Report on the
Employee Insurance Participation-Feasibility Study

For the
Joint Subcommittee on State Employees' Benefits

October 1, 2003

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INTRODUCTION AND SCOPE OF STUDY

Pursuant to Section 328 of the 2003 Wyoming budget, "The Wyoming Legislature is seeking professional assistance in order to review and analyze the cost effectiveness of some elements of its State employee benefits program. These elements include health insurance, sick leave and the ratio of pay to benefits.

The study shall review the State's group insurance program provided to state employees, including the impact of changes made to the plan last session. The contractor shall propose changes to provide additional insured and employer involvement in the decisions affecting the purchase of health care services, including taking into account the potential benefits of offering a choice of plans to employees with different levels of benefits. The contractor is specifically charged to consider health care or other medical savings accounts, maximizing federal income tax savings for the employee, a catastrophic coverage component and other issues pertinent to making the program as cost efficient as possible. The contractor shall examine and recommend the benefits of wellness and prevention programs as part of a health insurance package.

The study shall also include a review of the sick leave component of the benefits package and offer any recommendations for incentives that would reduce absenteeism and encourage better health choices. The study will also compare the State employees' pay-to-benefit ratio to other entities in the private and public sectors."

The Joint Subcommittee on State Employees' Benefits (the Committee) engaged Buck Consultants (Buck) to analyze State employee benefit plans and produce this report on the Employee Insurance Participation-Feasibility Study (the Study). Buck addresses each area of potential benefit plan improvement requested in this Study by modeling the financial impact of possible redesign through calendar 2012. We also include a description of general health care cost management techniques, indicating which types of programs are already in place. Specific recommendations follow a more detailed examination of each key Study area. Appendices detail calculations, provide comparison benefit survey data and include sample benefit changes based on report recommendations. After examining Wyoming benefit plans, data and policies, it is our opinion that:

- The July 1, 2003 dependent subsidy change will improve the overall spread of risk in Wyoming State medical and dental plans, lowering employee premium share and out-of-pocket costs. State Agencies will also realize soft-dollar savings from improved overall health status and resultant higher productivity.
- Many cutting-edge medical management techniques are already in place and generating positive return on investment. Continued efforts must be kept up to continue realizing these savings. Vendor and plan participant incentives can be added to the equation but require very careful data analysis to be cost effective. Projected savings for additional investment in this area are not trivial but are diluted because current programs are robust.
- Enhanced health care consumerism has potential for additional savings under the Wyoming plans. However, we do not project incremental return on investment in consumer-oriented plan design, communications and decision support tools to be as great as might be available in markets where health care providers are highly competitive on both price and volume.
- Changes to current sick leave policy may be the most difficult to make given the prevalence of similar plans among all surrounding state governments. However, we believe this area offers the most significant potential savings of all areas studied, even if the State moves to a "cost neutral" - but much more managed - disability-oriented plan. Potential sick leave policy savings are greatest because this is the least managed area studied.
- Wyoming State benefits are in line with surrounding states, especially after the July 2003 dependent subsidy increase. Wyoming State benefits are also more generous and more expensive than those of most other - smaller - Wyoming employers.

Appendix A is a glossary of key terms shown in bold. Specifically, questions addressed in this study are summarized as follows:

1. What is the impact over time of increased **employer subsidy** of dependent coverage effective July 1, 2003?
2. What savings can be expected over time from additional investment in health management? Health management consists of the following types of programs that often overlap:
   - Efforts to encourage employee and dependent participation in **health promotion** (wellness) programs
   - Administrative techniques to manage demand for medical services. Demand management administrative tools studied are **population health management** (including **predictive modeling**) and **disease management** (including **case management**).

3. What savings can be expected over time by increasing patient engagement in health care purchasing decisions through **consumer-driven health care** (CDHC) plan designs?
4. What savings can be expected over time by modifying current sick leave policy?
5. How do Wyoming State employee benefit plans compare to those of surrounding states and to those of private employers in Wyoming?

Several caveats are important to consideration of cost projections and benefit comparisons described herein:

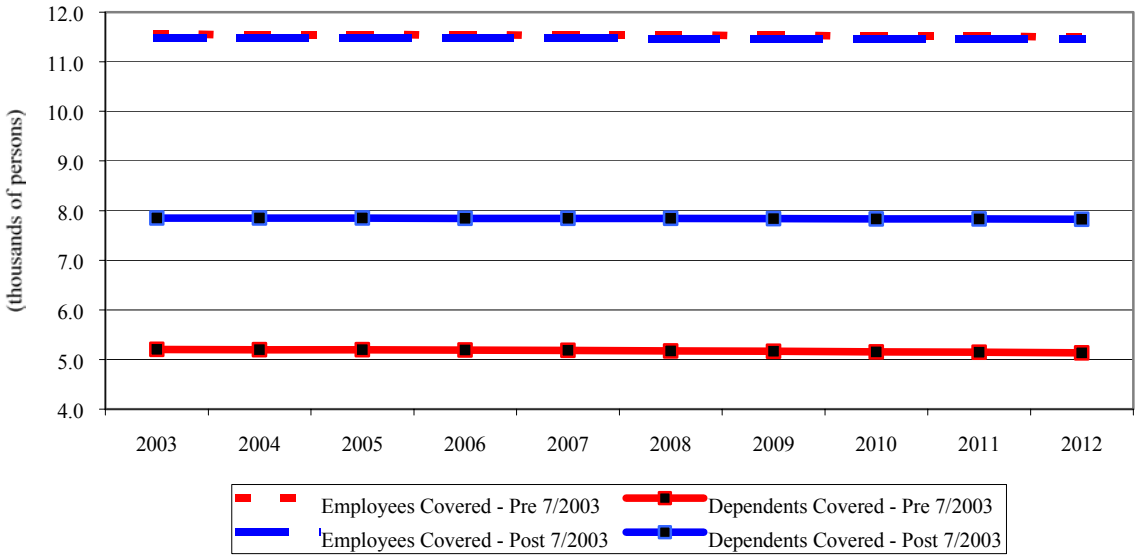
- University of Wyoming and Wyoming Community Colleges employees are included in total claim and enrollment data used to project underlying benefit costs. However, these groups use different employment and pay practices to determine employer contribution toward benefits, eligibility, etc. Payroll, employer contributions and eligibility are modeled for State employees only.
- To the extent that contract employees participate in benefits analyzed, they are included in total claim and enrollment data used to project underlying benefit costs. However, contract employee payroll is not included.
- Payroll data drawn from various sources - pension valuation census records, annual leave and sick leave data base records and survey responses regarding Wyoming State employees - result in different levels of average pay.
- The Executive Branch is currently conducting a study regarding potential design and use of a data warehouse tool to improve the efficiency of certain employee benefits. This report does not reflect any data or conclusions from the Executive Branch study. Reference is made to generic data warehouse applications as appropriate.

BASELINE PROJECTION

Buck analyzed demographic, claim and cost management data for Wyoming's medical, dental and sick leave plans to project costs under several scenarios through 2012. Each of the study questions described above is modeled as a separate scenario, with estimated incremental impact over time. Appendix B includes key projection output and assumptions. A brief description of methods, assumptions and results is summarized below; detailed narrative for each study question follows in the body of our report.

Buck projected total employment and payroll levels using census data and assumed rates of turnover, retirement, salary growth and other assumptions from the January 1, 2003 Wyoming Retirement System actuarial valuation. We projected total employment to remain constant by assuming a group of new hires each year equal in number to departing employees. We then applied average projected demographics to current medical and dental plan enrollees. Over time, we further assume that enrollment migrates from higher-premium plans to lower premium plans as costs grow compared to salary. Projected covered employees and dependents are shown in the following graph.

Covered Employees and Dependents, Before and After 7/2003 Subsidy Change

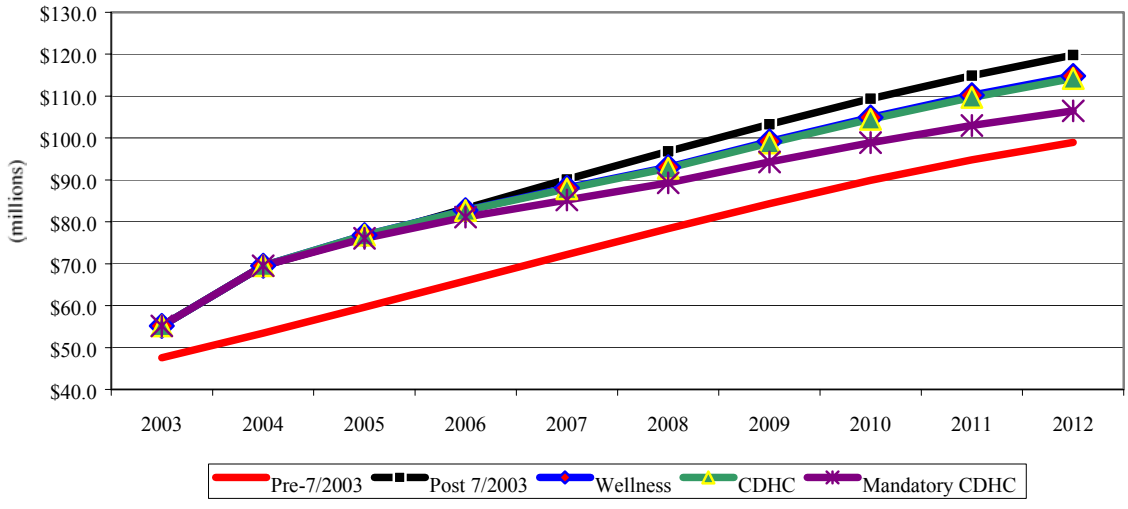


The immediate impact of increasing employer subsidy for medical, preventive dental and life insurance was an increase in the number of covered dependents combined with migration from the $350 deductible medical plan ($350 plan) to the $750 deductible medical plan ($750 plan). Prior to the subsidy change, and due to the high cost of covering dependents, employees with dependents either covered those dependents through a spouse's plan or did not cover their dependents at all. Given total plan costs and employer contributions, there was also incentive to enroll for single coverage under the higher-cost $350 plan. Increased subsidy of dependents resulted in enrollment of over 2,500 newly covered dependents effective July 1, 2003. Net employee cost to cover dependents under the $350 plan exceed $100 per month after the subsidy change, so some employees added dependents but switched to the lower-premium $750 plan. Total employee enrollment - $350 plan and $750 plan combined - did not change appreciably.

Total costs are projected using base-year 2003 claims and administrative fee estimates for each medical and dental plan, calculated separately for each plan for active employees (including COBRA) and retiree groups. Base-year total costs are split into patient out-of-pocket, employee-paid premium and employer subsidy. Costs are projected into future years using a standard health care cost trend model which reflects recent experience and longer term economic conditions. Trend rates are the annual percentage increase in average costs for each component of employee benefit - prescription drugs, non-prescription medical claims, dental costs, administrative fees, etc. Cost increases are driven by underlying CPI, **health care CPI**, **utilization**, **aging**, **cost shifting**, **new technology**, **mandated benefit coverage** and other factors. Recent experience for the Wyoming State employee plan includes medical cost increases per employee in the 15% to 20% per year range. Longer term, the model assumes that trend rates must moderate to a level that is fairly close to general CPI. Without this "grading down assumption" health care costs per capita, growing much faster than the rest of the economy, would eventually consume the Gross Domestic Product (GDP). National Health Expenditures (NHE) are currently about 15% of GDP. The trend model used herein implies that NHE growth approaches 20% of GDP and then levels out. Key statistics and assumptions are listed in Appendix B.

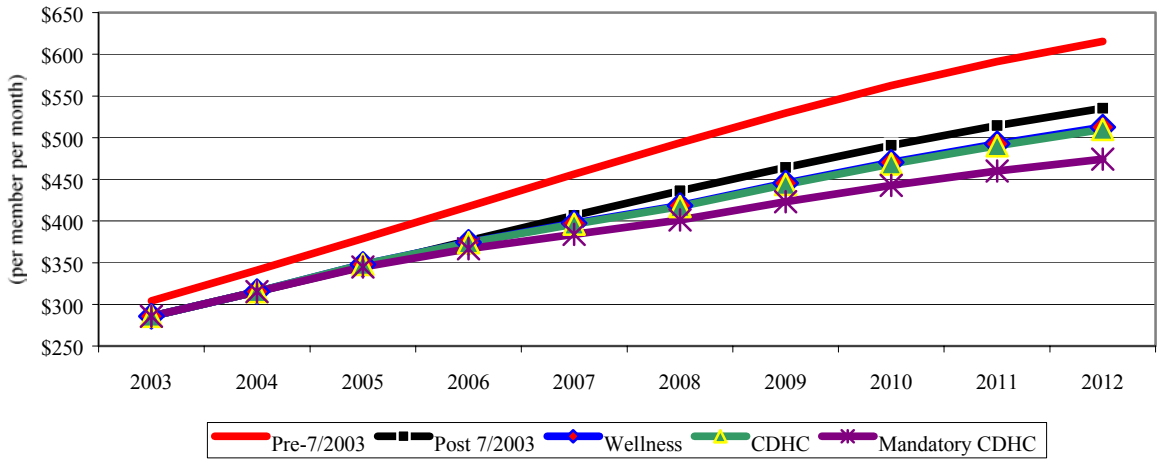
Employer subsidy is assumed to remain at about 85% of total medical, preventive dental and basic life insurance costs for all scenarios projected. Therefore, the total employer budget is primarily driven by employee and dependent enrollment in each plan. Each scenario in addition to the baseline also includes slightly lower total costs, which lower the employers' 85% share. Lower average age reduces all post-July 2003 subsidy levels. Reduced claims attributable to improved wellness and consumerism are reflected in separate scenarios. The graphs below shows total employer annual budget dollars for each scenario modeled. The increase for all post-7/2003 scenarios is not fully realized until 2004; 2003 includes six months at the lower dependent subsidy and enrollment level and six months at the higher dependent subsidy and enrollment level. The budget labeled "Wellness" assumes that additional health promotion and disease management investment is made in 2005 and 2006 with claims savings realized in 2006 and thereafter. The budget labeled "CDHC" assumes that consumer-driven health care options are introduced in 2005 with enrollment therein, and subsequent claims savings, gradually realized through 2012. The budget labeled "Mandatory CDHC" assumes that consumer-driven health care options *replace all current options* in 2005.

Calendar Year Employer Budget for Employer Share of Medical and Preventive Dental



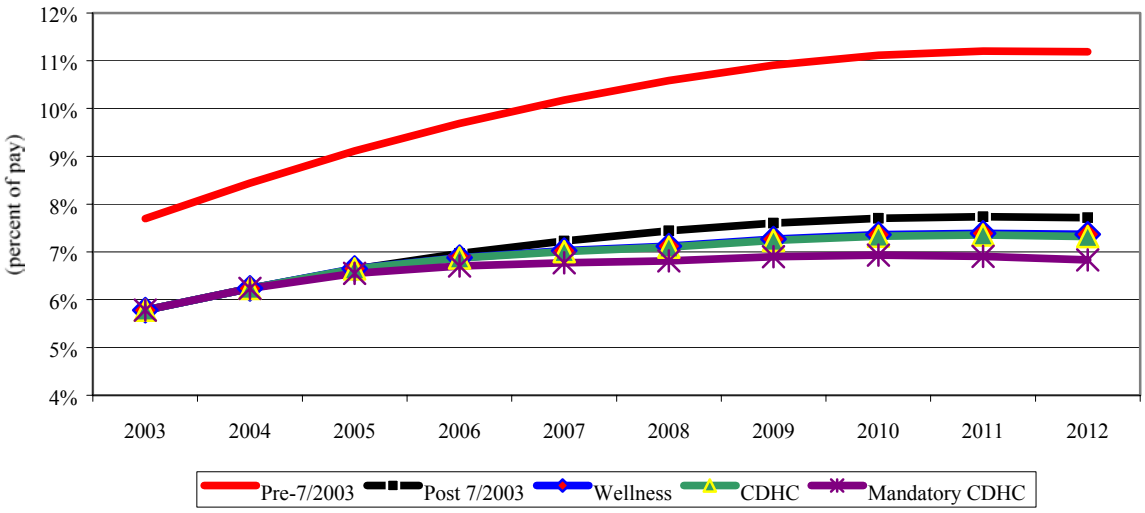
The graph below illustrates how the total premium for medical plans - incurred claims plus administrative costs - decreases immediately after the July 2003 subsidy change because the proportion of covered dependents jumped. The increased proportion of dependents lowers the overall average age of the group, thereby lowering the overall average health risk. This gap widens over time because higher dependent subsidies help keep dependents in the plan, thereby continually improving the average risk compared to baseline. Also, medical costs are lower under the "Wellness" and "CDHC" scenarios as employees and dependents become ever more engaged both in maintaining good health and in managing health care purchases.

Composite Active/COBRA Medical Premium PMPM (per member per month)



A key assumption underlying all cost projections regards the proportion of employees that elect single versus dependent coverage and high-premium versus low-premium plans. As mentioned above, employees can be expected to "move" dependents to spouse plans or drop dependent coverage altogether as premiums increase relative to pay. Employees can also be expected to elect lower premium plans, regardless of dependent status, as premiums increase relative to pay. Migration assumptions detailed in Appendix B are driven by projected employee out-of-pocket expense, both for monthly premiums and toward deductibles and coinsurance. The following chart highlights growth in out-of-pocket costs for each scenario. Note that cost growth as a percentage of pay flattens out because assumed health care cost trend is initially about triple the assumed salary increase, gradually declining to a rate slightly higher than salary increase:

Composite Active/COBRA Out-of-Pocket Costs (premium, deductible and coinsurance) as a Percentage of Pay



HEALTH PLAN STRATEGY – MEDICAL COST MANAGEMENT BACKGROUND

Employer-provided health care and many other tax-favored benefits gained prevalence after World War II when wage restrictions forced employers to create indirect compensation alternatives to attract and retain talent. Most employers structured health plans to shield employees from catastrophic medical bills. To gain competitive advantage, more and more routine services were covered; employee share of costs dropped and employee choice of providers expanded. Medical costs grew significantly as a percentage of payroll over the 1970s and 1980s. Employers shifted a greater percentage of total cost to employees through higher **patient out-of-pocket** cost and higher employee-paid premiums, but this cost shift did not keep pace with overall cost growth. Employers also tried to limit total plan costs through volume-for-discount arrangements, typically called **preferred provider organizations** (PPOs). **Gatekeeper arrangements** (HMOs, etc.) were embraced in the 1990s to address utilization of services. Employers and health plans are now more commonly implementing tools to improve health status, in addition to controlling health services. Also, more management of care by HMOs is done "behind the scenes," thereby changing the gatekeeper role of primary care providers.

Health plan cost control issues discussed in this report can be divided into four areas of analysis shown in the table below, for conceptual ease. Note that some tools address several areas of the quadrant:

	Manage total cost of services - Limit total expenditure on premiums and out-of-pocket while keeping employees healthy and productive	*Employer-employee cost sharing* - limit employer expenditure without sacrificing benefit package competitiveness
Reduce demand - Costs are lower for healthier groups; discretionary use decreases with higher out-of-pocket	• Health promotion (wellness) • Population health management • Disease management • Vendor management • Health care consumer engagement	• Premium share • Out-of-pocket share
Restrict supply (access) - Unlike commodities, health costs often increase with increased supply of providers or services; conversely, a limited supply of providers results in higher fees due to lower competition for patients	• Provider discounts • Medical management • Disease management • Vendor management • Health care consumer engagement	• Premium share • Out-of-pocket share

Tools used to manage total costs typically reduce demand for services by improving / maintaining health status or by promoting use of higher discount / higher efficiency providers. Strategies aimed at provider pricing and behavior require a competitive provider marketplace to work well. Volume-for-discount arrangements are less effective if most providers already have sufficient volume to meet their business plans. Similarly, providers have limited incentive to comply with the paperwork and protocols of broad-based medical management programs if their appointment schedules, hospital beds or lab facilities are already near capacity. Compare Denver, Cheyenne and Sheridan. The large number of physicians and hospitals in the Denver market routinely work with HMOs. Winhealth Partners is presently the sole HMO operating in Wyoming, primarily in the southeast corner of the State. Few providers in the Sheridan area participate in PPOs, no Sheridan-area primary care providers are in an HMO. Given the health care marketplace structure in Wyoming, recommendations for future total cost management do not focus on provider pricing and behavior. We believe that current efforts in this area - described below - should continue. Such efforts are responsible for significant cost savings already realized; ongoing efforts will be required to maintain these savings. However, incremental gains from additional efforts will likely be relatively small compared to other initiatives discussed in this report. While discussions to date have not been as fruitful as hoped, one approach to provider pricing and behavior management that merits additional ongoing investment is **direct contracting**.

Strategies aimed at member health behaviors require sophisticated data management and targeted incentives:

- Health promotion is intended to maintain the good health of healthy employees and dependents and to encourage more healthful lifestyles and preventive regimens for other members. Vendors collect and review **health risk assessments** and other data to appropriately target interventions such as dietary assistance, smoking cessation or stress management classes. Wyoming currently offers in-house and contracted health promotion programs. Vendor performance can be tied to overall health improvement by establishing baseline costs and sharing in savings achieved. Unfortunately, good health alone is not always sufficient incentive for members. Some employers reward participation with lower premiums, extra health care spending account dollars, etc.

- Population health management is highly data-intensive. Demographics, prescription claims, medical test results, diagnoses and other information is collated and screened for patterns that signal which patients are candidates for cost-effective interventions such as additional guidance for the provider(s) involved, educational materials for patients and recommended screenings. Even more promising, population health management algorithms can predict which members will generate large claim costs over a 12 to 24 month time-frame. Wyoming currently contracts for population management services. Similar to health promotion, vendor performance incentives can include risk-sharing around improved health and lowered claims. Patient financial incentives can also be used. However, **HIPAA privacy** requires that patient compliance incentives be tied to a treatment pattern and that standards of success accommodate patients limited by physical or mental conditions.

- Disease management helps patients and providers more effectively navigate treatment for specific conditions. Expert guidance for the provider(s), **care coaches** for patients and a system to monitor adherence to standardized protocols are typical components. Registered nurse case managers are assigned as patients near the high-cost treatment phase of their particular condition. Case managers help patients, providers and hospitals achieve high-quality outcomes at lower cost, including negotiating case rates. Wyoming currently contracts for disease management services. Similar to both health promotion and population health management, vendor performance incentives can include risk-sharing around improved health and lowered claims. Patient financial incentives can also be used. Again, HIPAA privacy rules dictate carefully crafted, flexible measures of patient success if incentives are used.

- Vendor management is the process of contracting **third-party administrators** (TPAs) and monitoring their performance. TPA services used by Wyoming include **claim adjudication**, contracting PPO providers (also called network maintenance), customer service assistance to help patients properly utilize medical and dental benefits and an array of health promotion, population health management, disease management and other tools. If credible and objective data can be maintained then performance guarantees can be established and monitored. Sample performance targets include a set percentage of customer service issues that are "resolved" on the first call, claim payment accuracy incidence and dollar amount measures and, ultimately, pay-for-performance disease management programs, etc. Key vendor management tools also include statistically valid audits of claim functions, performance measure data, etc., and periodic open bids for TPA services. Currently, the State monitors claim accuracy and timeliness, medical management statistics and other TPA performance metrics for use in annual renewal negotiations and performance reviews.

- Health care consumer engagement currently garners extensive press coverage. The IRS recently sanctioned one form of consumer-driven health plan, the health reimbursement arrangement (HRA) - an employer-funded account for health care expenses with rollover of any unused balance at year end. Any program that promotes data resources to help patients price and manage their own care, combined with plan designs that communicate total charges for care, can be considered consumer-driven. A core tenet of consumer-driven health care (CDHC) is that knowledgeable patients spending their own money will improve health care marketplace efficiency. There remains much debate as to whether commodity-like market functions apply to health care, whether employer-provided accounts are really treated as the patient's own money, etc. However, health care is at least partially priced at points where supply meets demand; consumer engagement is at least one tool that can help manage overall cost.

  Consumer engagement will improve health care market efficiency as patients choose more wisely whether or not to purchase a given test, procedure or prescription, and as patients choose more wisely among providers. As noted above, provider competition in Wyoming is limited compared to large urban areas, and so too is the

potential for CDHC to mitigate cost increases as regards provider selection. Prescription drugs may prove to be an area where consumerism tools can benefit the State. Prescriptions are perhaps the most commodity-like element of health care with some price competition among manufacturers, wholesalers and retailers.

CDHC typically differs from **defined contribution health care** in that the former promotes consumer engagement at the point of each purchase, while the latter promotes engagement during the annual open enrollment health plan purchasing process.

Employer-employee cost sharing as an avenue for lowering total cost may be less effective than many employers suppose. Shifting cost to employees via higher patient out-of-pocket can discourage use of cost-effective preventive services and may not materially reduce high-cost utilization [*Rand 1988 - The Demand for Episodes of Medical Treatment in the Health Insurance Experiment - "price affects the number of episodes and has much smaller effect on cost; small deductibles can effectively restrain demand, individual out-of-pocket maximums of $1,000 per year eliminate most overuse; large deductibles increase financial risk without substantially reducing excess use"*]. As an example, many "modern" CDHC plans mimic the current Wyoming plan provision that provides 100% coverage of up to $300 in calendar-year wellness costs. Further, studies in this area tend to address changes in out-of-pocket at increments below the State's current $350 and $750 deductibles. However, the employee share of medical costs declined from 34% in 1970 to 16% today. At least some portion of increased medical costs can be attributed to deductibles, coinsurance and copays that have not kept pace with total cost increases, thereby insulating consumers from true prices. Given current benefit levels and the Wyoming marketplace, there is greater opportunity for overall cost containment through targeted cost-sharing increases such as emergency room visits, prescriptions and certain diagnostic procedures. Broad-brush cost-shifting, e.g. simply increasing the deductible, may not result in expected long-term savings.

Cost shifting through increased employee premium is not separately analyzed in this report. The State reduced employee share of premium from 19% to 11% effective July 1, 2003, while increasing dependent coverage from 31% of members to 41%. As discussed below, this change will improve the spread of risk over the long-term as more employees and dependents remain insured. Absent unforeseen budget pressures, the State should not consider reversing the recent premium-share change at least until actual costs can be compared before and after dependents re-enrolled in the State's plans. Please note that all projections herein assume that initial employer-employee premium share remains constant, so dollar increases in employee premium are implied.

Many of the cost-containment concepts described above apply to dental coverage also. However, total dollars spent on dental care are much less than medical spending, as are returns on investment (ROI) through additional management techniques. This is due to the more elective nature of dental care and to current plan design. Currently, all medical plan participants are enrolled in preventive dental coverage with little or no patient out-of-pocket. Employees who desire additional coverage - typically for elective procedures - may buy up to optional coverage. Significant incentives for cost-effective use of dental care are already in place.

IMPACT OF INCREASED EMPLOYER SUBSIDY OF DEPENDENT COVERAGE EFFECTIVE JULY 1, 2003

The State increased the employer-paid share of medical, preventive dental and basic life insurance benefits effective July 1, 2003 to significantly reduce employee premiums for dependent coverage. The tables below compare State subsidy and employee share of monthly premiums before and after July 1, 2003:

Coverage Tier*	**$350 Medical Plan + Preventive Dental**			
	January-June 2003		***July-December 2003***	
	Employee Cost	Number Enrolled	Employee Cost	Number Enrolled
Employee	$ 24.45	7,312	$ 43.08	5,812
Employee+Spouse or Employee+Child(ren)	$ 398.08	981	$ 99.13	1,504
Family	$ 506.08	961	$ 115.33	1,432
Split	$ 81.29	754	$ 62.91	755
Total		10,008		9,503

Coverage Tier*	$750 Medical Plan + Preventive Dental			
	January-June 2003		*July-December 2003*	
	Employee Cost	Number Enrolled	Employee Cost	Number Enrolled
Employee	($ 0.96)	703	$ 17.67	734
Employee+Spouse or Employee+Child(ren)	$ 342.47	328	$ 43.52	532
Family	$ 441.88	400	$ 51.13	589
Split	$ 49.19	114	$ 30.81	116
Total		1,545		1,971

* Allocation of employee cost to each benefit can be structured differently. Also, dental coverage tier is no longer required to match medical. Allocations above serve for comparison purposes. See Appendix B for the calculation of employee share shown above.

The composite employee share of medical premium decreased from 19% to 11% of total premium, while dependent enrollment increased from 31% of members to 41%. At the same time, average costs per member per month (PMPM) are expected to decrease 6% due to the increased number of lower-health risk dependents. As described above, PMPM costs should decrease more overtime compared to "pre-July 2003 enrollment" due to lower average age and health risk of covered employees and dependents. Our modeling projects PMPM costs to be 13% lower than baseline by calendar 2012 due to greater dependent enrollment.
Overall employer medical / preventive dental budget increases due to the increased subsidy for dependents is projected as follows for fiscal years beginning July 1, 2003:

Employer Subsidy *Budget Excluding Basic Life Insurance*				
FYE 6/30	**Pre-7/2003 Subsidy**	**Post-7/2003 Subsidy**	**Fiscal Year Difference**	**Cumulative Difference**
2004	$50,562,500	$66,151,000	$15,588,500	$15,588,500
2005	56,565,500	72,906,500	16,341,000	31,929,500
2006	62,758,000	79,766,500	17,008,500	48,938,000

For the portion of State employees with non-State coverage available through a spouse's employer, increased dependent subsidy resulted in some dependents moving off of non-State plans onto the State plan. This can be viewed as a State subsidy for some employers. However, it is anticipated that a larger portion of newly enrolled dependents are those who had no coverage under the prior, high employee-cost approach to dependent subsidy. For this group of dependents who were not previously covered, some portion of current State cost can be viewed as a transfer from uncompensated care for uninsured individuals to employment-based dependent premium subsidy. Uninsured and underinsured individuals tend to generate higher medical claims over time. So, over the long run, medical and absence costs per employee will be lower due to the lower average cost of care for newly insured dependents and due to less productivity loss among employees tending to ill dependents. Finally, while there are currently adequate reserves and relatively good participation levels, adequate subsidy levels are necessary to maintain this position. If employer subsidy continually declines, then ultimately healthier participants drop coverage, participants in poorer health generate ever higher average claims, and a potential **death spiral** is created due to **adverse selection**.

Anecdotal confirmation of the sound plan management inherent in the recent subsidy change can be found in Colorado. The Colorado State employees plan currently subsidizes less than 50% of the total cost for all employees and dependents. Alarmed by significant numbers of employees and dependents going without coverage, the governor and Director of Personnel now propose to double employer subsidy for 2005 to 77% of total cost and eventually move to 85% of total cost as an acceptable benchmark.

ADDITIONAL INVESTMENT IN HEALTH MANAGEMENT

The second variable modeled is the potential impact of increased spending on programs designed to reduce total cost by targeting cost and utilization control interventions for members with emerging or ongoing costly conditions. Specific types of programs modeled are health promotion (wellness), population health management (including predictive modeling) and disease management (including case management). It is important to note that *incremental* savings are estimated, most program elements are already in place, "mature" - baseline data is in place for ongoing

analysis, and interventions have already been designed, implemented and measured, etc. One approach that can leverage programs already in place is to increase patient participation / compliance incentives.

The table below lists typical health management program elements and indicates which are in place, along with the name Great-West Healthcare, the current State medical plan administrator, uses for each element:

Medical Demand Management Program Element	Current Status	Comments
Health Promotion	• MyCare℠ - general wellness administered by Great-West • Great Beginnings - maternity management administered by Great-West • Wyoming Health Fairs - educational events and blood screening conducted by State personnel • Flu Immunizations - provided though State offices	Educational sessions and material are offered to the general covered population without data mining to target at-risk members (see population health management and disease management). In addition to promoting general health awareness, wellness tools often used include: • Health risk assessment • Exercise classes • Immunizations • Blood pressure measurement • Stress management classes • Blood screenings • Dietary consultation • Smoking cessation classes
Population Health Management	• Care*Compare*℠, Predictive Risk Symmetry - claims analysis tools administered by Great-West	Demographics and medical and prescription claim data are collected and analyzed to identify candidates for educational material and disease management programs.
Predictive Modeling	• Neural Net, Manual Predictive Risk - Great-West modeling tools	Data from population health management efforts is stratified to identify potential high-cost claimants before large claims are incurred.
Disease Management	• *Medical Outreach*℠ - outreach tool administered by Great-West • Neonatal Management Program, Oncology Management Program, Specialty Pharmacy and Transplant services - Great-West disease management programs for specific conditions	Patients identified through health promotion screenings, population health management data tools and as reported by providers receive education materials, care coaching, provider consultations and care monitoring.
Case Management	• Catastrophic case management - general case management administered by Great-West • Great Beginnings neonatal, Oncology program, Specialty Pharmacy and Transplant services - Great-West case management programs for specific conditions	Patients entering on or in high-cost phases of treatment for their conditions are assigned nurses to help improve care and reduce costs by reference to benchmark protocols. Medical managers and other physicians sometimes also join the team of patient, provider, hospital and case management nurse.

Discussion and Recommendations

- Health Promotion
  State-administered health fairs, blood screenings and influenza immunizations provide education, testing and preventive vaccines on a voluntary basis. Programs administered by the State's medical TPA augment general print and web-based education efforts and specifically provide maternity-related education and consultation.

There may also be additional, informal programs within various Agencies. As with every type of health management program, four factors are keys to successfully improving overall employee health and containing health plan costs:

- Develop and maintain reliable data on baseline health risks and associated costs in the covered group, plus actual program performance
- Effectively communicate the benefit to employees and dependents of participating in voluntary programs, often via economic incentives
- Demonstrate management buy-in, usually equating to broad management participation
- Coordinate management of all programs offered as much as possible and integrate data on participation and outcomes with health plan and absence data

The themes of baseline / performance data, communication, management buy-in and integration are repeated within the context of each additional type of the health management program described below.

Recommendation: The State, Great-West and other employee/dependent-health advocates should determine if focused performance measures can be agreed upon for programs in place and for any new programs considered. Incentives can be built into Great-West and other vendor contracts, but great care must be taken to avoid performance measures that are too easily met. For many aspects of health promotion, performance-based incentives may have to await greater consensus among medical and disability practitioners around expected outcomes. The State should also investigate incentives for employee and dependent participation in - and completion of - health promotion activities.

New investment - and ongoing programs - should be assessed on the basis of potential claims AND lost time savings and should include objective measurement standards. That is, the State should be satisfied that data can be tracked to answer key performance questions: how many members are at risk for the conditions addressed by a specific health promotion program? what baseline claim dollars can be expected for this group? how many work days are typically lost? what level of participation should be considered successful? Appendix D describes sample incentives for smoking cessation and health risk assessments. Note that HIPAA privacy issues complicate management of most health management programs, but can be surmounted. Finally, the State's data warehouse should be used to develop baseline health status measures and monitor performance of current and newly established health promotion programs.

- Population Health Management

  Currently, 76% of 2,000 Wyoming medical plan participants identified at risk for multi-disease conditions through *Hospital Comparison Program*SM are apparently well, exhibiting no claim characteristics warranting specific outreach. 20% are episodically ill. Great-West pushes print, telephonic and internet material to these members, offering educational assistance and help from health care professionals. 4% are chronically or catastrophically ill. Great-West pushes materials to help participants manage their conditions, contacts providers involved to assess patient progress and treatment plans and assigns case management nurses and pharmacists where expected claims warrant.

  Recommendation: As with health promotion, the State should work with vendors to establish baseline and performance measurement data. Again, incentives should be explored to encourage employees and dependents to respond to vendor outreach efforts and become more knowledgeable about their conditions.

  As with health promotion, new investment - and ongoing programs - should be assessed on the basis of potential claims AND lost time savings and should include objective measurement standards. That is, the State should be satisfied that data can be tracked to answer key performance questions: how many members are at risk for the condition addressed by a specific population health management program? what baseline claim dollars can be expected for this group? how many work days are typically lost? what level of participation should be considered successful? Again, the State's data warehouse can play an important role in this process. Appendix D describes a sample employee/dependent incentives for population health management program participation.

- Predictive Modeling

  Predictive software currently helps prioritize patients for disease management outreach by potential claim dollars in the coming year.

Recommendation: The State and Great-West should explore opportunities for using predicted claims versus actual claims in the subsequent period as part of population health management and disease management risk-sharing arrangements. Risk predictions may also be used to augment annual projected claim analysis as part of rate setting.

- Disease Management

  Through second quarter 2003, Great-West reports 400 of 1,448 Wyoming asthma management candidates identified through claims data participate in *Medical Outreach*[SM] (28%). 1,663 of 5,628 multi-disease candidates participate (41%) and 549 members completed health risk appraisals (HRAs). Since inception in January 2000, participation in Great-West demand-management programs has grown to 2,600 members. Health conditions of 800 members identified at risk for multi-disease conditions can be compared to baseline status. Baseline for this group was 94.5% apparently well and 5.5% chronically or catastrophically ill. Status has improved markedly through intervention, to 80.7% apparently well, 19.2% episodically ill and only 0.1% chronically or catastrophically ill. Other indicators of progress to date in disease management include:
  - Low-dose aspirin therapy use increased from 45% to 60% of the group of 600 Wyoming cardiac patients measured before and after receipt of educational material. About 90 more State-plan participants are now at lower risk for expensive, acute heart disease crises.
  - Availability of asthma-management action plans increased from 26% to 38% among 130 Wyoming providers measured before and after receipt of educational material. About 16 more State-plan participants now have planned alternatives to expensive emergency room visits during severe asthma attacks.
  - Prevalence of in-home peakflow meters to help asthma patients manage their condition increased from 30% to 75% among 130 Wyoming patients measured before and after receipt of educational material. About 59 more State-plan participants are now at lower risk for expensive, acute asthmatic crises.
  - Across all Great-West accounts, prevalence of office visits and prescription use among disease management program participants went up much faster than among non-participants, with corresponding slower growth in much more costly hospital days. 23% of members had physician office visits after program participation, compared to 18% among non-participants and 15% before program implementation. 32% of members had prescriptions after program participation, compared to 23% among non-participants and 20% before program implementation. More significantly for overall plan costs, hospital days per 1,000 members increased 7% among heart disease management program participants and went up 43% among non-participants. Going to a health care provider for regular treatment and adhering to maintenance medication regimens dramatically lowers total costs after accounting for avoided hospital stays [*Health Affairs Vol. 22, #2 - March/April 2003 "The Business Case for Quality: Case Studies and an Analysis" describes a 2 to 1 return on investment in statin therapy monitoring among high-cholesterol patients at Henry Ford, HealthPartners spent $330 per diabetic on provider guidelines, patient and provider education, screenings and performance evaluation. Savings per patient were $405 over the 10-year period, but annual benefit is expected to exceed cost by $1,500 per patient in year 10*].
  - Among all Great-West account members who are candidates for asthma, diabetes and heart disease management programs, average claims for program participants were $1,000 per member per month lower than for non-participants in 2001 and $1,250 per member per month lower in 2002. Great-West estimates overall annual savings for these programs within the State of Wyoming population at $2.9M during 2002 - about 2.8% of submitted charges and 5.0% of paid claims. Great-West projects savings to grow to 7% for a return in investment among all Great-West administered demand-management programs combined of 13 to 1.

Recommendation: Current levels of investment and return on investment in disease management programs are quite competitive compared to Buck client statistics and employer-specific studies. Some TPAs offer disease management programs specific to depression, high cholesterol and hypertension, eating disorders / obesity and musculoskeletal. Great-West addresses management of these conditions through utilization and case management personnel, without establishing additional disease management programs. Given that upwards of 80% of all claim dollars for conditions that are amenable to management have already been addressed, Great-West's approach may prove more efficient over the long run. However, the State should monitor depression and other disease category claim dollars to determine if such conditions present a large enough target within the State employee population to warrant disease-specific management programs.

As with health promotion and population health management, the State should explore performance-based vendor compensation and employee/dependent participation incentives and should integrate data from these programs into the data warehouse. Appendix D describes a sample approach to patient compliance incentives for disease management programs.

- Case Management
  Case management programs are currently used to improve outcomes and lower global cost of large claim cases. Tools include provider education on best practice protocols, on-site and remote case-manager nurse expertise and coaching to assist patient, recovery, rehabilitation and compliance. Great-West case managers also coordinate wellness, population health management and disease management data to help patients maximize these resources.

  Recommendation: The State should continue to monitor savings and improved outcomes attributable to case management compared to industry standards and to prior periods. Given the personal nature of case management services we recommend caution if any contractual incentives are explored with Great-West or other vendors.

Modeling of recommendations

Cost projections adjusted to reflect increased investment in health promotion, diseases management and case management services reflect the current level of investment in these programs, the amount of savings currently attributable to such programs, and both current TPA and industry estimates of realized program savings. Combining these factors, our projection assumes that if Wyoming invests an additional amount equal to 1.4% of annual expected incurred claims, incurred claims can be reduced by an additional 3.9% over time. Investment is assumed to ramp up in 2005 at 0.7% of incurred claims and to remain constant at 1.4% thereafter. Savings are projected to be realized at 1.3% of incurred claims in 2006, 2.6% by 2007 and 3.9% for 2008 and thereafter. Through 2012, this represents an additional $8.8 million spent on administrative services, including risk-sharing incentives, and $23.4 million in reduced claims, for an expected 2.65 to 1 return on investment before discount, 2.51 to 1 after discount. [*Employee Benefit Plan Review, May 2002 - "Wellness Program Returns Investment" indicates that $1.64 is returned for every $1 invested in wellness programs studied by Project Impact. Studies of health promotion programs at Chevron, Johnson & Johnson, Proctor and Gamble and General Motors show ROI ranging from $1.40 to $4.90 with a median return of $3 for every $1 spent. Studies of population health management programs at United HealthCare, Group Health, Inc., and Blue Cross of California show ROI ranging from $2.20 to $13.00 with a median return of $4.50 for every $1 spent. Studies of disease management programs at Henry Ford Hospital (asthma),Spohn Memorial Hospital (diabetes) and United Behavioral Health (depression) show ROI ranging from $7.30 to $10.40 with a median return of $9 for every $1 spent. Studies of multiple component programs at Bank of America, Citibank and California Public Employee Retirement System show ROI ranging from $4.70 to $5.50. Single-entity studies are not peer reviewed; the 2.5 to 1 ROI modeled for health promotion and disease management programs is a conservative average of available data.*] Increased ROI is possible through greater investment in health promotion, diseases management and case management services, but at lower marginal returns. Also, we strongly recommend that each additional program or risk-sharing arrangement be carefully monitored before more adjustments are made.

PATIENT ENGAGEMENT IN HEALTH CARE PURCHASING THROUGH CONSUMER-DRIVEN HEALTH CARE (CDHC)

Many consultants and plan sponsors believe health care consumer engagement is a potentially fruitful approach to cost control because in many cases the potential is untapped. Under copay-style HMO and POS plans, patients typically do not see or understand the total cost of care. The following table compares fairly standard HMO copay

amounts to total costs and resultant plan costs after copay:

Type of Service	HMO Copay	Typical Total Cost Range	Net Plan Cost
Routine office visit Specialist visit, intense	$10 to $50	$60 to $80 $150 to $250	$10 to $70 $100 to $240
Inpatient stay - 1 day Inpatient stay - 4 days	$250 to $1,000	$1,500 to $10,000 $10,000 to $60,000	$500 to $9,750 $9,000 to $59,000
30-day generic Rx	$5 to $15	$5 to $25	$0 to $20
90-day brand-name Rx (assumed non-preferred)	$15 to $100	$75 to $450	$0 to $435

CDHC plans are not designed to force consumers to pay every dollar of health care cost. A common HRA-style design of $1,000 "placed in account" actually pays first-dollar for all costs incurred by about two-thirds of U.S. patients [*Society of Actuaries 2001 Claim Study*]. Regardless of how much out-of-pocket a patient pays, a key element of CDHC plans is to educate consumers about the actual *total cost* of care and about the *variance of cost* among procedures and providers. This is accomplished by the fact that total cost of a given service, not a copay, is deducted from an employee's HRA account - or paid directly out-of-pocket to satisfy the deductible. Also, since HRA accounts can roll over from year to year, there is added incentive to spend employer money wisely. Using web tools in advance, or by dint of experience, patients will learn the price differentials between discounted in-network providers and others, generic versus brand name drugs, etc. Ultimately, as credible price and quality data is built, patients will assess total cost for a given episode of care, for example an estimate of ALL prescription, doctor, facility and ancillary charges for a routine delivery in- and out-of-network, combined with estimates by hospital of the percentage of complications arising during routine deliveries. Even more important, patients may someday be able to "price" the cost of improved exercise, diet and stress management during pregnancy compared to routine and complicated delivery costs. Price alone will not drive more efficient care, but price and quality data, combined with consumer engagement at the total-cost-of-care level, should add to overall efficiency.

Buck Consultants estimates that CDHC plans can typically save employers about 10% on claims for those employees who enroll, based on the assumptions that 35% of typical health dollars are spent on discretionary care [*proprietary analysis of Buck client database*] and that the combination of price-tag and web-based education, plus the HRA rollover feature, will eliminate one-third of discretionary care spending. Initial savings are highly dependent on CDHC plan design, other plans in place and access to enough providers or alternative treatments that patients can in fact shop around. Total savings should also grow over time as price/quality tools improve, as members gain experience and as unused HRA balances are forfeited at termination. Savings are diluted by additional internal and external administrative and educational costs and by allowing unused HRA balances to pay COBRA or retiree medical premiums. We do not believe that potential Wyoming CDHC plans will generate commensurate savings. Wyoming plans already include more patient out-of-pocket than most HMO and POS plans that employers have in place and compare to for CDHC savings. Also, Wyoming patients do not have access to a competitive health care marketplace, at least as compared to most urban areas where CDHC plans have been adopted. Nevertheless, some CDHC savings can accrue. We believe that employees inclined to enroll in CDHC plans are more likely to research the most appropriate type of care and "comparison shop" among types of treatment, even absent the opportunity to comparison shop among providers. While currently only anecdotal, this belief seems to be borne out by employer and TPA experience with the relatively few CDHC plans currently in place.

Recommendation: While we do not anticipate immediate CDHC plan savings for Wyoming as high as 10% and growing thereafter, we do think some savings - and improved care - can be obtained by continuing and enhancing Wyoming's current consumer-centric plan features:

- $350 and $700 deductible plans already "engage" consumers; current deductibles should be maintained. Deductibles and coinsurance should be explored for prescription coverage, at least for the $750 and $2,500 deductible plans.
- If claim data indicates that emergency room (ER) visits are too frequent despite current deductibles - perhaps for covered ER visits after meeting the deductible - an additional financial penalty could be imposed for ER visits that do not result in an admission.

- Wyoming should explore conversion of current copay-style prescription coverage to CDHC. This could entail a separate, smaller HRA and deductible amount for prescriptions.
- Even without adopting HRA-style plans, Wyoming should explore the benefits of adding various price and quality comparison tools, both web and print-based. These tools should become more powerful and less costly as CDHC vendors invest more to differentiate their products.
- If Wyoming adopts HRA-style plans, limits on the amount of rollover should be considered, along with a "split rollover" feature. A future Wyoming CDHC plan could state that 50% (or some other portion) of unused HRA amounts rollover to the following year's HRA (subject to any overall cap on HRA accumulation) and that the remainder rolls over to the employees "postemployment HRA." Payment from the postemployment HRA would be limited to COBRA and retiree medical premiums. This mechanism offers employees the benefits and incentives of accumulating employer money from unspent HRA accounts but targets some of the rollover to provide benefits after termination of employment.

Modeling of recommendations

Cost projections adjusted to reflect HRA-style or other CDHC plan designs reflect the current level of patient out-of-pocket cost sharing, generic substitution rates, and industry estimates of HRA plan claims savings adjusted for the Wyoming market. We also assumed that CDHC plans will be designed to be actuarially equivalent to current plans. That is, expected claims and out-of-pocket costs will be matched for the current $350, $750 and $2,500 plans versus prospective CDHC plans offered, after adjustment for anticipated average health risks of employees opting for CDHC plans versus remaining in PPOs. For HRA-style plans, this equivalence is achieved by establishing HRA levels large enough to attract enrollment, combined with mid-level employee deductibles and coinsurance amounts that are large enough compared to current PPOs to offset the cost of an up-front HRA. While it possible to create three HRA plans equivalent to the three PPOs currently available, in practice Wyoming may decide to offer only one or two CDHC designs. Our projection assumes three equivalent CDHC plans to accommodate migration from all current plans.

Combining these factors, our projection assumes that if Wyoming invests an additional $8.50 per employee to cover the estimated cost of implementing and administering CDHC plan design and health care decision support tools, incurred claims can be reduced by an additional 5.0% over time. Investment is assumed to begin at the $8.50 level in 2005, increasing with inflation thereafter. Savings are projected to be realized at 2.5% of incurred claims for employees enrolled in CDHC plans in 2005, 3.7% by 2006 and 5.0% for 2007 and thereafter. Enrollment in CDHC plans that are actuarially equivalent to current offerings is assumed to start at 5% of total employee enrollment in 2005 and gradually increase to 15% by 2012. Through 2012, this represents an additional $1.0 million spent on administrative services, including consumer-support websites and call centers, and $3.7 million in reduced claims, for an expected 3.7 to 1 return on investment before discount, 3.6 to 1 after discount. Any projected ROI for CDHC plans should be further reduced by the cost of additional communications efforts made to increase employee understanding and appreciation of the new design. Increased ROI can be significantly greater if CDHC enrollment is initially greater than 5% or grows to more than 15%. Such enrollment can be driven by additional communications and by plan design incentives, both of which offset additional claim savings. Given enrollment patterns among employers currently offering HRA-style plans, we believe assumed CDHC enrollment growing from 5% to 15% over time is neither overly optimistic nor pessimistic.

For illustration we also projected the impact of a mandatory or complete replacement CDHC plan(s). For this scenario we assumed the same additional TPA fees and initial claim savings. We further assumed that claim savings grow to 7.5% over time versus 5.0%, as consumerism now impacts all participants, not just those who voluntarily enroll. The final adjustment under our mandatory model is an assumption that termination forfeitures grow to 2% of claims over time. Termination forfeitures are unused HRA balances that revert to the employer when employees leave employment other than for retirement, disability or death. Many employers allow retired and disabled employees, or surviving dependents, to use HRA balances for some period of time. However, most CDHC plans do not allow access to HRA balances at termination. The result of 100% CDHC enrollment and higher total claim savings is an additional $9.8 million projected to be spent on administrative services, and $47.8 million in reduced claims, for an expected 4.9 to 1 return on investment before discount, 4.6 to 1 after discount.

MODIFICATIONS OF CURRENT SICK LEAVE POLICY

Wyoming State employees receive income protection during non-occupational illness or disability by accumulating paid sick leave. Employees accrue 12 paid days per year. Unused sick leave accumulates without limit. One-half of accumulated leave is paid out upon termination of employment, retirement and death or disablement of the employee, to a maximum of 60 days paid (up to 960 hours can be cashed out at 50% of the hourly pay rate then in effect). Employees with 10 or more years of service may also receive a disability income benefit under the Wyoming Retirement System. Employees can also donate accumulated sick leave to colleagues who are out due to illness or injury but who have exhausted their own accumulated leave. Note, however, that Sick Leave administration and accumulation rules differ for University of Wyoming and Wyoming Community Colleges employees. As survey data below indicates, Wyoming sick leave policy is similar to all surrounding states. Wyoming sick leave policy is also similar to many large public employers. In the private sector, employee disability income insurance is more typically provided through a collection of formal or **informal absence** policies, short-term disability (**STD**) plans and long-term disability (**LTD**) plans. Formal absence policies usually cover the first three to five days of absence, paying full salary so long as STD coverage is not triggered. STD coverage usually commences after three to five days of absence, replacing 80% to 100% of pre-tax income for up to six months or recovery from disability. LTD coverage typically replaces 50% to 60% of pre-tax income after six months of disability until recovery, retirement or death of the employee. Informal absence is similar to formal absence but is paid for a variety of reasons in addition to illness or disability.

Wyoming's current sick leave policy has the advantage of simplicity – employees earn coverage at a fixed rate that does not vary based on length of disability. There is also an incentive to stay on the job through the accumulation feature. However, current sick leave policy does not relate the amount of coverage to the type or severity of disability and dilutes incentives to return to work when healthy. Short service employees and employees with chronic but manageable conditions do not accrue sufficient protection against severe disability. Wyoming employees who accumulate significant sick leave balances receive the same income at work or on disability, whereas typical private employer plans pay less than 100% of pay for disabilities that last beyond several weeks. Finally, the current accumulation arrangement may also provide incentive to avoid absenteeism even when employee performance is below par due to illness or disability – a productivity concern referred to as "presenteeism." Thus, depending on individual employee circumstances, current Wyoming sick leave policy can provide inadequate coverage and misaligned incentives for productive return to work. In fact, some employees may view sick leave accumulation as deferred compensation.

Private sector approaches target benefit adequacy to the type of disability incurred and, where insured, have a built-in incentive to return productive employees to work quickly. STD and LTD benefits pay less than full salary, so employees have a financial as well as professional stake in getting back to work. LTD benefits can represent a significant lifetime liability for the insurer compared to annual premiums received. Given the high present value of payout and the low frequency of claims, insurers have developed a variety of tools to contact disabled employees early on, encourage participation in rehabilitation and re-training programs and to work with employers to accommodate partial or full return to possibly modified positions. LTD insurers also offer package deals to insure or at least administer STD also, so as to engage disabled employees even earlier and maximize return-to-work programs. All of these tools lower the insurer's liability and therefore result in competitive premiums. Insurers have also found that most disabled employees greatly desire to return to productive careers and that effective return-to-work techniques emphasize productivity - disabled employees who return too early tend to become disabled again, generating further claims.

Informal absence has been a private-sector exception to the targeted benefits and return-to-work tools of STD and LTD plans. However, many employers now track informal absence data as part of an overall program to manage disability costs and combine holidays, informal absence and STD into paid-time off (**PTO**) programs. PTO enhances flexibility from the employee perspective, simplifies administration from the employer perspective and provides a natural platform for integrating data from a financial management perspective.

Depending on systems and procedures implemented, a PTO plan can provide the soft-dollar benefit of minimizing unscheduled absences. On average, 68% of unscheduled absences are for reasons other than illness [*CCH Unscheduled Absence Survey, 2001*]. Currently, employees must "bend the rules" or rely on other family members to tend to non-illness related events outside of work. This situation increases unscheduled absence as compared to a PTO plan that fully anticipates absence other than for illness. Another valuable byproduct of the PTO and LTD plan

combination is the enhanced ability to track disability - why absences from work occur and the duration of absence by cause. Analysis of this data can highlight performance and productivity management issues by Agency, job type or any other data element tracked. In addition to all of the important health care data-mining programs described above, absence data can provide an even earlier opportunity to flag employees who may be at risk for debilitating medical conditions. In light of HIPAA privacy concerns, absence data prove much easier to manage as the "point of entry" for health promotion and disease management programs. All of these absence, health and disability management programs require investment in training, systems and vendors to properly collect, maintain and analyze absence data. The design variables involved in fully deploying such a program are too far ranging to estimate specific amounts invested and subsequent investment returns. However, more and more large employers are turning to absence data management, often integrated with health care data warehouse information, to maximize productivity and minimize health care costs.

Over the long term we expect that potential hard and soft dollar cost reductions from integrated medical and disability management, net of ramp-up and maintenance costs, will save the State more than any other investment described in this report [*Workforce Management, September 2003 "Sickened by the Cost of Absenteeism" - absenteeism cost employers 14.3% of payroll in 2000 and 15% in 2002; unscheduled absence has the largest impact on productivity and morale of all absence costs;3% to 6% of any given workforce is out on unscheduled absence every day and most companies overstaff 10% to 20% to mask lost productivity; managed disability programs save 10% to 20% of related absenteeism costs and return employees to work two weeks sooner on average than non-managed programs; PTO programs are ranked the most effective method for unscheduled absence control*] Regardless of potential transition to a PTO-LTD system, with or without integrated health and disability data management, the State can modify the accumulated leave payout practice to save federal taxes and to avoid future salary liability. Currently, unused sick leave and annual leave is cashed out via a regular payroll check, with appropriate tax deductions, including FICA and Medicare (i.e., Social Security taxes) of 7.65%. Absent Wyoming State laws and other considerations to the contrary, it is possible to set up an arrangement whereby unused leave is paid out of trust, thereby avoiding FICA/Medicare taxation. As of September 1, 2003 there is about $44M in accumulated leave that can be cashed out (after limiting sick leave cash out to 50% of 960 hours). If, over time, half this balance is paid out while active and half at termination, then termination payouts from trust on $22M can save Wyoming more than $1.5M. Also, if the State changes policy to bank the dollar amount of sick leave or annual leave accumulated instead of banking the days themselves, then from the State's perspective cash out is limited to the pay rate in effect when leave is accrued, not pay in effect at termination. Payout on termination at the pay rate then in effect, versus salary levels effective as leave is accrued, is referred to as future salary liability. The following table partially illustrates buildup in future salary liability, assuming employees maintain the current average balances of 21.41 days annual leave and 43.67 days sick leave, salaries grow 3% per year, 10% of leave is cashed out each year and that unused leave deposited in the dollar bank earns 2% annually:

Total Accumulated Annual and Sick Leave Balances Payable

		Alternate Approach: **Dollar Bank**	
	Current Approach	State	Employee Accounts
Balance at 9/1/	**- Day Bank -**	Liability	with Interest
2003	$ 44,128,000	$ 44,128,000	$ 44,128,000
2004	$ 45,452,000	$ 44,260,000	$ 45,055,000
2005	$ 46,816,000	$ 44,393,000	$ 46,000,000
2006	$ 48,220,000	$ 44,526,000	$ 46,964,000
2007	$ 49,667,000	$ 44,660,000	$ 47,948,000
2008	$ 51,157,000	$ 44,794,000	$ 48,952,000
2009	$ 52,692,000	$ 44,928,000	$ 49,976,000
2010	$ 54,273,000	$ 45,063,000	$ 51,020,000
2011	$ 55,901,000	$ 45,198,000	$ 52,085,000
2012	$ 57,578,000	$ 45,334,000	$ 53,172,000

Per assumptions described, the State's liability for payout of accumulated leave can be reduced from $57.6M in 2012 to $53.2M ($4.4M saved) if dollars banked are held in general assets and credited with the assumed investment return. The State's liability can be reduced to $45.3M in 2012 ($12.3M saved) if dollars banked are actually deposited in trust when earned, with employees at risk for investment earnings thereafter. Note that this example is

only a partial illustration of future salary liability, as all payouts are assumed to be made in 2012 at pay levels then in effect. In practice, the difference between a dollar bank and the current day bank will be even greater because, under a day bank, payouts for amounts accumulated by 2012 will be paid out at ever higher future salary levels thereafter. Another advantage to the dollar bank design is that Wyoming can transition from the current pay-as-you-go approach to a paid-up approach - thereby avoiding any potential liability for postemployment benefits under pending Government Accounting Standard Board (GASB) standards - at whatever rate budgets permit. For example, in lean years the State can credit accruals and interest to hypothetical employee accounts without actually contributing cash. In flush years the State can contribute as much cash as desired, up to the total current liability, thereby reducing or eliminating any GASB-mandated postemployment benefit liability.

Data on annual leave and sick leave accrual and use during the 12 months ended August 31, 2002 and 2003 is presented in Appendix B. Data on accumulated annual and sick leave by State Agency is also provided in Appendix B.

Recommendation: There are many nuances to PTO-LTD design and vacation / sick leave payout via trust to be considered before a fully defined solution can be proposed. Therefore, we have not modeled future savings from a specific course of action. However, the following changes to current annual and sick leave policy will generate the minimum Social Security tax and future salary liabilities savings shown and will likely generate much larger productivity gains and health care savings over time:

Annual Leave and Sick Leave Recommendations	
Action	**Potential Costs and Savings Over Time**
Pay current accumulated leave amounts through a trust arrangement instead of directly through payroll.	**Costs** - Internal and external time and expense confirm change is appropriate and to execute same. **Savings** - $1.5M lower employer-paid FICA/Medicare taxes based on current accumulated leave; savings grow with salary.

Convert annual and sick leave accumulation from a day bank to a dollar bank.	**Costs:**
	• Internal and external time and expense to:
	  ▪ Confirm change is appropriate and to execute same.
	  ▪ Track dollar-based banks and earnings; set-up and ongoing.
	  ▪ Establish a trust and manage investments, to the extent that Wyoming pre-funds accumulated leave payments.
	
	Savings:
	• $4.4M over 9 years if dollar bank and interest credits are "accounted for" in general assets but not contributed to trust.
	• $12.3M over 9 years if dollar bank contributions are pre-funded in the year earned; employees at risk for investment performance.
	• Soft dollar savings to the extent that dollar bank payouts are used to pay COBRA premiums and or retiree medical premiums.
	• Soft dollar value of improved employee perception of benefits to the extent that dollar bank payouts may be used to pay retiree medical premiums.

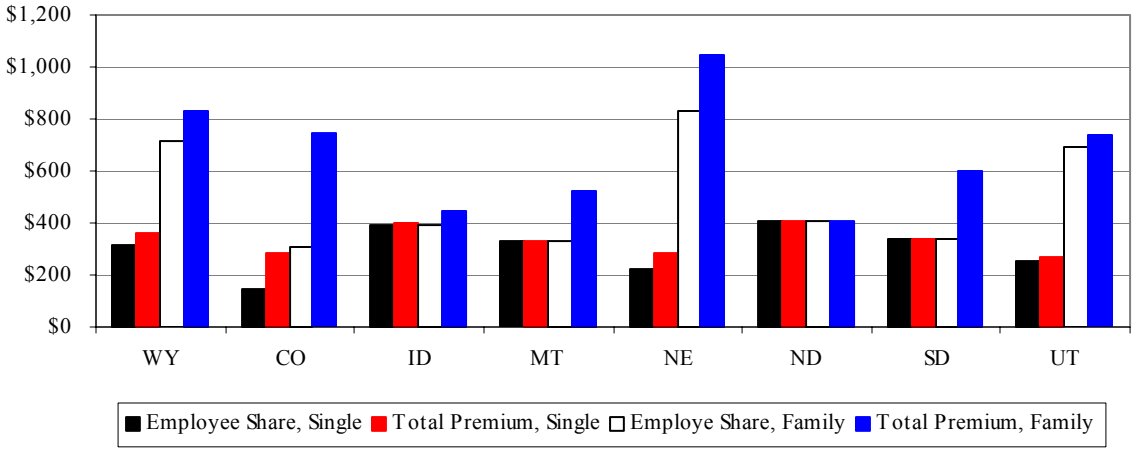
Annual Leave and Sick Leave Recommendations	
Action	**Potential Costs and Savings Over Time**
Convert annual and sick leave to PTO-LTD, integrating absence data with the health care data warehouse project.	**Costs:** • Internal and external time and expense to: ▪ Design appropriate number of vacation days (i.e. days off paid at 100%), salary continuation levels under STD and LTD plans and rollover limits to maintain cost-neutrality (or meet specified cost target). ▪ Determine which employees obtain greater benefits overall under new approach versus those who will not. ▪ Design cost-effective grandfather scheme for employees with balances at transition. ▪ Communicate new approach to employees. ▪ Conduct RFP for insurance carriers and/or third-party administrators. ▪ Develop new absence approval and reporting policies, including training managers and HR personnel. ▪ Develop and maintain absence database, ideally integrated with health care data through the data warehouse. **Savings:** • Minimum hard dollar savings equal to lower replacement pay for STD and LTD absences; offset by longer LTD payouts. Savings are not fully realized until grandfathered amounts are paid out. • Soft dollar savings from a variety of cost reductions and improved productivity. These savings can be measured over time and will likely prove substantial: ▪ Reduced number of unscheduled absences. ▪ Better absence management, i.e. earlier return to work by productive employees than under current system. ▪ Integrated absence and medical data, further speeding return to work and lowering medical plan costs through more effective medical care. ▪ Improved employee perception of benefits to the extent that PTO rollover may be used to pay retiree medical premiums.

SURVEY OF SURROUNDING STATE GOVERNMENT AND WYOMING EMPLOYER BENEFIT PLANS

Data for State employers summarized below and shown in detail in Appendix C is drawn from the "2003 State Employee Benefits Survey" copyright © 2003 Workplace Economics, Inc., and the 2002 Central States Compensation Association Benefit Survey, except as updated for the July 2003 change in Wyoming plan employer subsidy. Data for other employers in Wyoming summarized below is drawn from the Wyoming Department of Employment Research & Planning group's "Employee Benefits in Wyoming" surveys. Please refer to these publications for details on survey methodology, response rates, etc.

The graph below compares employer and total monthly cost for health insurance for Wyoming and surrounding state-employer plans. Key indicators of employer subsidy and employee cost comparability are subsidy ratios - employer amount divided by total cost - and net employee premium. The Wyoming employee-only $350 Plan is about at the average for these statistics; $350 Plan family coverage ranks above average. North Dakota and Utah fund 100% and 93% of health insurance costs respectively, for both single and family coverage. Idaho, Montana, North Dakota and South Dakota all contribute the same amount toward single and family coverage. Colorado lags behind but, as noted, is considering legislation to eventually double the current employer subsidy level.

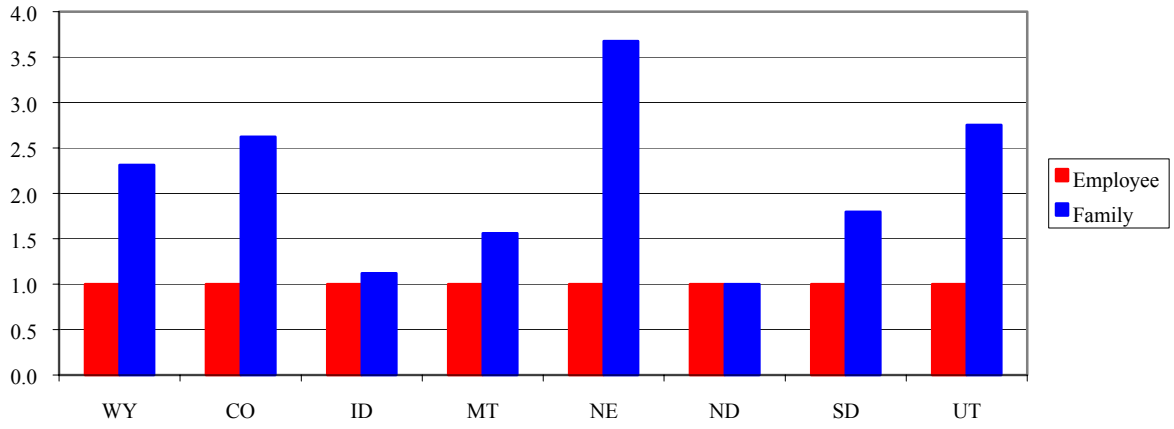
Employer Monthly Contribution and Total Premium for Health Insurance



Employer Medical Subsidy Ratio (employer contribution divided by total premium)								
	WY	CO	ID	MT	NE	ND	SD	UT
Employee	85%	52%	98%	100%	78%	100%	100%	93%
Family	85%	42%	87%	64%	79%	100%	56%	93%

It is important to also compare the ratio of total family premium to single. In addition to explicit subsidies described above, a low ratio of family to single premium implies that dependent coverage is subsidized by employees electing single coverage. Typically, a family to single ratio of 2.75 to 1 indicates that dependents are not subsidized or receive only a small subsidy implicit in total premiums. Actual subsidies are highly dependent on actual employee and dependent claims in a group. A ratio of 2.5 to 1 may also indicate little or no dependent subsidy, but a ratio near 2 to 1 very likely includes dependent subsidies. Ratios higher than 2.75 probably reflect high dependent claims compared to average groups, it is unlikely that total premiums are set with an implicit subsidy of employees by dependents. Based on the following graph, Idaho, Montana and South Dakota very likely subsidize dependents through the total premium structure. Wyoming may have some implicit dependent subsidy. North Dakota shows a ratio of 1 to 1, but 100% of premium - single or family - is employer-paid.

Ratio of Total Family Premium to Total Employee Premium for Health Insurance



Wyoming is also probably in the middle of the pack compared to surrounding states in terms of retiree medical coverage. Wyoming and all surrounding states offer retiree coverage and require some retiree premium, except that Nebraska's coverage stops after Medicare. A key consideration in the value of retiree medical is whether or not total costs are blended with active employees. Since younger active employees generate fewer, less costly claim on

average than do retires, blended plan result in lower retiree cost. Simply comparing premiums paid by retirees is not sufficient - lower premiums may be tied to plans with higher patient out-of-pocket. Wyoming retiree-paid premiums are higher than surrounding states and Wyoming retiree claim experience is not blended with actives. While it appears that some surrounding states blend retiree and active costs, survey data is not explicit in this regard. Finally, Wyoming and all surrounding states except Nebraska offer retiree coverage before and after Medicare. Nebraska coverage ceases after Medicare eligibility (age 65). Group plans for Medicare eligible retirees cover prescriptions, which typically average 60% of total claim dollars for such plans. Individual Medigap policies are available but very often cost more or provide less benefit than group Medicare supplement plans.

Using similar measures, Wyoming dental coverage ranks above average. Utah funds 100% of dental premium for both single and family coverage. Colorado, Idaho and Montana contribute the same amount toward single and family coverage. Nebraska, North Dakota and South Dakota do not contribute toward dental. Colorado, Idaho and Utah contribute toward vision coverage. North and South Dakota offer vision coverage as an employee-paid option. Montana and Nebraska provide vision exams through health coverage. Wyoming does not offer vision coverage.

Employer Dental Subsidy Ratio (employer contribution divided by total premium)								
	WY	CO	ID	MT	NE	ND	SD	UT
Employee	85%	100%	79%	100%	0%	0%	0%	100%
Family	85%	28%	25%	61%	0%	0%	0%	100%

Wyoming and surrounding states all offer similar sick leave and annual leave (vacation) benefits. Key features for each are summarized below, with exceptions between Wyoming and surrounding states noted. Accumulated Wyoming sick leave benefits are paid out at 50%, which is above average. But the number of days paid out by Wyoming is limited - many surrounding states have no limit on accumulated days paid out. Utah has a medical conversion payout feature of one month's premium for one day of accumulated sick day converted.

Sick Leave Benefit Features	Common Provisions	Exceptions
Accrual	12 days per year, no maximum	• CO = 10 days to 45-day max • NE = accrual rate increases to 14 and 18 days per year after 5 and 15 years service • SD = 14 days • UT = 13 days
Eligibility	May use and accrue immediately	• MT = 3 month wait to use
Other Uses	May be used for family death or illness	• CO = funeral leave is a separate benefit • ND = funeral leave is a separate benefit; 5 day max use for family illness • UT = funeral leave is a separate benefit
Unused Payout	• Termination = no payout • Retirement = 25%, no limit • Employee death = 25%, no limit • Disability = variable payout, no limit	• WY = 50%, max 60 days; also pays at termination • ID = pays 100%, max 75 days, no payout on employee's death • MT = payout at termination but not for disability • NE = payout at termination but not for disability • ND = 10% payout, termination payout after 10 years service • SD = max 60 days payout after 7 years of service • UT = may convert 1 day to 1 month health insurance, no payout for disability

Wyoming annual leave (vacation) accrual is at the average of surrounding states. Similar to most surrounding states, Wyoming allows immediate use of vacation; Montana and South Dakota require a 6-month wait. All surrounding states pay out unused vacation at termination or retirement.

Annual Leave Accrual Rates by Service								
	WY	CO	ID	MT	NE	ND	SD	UT
1 Year	12	12	12	15	12	12	15	13
5 Years	15	12	15	15	15	15	15	16.25
10 Years	18	15	18	18	20	18	15	19.5
15 Years	21	18	21	21	25	21	20	19.5
20 Years	24	21	21	24	25	24	20	22.75

The table below illustrates replacement income under Wyoming and surrounding state retirement plans for a single example, an employee who retires after 25 years of service with final average compensation of $40,000. Based on this limited illustration, Wyoming retirement benefits are slightly above average for the states shown. This report does not include a thorough comparison of replacement income ratios, which entails after-tax calculations using retirement at dozens of combinations of age, service and pay, plus retiree medical and other possible benefits. More detailed plan provisions are provided in Appendix C.

The table below also summarizes employer and employee retirement funding contributions as a percentage of pay. Total contributions for Wyoming are less than average for surrounding states and are entirely employer-paid. Note that both funding contributions and the funded status of a plan can vary over time due to asset performance compared to expectations and other experience.

Approximate Comparison of Retirement Plans*								
	WY	CO	ID	MT	NE	ND	SD	UT
Average Final Compensation	40,000	40,000	40,000	40,000	40,000	40,000	40,000	40,000
Service	25	25	25	25	25	25	25	25
Annual Benefit	21,750	25,000	20,000	17,850	(1)	20,000	16,250	20,000
Income Replacement % (pretax)	54%	63%	50%	45%	(1)	50%	41%	50%
Age required for full benefit	60	50	55	none	55	"rule of	55	none
Service required for full benefit	4	30	5	30	5	85"	30	30
Employer funding % of pay	11.25%	10.04%	9.77%	6.90%	7.13%	8.12%	6.00%	10.40%
Employee funding % of pay	0.00%	8.00%	5.86%	6.90%	4.57%	0.00%	6.00%	0.00%

(1) Nebraska has an individual account type plan.
* Each plan defines average final compensation differently, some have multiple eligibilities for full benefits, Nebraska funding % is based on each employee's pay, etc. See Appendix C.

From 2002 Central States survey data, Wyoming is below the average of surrounding states' salary levels. Wyoming is right at the average for vacation hours and sick leave hours. Wyoming lags behind the average for holiday hours, health insurance contribution and dental contribution. However, after the July 2003 employer subsidy change and reported salary increases for 2003, Wyoming is at or above average of surrounding state benefit plans and below average for salary, as described above. Per 2002 data, Wyoming spends more than average on life insurance and retirement. Total Wyoming compensation for 2002 is slightly lower than the average of surrounding states. Detail on 2002 data is provided in Appendix C. The following chart combines 2003 survey data and 2002 salaries projected at reported average salary increase estimates for 2003:

2003 Total Compensation Comparison	WY	CO	ID	MT	NE	ND	SD	UT	Average
Est. Average Salary	$35,020	$49,301	$44,177	$31,835	$32,560	$36,781	$33,246	$36,269	$37,399
increase % for 2003	*0.00%*	*4.70%*	*6.00%*	*3.40%*	*1.75%*	*2.00%*	*3.00%*	*0.00%*	*2.61%*
2003 Health Subsidy(1)	$ 6,199	$ 2,751	$ 4,673	$ 4,015	$ 6,302	$ 4,909	$ 4,036	$ 2,061	$ 4,368
2003 Retirement $$	$ 3,940	$ 4,950	$ 4,316	$ 2,197	$ 2,198	$ 1,515	$ 1,995	$ 3,772	$ 3,110
2003 Est. Other $$(2)	$ 5,099	$ 9,785	$ 6,463	$ 4,823	$ 5,121	$ 5,519	$ 5,445	$ 7,968	$ 6,278
Total Benefits	$15,238	$17,486	$15,452	$11,035	$13,621	$11,943	$11,476	$13,801	$13,757
Benefit % of Pay	*43.51%*	*35.47%*	*34.98%*	*34.66%*	*41.83%*	*32.47%*	*34.52%*	*38.05%*	*36.94%*
Total Compensation	$50,258	$66,787	$59,629	$42,870	$46,181	$48,724	$44,722	$50,070	$51,155
Max Deferred Comp Match	$ 240	$ 1,479	$ 0	$ 0	$ 0	$ 0	$ 0	$ 544	$ 283
Total Comp w/ Deferred	$50,498	$68,266	$59,629	$42,870	$46,181	$48,724	$44,722	$50,614	$51,438

(1) Average of single and family subsidy rates used for comparison.
(2) 6.2% FICA added for Colorado and Utah for comparison.

Appendix C provides detail on holidays, parental leave, other leave, life insurance and disability insurance for Wyoming and surrounding state employer plans.

Appendix C also includes data for 2001 and 2002 on other Wyoming employers from the Wyoming Department of Employment Research & Planning group (R&P). R&P data indicates the prevalence of various benefit plans by employer type and size, plus certain overall cost and leave data. The table below summarizes comparable data that is available from both the Workplace Economics survey and the R&P surveys. Most differences between Wyoming State Employee plans and other Wyoming employer plans that can be inferred from survey data are as expected as a function of employer size - State Employee plans cost more as a percentage of pay and are likely more comprehensive, richer programs. The State does not offer paid personal leave whereas one-third to one-half of other responding Wyoming employers did offer paid personal leave in 2001 and 2002, respectively. On the other hand, it is likely that most other Wyoming employer sick leave plans do not allow for significant accumulation of unused days. Note that R&P data for other Wyoming Employers includes local governments whose benefit plans are likely richer than small private employers. Also, R&P reported total benefit costs as a percentage of pay do not vary greatly when data is limited to responding employers offering benefits. Therefore, it is likely that few Wyoming employers who offer only statutory benefits or limited non-statutory benefits responded to the survey.

Wyoming State Employee Benefits vs. Other Wyoming Employers				
	Wyoming State EEs		Other Wyoming Employers	
Cost or Plan Type	Post 7/03	Pre 7/03	2002	2001
Employer Cost for Retirement, % of Pay	11.25%	11.25%	12.8%	6.6% **
Employer Cost for Other Benefits, % of Pay*	16.7%	12.6%	8.1%	12.0% **
Health Insurance - Employer Subsidy %	85.0%	77.0%	83.3%	79.5%
Dental Plan - Employer Subsidy %	85.0%	77.0%	72.2%	75.9%
Paid Holidays	9.0	9.0	8.6	7.9
Paid Sick Leave	12.0	12.0	12.5	8.9
Paid Vacation (after 1 year)	12.0	12.0	9.8	8.6 ***
Paid Vacation (after 5 years)	15.0	15.0	10.0	10.4 ***
Paid Vacation (after 10 years)	18.0	18.0	14.7	11.4 ***
Paid Personal Leave (after 1 year)	-	-	7.9	6.7 ***
Paid Personal Leave (after 5 years)	-	-	11.5	6.7 ****
Paid Personal Leave (after 10 years)	-	-	13.7	6.7 ****

* Medical and preventive dental -Wyoming State Employees; paid leave, insurances and miscellaneous - Other Wyoming employers.
** Other Wyoming employer costs as a % of pay shown above are for 2001 and 2000.
*** Other Wyoming employer vacation data collected for periods of "after 1 year, after 2 years" and "after 3 years" for 2001.
**** Other Wyoming employer personal leave data collected for all periods combined in 2001.

While State plans are probably richer and more comprehensive than those of most other Wyoming employers, State plans are also likely more efficient. Each benefit dollar spent by a large group buys proportionally more benefits

and less administration than the same dollar spent by small groups. This economy of scale applies to the fixed-cost administration of any benefit, but group size provides particular advantage for benefits with a low incidence of high-cost claims. Thus, State employees receive more benefits per dollar spent for health care, where typically 15% of participants generate 80% or more of claims. The State would enjoy a similar spread of risk advantage if LTD insurance replaces sick leave - the incidence of long-term disability claims are low, the reserve required to replace a portion of income until the earlier of recovery, retirement or death is large. A conservative rule-of-thumb for the point at which economies of scale and spread of risk based on group size provide little additional advantage is 10,000 to 15,000. In other words, an employer plan with 5,000 or more employees and 5,000 or more dependents gains little per-employee cost advantage by growing larger. Conversely, smaller employer groups could substantially improve benefit dollar efficiency by pooling with a larger group such as the State plan. However, the State plan is likely to suffer adverse selection to the extent that smaller groups join at a higher total cost than currently paid - State plan costs being higher because of relatively richer plan design. Groups who might join with the State would probably lose control of benefit design; willingness to join with a larger group under these conditions is also an indicator of likely adverse selection.

Survey Data Conclusions

- Most major State of Wyoming employee benefits are comparable in design to those of surrounding employers and are likely richer than the great majority of other Wyoming employer plans.
- The most significant recent change in Wyoming employee benefits - increased subsidy of dependent medical costs - brought Wyoming in line with the majority of surrounding states (and private employees nationally). Fortune 500 employers are beginning to charge more for dependent coverage, especially if a spouse has coverage [*Wall Street Journal, September 9, 2003*]. However, these employers are typically moving from relatively high dependent subsidies compared to the State's position prior to July 2003.
- The one area of State employee benefits that offers the greatest potential for long term cost management is conversion of sick leave accrual to paid-time off and long-term disability coverage. However, at least as compared to surrounding state employee benefit plans, this change may be difficult to implement. Wyoming, surrounding states and the many other large government employers offer sick leave accrual.

CONCLUSION

Buck analyzed demographic, claim and cost management data for Wyoming's medical, dental and sick leave plans to project costs under several scenarios through 2012. Based on our analysis and comparison to benefit plans of surrounding states, we believe Wyoming medical and dental plans are competitive and have in place most of the cost management tools used by leading large-employer plans. Additional participant and vendor incentives for cost containment should be considered. The data warehouse project should also provide cutting-edge cost management capabilities, especially if integrated with absence data. Current sick leave is not efficient when compared to paid-time off and long-term disability programs. However, current sick leave is in line with all surrounding state plans.

Repeated below are the five study questions we addressed and our conclusions for each:

1. <u>What is the impact over time of increased employer subsidy of dependent coverage effective July 1, 2003?</u>
   The July 1, 2003 dependent subsidy change is a significant investment that has improved the insurance status of several thousand dependents of Wyoming State employees. The overall spread of risk in Wyoming State medical and dental plans has also been improved, lowering future employee premium share and out-of-pocket costs. State Agencies will realize soft-dollar savings over time from improved overall health status and resultant higher productivity. Anecdotal confirmation of the fiscal sense inherent in the recent subsidy change can be found in Colorado. The Colorado State employees plan currently subsidizes less than 50% of the total cost for all employees and dependents. Alarmed by significant numbers of employees and dependents going without coverage, the governor and Director of Personnel now propose to double employer subsidy for 2005 to 77% of total cost and eventually move to 85% of total cost as an acceptable benchmark.

2. <u>What savings can be expected over time from additional investment in health management?</u>
   Many cutting-edge medical management techniques are already in place and generating positive return on investment. Continued efforts must be kept up to continue realizing these savings. The State, Great-West and other employee/dependent-health advocates should determine if focused performance measures can be agreed to

for programs in place and for any new programs considered. Incentives can be built into Great-West and other vendor contracts, but great care must be taken to avoid performance measures that are too easily met. For many aspects of health management, performance-based incentives may have to await greater consensus among medical and disability practitioners around expected outcomes. The State should also investigate incentives for employee and dependent participation in - and completion of - health management activities.

New investment - and ongoing programs - should be assessed on the basis of potential claims AND lost time savings and should include objective measurement standards. That is, the State should be satisfied that data can be tracked to answer key performance questions: how many members are at risk for the conditions addressed by a specific health promotion program? what baseline claim dollars can be expected for this group? how many work days are typically lost? what level of participation should be considered successful? Appendix D describes sample incentives health management programs.

Through 2012, we project that an additional $8.8 million spent on health management administrative services, including risk-sharing incentives, will reduce claims $23.4 million, for an expected 2.65 to 1 return on investment before discount, 2.51 to 1 after discount. Increased ROI is possible through greater investment in health promotion, diseases management and case management services, but at lower marginal returns. Also, we strongly recommend that each additional program or risk-sharing arrangement be carefully monitored before more adjustments are made.

3. What savings can be expected over time by increasing patient engagement in health care purchasing through consumer-driven health care (CDHC) plan designs?
   Enhanced health care consumerism has potential for additional savings under the Wyoming plans. However, we do not project incremental return on investment in consumer-oriented plan design, communications and decision support tools to be as great as might be available in markets where health care providers are highly competitive on both price and volume.

   Through 2012, we project that an additional $1.0 million spent on CDHC administrative services, including consumer-support websites and call centers, will reduce claims $3.7 million, for an expected 3.7 to 1 return on investment before discount, 3.6 to 1 after discount. Any projected ROI for CDHC plans should be further reduced by the cost of additional communications efforts made to increase employee understanding and appreciation of the new design. Increased ROI can be significantly greater if CDHC enrollment is initially greater than 5% assumed or grows to more than 15%. Such enrollment can be driven by additional communications and by plan design incentives, both of which offset additional claim savings.

4. What savings can be expected over time by modifying current sick leave policy?
   Changes to current sick leave policy may be the most difficult to make given the prevalence of similar plans among all surrounding state governments. However, we believe this area offers the most significant potential savings of all areas studied, even if the State moves to a "cost neutral" - but much more managed - disability-oriented plan. Potential sick leave policy savings are greatest because this is the least managed area studied.

   Wyoming should:
   - Pay current accumulated leave amounts through a trust arrangement instead of directly through payroll to possibly save Social Security taxes.
   - Convert annual and sick leave accumulation from a day bank to a dollar bank to avoid or minimize future salary liability.
   - Convert annual and sick leave to PTO-LTD, integrating absence data with the health care data warehouse project to better protect short-service disabled employees, improve productivity and reduce health care costs.

5. How do Wyoming State employee benefit plans compare to those of surrounding states and to those of private employers in Wyoming?
   Wyoming State benefits are in line with surrounding states, especially after the July 2003 dependent subsidy increase. Wyoming State benefits are also more generous and more expensive than those of most other – smaller – Wyoming employers.

The most significant recent change in Wyoming employee benefits - increased subsidy of dependent medical costs - brought Wyoming in line with the majority of surrounding states (and private employees nationally). Fortune 500 employers are beginning to charge more for dependent coverage, especially if a spouse has coverage. However, these employers are typically moving from relatively high dependent subsidies compared to the State's position prior to July 2003.

The one area of State employee benefits that offers the greatest potential for long term cost management is conversion of sick leave accrual to paid-time off and long-term disability coverage. However, at least as compared to surrounding state employee benefit plans, this change may be difficult to implement. Wyoming, surrounding states and the many other large government employers offer sick leave accrual.

APPENDIX A - GLOSSARY OF KEY TERMS

Acronym	Definition	Page References
AD&D	Accidental Death & Dismemberment	C-8
Admin	Administrative services / costs or fees for internal or external administration of benefit plans	B-4, B-5
AFC	Average Final Compensation	C-9
A/R	Accrual Rate	C-4
CDHC	Consumer-Driven Health Care	Table of Contents, 2, 3, 4, 6, 7, 12, 13, 14, 24, A-3, B-4, B-5, D-2, D-3
COBRA	Consolidated Omnibus Reconciliation Act	3, 4, 13, 14, 17, A-2, B-1, B-2, B-3, B-4, B-5, D-3, D-4
COLA	Cost of Living Adjustment	C-9
CPI	Consumer Price Index	3, A-4
DC	Defined Contribution	A-3
EE(s)	Employee(s)	22, B-1, B-2, B-3, B-4, B-5
EOB	Explanation of Benefits	A-2
EPO	Exclusive Provider Organization	A-4
ER(s)	Employer(s)	B-1, B-2
ER	Emergency Room	13
FICA	Social Security / Medicare tax (Federal Insurance Contributions Act)	16, 17
FIRE	Finance, Insurance & Real Estate	C-11, C-12
FMLA	Family Medical Leave Act	D-5
FYE	Fiscal Year End	8
GASB	Government Accounting Standard Board	17
GDP	Gross Domestic Product	3
HIPAA	Health Insurance Portability and Accountability Act	6, 10, 16, A-5, D-1
HMO	Health Maintenance Organization	5, 12, 13, A-4
HR	Human Resources	18
HRA	Health Reimbursement Arrangement	6, 13, 14, A-3, A-5, D-2, D-3
HRAs	Health Risk Appraisals	11
IRS	Internal Revenue Service	6, A-3, A-5
LTD	Long-Term Disability	15, 16, 17, 18, 23, 24, A-6, D-4, D-5
Medigap	Individual retiree insurance policies that fill **gaps** in **Medicare**	20
NHE	National Health Expenditures	3
PCP	Primary Care Providers	A-4
PMPM	Per Member Per Month (members include employees and dependents, also referred to as participants)	4, 8, B-1, B-2, B-3, B-4, B-5
POS	Point-Of-Service	12, 13, A-4
PPO	Preferred Provider Organization	5, 6, 14, A-4, A-6, C-15
PTO	Paid Time Off	15, 16, 17, 18, 24, A-7, D-4, D-5
RFP	Request For Proposal	18
R & P	Research & Planning	22
ROI	Return On Investment	7, 12, 14, 24
STD	Short-Term Disability	15, 18, A-7, D-5
TCPU	Transportation, Communications & Public Utilities	C-11, C-12
TPA	Third Party Administrator	6, 9, 11, 12, 13, 14, A-7
VEBA	Voluntary Employee Benefit Association	A-7

APPENDIX A - GLOSSARY OF KEY TERMS

Adverse selection

Medical plan participants with chronic or high-cost health conditions receive the most economic benefit per premium dollar spent. Participants in poor health therefore often have incentive to pay premiums and remain in a medical plan even as their share of premium increases to a high proportion of income. Healthy plan participants receive less economic benefit per premium dollar spent. As the employee share of total premium increases, healthy participants tend to gamble that they will not become ill while dropping coverage and pocketing premium share otherwise paid into the plan. This phenomenon is a major reason why group health plans typically have open enrollment no more than once a year, and that enrollment open occurs at a fixed time for all employees - not at a times selected individually. Adverse selection can also occur in dental, life insurance, disability and other coverages.

Aging

The number and types of health care services, prescriptions, etc., that average individuals use generally increases with age, reflecting deteriorating health (i.e., increasing morbidity). Typical assumptions are that medial costs increase from 2% to 5% each year as an individual goes from age 35 to age 80. Aging impacts large group and trend analysis as the average age of the covered group increases.

Care coaching

Registered nurses and other health care professionals can dramatically improve outcomes for conditions that are treated by complex or strict prescription, dietary and/or therapy regimens. Care coaches typically help patients better fit prescribed treatment into the patient's lifestyle and follow up with progress reports and general encouragement. Care coaching can be provided in person or remotely.

Case management

Patients entering on or in high-cost phases of treatment for their conditions are assigned nurses to help improve care and reduce costs by reference to benchmark protocols. Medical managers and other physicians sometimes also join the team of patient, provider, hospital and case management nurse.

Claim adjudication

Match of service date, patient eligibility, provider network participation or other discounts, reasonable and customary prevailing charge maximums, plan coverages and provisions, other coverage available, year-to-date patient out-of-pocket amounts and lifetime benefit payments to determine how much of each submitted claim is covered, allowed and payable by the plan versus the patient. Key data items and reasons for amounts not covered are reported to patients via an Explanation of Benefits (EOB).

COBRA

Employers with 20 or more employees are required to offer continuation of group health care coverage to employees and dependents after loss of coverage due to certain qualifying events (termination of employment except for cause, death of an employee, etc.). Employers may charge up to 102% of the total cost of continuation coverage elected (150% in the case of extension of coverage for disability). However, most potential continuees do not elect to pay full cost under COBRA if they are healthy or have a spouse's or new employer plan to fall back on. Therefore COBRA coverage typically generates severe adverse selection. COBRA is so named after its enabling legislation, the Consolidated Omnibus Budget Reconciliation Act of 1985.

Cost shifting

Costs for employer-provided health care increase as other sources of insurance are scaled back or eliminated. Providers pass their own costs for some portion of uncompensated care to members of insured groups; that is, as more individuals lose coverage or have reduced coverage, average hospital and other provider bills paid by remaining insured groups increase. Costs also shift to employer plans as Medicaid, Medicare and local assistance plans cut back.

Consumer-driven health care

Any program that promotes data resources to help patients price and manage their own care, combined with plan designs that communicate total charges for care, can be considered consumer-driven. A core tenet of consumer-driven health care (CDHC) is that knowledgeable patients spending their own money will improve health care marketplace efficiency. Consumer engagement will improve health care market efficiency as patients choose more wisely whether or not to purchase a given test, procedure or prescription, and as patients choose more wisely among providers.

CDHC typically differs from **defined contribution health care** in that the former promotes consumer engagement at the point of each purchase, while the latter promotes engagement during the annual open enrollment health plan purchasing process.

The IRS recently sanctioned one form of consumer-driven health plan, the health reimbursement arrangement (HRA) - an employer-funded account for health care expenses with rollover of any unused balance at year end. A common HRA-style design of $1,000 "placed in account" actually pays first-dollar for all costs incurred by about two-thirds of U.S. patients [*Society of Actuaries 2001 Claim Study*]. Regardless of how much out-of-pocket a patient pays, a key element of CDHC plans is to educate consumers about the actual *total cost* of care and about the *variance of cost* among procedures and providers. This is accomplished by the fact that total cost of a given service, not a copay, is deducted from an employee's HRA account - or paid directly out-of-pocket to satisfy the deductible. Also, since HRA accounts can roll over from year to year, there is added incentive to spend employer money wisely. Using web tools in advance, or by dint of experience, patients will learn the price differentials between discounted in-network providers and others, generic versus brand name drugs, etc. Price alone will not drive more efficient care, but price and quality data, combined with consumer engagement at the total-cost-of-care level, should add to overall efficiency.

Death spiral

With adverse selection, participants remaining in the plan - and playing premium - incur ever increasing average claims as healthy participants drop coverage. If premiums are then increased to match the greater average risk, more adverse selection occurs. Without other intervention this process results in a cycle that can bankrupt the plan, driving premiums out of reach of even the most ill members.

Direct contracting

Employers sometimes contract directly with hospitals and provider groups for discounted services, bypassing insurance plans and established networks. This technique works well for large groups in highly competitive provider marketplaces, and surprisingly well regardless of employer size in rural markets where providers perceive the contracting as investment in the local employer community. In many ways Wyoming already pursues direct contracting by sitting in with Great-West on certain provider negotiations.

Defined contribution (DC) health care

An arrangement wherein the employer defines a fixed contribution toward the cost of health care benefits regardless of which plan an employee elects. Employees pay the difference between options elected and the employer contribution amount. One logical extension of defined contribution funding is a voucher system - the employer might screen a slate of plans from which employees choose but the employer need not contract directly with the plans themselves. Managed competition is a form of DC health care. Truly flexible benefit plans are a DC approach to many types of benefit plans in addition to medical.

Disease management	Disease management helps patients and providers more effectively navigate treatment for specific conditions. Patients identified through health promotion screenings, population health management data tools and as reported by providers receive education materials, care coaching, provider consultations and care monitoring.
Employer subsidy	Portion of premium equivalent paid for by the employer; reminder of premium equivalent is paid by employees, typically through pre-tax payroll deduction.
Gatekeeper arrangements (EPO, HMO, POS	Arrangement whereby primary care providers (PCPs) who accept care management and referral pattern protocols, and also discount fees or other incentives, attempt to direct patients to efficient specialists and to control utilization. Total plan costs are lowered to the extent that patients see PCPs (when there is a choice) and to the extent that care management and referral protocols are cost-effective. Employer costs are lowered to the extent that provider savings offset inducements for patients to see PCPs - typically lower patient out-of-pocket. However, administrative overhead is typically higher than under PPOs. Forms of gatekeeper arrangements include exclusive provider organizations (EPOs), health maintenance organizations (HMOs) and point-of-service (POS) plans.
Health care CPI	The potion of the consumer price index attributable to medical services. Health care CPI is typically double total CPI. Further, CPI measures only the increase for the same set of goods (same level and type of utilization) over time.
Health promotion	Health promotion is intended to maintain the good health of healthy employees and dependents and to encourage more healthful lifestyles and preventive regimens for other members. Educational sessions and material are offered to the general covered population without data mining to target at-risk members (see population health management and disease management). In addition to promoting general health awareness, wellness tools often used include health risk assessment, exercise classes, immunizations, blood pressure measurement, stress management classes, blood screenings, dietary consultation and smoking cessation classes.
Health risk assessment	Voluntary health status and demographic questionnaires administered at open enrollment, health fares, etc., or disseminated through a controlled survey. Questions such as "describe your general health status" or "rank how great a factor stress is in your daily life" are designed to build predictive power without being overly intrusive or complex, thereby maximizing participation and accuracy.

HIPAA privacy

Among other provisions, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that "individually identifiable health care information" that is electronically maintained or transferred by a "covered entity" may not be disclosed without advance authorization from the individual – except if the information is needed for health care treatment, payment of health care claims, health care operations, or in furtherance of national policy activities (such as law enforcement and health oversight). Authorization is specifically required by the individual before any information on that individual may be disclosed for marketing, use by a non health-related covered entity, or certain other restricted uses.

The regulations also require that the covered entity take all reasonable steps to ensure that it discloses no more than the minimum amount of protected health care information needed to accomplish the intended purpose of the disclosure. This generally requires that written procedures be established on disclosure of data.

Individually identifiable health care information is any information on an individual's past, present or future health, or the provision of or payment for health care for an individual, if it identifies or could identify an individual. The privacy requirements only apply to information that is maintained or transferred electronically – they do not apply to paper records. The regulations define "maintained or transferred" very broadly, and once information is put into electronic form for any purpose, it becomes protected.

Covered entities include a health plan, a health care clearinghouse, and a health care provider. Although the regulations do not specifically include employers as covered entities, employers that operate self-funded health plans or employers that are otherwise significantly involved in the administration of their health plans are affected.

Health care providers who do not conduct electronic transactions themselves are still considered covered entities and subject to the requirements if another entity – such as a billing service or hospital – transmits individually identifiable health care information on their behalf. Certain non-covered entities must agree by contract to generally abide by the privacy requirements before covered entities may disclose any protected information to them. These non-covered entities (referred to as business associates) may include contractors, third-party administrators, outside attorneys, accountants, and consultants.

HRA

Health reimbursement arrangements under IRS code sections 105 and 106 allow employers to fund employee medical claims via accounts that may allow for rollover of unspent amounts from year to year. HRA accounts may also rollover into retirement. No employee money may be contributed to an HRA account. HRA monies may only be used for qualified medical expenses.

Informal absence

Informal absence policies usually cover the first three to five days of absence and pay full salary. Informal typically means that the employer does not invest in procedures to monitor reasons for absence, although utilization statistics are often maintained and considered during an employee's annual salary and performance review. Also called casual absence.

LTD

Long-term disability plans pay a portion of salary to employees who are disabled per the plan's definition of disability - typically the inability to perform one's own occupation due to illness or injury. Benefits typically start after short-term disability (e.g. absent 6 months) and continue until one of a variety of events occur: a fixed duration (e.g. 2 years) and age-based duration (e.g. age 65), recovery and return to one's own occupation or any occupation reasonably suited by education and experience, death of the disabled participant.

Mandated benefit coverage	Health care costs typically increase as new services - or more covered services - are mandated by state legislatures. For example, a mandated level of colorectal screenings, while ultimately beneficial in reducing costs associated with earlier detection of colon cancer, may result in inefficiently high levels of screening versus what might otherwise be provided. Mandates may play a lesser role in Wyoming than other states but do account for a significant portion of national health care cost increases.
New technology	Over the last several decades, most advances in medical care resulted in treatments that were initially more costly than prior approaches. Examples abound in new prescription therapies, scanning devices, etc. New technology may ultimately lower costs through hospital admissions avoided, earlier detection of conditions, etc. However, this effect is dampened by the increasing rate of health care innovation.
Open enrollment	Annual process whereby employees select among medical, dental, life insurance and other benefit options available, ideally weighing payroll deductions for each plan against perceived quality differences and perceived family need for coverage.
Patient out-of-pocket	Portion of medical cost paid directly by the patient, through deductibles, coinsurance and copayments.
Population health management	Population health management is highly data-intensive. Demographics, prescription claims, medical test results, diagnoses and other information is collated and screened for patterns that signal which patients are candidates for cost-effective interventions such as additional guidance for the provider(s) involved, educational materials for patients, recommended screenings and disease management.
Predictive modeling	Data from population health management efforts is stratified to identify potential high-cost claimants before large claims are incurred. Models generally attempt to rank candidates for intervention by projected claim costs in the next 12 to 24 months absent any intervention.
Preferred provider organization (PPO)	Arrangement whereby providers who discount fees below prevailing levels are listed as "preferred." Patients who see preferred providers pay less out-of-pocket than to non-preferred providers. Total plan costs are lowered to the extent that patients use preferred providers. Employer costs are lowered to the extent that provider discounts offset lower patient out-of-pocket. However, utilization controls are typically not as strong as under gatekeeper arrangements.
Premium equivalent	Fully insured plans are completely funded by paying contracted premium to the insurer. Self-funded plans are funded by paying allowed claims less patient out-of-pocket to providers, paying administrative and other fees to vendors and adding to employer-held reserves. Self-funded employers translate these costs to monthly premium equivalents which are then shared between employer and employee per the employer subsidy level.
PTO	Paid-time off programs typically combine vacation, informal leave and short-term disability coverage into a combined allowance of days off paid at 100%. Some portion of each employee's unused annual allowance typically accumulates, up to a defined maximum balance. Employees do not need to demonstrate their own or a dependent's illness to use PTO days. Ideally, while no reason need be given to access PTO days, the reason for and duration of each leave used should be tracked to manage absence expense and to integrate with disease management data.

STD	Short-term disability plans pay a portion of salary to employees who are disabled per the plan's definition of disability - typically per administrative guidelines or a health care provider's recommendation. Benefits typically start after informal or casual absence (e.g. 3 consecutive workdays) and stop upon qualification for long-term disability (e.g. absent 6 months).
TPA	Third-party administrators provide services for self-funded employee benefit plans, including one or more of the following: maintaining files of eligible participants, claim adjudication, provider contracting, re-pricing of discounted network claims, customer service assistance, health promotion, population health management, disease management and stop loss reinsurance.
Utilization	Rate at which health care services are used, as opposed to price of services. Efficient providers can reduce overall cost at higher costs per service if total utilization is held down. Note that utilization measures increased consumption regardless of age while aging or morbidity measure increased consumption attributable to age-related health status.
VEBA	Voluntary Employee Benefit Association under Internal Revenue Code section 501(c)(9) allow tax-free employee and employer contributions toward certain employee benefit plans. Despite many restrictions, VEBAs are often used by public employers to pre-fund retiree medical and disability coverage because of the security provided by keeping funds in trust.

Projection Summary

Active/COBRA Medical & Dental - pre-July 2003 Cost Sharing Strategy

Year	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Number										
$350 medical	10,008	9,871	9,737	9,604	9,474	9,347	9,221	9,097	8,976	8,856
$750 medical	1,545	1,651	1,754	1,853	1,948	2,040	2,128	2,213	2,295	2,374
$2500 medical	0	28	56	85	115	146	178	210	242	275
Total medical	11,553	11,550	11,547	11,543	11,538	11,533	11,527	11,520	11,513	11,505
Opt Out	0	2	6	10	15	20	26	32	39	47
Preventive dental	11,553	11,550	11,547	11,543	11,538	11,533	11,527	11,520	11,513	11,505
Optional dental	9,024	9,022	9,019	9,016	9,013	9,009	9,004	8,999	8,993	8,987
Average Pay	$ 32,699	$ 33,538	$ 34,628	$ 36,000	$ 37,568	$ 39,212	$ 40,967	$ 42,833	$ 44,799	$ 46,849
Monthly Costs	(composite rates including employees and dependents; "EE" = Employee, "ER" = Emloyer)									
EE Premium	$ 130.99	$ 146.50	$ 162.49	$ 178.71	$ 194.83	$ 210.55	$ 225.46	$ 239.08	$ 250.95	$ 260.87
EE Out-of-Pocket	$ 78.77	$ 89.38	$ 100.50	$ 112.04	$ 123.74	$ 135.44	$ 146.83	$ 157.58	$ 167.36	$ 175.98
EE Cost % of Pay	7.7%	8.4%	9.1%	9.7%	10.2%	10.6%	10.9%	11.1%	11.2%	11.2%
State Cost % of Pay	12.6%	13.8%	14.9%	15.9%	16.7%	17.3%	17.9%	18.2%	18.4%	18.4%
Annual State Cost	$47.6M	$53.5M	$59.6M	$65.9M	$72.2M	$78.4M	$84.3M	$89.9M	$94.8M	$99.0M

$ 4,248 <= average annual ER contribution, Jan-Jun 2003, including life insurance

Dependents w/ Medical Coverage	5,202	5,199	5,194	5,188	5,181	5,174	5,165	5,155	5,144	5,131
Dependent % of members:	*31.0%*	*31.0%*	*31.0%*	*31.0%*	*31.0%*	*31.0%*	*30.9%*	*30.9%*	*30.9%*	*30.8%*
Medical PMPM	(per member per month, members include employees and dependents)									
Total annual cost	$61.2M	$68.5M	$76.1M	$83.8M	$91.5M	$99.0M	$106.1M	$112.6M	$118.2M	$122.9M
PMPM	$ 304.32	$ 340.99	$ 378.93	$ 417.55	$ 456.06	$ 493.72	$ 529.60	$ 562.48	$ 591.31	$ 615.57

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Projection Summary

Active/COBRA Medical & Dental - post-July 2003 Cost Sharing Strategy

Year	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Number										
$350 medical	9,503	9,430	9,357	9,286	9,215	9,144	9,074	9,005	8,937	8,869
$750 medical	1,971	2,024	2,077	2,128	2,178	2,227	2,275	2,322	2,367	2,412
$2500 medical	0	19	38	57	77	96	116	136	157	177
Total medical	11,474	11,473	11,472	11,471	11,469	11,468	11,466	11,463	11,461	11,458
Opt Out	0	1	2	3	5	6	8	11	13	16
Preventive dental	11,474	11,473	11,472	11,471	11,469	11,468	11,466	11,463	11,461	11,458
Optional dental	9,024	9,023	9,023	9,022	9,020	9,019	9,017	9,016	9,014	9,012
Average Pay	$ 32,699	$ 33,542	$ 34,635	$ 36,010	$ 37,581	$ 39,229	$ 40,989	$ 42,858	$ 44,828	$ 46,882
Monthly Costs	(composite rates including employees and dependents; "EE" = Employee, "ER" = Emloyer)									
EE Premium	$ 69.40	$ 76.18	$ 83.01	$ 89.85	$ 96.58	$ 103.10	$ 109.26	$ 114.96	$ 120.06	$ 124.42
EE Out-of-Pocket	$ 88.10	$ 98.21	$ 108.59	$ 119.19	$ 129.83	$ 140.35	$ 150.52	$ 160.17	$ 169.09	$ 177.03
EE Cost % of Pay	5.8%	6.2%	6.6%	7.0%	7.2%	7.4%	7.6%	7.7%	7.7%	7.7%
State Cost % of Pay	16.7%	18.1%	19.2%	20.1%	20.9%	21.5%	22.0%	22.3%	22.4%	22.3%
Annual State Cost	$62.8M	$69.5M	$76.3M	$83.2M	$90.1M	$96.8M	$103.3M	$109.4M	$114.9M	$119.8M
	$ 5,403 <= average annual ER contribution, July 2003, including life insurance									
Dependents w/ Medical Coverage	7,852	7,851	7,849	7,847	7,844	7,841	7,838	7,834	7,830	7,825
Dependent % of members:	*40.6%*	*40.6%*	*40.6%*	*40.6%*	*40.6%*	*40.6%*	*40.6%*	*40.6%*	*40.6%*	*40.6%*
Medical PMPM	(per member per month, members include employees and dependents)									
Total annual cost	$66.2M	$73.1M	$80.2M	$87.2M	$94.2M	$101.1M	$107.6M	$113.6M	$119.1M	$123.9M
PMPM	$ 285.53	$ 315.39	$ 345.69	$ 376.25	$ 406.59	$ 436.16	$ 464.34	$ 490.63	$ 514.46	$ 535.28

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Projection Summary

Active/COBRA Medical & Dental - post-July 2003 Cost Sharing Strategy; Additional Health Promotion & Management

Year	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Number										
$350 medical	9,503	9,430	9,357	9,286	9,215	9,144	9,074	9,005	8,937	8,869
$750 medical	1,971	2,024	2,077	2,128	2,178	2,227	2,275	2,322	2,367	2,412
$2500 medical	0	19	38	57	77	96	116	136	157	177
Total medical	11,474	11,473	11,472	11,471	11,469	11,468	11,466	11,463	11,461	11,458
Opt Out	0	1	2	3	5	6	8	11	13	16
Preventive dental	11,474	11,473	11,472	11,471	11,469	11,468	11,466	11,463	11,461	11,458
Optional dental	9,024	9,023	9,023	9,022	9,020	9,019	9,017	9,016	9,014	9,012
Average Pay	$ 32,699	$ 33,542	$ 34,635	$ 36,010	$ 37,581	$ 39,229	$ 40,989	$ 42,858	$ 44,828	$ 46,882
Monthly Costs	(composite rates including employees and dependents; "EE" = Employee, "ER" = Emloyer)									
EE Premium	$ 69.40	$ 76.18	$ 83.47	$ 89.48	$ 94.73	$ 99.63	$ 105.50	$ 110.94	$ 115.81	$ 119.98
EE Out-of-Pocket	$ 88.10	$ 98.21	$ 108.59	$ 117.10	$ 125.36	$ 133.24	$ 142.84	$ 151.96	$ 160.38	$ 167.86
EE Cost % of Pay	5.8%	6.2%	6.7%	6.9%	7.0%	7.1%	7.3%	7.4%	7.4%	7.4%
State Cost % of Pay	16.7%	18.1%	19.3%	20.0%	20.4%	20.7%	21.1%	21.4%	21.4%	21.4%
Annual State Cost	$62.8M	$69.5M	$76.8M	$82.8M	$88.1M	$93.0M	$99.2M	$104.9M	$110.2M	$114.8M

Additional investment in health promotion & management, 2005-2012=> $8.8M

Claims savings attributable to additional investment in health promotion & management, 2005-2012=> $23.4M

Dependents w/ Medical Coverage	7,852	7,851	7,849	7,847	7,844	7,841	7,838	7,834	7,830	7,825
Dependent % of members:	*40.6%*	*40.6%*	*40.6%*	*40.6%*	*40.6%*	*40.6%*	*40.6%*	*40.6%*	*40.6%*	*40.6%*
Medical PMPM	(per member per month, members include employees and dependents)									
Total annual cost	$66.2M	$73.1M	$80.7M	$86.8M	$92.1M	$97.0M	$103.2M	$108.9M	$114.1M	$118.6M
PMPM	$ 285.53	$ 315.39	$ 347.99	$ 374.39	$ 397.29	$ 418.65	$ 445.33	$ 470.22	$ 492.79	$ 512.53

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Projection Summary

Active/COBRA Medical & Dental - post-July 2003 Cost Sharing Strategy; Additional Health Promotion & Management, CDHC

Year	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Number										
$350 medical	9,503	9,430	9,357	9,286	9,215	9,144	9,074	9,005	8,937	8,869
$750 medical	1,971	2,024	2,077	2,128	2,178	2,227	2,275	2,322	2,367	2,412
$2500 medical	0	19	38	57	77	96	116	136	157	177
Total medical	11,474	11,473	11,472	11,471	11,469	11,468	11,466	11,463	11,461	11,458
Opt Out	0	1	2	3	5	6	8	11	13	16
Preventive dental	11,474	11,473	11,472	11,471	11,469	11,468	11,466	11,463	11,461	11,458
Optional dental	9,024	9,023	9,023	9,022	9,020	9,019	9,017	9,016	9,014	9,012
Average Pay	$ 32,699	$ 33,542	$ 34,635	$ 36,010	$ 37,581	$ 39,229	$ 40,989	$ 42,858	$ 44,828	$ 46,882
Monthly Costs	(composite rates including employees and dependents; "EE" = Employee, "ER" = Emloyer)									
EE Premium	$ 69.40	$ 76.18	$ 83.43	$ 89.37	$ 94.52	$ 99.37	$ 105.18	$ 110.55	$ 115.35	$ 119.44
EE Out-of-Pocket	$ 88.10	$ 98.21	$ 108.47	$ 116.86	$ 124.94	$ 132.71	$ 142.19	$ 151.17	$ 159.45	$ 166.77
EE Cost % of Pay	5.8%	6.2%	6.6%	6.9%	7.0%	7.1%	7.2%	7.3%	7.4%	7.3%
State Cost % of Pay	16.7%	18.1%	19.3%	20.0%	20.4%	20.6%	21.0%	21.3%	21.3%	21.3%
Annual State Cost	$62.8M	$69.5M	$76.8M	$82.7M	$87.9M	$92.8M	$98.8M	$104.5M	$109.7M	$114.2M
CDHC enrollment (# of employes)=>			574	734	895	1,055	1,215	1,376	1,536	1,719
Additional investment in CDHC admin, 2005-2012=>								$1.0M		
Claims savings attributable to CDHC plans, 2005-2012=>								$3.7M		
Dependents w/ Medical Coverage	7,852	7,851	7,849	7,847	7,844	7,841	7,838	7,834	7,830	7,825
Dependent % of members:	*40.6%*	*40.6%*	*40.6%*	*40.6%*	*40.6%*	*40.6%*	*40.6%*	*40.6%*	*40.6%*	*40.6%*
Medical PMPM	(per member per month, members include employees and dependents)									
Total annual cost	$66.2M	$73.1M	$80.6M	$86.7M	$91.8M	$96.7M	$102.8M	$108.4M	$113.5M	$118.0M
PMPM	$ 285.53	$ 315.39	$ 347.83	$ 373.88	$ 396.24	$ 417.34	$ 443.70	$ 468.26	$ 490.48	$ 509.82

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Projection Summary

Active/COBRA Medical & Dental - post-July 2003 Cost Sharing; Addl. Health Promotion & Management, Mandatory CDHC

Year	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Number										
$350 medical	9,503	9,430	9,357	9,286	9,215	9,144	9,074	9,005	8,937	8,869
$750 medical	1,971	2,024	2,077	2,128	2,178	2,227	2,275	2,322	2,367	2,412
$2500 medical	0	19	38	57	77	96	116	136	157	177
Total medical	11,474	11,473	11,472	11,471	11,469	11,468	11,466	11,463	11,461	11,458
Opt Out	0	1	2	3	5	6	8	11	13	16
Preventive dental	11,474	11,473	11,472	11,471	11,469	11,468	11,466	11,463	11,461	11,458
Optional dental	9,024	9,023	9,023	9,022	9,020	9,019	9,017	9,016	9,014	9,012
Average Pay	$ 32,699	$ 33,542	$ 34,635	$ 36,010	$ 37,581	$ 39,229	$ 40,989	$ 42,858	$ 44,828	$ 46,882
Monthly Costs	(composite rates including employees and dependents; "EE" = Employee, "ER" = Emloyer)									
EE Premium	$ 69.40	$ 76.18	$ 82.78	$ 87.87	$ 92.07	$ 96.13	$ 101.05	$ 105.48	$ 109.32	$ 112.45
EE Out-of-Pocket	$ 88.10	$ 98.21	$ 106.25	$ 113.40	$ 120.05	$ 126.61	$ 134.67	$ 142.14	$ 148.84	$ 154.57
EE Cost % of Pay	5.8%	6.2%	6.5%	6.7%	6.8%	6.8%	6.9%	6.9%	6.9%	6.8%
State Cost % of Pay	16.7%	18.1%	19.2%	19.6%	19.8%	19.8%	20.1%	20.1%	20.1%	19.8%
Annual State Cost	$62.8M	$69.5M	$76.1M	$81.1M	$85.2M	$89.3M	$94.3M	$98.9M	$103.0M	$106.5M
CDHC enrollment (# of employes)=>			11,472	11,471	11,469	11,468	11,466	11,463	11,461	11,458
Additional investment in CDHC admin, 2005-2012=>								$9.8M		
Claims savings attributable to CDHC plans, 2005-2012=>								$47.8M		
Dependents w/ Medical Coverage	7,852	7,851	7,849	7,847	7,844	7,841	7,838	7,834	7,830	7,825
Dependent % of members:	*40.6%*	*40.6%*	*40.6%*	*40.6%*	*40.6%*	*40.6%*	*40.6%*	*40.6%*	*40.6%*	*40.6%*
Medical PMPM	(per member per month, members include employees and dependents)									
Total annual cost	$66.2M	$73.1M	$79.9M	$85.0M	$89.0M	$93.0M	$98.0M	$102.5M	$106.5M	$109.8M
PMPM	$ 285.53	$ 315.39	$ 344.77	$ 366.54	$ 384.10	$ 401.24	$ 423.01	$ 442.73	$ 459.95	$ 474.28

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Wyoming Annual Leave Statistics
12 months ending 8/31/2003
Status as of 9/1/2003

Status	Count	Avg. Accrual (Days)	Avg. Useage (Days)	Avg. Pay
Active	7,878	10.91	7.25	$35,450
Deceased	9	7.73	26.96	$38,827
Termination	746	4.77	14.59	$27,213
Other	14	5.82	5.16	$24,152
Total	8,647	10.37	7.90	$34,724
Turnover:	8.6%	<= # of Annual Leave termination status records prior 12 months divided by total		
Turnover:	15.5%	<= # of Avg Hourly Rate termination status records prior 12 months divided by total		

Wyoming Sick Leave Statistics
12 months ending 8/31/2003
Status as of 9/1/2003

Status	Count	Avg. Accrual (Days)	Avg. Useage (Days)	Avg. Pay
Active	7,873	7.58	4.95	$35,445
Deceased	9	-4.44	47.06	$38,827
Termination	741	2.98	21.88	$27,151
Other	14	4.93	4.80	$24,152
Total	8,637	7.17	6.45	$34,718

Wyoming Donated Sick Leave Statistics
12 months ending 8/31/2003
Status as of 9/1/2003

Status	Count	Avg. Accrual (Days)	Avg. Useage (Days)	Avg. Pay
Active	112	11.89	12.69	$34,833
Deceased	3	8.72	19.96	$42,310
Termination	25	18.77	19.16	$26,626
Other	2	27.29	27.95	$23,729
Total	142	13.25	14.20	$33,389

Wyoming Annual Leave Statistics
12 months ending 8/31/2002
Status as of 9/1/2002

Status	Count	Avg. Accrual (Days)	Avg. Useage (Days)	Avg. Pay
Active	7,297	16.04	14.53	$34,925
Deceased	26	8.30	16.11	$25,277
Termination	1,759	7.49	11.52	$25,501
Other	18	11.69	10.43	$24,059
Total	9,100	14.36	13.95	$33,054
Turnover:	19.3%	<= # of Annual Leave termination status records prior 12 months divided by total		
Turnover:	15.3%	<= # of Avg Hourly Rate termination status records prior 12 months divided by total		

Wyoming Sick Leave Statistics
12 months ending 8/31/2002
Status as of 9/1/2002

Status	Count	Avg. Accrual (Days)	Avg. Useage (Days)	Avg. Pay
Active	7,306	11.25	8.22	$34,931
Deceased	26	5.60	19.71	$25,277
Termination	1,755	5.84	14.24	$25,506
Other	18	10.18	9.06	$24,059
Total	9,105	10.19	9.41	$33,065

Wyoming Donated Sick Leave Statistics
12 months ending 8/31/2002
Status as of 9/1/2002

Status	Count	Avg. Accrual (Days)	Avg. Useage (Days)	Avg. Pay
Active	163	7.49	8.21	$34,446
Deceased	4	2.00	10.73	$27,881
Termination	68	16.65	18.11	$26,353
Other	2	6.16	5.50	$15,274
Total	237	10.02	11.07	$31,851

State of Wyoming
Annual and Sick Leave Balances as of September 1, 2003

		Accumulated Balances (Days)			Cash-Out Dollars	
Agency	Number Active	Annual Leave	Sick Leave	Average Pay Rate	Annual Leave	Sick Leave
001	20	7.43	10.58	$ 51,739	$ 29,562	$ 21,059
002	25	29.86	57.79	$ 38,818	$ 111,434	$ 96,382
003	23	28.44	49.76	$ 48,169	$ 121,172	$ 77,315
004	18	31.51	47.98	$ 47,239	$ 103,045	$ 69,547
005	93	19.75	33.32	$ 46,789	$ 330,516	$ 251,491
006	331	24.18	51.04	$ 36,826	$ 1,133,546	$ 1,024,604
007	151	22.33	39.50	$ 30,476	$ 395,282	$ 325,053
008	63	17.63	32.45	$ 49,468	$ 211,296	$ 188,531
010	76	27.35	67.34	$ 38,249	$ 305,845	$ 299,808
011	123	22.47	44.88	$ 34,116	$ 362,692	$ 319,422
015	175	22.41	50.10	$ 42,794	$ 645,394	$ 637,215
018	3	30.99	88.73	$ 46,207	$ 16,523	$ 21,180
019	6	35.31	46.27	$ 33,133	$ 26,996	$ 17,690
020	212	24.29	42.78	$ 49,678	$ 984,101	$ 784,821
021	98	15.61	33.71	$ 43,232	$ 254,442	$ 247,089
023	32	20.14	44.08	$ 49,665	$ 123,106	$ 114,380
024	189	25.88	47.92	$ 26,923	$ 506,512	$ 420,547
025	267	22.88	34.68	$ 39,233	$ 921,680	$ 654,756
026	252	22.22	41.84	$ 32,886	$ 708,260	$ 586,498
027	7	18.31	33.42	$ 56,429	$ 27,824	$ 25,388
029	22	31.66	65.33	$ 54,557	$ 146,162	$ 135,850
033	2	23.06	43.53	$ 43,246	$ 7,671	$ 7,239
037	126	20.76	46.47	$ 36,228	$ 364,396	$ 366,337
038	3	34.60	86.04	$ 43,022	$ 17,178	$ 21,056
040	341	35.77	124.61	$ 35,242	$ 1,653,203	$ 1,840,039
041	27	23.37	32.48	$ 36,357	$ 88,237	$ 53,263
042	20	24.48	61.09	$ 33,754	$ 63,551	$ 61,825
044	25	23.80	55.39	$ 40,427	$ 92,534	$ 101,053
045	1,968	23.48	52.19	$ 35,003	$ 6,219,768	$ 5,881,215
048	1,368	16.45	27.10	$ 31,182	$ 2,699,566	$ 2,074,836
049	686	18.27	30.28	$ 32,656	$ 1,574,362	$ 1,218,451
051	16	23.89	27.58	$ 25,589	$ 37,619	$ 21,713
052	3	38.76	47.35	$ 64,420	$ 28,808	$ 17,597
054	7	16.96	19.14	$ 35,911	$ 16,393	$ 9,254
055	33	24.82	55.96	$ 39,357	$ 123,984	$ 111,097
057	11	14.91	25.96	$ 52,952	$ 33,398	$ 29,078
059	4	7.23	48.59	$ 47,310	$ 5,262	$ 13,768
060	90	27.23	51.47	$ 38,632	$ 364,073	$ 276,593
061	2	37.79	94.17	$ 45,039	$ 13,091	$ 15,074
063	3	9.22	10.55	$ 27,042	$ 2,876	$ 1,646
072	17	30.29	47.19	$ 36,279	$ 71,846	$ 54,541
075	4	38.36	54.50	$ 38,321	$ 22,615	$ 16,065
080	744	16.88	28.33	$ 32,765	$ 1,583,051	$ 1,249,240

State of Wyoming
Annual and Sick Leave Balances as of September 1, 2003

		Accumulated Balances (Days)			Cash-Out Dollars	
Agency	Number Active	Annual Leave	Sick Leave	Average Pay Rate	Annual Leave	Sick Leave
081	4	11.70	12.71	$ 36,001	$ 6,480	$ 3,521
083	1	51.01	29.86	$ 25,106	$ 4,925	$ 1,442
084	2	17.44	26.45	$ 25,281	$ 3,391	$ 2,572
085	32	11.75	9.91	$ 40,763	$ 58,930	$ 24,870
101	151	18.18	30.35	$ 41,431	$ 437,504	$ 345,518
103	1	58.97	49.13	$ 49,573	$ 11,243	$ 4,683
120	1	60.44	85.13	$ 55,817	$ 12,975	$ 9,137
121	2	30.00	26.06	$ 59,441	$ 13,717	$ 5,958
122	1	41.88	116.13	$ 60,780	$ 9,789	$ 13,573
123	3	15.83	33.94	$ 55,817	$ 10,194	$ 10,931
124	3	9.19	49.43	$ 55,329	$ 5,868	$ 15,778
125	2	27.75	96.38	$ 54,196	$ 11,569	$ 14,122
126	3	14.25	55.10	$ 53,752	$ 8,838	$ 17,087
127	3	23.38	56.22	$ 51,891	$ 13,998	$ 16,830
128	2	6.00	3.31	$ 54,335	$ 2,508	$ 692
129	2	19.81	44.94	$ 60,780	$ 9,263	$ 10,505
130	2	1.30	1.01	$ 55,125	$ 549	$ 214
131	2	10.16	47.76	$ 57,128	$ 4,466	$ 10,495
132	3	2.71	3.50	$ 52,273	$ 1,632	$ 1,055
133	3	13.15	112.56	$ 55,817	$ 8,466	$ 20,200
134	2	54.13	127.75	$ 60,780	$ 25,305	$ 16,685
135	3	20.95	48.42	$ 55,817	$ 13,491	$ 15,591
136	2	62.50	51.00	$ 60,780	$ 29,221	$ 11,922
137	2	14.81	25.92	$ 50,053	$ 5,701	$ 4,990
138	1	29.75	33.25	$ 60,780	$ 6,955	$ 3,886
139	1	1.25	1.00	$ 67,000	$ 322	$ 129
151	17	15.58	25.68	$ 43,998	$ 44,833	$ 35,971
157	20	15.85	46.81	$ 40,800	$ 49,745	$ 65,519
201	35	19.56	51.79	$ 34,916	$ 91,946	$ 103,156
211	6	13.45	23.89	$ 60,189	$ 18,689	$ 16,588
220	3	39.08	77.49	$ 42,219	$ 19,039	$ 18,874
270	7	29.47	30.68	$ 46,370	$ 36,795	$ 19,150
	8,008	21.41	43.67	$ 35,452	$ 23,527,222	$ 20,601,250

P:\HealthWelfare\Wyoming\2003 Feasibility Study\SickLeave\[LeaveBal.XLS]Summary

Health Insurance

Note - data below from the "2003 State Employee Benefits Survey" copyright © 2003 Workplace Economics, Inc.

Wyoming

Health Insurance (monthly costs)			
*State Cost**	Employee Only	$	316.48
	Family	$	716.71
*Employee Cost**	Employee Only	$	41.60
	Family	$	112.23
*Retirees Under 65***	State Cost	$	-
	Retiree Cost	$	406.60
*Retirees Over 65***	State Cost	$	-
	Retiree Cost	$	255.72

* Amounts shown for $350 Plan, see Appendix__ for allocation of State Cost

** Retirees may only elect $750 Plan shown

Nebraska

Health Insurance (monthly costs)			
State Cost	Employee Only	$	223.03
	Family	$	827.27
Employee Cost	Employee Only	$	61.95
	Family	$	219.91
Retirees Under 65	State Cost	$	-
	Retiree Cost	$	294.98
Retirees Over 65	State Cost		*
	Retiree Cost		*

* No coverage under state plan for those over 65

Colorado

Health Insurance (monthly costs)			
State Cost	Employee Only	$	147.86
	Family	$	310.62
Employee Cost	Employee Only		varies*
	Family		varies*
Retirees Under 65	State Cost	$	-
	Retiree Cost		varies**
Retirees Over 65	State Cost	$	-
	Retiree Cost		varies**

* Cost varies by plan selected: from $76.04 to $197.02 for individual and from $272.34 to $598.52 for family coverage

** Cost varies by region and plan selected: from $143 to $469 for pre-Medicare and from $12 to $112 for Medicare eligible retirees

North Dakota

Health Insurance (monthly costs)			
State Cost	Employee Only*	$	409.09
	Family*	$	409.09
Employee Cost	Employee Only	$	-
	Family	$	-
Retirees Under 65	State Cost	$	-
	Retiree Cost**	$	285.25
Retirees Over 65	State Cost	$	-
	Retiree Cost**	$	173.45

* State pays flat rate of $409.09 per contract ($190.33 single and $469.78 family)

** $570 for retirees under 65 and $339.30 for retirees 65 and older

Idaho

Health Insurance (monthly costs)			
State Cost	Employee Only	$	389.42
	Family	$	389.42
Employee Cost	Employee Only	$	8.08
	Family	$	56.11
Retirees Under 65	State Cost	$	-
	Retiree Cost*	$	333.72
Retirees Over 65	State Cost	$	-
	Retiree Cost*	$	157.90

* Cost is $690.84 for family coverage, $590.73 with one member on Medicare and $403.92 for two Medicare eligible retirees

South Dakota

Health Insurance (monthly costs)			
State Cost	Employee Only	$	336.36
	Family	$	336.36
Employee Cost	Employee Only	$	-
	Family*	$	267.26
Retirees Under 65	State Cost	$	-
	Retiree Cost	$	199.89
Retirees Over 65	State Cost	$	-
	Retiree Cost	$	137.58

* Reported for most popular plan (spouse plus two or more children)

Montana

Health Insurance (monthly costs)			
State Cost	Employee Only*	$	334.60
	Family*	$	334.60
Employee Cost	Employee Only	$	-
	Family		varies**
Retirees Under 65	State Cost	$	-
	Retiree Cost		varies***
Retirees Over 65	State Cost	$	-
	Retiree Cost		varies***

* State contributes $366/month for medical, dental, and core life, of which $334.60 may be applied toward healthcare coverage

** Varies on plan selected, from $172 to $202 for family coverage

*** Retirees are given the same options as active employees, and pay 100% of premium, from $308 to $335 for single coverage; Medicare-eligibles pay from $177 to $209

Utah

Health Insurance (monthly costs)			
State Cost	Employee Only	$	250.60
	Family	$	689.82
Employee Cost	Employee Only	$	18.87
	Family	$	51.91
Retirees Under 65	State Cost*	$	250.60
	Retiree Cost*	$	18.87
Retirees Over 65	State Cost	$	-
	Retiree Cost**	$	93.00

* State pays as if active employee for 5 years or until age 65, whichever occurs first

** Reported for "low" option; $275 for "high" option

Dental and Vision

Note - data below from the "2003 State Employee Benefits Survey" copyright © 2003 Workplace Economics, Inc.

Wyoming

Dental and Vision (monthly costs)			
State Cost	Employee Only	$	8.39
	Family	$	17.54
Employee Cost	Employee Only*	$	1.48
	Family*	$	3.10
Vision Coverage?			No

* Rates are for preventive care AND reflect assumed allocation of employer dollars between medical, dental and life insurance. For comprehensive, $8.58 for single and $20.10 for family.

Nebraska

Dental and Vision (monthly costs)			
State Cost	Employee Only	$	-
	Family	$	-
Employee Cost	Employee Only	$	18.12
	Family	$	56.84
Vision Coverage?			Yes*

* Vision exam covered under the health plan

Colorado

Dental and Vision (monthly costs)			
State Cost	Employee Only	$	16.26
	Family	$	16.26
Employee Cost	Employee Only	$	-
	Family*	$	41.74
Vision Coverage?			Yes**

* Rates are based on Basic plan; $8.08 for single and $84.22 for family for Basic Plus

** Cost to the state included in the health insurance contribution

North Dakota

Dental and Vision (monthly costs)			
State Cost	Employee Only	$	-
	Family	$	-
Employee Cost	Employee Only	$	27.72
	Family*	$	87.84
Vision Coverage?			Yes**

* $53.40 for employee and spouse or $62.16 for employee plus children

** Employee paid option

Idaho

Dental and Vision (monthly costs)			
State Cost	Employee Only	$	13.65
	Family	$	13.65
Employee Cost	Employee Only	$	3.54
	Family	$	41.81
Vision Coverage?			Yes*

* Cost to the state included in the health insurance contribution

South Dakota

Dental and Vision (monthly costs)			
State Cost	Employee Only	$	-
	Family	$	-
Employee Cost	Employee Only	$	16.10
	Family	$	45.99
Vision Coverage?			Yes*

* Employee paid option

Montana

Dental and Vision (monthly costs)			
State Cost	Employee Only*	$	28.60
	Family*	$	28.60
Employee Cost	Employee Only	$	-
	Family	$	18.00
Vision Coverage?			Yes**

* Cost to the state included in the health insurance contribution

** Vision exam covered under the health plan

Utah

Dental and Vision (monthly costs)			
State Cost	Employee Only	$	38.44
	Family	$	71.11
Employee Cost	Employee Only	$	-
	Family	$	-
Vision Coverage?			Yes

Sick Leave

Note - data below from the "2003 State Employee Benefits Survey" copyright © 2003 Workplace Economics, Inc.

Wyoming

Sick Leave		
Accrual	Rate Per Year	12 days
	Maximum # Days	none
Eligibility	To Use	immed
	To Accrue	immed
Other Uses	Family Death	yes
	Family Illness	yes
Payment for Unused Sick Leave	Termination	50%*
	Retirement	50%*
	Beneficiary at Death	50%*
	Permanent Disability	yes*
Sick Leave Pool		no**

* Maximum of 480 hours

** Time may be donated by other employees

Nebraska

Sick Leave		
Accrual	Rate Per Year	12 days*
	Maximum # Days	none
Eligibility	To Use	immed
	To Accrue	immed
Other Uses	Family Death	no**
	Family Illness	yes
Payment for Unused Sick Leave	Termination	25%
	Retirement	25%
	Beneficiary at Death	25%
	Permanent Disability	no
Sick Leave Pool		no***

* Rates apply to first five years; 14 days/year for years 6-15 and 18 days/year thereafter

** Funeral leave provided separately from sick leave

*** Time may be donated by other employees

Colorado

Sick Leave		
Accrual	Rate Per Year	80 hrs.
	Maximum # Days	45 days*
Eligibility	To Use	immed
	To Accrue	immed
Other Uses	Family Death	no**
	Family Illness	yes
Payment for Unused Sick Leave	Termination	no
	Retirement	25%
	Beneficiary at Death	25%
	Permanent Disability	25%
Sick Leave Pool		no***

* If hired prior to 7/1/88, limited to accrual as of 7/1/88 plus 45 hours

** Funeral leave provided separately from sick leave

*** Time may be donated by other employees

North Dakota

Sick Leave		
Accrual	Rate Per Year	12 days
	Maximum # Days	none
Eligibility	To Use	immed
	To Accrue	immed
Other Uses	Family Death	no*
	Family Illness	yes**
Payment for Unused Sick Leave	Termination	10%***
	Retirement	10%
	Beneficiary at Death	10%
	Permanent Disability	no
Sick Leave Pool		no****

* Funeral leave provided separately from sick leave

** May not exceed 40 hours per year

*** After ten years of continuous service

**** Time may be donated by other employees

Idaho

Sick Leave		
Accrual	Rate Per Year	12 days
	Maximum # Days	none
Eligibility	To Use	immed
	To Accrue	immed
Other Uses	Family Death	yes
	Family Illness	yes
Payment for Unused Sick Leave	Termination	no
	Retirement	yes*
	Beneficiary at Death	no
	Permanent Disability	yes
Sick Leave Pool		no

* The smaller of half of the monetary value earned since 7/1/76 or 600 hours

South Dakota

Sick Leave		
Accrual	Rate Per Year	14 days
	Maximum # Days	none
Eligibility	To Use	immed
	To Accrue	immed
Other Uses	Family Death	yes
	Family Illness	yes
Payment for Unused Sick Leave	Termination	25%*
	Retirement	25%*
	Beneficiary at Death	yes
	Permanent Disability	yes
Sick Leave Pool		no

* 7 years service required; maximum of 480 hours

Montana

Sick Leave		
Accrual	Rate Per Year	12 days
	Maximum # Days	none
Eligibility	To Use	3 mos
	To Accrue	immed
Other Uses	Family Death	yes
	Family Illness	yes
Payment for Unused Sick Leave	Termination	25%
	Retirement	25%
	Beneficiary at Death	25%
	Permanent Disability	no
Sick Leave Pool		yes*

* 8 hours must be donated to join the sick leave pool; employees may donate without joining

Utah

Sick Leave		
Accrual	Rate Per Year	13 days
	Maximum # Days	none
Eligibility	To Use	immed
	To Accrue	immed
Other Uses	Family Death	no*
	Family Illness	yes
Payment for Unused Sick Leave	Termination	no
	Retirement	25%**
	Beneficiary at Death	25%**
	Permanent Disability	no
Sick Leave Pool		yes***

* Funeral leave provided separately from sick leave

** May use to purchase health insurance (8 hours = 1 month)

*** donations available in addition to 25% payout if death is in line of duty

Annual Leave (Vacation)

Note - data below from the "2003 State Employee Benefits Survey" copyright © 2003 Workplace Economics, Inc.

Wyoming

Annual Leave		
Days Per Year Accrual Rate (A/R)	1 Year	12
	5 Years	15
	10 Years	18
	15 Years	21
	20 Years	24
Maximum # of Days Accumulated		30-48*
Eligibility	To Use	immed
	Accrue	immed
Payment for Unused Leave	Retirement	yes
	Termination	yes

* Based on years of service: 0-9 years: 30 days; 9.1-14 years: 36; 14.1-19 years: 42; 19.1 and more: 48 days

Nebraska

Annual Leave		
Days Per Year Accrual Rate (A/R)	1 Year	12
	5 Years	15
	10 Years	20
	15 Years	25
	20 Years	25
Maximum # of Days Accumulated		35
Eligibility	To Use	immed
	Accrue	immed
Payment for Unused Leave	Retirement	yes
	Termination	yes

Colorado

Annual Leave		
Days Per Year Accrual Rate (A/R)	1 Year	12
	5 Years	12
	10 Years	15
	15 Years	18
	20 Years	21
Maximum # of Days Accumulated		2xA/R
Eligibility	To Use	immed
	Accrue	immed
Payment for Unused Leave	Retirement	yes
	Termination	yes

North Dakota

Annual Leave		
Days Per Year Accrual Rate (A/R)	1 Year	12
	5 Years	15
	10 Years	18
	15 Years	21
	20 Years	24
Maximum # of Days Accumulated		30
Eligibility	To Use	immed
	Accrue	immed
Payment for Unused Leave	Retirement	yes
	Termination	yes

Idaho

Annual Leave		
Days Per Year Accrual Rate (A/R)	1 Year	12
	5 Years	15
	10 Years	18
	15 Years	21
	20 Years	21
Maximum # of Days Accumulated		2xA/R
Eligibility	To Use	immed
	Accrue	immed
Payment for Unused Leave	Retirement	yes
	Termination	yes

South Dakota

Annual Leave		
Days Per Year Accrual Rate (A/R)	1 Year	15
	5 Years	15
	10 Years	15
	15 Years	20
	20 Years	20
Maximum # of Days Accumulated		30-40*
Eligibility	To Use	6 mos
	Accrue	immed
Payment for Unused Leave	Retirement	yes
	Termination	yes

*Maximum for lest than 15 years services is 30 days

Montana

Annual Leave		
Days Per Year Accrual Rate (A/R)	1 Year	15
	5 Years	15
	10 Years	18
	15 Years	21
	20 Years	24
Maximum # of Days Accumulated		2xA/R
Eligibility	To Use	6 mos
	Accrue	immed
Payment for Unused Leave	Retirement	yes
	Termination	yes

Utah

Annual Leave		
Days Per Year Accrual Rate (A/R)	1 Year	13
	5 Years	16.25
	10 Years	19.5
	15 Years	19.5
	20 Years	22.75
Maximum # of Days Accumulated		40
Eligibility	To Use	immed
	Accrue	immed
Payment for Unused Leave	Retirement	yes
	Termination	yes

Holidays

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Wyoming

Holidays [1]		
Legal Holidays	King's Birthday	yes
	Presidents' Day	yes
	Memorial Day	yes
	Columbus Day	no
	Veterans Day	yes
	General Election	no
Other Holidays		none
Total Days		9

[1] Legal holidays in addition to New Year's Day, Independence Day, Labor Day, Thanksgiving Day and Christmas

Nebraska

Holidays		
Legal Holidays	King's Birthday	yes
	Presidents' Day	yes
	Memorial Day	yes
	Columbus Day	yes
	Veterans Day	yes
	General Election	none
Other Holidays		Arbor Day
		Day After Thanksgiving
Total Days		12

Colorado

Holidays		
Legal Holidays	King's Birthday	yes
	Presidents' Day	yes
	Memorial Day	yes
	Columbus Day	yes
	Veterans Day	yes
	General Election	no
Other Holidays		none*
Total Days		10

* May substitute Cesar Chavez Day for another holiday

North Dakota

Holidays		
Legal Holidays	King's Birthday	yes
	Presidents' Day	yes
	Memorial Day	yes
	Columbus Day	no
	Veterans Day	yes
	General Election	no
Other Holidays		Good Friday
		1/2 day Christmas Eve
Total Days		10

Idaho

Holidays		
Legal Holidays	King's Birthday	yes
	Presidents' Day	yes
	Memorial Day	yes
	Columbus Day	yes
	Veterans Day	yes
	General Election	no
Other Holidays		none
Total Days		10

South Dakota

Holidays		
Legal Holidays	King's Birthday	yes
	Presidents' Day	yes
	Memorial Day	yes
	Columbus Day	no
	Veterans Day	yes
	General Election	no
Other Holidays		Day After Thanksgiving
		Native Americans Day
Total Days		10

Montana

Holidays		
Legal Holidays	King's Birthday	yes
	Presidents' Day	yes
	Memorial Day	yes
	Columbus Day	yes
	Veterans Day	yes
	General Election	yes
Other Holidays		none
Total Days		10

Utah

Holidays		
Legal Holidays	King's Birthday	yes
	Presidents' Day	yes
	Memorial Day	yes
	Columbus Day	yes
	Veterans Day	yes
	General Election	no
Other Holidays		Pioneers Day
Total Days		11

Parental Leave

Note - data below from the "2003 State Employee Benefits Survey" copyright © 2003 Workplace Economics, Inc.

Wyoming

Parental Leave		
Unpaid	Mother	yes
	Father	yes
Circumstances for Paid Leave	Both may use sick leave before unpaid leave	
Adoption Leave		yes*

* May use sick leave and unpaid leave

Nebraska

Parental Leave		
Unpaid	Mother	12 weeks
	Father	12 weeks
Circumstances for Paid Leave	Both may use sick leave	
Adoption Leave		12 weeks*

* 12 weeks unpaid; mother may use 6 weeks accrued paid leave

Colorado

Parental Leave		
Unpaid	Mother	yes
	Father	yes
Circumstances for Paid Leave	After one year, may use up to 520 hours of annual, sick, and unpaid family leave for birth, adoption, or care of family member	
Adoption Leave		yes

North Dakota

Parental Leave		
Unpaid	Mother	4 months
	Father	4 months
Circumstances for Paid Leave	Mother paid subject to disability plan	
Adoption Leave		4 months*

* Leave without pay

Idaho

Parental Leave		
Unpaid	Mother	yes
	Father	yes
Circumstances for Paid Leave	May use annual or sick leave	
Adoption Leave		yes

South Dakota

Parental Leave		
Unpaid	Mother	varies
	Father	varies
Circumstances for Paid Leave	Mother may use 4-6 weeks sick leave. Father may use 5 days personal leave. Both may use annual leave.	
Adoption Leave		yes

Montana

Parental Leave		
Unpaid	Mother	12 weeks
	Father	12 weeks
Circumstances for Paid Leave	Mother may use up to 6 weeks disability or accrued paid leave; father may use 15 days	
Adoption Leave		yes*

* Both mother and father may use 15 days accrued paid leave

Utah

Parental Leave		
Unpaid	Mother	yes
	Father	yes
Circumstances for Paid Leave	Both may use any accumulated leave	
Adoption Leave		yes

Other Leave

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Wyoming

Other Leave		
Personal	Days Per Year	0
Educational	Available	yes
	With Pay	yes
	Maximum Length	24 months
	Tuition Paid	yes
Military	Days Per Year	15
Civic(1)	Salary + Jury Pay	yes
Funeral	Separate from Sick Leave	3 days

* At agency discretion; tuition assistance up to $5,250 per year may be available

** Annual leave may be used; employee does not receive both salary and jury pay

Nebraska

Other Leave		
Personal	Days Per Year	0
Educational	Available	yes
	With Pay	----
	Maximum Length	----
	Tuition Paid	50-100%
Military	Days Per Year	15
Civic(1)	Salary + Jury Pay	no
Funeral	Separate from Sick Leave	no

Colorado

Other Leave		
Personal	Days Per Year	0
Educational	Available	yes
	With Pay	yes*
	Maximum Length	varies
	Tuition Paid	no
Military	Days Per Year	15**
Civic(1)	Salary + Jury Pay	yes
Funeral	Separate from Sick Leave	1-5 days

* Allowed, but seldom used

** Additional 90 days for active duty; additional 90 days if agency has leave bank

North Dakota

Other Leave		
Personal	Days Per Year	0
Educational	Available	yes
	With Pay	varies
	Maximum Length	varies
	Tuition Paid	varies
Military	Days Per Year	20
Civic(1)	Salary + Jury Pay	no
Funeral	Separate from Sick Leave	3 days

Idaho

Other Leave		
Personal	Days Per Year	0
Educational	Available	no
	With Pay	----
	Maximum Length	----
	Tuition Paid	----
Military	Days Per Year	15
Civic(1)	Salary + Jury Pay	yes
Funeral	Separate from Sick Leave	no

South Dakota

Other Leave		
Personal	Days Per Year	5*
Educational	Available	no
	With Pay	no
	Maximum Length	----
	Tuition Paid	----**
Military	Days Per Year	15
Civic(1)	Salary + Jury Pay	yes
Funeral	Separate from Sick Leave	no

* Deducted from sick leave

** Reduced tuition at state universities

Montana

Other Leave		
Personal	Days Per Year	0
Educational	Available	yes*
	With Pay	varies
	Maximum Length	varies
	Tuition Paid	varies
Military	Days Per Year	15
Civic(1)	Salary + Jury Pay	no
Funeral	Separate from Sick Leave	no

* At agency discretion

Utah

Other Leave		
Personal	Days Per Year	0
Educational	Available	yes*
	With Pay	----
	Maximum Length	----
	Tuition Paid	yes*
Military	Days Per Year	15
Civic(1)	Salary + Jury Pay	no**
Funeral	Separate from Sick Leave	3 days

* At agency discretion; tuition assistance up to $5,250 per year may be available

** Annual leave may be used; employee does not receive both salary and jury pay

Life and Other Insurance

Note - data below from the "2003 State Employee Benefits Survey" copyright © 2003 Workplace Economics, Inc.

Wyoming

Life and Other Insurance		
Substance Abuse Assistance		yes*
Disability Insurance	Short-Term	no
	Long-Term	no
Total Liability		yes
AD&D		yes
Life Insurance	Provided	yes
	Cost to State (Monthly)	varies**
	Age Based	yes
	Salary Based	no
	Fixed Amount	no
	Maximum Coverage	$ 50,000.00

* Provided through Life and Other Insurance

** Varies from $0.07 to $0.42 based on age

Nebraska

Life and Other Insurance		
Substance Abuse Assistance		yes*
Disability Insurance	Short-Term	no**
	Long-Term	no**
Total Liability		no**
AD&D		no**
Life Insurance	Provided	yes
	Cost to State (Monthly)	$ 0.19
	Age Based	no
	Salary Based	no
	Fixed Amount	yes
	Maximum Coverage	$ 20,000.00

* Employee Assistance Plan

** Available at employee's expense

Colorado

Life and Other Insurance		
Substance Abuse Assistance		yes*
Disability Insurance	Short-Term	yes
	Long-Term	no
Total Liability		no
AD&D		yes
Life Insurance	Provided	yes
	Cost to State (Monthly)	$ 0.17
	Age Based	no
	Salary Based	no
	Fixed Amount	yes
	Maximum Coverage	$ 12,000.00

* Provided by Colorado State Employees Assistance Program or through health plan

North Dakota

Life and Other Insurance		
Substance Abuse Assistance		yes
Disability Insurance	Short-Term	no
	Long-Term	yes
Total Liability		yes
AD&D		yes
Life Insurance	Provided	yes
	Cost to State (Monthly)	$ 0.22
	Age Based	yes
	Salary Based	no
	Fixed Amount	yes
	Maximum Coverage	$1,300*

* Additional optional available up to $200,000

Idaho

Life and Other Insurance		
Substance Abuse Assistance		yes
Disability Insurance	Short-Term	yes*
	Long-Term	yes*
Total Liability		yes
AD&D		yes
Life Insurance	Provided	yes
	Cost to State (Monthly)	*
	Age Based	no
	Salary Based	yes
	Fixed Amount	no
	Maximum Coverage	salary

* Life, STD and LTD = 0.081% of payroll

South Dakota

Life and Other Insurance		
Substance Abuse Assistance		yes
Disability Insurance	Short-Term	yes*
	Long-Term	yes
Total Liability		no
AD&D		yes
Life Insurance	Provided	yes
	Cost to State (Monthly)	$0.206**
	Age Based	----
	Salary Based	no
	Fixed Amount	yes
	Maximum Coverage	$25,000***

* If work-related

** Provided through Life and Other Insurance

*** Additional optional available up to $5 X salary

Montana

Life and Other Insurance		
Substance Abuse Assistance		yes
Disability Insurance	Short-Term	no*
	Long-Term	no*
Total Liability		yes
AD&D		**
Life Insurance	Provided	yes
	Cost to State (Monthly)	***
	Age Based	no
	Salary Based	no
	Fixed Amount	yes
	Maximum Coverage	$12,000***

* For University System employees only

** Optional benefit available for employees and dependents

*** Basic available out of State contribution ($2.80/mo.); additional optional available to $200,000 maximum

Utah

Life and Other Insurance		
Substance Abuse Assistance		yes
Disability Insurance	Short-Term	no*
	Long-Term	no*
Total Liability		yes
AD&D		no*
Life Insurance	Provided	yes
	Cost to State (Monthly)	$ 0.08
	Age Based	no**
	Salary Based	no
	Fixed Amount	yes
	Maximum Coverage	$ 25,000.00

* Available at employee's expense

** State plan is not based on age; optional plan is based on age

Retirement

Note - data below from the "2003 State Employee Benefits Survey" copyright © 2003 Workplace Economics, Inc.

Wyoming

Retirement		
Contribution Rate	State	5.68%
(% of salary)	Employee*	5.57%
Full Vesting (years)		4
Normal Full Benefit	Minimum Age	60 and
Requirements	Service Years	4**
Benefit Formula (AFC = Avg. Final Comp.)		***
In Social Security?		yes
Integrated Plan?		no
COLA		3%****

* State pays employee contribution

** Or age and service combination of 85

*** [(2.125 x yrs 1 through 15) + (2.25 x yrs 16 and over)] x AFC(3yrs.)

**** Based on Wyoming cost-of-living index

Nebraska

Retirement**		
Contribution Rate	State	*
(% of salary)	Employee	*
Full Vesting (years)		5
Normal Full Benefit	Minimum Age	65 and
Requirements	Service Years	5
Benefit Formula (AFC = Avg. Final Comp.)		No formula*
In Social Security?		yes
Integrated Plan?		no
COLA		none

* State contributes 6.75% on first $19,954 and 7.5% on amount over; employee contributes 4.33% and 4.8%, respectively

** Most employees in defined contribution plan

Colorado

Retirement		
Contribution Rate	State	10.04%
(% of salary)	Employee	8.00%
Full Vesting (years)		5
Normal Full Benefit	Minimum Age	50
Requirements	Service Years	30*
Benefit Formula (AFC = Avg. Final Comp.)		2.5% x yrs x AFC(3yrs.)
In Social Security?		no
Integrated Plan?		no
COLA		3.50%

* Or Rule of 80 with minimum age of 55

North Dakota

Retirement		
Contribution Rate	State*	4.12%
(% of salary)	Employee *	4.00%
Full Vesting (years)		3
Normal Full Benefit	Minimum Age	Rule of 85
Requirements	Service Years	**
Benefit Formula (AFC = Avg. Final Comp.)		2.0% x yrs x AFC(3yrs)***
In Social Security?		yes
Integrated Plan?		no
COLA		ad hoc

* State pays employee contribution; additional 1% contributed to pre-fund retiree health insurance

** Any combination of age and service 85 or more; retirement at 65 with no years of service

*** Average of highest 36 (non-consecutive) of last 120 months

Idaho

Retirement		
Contribution Rate	State	9.77%
(% of salary)	Employee	5.86%
Full Vesting (years)		5
Normal Full Benefit	Minimum Age	55 and
Requirements	Service Years	5*
Benefit Formula (AFC = Avg. Final Comp.)		2.0% x yrs x AFC(3.5yrs.)
In Social Security?		yes
Integrated Plan?		no
COLA		CPI to 1% minimum mandatory**

* Or, any combination of age and service 90 or greater; 65 with 5 years of service

** Discretionary adjustment of up to 5% if plan is fully funded; adjustment cannot exceed the greater of change in CPI or 6%, whichever is less

South Dakota

Retirement		
Contribution Rate	State	6.00%
(% of salary)	Employee	6.00%
Full Vesting (years)		3
Normal Full Benefit	Minimum Age	55 and
Requirements	Service Years	30*
Benefit Formula (AFC = Avg. Final Comp.)		1.625% x yrs x AFC**
In Social Security?		yes
Integrated Plan?		yes
COLA		3.10%

* Or age 60 and 25 years of service; or age 65 with 3 years of service

** Applies prior to 7/1/2002. AFC = average of 12 highest consecutive quarters of the last 40 quarters

Montana

Retirement		
Contribution Rate	State	6.90%
(% of salary)	Employee	6.90%
Full Vesting (years)		5
Normal Full Benefit	Minimum Age	none
Requirements	Service Years	30
Benefit Formula (AFC = Avg. Final Comp.)		*
In Social Security?		yes
Integrated Plan?		no
COLA		3.00%

* For less than 25 service years: 1.785% x yrs x AFC(3yrs.); for 25 or more years: 2.0% x yrs x AFC

Utah

Retirement		
Contribution Rate	State	10.40%
(% of salary)	Employee*	0.00%
Full Vesting (years)		4
Normal Full Benefit	Minimum Age	none
Requirements	Service Years	30**
Benefit Formula (AFC = Avg. Final Comp.)		***
In Social Security?		yes
Integrated Plan?		no
COLA		CPI to 4%

* Contributory plan available where state and employee pay 6%

** Or age 65 and 4 years of service

*** For contributory plan: 1.1% x yrs service prior to 1967 + 1.25 yrs (1967-1975) + 2% yrs service after 1975 x AFC. AFC = 4 yrs. For non-contributory plan: 2.0% x yrs service x AFC. AFC = 3 yrs.

Deferred Compensation

Note - data below from the "2003 State Employee Benefits Survey" copyright © 2003 Workplace Economics, Inc.

Wyoming

Deferred Compensation	
Available	yes
Maximum Monthly State Match	$20

Nebraska

Deferred Compensation	
Available	yes
Maximum Monthly State Match	no

Colorado

Deferred Compensation	
Available	yes
Maximum Monthly State Match	3.00%

North Dakota

Deferred Compensation	
Available	yes
Maximum Monthly State Match	no

Idaho

Deferred Compensation	
Available	yes
Maximum Monthly State Match	no

South Dakota

Deferred Compensation	
Available	yes
Maximum Monthly State Match	no

Montana

Deferred Compensation	
Available	yes
Maximum Monthly State Match	no

Utah

Deferred Compensation	
Available	yes
Maximum Monthly State Match	1.50%

Percentage of Full-Time Employees Offered Select Benefits in Wyoming by Industry, 2002

	All Respondents	Agriculture	Mining	Construction	Manufacturing	TCPU*	Wholesale	Retail	FIRE**	Servces	Government (local only)
Dental Plan	78.7%		80.9%	69.2%	74.5%	83.1%	71.0%	56.4%	84.3%	83.2%	90.6%
Disability Insurance	39.8		65.5	43.4	61.2	45.4	50.3	14.2	35.2	50.8	27.3
Flex Time	33.0		31.2	51.8	28.7	29.2	23.5	17.7	43.6	18.6	48.9
Health Insurance	91.3		96.2	82.4	94.2	91.2	88.2	76.2	97.2	94.7	97.4
Life Insurance	83.3		93.1	64.0	83.1	83.8	77.2	59.0	93.8	89.4	94.6
Long-Term Disability	49.1		61.8	34.1	55.8	57.0	64.0	25.5	73.0	62.2	41.5
Paid Maternity Leave***	7.7		6.2	9.2	1.8	11.7	7.6	1.3	10.5	13.9	6.0
Paid Holidays	84.2		81.3	63.0	90.5	88.6	87.1	59.2	90.8	89.2	99.8
Paid Personal Leave	49.3		38.6	29.6	19.4	39.7	27.5	27.2	62.8	72.7	62.5
Paid Sick Leave	60.0		42.4	26.4	51.0	62.2	48.5	19.3	53.7	72.7	95.5
Paid Vacation	70.9		82.1	47.6	83.5	72.8	76.4	60.0	65.1	74.8	76.1
Profit Sharing	18.5		35.2	32.9	26.1	17.2	43.9	12.8	49.9	15.2	2.4
Retirement Plan	83.3		89.7	65.9	83.6	78.4	68.6	63.4	88.1	88.7	97.0
Wellness Program	38.8		61.6	11.9	37.0	45.9	31.4	13.2	40.5	37.6	55.5
# sampled	*2,287*		*168*	*287*	*115*	*144*	*117*	*518*	*141*	*683*	*114*
# responded	*1,583*		*104*	*185*	*87*	*107*	*65*	*335*	*107*	*488*	*105*
response rate	*69%*		*62%*	*64%*	*76%*	*74%*	*56%*	*65%*	*76%*	*71%*	*92%*

*TCPU = Transportation, Communications & Public Utilities
**FIRE = Finance, Insurance & Real Estate
***Paid maternity leave in addition to state mandated amount; FMLA does not require paid leave

Percentage of Full-Time Employees Offered Select Benefits in Wyoming by Firm Size, 2002

	All Respondents	1-4 Employees	5-9 Employees	10-19 Employees	20-49 Employees	50-99 Employees	100 or More
Dental Plan	78.7%	39.7%	39.0%	54.4%	67.8%	77.0%	90.0%
Disability Insurance	39.8	28.4	14.3	23.1	35.2	41.6	45.1
Flex Time	33.0	41.9	32.0	26.2	27.3	20.2	38.4
Health Insurance	91.3	54.6	60.7	81.3	83.5	93.5	97.9
Life Insurance	83.3	40.6	41.3	61.2	66.0	85.7	95.4
Long-Term Disability	49.1	31.5	15.0	24.3	37.2	44.6	59.7
Paid Maternity Leave***	7.7	27.9	3.3	5.4	3.9	5.8	9.1
Paid Holidays	84.2	59.6	58.0	72.8	71.6	85.7	91.8
Paid Personal Leave	49.3	47.1	38.4	54.3	35.2	46.9	54.0
Paid Sick Leave	60.0	39.5	26.9	36.5	43.5	52.3	72.7
Paid Vacation	70.9	50.8	45.8	54.0	64.3	37.5	78.6
Profit Sharing	18.5	5.7	11.4	13.6	21.2	20.8	18.9
Retirement Plan	83.3	41.3	43.4	56.5	64.7	82.1	97.0
Wellness Program	38.8	23.6	4.6	9.6	15.9	23.8	55.9
# sampled	*2,287*	*643*	*439*	*418*	*359*	*190*	*238*
# responded	*1,583*	*434*	*325*	*301*	*252*	*121*	*150*
response rate	*69%*	*67%*	*74%*	*72%*	*70%*	*64%*	*63%*

Average Employer Subsidy % and Leave Days for Full-Time Wyoming Employees, 2002

	Mean	Mode
Health Insurance	83.3%	100%
Dental Plan	72.2	100
Paid Holidays	8.6	6
Paid Sick Leave	12.5	12
Paid Vacation (after 1 year)	9.8	10
Paid Vacation (after 5 years)	10.0	10
Paid Vacation (after 10 years)	14.7	10
Paid Personal Leave (after 1 year)	7.9	5
Paid Personal Leave (after 5 years)	11.5	10
Paid Personal Leave (after 10 years)	13.7	2

Wyoming Compensation Costs, 2001

	Precent of Total Comp	Percent of Pay
Wages & Salary	77.9%	100.0%
Retirement	10.0	12.8
Legally Required(1)	5.9	7.6
Other Benefits(2)	6.3	8.1

(1) = Social Security, Unemployment, Worker's Comp
(2) = paid leave, insurances and miscellaneous benefits

Percentage of Full-Time Employees Offered Select Benefits in Wyoming by Industry, 2001

	All Respondents	Agriculture	Mining	Construction	Manufacturing	TCPU*	Wholesale	Retail	FIRE**	Servces	Government (local only)
Dental Plan	83.6%	41.3%	93.5%	71.0%	58.5%	80.1%	88.3%	83.9%	80.5%	89.5%	85.9%
Disability Insurance	60.1	11.0	81.2	31.7	62.0	43.5	65.6	54.8	74.2	64.8	63.1
Flex Time	34.9	33.6	15.7	9.9	17.9	17.6	8.6	43.6	41.9	47.9	41.9
Health Insurance	94.1	82.9	99.0	82.8	90.6	89.6	95.3	92.5	89.1	94.2	99.9
Life Insurance	87.6	51.8	94.8	68.4	84.6	82.9	91.7	83.3	83.2	88.2	97.0
Long-Term Disability	50.9	1.4	34.9	8.1	52.3	68.9	61.7	55.1	47.7	60.6	56.4
Maternity Leave***	21.1	17.0	61.2	0.3	0.4	11.7	3.3	28.9	47.8	6.9	25.4
Paid Holidays	87.1	78.8	86.8	47.5	94.0	86.0	99.0	78.1	95.3	92.0	97.5
Paid Personal Leave	37.1	32.8	63.7	17.7	15.9	1.7	10.7	12.9	69.1	38.8	59.6
Paid Sick Leave	70.2	71.4	77.1	20.5	46.6	68.2	86.6	59.2	50.1	68.9	98.4
Paid Vacation	91.0	87.1	98.3	83.7	96.6	90.2	98.7	90.4	52.6	87.7	97.5
Profit Sharing	26.7	26.7	26.1	23.0	24.7	52.7	63.0	56.5	20.7	24.1	1.0
Retirement Plan	84.3	34.4	92.8	66.4	84.3	83.4	86.9	86.8	85.5	91.3	81.1
Wellness Program	42.9	11.2	76.3	33.9	34.4	23.8	48.2	7.4	59.5	43.0	58.0
# sampled	*2,000*	*74*	*139*	*229*	*126*	*142*	*132*	*310*	*154*	*461*	*233*
# responded	*1,166*	*48*	*80*	*135*	*76*	*72*	*61*	*154*	*92*	*280*	*168*
response rate	*58%*	*65%*	*58%*	*59%*	*60%*	*51%*	*46%*	*50%*	*60%*	*61%*	*72%*

*TCPU = Transportation, Communications & Public Utilities
**FIRE = Finance, Insurance & Real Estate
***Maternity leave in addition to state mandated amount

Percentage of Full-Time Employees Offered Select Benefits in Wyoming by Firm Size, 2001

	All Respondents	1-4 Employees	5-9 Employees	10-19 Employees	20-49 Employees	50-99 Employees	100 or More
Dental Plan	83.6%	25.3%	46.3%	58.3%	65.6%	85.2%	91.4%
Disability Insurance	60.1	13.6	20.0	27.6	31.8	64.5	69.0
Flex Time	34.9	26.0	24.8	21.2	21.5	31.6	38.8
Health Insurance	94.1	47.1	70.4	77.8	85.4	91.0	99.7
Life Insurance	87.6	26.2	54.6	62.6	62.0	85.9	96.8
Long-Term Disability	50.9	10.4	15.8	18.0	24.4	30.9	63.3
Maternity Leave***	21.1	2.9	12.6	5.2	6.9	41.1	21.3
Paid Holidays	87.1	51.6	75.1	71.9	80.7	82.8	91.6
Paid Personal Leave	37.1	10.8	20.7	22.9	18.8	47.1	40.3
Paid Sick Leave	70.2	33.5	45.1	52.5	46.1	71.0	76.9
Paid Vacation	91.0	64.1	80.2	87.7	89.7	92.8	92.5
Profit Sharing	26.7	9.6	15.3	28.5	24.0	15.0	30.2
Retirement Plan	84.3	26.3	49.1	55.7	69.9	86.2	91.6
Wellness Program	42.9	5.4	11.1	10.6	15.7	63.0	47.8
# sampled	*2,000*	*724*	*330*	*262*	*215*	*131*	*338*
# responded	*1,166*	*427*	*204*	*158*	*136*	*67*	*174*
response rate	*58%*	*59%*	*62%*	*60%*	*63%*	*51%*	*51%*

Average Employer Subsidy % and Leave Days for Full-Time Wyoming Employees, 2001

	Mean	Mode
Health Insurance	79.5%	100%
Dental Plan	75.9	100
Paid Holidays	7.9	6
Paid Sick Leave	8.9	12
Paid Vacation (after 1 year)	8.6	10
Paid Vacation (after 2 years)	10.4	10
Paid Vacation (after 3 years)	11.4	10
Paid Personal Leave	6.7	2

Wyoming Compensation Costs, 2000

	Precent of Total Comp	Percent of Pay
Wages & Salary	78.5%	100.0%
Retirement	5.2	6.6
Legally Required(1)	6.9	8.8
Other Benefits(2)	9.4	12.0

(1) = Social Security, Unemployment, Worker's Comp
(2) = paid leave, insurances and miscellaneous benefits

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Table 13 - Average & Median Salaries

	Average 2002 Salaries					Median 2002 Salaries				
	Classified	Unclassified	Classified & Unclassified	Higher Ed	Total	Classified	Unclassified	Classified & Unclassified	Higher Ed	Total
Wyoming	$ 35,020		$ 35,020	separate system	$ 35,020	$ 32,864		$ 32,864	separate system	$ 32,864
Colorado	$ 47,088	n/a	n/a	n/a	n/a					
Idaho	$ 34,075	$ 49,276	$ 41,676	$ 50,133	$ 45,904					
Montana	$ 30,580	$ 33,430	$ 30,788	n/a	n/a					
Nebraska			$ 32,000	n/a	$ 32,000					
North Dakota	$ 32,292	$ 57,132	$ 36,060	n/a	n/a	$ 30,552	$ 42,108	$ 31,344	n/a	n/a
South Dakota	$ 29,859	$ 47,231	$ 32,278	n/a	$ 32,278	$ 29,854	$ 45,217	$ 31,998		
Utah	$ 35,433	$ 70,345	$ 36,269	separate system	$ 36,269	$ 32,990	$ 68,612	$ 32,990	separate system	$ 32,990
Average	$ 34,907	$ 51,483	$ 34,870	$ 50,133	$ 36,294	$ 31,565	$ 51,979	$ 32,299		$ 32,927

= most comparable pay statistics as all Wyoming employees are included in "Classified" data.

Table 12 - Number of State Employees

	Classified	Unclassified	Classified & Unclassified	Higher Ed	Total*
Wyoming	7,132		7,132		7,132
Colorado	28,543	n/a	n/a	44,106	75,506
Idaho	12,821	1,240	14,061	5,237	19,298
Montana	11,984	942	12,926		n/a
Nebraska	14,193	2,381	16,574	n/a	16,574
North Dakota	6,399	541	6,940	6,132	13,431
South Dakota	6,329	1,024	7,353	n/a	7,353
Utah	16,898	416	17,314	separate system	17,314
Average	13,037	1,091	11,757	18,492	22,373

Table 14 - Turnover

	Total	Voluntary	Involuntary	Retirement
Wyoming	14.30%			
Colorado	12.70%			
Idaho	12.30%	8.20%	2.20%	1.80%
Montana	11.77%	9.42%	0.40%	1.92%
Nebraska	15.00%	10.90%	2.50%	1.60%
North Dakota	9.00%	6.70%	1.00%	1.40%
South Dakota	13.20%	9.20%	2.60%	1.40%
Utah	9.29%	6.27%	1.22%	1.80%
Average	12.20%	8.45%	1.65%	1.65%

Table 15

	% Unionized
Wyoming	0.00%
Colorado	0.00%
Idaho	
Montana	65.00%
Nebraska	80.00%
North Dakota	0.00%
South Dakota	11.00%
Utah	0.00%
Average	22.29%

*Reported totals may not add to sum of reported components
n/a = not applicable or not available
blank = no response provided to Cenral States Compensation Association

P:\HealthWelfare\Wyoming\2003 Feasibility Study\SickLeave\[PayStats.xls]Sheet1

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Table 35 - Regional Total Compensation Analysis (Classified and Unclassified)

	WY	CO	ID	MT	NE	ND	SD	UT	Average
Average Salary	$ 35,020	$ 47,088	$ 41,676	$ 30,788	$ 32,000	$ 36,060	$ 32,278	$ 36,269	$ 36,397
per hour	*$ 16.84*	*$ 22.64*	*$ 20.04*	*$ 14.80*	*$ 14.89*	*$ 17.34*	*$ 15.52*	*$ 17.44*	*$ 17.44*
Vacation Hours	120	120	120	120	120	120	120	130	121.3
per hour	*$ 0.97*	*$ 1.31*	*$ 1.16*	*$ 0.85*	*$ 0.86*	*$ 1.00*	*$ 0.90*	*$ 1.09*	*$ 1.02*
Sick Hours	96	80	96	96	96	96	112	104	97.0
per hour	*$ 0.78*	*$ 0.87*	*$ 0.92*	*$ 0.68*	*$ 0.69*	*$ 0.80*	*$ 0.84*	*$ 0.87*	*$ 0.81*
Holiday Hours	72	80	80	84	96	84	92	88	84.5
per hour	*$ 0.58*	*$ 0.87*	*$ 0.77*	*$ 0.60*	*$ 0.69*	*$ 0.70*	*$ 0.69*	*$ 0.74*	*$ 0.71*
Health Insurance	$ 225.00	$ 147.86	$ 389.42	$ 293.98	$ 240.33	$ 191.33	$ 366.36	$ 250.60	$ 263.11
per hour	*$ 1.30*	*$ 0.85*	*$ 2.25*	*$ 1.70*	*$ 1.39*	*$ 1.10*	*$ 2.11*	*$ 1.45*	*$ 1.52*
Dental Insurance	$ -	$ 16.26	$ 13.65	$ 28.60	$ -	$ -		$ 38.44	$ 13.85
per hour	*$ -*	*$ 0.09*	*$ 0.08*	*$ 0.17*	*$ -*	*$ -*		*$ 0.22*	*$ 0.08*
Vision Insurance				$ 0.88					$ 0.88
per hour				*$ 0.01*					*$ 0.01*
Life Insurance	$ 0.28	$ 0.18	$ 0.09	$ 0.23	$ 0.19	$ 0.19	$ 0.21	$ 0.20	$ 0.20
per hour	*$ 0.06*	*$ 0.04*	*$ 0.02*	*$ 0.05*	*$ 0.04*	*$ 0.04*	*$ 0.05*	*$ 0.05*	*$ 0.04*
Retirement	11.25%	10.04%	9.77%	6.90%	6.75%	4.12%	6.00%	10.40%	8.15%
per hour	*$ 1.89*	*$ 2.27*	*$ 1.96*	*$ 1.02*	*$ 1.01*	*$ 0.71*	*$ 0.93*	*$ 1.81*	*$ 1.45*
Social Security	6.20%		6.20%	6.20%	6.20%	6.20%	6.20%		6.20%
per hour	*$ 1.04*		*$ 1.24*	*$ 0.92*	*$ 0.92*	*$ 1.07*	*$ 0.96*		*$ 1.03*
Total Benefits*	$ 6.63	$ 6.31	$ 8.40	$ 5.99	$ 5.59	$ 5.44	$ 6.47	$ 6.23	$ 6.66
Benefit % of Pay	39.39%	27.87%	41.91%	40.49%	37.56%	31.36%	41.70%	35.73%	38.17%
Total Compensation	$ 23.47	$ 28.95	$ 28.43	$ 20.80	$ 20.48	$ 22.77	$ 21.99	$ 23.67	$ 24.10

*Reported totals may not add to sum of reported components

P:\HealthWelfare\Wyoming\2003 Feasibility Study\SickLeave\[PayStats.xls]Sheet3

STATE OF WYOMING
Employees' and Officials' Benefit Plans
For Plan Years 2002 and 2003

MEDICAL PLAN

The State of Wyoming offers employees medical coverage through Great West Life's Wyoming PPO and National PPO networks. Highlights of the Plan are included below:

Calendar Year Deductible:

Option 1:	Individual	$350
	Family	$700
Option 2:	Individual	$750
	Family	$1,500
Option 3:	Individual	$2,500
Retiree Over 65:	Individual	$750
	Family	$1,500
Retiree Under 65:	Individual	$750
	Family	$1,500

Payable After Deductible Within the State of Wyoming:

Coinsurance

In-Network:	85%
Out-of-Network	80%

Maximum Out-of-Pocket

Individual:	$10,000
Family:	$20,000

Payable After Deductible Outside of Wyoming:

Coinsurance

In-Network:	80%
Out-of-Network	60%

Maximum Claims Subject to Coinsurance

Individual:	$15,000	(e.g. 15% x $15,000 = $2,250 maximum coinsurance paid if all claims are In-Network within Wyoming. Combined with deductible, annual patient out-of-pocket maximum is $2,600 under Option 1. Patient out-of-pocket will be higher to extent claims are incurred Out-of-Network or outside Wyoming.)
Family:	$30,000	(e.g. 15% x $30,000 = $4,500 maximum coinsurance paid if all claims are In-Network within Wyoming. Combined with deductible, annual patient out-of-pocket

maximum is $6,000 under Option 2. Patient out-of-pocket will be higher to extent claims are incurred Out-of-Network or outside Wyoming.)

Prescription Drug Coverage:

Generic:	$10.00 co-pay
Preferred Brand:	$20.00 co-pay
Non-preferred:	$40.00 co-pay

Mail Order (60-day supply)

Generic:	$10.00 co-pay
Preferred Brand:	$20.00 co-pay
Non-preferred:	$40.00 co-pay

Wellness Benefit:

100% coverage for up to $300 per calendar year

DENTAL PLAN

Preventive dental coverage is included in the health plan for active employees. Employees and retirees have the option of purchasing additional dental coverage through Delta Dental Plan of Wyoming. The optional plan is described below:

Deductible:

Individual	$50
Family	$100

Co-insurance After Deductible:

Preventive and Diagnostic	100%
Basic Services	50%
Includes: oral surgery, restorative dentistry, endodontics and periodontics	
Major Services	50%
Includes: prosthodontics, partial dentures, complete dentures, crowns and onlays	

Maximum Benefit:

$1,200 per person per year

LIFE AND DISABILITY INSURANCE

Noncontributory Life and Disability insurance is offered through Standard Life Insurance for active employees.

FLEXIBLE BENEFITS PLAN

The State of Wyoming Flexible Benefits Plan includes three accounts: the Flexible Spending Account (no annual maximum); Dependent Care Account ($3,000 annual maximum); and Medical Reimbursement Account ($2,500 individual and $5,000 family maximum per year). Employees have the option of

contributing to one or more of these accounts on a pre-tax basis, and are then reimbursed for eligible expenses from the respective account.

STATE HEALTH CARE CONTRIBUTION

In mid-2003, the State adjusted its contribution levels from a flat contribution to a three-tier system based on approximately 85% employer contribution. Contribution rates for 2002, 2003 and Mid-2003 are provided below.

	Jan. 1, 2002	Jan. 1, 2003	April 1, 2003
Single	$301.00	$354.00	$335.37
Two Party	$301.00	$354.00	$652.95
Family	$301.00	$354.00	$744.75

ANNUAL LEAVE (VACATION)

Employees accrue 12 days per year. Unused days accumulate without limit. Accumulated days are paid at 100% of the rate of compensation in effect at termination. Practices differ for University of Wyoming and Wyoming Community Colleges employees.

SICK LEAVE

Employees accrue 12 days per year. Unused days accumulate without limit. Accumulated days - to a maximum of 960 hours - are paid at 50% of the rate of compensation in effect at termination. Thus, the maximum payout at termination is 60 full days pay. Accumulated sick leave may be donated to colleagues in need.

Sample Health Promotion, Population Health Management and Disease Management Incentives

A key employer concern regarding health promotion programs is the potential that, even if an effective program is designed, only employees who are already health conscious will participate. Incentives can be used to broaden participation and therefore have a chance at getting employees and dependents in poor health - those for whom the most economies can be obtained - into the program. A sample "carrot" approach is payment or prize drawings for employees who complete health risk appraisal questionnaires. Ideally, incentives should also apply for employees who get their dependents to complete the questionnaire. A "stick" approach is a medical plan premium surcharge for smokers. Such plans typically rely on self-reporting and must allow waivers for participants who attempt to quit smoking but demonstrate they cannot due to addiction or other disabling condition. Nevertheless, IBM and other employers believe there is value in simply establishing a smoker premium differential [Employee Benefit News - August 2003]. Another employer concern with wellness is that return on investment is diminished due to turnover - even if less healthy employees benefit from health promotion, real savings are expected to be long term, after many such employees have moved on to new employers. Given the ever higher cost of health care and the improved efficiency of wellness programs, this concern should be given less weight. In fact, Aetna, Destiny Health, PacifiCare, WellPoint and other health plans now offer healthy; lifestyle incentives to their insured populations [Wall Street Journal - September 25, 2003].

Similar incentives can be applied to participation in population health management programs. Here the potential return on investment is greater since candidates for such programs are identified using age, gender, prescription claim and diagnosis data that are assumed to indicate the existence or onset of a preventable health condition. However, given that candidates are targeted using health data, HIPAA privacy probably dictates that third-party population health managers - not the employer - control all communications and incentives. A sample incentive program might include coupons for or supplies of low-fat foods, dietary supplements, etc., given to employees or dependents who are identified as potential obesity-related claimants and who then complete a series of on-line diet and food preparation courses, score well on tests administered by dieticians, etc.

Disease management participation incentives have the greatest potential for immediate savings, as they target patients who already have treatable conditions. The January 2002 issue of HR Magazine includes the following disease management incentive recommendation in the article "Making Disease Management Work":

- Disease self-management is about lifestyle, as well as care regimens. An employer culture of health promotion and management can communicate the importance of lifestyle through exercise classes, wellness education, health fairs and screenings. Note that Wyoming currently conducts health fairs and screenings.

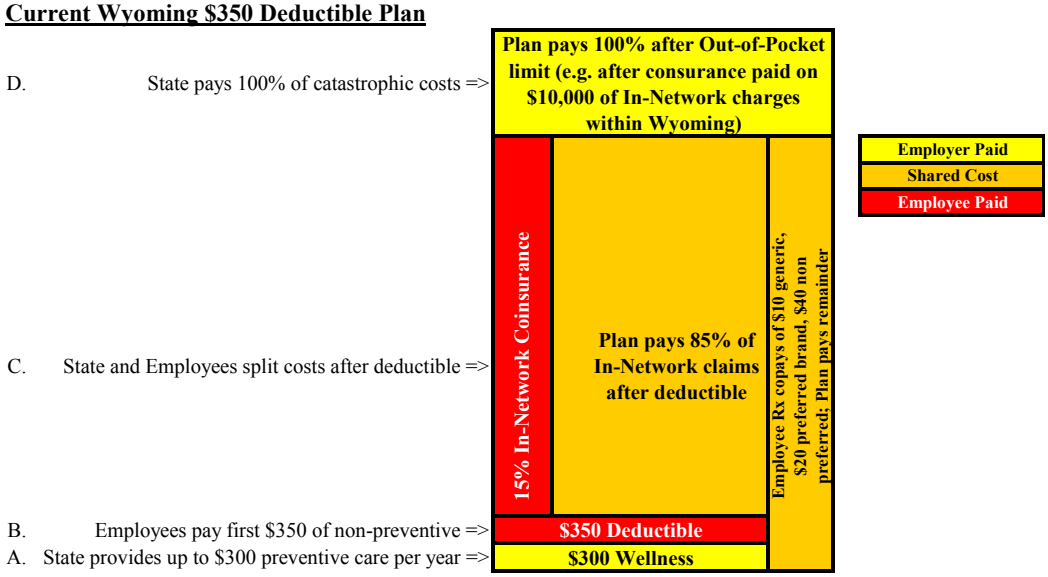
- Incentives certainly include improved health and can be augmented financially, but employers should also communicate how disease management programs improve the patient's quality of life. Participants who are reluctant to address health issues may respond to improved daily life resulting from managing their conditions.

- Financial incentives related to the disease under management can include free diabetic supplies, free peak flow meters for asthmatics, free smoking cessation classes or medications for cardiac patients, etc. Again, it is probably best if incentives related to specific conditions are provided directly by third-parties.

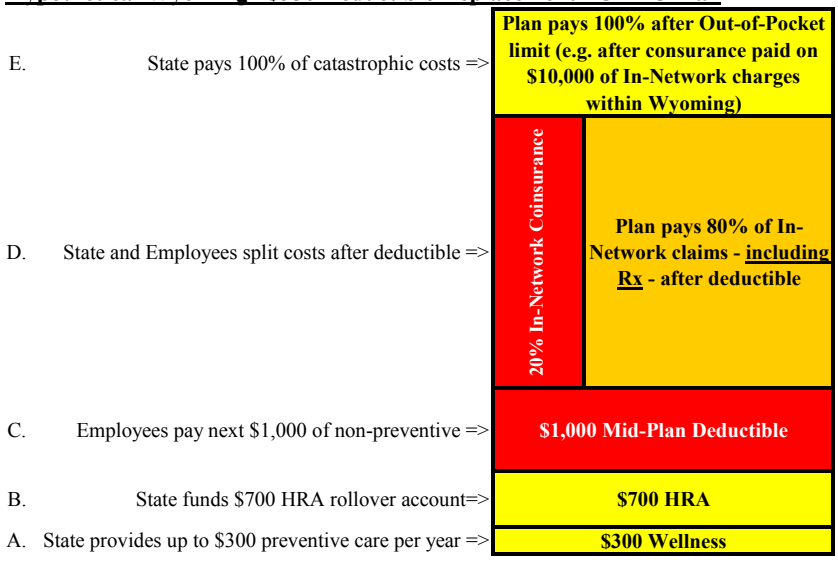
Sample Consumer-Driven Health Care (CDHC) Plan Design

The following chart graphically compares the current State $350 Deductible Plan to a corresponding Consumer-Driven Health Care (CDHC) design. The CDHC design could be offered alongside the current $350 Plan or could replace the $350 Plan. The comparison graphic below is limited to in-network claims within Wyoming. However, as with current plans, coverage for non-network claims - and for claims outside Wyoming - can be lower than for in-network claims within Wyoming. Final actuarially equivalent CDHC plan design features - HRA amount, mid-plan deductible, coinsurance - will differ somewhat; the chart below is a first cut only. The chart addresses employee-only coverage tier, similar CDHC benefit levels would be developed for spouse and dependent tiers. Coexisting or replacement CDHC design(s) can also be developed to correspond to the current $750 Plan. Finally, CDHC plans and required employee premiums must be designed in concert with employee premiums for other options to maintain the expected net cost of all plans combined.

Current Wyoming $350 Deductible Plan



Hypothetical Wyoming "$350 Deductible Replacement" CDHC Plan



The main distinction between the $350 Plan and "$350 Replacement" CDHC Plan below is the Health Reimbursement Arrangement (HRA) rollover account under the CDHC plan. This account applies to the same expenses as the current plan. Unspent amounts at year-end rollover to build a larger HRA account for subsequent

years. Total HRA accounts should be capped so they cannot grow too large relative to the deductible. Also, rollover could be split between annual increments to the following year's HRA account and annual deposits in a "post-employment" HRA account. This post-employment account would be limited to paying COBRA or retiree medical premiums. In the examples below, year-end rollover is limited to twice the HRA amount, so that after the next year's HRA addition the total HRA never exceeds three times the base amount. Also, 25% of unused HRA dollars are allocated to a post-employment account. The examples below illustrate how single employees with no claims, moderate claims and large claims fare under the sample CDHC and the current $350 Deductible plan:

Sample Employee #1	Starting HRA	Non-Wellness In-Network In-Wyoming Claims	Unused HRA	25% Post-Employment Rollover	Regular Rollover (2 x max)	Total Post-Employment Account	CDHC Employee Out-of-Pocket	$350 Plan Employee Out-of-Pocket
Year 1	$ 700	$ 0	$ 700	$ 175	$ 525	$ 175	$ 0	$ 0
Year 2	$ 1,225	$ 0	$ 1,225	$ 306	$ 919	$ 481	$ 0	$ 0
Year 3	$ 1,619	$ 0	$ 1,619	$ 405	$ 1,214	$ 886	$ 0	$ 0
Year 4	$ 1,914	$ 0	$ 1,914	$ 479	$ 1,400	$ 1,365	$ 0	$ 0
Year 5	$ 2,100	$ 0	$ 2,100	$ 525	$ 1,400	$ 1,890	$ 0	$ 0
Year 6	$ 2,100	$ 0	$ 2,100	$ 525	$ 1,400	$ 2,415	$ 0	$ 0
Year 7	$ 2,100	$ 0	$ 2,100	$ 525	$ 1,400	$ 2,940	$ 0	$ 0
Year 8	$ 2,100	$ 0	$ 2,100	$ 525	$ 1,400	$ 3,465	$ 0	$ 0
Year 9	$ 2,100	$ 0	$ 2,100	$ 525	$ 1,400	$ 3,990	$ 0	$ 0

Sample Employee #2	Starting HRA	Non-Wellness In-Network In-Wyoming Claims	Unused HRA	25% Post-Employment Rollover	Regular Rollover (2 x max)	Total Post-Employment Account	CDHC Employee Out-of-Pocket	$350 Plan Employee Out-of-Pocket
Year 1	$ 700	$ (350)	$ 350	$ 88	$ 262	$ 88	$ 0	$ 350
Year 2	$ 962	$ (800)	$ 162	$ 41	$ 121	$ 129	$ 0	$ 418
Year 3	$ 821	$ (2,500)	$ 0	$ 0	$ 0	$ 129	$ 1,136	$ 673
Year 4	$ 700	$ 0	$ 700	$ 175	$ 525	$ 304	$ 0	$ 0
Year 5	$ 1,225	$ (350)	$ 875	$ 219	$ 656	$ 523	$ 0	$ 350
Year 6	$ 1,356	$ (1,500)	$ 0	$ 0	$ 0	$ 523	$ 144	$ 523
Year 7	$ 700	$ 0	$ 700	$ 175	$ 525	$ 698	$ 0	$ 0
Year 8	$ 1,225	$ (750)	$ 475	$ 119	$ 356	$ 817	$ 0	$ 410
Year 9	$ 1,056	$ (100)	$ 956	$ 239	$ 717	$ 1,056	$ 0	$ 100

Sample Employee #3	Starting HRA	Non-Wellness In-Network In-Wyoming Claims	Unused HRA	25% Post-Employment Rollover	Regular Rollover (2 x max)	Total Post-Employment Account	CDHC Employee Out-of-Pocket	$350 Plan Employee Out-of-Pocket
Year 1	$ 700	$ (12,000)	$ 0	$ 0	$ 0	$ 0	$ 3,060	$ 2,098
Year 2	$ 700	$ (13,000)	$ 0	$ 0	$ 0	$ 0	$ 3,260	$ 2,248
Year 3	$ 700	$ (14,000)	$ 0	$ 0	$ 0	$ 0	$ 3,460	$ 2,398
Year 4	$ 700	$ (15,000)	$ 0	$ 0	$ 0	$ 0	$ 3,660	$ 2,548
Year 5	$ 700	$ (16,000)	$ 0	$ 0	$ 0	$ 0	$ 3,860	$ 2,600
Year 6	$ 700	$ (17,000)	$ 0	$ 0	$ 0	$ 0	$ 4,000	$ 2,600
Year 7	$ 700	$ (18,000)	$ 0	$ 0	$ 0	$ 0	$ 4,000	$ 2,600
Year 8	$ 700	$ (19,000)	$ 0	$ 0	$ 0	$ 0	$ 4,000	$ 2,600
Year 9	$ 700	$ (20,000)	$ 0	$ 0	$ 0	$ 0	$ 4,000	$ 2,600

Sample PTO-LTD Plan Design

The chart on the following page compares current Wyoming annual and sick leave programs to a replacement PTO-LTD (paid time off / long-term disability) approach. Final actuarially equivalent PTO-LTD design features will differ somewhat; the chart below is a first cut only. The main distinction between the current and the hypothetical approaches shown are that the PTO-LTD plan:

- Maintains but limits carryover. Without carryover there is incentive to use all days every year. With limited and "directed" carryover the "deferred compensation entitlement" aspects of the current approach are mitigated, plus some carryover is applied to post-employment accounts used for COBRA and retiree medical premiums. This latter feature increases the spread of risk among former employees electing COBRA and helps retirees defray some of the premium cost of retiree medical. Note that the amount and timing of conversion of unused days to post-employment accounts may not be individually controlled without creating a tax liability for the individual through constructive receipt of converted amounts.
- Provides income protection regardless of length of service in the event of severe disability combined with return-to-work expertise of disability insurance carriers.
- Appeals to employees as more flexible than current system while reducing unscheduled absences. There may be potential for long-term hard dollar savings since employees in general are less likely to use sick days when sick leave and vacation are combined into one allowance.

APPENDIX D - SAMPLES OF RECOMMENDED PROGRAM CHANGES

	Annual Accrual and Maximum Accumulation	PTO - LTD Plan		
Holiday	9 days	Add to total days for "24/7" operations**		
Vacation				
1-4 Years	12 days *30-day max accum.*			
5-9 Years	15 days *30-day max accum.*			
10-14 Years	18 days *36-day max accum.*			
15-19 Years	21 days *42-day max accum.*			
20+ Years	24 days *48-day max accum.*			
	Termination payout = 100%			
Sick Leave	Accrue 12 days/year *Unlimited accumulation*			
	Termination payout = 50% of max 960 hours			
Personal Time	none			
Other*	various			
Total Time Off	(excl. Holidays)	w/ separate STD plan	no separate STD plan	*10 days are use-it-or-lose-it (no rollover). 50% of remainder rollover "normally" and 25% of unused days added to "post-employment" account. No limit on post-employment account; normal rollover limited to 1.5 times annual accrual.*
1-4 Years	24 days	16 days	24 days	
5-9 Years	27 days	19 days	27 days	
10-14 Years	30 days	22 days	30 days	
15-19 Years	33 days	25 days	33 days	
20+ Years	36 days	28 days	36 days	
Short-Term Disability (STD)	Accumulated leave days + donated Sick Leave	Roll into total days OR pay 100% for 5 days after 5 days out, 80% thereafter until LTD starts		
Long-Term Disability (LTD)	Accumulated leave days + donated Sick Leave + pension plan disability benefit	Replace 60% of pre-tax income after 6-months of disability; payable to earlier of recovery, retirement or death.		

* Detailed study will include analysis of bereavement, FMLA, jury duty, parental and any other paid time off.

** Holiday time can be rolled into PTO to better control staffing for Agencies with critical round-the-clock full-staff requirements.