Health & OPEB Funding Strategies

2010 NATIONAL SURVEY OF LOCAL GOVERNMENTS

Study by Cobalt Community Research

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

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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 state and local government 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, made all the more difficult by the recent financial market crisis and economic recession. The awareness of this new liability and the requirement to disclose it have created heightened concerns with the affordability of public sector health care.

The 2010 survey report (representing the third year of the annual study) provides detailed insight into the response to GASB Statement No. 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.

Major questions this study seeks to answer include:

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 Statement No. 45 requirements and has done the valuation?

Which strategies are local governments using to reduce or fund their liabilities?

Four key findings emerge from the research:

1

The economic environment is having a clear effect on the revenue and employment expectations of local governments.

- 50% of responding local governments expect their revenues to decline over the next year and 16% expect the decline to be greater than 5%. Interestingly, a greater percentage of respondents from larger governments expect revenues to decline than respondents from smaller governments.
- 19% of responding local governments expect employment levels to decrease over the next year.
- 26% of responding local governments expect workforce changes through consolidation/ shared services and 23% expect employment declines through attrition.

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With regard to providing health care, 77% of responding local governments provide health care to their active employees, and 29% provide health care to retirees. Generally, governments serving larger populations are more likely to provide retiree health care.

- Of the governments that provide active employee health care, 68% pay between 81% and 100% of their active employee's health care premiums (with 40% paying 100% of the premium).
- Of the governments that provide retiree health care, about one-third pay between 81% and 100% of retiree health care premiums (with 21% paying 100% of the premium). In addition, one-third pay none of the retirees' health care premiums.
- Employer payments for early (pre-Medicare) retirement premiums fell somewhat from 2009 to 2010.

3

With regard to awareness of the Statement No. 45 requirements and calculation of the OPEB liability, 87% of the responding local governments that provide retiree health care are aware of the GASB 45 requirements, up from 81% in 2009. In addition, 74% report that they have already calculated the liability or the calculation is in process.

- For the survey respondents who have completed their OPEB valuation, 59% have OPEB liabilities of less than $10 million, compared with 62% in 2009. However, for 10%, the liability exceeds $100 million.
- Of the governments that have completed their OPEB valuations, 30% plan to fully or partially prefund the liability, a drop from 40% in 2009. Of those that plan to fully or partially prefund, 31% plan to establish formal trusts.
- 65% of responding governments plan to use a pay-as-you-go approach to funding retiree health costs. This is up from 52% as reported in last year's survey.

4

With regard to strategies for controlling health care costs:

- The most frequently used methods for controlling health care costs include: increasing deductibles and copays, increasing the employees' share of premium costs, implementing wellness programs, expanding use of generic drugs, implementing HSAa and HRAs, negotiating lower costs with current carriers, and educating employees/retirees to make better health care decisions.
- While many local governments are implementing health care cost-containment strategies, there appear to be several untapped cost-containment strategies, including: implementing disease management initiatives, and implementing drug formularies.

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Characteristics of the Respondents

The 1,963 governments that responded to the 2010 survey serve a wide range of populations, but were mostly representative of smaller governments. Of these respondents, 841 (43% of the total) represent governments that serve populations of less than 5,000. Another 757 respondents (39% of the total) represent governments with populations of over 10,000. This compares with the 1,563 governments that responded to the 2009 survey. Although 2010 survey responses numbered 26% higher than for 2009 survey, the distribution of respondents by population size was similar. See Section 7 for details on how the survey respondents compare with other local governments in the U.S. Census. (Note: numbers in parentheses after the chart title refer to the question number in the survey questionnaire).

CHART 1

How many people live in the jurisdiction of your local government? (Q2)

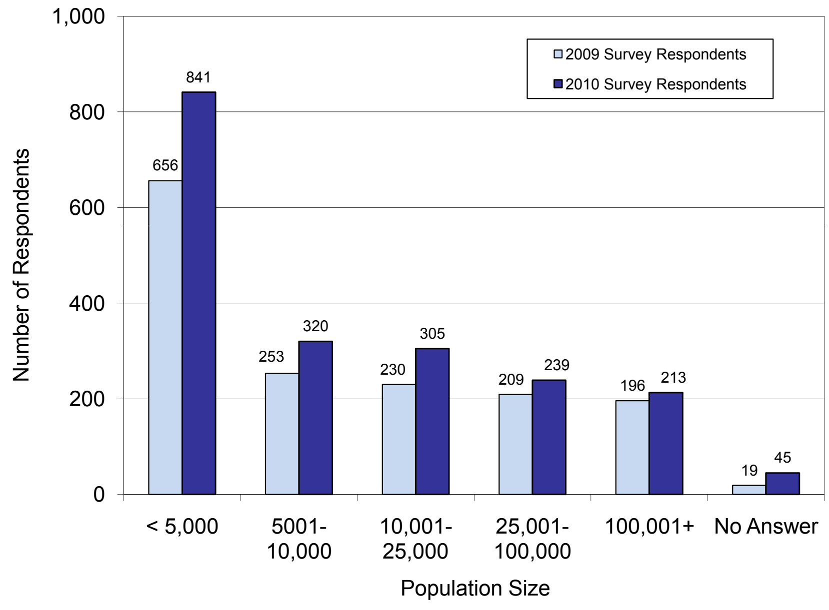

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Chart 2 shows the distribution of the respondents by population size and region. Many of the respondents represent smaller jurisdictions in the Midwest, which reflects the large number of township governments in that region. In addition, a relatively small number of respondents were from the Northeast, which correlates with the relatively small number of governments overall in that region.

CHART 2

Respondents by population size and region

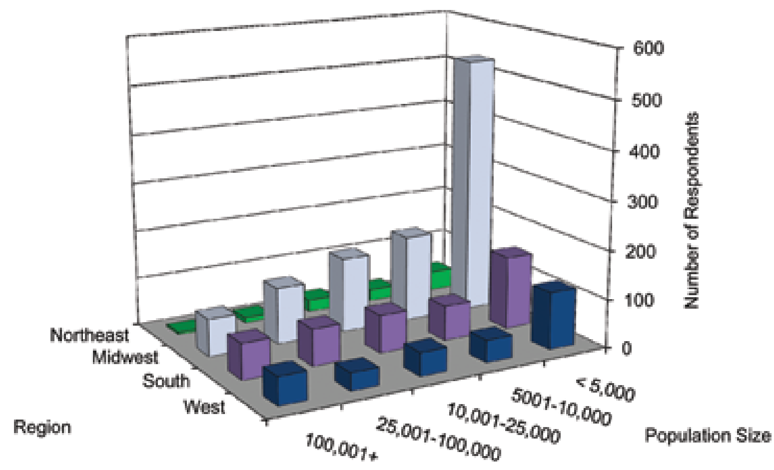
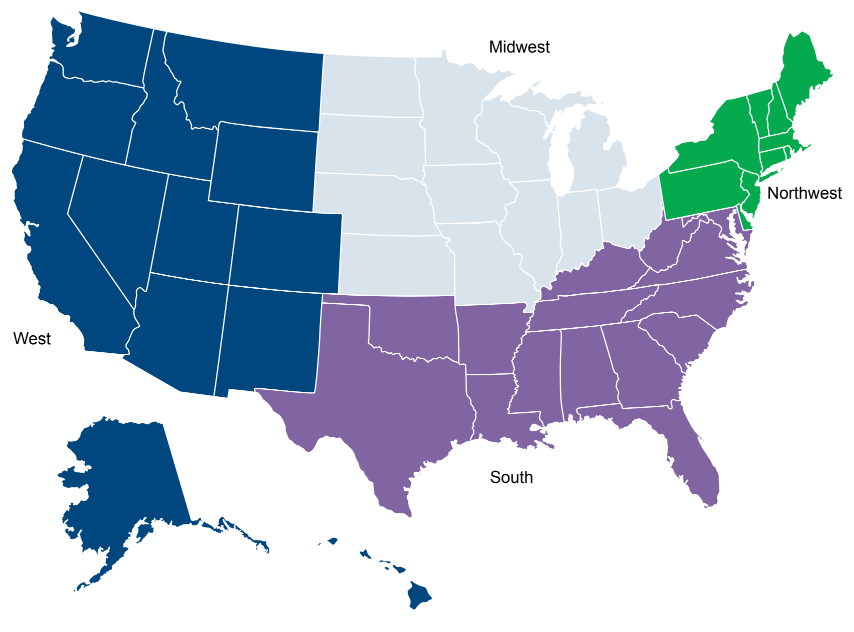


CHART 3

Census Bureau Regions

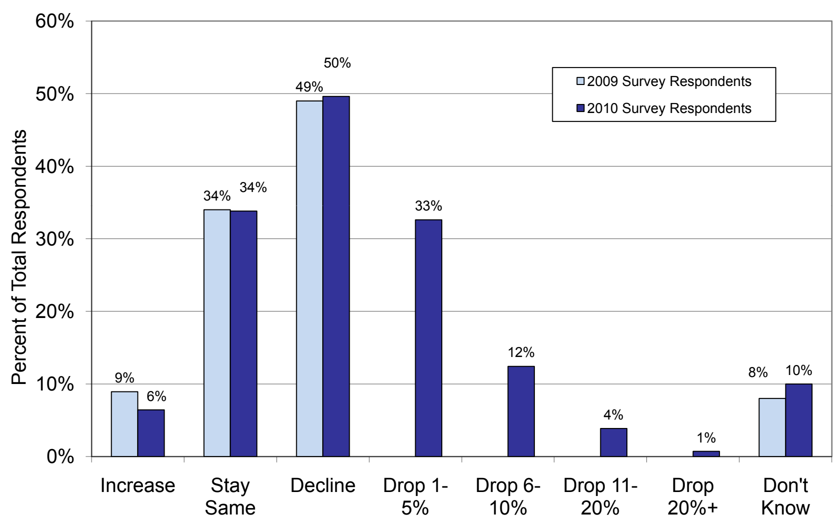


Expected Revenue and Employment Changes

Chart 4 shows the distribution of the 2010 and 2009 survey respondents by expected changes in next year"s level of revenues. As one would expect in the current economic environment, a large proportion (50%) of the 2010 survey respondents expect revenues to decline in the coming year. This was similar for the 2009 survey respondents. The 2010 survey questionnaire added questions asking about the expected degree of revenue declines. Sixteen percent of the 2010 survey respondents expected revenues to decline by 6% or more.

CHART 4

How do you expect your local government's revenue levels to change next year compared to this year? (Q4)



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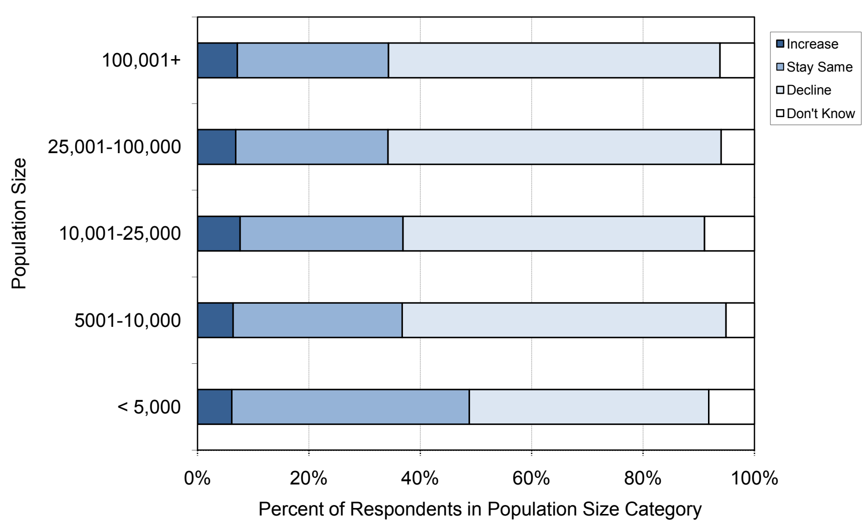
Charts 5, 6, and 7 show expected changes in revenues by different groups of respondents. For the 2010 survey, the chart below shows that about 60% of the respondents with populations of more than 25,000 expect revenues to decline next year, compared with about 45% of respondents with populations of 5,000 or less.

CHART 5

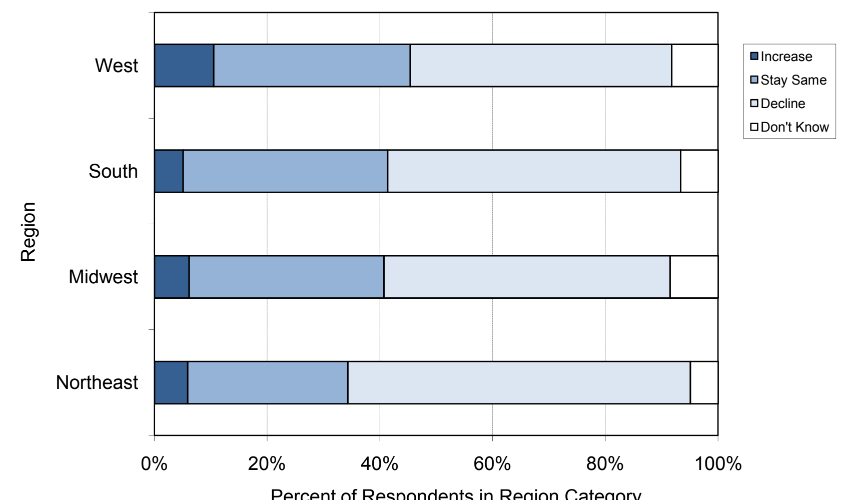
Comparison of expected change in annual revenues by population size



While larger governments appear more likely to expect revenues to decline next year, the relationship between expected revenue changes and geographic region is not as clear. For the 2010 survey, the chart belowshows that about 50% of respondents in three of the four major geographic regions expect revenues to decline next year and about 35% expect revenues to stay the same. In the Northeast, a larger portion of jurisdictions (about 60%) expect revenues to decline and a smaller portion (about 30%) expect them to remain the same.

CHART 6

Comparison of expected change in annual revenues by region



Expected Revenue and Employment Changes

For the 2010 survey, chart 7 shows that respondents representing county, municipal, and township governments were more likely to expect revenues to decline next year, compared with special districts. On average, 60% (or more) of the respondents from county, municipal, and township governments expect revenues to decline, compared with less than 30% of respondents from special districts.

CHART 7

Comparison of expected change in annual revenues by type of government

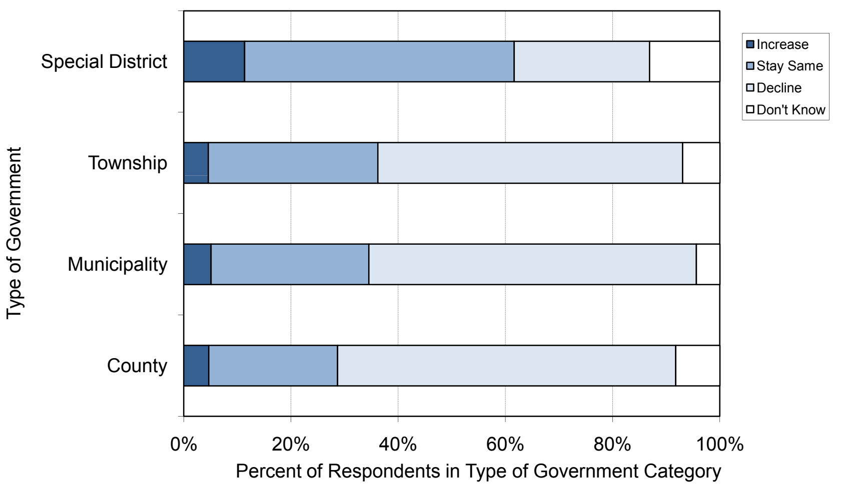
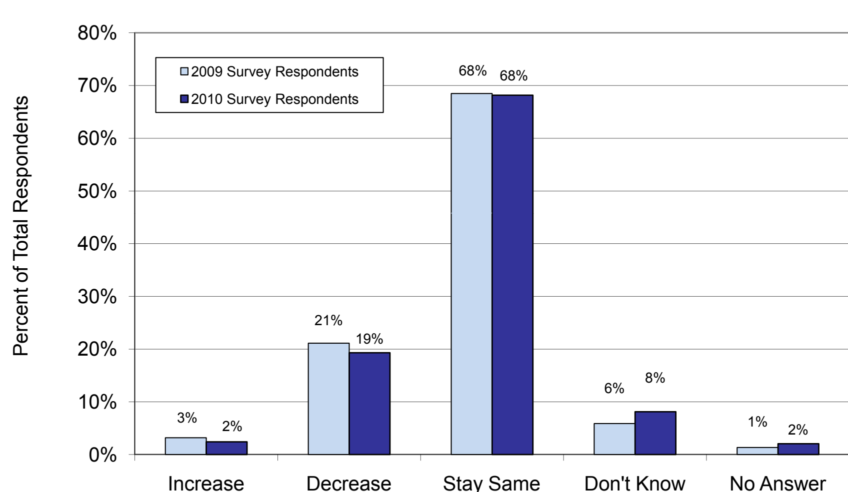


Chart 8 shows the distribution of the survey respondents by the expected change in next year‟s level of government employment . For the 2010 survey respondents, the majority (68%) expect next year‟s employment levels to stay the same. In addition, 21% expect their local governments‟ employment to decrease in the next year. The 2009 survey showed similar results.

CHART 8

How do you expect your local government's employment levels to change next year compared to this year? (Q5)



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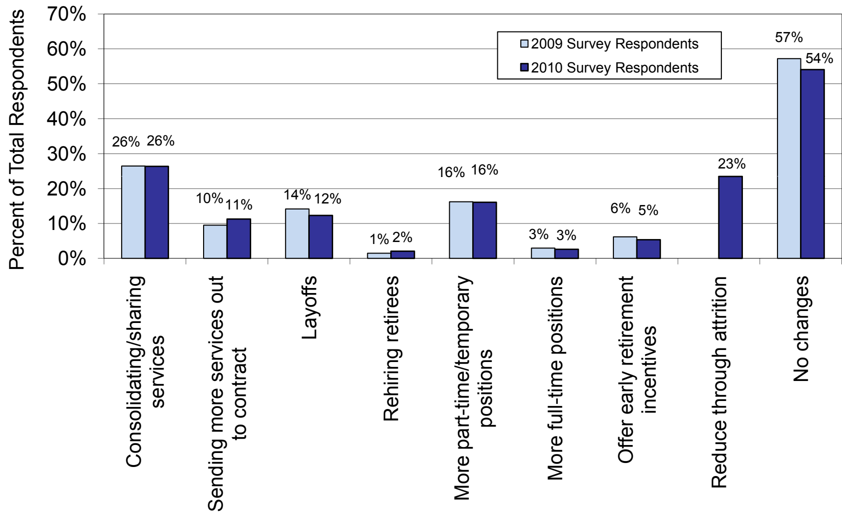
The majority of respondents to both the 2010 and 2009 surveys expect no change in their local government workforce over the next two years. However, to the extent the workforce is expected to change, it will most likely involve the consolidation of public services, layoffs, the greater use of part-time and temporary positions, and attrition.

CHART 9

What changes do you expect in your local government workforce in the next two years? (Q6)

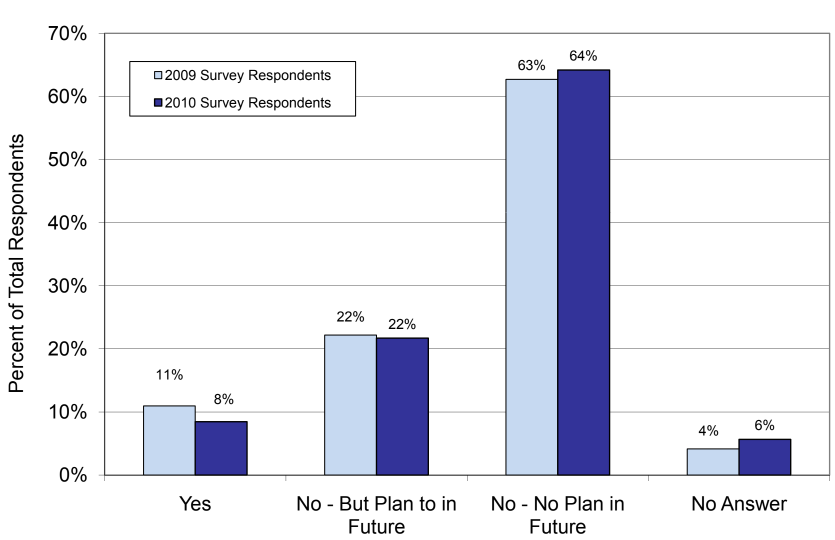


NOTE: Numbers do not add to 100% due to multiple applicable responses.

While a small percentage of respondents in both the 2009 and 2010 surveys have adopted a formal policy to review long-term benefit costs and 22% plan to do so in the future, the majority have not adopted a formal policy to review the long-term costs of benefit changes.

CHART 10

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

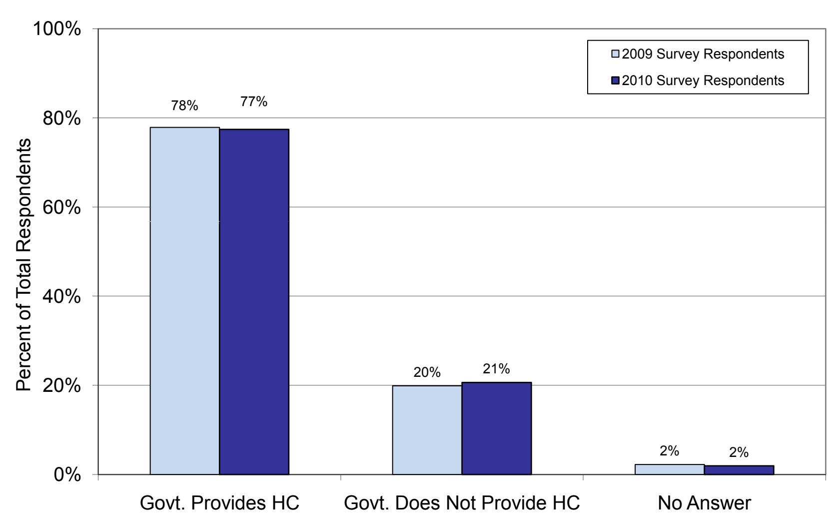


Provision of Health Care to Active Employees

One focus of the survey was to gauge the extent to which local governments provide health care benefits. Chart 11 shows that over three-quarters of the respondents to both the 2009 and 2010 surveys provide health care benefits to active employees.

CHART 11

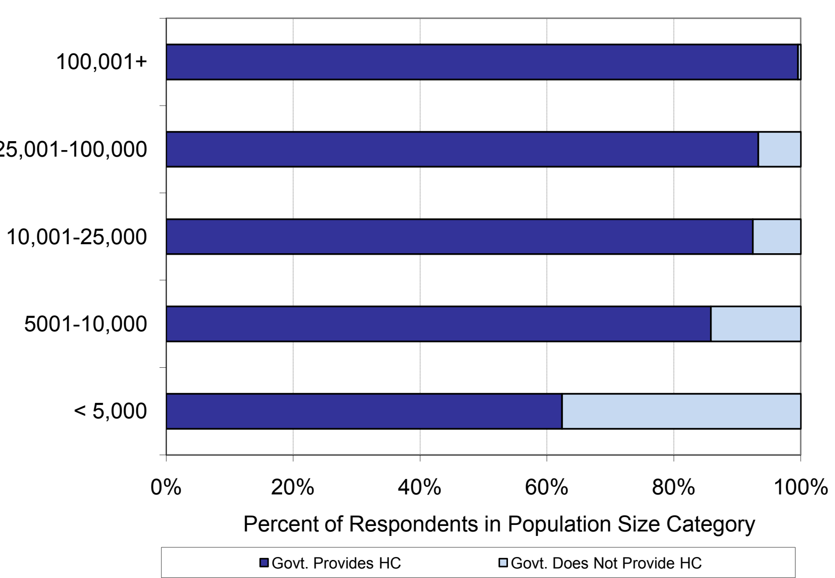
Does the government provide health care benefits to active employees? (Q8)



For the 2010 survey, chart 12 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 63% 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.

CHART 12

Comparison of respondents providing active employees health care by population size



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For the 2010 survey, chart 13 shows the extent to which the 2010 survey respondents" provision of active employee health care varies by major geographic region. Over 90% of respondents in the Northeast and South offer health care to active employees, compared with about 77% for Western respondents. The somewhat lower percentage of Midwest respondents offering health care to active employees (73%) may reflect the relatively large proportion of Midwest respondents representing small governments.

CHART 13

Comparison of respondents providing active employee health care by region

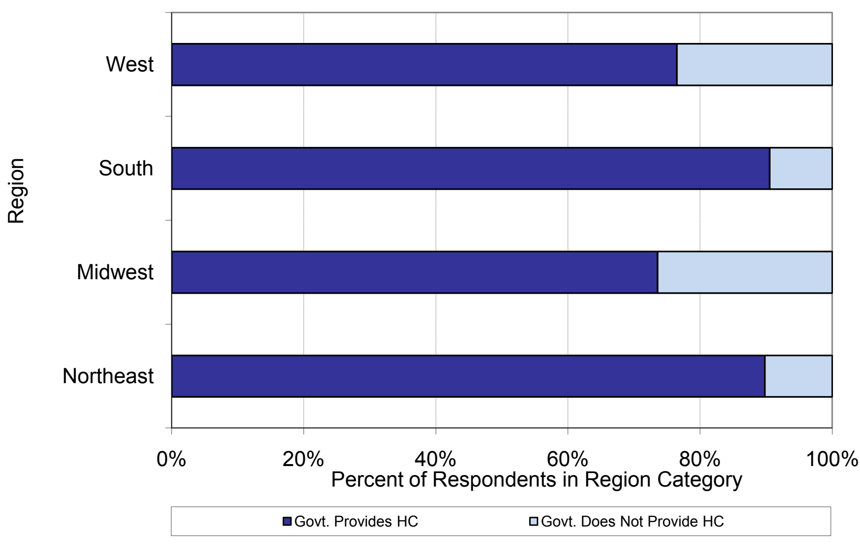
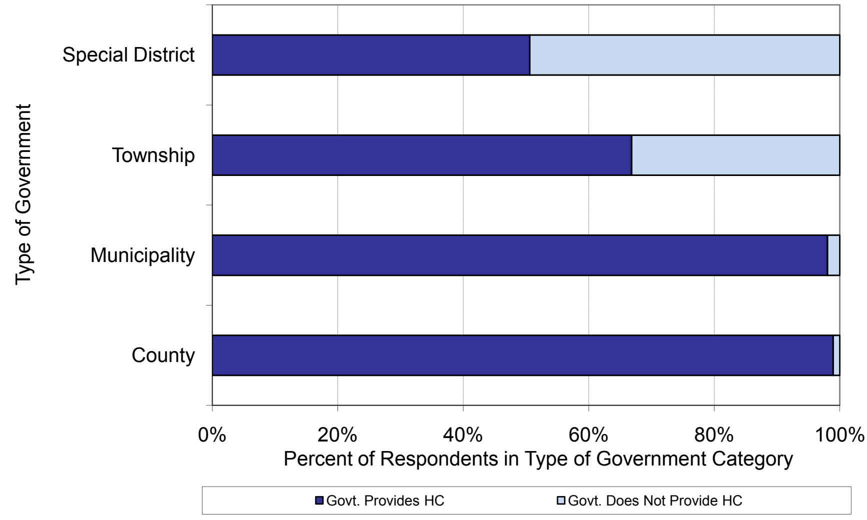


Chart 14 shows that the vast majority of respondents representing county and municipal governments (98%) provide health care to active employees. Smaller proportions of respondents from townships and special districts offer health care to active employees. However, readers should note that the respondents 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.

CHART 14

Comparison of respondents providing active employee health care by type of government



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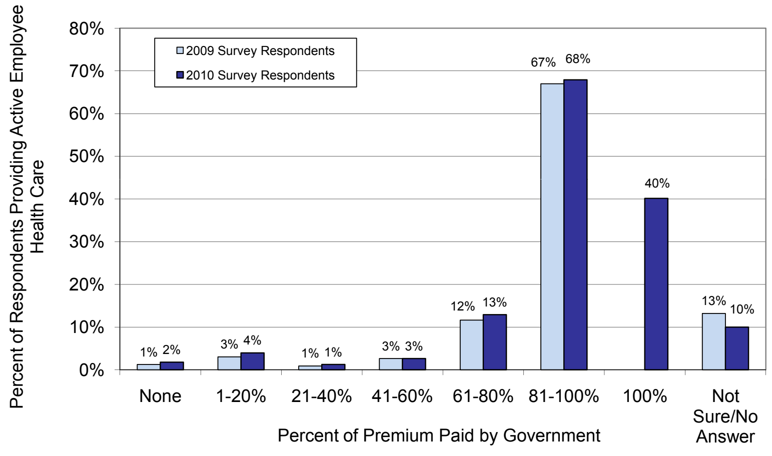
Provision of Health Care to Active Employees

For the government respondents that provide health care to active employees, two-thirds pay between 81% and 100% of the premium. Most of the remaining respondents pay between 60% and 80% of the premium. The 2010 questionnaire separately asked which respondents were paying exactly 100% of the premium. As shown in chart 15, 40% of the respondents pay 100% of the premium for active employees.

CHART 15

For governments providing active employee health care, what percentage of premium is paid by the local government? (Q10)

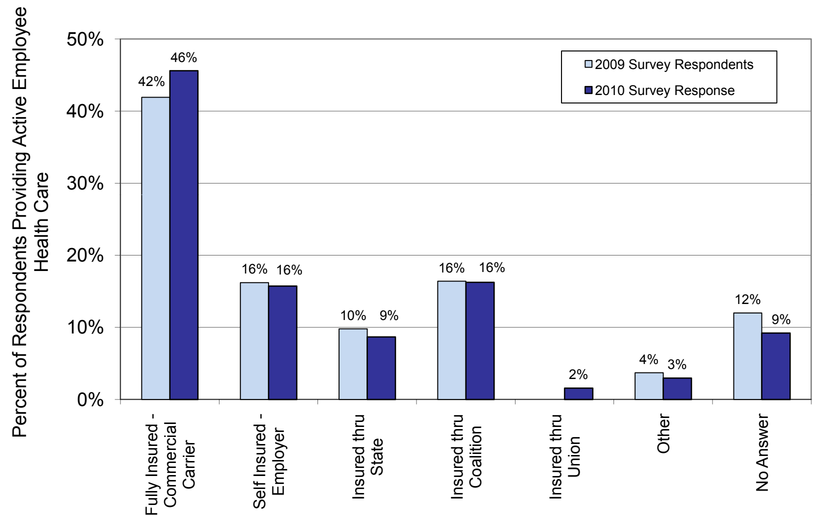


NOTE: The 2009 survey requested information regarding respondents paying 81-100% of the premium. The 2010 survey requested information regarding respondents paying 81-99% and 100%. Both are shown above for comparative purposes.

For the government respondents that provide health care to active employees, almost half (46% in 2010 and 42% in 2009) are fully insured through a commercial carrier, 16% are self-insured, about 10% obtain insurance through their state government, 16% obtain it through a coalition, and 2% have active employee health care provided through a union.

CHART 16

For governments providing active employee health care, how are health care benefits insured for active employees? (Q11)



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Provision of Health Care to Retirees

Twenty-eight percent of the governments that responded to the 2010 survey provide retiree health care. About 18% 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. As shown in chart 17, the majority (64% in 2009 and 71% in 2010) do not provide retiree health care. Many of these represent local governments serving populations of 5,000 or less.

CHART 17

Which retirees receive health care benefits from your local government? (Q12)

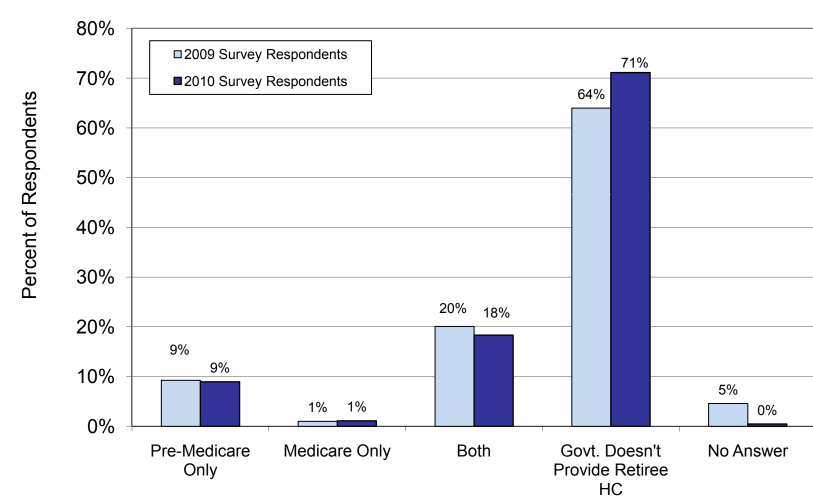
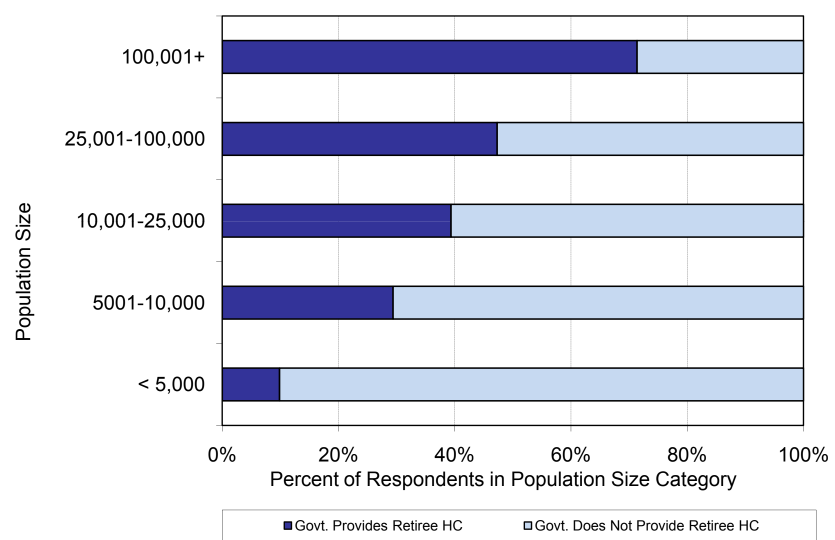


Chart 18 shows a clear correlation between the size of local government (measured by population) and the provision of retiree health care. Over two-thirds of the respondents from governments with populations of more than 100,000 provide retiree health care, compared with about 40% from governments with populations between 10,001 and 25,000 and 30% from governments with populations between 5,001 and 10,000. Only about 10% of respondents from governments with populations of 5,000 or less provide retiree health care.

CHART 18

Provision of retiree health care by population size

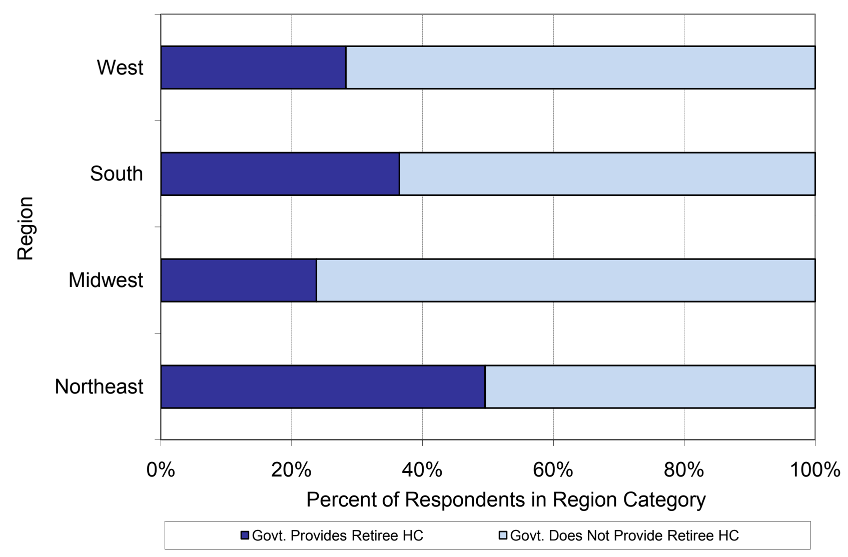


Provision of Health Care to Retirees

For the 2010 survey, a larger percentage of respondents from the Northeast provide retiree health care (50%) than those from the other geographic regions. A smaller percentage of respondents from the West and Midwest provide retiree health care (28% and 24%, 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.

CHART 19

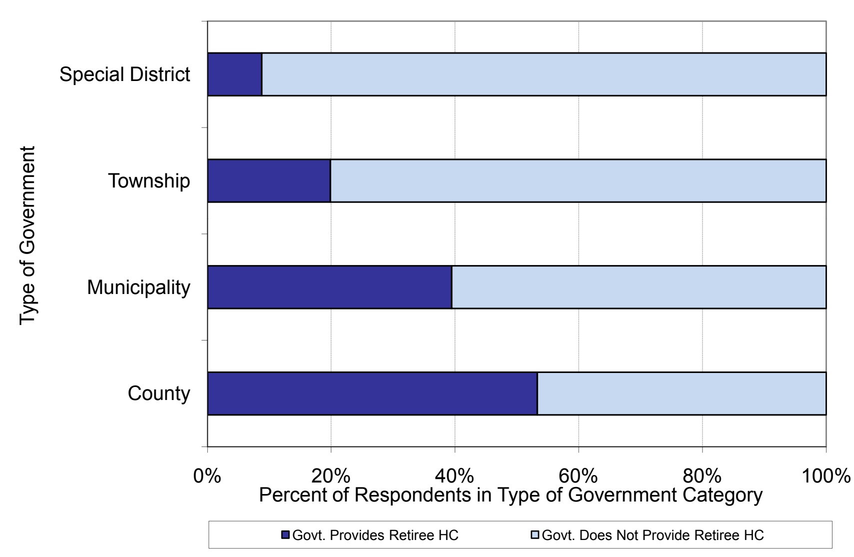
Provision of retiree health care by region



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. For the 2010 survey respondent county governments, 53% offer health care benefits for retirees. This compares with 40% for municipalities, 20% for townships, and about 8% for special districts.

CHART 20

Provision of retiree health care by type of government



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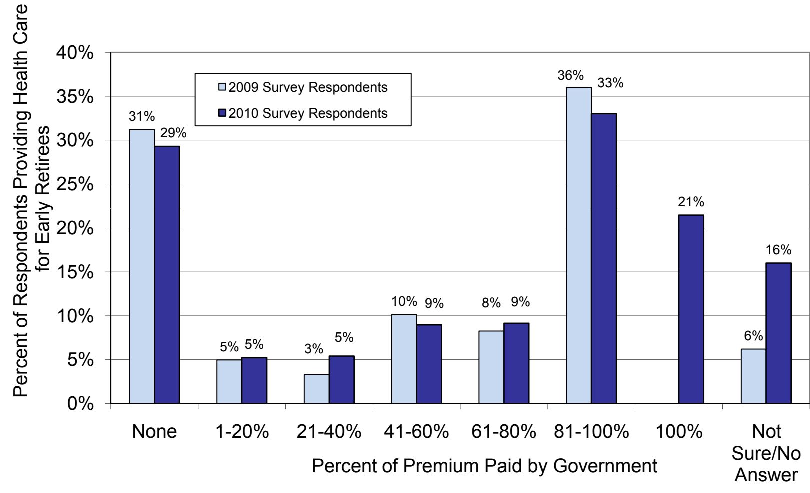
Of the respondents offering health care for early (pre-Medicare eligible) retirees, roughly one-third pay between 81% and 100% of the premium, one-third pay none of the premium, and the remainder pay some portion in between. It is likely that many of the respondent governments that pay none of the premium are essentially offering retirees access to active member group health coverage. Thus, they are likely offering what the GASB describes as an "implicit rate subsidy" –i.e., access to health care coverage at a premium rate that blends active employee and retiree health care costs. The 2010 questionnaire separately asked which respondents were paying exactly 100% of the premium. As shown in chart 21, 21% of the respondents pay 100% of the premium for early retirees.

CHART 21

For governments providing health care for early retirees (pre-Medicare), what percent of the premium is paid by the local government? (Q13)

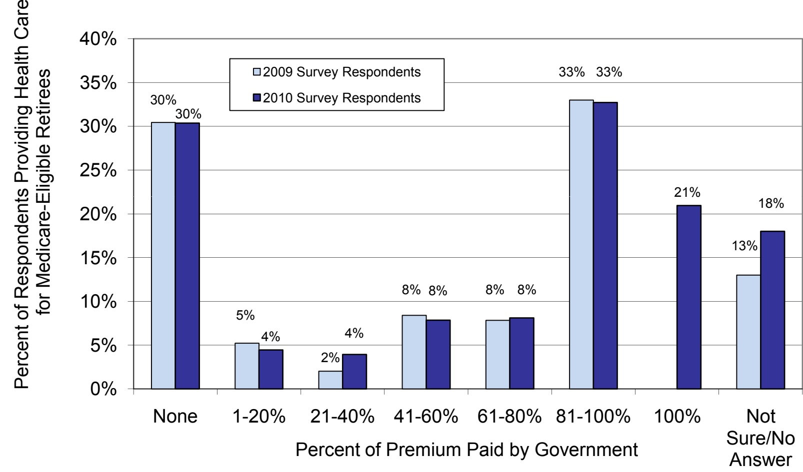


NOTE: The 2009 survey requested information regarding respondents paying 81-100% of the premium. The 2010 survey requested information regarding respondents paying 81-99% and 100%. Both are shown above for comparative purposes.

CHART 22

For governments providing health care for Medicare-eligible retirees, what percent of the premium is paid by the local government? (Q14)

Of the respondents offering health care coverage to Medicare-eligible retirees, the pattern of premium payments is almost identical to that of early retirees: roughly one-third pay between 81% and 100% of the premium, one-third pay none of the premium, and the rest pay somewhere in between. The 2010 questionnaire separately asked which respondents pay exactly 100% of the premium. As shown in chart 22, 21% of the respondents pay 100% of the premium for Medicare eligible retirees.



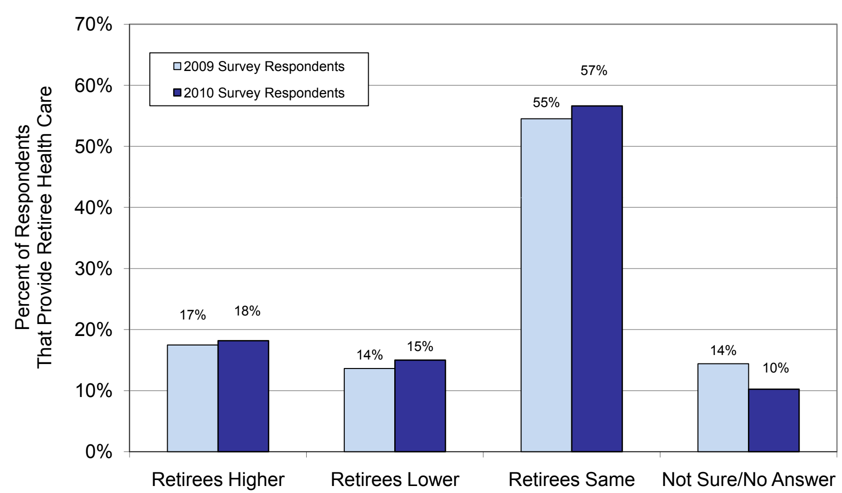
NOTE: The 2009 survey requested information regarding respondents paying 81-100% of the premium. The 2010 survey requested information regarding respondents paying 81-99% and 100%. Both are shown above for comparative purposes.

Provision of Health Care to Retirees

Retiree health care premiums are the same as active member premiums for over half of the respondents that offer retiree health care (55% in 2009 and 57% in 2010). This suggests that many of the governments offering retiree health care do so using a premium rate that blends the costs of active and retired members. For the 2010 survey, retiree health care premiums were higher than active member premiums for 18% of the respondents and lower than active member premiums for 15% of the respondents. The 2009 survey showed similar results.

CHART 23

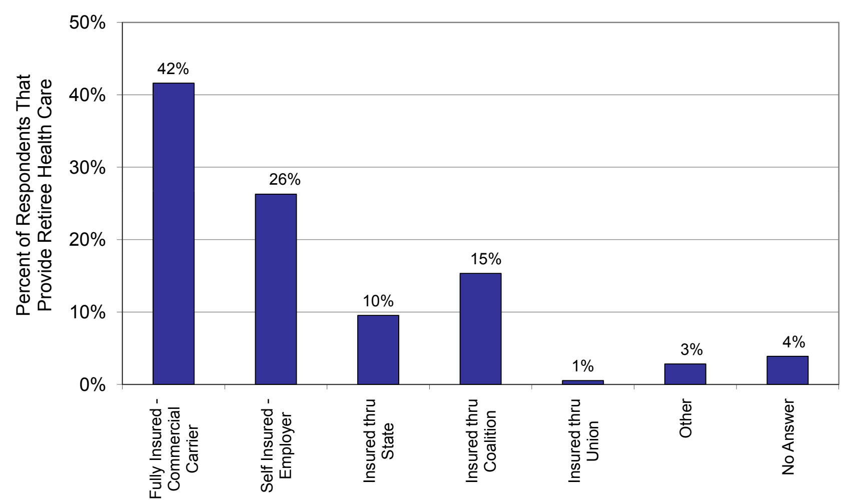
For governments providing retiree health care, how do retiree premiums compare to active employee premiums? (Q15)



Many of the respondents providing retiree health care purchased the care as a single employer, rather than through the state or a coalition. For the 2010 survey, 42% of the respondents were fully insured through a commercial carrier, 26% were self-insured, 10% purchased it through the state, 15% through a coalition, 1% through a union, and 3% through some other arrangement.

CHART 24

For governments providing retiree health care, how are health care benefits for your retirees insured? (Q16)



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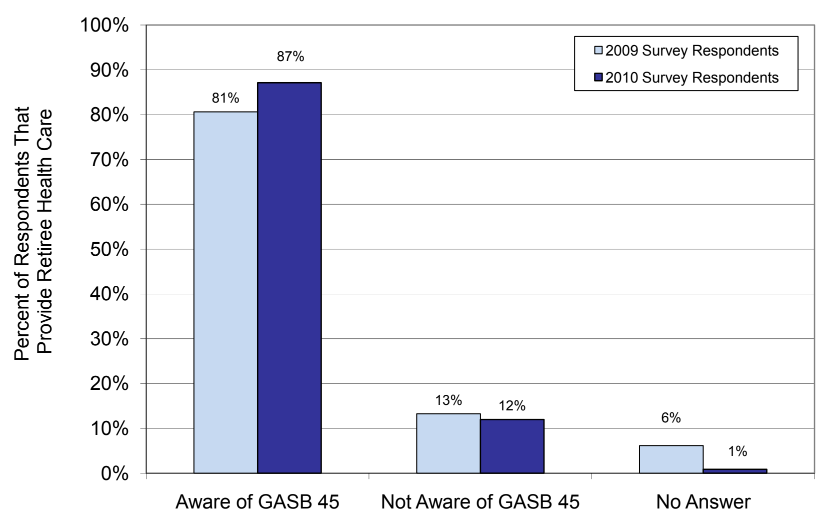
SECTION 5

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. Chart 25 shows that, of the respondents providing retiree health care, the vast majority (87% in 2010 and 81% in 2009) are aware of Statement No. 45.

CHART 25

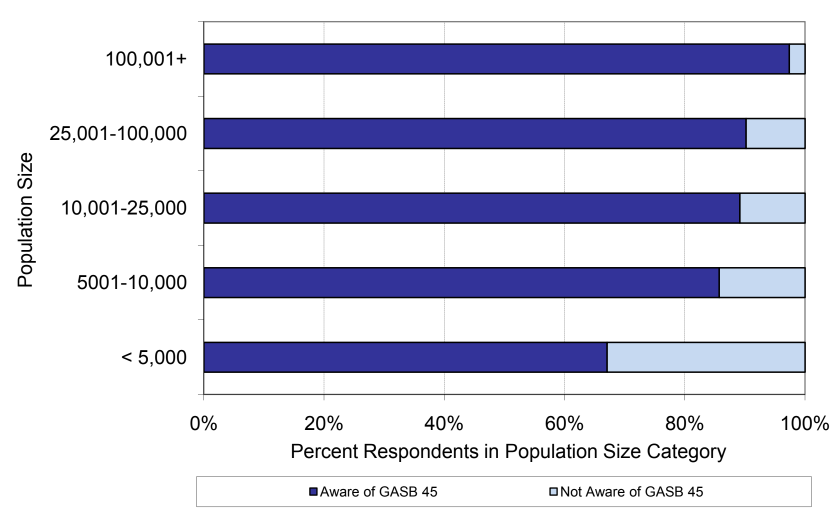
For governments providing retiree health care, are you aware of GASB Statement No. 45? (Q17)



For the 2010 survey respondents from governments with populations of more than 25,000, the vast majority (over 90%) 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 No. 45.

CHART 26

Awareness of GASB Statement no. 45 by population size for governments providing retiree health care



Addressing GASB

Chart 27 shows that awareness of GASB Statement No. 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 Statement No. 45.

CHART 27

Awareness of GASB Statement No. 45 by region for governments providing retiree health care

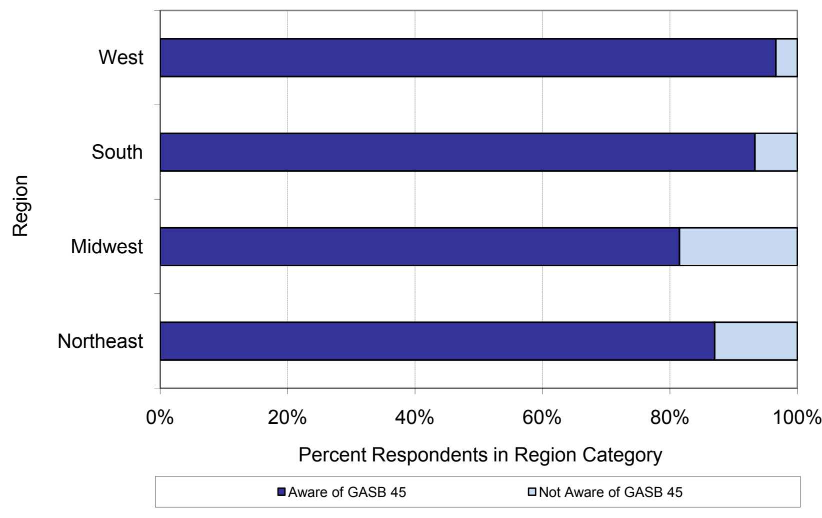
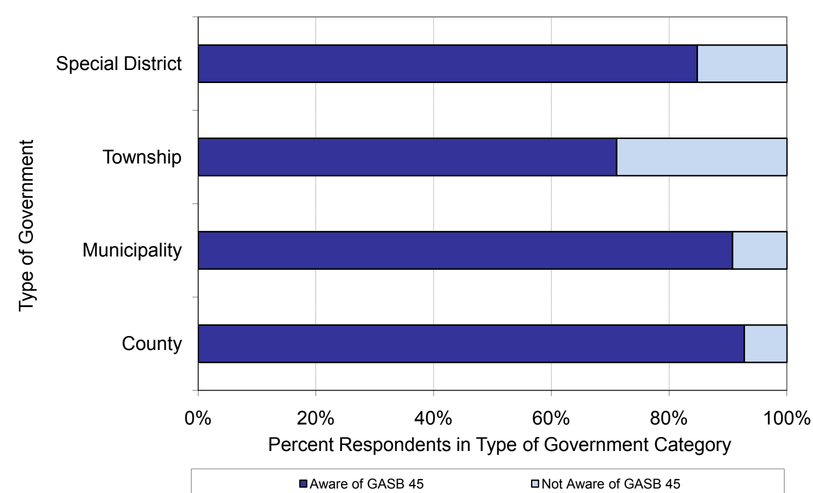


Chart 28 shows that at least 90% of respondents from county and municipal governments that provide retiree health care are aware of Statement No. 45. However, only about 70% of respondents from townships are so aware.

CHART 28

Awareness of GASB Statement No. 45 by type of government for governments providing retiree health care



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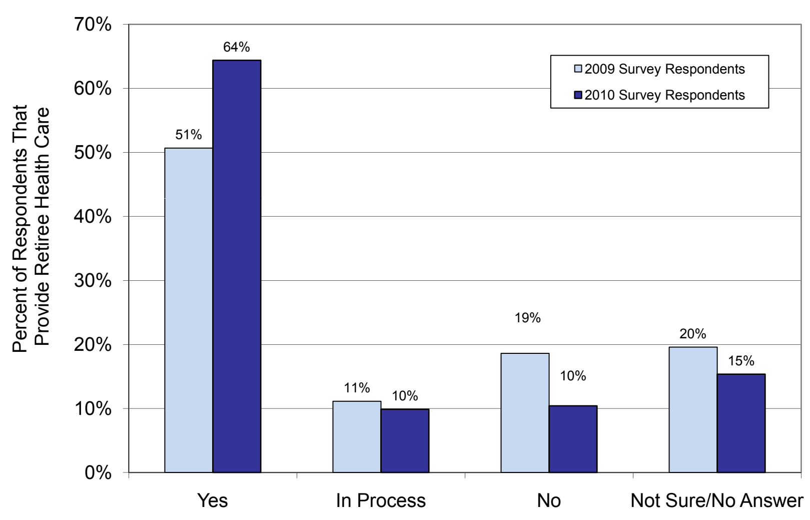
The survey also examined the extent to which local governments that offer retiree health care have taken steps to calculate their related other postemployment benefit (OPEB) liability. For the 2010 survey respondents, the chart belowshows that 64% have calculated their OPEB liability, 10% are in the process of calculating it, and another 10% have not calculated it. These numbers represent a significant improvement over the 2009 survey results. However, 15% were not sure or did not respond to this question.

CHART 29

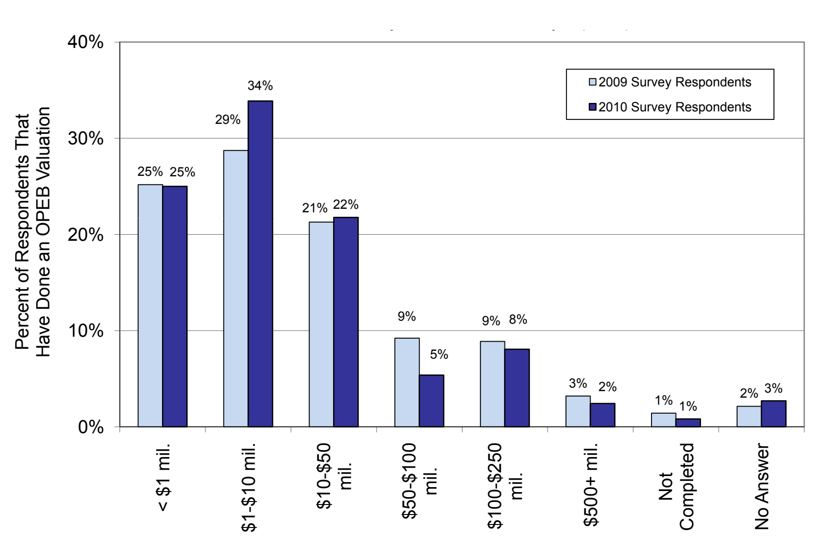
For governments providing retiree health care, have you calculated your OPEB liability? (Q18)



For the 2010 respondents that have done an OPEB valuation, the majority (59%) have OPEB liabilities of less than $10 million. This reflects the fact that many of the respondents represent smaller local governments. However, 10% of these respondents have OPEB liabilities of $100 million or more. The 2009 survey showed a similar distribution.

CHART 30

For governments that have done an OPEB valuation, what is your OPEB liability? (Q19)

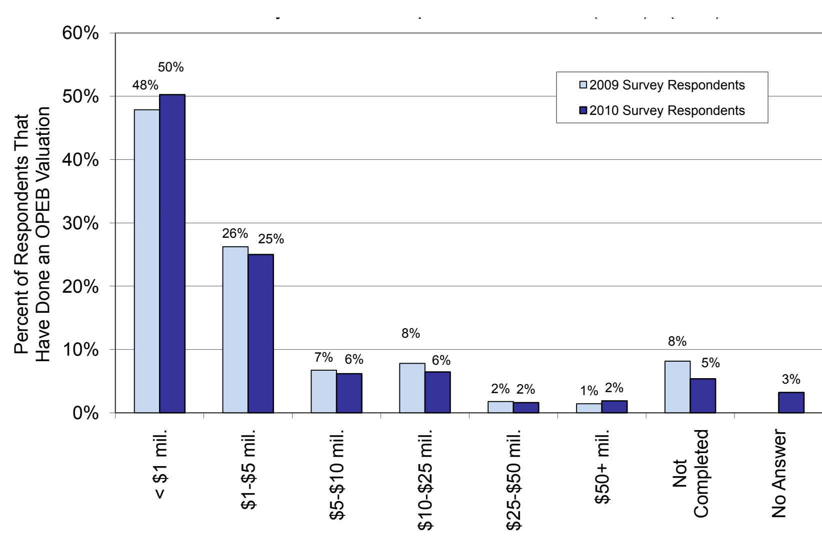


Addressing GASB

For the 2010 survey respondents that have done an OPEB valuation, the majority of respondents (75%) have annual required contributions for funding their retiree health care benefits of $5 million or less. Again, this reflects the fact that the respondents generally represent smaller governments. The 2009 survey showed similar results.

CHART 31

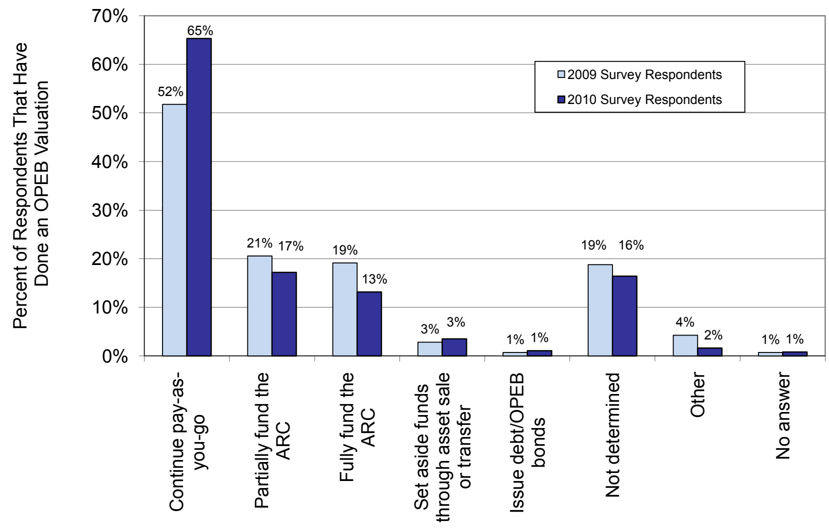
For governments that have done an OPEB valuation,what is your annual required contribution (ARC)? (Q20)



For respondent governments that have actuarially valued their OPEB benefits, there are several approaches to financing the OPEB liability. For the 2010 survey respondents, 65% indicated they would not pre-fund, but rather continue the pay-as-you-go approach (up from 52% in 2009). Only 13% indicated they would fully fund their annually required contribution (ARC), and another 17% indicated they would partially prefund the benefits (down from 19% and 21% respectively in 2009). Another 18% 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.

CHART 32

For governments that have done an OPEB valuation, how do you plan to fund your OPEB liability? (Q21)



NOTE: Percentages do not add to 100% due to multiple applicable responses.

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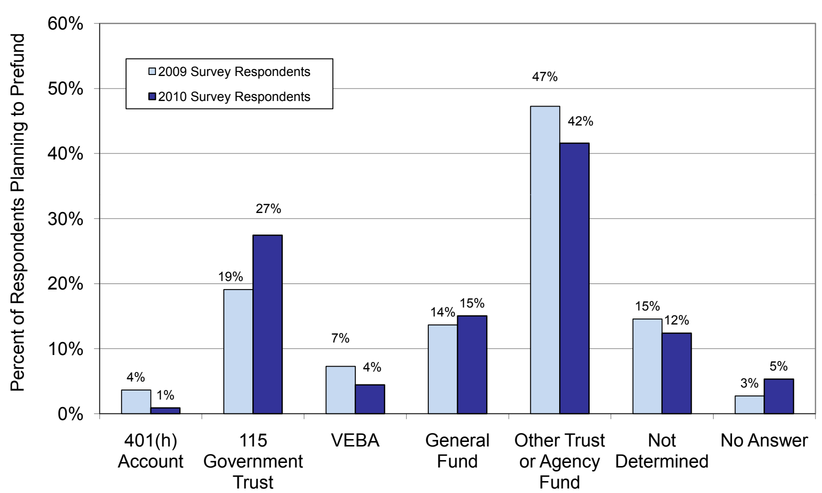
For the 2010 survey respondents that provide retiree health care, 30% have decided to fully or partially prefund the OPEB liability (as shown on the previous page). Chart 33 shows that of these, 57% expect to rely on the general fund or an agency fund as the funding vehicle. In addition, 32% are planning 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. Compared with the 2009 survey results, a greater portion plan to use 115 trusts and a lower portion plan to use 401(h) accounts or VEBAs.

CHART 33

For governments planning to fully or partially prefund OPEB, what kind of reserve account or trust do you plan to use? (Q22)

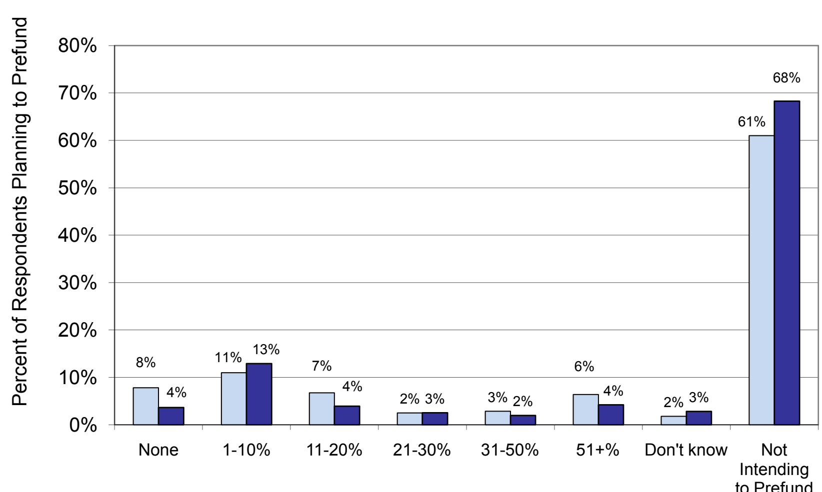


NOTE: Percentages do not add to 100% due to multiple applicable responses.

For the 2010 survey respondents, of those that have done an OPEB valuation, 26% indicated they have set aside assets to fund the benefits. Chart 34 shows that 13% reported accumulating between 1% and 10% of the assets needed to fund the liability and 4% reported accumulating more than 50% of the assets. Over half (68%) of those that have done an OPEB valuation do not intend to prefund the benefits. This is up from 61% in the 2009 survey and may reflect the impact of the economic downturn on governments.

CHART 34

For governments that have done and OPEB valuation, what portion of the OPEB liability has already been set aside? (Q23)

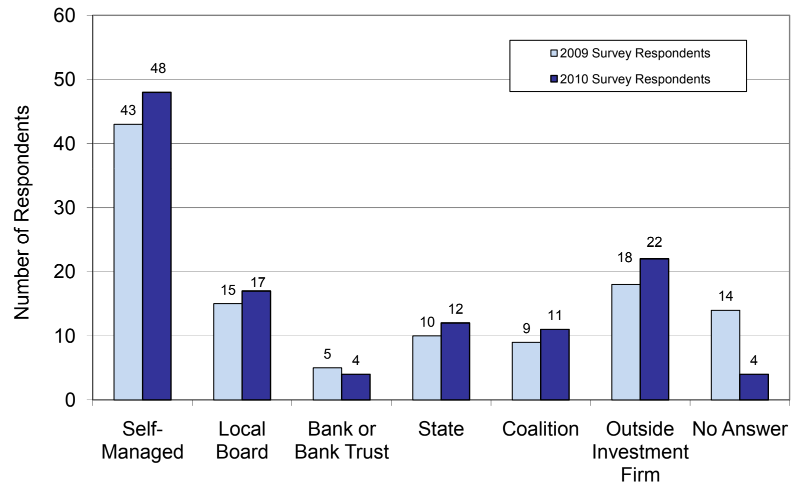


Addressing GASB

For governments that have set aside OPEB assets, chart 35 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.

CHART 35

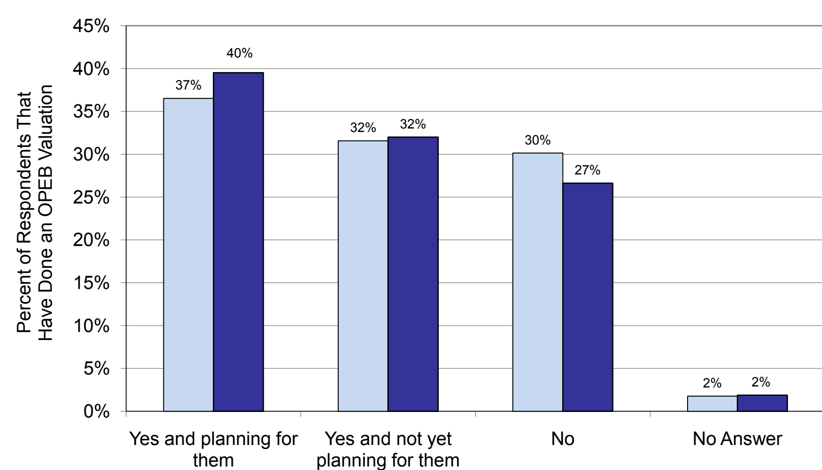
For governments that have set aside OPEB assets, who manages the investments? (Q24)



For the 2010 survey respondents who have done an OPEB valuation, 40% indicated that the experience has heightened their awareness of other long-term liabilities and that they have begun planning for them. For another 32%, the experience has heighted awareness, but the governments have not yet begun planning for them. For 27%, the experience has not heightened their awareness.

CHART 36

For the governments that have done an OPEB valuation, has the OPEB experience heightened your awareness of other long-term liabilities? (Q25)



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Health Care Strategies

The final goal of the survey was to examine various approaches to controlling health care costs that have been implemented bygovernments during the past two years or are expected to be implemented over the next two years. Chart 37 shows the 2010 survey responses regarding 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, with the exception of increasing the member"s share of premium costs, 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.)

CHART 37

What changes have you implemented or plan to implement to reduce health care costs with regard to plan eligibility and contributions? (Q27&28)

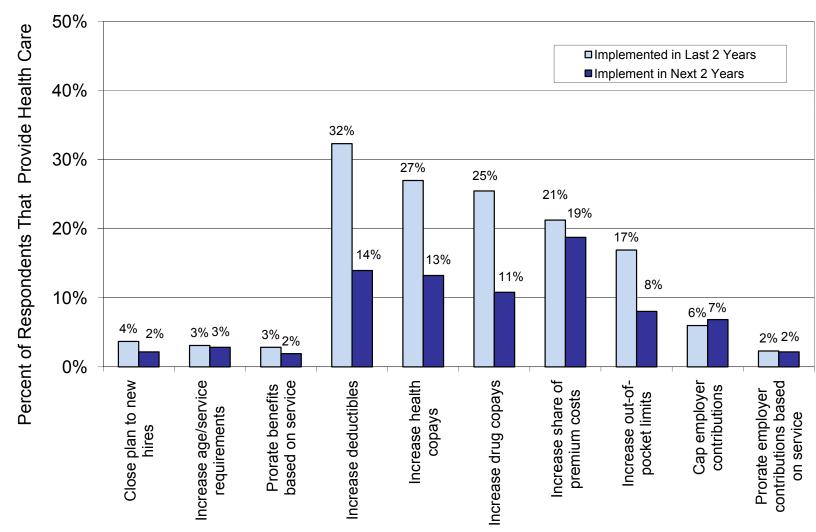
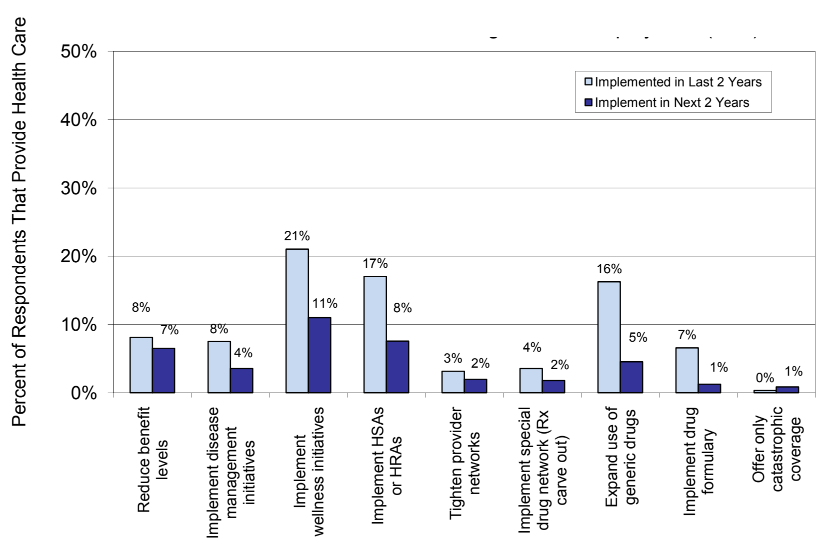


Chart 38 shows the 2010 survey responses related to various changes in health care plan design for all employees made over the past two years or planned over the next two years. Of these, the most frequent changes over the past two years include: implementing wellness initiatives, expanding the use of generic drugs, and implementing health savings accounts (HSAs) or heath reimbursement arrangements (HRAs). A smaller percentage expect to implement such changes over the next two years.

CHART 38

What plan design changes have you implemented or plan to implement to reduce health care costs with regard to all employees? (Q29)



Health Care Strategies

Chart 39 shows the 2010 survey responses regarding various changes in health care plan design made for retired employees over the past two years or planned over the next two years. Of these, the most frequent change was to require Medicare Part D coverage, but this was implemented by only 8% of the respondents that offered retiree health care benefits. In addition, 5% of the respondents that offered retiree health care offered a Medicare Advantage plan within the last two years.

CHART 39

What plan design changes have you implemented or plan to implement within the next two years related to retired employees? (Q29)

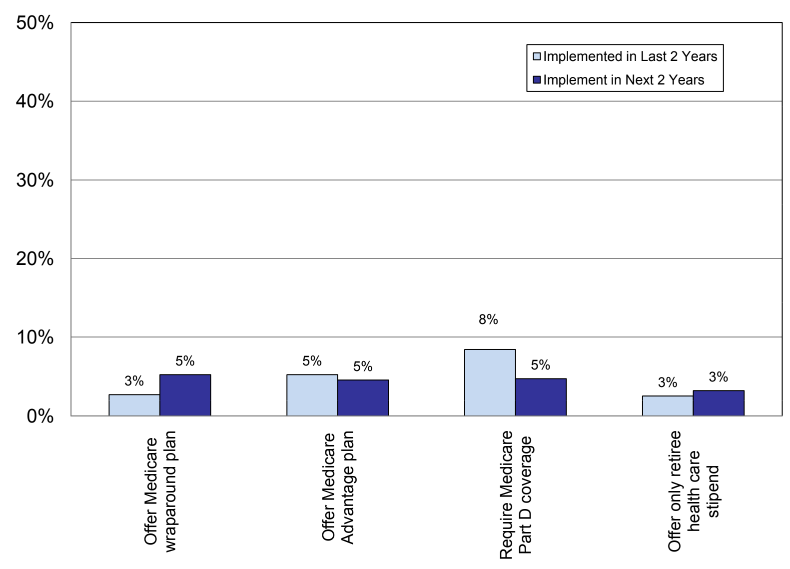
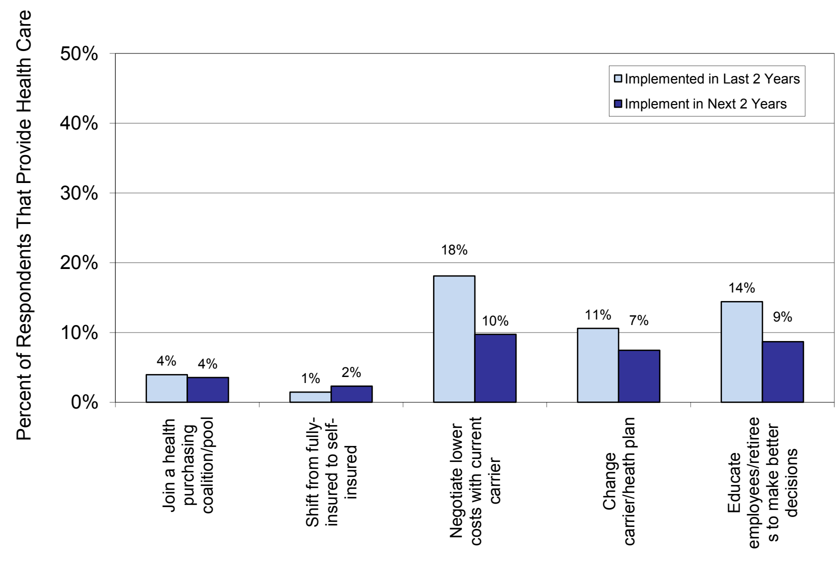


Chart 40 shows the 2010 survey responses for health care purchasing changes that have been implemented over the past two years or are planned for the next two years. The changes that stand out include negotiating lower costs with the current carrier, changing the current carrier or health plan, and educating employees/retirees to make better health care decisions.

CHART 40

What changes have you implemented or plan to implement to reduce health care costs with regard to health care purchasing? (Q30)



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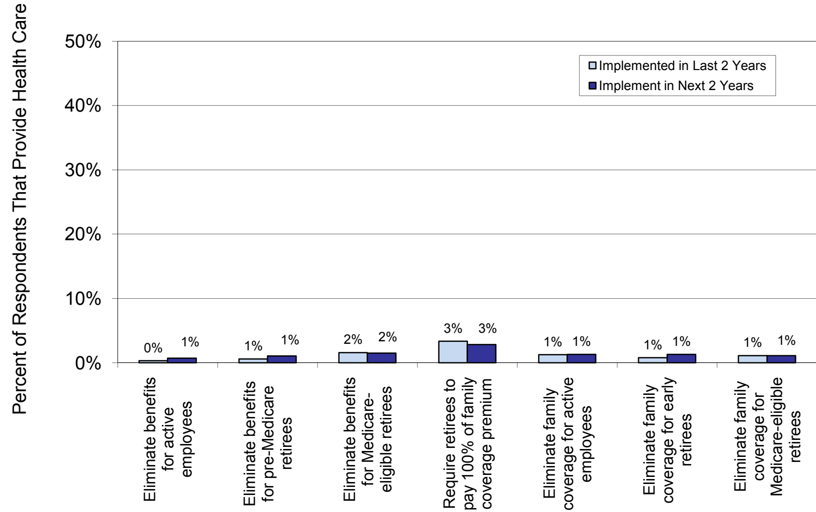
The 2010 survey also asked about health care changes that have recently been implemented or are planned to be implemented with regard to benefit elimination. Chart 41 shows that very few of the respondents have taken steps to eliminate benefits for active members or retirees. Of these, the most frequent change has been to require retirees to pay 100% for family coverage, but this change has been implemented by only 3% of the respondents.

CHART 41

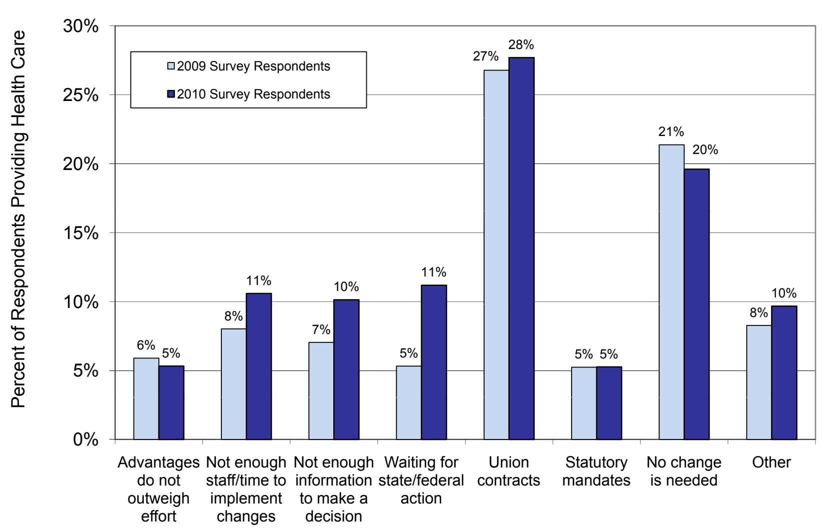
What changes have you implemented or plan to implement to reduce health care costs with regard to benefit elimination? (Q31)



The survey also asked respondents about what they believed were significant barriers to health plan changes. Chart 42 shows that about one-quarter cited union contracts as a significant barrier. Other barriers included: lack of available time; lack of information; and waiting for additional federal and state government action. Interestingly, about 20% did not think changes were needed.

CHART 42

What are significant barriers to health plan design changes? (Q32)



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 8,000 surveys were distributed by mail between February and April 2010.

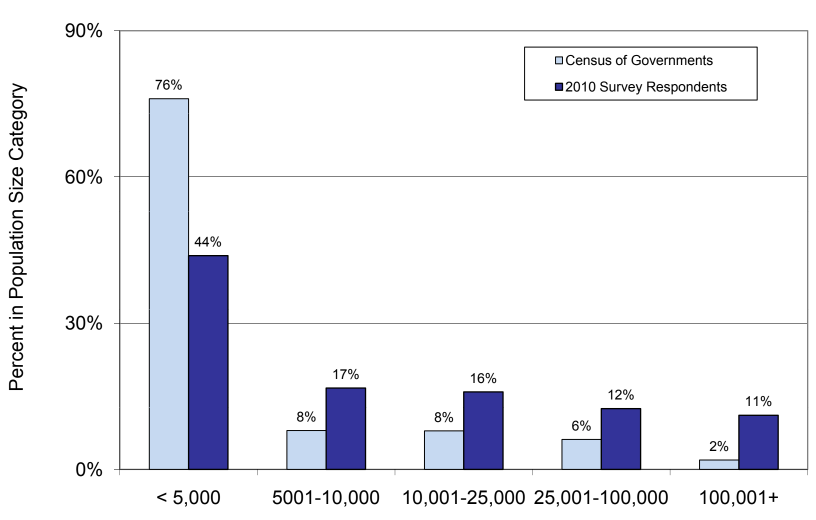
Based on the 1,963 valid responses collected for this survey, the response rate is approximately 25 percent. This provides a significant dataset for analysis, although all surveys are subject to inaccuracies based on sampling and response error, etc. The results represent a margin of error of +/-2.5 percent, at a 95 percent confidence interval.

It should be noted that the 2010 sample is similar to the sample used in 2009, 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.

Chart 43 compares the distribution of the 2010 survey respondents with the U.S. Census Bureau „s distribution of local governments by size of population. The exhibit illustrates the effect that the over/under sampling had on the distribution of survey respondents. While governments serving populations of less than 5,000 represent 76% of U.S. local governments (excluding special districts) , they constitute only 44% of the 2010 survey respondents. Similarly, while governments serving populations of over 100,000 represent only 2% of U.S. local governments, they constitute 11% of the 2010 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.

CHART 43

Comparison of respondents with U.S. Local Governments by population size (excluding special districts)



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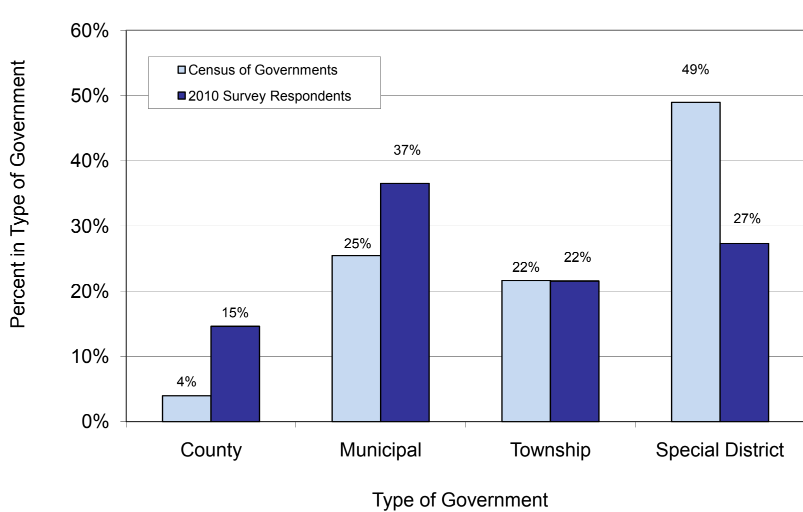
Methodology & Detailed Tables

Chart 44 compares the distribution of the 2010 survey 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.

CHART 44

Comparison of respondents with U.S. Local Governments by type of government



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 chart 45, 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.

CHART 45

What were the annual revenues for your local government for the most recently completed fiscal year? (Q3)

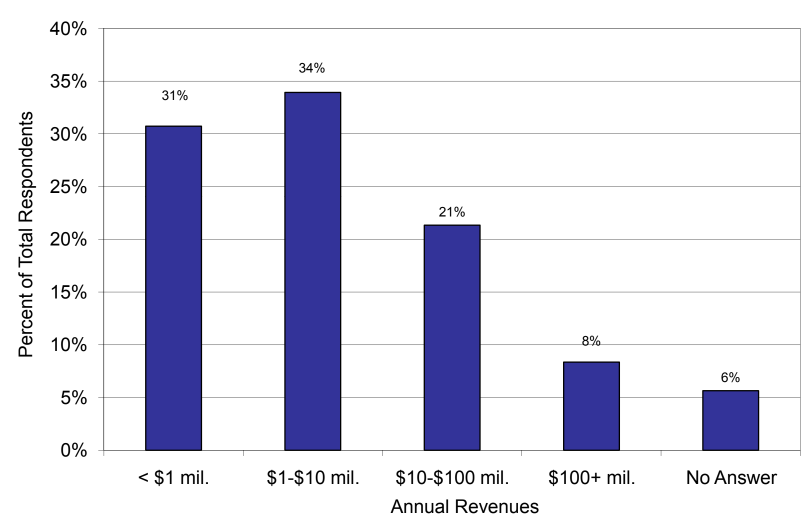


Chart 46 shows the distribution of respondents by population and annual revenues. The most striking aspect of this exhibit is the extent to which the respondents represent local governments with annual revenues of less than $10 million. These governments conform to the GASB‟s definition of "Phase 3" governments, for which the GASB‟s Statement 45 OPEB accounting standards apply for financial reporting periods beginning after December 15, 2008.

CHART 46

Respondents by population size and annual revenues

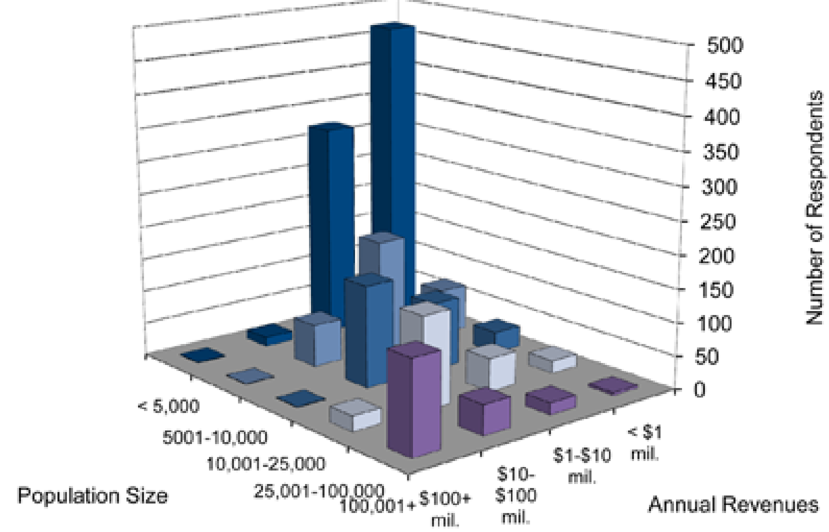


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Table 1: Descriptive Information

	Number of Respondents	% of Respondents
Number of Full-Time Employees (Q1)		
< 5	604	30.8%
5 -10	138	7.0%
11-25	264	13.4%
26 - 50	201	10.2%
51-100	227	11.6%
101 - 250	220	11.2%
251+	284	14.5%
No Answer	25	1.3%
Total	**1,963**	**100.0%**
Population Size (Q2)		
< 5,000	841	42.8%
5001-10,000	320	16.3%
10,001-25,000	305	15.5%
25,001-100,000	239	12.2%
100,001+	213	10.9%
No Answer	45	2.3%
Total	**1,963**	**100.0%**
Geographic Region		
Northeast	109	5.6%
Midwest	1,081	55.1%
South	458	23.3%
West	315	16.0%
Total	**1,963**	**100.0%**
Type of Government		
County	287	14.6%
Municipality	717	36.5%
Township	423	21.5%
Special District	536	27.3%
Total	**1,963**	**100.0%**

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

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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.	603	30.7%
$1-$10 mil.	666	33.9%
$10-$100 mil.	419	21.3%
$100+ mil.	164	8.4%
No Answer	111	5.7%
Total	**1,963**	**100.0%**
How do you expect your local government's revenue levels to change next year compared to this year? (Q4)		
Increase	126	6.4%
Stay Same	664	33.8%
Drop 1-5%	640	32.6%
Drop 6-10%	244	12.4%
Drop 11-20%	76	3.9%
Drop 20%+	14	0.7%
Don't Know	150	7.6%
No Answer	49	2.5%
Total	**1,963**	**100.0%**
How do you expect your local government's employment levels to change next year compared to this year? (Q5)		
Increase	47	2.4%
Decrease	379	19.3%
Stay Same	1,338	68.2%
Don't Know	159	8.1%
No Answer	40	2.0%
Total	**1,963**	**100.0%**

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

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Table 3: Expected Changes

	Number of Respondents	% of Applicable Respondents
What changes do you expect in your local government workforce in the next two years? (Q6)		
Consolidating/sharing services	495	26.4%
Sending more services out to contract	212	11.3%
Layoffs	231	12.3%
Rehiring retirees	39	2.1%
More part-time/temporary positions	302	16.1%
More full-time positions	49	2.6%
Offer early retirement incentives	100	5.3%
Reduce through attrition	441	23.5%
No changes	1,016	54.1%
Total Respondents	**1,878**	**NA***
Has your elected governing body adopted a formal policy to review long-term costs of benefit changes? (Q7)		
Yes	166	8.5%
No - But Plan to in Future	426	21.7%
No -No Plan in Future	1,260	64.2%
No Answer	111	5.7%
Total	**1,963**	**100.0%**

** Number of responses may exceed total respondents due to multiple applicable responses.*
Note: Percentages may not add to 100% due to rounding.

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Table 4: Health Care for Active Employees

	Number of Respondents	% of Applicable Respondents
Do your active employees receive health care benefits? (Q8)		
Actives Receive	1,520	77.4%
Actives Do Not Receive	405	20.6%
No Answer	38	1.9%
Total	**1,963**	**100.0%**
What percentage of the premium for active employees is paid by the local government? (Q10)		
None	27	1.8%
1-20%	60	3.9%
21-40%	19	1.3%
41-60%	40	2.6%
61-80%	196	12.9%
81-99%	422	27.8%
100%	610	40.1%
Not sure	146	9.6%
Total Providing Health Care to Active Employees	**1,520**	**100.0%**
How are health care benefits for your active employees insured? (Q11)		
Fully Insured -Commercial Carrier	693	45.6%
Self Insured -Employer	239	15.7%
Insured thru State	132	8.7%
Insured thru Coalition	247	16.3%
Insured thru Union	24	1.6%
Other	45	3.0%
No Answer	140	9.2%
Total Providing Health Care to Active Employees	**1,520**	**100.0%**

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

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Table 5: Health Care for Retired Employees

	Number of Respondents	% of Applicable Respondents
Which retirees receive health care benefits from the local government? (Q12)		
Pre-Medicare Only	176	9.0%
Medicare Only	22	1.1%
Both	360	18.3%
Govt. Doesnt Provide Retiree HC	1,396	71.1%
No Answer	9	0.5%
Total	**1,963**	**100.0%**
What percentage of the premium for early retirees (pre-Medicare) is paid by the local government? (Q13)		
None	157	29.3%
1-20%	28	5.2%
21-40%	29	5.4%
41-60%	48	9.0%
61-80%	49	9.1%
81-99%	62	11.6%
100%	115	21.5%
Not Sure	48	9.0%
Total Providing Early Retiree Health Care	**536**	**100.0%**
What percentage of the premium for Medicare retirees is paid by the local government? (Q14)		
None	116	30.4%
1-20%	17	4.5%
21-40%	15	3.9%
41-60%	30	7.9%
61-80%	31	8.1%
81-99%	45	11.8%
100%	80	20.9%
Not Sure	48	12.6%
Total Providing Medicare Retiree Health Care	**382**	**100.0%**

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

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Table 5: Health Care for Retired Employees (continued)

	Number of Respondents	% of Applicable Respondents
How do retiree premiums compare to active employee premiums? (Q15)		
Retirees Higher	103	18.2%
Retirees Lower	85	15.0%
Retirees Same	321	56.6%
Not Sure/No Answer	58	10.2%
Total Providing Retiree Health Care	**567**	**100.0%**
How are health care benefits for your retired employees insured? (Q16)		
Fully Insured - Commercial Carrier	236	41.6%
Self Insured - Employer	149	26.3%
Insured thru State	54	9.5%
Insured thru Coalition	87	15.3%
Insured thru Union	3	0.5%
Other	16	2.8%
No Answer	22	3.9%
Total Provided Retiree Health Care	**567**	**100.0%**

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

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Table 6: OPEB Costs and Liabilities

	Number of Respondents	% of Applicable Respondents
Are you aware of GASB Statement 45, which establishes reporting requirements for OPEB liabilities? (Q17)		
Aware of GASB 45	494	87.1%
Not Aware of GASB 45	68	12.0%
No Answer	5	0.9%
Total Providing Retiree Health Care	**567**	**100.0%**
Have you calculated your OPEB liability? (Q18)		
Yes	365	64.4%
In Process	56	9.9%
No	59	10.4%
Not Sure/No Answer	87	15.3%
Total Providing Retiree Health Care	**567**	**100.0%**
What is your OPEB liability? (Q19)		
< $1 mil.	93	25.0%
$1-$10 mil.	126	33.9%
$10-$50 mil.	81	21.8%
$50-$100 mil.	20	5.4%
$100-$250 mil.	30	8.1%
$500+ mil.	9	2.4%
Not Completed	3	0.8%
No Answer	10	2.7%
Total Having Calculated the OPEB Liability *(Includes calculations in process)*	**372**	**100.0%**
What is your OPEB annual required contribution (ARC)? (Q20)		
< $1 mil.	187	50.3%
$1-$5 mil.	93	25.0%
$5-$10 mil.	23	6.2%
$10-$25 mil.	24	6.5%
$25-$50 mil.	6	1.6%
$50+ mil.	7	1.9%
Not Completed	20	5.4%
No Answer	12	3.2%
Total Having Calculated the OPEB Liability *(Includes calculations in process)*	**372**	**100.0%**

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

Table 7: OPEB Funding

	Number of Respondents	% of Applicable Respondents
How do you plan to fund your OPEB liability? (Q21)		
Continue pay-as-you-go	243	65.3%
Partially fund the ARC	64	17.2%
Fully fund the ARC	49	13.2%
Set aside funds through asset sale or transfer	13	3.5%
Issue debt/OPEB bonds	4	1.1%
Not determined	58	15.6%
Other	6	1.6%
Total Having Calculated the OPEB Liability	**372**	**NA***
What kind of account do you use for your OPEB reserve? (Q22)		
401(h) Account	1	0.9%
115 Government Trust	31	27.4%
VEBA	5	4.4%
General Fund	17	15.0%
Other Trust or Agency Fund	47	41.6%
Not Determined	14	12.4%
No Answer	6	5.3%
Total That Plan to Fully or Partially Prefund	**113**	**NA**
How much funding have you set aside to offset the OPEB liability? (Q23)		
None	13	3.6%
1-10%	46	12.9%
11-20%	14	3.9%
21-30%	9	2.5%
31-50%	7	2.0%
51+%	15	4.2%
Don't know	10	2.8%
Not Intending to Prefund	243	68.1%
Total Having Calculated the OPEB Liability	**357**	**100.0%**

* *Number of responses may exceed total respondents due to multiple applicable responses.*
Note: Percentages may not add to 100% due to rounding.

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Table 7: OPEB Funding (continued)

	Number of Respondents	% of Applicable Respondents
Who manages the investment of your OPEB reserves? (Q24)		
Self-Managed	48	52.7%
Local Board	17	18.7%
Bank or Bank Trust	4	4.4%
State	12	13.2%
Coalition	11	12.1%
Outside Investment Firm	22	24.2%
Total	**9**	**NA**
Has the OPEB experience heightened your awareness of other long-term liabilities? (Q25)		
Yes and planning for them	147	39.5%
Yes and not yet planning for them	119	32.0%
No	99	26.6%
No Answer	7	1.9%
Total	**372**	**100.0%**
What effect has your OPEB liability had on your credit rating? (Q26)		
No effect	397	70.0%
Improved credit rating	16	2.8%
Degraded credit rating	4	0.7%
No Answer	150	26.5%
Total	**567**	**100.0%**

* *Number of responses may exceed total respondents due to multiple applicable responses.*
Note: Percentages may not add to 100% due to rounding.

Table 8: Health Care Changes Recently Implemented or Planned

(% of Respondents Offering Health Care)

	IMPLEMENTED IN LAST 2 YEARS		IMPLEMENT IN NEXT 2 YEARS	
	Number of Respondents	% of Those Offering HC	Number of Respondents	% of Those Offering HC
Eligibility Changes (Q27)				
Close plan to new hires	56	3.7%	33	2.2%
Increase age/service requirements	47	3.1%	43	2.8%
Prorate benefits based on service	43	2.8%	29	1.9%
Contribution Changes (Q28)				
Increase deductibles	491	32.3%	212	13.9%
Increase health copays	410	27.0%	201	13.2%
Increase drug copays	387	25.5%	164	10.8%
Increase share of premium costs	323	21.3%	285	18.8%
Increase out-of-pocket limits	257	16.9%	122	8.0%
Cap employer contributions	91	6.0%	104	6.8%
Prorate employer contributions based on service	35	2.3%	33	2.2%
Design Changes - All Members (Q29)				
Reduce benefit levels	123	8.1%	99	6.5%
Implement disease management initiatives	114	7.5%	54	3.6%
Implement wellness initiatives	320	21.1%	167	11.0%
Implement HSAs or HRAs	259	17.0%	115	7.6%
Tighten provider networks	48	3.2%	30	2.0%
Implement special drug network (Rx carve out)	54	3.6%	27	1.8%
Expand use of generic drugs	247	16.3%	69	4.5%
Implement drug formulary	100	6.6%	19	1.3%
Offer only catastrophic coverage	5	0.3%	13	0.9%
Total Respondents Offering Health Care	**1,520**			
Design Changes -Retirees (Q29) *(% of Respondents Offering Retiree Health Care)*				
Offer Medicare wraparound plan	16	2.8%	31	5.5%
Offer Medicare Advantage plan	31	5.5%	27	4.8%
Require Medicare Part D coverage	50	8.8%	28	4.9%
Offer only retiree health care stipend	15	2.6%	19	3.4%
Total Respondents Offering Retiree Health Care	**567**			

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

(% of Respondents Offering Health Care)

	IMPLEMENTED IN LAST 2 YEARS		IMPLEMENT IN NEXT 2 YEARS	
	Number of Respondents	% of Those Offering HC	Number of Respondents	% of Those Offering HC
Purchasing Changes (Q30)				
Join a health purchasing coalition/pool	60	3.9%	54	3.6%
Shift from fully-insured to self-insured	22	1.4%	35	2.3%
Negotiate lower costs with current carrier	275	18.1%	148	9.7%
Change carrier/heath plan	161	10.6%	113	7.4%
Educate employees/retirees to make better decisions	219	14.4%	132	8.7%
Benefit elimination (Q31)				
Eliminate benefits for active employees	5	0.3%	11	0.7%
Eliminate benefits for pre-Medicare retirees	9	0.6%	16	1.1%
Eliminate benefits for Medicare-eligible retirees	24	1.6%	23	1.5%
Require retirees to pay 100% of family coverage premium	51	3.4%	43	2.8%
Eliminate family coverage for active employees	19	1.3%	20	1.3%
Eliminate family coverage for early retirees	12	0.8%	20	1.3%
Eliminate family coverage for Medicare-eligible retirees	17	1.1%	17	1.1%
Total Respondents Offering Health Care	**1,520**			

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?

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Category: Coverage Change

- $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.
- 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.
- Cut personnel. Increase share of premium costs.
- Employees hired after 7-1-2008 are in retirement health savings plan & defined contribution. Old plan retirees have same benefit of existing employees
- Getting higher premium share w employees with co-pays by adding a LTD benefit.
- New hires pay 20% or health premiums. New hires not eligible for retiree health. County has capped 10% increase on health insurance rates
- Proactive negotiations with bargaining units to share in greater contribution towards health costs.
- RESEARCHING HYBRID PLANS THAT INVOLVE PARTIAL EMPLOYER FUNDING
- 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).
- 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.
- VEBA plan-reduced employer portion of Healthcare costs
- We are currently looking at a cost-share for employees.
- We have changed coverage for new employees. They must contribute 15%. At retirement must purchase insurance themselves.
- 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.

Category: Education

- Discuss current trends with State organization. Attend local training/ information seminars. Interact with other entities within the State.
- Develop educational programs for our people.
- Online information on drugs, personal health and plan information.
- 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.
- 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.

Category: Opt Outs

- 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.
- Allow dependents to opt off Medicare if they have other options available. Cost savings is shared between city and employee (50/50)
- We closed our OPEB plan to new hires effective Jan 1, 2008, but we continue to offer health benefits to full-time active employees.
- In 1998, our Board of Supervisors opted to not guarantee health coverage to retirees hired after 9/30/1998.
- Offered a buy-out of retiree health benefits to current employees.
- Opt out option with payment to employee.
- Reduced hours to eliminate coverage.

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- 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.

- 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.

- 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.

Category: Fund OPEB

- 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

- ALREADY SET ASIDE MONEY FORM BOTH EMPLOYER AND EMPLOYEES PAY PART FOR 5 YEARS. JUST STARTED THE PROCESS FOR GASB 45.

- 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.

Category: Health Coalition

- employees are insured in state pool
- Formed local government co-op with fire and other municipalities to increase employee pool to over 250+
- 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.
- Joined a purchasing coalition. Raised co-pays in conjunction with providing a matching flex benefit program
- Joined association HRA implemented
- Joined pool developed wellness programs.
- Our government has no control over adjusting rates or premiums. Our plan is provided by the State of New Mexico.
- The actual health insurance program managed by the State.
- We are part of a state of Wisconsin plan. The state does all the work on rates being competitive.
- We belong to a coalition of self insured employers that own a network provider that provides its members discounts from local medical providers.

Category: High Deductible

- Add employee contribution, increase deductible.
- Changed to a high deductible plan through a broker; with the same carrier (capital blue cross)
- 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 plans with HRS and HSAs.
- High deductible than Wellmark -then the city self insures the difference between regular deductible 250/500 and high deductible 5000/10,000
- Move to a high deductible plan and increased co-pays. Annually review insurance options with agent
- No health insurance for the family of new hires. High deductible high co-pay plan. HSA accounts
- Offer employees option for HDHP/HSA
- Raise the deductable and the co-pays. Started an HRA
- Switch to high deductible plans with 3rd party wrap for medical and prescription coverage.

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- 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.

- The Town has implemented voluntary health plans with high deductibles for which employees/ retirees are reimbursed in order to lower overall premiums

- 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.

- 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.

- We do have a high deductible plan with our commercial carrier and basically self-insure for the deductible for a significant savings.

- 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.

- 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.

- We have switched to a high deductable plan and a 10/40 drug plan.

- 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 savea 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.

- We switched carriers and implemented a high deductible plan with mandatory mail order for prescriptions and noticed significant savings.

Category: Savings Programs

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

Category: Medicare

- Adopted MGL Ch 325; Section 18 requiring Medicare eligible retirees to pick up Medicare as their primary coverage.
- Moved Medicare-eligible retirees into Medicare advantage plan.

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Category: Union Ideas

- Created a committee representing unions, non-union, and management which selects coverage options each year to be offered to employees.
- Formed a health benefit committee to review possible cost savings; committee includes all level of employee classes/unions.
- 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.

Category: Self Insured

- 15 years ago formed self-insured consortium with local towns and villages which doubled the size of the group plan.
- Change to self-insured program.
- Counties have formed a self insurance group "gem plan"
- Implemented a partially self insured/ fully insured plan (high deductible). Higher costs to new employees and eliminating future employee retiree health care.
- 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.

Category: Shop Plans

- 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.

- By contract, the municipality pays 100% of premiums and deductibles. In return the municipality is free toshop 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.

- Change provider, design plan to fit employees, negotiate with provider, loss control

- Changed carriers and will consider next year when police contract expires to start employee paying a percentage at premium.

- Gone from multiple plans to one carrier. Plan with buy-up paid for by employees. Health and wellness fairs.

- I review plans two or three times a year

- Member Iowa health buyers alliance which promotes leap frog reporting. City uses four cornerstone principles of health care purchasing

- Switched to a different plan with same carrier. Have changed to partial self-insured program.

- Switching to lower cost plans for those unions to avoid additional furlough days

- The district has not received significant increases in the last 2 years. The district has looked at different carriers and different coverage levels.

- 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.

- 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.

- We're usually ahead of the curve in plan changes which are recommended by our insurance agent. They represent several counties.

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Category: Wellness Plans

- Addition of best doctors and biologics program. Programs such as complex care and cancer treatments are more effective. We have maintained a strong wellnes s program.

- Began wellness initiatives 4 years ago. Beginning to see downward trends. Disease management and lifestyle management programs. Continuing education.

- Cardiac wellness

- Contractual Health Care Advisor. Instituted Wellness Program.

- Cost sharing ensures employees are aware of costs and support changes to reduce costs. Implemented Wellness Program 8 years ago.

- Created a wellness program, safety programs

- 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.

- Implemented a wellness plan and reward employees with a day off if they meet their wellness goals.

- 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

- Opened employee health clinic; cover more wellness programs; educate employees on generic usage; conduct regular health fairs.

- Substantial investment (& employee participation) in wellness programs.

- 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.

- 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.

- We have started to implement a wellness program to become more proactive in controlling costs. Measurement and incentives are part of this plan.

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October 27, 2008 - Expanded testimony written for the hearing record

EBRI Issue Brief – *October 2008*

Employment-Based Retirement Plan Participation: Geographic Differences and Trends, 2007

The percentage of workers participating in an employment-based retirement plan increased significantly in 2007 for the first time since 1998, with the increase affecting virtually all categories of workers, according to a study released today by the nonpartisan Employee Benefit Research Institute (EBRI). Press release

EBRI Testimony

EBRI Research Director Jack VanDerhei testifies at today's hearing (Oct. 7) by the House Education and Labor Committee on "The Impact of the Financial Crisis on Workers' Retirement Security." VanDerhei testimony Education and Labor Committee Hearing Web site

EBRI Notes – *October 2008*

The 2008 Health Confidence Survey: Rising Costs Continue to Change the Way Americans Use the Health Care System

Americans continued to be battered by rising health care costs this year, with more than half of those with health insurance reporting they experienced higher costs. Some said the increases adversely affected their household finances and some said the U.S. health care system is so flawed that it should be completely overhauled, according to the 2008 Health Confidence Survey (HCS). Press release

Most Viewed *last 30 days*

1. *Issue Brief*: Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2008 Current Population Survey
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3. *Fast Fact*: Gen X and Gen Y Self Description: "Hard-Working"
4. *Notes*: 'IRA Assets and Contributions, 2007,' and 'Domestic Partner Benefits: Facts and Background'
5. *Issue Brief*: The 2008 Retirement Confidence Survey: Americans Much More Worried About Retirement, Health Costs a Big Concern

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It is a revolutionary leap forward in citizen satisfaction. **Here's why:**

Better Science. Cobalt (www.CobaltCommunityResearch.org) uses the science of the American Customer Satisfaction Index (www.theACSI.org), which is widely respected from a scholarly and business perspective. The methodology is considered the gold standard in customer and citizen satisfaction measurement in more than 40 industries, including public service. The credibility of the data is unmatched.

Better Benchmarks. Cobalt builds the most up-to-date baseline indices each year using a scientifically representative sample of citizens across the United States and across the region. This keeps your comparison scores valid as changes in economics and events can significantly change how residents look at local governments. In addition, Cobalt benchmarks allow local leaders to compare performance to similarly-sized governments across the country and region. They also can be compared to the 40 industries measured by the ACSI, from the federal government to financial institutions. Because of these statistically-sound comparisons, the program is a valuable tool for economic development and community branding.

Better Decisions. The sophisticated quantitative analysis of the ACSI identifies not only where performance is weak and strong, but what the actual drivers are of citizen satisfaction and behaviors such as remaining in the community, recommending it to others, volunteering, encouraging businesses to start up in the community, and supporting the current administration. In addition, results are available 24 hours per day/7 days per week on a dynamic portal that enables staff to easily create hands-on analysis of the data based on evolving questions from the board or council. Participants are not limited to a one-time analysis captured in a thick, static report.

Better Price. Because of Cobalt's nonprofit mission and use of technology in data analysis, collection, and reporting, program fees are significantly lower than similar services provided by any other private company. In addition, with the combination of time-tested questions and custom community-specific questions, the staff time requirement is significantly lower as well.

"Cobalt has introduced a professional research instrument which provides comparative state and national benchmark data at a competitive rate."

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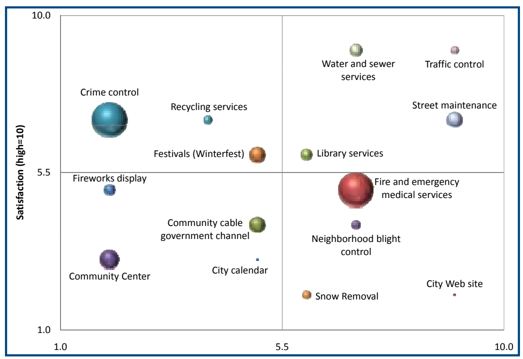
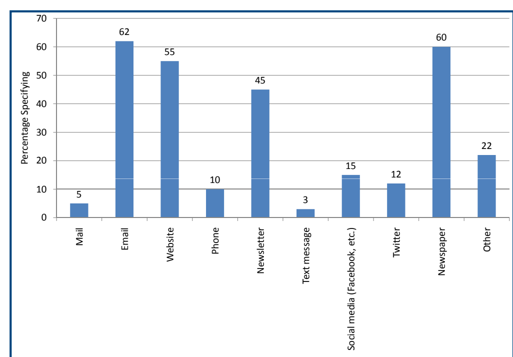
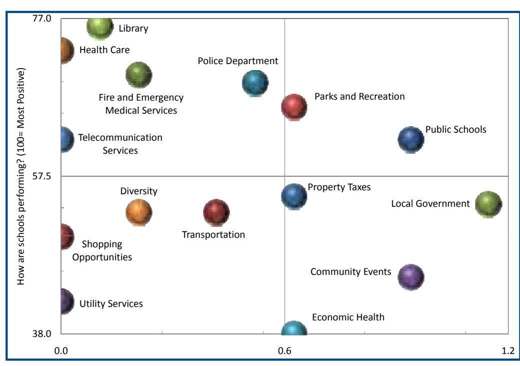


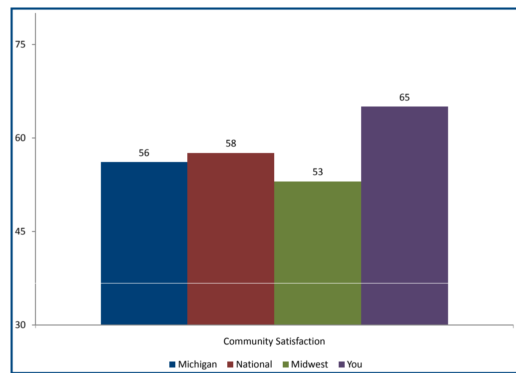
Map service importance and citizen satisfaction to guide budget decisions (bubble size based on what you spend on the service)



Strengthen the effectiveness and efficiency of communication efforts by focusing on how demographic groups in your community prefer to hear news about your local government



Identify drivers of citizen engagement and behaviors such as remaining in the community, recommending it, volunteering, encouraging business startups and supporting the current administration.



Compare current year scores against similar local governments and even the broader public and private sectors

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