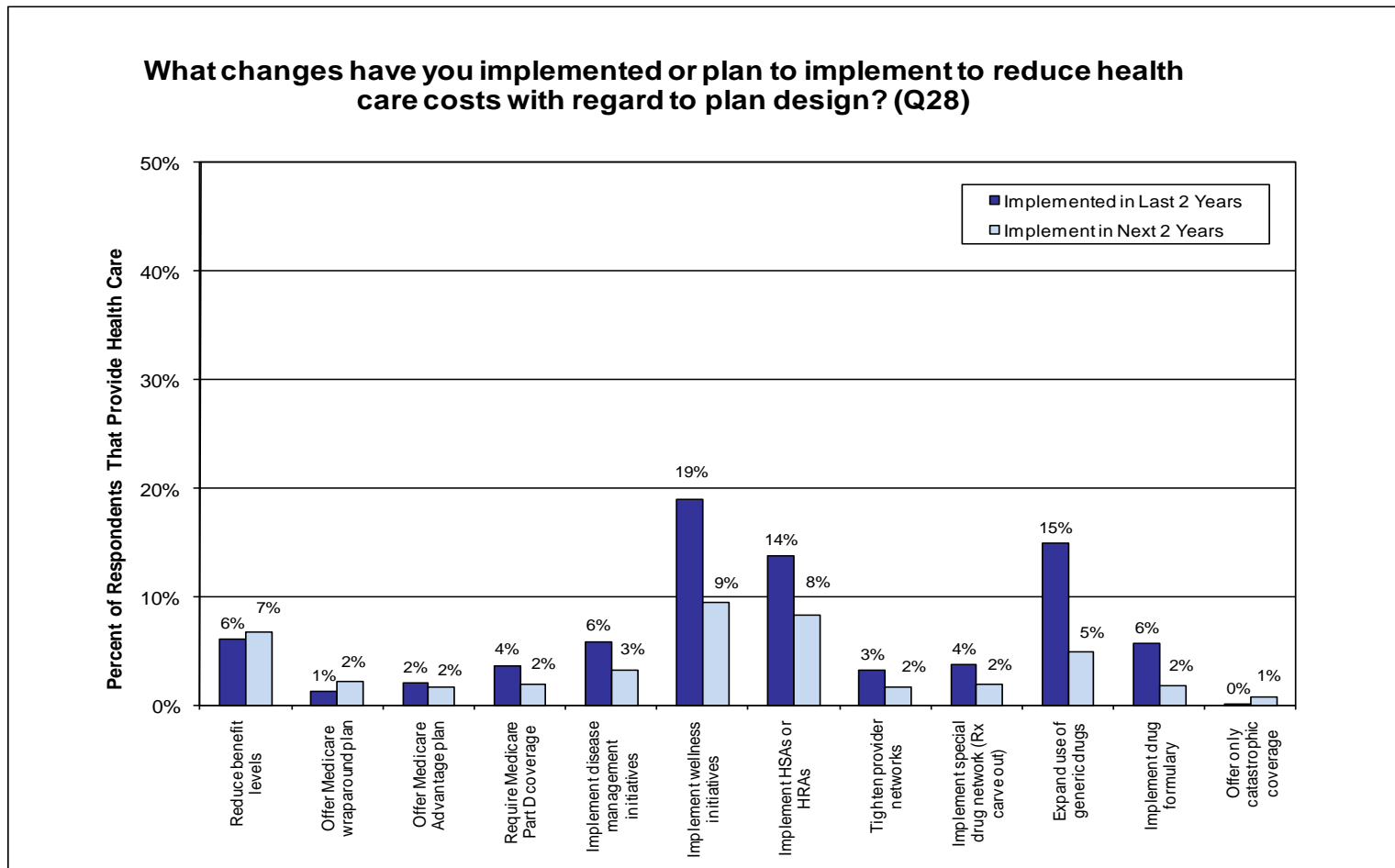
Section 6: Health Care Strategies

The final goal of the survey was to examine various approaches to controlling health care costs that have been implemented by governments during the past two years or are expected to be implemented over the next two years. The chart below shows potential approaches related to changes in plan eligibility requirements or employee/retiree cost sharing. Many of the respondents indicated they implemented increases in deductibles, increases in health and drug co-pays, and increases in the members' share of premium costs during the past two years. Interestingly, a noticeably smaller percentage expect to implement such changes over the next two years. (Note: changes made more than two years ago and are not reflected in the survey data.)



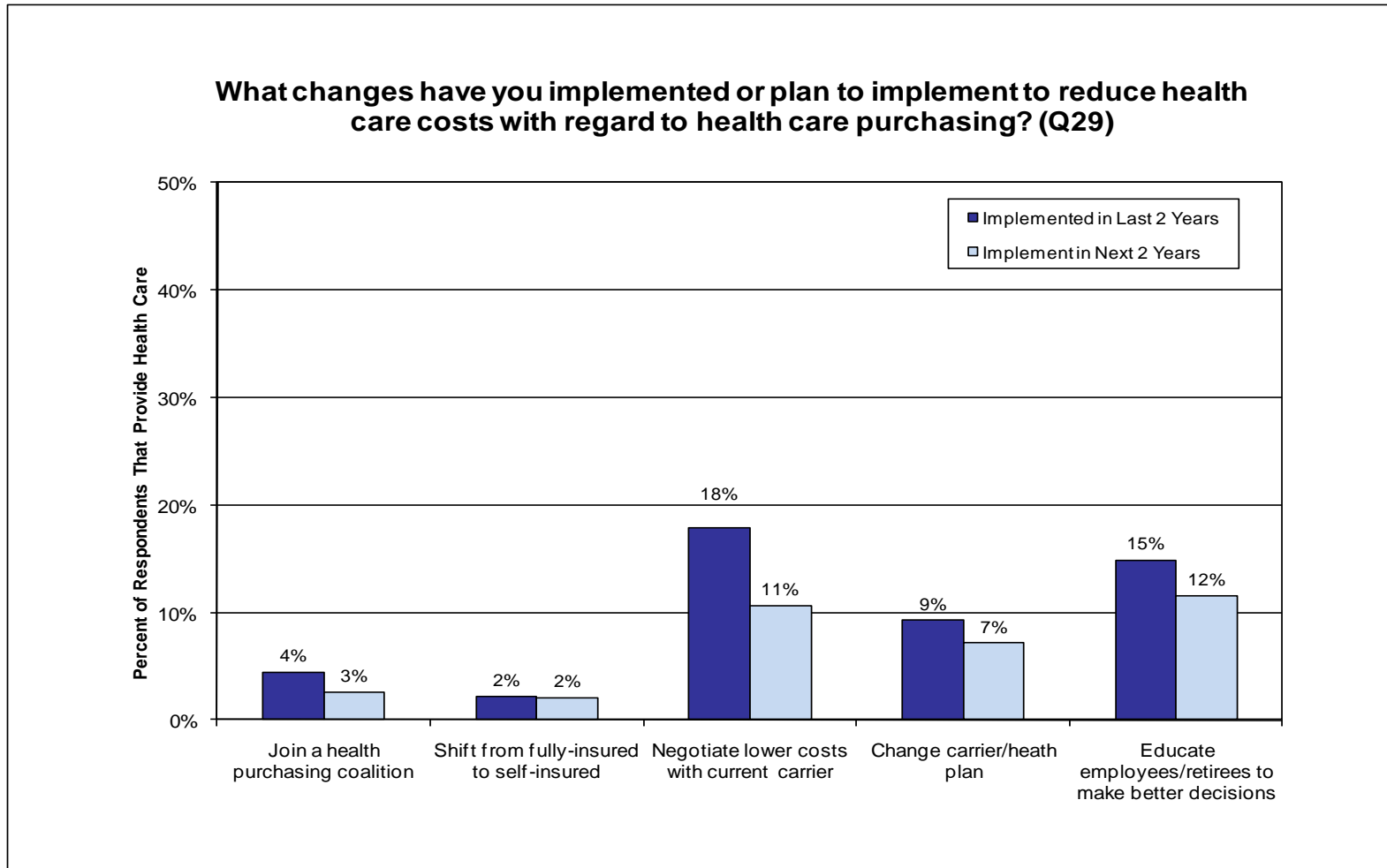
Section 6: Health Care Strategies

The chart below shows various changes in health care plan design made over the past two years or planned over the next two years. Of these, the most frequent changes over the past two years include: implementing wellness initiatives, expanding the use of generic drugs, and implementing health savings accounts (HSAs) or health reimbursement arrangements (HRAs). A smaller percentage expect to implement such changes over the next two years.



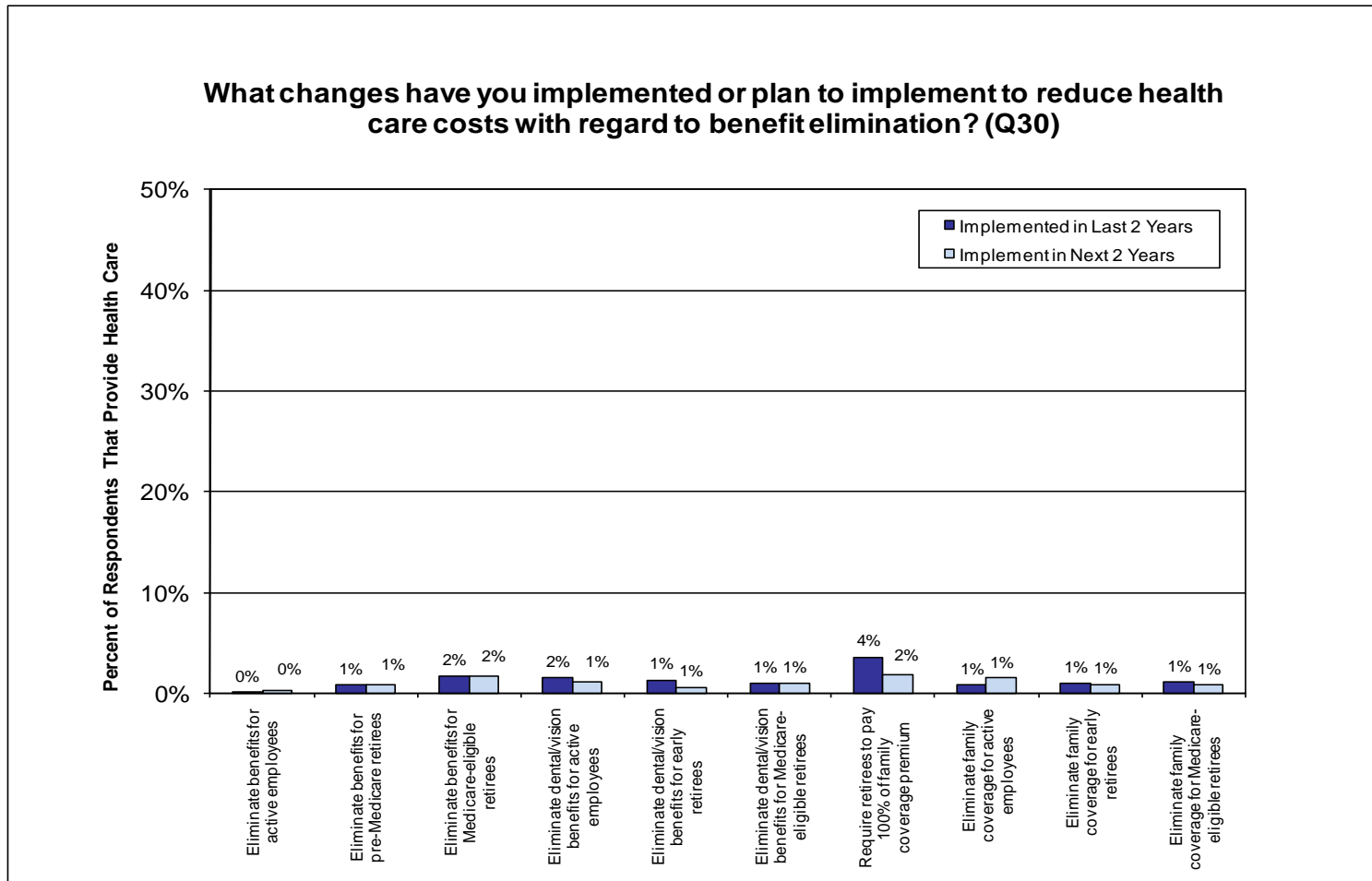
Section 6: Health Care Strategies

The chart below shows health care purchasing changes that have been implemented over the past two years or are planned for the next two years. The changes that stand out include negotiating lower costs with the current carrier, changing the current carrier or health plan, and educating employees/retirees to make better health care decisions.



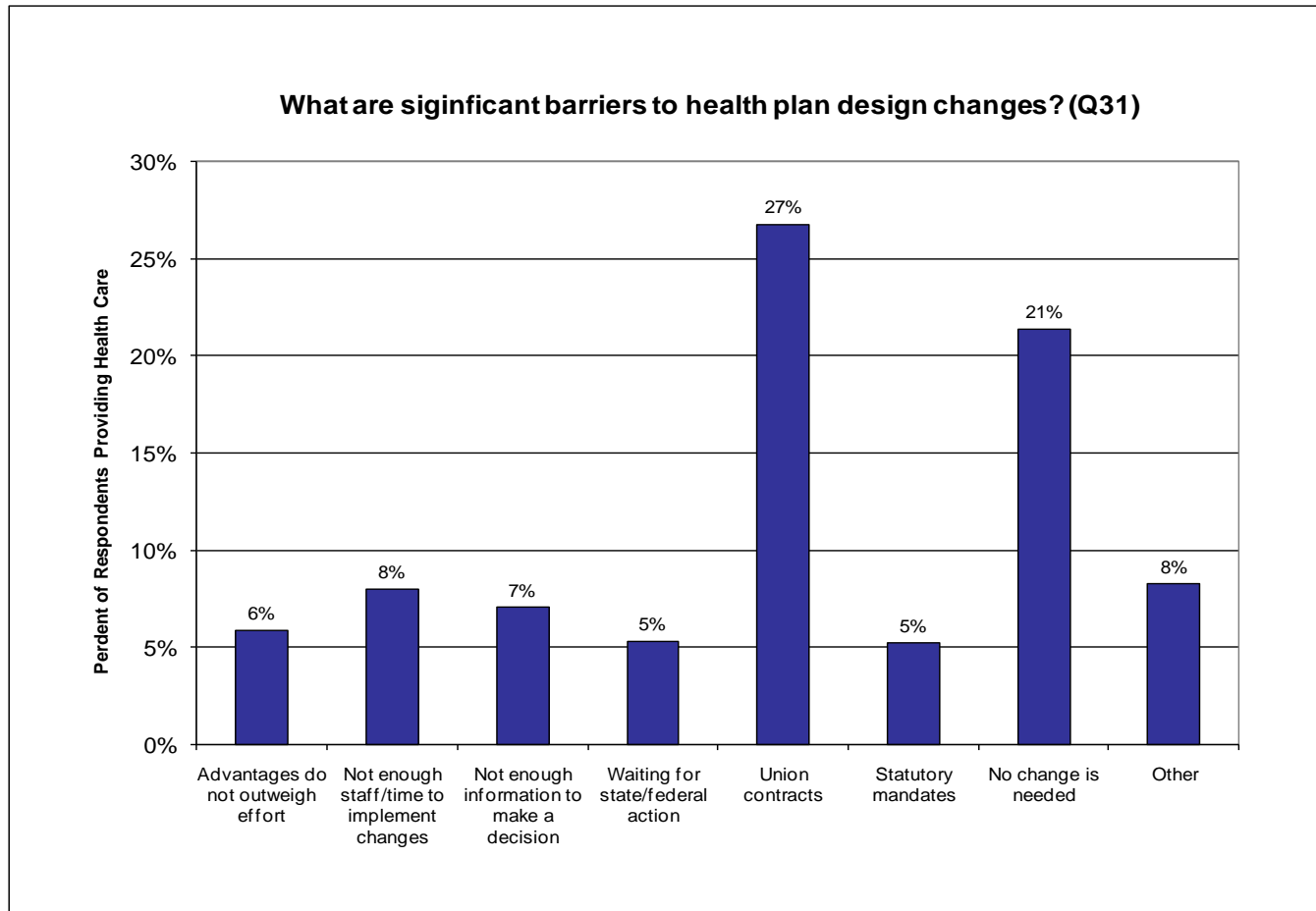
Section 6: Health Care Strategies

The survey also asked about health care changes that have recently been implemented or are planned to be implemented with regard to benefit elimination. The chart below shows that very few of the respondents have taken steps to eliminate benefits for active members or retirees. Of these, the most frequent change has been to require retirees to pay 100% for family coverage, but this change has been implemented by only 4% of the respondents.



Section 6: Health Care Strategies

The survey also asked respondents about what they believed were significant barriers to health plan changes. The chart below shows that 27% of the 2009 survey respondents cited union contracts as a significant barrier. Another 20% cited statutory mandates, the lack of available time, or the lack of information. Interestingly, 21% did not think changes were needed.

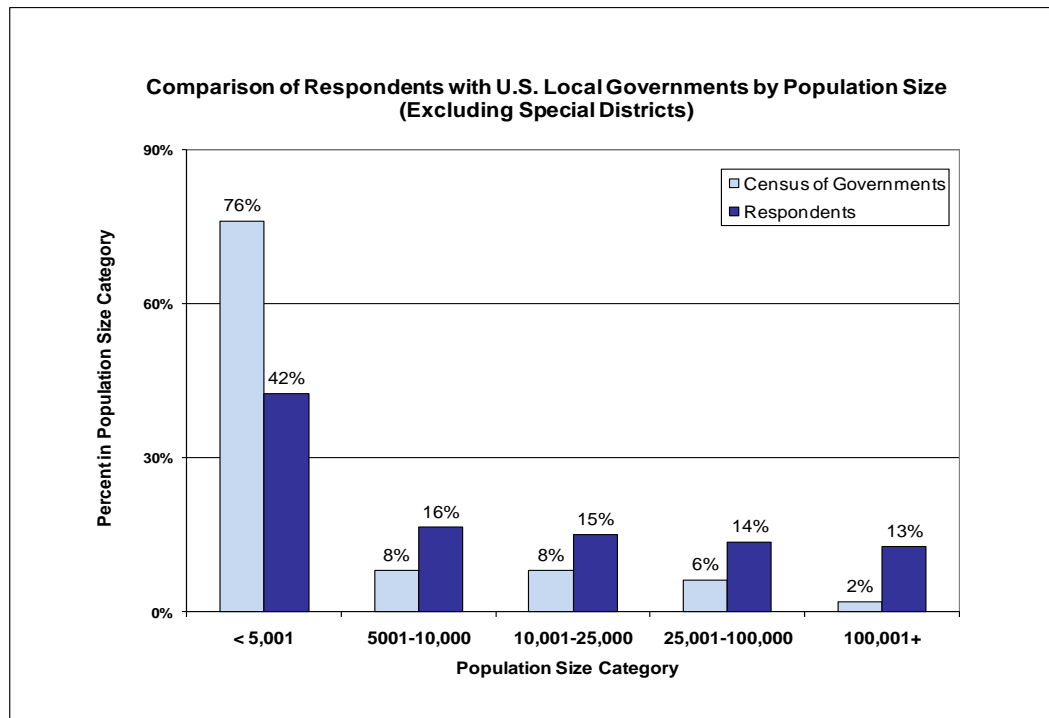


Section 7: Methodology & Detailed Tables

- Cobalt Community Research conducted a stratified random survey of local governments based on the U.S. Census Bureau's 2007 Governments Integrated Directory (GID), augmented with contact information from the Government Finance Officers Association. Approximately 7,500 surveys were distributed by mail between February and May 2009.
- Based on the 1,563 valid responses collected for this survey, the response rate is over 20 percent. This provides a significant dataset for analysis, although all surveys are subject to inaccuracies based on sampling and response error, etc. The results represent a margin of error of +/- 2.5 percent, at a 95 percent confidence interval.
- It should be noted that the 2009 sample is different than the sample used in 2008, in that it oversamples larger governments and does not include governments with populations of 1,500 or less. This was done to obtain a greater representation in the survey by the governments that are more likely to provide health care benefits to active and retired employees.

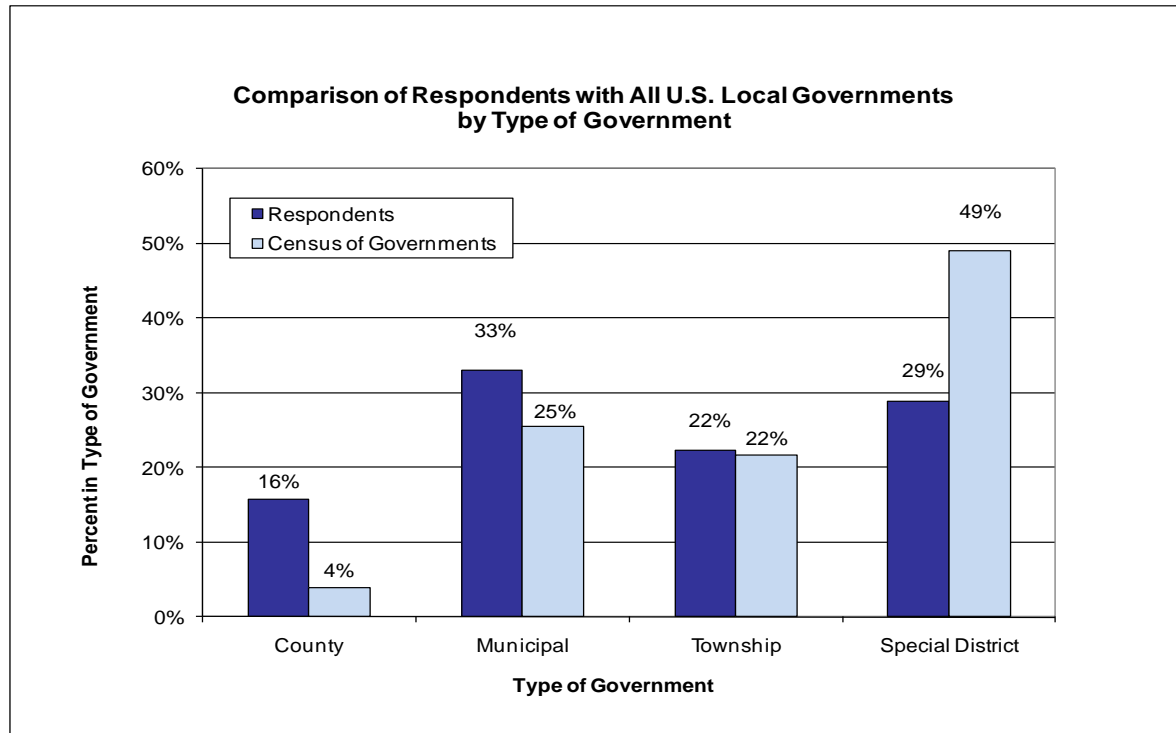
Section 7: Methodology & Detailed Tables

The chart below compares the distribution of the 2009 survey respondents with the distribution of local governments by size of population, as determined by the U.S. Census Bureau. The exhibit illustrates the effect that the over/under sampling had on the distribution of survey respondents. Whereas governments serving populations of less than 5,000 represent 76% of U.S. local governments (excluding special districts), they constitute only 42% of the 2009 survey respondents. Similarly, while governments serving populations of over 100,000 represent only 2% of U.S. local governments, they constitute 13% of the 2009 survey respondents. The over/under-sampling was done to obtain a greater representation in the survey by governments that were more likely to provide health care benefits to active and retired employees. This sampling method will be continued in 2010 to strengthen the comparison to 2009 results.



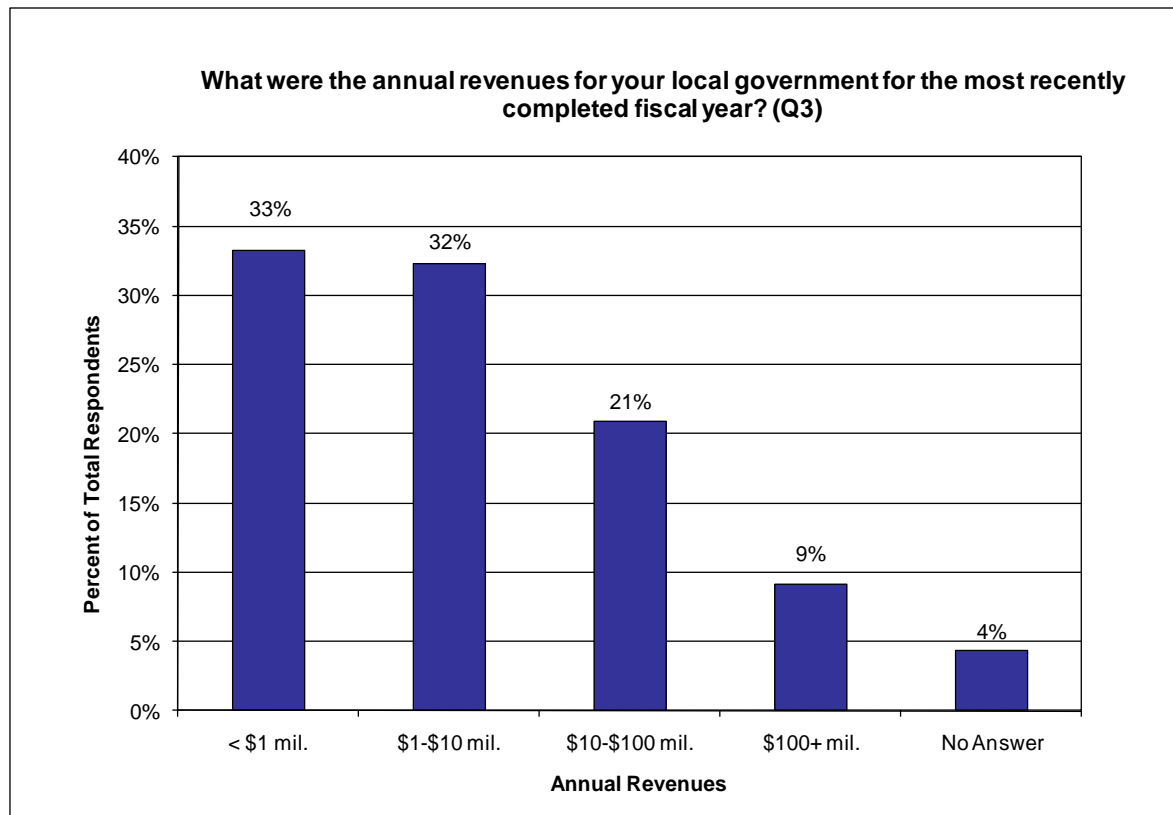
Section 7: Methodology & Detailed Tables

The chart below compares the distribution of the respondents with the distribution of U.S. local governments by type of government, as determined by the U.S. Census Bureau. It indicates that the respondents represent a larger proportion of county and municipal governments than are found in the U.S., as well as a smaller portion of special districts. This is likely the result of the over/under-sampling process, since counties and municipalities tend to have larger populations than special districts.



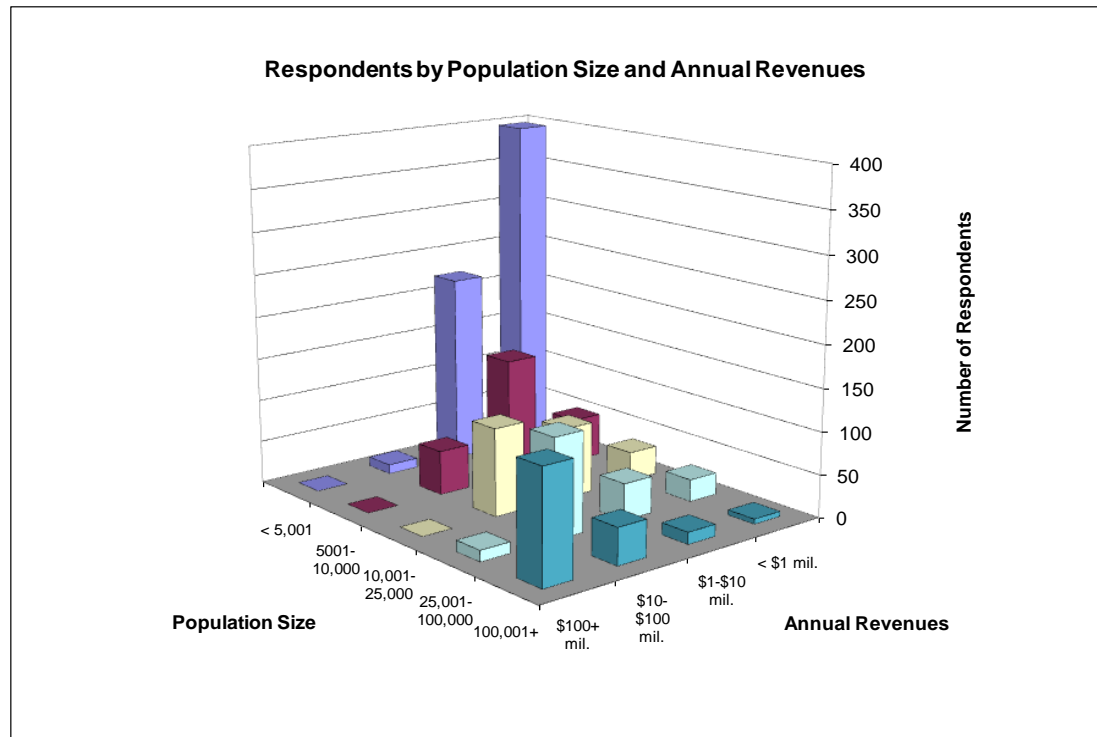
Section 7: Methodology & Detailed Tables

In order to help gauge the respondent governments' current fiscal capacity and potential future fiscal stress, the survey requested information about annual revenues for the most recently completed fiscal year, as well as expected changes in next year's revenues and levels of employment. As shown in the chart below, for the most recently complete fiscal year, 65% of the respondents had annual revenues of less than \$10 million, 21% had revenues between \$10 million and \$100 million, and 9% had revenues of \$100 million or more.



Section 7: Methodology & Detailed Tables

The chart below shows the distribution of respondents by population and annual revenues. The most striking aspect of this exhibit is the extent to which the respondents represent local governments with annual revenues of less than \$10 million. These governments conform to the GASB's definition of "Phase 3" governments, for which the GASB's Statement 45 OPEB accounting standards apply for financial reporting periods beginning after December 15, 2008. This helps explain why some of the respondent governments that provide retiree health care have yet to calculate their OPEB liabilities, as discussed earlier in this report.



Section 7: Methodology & Detailed Tables

Table 1: Descriptive Information

	Number of Respondents	% of Respondents
Number of Full-Time Employees (Q1)		
< 5	492	31.5%
5 - 10	113	7.2%
11-25	215	13.8%
26 - 50	172	11.0%
51-100	169	10.8%
101-250	151	9.7%
251+	241	15.4%
No Answer	10	0.6%
Total	1,563	100.0%
Population Size (Q2)		
< 5,001	656	42.0%
5001-10,000	253	16.2%
10,001-25,000	230	14.7%
25,001-100,000	209	13.4%
100,001+	196	12.5%
No Answer	19	1.2%
Total	1,563	100.0%
Geographic Region		
Northeast	79	5.1%
Midwest	888	56.8%
South	334	21.4%
West	262	16.8%
Total	1,563	100.0%
Type of Government		
County	247	15.8%
Municipality	515	32.9%
Township	349	22.3%
Special District	452	28.9%
Total	1,563	100.0%

Note: Percentages may not add to 100% due to rounding.

Section 7: Methodology & Detailed Tables

Table 2: Local Government Revenues and Employment

	Number of Respondents	% of Applicable Respondents
What were the annual revenues for your local government for the most recently completed fiscal year? (Q3)		
< \$1 mil.	521	33.3%
\$1-\$10 mil.	507	32.4%
\$10-\$100 mil.	328	21.0%
\$100+ mil.	144	9.2%
No Answer	63	4.0%
Total	1,563	100.0%
How do you expect your local government's revenue levels to change next year compared to this year? (Q4)		
Increase	140	9.0%
Decrease	772	49.4%
Stay Same	526	33.7%
Don't Know	110	7.0%
No Answer	15	1.0%
Total	1,563	100.0%
How do you expect your local government's employment levels to change next year compared to this year? (Q5)		
Increase	50	3.2%
Decrease	331	21.2%
Stay Same	1,074	68.7%
Don't Know	92	5.9%
No Answer	16	1.0%
Total	1,563	100.0%

Note: Percentages may not add to 100% due to rounding.

Section 7: Methodology & Detailed Tables

Table 3: Expected Changes

	Number of Responses	% of Applicable Responses
What changes do you expect in your local government workforce in the next two years? (Q6)		
Consolidating/sharing services	415	26.6%
Sending more services out to contract	149	9.5%
Layoffs	222	14.2%
Rehiring retirees	23	1.5%
More part-time/temporary positions	254	16.3%
More full-time positions	46	2.9%
Offer early retirement incentives	97	6.2%
No changes	897	57.4%
Total Respondents	1,563	NA

Note: Number of responses may exceed total respondents due to multiple applicable responses.

Has your elected governing body adopted a formal policy to review long-term costs of benefit changes? (Q7)

Yes	172	11.0%
No - But Plan to in Future	348	22.3%
No - No Plan in Future	983	62.9%
No Answer	60	3.8%
Total	1,563	100.0%

Note: Percentages may not add to 100% due to rounding.

Section 7: Methodology & Detailed Tables

Table 4: Health Care for Active Employees

	Number of Responses	% of Applicable Responses
Do your active employees receive health care benefits? (Q8)		
Actives Receive	1,221	78.1%
Actives Do Not Receive	312	20.0%
No Answer	30	1.9%
Total	1,563	100.0%
What percentage of the premium for active employees is paid by the local government? (Q10)		
None	15	1.2%
1-20%	37	3.0%
21-40%	11	0.9%
41-60%	32	2.6%
61-80%	142	11.6%
81-100%	823	67.4%
Not Sure/ No Answer	161	13.2%
Total Providing Health Care to Active Employees	1,221	100.0%
How are health care benefits for your active employees insured? (Q11)		
Fully Insured - Commercial Carrier	512	41.9%
Self Insured - Employer	198	16.2%
Insurance through State	120	9.8%
Insurance through Coalition	200	16.4%
Other	45	3.7%
No Answer	146	12.0%
Total Providing Health Care to Active Employees	1,221	100.0%

Note: Percentages may not add to 100% due to rounding.

Section 7: Methodology & Detailed Tables

Table 5: Health Care for Retired Employees

	Number of Responses	% of Applicable Responses
Which retirees receive health care benefits from the local government? (Q12)		
Pre-Medicare Only	145	9.3%
Medicare Only	16	1.0%
Both	315	20.2%
Govt. Does Not Provide Retiree HC	1,003	64.2%
No Answer	84	5.4%
Total	1,563	100.0%
What percentage of the premium for <u>early retirees</u> (pre-Medicare) is paid by the local government? (Q13)		
None	151	31.2%
1-20%	24	5.0%
21-40%	16	3.3%
41-60%	49	10.1%
61-80%	40	8.3%
81-100%	174	36.0%
Not Sure/No Answer	30	6.2%
Total Providing Early Retiree Health Care	484	100.0%
What percentage of the premium for <u>Medicare</u> retirees is paid by the local government? (Q14)		
None	105	30.4%
1-20%	18	5.2%
21-40%	7	2.0%
41-60%	29	8.4%
61-80%	27	7.8%
81-100%	115	33.3%
Not Sure/No Answer	44	12.8%
Total Providing Medicare Retiree Health Care	345	100.0%

Note: Percentages may not add to 100% due to rounding.

Section 7: Methodology & Detailed Tables

Table 5: Health Care for Retired Employees (continued)

	Number of Responses	% of Applicable Responses
How do retiree premiums compare to active employee premiums? (Q15)		
Retirees Higher	91	17.5%
Retirees Lower	71	13.6%
Retirees Same	284	54.5%
Not Sure/No Answer	75	14.4%
Total Providing Retiree Health Care	521	100.0%
How do you purchase health care benefits for your retired employees? (Q16)		
As Single Employer	255	48.9%
Thru State	58	11.1%
Thru Coalition	91	17.5%
Other	80	15.4%
No Answer	37	7.1%
Total Provided Retiree Health Care	521	100.0%

Note: Percentages may not add to 100% due to rounding.

Section 7: Methodology & Detailed Tables

Table 6: OPEB Costs and Liabilities

	Number of Responses	% of Applicable Responses
Are you aware of GASB Statement 45, which establishes reporting requirements for OPEB liabilities? (Q17)		
Aware of GASB 45	420	80.6%
Not Aware of GASB 45	69	13.2%
No Answer	32	6.1%
Total Providing Retiree Health Care	521	100.0%
Have you calculated your OPEB liability? (Q18)		
Completed	264	50.7%
In Process	58	11.1%
Not Calculated	97	18.6%
Not Sure/No Answer	102	19.6%
Total Providing Retiree Health Care	521	100.0%
What is your OPEB liability? (Q19)		
< \$1 mil.	71	25.2%
\$1-\$10 mil.	81	28.7%
\$10-\$50 mil.	60	21.3%
\$50-\$100 mil.	26	9.2%
\$100-\$250 mil.	25	8.9%
\$250-\$500 mil.	9	3.2%
\$500+ mil.	4	1.4%
No Answer	6	2.1%
Total Having Calculated the OPEB Liability (Includes calculations in process)	282	100.0%
What is your OPEB annual required contribution (ARC)? (Q20)		
< \$1 mil.	135	47.9%
\$1-\$5 mil.	74	26.2%
\$5-\$10 mil.	19	6.7%
\$10-\$25 mil.	22	7.8%
\$25-\$50 mil.	5	1.8%
\$50+ mil.	4	1.4%
No Answer	23	8.2%
Total Having Calculated the OPEB Liability (Includes calculations in process)	282	100.0%

Note: Percentages may not add to 100% due to rounding.

Section 7: Methodology & Detailed Tables

Table 7: OPEB Funding		
	Number of Responses	% of Applicable Responses
How do you plan to fund your OPEB liability? (Q21)		
Continue pay-as-you-go	146	51.8%
Partially fund the ARC	58	20.6%
Fully fund the ARC	54	19.1%
Set aside funds through asset sale or transfer	8	2.8%
Issue debt/OPEB bonds	2	0.7%
Not determined	51	18.1%
Other	12	4.3%
Total Having Calculated the OPEB Liability	282	NA
<i>Note: Number of responses may exceed total respondents due to multiple applicable responses.</i>		
What kind of account do you use for your OPEB reserve? (Q22)		
401(h) Account	4	3.6%
115 Government Trust	21	18.8%
VEBA	8	7.1%
General Fund	15	13.4%
Other Trust or Agency Fund	52	46.4%
Not Determined	16	14.3%
No Answer	3	2.7%
Total That Plan to Fully or Partially Prefund	112	NA
<i>Note: Percentages do not add to 100% due to multiple applicable responses.</i>		
How much funding have you set aside to offset the OPEB liability? (Q23)		
None	22	7.8%
1-10%	31	11.0%
11-20%	19	6.7%
21-30%	7	2.5%
31-50%	8	2.8%
51+%	18	6.4%
Don't Know	5	1.8%
Not Intending to Prefund	172	61.0%
Total Having Calculated the OPEB Liability	282	100.0%
<i>Note: Percentages may not add to 100% due to rounding.</i>		

Section 7: Methodology & Detailed Tables

Table 8: Health Care Changes Recently Implemented or Planned

(% of Respondents Offering Health Care)

	<u>Implemented in Last 2 Years</u>		<u>Implement in Next 2 Years</u>	
	Number of Respondents	% of Those Offering HC	Number of Respondents	% of Those Offering HC
Eligibility Changes (Q26)				
Close plan to new hires	47	3.8%	25	2.0%
Increase age and service requirements	40	3.3%	40	3.3%
Prorate benefits based on service	32	2.6%	41	3.4%
Contribution Changes (Q27)				
Increase deductibles	329	26.9%	164	13.4%
Increase health copays	300	24.6%	161	13.2%
Increase drug copays	276	22.6%	127	10.4%
Increase share of premium costs	222	18.2%	209	17.1%
Increase out-of-pocket limits	162	13.3%	93	7.6%
Cap employer contributions	64	5.2%	91	7.5%
Prorate employer contributions based on service	18	1.5%	27	2.2%
Design Changes (Q28)				
Reduce benefit levels	74	6.1%	83	6.8%
Offer Medicare wraparound plan	16	1.3%	26	2.1%
Offer Medicare Advantage plan	25	2.0%	20	1.6%
Require Medicare Part D coverage	45	3.7%	24	2.0%
Implement disease management initiatives	72	5.9%	40	3.3%
Implement wellness initiatives	231	18.9%	115	9.4%
Implement HSAs or HRAs	168	13.8%	102	8.4%
Tighten provider networks	39	3.2%	20	1.6%
Implement special drug network (Rx carve out)	46	3.8%	23	1.9%
Expand use of generic drugs	182	14.9%	60	4.9%
Implement drug formulary	69	5.7%	22	1.8%
Offer only catastrophic coverage	1	0.1%	9	0.7%
Total Respondents Offering Health Care	1,221			

Section 7: Methodology & Detailed Tables

Table 8: Health Care Changes Recently Implemented or Planned (continued)

	<u>Implemented in Last 2 Years</u>		<u>Implement in Next 2 Years</u>	
	Number of Respondents	% of Those Offering HC	Number of Respondents	% of Those Offering HC
Purchasing Changes (Q29)				
Join a health purchasing coalition	54	4.4%	31	2.5%
Shift from fully-insured to self-insured	26	2.1%	25	2.0%
Negotiate lower costs with current carrier	219	17.9%	130	10.6%
Change carrier/health plan	113	9.3%	87	7.1%
Educate employees/retirees to make better decisions	182	14.9%	141	11.5%
Benefit elimination (Q30)				
Eliminate benefits for active employees	1	0.1%	4	0.3%
Eliminate benefits for pre-Medicare retirees	10	0.8%	10	0.8%
Eliminate benefits for Medicare-eligible retirees	21	1.7%	20	1.6%
Eliminate dental/vision benefits for active employees	19	1.6%	13	1.1%
Eliminate dental/vision benefits for early retirees	16	1.3%	7	0.6%
Eliminate dental/vision benefits for Medicare-eligible retirees	12	1.0%	12	1.0%
Require retirees to pay 100% of family coverage premium	44	3.6%	22	1.8%
Eliminate family coverage for active employees	10	0.8%	18	1.5%
Eliminate family coverage for early retirees	12	1.0%	11	0.9%
Eliminate family coverage for Medicare-eligible retirees	13	1.1%	10	0.8%
Total Respondents Offering Health Care	1,221			

Section 8: Ideas From Respondents

To provide a feeling of what communities are doing, the following section provides verbatim responses to this question:

What innovations or best practices have you put in place to address health cost trends?

Section 8: Ideas From Respondents

Idea	Category
\$0 copay for generic drugs. \$0 copay for routine/preventative doc visits. Employer contribution to FSA for basic plan. Dental reimbursement and vision benefits encourage annual visits and preventative care.	Coverage Change
All vested employees (over 15 years) will remain in the covered plan. All employees under 15 years and any new hires will be under a plan upon retirement for partial benefits to be paid by the city.	Coverage Change
Cut personnel. Increase share of premium costs.	Coverage Change
Employees hired after 7-1-2008 are in retirement health savings plan & defined contribution. Old plan retirees have same benefit of existing employees	Coverage Change
Getting higher premium share w employees with co-pays by adding a LTD benefit.	Coverage Change
New hires pay 20% or health premiums. New hires not eligible for retiree health. County has capped 10% increase on health insurance rates	Coverage Change
Proactive negotiations with bargaining units to share in greater contribution towards health costs.	Coverage Change
RESEARCHING HYBRID PLANS THAT INVOLVE PARTIAL EMPLOYER FUNDING	Coverage Change
Review costs of plan alternatives and make minor changes in copay, deductibles, coverage to keep costs from escalating too much. A very small population (4).	Coverage Change
The local government is self-insured and negotiated capping the contribution to the plan at 10% above the prior year for 3 years. Any additional increase in cost will be paid by covered employees or the plan design will change. While 10% is a large increase, it has made it easier to forecast and budget for.	Coverage Change
VEBA plan- reduced employer portion of Healthcare costs	Coverage Change
We are currently looking at a cost-share for employees.	Coverage Change
We have changed coverage for new employees. They must contribute 15%. At retirement must purchase insurance themselves.	Coverage Change
We have changed premium to a lump sum per employee, guaranteed coverage for employee but wife and family only paid as excess amount of individual lump sum.	Coverage Change

Section 8: Ideas From Respondents

Idea	Category
Discuss current trends with State organization. Attend local training/information seminars. Interact with other entities within the State.	Education
Develop educational programs for our people.	Education
Online information on drugs, personal health and plan information.	Education
We have managed our plan well through the years, we are our own "small group" and have educated our employees on usage and focused on wellness benefits. Our rates are very low compared to other agencies.	Education
We hold a "Benefits Fair" each fall during open enrollment. All insurance providers are on-site to meet one-on-one with employees to provide information about their particular benefit. The goal is to better inform employees about the scope of their benefits package and how to better utilize. The County also provides free flu vaccines to all employees and dependents during the fair.	Education

Section 8: Ideas From Respondents

Idea	Category
All new hires no longer receive health benefits at retirement. The city has implemented a defined contribution retiree health care plan. The City contributes \$2.00 for every \$1.00 an employee contributes towards health care at retirement with a \$100/month cap on the employer contribution. These funds are contributed bi-weekly by the City to a third party investment group. Vesting for the employer contribution is 6 years. Funds are available to the employee when they leave City employ.	Opt Outs
Allow dependents to opt off Medicare if they have other options available. Cost savings is shared between city and employee (50/50)	Opt Outs
We closed our OPEB plan to new hires effective Jan 1, 2008, but we continue to offer health benefits to full-time active employees.	Opt Outs
In 1998, our Board of Supervisors opted to not guarantee health coverage to retirees hired after 9/30/1998.	Opt Outs
Offered a buy-out of retiree health benefits to current employees.	Opt Outs
Opt out option with payment to employee.	Opt Outs
Reduced hours to eliminate coverage.	Opt Outs
We have been told we can't alter prior promises to our retired employees. We are looking at lowering head count of employees who are eligible for benefits.	Opt Outs
We have medical insurance for one employee and one retiree. We pay half the premium on each one and they pay half the premium. All other employees are covered by their spouses insurance.	Opt Outs
We offer \$ for those opting out of health care and pay them 25% of cost w/cap @5000/year. Savings per employee is roughly \$20,000/employee.	Opt Outs

Section 8: Ideas From Respondents

Idea	Category
1. Funding OPEB since 1990 2. HRA Plan implementation 3. Close one of the health plans to non union new hires 4. Hybrid Plan carrier/self insured	Fund OPEB
ALREADY SET ASIDE MONEY FORM BOTH EMPLOYER AND EMPLOYEES PAY PART FOR 5 YEARS. JUST STARTED THE PROCESS FOR GASB 45.	Fund OPEB
Establish health funding vehicle through MERS and utilize their investment strategy to help fund costs. Budgeted retiree premiums plus \$50,000 is deposited annually with reimbursements of actual premiums paid occurring quarterly.	Fund OPEB

Section 8: Ideas From Respondents

Idea	Category
employees are insured in state pool	Health coalition
Formed local government co-op with fire and other municipalities to increase employee pool to over 250+	Health coalition
Health Insurance is provided through the Illinois Libraries Employment Benefit Plan (ILEBP). Individual participating libraries do not make the decisions for the benefits, a board of trustees for the ILEBP has the sole discretion.	Health coalition
Joined a purchasing coalition. Raised co-pays in conjunction with providing a matching flex benefit program	Health coalition
Joined association HRA implemented	Health coalition
Joined pool developed wellness programs.	Health coalition
Our government has no control over adjusting rates or premiums. Our plan is provided by the State of New Mexico.	Health coalition
The actual health insurance program managed by the State.	Health coalition
We are part of a state of Wisconsin plan. The state does all the work on rates being competitive.	Health coalition
We belong to a coalition of self insured employers that own a network provider that provides its members discounts from local medical providers.	Health coalition

Section 8: Ideas From Respondents

Idea	Category
Add employee contribution, increase deductible.	High deductible
Changed to a high deductible plan through a broker; with the same carrier (capital blue cross)	High deductible
Effective 2-1-08 we implemented a high deductible BCBS plan. The county returns the employee a portion of the deductible (HRA). This saved us \$150,000 in 2008. However, our 2009 BCBS premium increased 15% over the 2008 premium which brought us back to the 2007 level of BCBS premium.	High deductible
High deductible plans with HRS and HSAs.	High deductible
High deductible than Wellmark - then the city self insures the difference between regular deductible 250/500 and high deductible 5000/10,000	High deductible
Move to a high deductible plan and increased co-pays. Annually review insurance options with agent	High deductible
No health insurance for the family of new hires. High deductible high co-pay plan. HSA accounts	High deductible
Offer employees option for HDHP/HSA	High deductible
Raise the deductible and the co-pays. Started an HRA	High deductible
Switch to high deductible plans with 3rd party wrap for medical and prescription coverage.	High deductible
The city is paying everyone's deductibles; they get a benefit card which the city funds (\$1250 per person, \$2500 per family). This lowered our policy cost enough to make it cost effective.	High deductible
The Town has implemented voluntary health plans with high deductibles for which employees/retirees are reimbursed in order to lower overall premiums	High deductible
Three years ago we moved active employees to a CDHP. High Deductible BCBS Flexible Blue, with and HSA. We also offered a 40% Opt Out Option. We eliminated health coverage after retirement for all new hires.	High deductible
We are using high deductible health plans. We offer 2 plans- the first plan the employer pays a portion of the premium. The county self insures "deductible." There is no deductible to employees. The other plan the city set up HSA accounts for employees. The city deposits money into the HSA on behalf of the employees there is a possible deductible to employees.	High deductible
We do have a high deductible plan with our commercial carrier and basically self-insure for the deductible for a significant savings.	High deductible
We have begun the transition to a self-funded plan by moving to a high deductible plan with the insurance carrier and self funding the difference between the old deductible and out-of-pocket limits and the new deductible and out-of-pocket limits.	High deductible
We have increased the deductible from \$500 per person to \$2900 per person. We have setup a HSA and the City has partially funded it. This has lowered claims.	High deductible
We have switched to a high deductible plan and a 10/40 drug plan.	High deductible
We have went to a HDHP/HSA. This is the most significant way to save money on health insurance. Other changes governments are making only save a little money and reduce benefits for employees. A HDHP/HSA increases the benefit received. For the Township we are saving about \$100,000 a year, which is a ton.	High deductible
We switched carriers and implemented a high deductible plan with mandatory mail order for prescriptions and noticed significant savings.	High deductible

Section 8: Ideas From Respondents

Idea	Category
Created VEBA, employees make 1% contribution. Co-contributes to VEBA.	Savings Programs
HSA and HMO Plans	Savings Programs
HSA only. Spousal Parity	Savings Programs
Implemented HRA (self-insured) for dental & health co-pays. Offered HSA plans for all full-time employees.	Savings Programs
Implemented HRA plans with employee contributions and back-filling employer costs for the HRA through a third party to make it seamless to the employee	Savings Programs
Increased out of pocket expenses and funded HRA plan	Savings Programs
Moved to HSA effective July, 2009. No other local agencies have done this that I have found	Savings Programs
No retiree health for new hires, 2% into HSA in lieu of.	Savings Programs
Offered a health savings type of plan	Savings Programs
We offer an HSA plan along with a HSHP. This enables employees to choose which doctors to go to and when.	Savings Programs

Section 8: Ideas From Respondents

Idea	Category
Adopted MGL Ch 325; Section 18 requiring Medicare eligible retirees to pick up Medicare as their primary coverage.	Medicare
Moved Medicare- eligible retirees into Medicare advantage plan.	Medicare
Created a committee representing unions, non-union, and management which selects coverage options each year to be offered to employees.	Union Ideas
Formed a health benefit committee to review possible cost savings; committee includes all level of employee classes/unions.	Union Ideas
We have established a "Health Alliance" that represents all union groups and non-union employees. All renewal information shared. Cost share is based on premium annual increase. Thus, there is strong incentive to manage plan design to limit premium increases. Averaged less than 3% over last five years.	Union Ideas

Section 8: Ideas From Respondents

Idea	Category
15 years ago formed self-insured consortium with local towns and villages which doubled the size of the group plan.	self insured
Change to self-insured program.	self insured
Counties have formed a self insurance group "gem plan"	self insured
Implemented a partially self insured/fully insured plan (high deductible). Higher costs to new employees and eliminating future employee retiree health care.	self insured
In the past five years, we have changed from a coalition of fully insured through BX-BS to a completely self insured coalition of 5 Grosse Pointe communities. Benefits are still administered through Blue Cross. Prescription drugs are dispensed by Express Scripts.	self insured

Section 8: Ideas From Respondents

Idea	Category
Adopted a plan that saved us 40%. Plan requires that all employees under go an annual Health Examination and consulting session. That is all, and no 'results' are required.	shop plans
By contract, the municipality pays 100% of premiums and deductibles. In return the municipality is free to shop for best policies or rates, provided that the co-pays increase no more than 100% from baseline and policy is equal or better than current. We actively shop around, and in an era of massive increases we think we have managed well.	shop plans
Change provider, design plan to fit employees, negotiate with provider, loss control	shop plans
Changed carriers and will consider next year when police contract expires to start employee paying a percentage at premium.	shop plans
Gone from multiple plans to one carrier. Plan with buy-up paid for by employees. Health and wellness fairs.	shop plans
I review plans two or three times a year	shop plans
Member Iowa health buyers alliance which promotes leap frog reporting. City uses four cornerstone principles of health care purchasing	shop plans
Switched to a different plan with same carrier. Have changed to partial self-insured program.	shop plans
Switching to lower cost plans for those unions to avoid additional furlough days	shop plans
The district has not received significant increases in the last 2 years. The district has looked at different carriers and different coverage levels.	shop plans
We continue to review end evaluate different health packages associated with the costs offered by the broker and select the best benefits without substantially increase of the costs.	shop plans
We have formed an in-house committee between management, dept. heads and employees to address the issues of rising health care and to look at what other options are available to lower costs.	shop plans
We're usually ahead of the curve in plan changes which are recommended by our insurance agent. They represent several counties.	shop plans

Section 8: Ideas From Respondents

Idea	Category
Addition of best doctors and biologics program. Programs such as complex care and cancer treatments are more effective. We have maintained a strong wellness program.	wellness program
Began wellness initiatives 4 years ago. Beginning to see downward trends. Disease management and lifestyle management programs. Continuing education.	wellness program
Cardiac wellness Contractual Health Care Advisor. Instituted Wellness Program.	wellness program
Cost sharing ensures employees are aware of costs and support changes to reduce costs. Implemented Wellness Program 8 years ago.	wellness program
Created a wellness program, safety programs	wellness program
Implemented a non smoking policy for all new hires in the early 1990's (at work or at home). Provide quarterly cholesterol checks and monthly blood pressure checks.	wellness program
Implemented a wellness plan and reward employees with a day off if they meet their wellness goals.	wellness program
Implemented Health and Wellness program for all employees and retirees on health plan. Online interactive tools and education, newsletter, website, lunch and learn sessions with local health speakers, outreach. Also, 100% preventative care, 24 hour nurse line	wellness program
Opened employee health clinic; cover more wellness programs; educate employees on generic usage; conduct regular health fairs.	wellness program
Substantial investment (& employee participation) in wellness programs.	wellness program
We have an exceptional and complete Health Wellness Program where employees are offered a financial incentive to participate through increased employer contributions in their health insurance premium costs.	wellness program
We have implemented a wellness fair that helped lower out rates. Also have proposed having a nurse or PA come onsite for ten hours a week but do not know yet if Board will approve.	wellness program
We have started to implement a wellness program to become more proactive in controlling costs. Measurement and incentives are part of this plan.	wellness program

Cobalt Community Research

1134 Municipal Way Lansing, MI 48917

Cobalt is a 501c3 nonprofit organization with a mission to provide research and educational tools that help local governments and other nonprofit organizations thrive as changes emerge in the economic, demographic and social landscape.

Citizen Satisfaction Survey

- Measures citizen satisfaction with public safety, schools, economic vitality, and culture. The program maps drivers of satisfaction and practical outcomes such as community image, remaining in the community, and recommending it to others. Provides local officials with high-quality information to support strategic planning and budgeting priorities. The scores are compared to similar local governments across the state and nation.

Budget Survey Program

- Uses resident feedback on specific community programs and services to prioritize budget allocations as local governments tighten spending. Results are provided in a spreadsheet and graph that allows budget analysts to map program/service importance, satisfaction and cost.

Custom Survey Program

- Allows organizations to evaluate awareness and effectiveness of programs and initiatives specific to their needs through scientific sampling techniques and collaboration on the survey instrument. Provides quantitative data to strengthen program development, outreach, marketing and decision making.

Focus Group Program

- A focus group is a powerful and persuasive tool that can significantly enhance communication and educational program effectiveness. Such groups often yield unexpected insights and a human touch that enriches an organization's program evaluation.

Special Benchmarking Program

- Helps membership organizations to work more closely with their members or special audiences to identify best practices, track awareness levels over time, improve services, and strengthen educational, media and sponsorship outreach programs.

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About the Government Finance Officers Association

The purpose of the Government Finance Officers Association is to enhance and promote the professional management of governments for the public benefit by identifying and developing financial policies and practices and promoting them through education, training and leadership.

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- **Financial Leadership.** Engage in efforts to assist finance officers to develop the skills and capabilities necessary to enable them to become organizational leaders as well as technical experts.
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