Attachment A

RETIREMENT (*)

CRS HEALTHCARE COSTS

	MEDICAL			DRUG			COMBINED	
YEAR	MEDICAL	MED. As % TOTAL	% INCR.	RX	RX as % TOTAL	% INCR.	TOTAL SPEND	% INCR.
2000	NA			NA			$ 19,226,859.00	
2001	NA			NA			$ 24,531,675.00	127.6%
2002	NA			NA			$ 26,522,142.00	108.1%
2003	$ 19,958,276	63.2%		$ 9,477,420	30.0%		$ 31,593,739.00	119.1%
2004	$ 20,808,053	58.3%	104.3%	$ 12,720,765	35.6%	134.2%	$ 35,705,176.00	113.0%
2005	$ 23,508,967	59.7%	113.0%	$ 14,162,812	36.0%	111.3%	$ 39,391,301.00	110.3%
2006	$ 23,089,533	57.3%	98.2%	$ 15,448,174	38.3%	109.1%	$ 40,289,215.00	102.3%
2007	$ 25,113,602	57.4%	108.8%	$ 17,070,061	39.0%	110.5%	$ 43,749,500.00	108.6%
2008	??????			??????			??????	

ACTIVES (*)

CITY HEALTHCARE COSTS

	MEDICAL			DRUG			COMBINED	
YEAR	MEDICAL	MED. As % TOTAL	% INCR.	RX	RX as % TOTAL	% INCR.	TOTAL SPEND	% INCR.
2000	NA			NA			$ 21,992,052.00	
2001	NA			NA			$ 25,240,293.00	114.8%
2002	NA			NA			$ 26,309,335.00	104.2%
2003	$ 23,709,001	74.2%		$ 5,446,320	17.0%		$ 31,965,199.00	121.5%
2004	$ 30,259,994	78.0%	127.6%	$ 6,511,456	16.8%	119.6%	$ 38,774,226.00	121.3%
2005	$ 26,666,054	74.9%	88.1%	$ 6,486,722	18.2%	99.6%	$ 35,623,026.00	91.9%
2006	$ 25,307,538	73.3%	94.9%	$ 6,688,432	19.4%	103.1%	$ 34,508,179.00	96.9%
2007	$ 27,361,831	73.7%	108.1%	$ 7,413,205	20.0%	110.8%	$ 37,111,743.00	107.5%
2008	??????			??????			??????	

(*) These figures do not include retiree or active employee out-of-pocket costs including premiums, deductibles, coinsurance, and copays.
RETIREE out-of-pocket costs average approximately 4%.
ACTIVEs out-of-pocket costs average approximately 23%.

Attachment B

Attachment B
Financial Data Regarding Healthcare Coverage and Contributions for the CRS
Based on Actuarial Data 12/31/2006

#1 Grandfather Current Retirees to 96/4 Healthcare (Current Plan)		**% Contribution**	**Funding Ratio**
Unfunded Liability	$255 million	30.2%	90.8%
City Contribution	$48 million		
Plus Early Retirement	+$ 5.6 million		
Total City Contribution	**$53.6 million**	33.7%	89.2%
General Fund Portion	$22 million		

# 2 Grandfather Current Retirees and Employees Hired prior to 1/1/2003 to 96/4 Healthcare			
Unfunded Liability	$341 million	38.2%	88.1%
City Contribution	$60.6 million		
Plus Early Retirement	+$ 5.6 million		
Total City Contribution	**$66.2 million**	41.7%	86.6%
General Fund Portion	$27.1 million		

No Change to 96/4 Healthcare for Current/Future Retirees			
Unfunded Liability	$346 million	38.7%	87.9%
City Contribution	$61.5 million		
Plus Early Retirement	+$ 5.6 million		
Total City Contribution	**$67.1 million**	42.2%	86.5%
General Fund Portion	$27.5 million		

All Members of the CRS on 80/20 Healthcare			
Unfunded Liability	$79 million	24.1%	96.9%
City Contribution	$38 million		
Plus Early Retirement	+$ 5.6 million		
Total City Contribution	**$43.6 million**	27.4%	95.1%
General Fund Portion	$17.9 million		

#3 Grandfather Current Retirees and Employees with 15 years of Service

Unfunded Liability	$329 million	36.7%	88.5%
City Contribution	$58.3 million		
Plus Early Retirement	+$ 5.6 million		
Total City Contribution	**$63.9 million**	40.2%	87.1%
General Fund Portion	$26.2 million		

#4 Grandfather Current Retirees and Employees with 25 years of Service

Unfunded Liability	$286 million	32.8%	89.8%
City Contribution	$52.1 million		
Plus Early Retirement	+$ 5.6 million	36.3%	88.4%
Total City Contribution	$**57.7 million**		
General Fund Portion	$23.7 million		

All amounts are approximations. The Early Retirement amounts are approximations based on 100% usage.
Draft date 12/05/2007

Attachment C

2007 Self-Insured Monthly Premium for Benefit Recipients[1]

	OPERS**						SERS		OP&F				State Highway Patrol		STRS Ohio**				Cincinnati Retirement 80/20	
	MMO PPO						Aetna/MMO PPO		Aetna/MMO PPO Pre 7/24/1986		Aetna/MMO PPO Post 7/24/1986		Basic Plan		MMO Plus Plan		MMO Basic Plan			
	Enhanced		Intermediate		Basic															
Premium	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare
Medical	$0	$0	$0	$0	$0	$0	$163	$45	$143.92	$27.58	$143.92	$27.58	TBD	TBD	$163	$67	$94	$40	$13.18/sgle $36.40/fam	$13.18/sgle $36.40/fam
Prescription Drug	included	included	included	included	included	included	included	included	$54.56	$54.56	$54.56	$54.56	included	included	included	included	included	included	included	included
Total BR Premium*	$0	$0	$0	$0	$0	$0	$163	$45	$198.48	$82.14	$198.48	$82.14	TBD	TBD	$163	$67	$94	$40	$13.18/sgle $36.40/fam	$13.18/sgle $36.40/fam
Spouse*	$80	$40	$80	$40	$80	$40	$520	$181	$293.34	$149.31	$440.01	$223.96	TBD	TBD	$581	$301	$313	$148	N/A ***	N/A ***
Child*	$40	$40	$40	$40	$40	$40	$113	$181	$130.15	$77.08	$195.22	$115.60	TBD	TBD	$182	$301	$108	$148	N/A ***	N/A ***

* Includes premium for prescription drug plan

** Base plan rates

*** Included in family premium

****The Cincinnati Retirement plan items are not official. They are preliminary plan features and costs and should not be construed as the official plan.

[1] Benefit recipient premium is based on the following definition for each system:

OPERS – Any benefit recipient

SERS – Any service retiree with 25 or more years of service, any service retiree who retired prior to 8/1/89, any disability retiree, or any survivor.

OP&F – Benefit recipients who retired prior to July 24, 1986 receives a 75% subsidy, Spouses & dependents are subsidized at 50%. Benefit recipients who retired after July 24, 1986 receives a subsidy of 75%, Spouses & dependents are subsidized at 25%. Prescription Drug premiums are equalized between Medicare & Non Medicare for both Pre & Post July 24, 1986.

State Highway Patrol – Any benefit recipient. If a spouse or retiree is currently employed and medical coverage is offered, then they are required to enroll in the active employer's coverage as primary.

STRS Ohio – Any benefit recipient with 30 or more years of service.

Attachment C
2007 ORS Benefit Design Comparison

In-Network Medical Benefits*										
		OPERS			SERS	OP&F	State Highway Patrol	STRS Ohio		Cincinnati Retirement**
		PPO Plan								
Plan Feature		Enhanced	Intermediate	Basic	Aetna/MMO PPO	Aetna/MMO PPO	Basic Plan	Plus Plan	Basic Plan	Anthem Blue Access 80/20
Annual Deductible		$250/single $400/family	$400/single $800/family	$900/single $1,800/family	$340/person $700/family	$500/individual $1,000/family	$100/person (Non-Medicare) $25/person (Medicare)	$500/person	$1,500/person	$300/person $600/family
Annual Out-of-Pocket Maximum	Single	$850	$1,000	$1,500	$1,500	$1,500	$750	$1,500	$2,500	$1,500
	Family	$1,600	$2,000	$3,000	$3,000	$3,000	$1,500	$3,000	$5,000	$3,000
Copay		$15	$25	N/A	$25	$30	$15 PCP $25 SPC	N/A		N/A
Enrollee coinsurance for physician services		0% after office visit copay; 20% for all other associated services		20%	0% after office visit copay; 20% for all other associated services	0% after office visit copay; 20% for all other associated services	0% after office visit copay; 20% for all other associated services	20%		Deductible then 20% until reaching max out of pocket
Enrollee coinsurance for hospital services		20% after $100 Admission Deductible			20% after $250 Admission Deductible	20% after $250 Admission Copay	0% after $100 Admission Deductible for Non-Medicare	20%		Deductible then 20% until reaching max out of pocket
Preventive Services		Member pays any costs exceeding the established usual, customary, and reasonable fees for screenings (No deductible) Member pays any costs exceeding $100 per year for routine physicals			Member pays 10% of any costs exceeding $100 for mammography, PAP, and PSA tests after deductible	Member pays 0% for screening after OV copay, if applicable Member pays 20% for diagnostic tests after deductible and OV copay, if applicable	Member pays 20% for mammography, PAP, and PSA tests Member pays any costs exceeding $400 over a 2-year period for other screenings and physicals (No deductible)	Member pays 20% after deductible	Member pays 0% (No deductible)	Most preventive and wellness covered in full

* Benefits shown here apply when members use in-network PPO providers. Reduced benefits apply when members use providers not participating in the PPO network.
**Benefits presented in this column subject to change. Information shown represents current health care benefits for City of Cincinnati employees.

2007 Prescription Drug Benefits											
Plan Feature		OPERS Enhanced	OPERS Intermediate	OPERS Basic	SERS	OP&F	Highway Patrol	STRS Ohio Plus Plan	STRS Ohio Basic Plan	Cincinnati Retirement
ADMINISTRATOR										
PBM Administrator		Medco Health Solutions			Medco Health Solutions	Medco Health Solutions	Medco Health Solutions	Caremakr (AdvancePCS)		
RETAIL										
Copay/ Coinsurance	Tier I - Generic	$5	$15	35%	20%w/ minimum of $2.50	$5	$5	$10	$10	$10
	Tier II – Formulary Brand	$10	$35	35%	20% w/ minimum of $2.50	$20	$10	$30	$30	$20
	Tier III – Non-formulary Brand	$25	$50	50%	35% w/ minimum of $5	$30	$30	$50	$50	$30
Days Supply		34			34	30	30	30	30	30 day
MAIL-SERVICE										
Copay/ Coinsurance	Tier I - Generic	$15	$45	35%	$15	$10	$10	$25	$25	$20
	Tier II – Formulary Brand	$30	$105	35%	$45	$40	$20	$75	$75	$40
	Tier III – Non-formulary Brand	$75	$150	50%	$80	$60	$60	$125	$125	$60
Days Supply		90			90	90	90	90	90	90 day
OTHER FEATURES										
Deductible		N/A	N/A	$500/single $1,000/family	N/A	N/A	N/A	N/A	N/A	N/A
Annual Out-of-Pocket Max		N/A			N/A	N/A	N/A	$2,000	N/A	$1,000
Maximum Annual Benefit		N/A			N/A	N/A	N/A	N/A	$5,000 Tier 2 & 3 drugs only	N/A
Medicare Part D enrollment rules		Dual enrollment in Medicare Part D is not permitted for plan-sponsored coverage.			Dual enrollment in Medicare Part D is not permitted for plan-sponsored coverage.	Dual enrollment in Medicare Part D is not permitted for plan-sponsored drug coverage.	Dual enrollment in Medicare Part D is not permitted for plan-sponsored coverage.	Dual Enrollment is permitted.		Dual enrollment is permitted.
Other		If brand-name medication is dispensed when a generic is available, member pays generic copay plus the difference in cost between the brand and generic drugs up to $100.			Two-fill limit at retail for maintenance medications	Oral & pellet MEDs: 3/30 days Injectible MEDs: 2/30 days NSAs no longer covered	Two-fill limit at retail for maintenance medications			Supplies for diabetes and asthma may be covered from 80% to 100%

Attachment D

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MAR 2 1 2008

March 21, 2008

Mr. John K. Boudinot, D.B.A.
Executive Director of the CRS
City of Cincinnati
City Hall
801 Plum Street, Suite 240
Cincinnati, OH 45202

Re: Proposal for Independent Pension and Post-Retirement Benefit Actuarial Review

Dear Mr. Boudinot:

We appreciate the City of Cincinnati's consideration of our firm for an independent actuarial review of the pension and post-retirement benefits provided by the Cincinnati Retirement System (CRS). We understand the Task Force's objective to make recommendations to City Council to insure the long-term solvency of CRS. We are prepared to assist the Task Force immediately in examining the underlying actuarial assumptions, financial projections, and recommending alternatives and the associated impact on the solvency of the CRS.

About Buck

Buck's expertise stems from over 90 years of actuarial excellence – a history dominated by service to public sector entities. CRS can feel confident that Buck provides unparalleled capabilities, offering deep resources in the full-range of pension and health-related retirement services as well as best practices gained from our publicly traded parent company, Affiliated Computer Services (ACS), which derives over 40 percent of their six billion dollars of annual revenue from the public sector. We feel strongly Buck offers CRS the ideal solution for your needs now, and moving forward – due to our local presence, unmatched actuarial reputation and depth and breadth of experience related to pension and healthcare plan consulting.

Buck is a leader in the delivery of pension and post-retirement actuarial services in Cincinnati with the largest pension actuarial staff in the city. Buck employs 9 credential actuaries in its local office, including 2 Fellows of the Society of Actuaries (FSAs), 4 Associates of the American Society of Actuaries and 3 additional Enrolled Actuaries. In addition to the pension and healthcare actuarial staff, Buck employs communications consultants locally.

2090 Florence Avenue, Suite 101 • Cincinnati, OH 45206-2473
513.784.0005 • 513.784.9734 (fax)

The local team will be supplemented by a National Resource who spends the majority of his time consulting with municipalities of size similar to the City of Cincinnati. This resource will provide
insight and experience with how other cities are dealing with similar situations and will serve as peer reviewer to insure quality results. Buck's peer review process is unmatched in the industry.

We believe quality consulting services involve more than just highly technical expertise. Thus, the proposed Buck team is comprised of experienced, innovative and responsive consultants who value clear communication skills, broad business viewpoints as much as solid technical proficiency and processes.

As evidenced by our 90-year history, Buck has a well-earned reputation for excellence in the provision of valuation and other on-going actuarial services to major public retirement systems and understands the pressures a public sector system of CRS' size faces. To function successfully in this environment, CRS must understand all of its available options. You need to know both the short- and long-term implications of proposed changes and current plan of action. That's where Buck can help. By providing CRS with accurate data to drive decision making, Buck provides CRS with justifiable evidence, either for change or maintenance of plans in place.

Buck is a leader and widely recognized expert on human resources issues affecting the rapidly evolving public sector community. As consultants, one of our primary responsibilities is the benefit security of participants in the plans we serve. We realize, however, that fiscal constraints produce pressure to lower costs. Our public-sector-focused pension and healthcare consultants will support the Task Force and CRS by crafting the appropriate message to City Council regarding the sound actuarial financing of CRS.

Our Proposed Services

As requested, Buck Consultants will provide the following Services to the Cincinnati Retirement System:

- Estimate a reasonable range for the liabilities for both retirement and medical benefits based on the data summary, plan provisions and actuarial assumptions described in the December 31, 2006 valuation report
- Estimate a reasonable range for the contribution to the plan for 2007 and 2008
- Estimate a reasonable range for the change in liability for the medical plan under the 3 suggested change scenarios
- Review the actuarial assumptions for reasonableness for both retirement and medical liabilities
- Estimate a reasonable range for the change in assets and liabilities due to the change in investment return assumption from 8.75% gross of fees to 8.00% net of fees, effective December 31, 2006
- Provide a written report summarizing the findings

- Provide advice regarding current benefits and potential changes to benefits to enhance future funding levels and lower employer required contributions;
- Provide responses related to the following
    - Any administrative and procedural changes that would reduce costs, including opening to bid provision of health care coverage
    - Any changes in contribution rates, actuarial assumptions, benefit calculations that should be instituted to insure the solvency of the CRS
    - Any reforms that would protect the city of Cincinnati's General Fund from continuously increasing contribution requirements
    - The Task Force should examine all possible improvements and changes that would reduce the long-term liabilities of the taxpayers of Cincinnati
    - Any recommendation should recognize the needs of individuals who retired due to disability, and whose service retirement was not calculated under 2.2%/2.5% upon reaching age 65
- Provide both a retirement actuary and a health actuary to attend a Task Force meeting to answer any questions about the results

Timeline

We are prepared to begin work immediately, and will be prepared to provide our written report summarizing our findings within four weeks of receiving data and valuation results. We recommend the follow-up meeting, to answer questions related to the report, take place two weeks after the report is issued. This two-week period will provide time for the Task Force to review findings and request follow-up items prior to the meeting. We propose to bring all senior members of our team to this Task Force meeting.

Schedule of Fees

Fees for the services outlined above will be $12,500, which will include travel expenses for our National Resource to attend the Task Force meeting. Additional meetings to include both a pension and health actuary will be priced at $1,000.

Your Team

The required services will be conducted and delivered primarily by professionals in the Cincinnati office. Jeff Leonard will function as the lead actuary with local actuarial support from Matt Crouch and Chris Marshall. Larry Langer will be our National Resource and provide overall peer-review.

Jeff Leonard is the Managing Director of Buck's Midwest region as well as the leader of the local Cincinnati office. Jeff is an FSA and EA with over 20 years of experience. Matt Crouch is the Retirement Practice Leader for the Cincinnati office and is an ASA and EA with over 10 years of experience. Chris Marshall is an ASA with over 15 years of experience with public sector clients.

Biographies of your team members are attached as Exhibit I.

Next Steps

As stated above, we are prepared to begin work immediately. If you would like to meet our team to gauge our breadth and depth of experience and better understand our process, we can be available on short notice as we are literally right down the street.

For your convenience, enclosed are two copies of our engagement letter ("Exhibit II"). If you agree to the scope of services and fees, you may return a signed copy to me and retain a copy for your records.

Again, thank you for the opportunity to work with CRS on such an important project.

Sincerely,

Matthew H. Crouch

Matthew H. Crouch, A.S.A., E.A.
Director, Retirement Actuary

MC:kp

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Exhibit I
Team Member Biographies

JEFF LEONARD

Managing Director and Consulting Actuary

Jeff Leonard is the Managing Director for Buck Consultants' U.S. Central Region and a Consulting Actuary in Buck's Cincinnati office. Jeff consults with clients on strategic retirement financial management and plan design issues. In addition to managing the Central Region, Jeff is the leader of the Cincinnati office and a member of Buck's Consulting Leadership Council.

EXPERIENCE

- Jeff joined Buck in 2005 and has more than 20 years of experience in retirement consulting.
- Prior to joining Buck, Jeff managed the retirement practice of another major HR consulting firm.
- He has provided consulting services to a broad range of clients in both the public and private sector, as well as for-profit and not-for-profit. Some of Jeff's recent projects include:
  - Developing objectives and design for retirement program redesign;
  - Developing a transition strategy for a new retirement program and providing assistance with a communication strategy for retirement program changes;
  - Conducting an asset/liability modeling study to assist with development of recommendations for the strategic allocation of qualified pension plan assets; and
  - Developing a funding and accounting policy for a complex organization with 10 pension plans, covering 20 locations.

CLIENTS

Jeff's current consulting clients include:

- Cincinnati Bell, Inc.
- Jewish Federation
- Kao America, Inc.
- Sparrow Health System

EDUCATION & ACHIEVEMENTS

- B.S. in Mathematics and Economics from Centre College in Danville, KY
- Fellow of the Society of Actuaries
- Enrolled Actuary
- Member of the American Academy of Actuaries

MATTHEW CROUCH

Director, Retirement Actuary

Matt Crouch is the Retirement Practice Leader in the Cincinnati office of Buck Consultants, an ACS company. His responsibilities include managing annual actuarial services for defined benefit plans, reviewing and performing non-discrimination testing for retirement plans, and consulting with clients on retirement plan design.

EXPERIENCE

- Matt joined Buck Consultants in 1996.
- Matt has experience with the valuation of defined benefit plans and determination of annual costs.
- He also has experience with forecasting future results and determining the effect of plan changes on future expenses and contributions.
- His expertise covers nondiscrimination testing including cross-testing of defined contribution plans and testing of multiple plans of plan sponsors.

CLIENTS

Matt's consulting clients have included:

- Castellini Company
- Cincinnati Bell
- Disabled American Veterans
- Makino
- toteslsotoner
- Transit Authority of Northern Kentucky

EDUCATION & ACHIEVEMENTS

- B.S. degree in Mathematics from Case Western Reserve University, 1995
- Associate of the Society of Actuaries
- Enrolled Actuary

CHRIS MARSHALL

Director, Health and Productivity Actuary

Chris Marshall is a Director in the Cincinnati office of Buck Consultants, an ACS company. He joined Buck in 2007 and has 12 years' experience in health care benefits consulting.

EXPERIENCE

- Self-insured claims analysis
- Value and recommend health benefits rates and plan changes
- FAS 106, FAS 112, LTD, and STD valuations/reporting
- Medicare Part D analysis and actuarial attestations
- Valuing of liability for vacation/PTO plans

CLIENTS

Chris' consulting clients have included:

- Catholic Healthcare Partners
- Cincinnati Bell
- Disabled American Veterans
- Tower Automotive
- Wheeling-Pittsburgh Steel

EDUCATION & ACHIEVEMENTS

- B.A. degree in Mathematics/Statistics from the University of Rochester in 1995 (cum laude)
- Completed the University of Rochester's Certificate of Actuarial Studies Program
- Associate of the Society of Actuaries
- Member of the American Academy of Actuaries
- Acquired health/life insurance agent licenses in 13 states, including OH, KY, IN

LARRY LANGER, ASA, MAAA, EA

Principal, Consulting Actuary

Larry Langer is a Principal and Consulting Actuary in the Chicago office of Buck Consultants, an ACS Company. Larry has actuarial and consulting experience with a wide variety of clients in the public and corporate sectors. He joined Buck in 2008.

EXPERIENCE

- Supervising, reviewing, and certifying actuarial valuations and studies for defined benefit retirement plans and postretirement health care plans, including FASB disclosure for corporate clients and GASB disclosure for public pension plans.
- Consulting on design and interpretation of plan provisions for defined benefit and defined contribution retirement plans and their relationship to ERISA, IRS regulations, and new legislation.
- Analyzing benefits provided from defined benefit, defined contribution and postretirement health care plans for purposes of restating retirement income policies, with recommendations based on client goals.
- Performing experience analysis studies resulting in changes to actuarial assumptions used in the actuarial valuations of defined benefit retirement plans.
- Performing asset/liability modeling studies for large retirement plans, including projection forecasts under various funding and investment scenarios.
- Consulting Actuary: Gabriel, Roeder, Smith & Company, 1997-2008; Towers Perrin, 1989-1997.

CLIENTS

Larry's consulting clients have included:

- City of Flint Employees' Retirement System
- City of Kalamazoo Employees' Retirement System
- Connecticut Teachers' Retirement Board
- Laborers and Retirement Board Employee Annuity Benefit Fund
- Municipal Employees and Annuity Benefit Fund of Chicago
- State Employees Retirement System of Illinois
- State Universities Retirement System of Illinois

EDUCATION & ACHIEVEMENTS

- B.S. in Actuarial Science from Central Michigan University
- Associate of the Society of Actuaries
- Member of the American Academy of Actuaries
- Enrolled Actuary
- Frequent speaker and presenter at professional organizations and to boards of public pension funds

Exhibit II
Engagement Letter

buckconsultants
an ACS company

March 21, 2008

Mr. John Boudinot
Executive Director
Cincinnati Retirement System
City of Cincinnati
801 Plum Street, Suite 240
Cincinnati, OH 45202

Dear John:

This letter of agreement ("Agreement") confirms the terms under which Cincinnati Retirement System ("Client") has engaged Buck Consultants, LLC ("Buck Consultants") to perform certain employee benefit consulting services as more particularly described in Exhibit A attached hereto (the "Services"). The contractual terms under which Buck Consultants and Client are undertaking this engagement are as follows:

1. The Services. In consideration for, and subject to, the mutual undertakings set forth herein, Buck Consultants agrees to provide the Services described in Exhibit A to this Agreement.

2. Client Information. To enable us to perform the Services, Client will promptly provide Buck Consultants with such direction, materials, information and access to its representatives as Buck Consultants reasonably requests. Please note that Buck Consultants does not take responsibility for verifying the accuracy or completeness of information supplied to us by Client representatives. If Buck Consultants receives inaccurate, incomplete or improperly formatted information, Buck Consultants shall have no liability for relying on the same and any additional time and expense required to correct the information will be billed to Client as additional Services.

3. Term and Termination. The initial term of this Agreement will be three months beginning April 1, 2008 and ending June 30, 2008. In the event of a material breach of this Agreement, the non-breaching party will have the right to terminate this Agreement by ten (10) days prior written notice.

4. Fees and Expenses, Invoicing and Payment. For and during the term of this Agreement, Client will pay Buck Consultants the Fees specified on Exhibit B hereto ("Schedule of Fees") and subject to the payment terms set forth therein.

2090 Florence Avenue, Suite 101 • Cincinnati, OH 45206-2473
513.784.0005 • 513.784.9734 (fax)

5. Limited Warranty. Buck Consultants warrants to Client that the Services performed under this Agreement will be performed in accordance with generally accepted industry standards. ANY AND ALL CLAIMS SHALL BE MADE WITHIN ONE YEAR FROM THE DATE THE ALLEGED FAULT OR ERROR WAS MADE OR SHALL BE FOREVER BARRED.

6. Limitation on Liability. Buck Consultants and Client agree that the liability of Buck Consultants in connection with the Services provided hereunder will be limited to direct losses Client suffers as a result of the negligence and/or errors or omissions of Buck Consultants, up to, but in no event to exceed, the amount of the initial annual fee paid to Buck Consultants pursuant hereto or fifty thousand dollars ($50,000.00), whichever is greater.

7. Dispute Resolution; Arbitration. In the event of a breach of this Agreement, or a dispute as to the meaning of this Agreement, or any of its terms which the parties cannot resolve by themselves amicably through direct discussions, the parties agree to submit any such dispute to resolution in the following manner. The parties shall endeavor to resolve the dispute through the use of non-binding mediation. If within ninety (90) days after one party notified the other in writing of the existence of a dispute and the relief requested which it desires to be resolved by mediation, and the dispute is not resolved through mediation, then the dispute shall be resolved by final and binding arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association.

   Within ten (10) days after the failure to agree to an acceptable resolution through mediation, either party may submit the dispute to arbitration and within fourteen (14) days thereafter the parties will cooperate with one another to select an arbitrator. In the absence of agreement on an arbitrator, the arbitrator shall be selected through the rules and procedures of the governing alternative dispute resolution association as referenced above. A hearing by the arbitrator shall be held within sixty (60) days of the arbitrator's appointment, and a decision and resolution must be reached within sixty (60) days of the arbitration hearing. No discovery will be permitted in connection with the arbitration unless it is expressly authorized by the arbitrator upon a showing of substantial need by the party seeking discovery.

   Judgment upon the arbitration award may be entered in any court having jurisdiction. All mediation or arbitration hearings shall be held in Cincinnati, Ohio and all aspects of the same shall be treated as confidential. Each party shall bear its own cost of presenting its case, including one-half (1/2) the cost of mediation. In the event of arbitration or litigation to enforce the terms of this Agreement or any arbitration award, the prevailing party will be entitled to recover its reasonable attorney's fees and related court and/or arbitration costs. The arbitrator shall have no authority to award damages inconsistent with the terms of this Agreement and the parties expressly waive their right to obtain such damages in arbitration or in any other forum. Decisions of the arbitrator shall be in writing and will be final and binding on the parties.

8. Confidentiality. Both Buck Consultants and Client recognize that in the course of this Agreement information will be exchanged consisting of confidential trade secret or business information

   ("Confidential Information"). Each party shall treat the other party's Confidential Information as it would treat its own confidential trade secret or business information.

9. Independent Contractor. All of the Services provided by Buck Consultants will be rendered in its capacity as an independent contractor. None of the terms set forth in this Agreement will be

interpreted to create any agency, master-servant, employment or any other relationship between Client and Buck Consultants. Buck Consultants does not accept any fiduciary or trust responsibilities in connection with the performance of the Services.

10. Excuse of Performance. No liability shall result from delay or non-performance by Buck Consultants or Client caused by an act of God, terrorist act, fire, war, action, labor trouble or shortage or similar circumstances beyond the reasonable control of Buck Consultants or Client.

11. Complete Agreement; Governing Law; Compliance with Laws; No Assignment Amendment. This writing contains the entire agreement of the parties with respect to the matters dealt with herein, supercedes all previous agreements between the parties with respect to the matters dealt with herein, and there are no promises, understandings or agreements of any kind pertaining to this Agreement other than stated herein. This Agreement will be construed and enforced in accordance with the laws of the State of Ohio. The parties agree to comply with all provisions of law applicable to this Agreement and the Services to be performed hereunder and with all applicable rules, regulations, orders and directives of all governmental bodies having jurisdiction. Client may not voluntarily or involuntarily assign its rights or delegate its duties under this Agreement to any person without the prior written consent of Buck Consultants. This Agreement may be amended only by a writing signed by the parties hereto.

If the foregoing accurately reflects your understanding and agreement, please acknowledge by signing below and returning a duplicate of this Agreement to the undersigned at the address above.

Sincerely,

Matthew H Crouch

Buck Consultants, LLC

The Agreement set forth herein is hereby agreed to and accepted this _____ day of _____, _____.

_____

Cincinnati Retirement System

Exhibit A

Scope of Services

During the term and subject to the conditions set forth in the accompanying Agreement, Buck Consultants will provide the following Services to the Cincinnati Retirement System:

- Estimate a reasonable range for the liabilities for both retirement and medical benefits based on the data summary, plan provisions and actuarial assumptions described in the December 31, 2006 valuation report
- Estimate a reasonable range for the contribution to the plan for 2007
- Estimate a reasonable range for the change in liability for the medical plan under the 3 suggested change scenarios
- Review the actuarial assumptions for reasonableness for both retirement and medical liabilities
- Estimate a reasonable range for the change in assets and liabilities due to the change in investment return assumption from 8.75% gross of fees to 8.00% net of fees, effective December 31, 2006
- Provide a written report summarizing the findings
- Provide advice regarding current benefits and potential changes to benefits to enhance future funding levels and lower employer required contributions
- Provide responses related to the following
    - Any administrative and procedural changes that would reduce costs, including opening to bid provision of health care coverage
    - Any changes in contribution rates, actuarial assumptions, benefit calculations that should be instituted to insure the solvency of the CRS
    - Any reforms that would protect the city of Cincinnati's General Fund from continuously increasing contribution requirements
    - The Task Force should examine all possible improvements and changes that would reduce the long-term liabilities of the taxpayers of Cincinnati
    - Any recommendation should recognize the needs of individuals who retired due to disability, and whose service retirement was not calculated under 2.2%/2.5% upon reaching age 65
- Provide both a retirement actuary and a health actuary to attend a Task Force meeting to answer any questions about the results

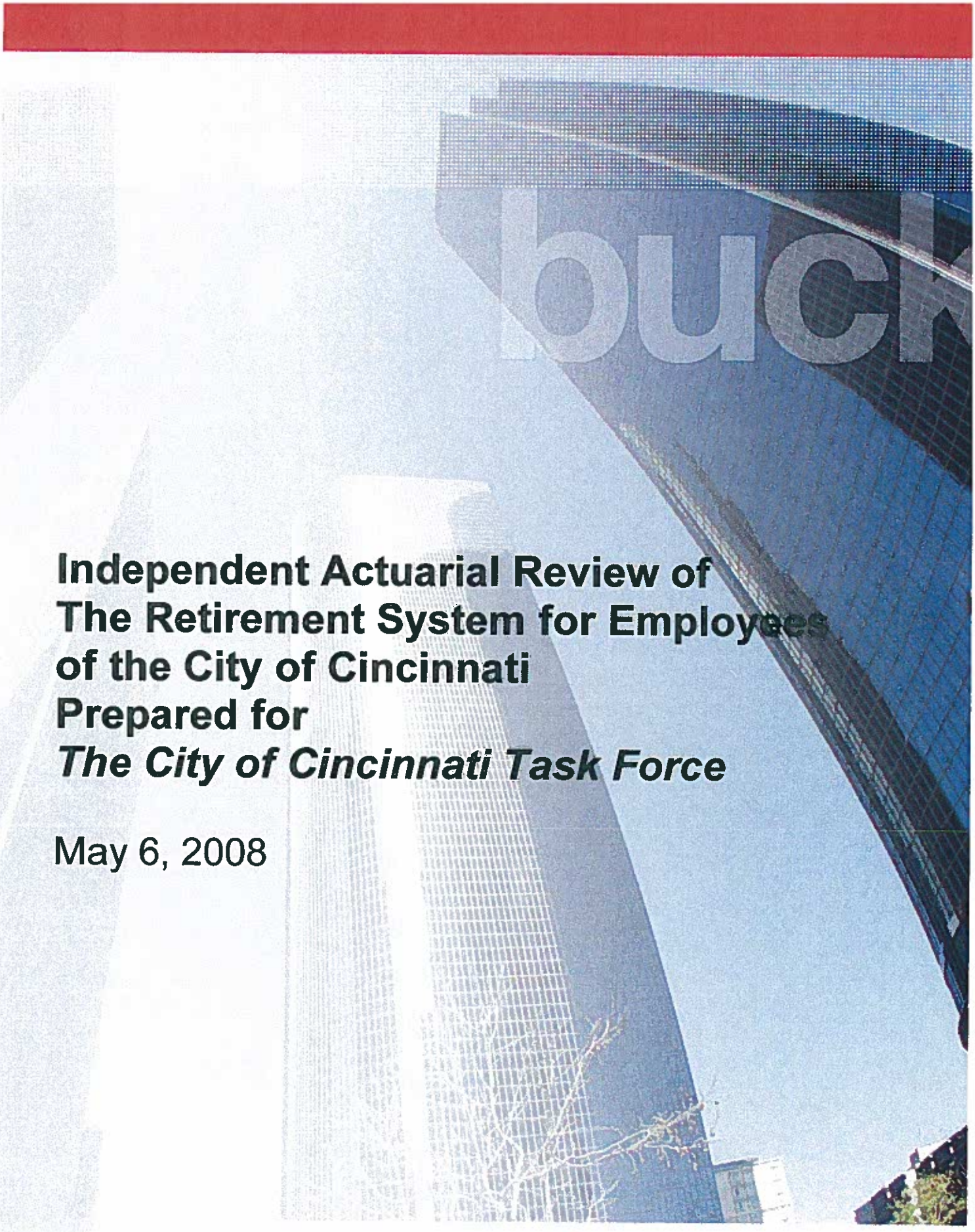
Exhibit B

Schedule of Fees

In consideration of the services provided pursuant to this Agreement, Client shall pay to Buck Consultants the following fees:

Written report to cover service listed in Exhibit A and meeting With Task Force to discuss and answer questions:	$12,500
Additional meetings between Task Force and Buck actuaries from Retirement and health fields	$ 1,000

Attachment E



Independent Actuarial Review of The Retirement System for Employees of the City of Cincinnati

Prepared for

The City of Cincinnati Task Force

May 6, 2008

buckconsultants
an ACS company

EXECUTIVE SUMMARY

The Cincinnati of Cincinnati Task force has asked Buck Consultants to perform an independent actuarial review of the recent actuarial calculations provided to the Retirement System for Employees of the City of Cincinnati. Below are the highlights of our review:

1. We find that the results as of December 31, 2006 are within our expectations. Our estimated Present Value of Benefits and Accrued Liability was 6.85% and 1.50% higher than Mercer's reported result, respectively. Actuarial Standards of Practice generally require two different actuaries to generate results within 5% of each other in order to call it a "match". However, given that we did not have the actual data and had to make estimates, being slightly outside this 5% range is not cause for concern. **Note that in matching we valued the total liability including the credit due to the Medicare Part D Subsidy (which is not allowed to be recognized under GASB).**

2. We estimated an expected reduction of $62.8 million as of December 31, 2007 from switching current actives to an "80/20" PPO. This was very close to Mercer's estimate of $64.5 million.

3. Our review of the actuarial assumptions that Mercer utilized in the valuation is summarized as follows:
   - An 8% discount rate is within standards of practice for public plans
   - The amortization period (currently 15 years) for funding the shortfall could reasonably be extended to 30 years for benefits other than the Early Retirement Window, which should be amortized over a shorter period
   - Retirement rates are currently age based (maybe move to age & service based)
   - The Group 1 female spouse participation rate of 25% may be low

4. Keeping benefits at the current levels and contributing $40,000,000 per year results in a stable funded status over the short term, but eventually the funded status declines because the contribution is not adjusted for inflation. A policy of contributing the normal cost plus a 30-year open amortization of the shortfall is projected to maintain a funded status of about 92%.

5. The current plan design of the post-retirement medical plan is richer than the average employer, according to the 2007/2008 Survey Report on Employee Benefits from Watson Wyatt Data Services. The survey also shows that current retiree contributions (Group 1) are much lower than other employers, with the new structure for Group 2 retirees being slightly higher as a percentage of total cost than the other employers in the survey (57% versus 45%-47%).

6. Several potential plan design alternatives/programs for the post-retirement medical plan are summarized in Section 8.

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SECTION 1: ESTIMATED LIABILITY FOR POST-RETIREMENT HEALTHCARE

We have performed an estimate on the valuation liability for the post-retirement healthcare (medical, dental, and vision) plan and come up with an estimate based on the data summary, plan provisions, and actuarial assumptions described in the "Retirement System for Employees of The City of Cincinnati Actuarial Valuation Report as of December 31, 2006" prepared by Mercer. Please keep in mind that this was only an estimate and not a range determined by a detailed valuation process.

We have estimated the Present Value of Benefits (which is the complete and total expected liability of the plan for all participants who are currently retired or actively working including prior and future service) as of December 31, 2006 to be **$1,066,000,000**. The Present Value of Benefits as calculated by Mercer as of December 31, 2006 is **$997,643,922**. Our estimate is 6.85% higher than the Mercer reported result, which is a reasonable difference given that we did not have exact data and had to make several estimates.

Range for Actuarial Accrued Liability (the portion of the Present Value of Benefits that is allocated for service-to-date) as of December 31, 2006 is **$918,000,000**. The Actuarial Accrued Liability as calculated by Mercer as of December 31, 2006 is **$904,423,237**. Our estimate is 1.50% higher than the Mercer reported result.

The following were the assumptions that we made in our estimate:

- We valued the total liability including the credit due to the Medicare Part D Subsidy (which is not allowed to be recognized under GASB).
- We did not have actual census data for full-time employees, so we assigned an age and service based upon the data summary in the Mercer Report as of December 31, 2006.
- We did not have actual census data or a data summary for part-time employees, so we estimated their demographics.
- Based on information supplied by the City, we assumed that 58% of all active employees are male and 59% of all retirees are male.
- We did not have the complete 2006 City of Cincinnati Rate of Termination Experience Table (only rates for ages 25, 30, 40, 50 and 60 were shown in the Mercer Report). Interpolation was used to estimate rates for the other ages.
- We did not have the complete 2006 City of Cincinnati Disability Experience Table (only rates for ages 25, 30, 40, 50 and 60 were shown in the Mercer Report). Interpolation was used to estimate rates for the other ages.

SECTION 2: ESTIMATED IMPACT TO LIABILITY FOR POST-RETIREMENT HEALTHCARE UNDER THREE SCENARIOS

Prior to January 1, 2008 the City of Cincinnati has a post-retirement medical plan in place in which the City pays for approximately 96% of all out-of-pocket expenses (services) with the participants paying the other 4% in the form of deductible, copays, or coinsurance. These percentages do not take into account the contributions (i.e. $64.20 or $62.40 for the HMO). On January 1, 2008 the City is changed the plan design for future retirees to be the same as the active medical plan (which is an "80/20" PPO plan) with some minor tweaks to the retiree contributions. Per the City's request, we have estimated the savings as of December 31, 2007 for the post-retirement healthcare plan under the following three scenarios:

1) Current plan of benefits (96/4) for current retirees and 80/20 for actives

2) 80/20 for current retirees and actives

As in Section 1, note that these are estimates and not values determined by a detailed valuation process. We performed relative value analysis on the retiree Indemnity, PPO, HMO and active 80/20 PPO to determine the difference in cost and assumed that the retiree contributions for Group 1 retirees in the 80/20 PPO to be equal to the actives, and the "point system" for Group 2 (with a floor contributions equal to the actives).

Below is a summary of the savings to the Accrued Liability (AL) as of December 31, 2007:

	Buck	Mercer	Difference
1) Grandfather Current Retirees, New Retirees 80/20	$62,800,000	$64,500,000	$1,700,000
2) All Retirees Move to 80/20 Plan	$151,300,000	N/A*	N/A*

**Mercer did not provide an estimate as of December 31, 2007 for this plan change. Mercer did provide and estimate for this change as of December 31, 2006, however, they also provided a valued for the change due to 1) of $90,000,000, which is much different than $64,500,000 (we therefore concluded that the plan change being valued was significantly different from the December 31, 2006 and December 31, 2007 Report).*

SECTION 3: RANGE OF CONTRIBUTIONS TO THE PLAN FOR 2008 AND 2009

The City's funding policy uses the valuation contribution results to set the contribution rate for the second succeeding year. The contribution for 2008 is based on the December 31, 2006 valuation; the contribution for 2009 is based on the December 31, 2007 valuation. A summary of the contributions is as follows:

	2009		2008	
	Dollar	**% of Pay**	**Dollar**	**% of Pay**
Normal Cost	$32,569,388	21.91%	$34,208,326	21.52%
Employee Contributions	$10,848,052	7.30%	$11,596,852	7.30%
City Normal Cost	$21,721,336	14.61%	$22,611,474	14.22%
Amortization Payment	$29,301,420	21.29%	$38,922,823	24.49%
City Contribution	$53,376,572	35.90%	$61,534,297	38.71%

The Normal Cost represents the annual cost of the plan. For CRS, the normal cost is calculated to remain level as a percent of pay as long as the assumptions, plan provisions and group characteristics remain the same. The employees contribute a fixed percent of pay to the plan in the form of member contributions. The City is responsible for the remainder of the plan liabilities. Currently, over half of the City contribution is an amortization payment for unfunded actuarial accrued liabilities. The City's funding policy is to amortize unfunded actuarial accrued liability generated each year as a level dollar over a closed 15-year period. Liabilities generated by the early retirement window are to be amortized over 15 years using an increasing schedule of payments that levels off in year 5. Note that if the plan had enough assets to cover the liabilities of the plan, the City Contribution would be comprised of its portion of the normal cost.

In the public sector, much latitude exists when financing the unfunded actuarial accrued liabilities of the system. There are no minimum or maximum funding requirements similar to those that exist in the corporate world. The Governmental Accounting Standards Board, or GASB, establishes a maximum period before a Net Pension Obligation is on the books of the employer. That maximum period is generally a 30-year amortization determined as a level percent of pay. If the amortization period is extended to a 30-year level percent of pay amortization period, a summary of the 2008 and 2009 contributions would be:

	2009		2008	
	Dollar	**% of Pay**	**Dollar**	**% of Pay**
Normal Cost	$32,569,388	21.91%	$34,208,326	21.52%
Employee Contributions	$10,848,052	7.30%	$11,596,852	7.30%
City Normal Cost	$21,721,336	14.61%	$22,611,474	14.22%
Amortization Payment	$17,120,223	11.51%	$19,290,382	12.14%
City Contribution	$38,841,559	26.12%	$41,901,856	26.36%

SECTION 4: RANGE OF CHANGE IN ASSETS/LIABILITIES

Liabilities

The task force asked for a reasonable range for the change in assets and liabilities due to the change in investment return assumption from 8.75% gross of fees (8.40% net) to 8.00% net of fees, effective December 31, 2006. Mercer provided us with the retirement plan and post-retirement healthcare projected cash flows, and we have assumed that these are correct and used these as the basis for the liability calculations below. When we discounted the Mercer cash flows at 8.00%, we calculated a present value of benefits (not accrued liability) of $997,643,917. This is $5 lower than the $997,643,922 as stated in the report (which is the sum of $584,317,911 for inactives and $413,326,011 for actives from page 6 of the report).

The calculation of discounting items back to the valuation date is a simple exercise such that there should not be any variance between two actuarial firms since we matched the current present value of benefits. We have calculated a projected increase to the present value of benefits of $49,881,603 (or 5.26%) as a result of decreasing the discount rate from 8.75% gross of fees to 8.00% net of fees. Since we were not provided the cash flows for the accumulated liabilities, we will provide a range for the impact on the accumulated liabilities due the discount rate change. **This range is $44.7 million to $45.7 million for the accumulated liability for post-retirement medical.**

The discounted Mercer pension cash flows at 8.00% that we calculated at $1,971,525,208 was close (within 0.15%) to the accrued liability (not the present value of benefits) of $1,968,675,503 (which is the sum of $1,349,628,548 for inactives and $619,046,955 for actives from page 7 of the report). **We have calculated a projected increase to the accumulated liability of the pension plan of $88,482,874 (or 4.70%)** as a result of decreasing the discount rate from 8.75% gross of fees to 8.00% net of fees.

Assets

Unlike the corporate accounting world where the discount rate and the rate of return assumptions are determined independently and are almost always different, the investment return assumption in the public sector is used to discount benefit cash flows to determine the liabilities of the retirement system. The change in investment return above is captured in the liabilities above; there is no immediate change to the asset values used in the valuation. However, when determining future contributions of the system, lower returns on the system assets are assumed, resulting in higher contribution requirements. An additional impact on the assets involves the development of the actuarial, or smoothed value, of assets used to determine contribution requirements under the plan. Under the actuarial value, the assumed investment return is reflected immediately each year. The difference between the assumed return and the actuarial return is reflected over a 5-year period. The reduction in the investment return has the affect of more conservatively reflecting the asset return over the course of time.

SECTION 5: REVIEW OF RETIREMENT SYSTEM ASSUMPTIONS AND METHODS

We have reviewed the assumptions and methods used in the "Retirement System for Employees of The City of Cincinnati Actuarial Valuation Report as of December 31, 2006" as prepared by Mercer Human Resource Consulting. We have also reviewed the "Demographic Experience Analysis" presentation dated November 2, 2006, also prepared by Mercer. We have not attempted to replicate the results of the experience review presentation. Below we address the overall appropriateness of each assumption and method based on the information available:

Assumptions

Actuarial assumptions are used to estimate the amount of benefits to be paid in the future. There are two broad types of assumptions: economic, or money assumptions, and demographic, or people assumptions. Economic assumptions include expectations for investment returns, medical and wage inflation, and salary increases. Demographic assumptions include when and if people are expected to terminate, become disabled, retire or die. Our review of the assumptions is as follows:

Investment Return: In the public sector, the investment return assumption for pensions is used not only to project assets of the retirement system, but also to discount the benefit cash flows of the system to determine the liabilities. The assumption is typically based on the long-term expectation of the asset return based on the system's asset allocation. The asset class allocation targets from the December 2007 Investment Policy is as follows:

Asset Class	Target %
Domestic Equity	43.5%
International Equity	17.0%
Fixed Income	17.0%
Alternative Assets	22.5%
Total	**100.0%**

The above allocation does support the use of an 8.00% net investment return currently used by the retirement system. This return is within the range of investment returns commonly used in the public sector, which is currently 7.75% to 8.50%. This range has narrowed considerably from the broad 7.00% to 9.00% observed within the past 10 years. In addition to the advice of the actuary, the advice of the system's investment consultant should also be sought out to assist in the determination of the appropriateness of the 8.00% return over the long term.

Governmental Accounting Standards Board (GASB) statement 43 and 45 dictate the considerations to use when determining the investment return assumption for post-retirement health care benefits. If these benefits are not actuarially funded, the return

SECTION 5: REVIEW OF RETIREMENT SYSTEM ASSUMPTIONS AND METHODS (CONTINUED)

assumption used is based on the returns generated on internal funds, which is currently around 4.00%. If the benefits are actuarially funded, as is the case for the Retirement System, the investment return is determined in the same fashion as pensions. Assuming the post retirement health care benefits will be fully funded on an actuarial basis, the 8.00% assumption is appropriate.

Mortality: The mortality assumption is generally based on standard industry tables adjusted to account for observed deviations in experience. In addition, the assumption is usually set with a level of conservatism to account for future increases in life expectancy. The current table, the UP 1994 mortality table projected to 2009, provides for future improvements in mortality and is appropriate. In the future, consideration should be given to generational mortality tables, which automatically update life expectancies. While currently not an industry standard, this likely will become the standard within the next decade.

The mortality assumption currently used for post-retirement is also used for pre-retirement purposes. Generally members do not die directly from the active population, but terminate or become disabled before dying. To account for this, it is common to use 50% to 75% of the post retirement mortality as a pre-retirement mortality assumption. The impact of such a change is generally minor, but should be given consideration.

Turnover: Turnover is generally set using a select and ultimate pattern, which means that termination is high in the first few years of a career and then levels off and become based on age instead of service. The current assumption is based on this type of pattern. The sample rates of the 2006 City of Cincinnati Rate of Termination Experience Table provided by Mercer in the report are consistent with our expectations for a governmental agency and are appropriate.

Disability: The sample rates of the 2006 City of Cincinnati Disability Experience Table provided by Mercer in the report are lower than our expectations for a governmental employer (which means we would expect to see a higher rate of disability). Disabilities generally occur at a rate of 4 disabilities per year per 1,000 lives – and given the physical nature of many of the City's jobs, we would expect this rate to be higher for the City of Cincinnati. However, adjusting this table would have only a minor impact on the post-retirement medical plan liability. All that being said, disability is very dependent on how the claims are administered by the Retirement System. Recent experience in the experience review indicates that the reduction in the disability assumption is warranted, and the assumption seems appropriate given the current level of disabilities.

SECTION 5: REVIEW OF RETIREMENT SYSTEM ASSUMPTIONS AND METHODS (CONTINUED)

Salary: The salary assumption is typically disclosed as three components: base inflation, productivity and merit and longevity. The base inflation and merit and longevity components combine to make the base wage inflation. These components are not identified separately. The current assumption used is based on service, with rates starting at 7.50% in the first year of service and declining to 4.00% for service from 30 years of service and above. Based on the demographic assumption presentation, this presentation appears to be appropriate. The rates indicate that the base wage inflation is 4.00%. From this a base inflation component of 2.5% to 3.5% with a corresponding productivity component of 1.5% to 0.5% can be inferred. All of these amounts are reasonable assumptions. The merit component starts at 3.5% at hire and declines to 0.0% after 30 years. This is a typical pattern that we see in the public sector, and again, is reasonable.

Retirement: As noted in the experience review presentation, the retirement patterns are largely based on the past experience of the plan, which is appropriate. The rates are based on age, which can be appropriate for age based service, such as age 60 and 5 years of service, but may not be appropriate for service based retirement such as 30 and out. It is not clear whether a retirement assumption based on service was considered. The general levels of retirement shown are consistent with what we have seen in the public sector systems. The large increase in the number of reduced early retirements should be explored to make sure that other one time influences, such as early retirement incentives, did not contribute to the increase.

Medical Claim Costs: The Pre-Medicare eligible costs of $12,958 for Group 1 and $13,033 for Group 2 as well as the Medicare eligible costs of $4,888 for Group 1 and $4,639 for Group 2 are the highest we have ever observed on any post-retirement medical valuation. However, we feel that given the richness of the benefits offered, these claim costs are in line with expectations – although please keep in mind that we did not have the opportunity to review actual claims data.

Medical Trend Rates: The initial (first year) trend of 8.5% for Pre-Medicare is somewhat lower than what we would like to see. Currently, 10% is generally the lowest we employ for Pre-Medicare. Medicare eligible (first year) trend of 9.0% is reasonable, we would not (in the current environment) select a lower first year rate however. We are aware of the many published medical trend surveys which report medical costs increasing at rates of 6% to 8% - but please keep in mind that most of these surveys do not adjust for plan design and/or contribution differences (so plans that become less rich due to benefit

SECTION 5: REVIEW OF RETIREMENT SYSTEM ASSUMPTIONS AND METHODS (CONTINUED)

cutbacks artificially deflate the survey's results). The ultimate trend rate of 5.0% is reasonable, we have seen 4.5% utilized but would not typically go any lower than 4.75% in the current environment.

Medical & Rx Aging: The aging rates shown on page 27 of the report are in line with our expectations.

Participation: The 100% assumption for Group 1 is exactly what we would expect. We also agree with the methodology of selecting participation rates by retiree contribution percentage for Group 2. However, we might expect a higher percentage than 80% to elect coverage at the 25% cost share. Also, given the high claims cost, the participation rates may be lower than 50% for both the 50% and 75% cost share groups. We really do not have a strong argument against the table on page 27 of the report but as Mercer mentions, it may be that actual experience results in significant revisions to this table as it becomes available.

Medicare Reform Impact: The Medicare Part D Annual Subsidy amounts of $570 for Group 1 current retirees and $560 for all other retirees are outside the range we typically see, but we believe these are reasonable based on the prescription drug plan design and claim costs for the City. All of the assumed subsidy amounts are over 24% higher than what was assumed for the 12/31/05 valuation (while at the same time claim costs increased only 12% on average). The 2006 subsidy reconciliation should have been completed or will be soon – those results should be compared on a per participant basis to the assumed costs.

Other Health Benefits (Medicare Part B): The assumed increases for Medicare Part B are in line with our expectations.

Other Health Benefits (Dental): The assumed claim costs and annual trend increases are in line with our expectations.

Other Health Benefits (Vision): The assumed claim costs are in line with our expectations. However, the 3% trend rate will eventually lead to a claims cost that is higher than the maximum benefit. Note though that any change to the vision trend rate would have a de minimus impact on the valuation liability.

SECTION 5: REVIEW OF RETIREMENT SYSTEM ASSUMPTIONS AND METHODS (CONTINUED)

Option Electives: 75% of male participants and 25% of female participants having a spouse who is covered under medical, dental, and vision seems to be appropriate to us for the Group 2 employees. However, we feel that a higher percentage of Group 1 female participants would have a spouse that would also elect medical since the plan of benefits is very rich and the contributions would be $0 in most cases.

Actuarial Methods

While actuarial assumptions are used to estimate the value of benefits to be paid in the future, actuarial methods are used to determine how the benefits are to be funded. Our review of the actuarial methods follows.

Actuarial Cost Method: The purpose of the actuarial cost method is to allocate the costs of the benefits of the system over time. The actuarial cost method of the retirement system is the entry age normal cost method. Under the entry age normal cost method, the retirement benefit costs of an active member are funded as a level percent of the members payroll over the member's career. The level percent of pay feature results in a more level contribution pattern than other methods. It also results in current taxpayers paying for the services of the member while the member is still working. The entry age normal cost method is used by three-quarters of all public retirement systems in the United States. We believe that its use is appropriate.

Asset Valuation Method: For purposes of determining the contribution requirements, an actuarial, or smoothed value, of asset is commonly used in the actuarial valuation of public retirement systems. For the Retirement System, the asset valuation method used reflects the assumed rate of return immediate and phases in the difference between the actual return and the expected return over 5 years. The effect of this method is that the contributions are more level than they would have been without the asset valuation method in place. We believe that the method is appropriate.

Amortization Method: The unfunded actuarial accrued liability of a public retirement system is generally amortized, or paid off, over several years. The retirement system policy was established for the December 31, 2003 valuation. At that point, the unfunded actuarial accrued liability of the system was amortized as a level dollar amount over a closed 15-year period. Unexpected changes in unfunded actuarial accrued liability that have occurred with each subsequent valuation have also been amortized in a similar fashion. Unlike the world of corporate pensions where the amortization method is prescribed, there is a fair amount of latitude in the public sector. The selection of the amortization method tends to be a trade off between affordability and benefit security.

SECTION 5: REVIEW OF RETIREMENT SYSTEM ASSUMPTIONS AND METHODS (CONTINUED)

The primary decisions when selecting an amortization method are:

- The amortization period is the number of years over which the unfunded liability is amortized. It is analogous to the term of a mortgage. The Governmental Accounting Standards Board (GASB) statements 25 and 27 for pension and 43 and 45 place a limit of 30 years on the amortization period. If the period used is longer than 30 years, a net pension obligation is put on the books of the sponsor. When contributions increase rapidly, there is a tendency among public sector retirement systems to extend the amortization to 30 years to lower contributions. Unfortunately, there is not a tendency to lower the amortization to keep contributions from decreasing when contributions are otherwise determined to be lower. Some retirement systems chose to implement a policy where the contribution rate is fixed from year to year and solve for the amortization period. As long as the resulting amortization period is under 30 years (or some other policy amount), the contribution amount can remain at the predetermined level. If the amortization period exceeds the policy amortization period, the contribution is increased until the underlying amortization period is less than the policy.

- Amortization periods are determined to be either *closed or open.* A closed method works similar to a traditional mortgage. For CRS, the amortization method is a 15-year closed method, which means that after 15 years of making payments towards a portion of the unfunded liability, that unfunded liability is paid off. Under an open method, the unfunded liability is amortized over the same period year after year. Theoretically, the unfunded liability is never paid off. Many retirement systems use open periods for the total unfunded liability of the system, as opposed to the closed method with many bases used under CRS.

- The amortization method can either be *level dollar* or *level percent of pay.* The level dollar method is similar to a traditional mortgage. The payments are determined in such a way that the *dollar* amounts do not change from year to year. The CRS amortization amounts are determined as a level dollar. A more common approach in the public sector is to determine amortization amounts as a level percent of pay. Under level percent of pay amortization, the amortization payment is determined in such a way that the rate stays level as a percent of pay. The dollar amounts increase with payroll. This treatment is common in the public sector because of the prevalence of the entry age normal cost method. To fund on a level percent of pay basis, both the level percent of pay entry age normal cost method must be used and the amortization method must be determined as a level percent of pay. The current method of using level dollar amortization and level percent of pay cost method is internally inconsistent and should be reviewed.

Section 5: Review of Retirement System Assumptions and Methods (continued)

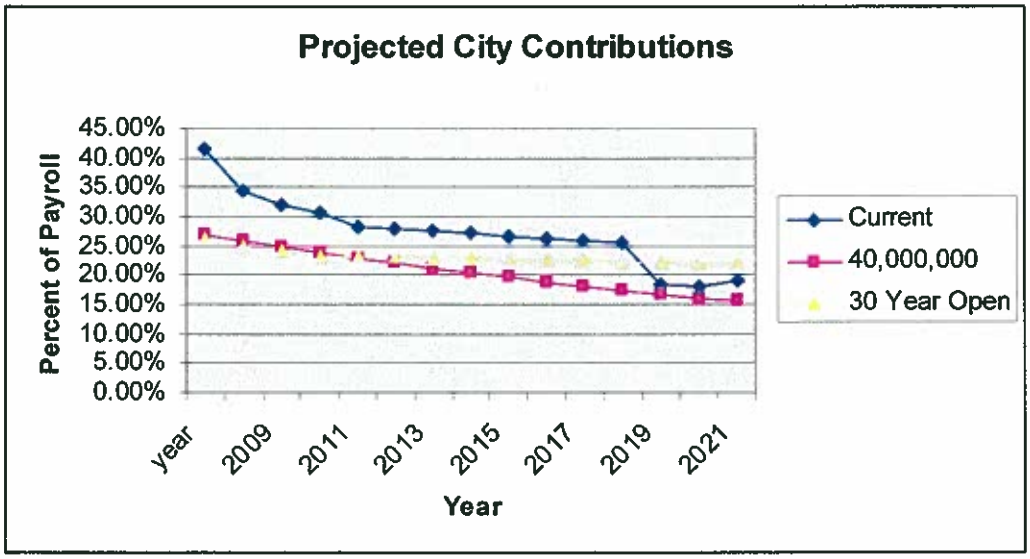
The amortization method is a significant contributor to the contribution pattern of the retirement system. We encourage policy makers to review the current amortization method. We have projected contributions using the current and alternate amortization methods commonly used in the public sector.

SECTION 6: PROJECTED CONTRIBUTIONS AND FUNDED STATUS

We have developed a 15-year projection of the projected City contributions and funded status of CRS under three alternate funding scenarios:

- The current policy of funding
- City contributions of $40,000,000 per year
- A thirty-year open level percent of pay amortization

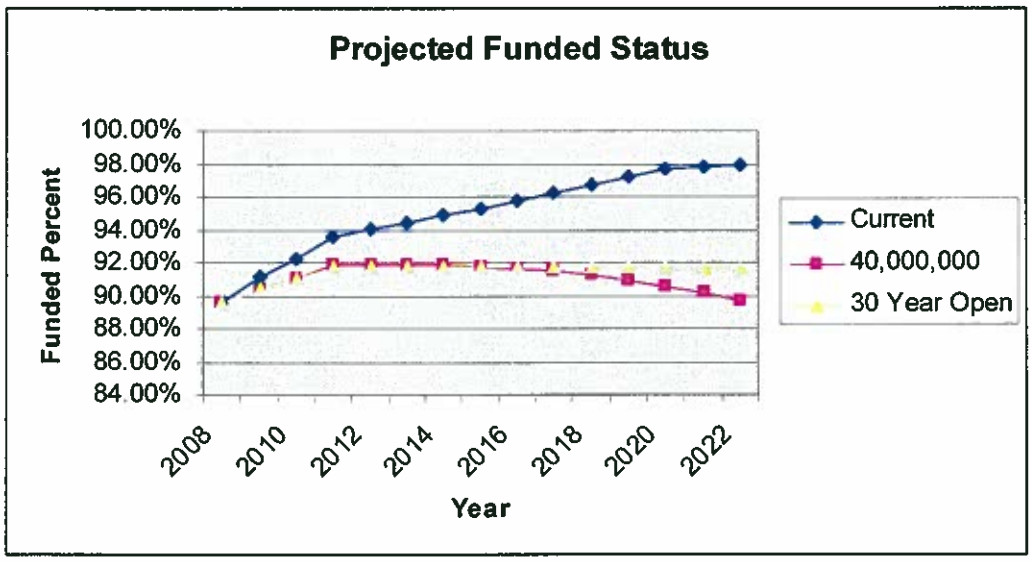
A projection of the percent of payroll contribution is as follows:



The total projected dollar contributions over the 15-year period are $785, $600 and $685 million for the current policy, $40 million per year, and 30-year open level percent of pay amortization, respectively.

SECTION 6: PROJECTED CONTRIBUTIONS AND FUNDED STATUS (CONTINUED)

The projected funded status over that period of time is depicted in the following graph:



Predictably, the current policy results in the highest funded status, effectively reaching 100% funded status in 15 years. A policy contributing $40,000,000 per year results in a stable funded status over the short term, but eventually the funded status declines because the contribution is not adjusted for inflation. The funded status continues to decline beyond the 15-year period. The 30-year open policy is projected to maintain a funded status of about 92%. This stays remarkably level well after the 15-year projection period, primarily because the contribution is adjusted for wage inflation.

The Early Retirement Window is currently being amortized over a 15-year period. Best practices suggest that the cost of an Early Retirement Window be paid off over a period that does not exceed the payroll savings period. Generally this is 5 years or less.

SECTION 7: BENCHMARKING POST-RETIREMENT MEDICAL

Compiled below is summarized information from the 2007/2008 Survey Report on Employee Benefits from Watson Wyatt Data Services on pre-65 retirement medical plans for all employers. Post-65 retirement medical plans are not contained in the survey – information for comparative purposes for post-65 plans is hard to capture due to Medicare integration with the employer plan. We wanted to compare the City to all employers (as opposed to just other municipalities) as more than likely the City does not compete for employees with other governmental entities. Please note the following on the Survey Results below:

- We used the "2,500 Employees or More" category to compare to the City in each of the items below.
- Only In-Network cost sharing arrangements are displayed.
- Any percentages shown reflect the portion of costs that the plan pays.

Retiree Medical Plan Design Feature (Pre-65)	**City of Cincinnati Current Retiree Medical Plan**				**Survey Result**
	Traditional	**PPO**	**HMO**	**80/20 Plan**	
Single Deductible	$50	$0	$0	$300	$460
Single Out-of-Pocket Maximum	$450	$300	$500	$1,500	$1,878
Office Visit	80%	92%*	100%	80%	90.8%
Inpatient Hospital/Surgery	100%	98%**	100%	80%	86.2%
Prescription Drug Generic Copay	$5	$5	$3	$10	$10
Prescription Drug Brand Copay	$5	$12	$3	$20	$25

**The PPO charges a $10 copay which we estimate to be approximately 92% of the charges.*

***The PPO charges a $100 copay then pays 100% which we estimate to be approximately 98% of charges*

The survey also indicated that 52% of employers had implemented an increase to the deductible in the prior plan year and/or planned to increase the deductible again in the next plan year.

SECTION 7: BENCHMARKING POST-RETIREMENT MEDICAL (CONTINUED)

We also looked at Retiree Contributions. Summarized below is information from the 2007/2008 Survey Report on Employee Benefits from Watson Wyatt Data Services on pre-65 retirement medical plans for all employers. As on the prior page, we used the "2,500 Employees or More" category. **Note that all contributions shown are for retirees who are retiring in 2007.**

Monthly Retiree Contributions	City of Cincinnati 2007 Retiree Medical Contributions (in dollars)*		Survey Result
	Group 1 HMO	Group 1 (Non-HMO)	
Retiree Only Pre-65	$5	$0	$329
Retiree + Spouse Pre-65	$11	$0	$709
Retiree Only Post-65	$5	$0	$168
Retiree + Spouse Post-65	$10	$0	$350

**Have not included Group 2 contributions since there will not be any Group 2 retirees until 2012*

***Estimated the current active population's retirement status for post-retirement medical assuming everyone makes it to retirement eligibility*

However, the City of Cincinnati's plan costs are much higher than those in the Watson Wyatt Survey, so we have provided a table showing the retiree contribution as a percentage of total cost for an apples to apples comparison.

Retiree Contributions	City of Cincinnati 2007 Retiree Medical Contributions (as a % of total cost)*		Survey Result
	Group 1 HMO	Group 1 (Non-HMO)	
Retiree Only Pre-65	<1%	0%	45%
Retiree + Spouse Pre-65	<1%	0%	47%
Retiree Only Post-65	1%	0%	45%
Retiree + Spouse Post-65	1%	0%	46%

**Have not included Group 2 contributions since there will not be any Group 2 retirees until 2012*

The survey also finds that 52% of employers have increased retiree contributions in the prior plan year and/or plan to increase contributions in the next plan year. Additionally, 5% of employers plan on switching to a defined contribution or fixed dollar plan for retiree medical in the near future.

SECTION 8: POTENTIAL CHANGES TO CURRENT HEALTHCARE BENEFITS

As laid out in the previous section, the current medical benefits for the retirees of the City of Cincinnati are higher in value when benchmarked against other employer plans. Below we outline several potential changes to the retiree medical plan, several of which have already been recommended by Mercer in their "Cincinnati Retirement System Alternative Benefit Cost Analysis" report.

1) **Dependent Eligibility Audit:** Ineligible dependents often make their way into the plan. Under such an audit, all dependents are required to send proof that they are legitimate dependents as defined by the plan. A higher number of aunts, uncles, neighbors, pets, etc. are being claimed as spouses and thus getting coverage in employer health plans. This would impact active employees as well as retirees.

2) **Revise Prescription Drug Copays:** Currently there is no difference in cost for generics and brand name drugs for the Traditional (Indemnity) Plan and the HMO which are $5 and $3 for all prescriptions respectively. Putting in a "tiered" copay arrangement for these plans in which the current copay would be for generics only and the brand name copay moving to 3 times the generic copay or $10 more than the generic copay would help to dramatically increase utilization of generic drugs.

3) **Mandatory Mail-Order for "Maintenance" Prescription Drugs:** Prescription drug costs are typically around 60% of the total medical costs for post-65 retirees and 25% for pre-65 retirees, a significant portion of those costs are pharmacy dispensing fees. By having a higher utilization for mail-order drugs, dispensing fees would decrease. This would impact active employees as well as retirees.

4) **Consumerism:** Many employers are incorporating consumerism into their medical plans. There are many possible approaches. One such possibility is to increase the health plan deductibles to $1,000, but then also providing $1,000 to retirees in an account each year. Any unused balance in the account would roll-over to the next year. The theory is that the medical plan design is essentially still the same ($0 cost to the retiree) but that since the account is "his/her money", the retiree will not simply view healthcare as free or inexpensive anymore and will manage their services better.

   Another possibility is to charge higher copayments for all services if the participant is targeted for a disease management program and does not follow the recommended steps.

SECTION 8: POTENTIAL CHANGES TO CURRENT HEALTHCARE BENEFITS (CONTINUED)

5) **Wellness Programs:** Can take many forms, but each has a common goal: to improve employee health and reduce the risk of disease. Common risk factors that wellness programs focus on are tobacco use, poor nutrition, lack of physical activity, excessive stress, and other unhealthy habits. Wellness programs involve raising awareness, health screening, and promoting healthy lifestyles, with a focus on changing employee behaviors and workplace environment and culture. Typical wellness components include, but are not limited to, health risk assessments, onsite health fairs, onsite fitness centers, workplace health "challenges", online healthy lifestyle programs, personal health coaches, gym memberships, and Employee Assistance Programs (EAP).

6) **Communication Audit:** A systematic look at your health and wellness communication vehicles and channels. This review goes well beyond an inventory list of your current communication tools. It is a proactive, strategic analysis to help you evaluate where you are and where you want to be - and will provide actionable steps to get you there. The audit can help manage communication costs by identifying which current communications efforts do not yield benefits to employees and provide the opportunity to improve, eliminate or change those programs accordingly. Healthcare costs can be impacted by employees/retirees taking advantage of wellness, disease management, and consumerism programs.

7) **Medicare Coordination:** Our understanding is that Medicare eligible retirees have their medical claims processed secondary to Medicare on a "coordination of benefits" basis. Of the three potential Medicare methods, "coordination of benefits" results in the highest costs to the plan (and conversely the lowest costs to the retiree). Switching to "exclusion" or "carve-out" would result in savings to the plan by passing more of the cost along to the retiree.

8) **Changing Retiree Medical Plan:** The current retiree medical plans cover approximately 96% of all medical charges, as opposed to 80% for actives. The cost sharing provisions of the retiree medical plans could be changed to mirror the current active medical plans or perhaps increased to somewhere in-between 80% and 96%. Current retirees and actives hired prior to a cut-off date could be grandfathered under the current arrangement. Wellness benefits, such as annual physicals and annual OB/GYN visits, could be left unchanged.

SECTION 8: POTENTIAL CHANGES TO CURRENT HEALTHCARE BENEFITS (CONTINUED)

9) **Eliminating Indemnity Option:** Indemnity plans typically have no networks. So if a non-network provider is visited by the retiree, network discounts are not being applied to the cost of the service. Discounts are typically around 50% for Anthem. Current retirees and actives hired prior to a cut-off date could be allowed to continue with the Indemnity plan.

10) **Revise Retirement Eligibility:** Currently anyone with 30 years of service may retire with post-retirement medical benefits. This allows for many people to retire before age 50. A person's most expensive years for medical costs are between ages 50-64 (since Medicare doesn't apply until age 65). Revising the retirement eligibility to be a minimum age such as 55 would help to cut down on post-retirement costs (but the costs would still be incurred by the City, just on the active plan and not under GASB).

11) **Put Medical Plans Out to Bid:** Perhaps a better administrative fee arrangement and/or better discounts/rebates could be attained than what is currently in place. An RFP for both the medical and prescription drug plans could be sent out to the marketplace. Given Anthem's deep discounts and large network, it is more likely that savings would be achieved on the prescription drug plan versus the medical. Any change would impact not only retirees but the current active employees as well.

12) **Claims Audit:** We believe that the City has already performed such an audit recently, but in the event you have not, we wanted to make sure we mention this possibility. The biggest potential savings result from identifying services that are covered but should be excluded. This would impact active employees as well as retirees. Such audits need not be performed every year - every few years generally is adequate.

Attachment F

City of Cincinnati
Cincinnati Retirement System

Alternatives for Reducing Costs
Presented May 20, 2008

There are four ways to reduce the City's expected future contributions to the Cincinnati Retirement System in either the short or long term:

- Reduce the post-retirement health benefits for either current retirees or current active employees
- Refinance the current shortfall by making amortization payments over a longer period than the current 15 year period
- Reduce the retirement benefits for future hires
- Increase in participants' contributions and cost sharing

Note that the first and fourth bullets can change both short and long term costs. The second point spreads costs from the short term into the long term. The third bullet could change only long term costs.

Please keep in mind throughout the discussion that as of December 31, 2007, the medical benefits are funded at a level of 99% and the pension benefits are funded at a level of 88%. Future contributions could be dedicated to funding more heavily the pension shortfall.

Summary of Current Costs

The cost of the plan is the sum of two items:

- **Normal Cost** – present value of benefits expected to be earned by active participants in the coming plan year.
- **Amortization Charge** – payments to make up any losses based on differences in actual experience compared to that expected by the assumptions used to value the liabilities.

The Normal Cost of the plan, based on December 31, 2007 results, is as follows:

Normal Cost	Dollar Amount	% of Payroll
Pension Benefits	$ 23,300,000	15.7%
Medical Benefits	9,300,000	6.2%
Total Normal Cost	$ 32,600,000	21.9%
Annual Employee Contribution	(10,800,000)	7.3%
Annual City Contribution Remaining	$ 21,700,000	14.6%

The City's portion of the Normal Cost contribution could be reduced by:

- Reducing post-retirement medical benefits of current active participants
- Increasing employee contributions
- Reducing pension benefits for new hires

The Amortization Charges are, based on December 31, 2007 results, as follows:

Year	Payments Remaining	Outstanding Balance	Current Payment	Payment as % of 12/31/07 Payroll
2003	11	$ 117,000,000	$ 15,900,000	10.7%
2004	12	3,000,000	400,000	0.3%
2005	13	(25,000,000)	(3,200,000)	(2.1%)
2006	14	220,000,000	25,800,000	17.3%
2007	15	(85,000,000)	(9,600,000)	(6.3%)
2007 Window	15	42,000,000	2,400,000*	1.6%
Total		$ 272,000,000	$ 31,700,000	21.3%

*The 2007 Window has an increasing amortization schedule reaching approx. $4 million by 2012.

Options for Reducing Costs of Medical Benefits

The liability for post-retirement medical benefits has been greatly reduced for retirees after December 31, 2007 due to the adoption of the 80/20 plan. The liability for the medical benefits breaks down as follows:

	Liability	Normal Cost	NC as % of Payroll
Inactive Members	$ 640,000,000	$ 0	0.0%
Active Members	220,000,000	9,300,000	6.2%
Total	$ 860,000,000	$ 9,300,000	6.2%

There are several methods to reduce medical liabilities and costs. These methods fall into three general categories:

- Reduce plan of benefits
- Increase employee cost sharing
- Long term changes that may not show immediate impact

The attached Exhibit I details some of the options previously presented and the amounts of the associated savings.

Refinance Current Amortizations of Unfunded Liabilities

Exhibit II shows the impact of amortizing the unfunded amount of $272 million over the current 15 year period as a flat amount and over a 30 year period as percentage of payroll. This effectively refinances the debt: the annual payments at 8.00% interest would be approximately $23.2 million or 15.6 % of current payroll and then would create a cash flow savings of $8.5 million per year initially. Note that any period between 15 and 30 years could be chosen and still stay within the bounds of customary practice.

Comments:

- The smoothing method for assets is currently deferring $55 million in gains. This amount serves as a reserve to offset future investment losses under the funding method. This may be

important for 2008 results due to the market losses realized to this point. In some cases it is appropriate to "refresh" to market value of assets for purposes of determining the plan's shortfall. This approach could reduce the amortization amount by $3 to 6 million over the next several years.

- The future payroll is unlikely to increase significantly and may even decrease as the City's workforce is further reduced. In this case a fixed dollar contribution would become a larger percentage of payroll as payroll decreases. However, it may remain constant as percentage of city budget. In addition a level percent of payroll contribution policy based on an expected 4% increase per year may not be realistic if the City's workforce continues to decline in numbers.

As an alternative to funding the System through future contributions, a Pension Obligation Bond (POB) could be issued. The proceeds of the POB would be deposited in the trust, brining the System to one-hundred percent funding. The POB would be paid off outside the trust. Currently, the POB could be issued at a lower rate, say 6.00%, while the proceeds earn a higher rate in the retirement System. In addition, the financing flexibility afforded by POB can be attractive to those responsible for finance. This is a very brief explanation of POBs. Extreme caution should be used when determining the impact of issuing a POB.

Managing Investment Performance

Perhaps the greatest source of volatility that generates amortization bases is the investment performance of the assets in the trust fund. The approximately $2.7 billion in assets presents a challenge to maintain a reasonable rate of growth and minimize losses due to asset market volatility. For example, an investment return of 7% in a year, 1% less than expected from the actuarial model, creates a loss of $27 million that must be made up either through additional contributions or through future investment returns in excess of 8%. A zero percent return for a year would result in a loss of approximately $220 million for funding purposes. These losses are currently smoothed over 5 years based on the asset smoothing method and then amortized over 15 years.

See Exhibit II for examples of how the asset volatility could create large future contributions. Note that under the current funding policy of the Retirement System and the thirty year amortization shown, the impact of a zero percent is recognized over the course of several years and results in modest increases in the contribution. Under the current policy, about one third of the loss created by the zero percent return or $70 million is contributed over the five subsequent years.

One way to minimize future expected contributions is to manage the asset allocation of the trust fund such that the chance that the shortfall gets worse is minimized. Buck's understanding is that a new asset allocation is in place since late 2007 for expressly this purpose. It can be important to fully implement this investment approach so that large asset losses do not increase the amortization amounts.

Reduce Retirement Benefits for Future Hires

The current retirement benefit formula could be reduced for new hires. This might include both the basic benefit of services times 2.2% and the automatic cost of living allowance that is in effect for the current benefit. The impact of these changes is not significant until a large portion of the current active workforce has terminated and been replaced by new employees. Note that we understand that

no reduction can be made in benefits for current active members of the retirement system. Reductions in benefits can only be made for new hires.

Conclusion

There are many options to reduce future costs of the Retirement Plan to the City. None by itself would provide a fix but in combination several of the options presented could bring the System closer to a fully funded position with a sound plan for future benefit accruals and reducing the current shortfall.

Exhibit I
Impact of Changes to Post-Retirement Medical Plan

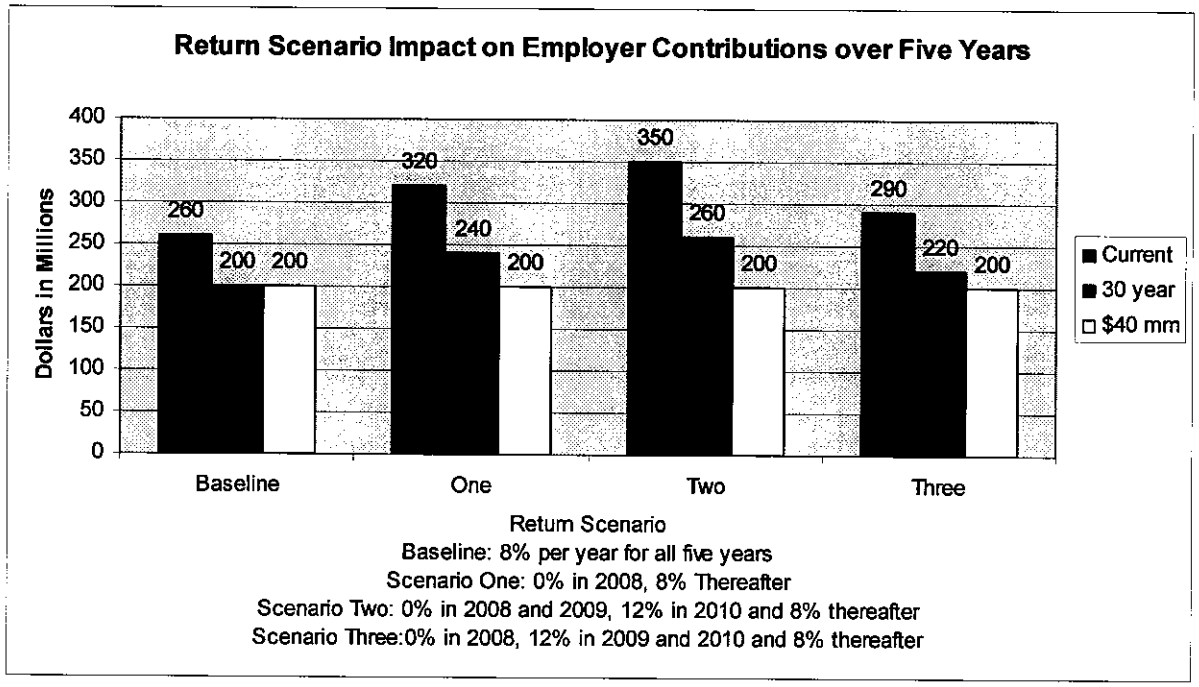
Potential Change to Post-Retirement Medical	Effect of Change	($) Reduction in Liability	($) Reduction in Normal Cost	($) Reduction in Amortization 15 years	($) Reduction in Amortization 30 years
1. Dependent Eligibility Audit	Reduce liability	Up to $5 mil.	N/A	Up to $500,000	Up to $400,000
2. Revise Grandfathered Pres. Drug Co-pays*	Increase participant cost	$15 to 35 mil.	N/A	$1.5 to 3.0 mil.	$1.0 to 2.5 mil.
3. Mandatory Mail-Order for Maintenance Drugs	Reduce liability	Up to $5 mil.	Less than $50,000	Up to $500,000	Up to $400,000
4. Consumerism Plan Replacing 80/20	Various	Up to $5 mil.	Less than $50,000	Up to $500,000	Up to $400,000
5. Wellness Programs	Reduce liability over time	Up to $5 mil.	Less than $50,000	Up to $500,000	Up to $400,000
6. Communication Audit	Reduce liability over time	Up to $1 mil.	Less than $50,000	Up to $100,000	Up to $80,000
7. Change Medicare Coordination Method	Increase participant cost	$45 to 60 mil.	$500 to 600,000	$5 to 6 mil.	$4 to 5 mil.
8. Changing Grandfathered to 80/20 plan	Increase participant cost	$70 to 100 mil.	N/A	$8 to 10 mil.	$6 to 8 mil.
9. Eliminating Grandfathered Indemnity Option	Reduce liability	$20 to 40 mil.	N/A	$2 to 4 mil.	$1.5 to 3.5 mil.
10. Change Eligibility Requirements for Actives	Reduce liability	$2 to 20 mil.	$100,000 to 1 mil.	Up to $2 mil.	Up to $1.5 mil.

Note that a combination of the effect of two or more of these changes does not necessarily add to the total of the individual changes.
Other options that were suggested and their status:

- **Put medical plans out to bid for greater discounts** – the current provider is a low cost provider, likely only small savings to be found here
- **Claims audit** – this was done within the last 12 months and there is no need to perform another one currently
- **Mandatory generic prescription drugs** – the impact of this change is complex and will require more detailed analysis from the current provider

* Assumes brand co-pays of $15 for Indemnity ($5 currently), $15 for PPO ($12 currently) and $10 for HMO ($3 currently)

Exhibit II
Investment Return Scenarios



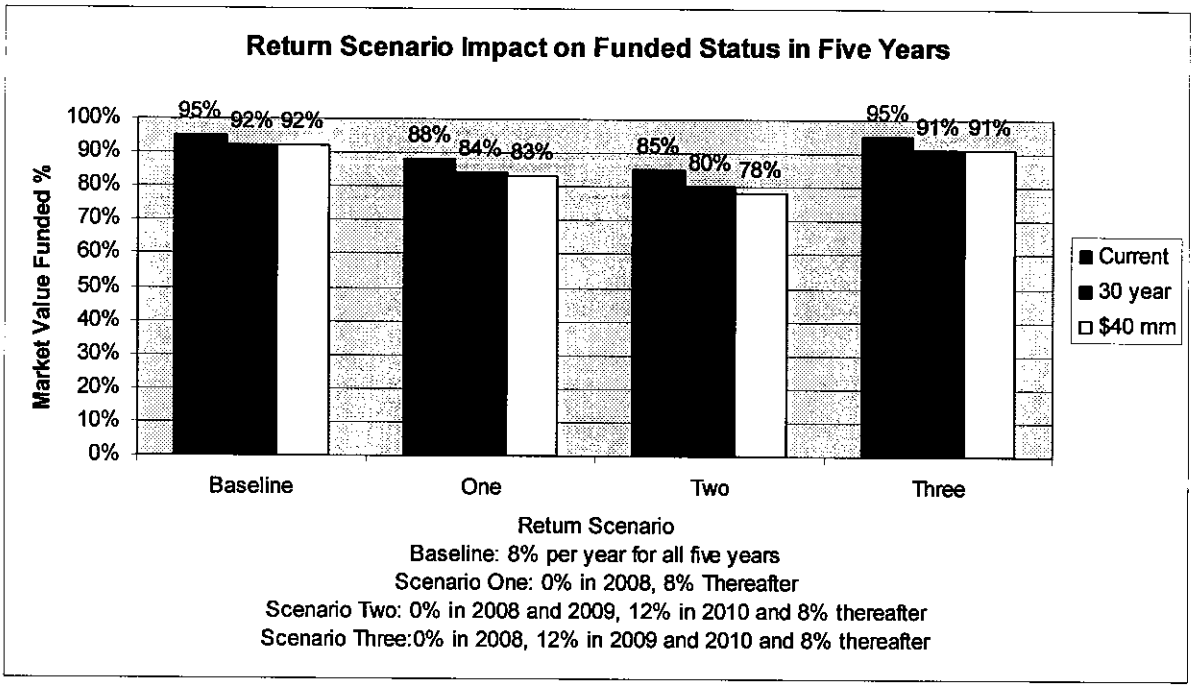
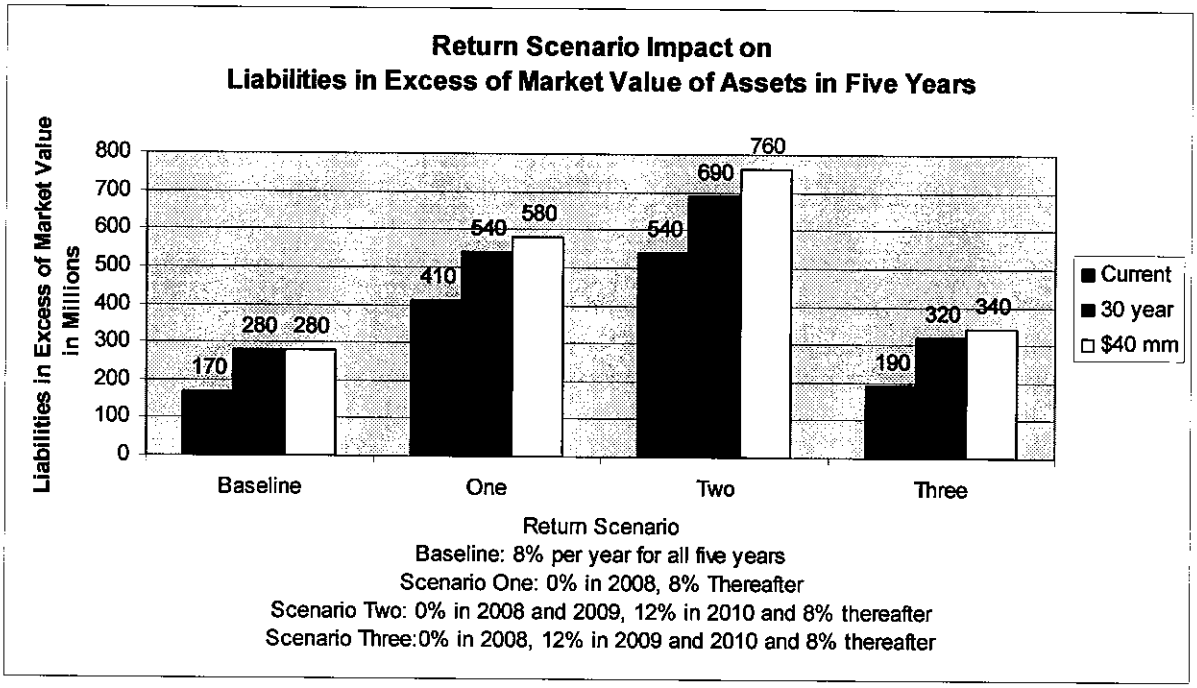


Exhibit II (cont.)
Investment Return Scenarios



Attachment G

POTENTIAL RETIREE MEDICAL PLAN SAVINGS - ANNUAL BASIS

(ALL OF THE FOLLOWING SAVINGS ARE BASED UPON 2006 ACTUAL DATA FOR RETIREES)

				SAVINGS
RECOMMENDATION #1: ELIMINATE THE TRADITIONAL INDEMNITY PLAN OPTION				
2006 TRADITIONAL PLAN MEDICAL SPEND (MEDICAL ONLY - EXCLUDES MEDICARE)		$ 6,457,672.00		
MOVING TO THE PPO PLAN OPTION WOULD REDUCE CRS REIMBURSEMENTS TO PROVIDERS BY 20%			$	1,291,534.40
RECOMMENDATION #2: REVISE THE PRESCRIPTION DRUG COPAYS				
2006 CURRENT RETIREE COPAYS =		$ 1,326,337.00		
MOVING TO A $5 GENERIC, $15 BRAND AND $30 NON-FORMULARY COPAY SCHEDULE				
AND ASSUMING NO NON-FORMULARY PRESCRIPTIONS AND NO OUT-OF-POCKET CAP - RETIREE COPAYS =		$ 2,771,015.00	$	1,444,678.00
WITH A $1,000 OUT-OF-POCKET MAXIMUM (CAP) FOR DRUG COPAYS - RETIREE COPAYS =		$ 1,808,030.00	$	481,693.00
RECOMMENDATION #3: CHANGE THE COORDINATION OF BENEFITS METHODOLGY				
2006 CRS MEDICAL SPEND FOR RETIREES WITH MEDICARE AS PRIMARY PAYOR		$ 7,785,813.00		
RETIREE OUT-OF-POCKET UNDER CURRENT COB METHODOLOGY (ESTIMATE ONLY)		$ -		
RETIREE OUT-OF-POCKET UNDER PROPOSED COB METHODOLOGY (ESTIMATE ONLY)		$ 848,653.61	$	848,653.61
RECOMMENDATION #4: REPLACE THE INDEMNITY PLAN W/MODIFIED PPO PLAN				
2006 RETIREE OUT-OF-POCKET (DEDUCTIBLES,COPAYS & COINSURANCE) MEDICAL ONLY	(1.43%)	$ 335,943.00		
RETIREE OUT-OF-POCKET UNDER MODIFIED PPO PLAN				
($100 DEDUCTIBLE ; 20% COINSURANCE ; OUT-OF-POCKET MAXIMUM OF $1,000)	(10.99%)	$ 2,587,200.00	$	2,251,257.00

TOTAL ANNUAL SAVINGS COMBINED WITHOUT DRUG CAP	**$ 5,836,123.01**
TOTAL ANNUAL SAVINGS COMBINED WITH $1,000 DRUG CAP	**$ 4,873,137.61**

(706 members exceed the $1,000 cap by $962,985)

TASK FORCE RECOMMENDATIONS COST SAVINGS

Attachment H

Gary D. Dickson, FSA
Principal

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MERCER

MARSH MERCER KROLL
GUY CARPENTER OLIVER WYMAN

July 1, 2008

Mr. John Boudinot
Executive Director of CRS
City of Cincinnati
Room 240, City Hall
801 Plum St.
Cincinnati, Ohio 45202

via e-mail

Subject: Benefit Alternatives for the Cincinnati Retirement System

Dear John:

We have completed our calculations regarding the various benefit change alternatives for the Cincinnati Retirement System (CRS). The results are shown in the attached chart. The cost calculations are as of December 31, 2007 and are directly comparable to the results of the actuarial valuation as of December 31, 2007.

We have analyzed the impact of the plan change on four measurements: the unfunded accrued liability, the normal cost, the City's contribution amount, and the funded status. The change in the unfunded accrued liability represents the change in the liability for benefits assigned to past service. For alternatives that apply to new hires, this change is always zero. The change in the normal cost represents the change in the cost of one year's accrual of benefits. For alternatives that apply to new hires, this change was calculated on the total population as if the benefit alternative had always existed. The change in the City's contribution amount reflects the immediate change in the contribution amount. For alternatives that apply to new hires, this change is always zero. The change in the funded status is just another way of looking at the change in the unfunded accrued liability.

For the alternatives that apply to new hires, the cost impact of any change would be realized only as the population turns over from current employees to new employees. The change in normal cost represents the ultimate savings that would be realized once all of the current employees have been replaced. This savings is based on the assumption that the future employee population would have a demographic profile similar to the existing population. If the new population has a different demographic profile, the ultimate cost change could be higher or lower than shown in our analysis.

Description of Alternatives

Provide 80/20 medical plan to retirees under age 65 – Change the retiree medical plan for existing retirees currently under the age of 65 to the 80/20 medical plan. They would continue to be covered by the 80/20 plan after age 65.

Change 30 and out to 33 and out (new hires) – The retirement eligibility condition for an unreduced benefit after 30 years of service would be changed to 33 years of service. This alternative would be applied to new hires only.

Change 30 and out to 35 and out (new hires) – The retirement eligibility condition for an unreduced benefit after 30 years of service would be changed to 35 years of service. This alternative would be applied to new hires only.

Add age 55 minimum for retirement eligibility (new hires) – The retirement eligibility condition for an unreduced benefit after 30 years of service would be changed to include an additional requirement to be at least 55 years of age. This alternative would be applied to new hires only.

Change multiplier to 2.2% (new hires) – The benefit multiplier of 2.5% of pay would be changed to 2.2% of pay. This alternative would be applied to new hires only.

Change multiplier to 2.0% (new hires) – The benefit multiplier of 2.5% of pay would be changed to 2.0% of pay. This alternative would be applied to new hires only.

Eliminate traditional indemnity plan for existing retirees – Current retirees would be moved from the traditional indemnity plan to their choice of either the existing HMO or PPO plan available to retirees.

Revise Rx co-pays for existing retirees (no OOP limit) – The prescription drug coverage co-pays would be changed to $5/$15/$30 for retirees in the current Traditional Indemnity, HMO and retiree PPO plans. There would be no out of pocket limit on prescription drug payments by the retiree. Current and future enrollees in the active "80/20" PPO would not be impacted

Revise Rx co-pays for existing retirees ($1,000 OOP limit) – The prescription drug coverage co-pays would be changed to $5/$15/$30 for retirees in the current Traditional Indemnity, HMO and retiree PPO plans. There would be a $1,000 annual per member out of pocket

limit on prescription drug payments by the retiree. Current and future enrollees in the active "80/20" PPO design would not be impacted.

Change coordination of benefits with Medicare for existing and future retirees – The current method for coordination of benefits would be changed to a carve-out basis.

Replace pre-08 retiree plans with a modified PPO for existing retirees (no OOP limit on Rx) – The three retiree medical options (Traditional Indemnity, HMO, retiree PPO) would be replaced by a modified PPO plan with a $100 deductible, 20% coinsurance, $1,000 out of pocket limit on medical, $5/$15/$30 prescription drug copayment schedule, and no out of pocket limit on prescription drugs. Current and future enrollees in the active "80/20" PPO design would not be impacted.

Replace pre-08 retiree plans with a modified PPO for existing retirees ($1,000 OOP limit on Rx) – The three retiree medical options (Traditional Indemnity, HMO, retiree PPO) would be replaced by a modified PPO plan with a $100 deductible, 20% coinsurance, $1,000 out of pocket limit on medical, $5/$15/$30 prescription drug copayment schedule, and a separate $1,000 annual per member out of pocket limit on prescription drugs. Current and future enrollees in the active "80/20" PPO design would not be impacted.

Change amortization period to 30 years – The payment to amortize the unfunded accrued liability would be based on a 30 year time period instead of the current 15 year time period. This alternative was calculated assuming a "fresh start" of the amortization base.

Increase employee contribution rate over 4 years to 8% of pay – Employee contributions would be increased from 7% of pay to 8% of pay over 4 years. This option essentially shifts the cost of benefits to employees.

Increase employee contribution rate over 4 years to 9% of pay – Employee contributions would be increased from 7% of pay to 9% of pay over 4 years. This option essentially shifts the cost of benefits to employees.

Change compound COLA to 3% simple COLA (new hires) – The current automatic Cost-of-Living Adjustment (COLA) would be changed from a compounded adjustment to a simple adjustment. A simple adjustment would mean that each year's adjustment is the same dollar amount and would equal 3% of the original benefit amount. This alternative would be applied to new hires only.

Eliminate points system for healthcare coverage – Currently, employees hired after January 9, 1997 will make contributions for retiree medical coverage based on the number of age / service points accumulated at retirement. This contribution requirement would be dropped and only the contributions required under the 80 / 20 plan would be payable.

Add 5 years for medical coverage - from 15 to 20 years (new hires) – The 15 years of service requirement to be eligible for retiree medical coverage would be increased to 20 years of service. This alternative would be applied to new hires only.

Basis of Calculations

Our calculations were based upon the data, assumptions, methods and plan provisions as stated in the December 31, 2007 actuarial valuation report except as stated below. The plan provisions were modified to reflect the plan alternative under analysis. The retirement rate assumption was modified for the alternative adding a minimum age of 55. In this case the retirement rate was increased to 50% for those participants attaining 30 years of service on or before age 55. Claims costs and other medical plan assumptions for the alternatives are described in the attachment to this letter.

We are available to answer any questions or provide further explanations and detail on this information. The undersigned credentialed actuaries meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained in this letter.

Please call us if you have any questions.

Sincerely,

Gary D. Dickson, FSA
Principal

Tom Hackman, ASA
Principal

The information contained in this document (including any attachments) is not intended by Mercer to be used, and it cannot be used, for the purpose of avoiding penalties under the Internal Revenue Code that may be imposed on the taxpayer.

Enclosures
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Attachment I

Gary D. Dickson, FSA
Principal

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MERCER

MARSH MERCER KROLL
GUY CARPENTER OLIVER WYMAN

July 15, 2008

Mr. John Boudinot ***via e-mail***
Executive Director of CRS
City of Cincinnati
Room 240, City Hall
801 Plum St.
Cincinnati, Ohio 45202

Subject: Benefit Alternatives for the Cincinnati Retirement System – Expanded Options

Dear John:

We have updated our calculations regarding the various benefit change alternatives for the Cincinnati Retirement System (CRS) to include three additional alternatives. The results are shown in the attached chart. The cost calculations are as of December 31, 2007 and are directly comparable to the results of the actuarial valuation as of December 31, 2007.

We have analyzed the impact of the plan change on four measurements: the unfunded accrued liability, the normal cost, the City's contribution amount, and the funded status. The change in the unfunded accrued liability represents the change in the liability for benefits assigned to past service. For alternatives that apply to new hires, this change is always zero. The change in the normal cost represents the change in the cost of one year's accrual of benefits. For alternatives that apply to new hires, this change was calculated on the total population as if the benefit alternative had always existed. The change in the City's contribution amount reflects the immediate change in the contribution amount. For alternatives that apply to new hires, this change is always zero. The change in the funded status is just another way of looking at the change in the unfunded accrued liability.

For the alternatives that apply to new hires, the cost impact of any change would be realized only as the population turns over from current employees to new employees. The change in normal cost represents the ultimate savings that would be realized once all of the current employees have been replaced. This savings is based on the assumption that the future employee population would have a demographic profile similar to the existing population. If the new population has a different demographic profile, the ultimate cost change could be higher or lower than shown in our analysis.

Description of Alternatives

Provide 80/20 medical plan to retirees under age 65 – Change the retiree medical plan for existing retirees currently under the age of 65 to the 80/20 medical plan. They would continue to be covered by the 80/20 plan after age 65.

Change 30 and out to 33 and out (new hires) – The retirement eligibility condition for an unreduced benefit after 30 years of service would be changed to 33 years of service. This alternative would be applied to new hires only.

Change 30 and out to 35 and out (new hires) – The retirement eligibility condition for an unreduced benefit after 30 years of service would be changed to 35 years of service. This alternative would be applied to new hires only.

Add age 55 minimum for retirement eligibility (new hires) – The retirement eligibility condition for an unreduced benefit after 30 years of service would be changed to include an additional requirement to be at least 55 years of age. This alternative would be applied to new hires only.

Change multiplier to 2.2% (new hires) – The benefit multiplier of 2.5% of pay would be changed to 2.2% of pay. This alternative would be applied to new hires only.

Change multiplier to 2.0% (new hires) – The benefit multiplier of 2.5% of pay would be changed to 2.0% of pay. This alternative would be applied to new hires only.

Eliminate traditional indemnity plan for existing retirees – Current retirees would be moved from the traditional indemnity plan to their choice of either the existing HMO or PPO plan available to retirees.

Revise Rx co-pays for existing retirees (no OOP limit) – The prescription drug coverage co-pays would be changed to $5/$15/$30 for retirees in the current Traditional Indemnity, HMO and retiree PPO plans. There would be no out of pocket limit on prescription drug payments by the retiree. Current and future enrollees in the active "80/20" PPO would not be impacted

Revise Rx co-pays for existing retirees ($1,000 OOP limit) – The prescription drug coverage co-pays would be changed to $5/$15/$30 for retirees in the current Traditional Indemnity, HMO and retiree PPO plans. There would be a $1,000 annual per member out of pocket

limit on prescription drug payments by the retiree. Current and future enrollees in the active "80/20" PPO design would not be impacted.

Change coordination of benefits with Medicare for existing and future retirees – The current method for coordination of benefits would be changed to a carve-out basis.

Replace pre-08 retiree plans with a modified PPO for existing retirees (no OOP limit on Rx) – The three retiree medical options (Traditional Indemnity, HMO, retiree PPO) would be replaced by a modified PPO plan with a $100 deductible, 20% coinsurance, $1,000 out of pocket limit on medical, $5/$15/$30 prescription drug copayment schedule, and no out of pocket limit on prescription drugs. Current and future enrollees in the active "80/20" PPO design would not be impacted.

Replace pre-08 retiree plans with a modified PPO for existing retirees ($1,000 OOP limit on Rx) – The three retiree medical options (Traditional Indemnity, HMO, retiree PPO) would be replaced by a modified PPO plan with a $100 deductible, 20% coinsurance, $1,000 out of pocket limit on medical, $5/$15/$30 prescription drug copayment schedule, and a separate $1,000 annual per member out of pocket limit on prescription drugs. Current and future enrollees in the active "80/20" PPO design would not be impacted.

Change amortization period to 30 years – The payment to amortize the unfunded accrued liability would be based on a 30 year time period instead of the current 15 year time period. This alternative was calculated assuming a "fresh start" of the amortization base.

Increase employee contribution rate over 4 years to 8% of pay – Employee contributions would be increased from 7% of pay to 8% of pay over 4 years. This option essentially shifts the cost of benefits to employees.

Increase employee contribution rate over 4 years to 9% of pay – Employee contributions would be increased from 7% of pay to 9% of pay over 4 years. This option essentially shifts the cost of benefits to employees.

Change compound COLA to 3% simple COLA (new hires) – The current automatic Cost-of-Living Adjustment (COLA) would be changed from a compounded adjustment to a simple adjustment. A simple adjustment would mean that each year's adjustment is the same dollar amount and would equal 3% of the original benefit amount. This alternative would be applied to new hires only.

Eliminate points system for healthcare coverage – Currently, employees hired after January 9, 1997 will make contributions for retiree medical coverage based on the number of age / service points accumulated at retirement. This contribution requirement would be dropped and only the contributions required under the 80 / 20 plan would be payable.

Add 5 years for medical coverage - from 15 to 20 years (new hires) – The 15 years of service requirement to be eligible for retiree medical coverage would be increased to 20 years of service. This alternative would be applied to new hires only.

Replace pre-08 retiree plans with a modified PPO for existing retirees ($1,000 OOP limit on Rx); Change coordination of benefits with Medicare for existing and future retirees; Change amortization period to 30 years – This option combines three of the alternatives listed above.

Change multiplier to 2.2% effective 1/1/2009 for all current active participants - The benefit multiplier of 2.5% of pay would be changed to 2.2% of pay for service earned after 12/31/2008. This would apply to current active employees and assumes that it would also apply to union employees. Note that the normal cost for this option will decrease over time to that of the option above for new hires as the workforce turns over.

Change Normal Retirement Age to 65; Early Retirement at age 60 with 25 years of service; Add age 55 to 30 and out retirement (new hires) – This alternative increases normal and early retirement eligibility by 5 years of age. It also adds a minimum age of 55 for the 30 and out retirement eligibility. This alternative would be applied to new hires only.

Basis of Calculations

Our calculations were based upon the data, assumptions, methods and plan provisions as stated in the December 31, 2007 actuarial valuation report except as stated below. The plan provisions were modified to reflect the plan alternative under analysis. The retirement rate assumption was modified for the alternative adding a minimum age of 55. In this case the retirement rate was increased to 50% for those participants attaining 30 years of service on or before age 55. Claims costs and other medical plan assumptions for the alternatives are described in the attachment to this letter. For the alternative to increase Normal Retirement Age to 65, change early retirement to age 60 with 25 years, and add age 55 as a minimum age, the retirement rates were modified to provide a 50% probability of retirement at age 55 for anyone attaining 30 years of service on or before age 55 and to shift the other retirement rates five years.

We are available to answer any questions or provide further explanations and detail on this information. The undersigned credentialed actuaries meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained in this letter.

Please call us if you have any questions.

Sincerely,

Gary D. Dickson, FSA
Principal

Tom Hackman, ASA
Principal

The information contained in this document (including any attachments) is not intended by Mercer to be used, and it cannot be used, for the purpose of avoiding penalties under the Internal Revenue Code that may be imposed on the taxpayer.

Enclosures

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Cincinnati Retirement System

Summary of costs for plan alternatives

(in millions)

Alternative - see explanations	**Unfunded Accrued Liability**	**Change**	**Normal Cost**	**Change**	**City Contribution**	**Change**	**Funded Status**
12/31/2007 Valuation Results	**307.45**	**NA**	**32.57**	**NA**	**51.02**	**NA**	**89.5%**
Provide 80/20 medical plan to retirees under age 65	246.23	(61.22) 19.9%	32.57	- 0.0%	44.12	(6.90) 13.5%	91.4%
Change 30 and out to 33 and out (new hires)	307.45	- 0.0%	31.29	(1.28) 3.9%	51.02	- 0.0%	89.5%
Change 30 and out to 35 and out (new hires)	307.45	- 0.0%	30.84	(1.73) 5.3%	51.02	- 0.0%	89.5%
Add age 55 minimum for retirement eligibility (new hires)	307.45	- 0.0%	32.04	(0.53) 1.6%	51.02	- 0.0%	89.5%
Change multiplier to 2.2% (new hires)	307.45	- 0.0%	30.35	(2.22) 6.8%	51.02	- 0.0%	89.5%
Change multiplier to 2.0% (new hires)	307.45	- 0.0%	28.82	(3.75) 11.5%	51.02	- 0.0%	89.5%
Eliminate traditional indemnity plan for existing retirees	280.43	(27.02) 8.8%	32.57	- 0.0%	47.98	(3.05) 6.0%	90.4%

Cincinnati Retirement System

Summary of costs for plan alternatives

(in millions)

Alternative - see explanations	Unfunded Accrued Liability	Change	Normal Cost	Change	City Contribution	Change	Funded Status
12/31/2007 Valuation Results	**307.45**	**NA**	**32.57**	**NA**	**51.02**	**NA**	**89.5%**
Revise Rx co-pays for existing retirees (no OOP limit)	262.06	(45.40) 14.8%	32.57	- 0.0%	45.90	(5.12) 10.0%	90.9%
Revise Rx co-pays for existing retirees ($1,000 OOP limit)	266.49	(40.97) 13.3%	32.57	- 0.0%	46.40	(4.62) 9.1%	90.8%
Change coordination of benefits with Medicare for existing and future retirees	255.96	(51.49) 16.7%	31.84	(0.73) 2.2%	44.49	(6.53) 12.8%	91.1%
Replace pre-08 retiree plans with a modified PPO for existing retirees (no OOP limit on Rx)	235.74	(71.71) 23.3%	32.57	- 0.0%	42.94	(8.09) 15.8%	91.8%
Replace pre-08 retiree plans with a modified PPO for existing retirees ($1,000 OOP limit on Rx)	240.17	(67.28) 21.9%	32.57	- 0.0%	43.44	(7.59) 14.9%	91.6%
Change amortization period to 30 years	307.45	- 0.0%	32.57	- 0.0%	41.42	(9.60) 18.8%	89.5%

Cincinnati Retirement System

Summary of costs for plan alternatives

(in millions)

Alternative - see explanations	**Unfunded Accrued Liability**	**Change**	**Normal Cost**	**Change**	**City Contribution**	**Change**	**Funded Status**
12/31/2007 Valuation Results	**307.45**	**NA**	**32.57**	**NA**	**51.02**	**NA**	**89.5%**
Increase employee contribution rate over 4 years to 8% of pay[1]	307.82	0.37 0.1%	32.60	0.03 0.1%	49.55	(1.47) 2.9%	89.5%
Increase employee contribution rate over 4 years to 9% of pay[1]	308.18	0.73 0.2%	32.64	0.07 0.2%	48.07	(2.95) 5.8%	89.5%
Change compound COLA to 3% simple COLA (new hires)	307.45	- 0.0%	31.78	(0.79) 2.4%	51.02	- 0.0%	89.5%
Eliminate points system for healthcare coverage	323.00	15.54 5.1%	35.17	2.60 8.0%	55.37	4.35 8.5%	89.1%
Add 5 years for medical coverage - from 15 to 20 years (new hires)	307.45	- 0.0%	32.45	(0.12) 0.4%	51.02	- 0.0%	89.5%

Cincinnati Retirement System

Summary of costs for plan alternatives

(in millions)

Alternative - see explanations	**Unfunded Accrued Liability**	**Change**	**Normal Cost**	**Change**	**City Contribution**	**Change**	**Funded Status**
12/31/2007 Valuation Results	**307.45**	**NA**	**32.57**	**NA**	**51.02**	**NA**	**89.5%**
Replace pre-08 retiree plans with a modified PPO for existing retirees ($1,000 OOP limit on Rx); Change coordination of benefits with Medicare for existing and future retirees; Change amortization period to 30 years	169.93	(137.52) 44.7%	31.84	(0.73) 2.2%	28.90	(22.12) 43.3%	93.9%
Change multiplier to 2.2% effective 1/1/2009 for all current active participants[2]	291.32	(16.14) 5.2%	31.63	(0.94) 2.9%	48.26	(2.76) 5.4%	90.0%
Change Normal Retirement Age to 65; Early Retirement at age 60 with 25 years of service; Add age 55 to 30 and out retirement (new hires)	307.45	- 0.0%	28.91	(3.66) 11.2%	51.02	- 0.0%	89.5%

Cincinnati Retirement System

Summary of costs for plan alternatives

[1] This represents the City contribution after ultimate level of employee contributions is reached. One fourth of the savings would be recognized in each of the next three years.

[2] The normal cost under this options will eventually decrease to the normal cost of the 2.20% option for new hires as the population turns over.

Results from different alternatives may not be additive.

For options that apply to new hires, there would be no immediate change in Unfunded Accrued Liability, Normal Cost, and Contribution. We have shown the change in the Normal Cost as if the new plan provisions had always applied to the existing population. This represents the reduction in annual costs that will eventually be attained once the total current population has been replaced by new hires assuming the future population has the same general demographics as the current population.

Contributions for the early retirement window program are in addition to the contributions shown here.

Basis of Calculations
The cost estimates are based upon the data, assumptions, methods and plan provisions as stated in the 12/31/2007 actuarial valuation report except as stated below.

- Plan changes reflected according to the design alternative.
- For the alternative to add age 55 as a minimum age, the retirement rates were modified to provide a 50% probability of retirement at age 55 for anyone attaining 30 years of service on or before age 55.
- Claims costs for medical options as described in the attachment

- For the alternative to increase Normal Retirement Age to 65, change early retirement to age 60 with 25 years, and add age 55 as a minimum age, the retirement rates were modified to provide a 50% probability of retirement at age 55 for anyone attaining 30 years of service on or before age 55 and to shift the other retirement rates five years.

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GUY CARPENTER OLIVER WYMAN

Cincinnati Retirement System

Pricing Assumptions Regarding Medical Plan Design Considerations

July 15, 2008

The information contained in this document highlights the key assumptions behind the expected changes in plan cost as a result of the retiree medical plan design alternatives being considered by the Cincinnati Retirement System (CRS).

For each plan design alternative listed below, a table has been included to compare the Group 1 (current inactive (retiree) and active participants hired prior to 1997) annual starting costs at age 65 before and after the recommended plan change. Other than the alternative below that changes the coordination of benefits provision, the Group 2 (active participants hired in 1997 or later) employees are unaffected by these potential alternatives. (Note that as assumed in the valuation Group 2 members are expected to have total costs that are 4-5% higher on average than Group 1 based on the fact that the contribution methodology is materially different for those employees and some adverse selection is expected.)

Please refer to the Actuarial Valuation Report as of December 31, 2007 for all other actuarial assumptions not listed below. (All health care related assumptions not included below are assumed to be unchanged from the December 31, 2007 valuation report for these alternatives.)

Pricing of these alternatives is based on a combination of CRS experience information provided for historical pricing, Mercer proprietary pricing software and historical pricing factors from analyses performed by Mercer for CRS in pricing similar alternatives early in 2007.

Note: The City recently provided some preliminary internal pricing analysis (& data) that the City performed on some of these alternatives. Mercer has not reconciled the pricing it performed in the following alternatives vs. the estimates produced by the City. Should the City decide to further act on and pursue one or more of these alternatives moving forward, Mercer will reconcile its' estimates utilized to develop the figures here with the internal estimates of the City to be sure both the City & Mercer are comfortable with the final estimate to utilize moving forward for decision-making and action.

Note that future projections of costs are only estimates. All estimates, based upon the information available at a point in time, are subject to unforeseen and random events. Therefore any projection must be interpreted as having a likely range of variability from the estimate.

Eliminate traditional indemnity plan for existing retirees

Elimination of the Traditional Indemnity Plan as an option to all current retirees would require all current participants in the Traditional Indemnity Plan to choose between the options of the current retiree PPO or HMO plans in order to maintain medical coverage. As a result of this change, we have assumed that 70% of the current Traditional Indemnity plan participants will enroll in the retiree PPO plan, and 30% will enroll in the HMO plan. A summary comparison of the Group 1 annual starting costs (including administrative fees) at age 65 before and after the plan change is displayed below:

Annual average age 65 adult per capita medical & prescription drug claims cost

	2008 Projected Cost Under this Recommendation		2008 Cost Reported in 12/31/07 Valuation	
	Current Retirees in Old Plans	Active 80/20 Plan Participants	Current Retirees in Old Plans	Active 80/20 Plan Participants
Pre-Medicare	$12,513	$10,605	$13,273	$10,605
Medicare	$4,654	$3,719	$5,143	$3,719
Medicare Part D Subsidy	$570	$550	$600	$550

Revise Rx co-pays for existing retirees (no OOP limit)

This alternative would change the prescription drug copayments of the current grandfathered Traditional Indemnity, retiree PPO and HMO plan designs to a $5 Generic, $15 Brand, and $30 Non-formulary copayment schedule for retail prescriptions. The copayments required for the mail-order benefit are assumed to be two times the retail copayment amount. For this alternative, no member prescription drug annual Out of Pocket Maximum is assumed. A summary comparison of the Group 1 annual starting costs (including administrative fees) at age 65 before and after the plan change is displayed below:

Annual average age 65 adult per capita medical & prescription drug claims cost

	2008 Projected Cost Under this Recommendation		2008 Cost Reported in 12/31/07 Valuation	
	Current Retirees in Old Plans	Active 80/20 Plan Participants	Current Retirees in Old Plans	Active 80/20 Plan Participants
Pre-Medicare	$12,687	$10,605	$13,273	$10,605
Medicare	$4,410	$3,719	$5,143	$3,719
Medicare Part D Subsidy	$540	$550	$600	$550

Revise Rx co-pays for existing retirees ($1,000 OOP limit)

This alternative is the same as the alternative immediately above, with the exception that the prescription drug plans include a $1,000 member annual Out of Pocket Maximum for prescription drug copayments. A summary comparison of the Group 1 annual starting costs (including administrative fees) at age 65 before and after the plan change is displayed below:

Annual average age 65 adult per capita medical & prescription drug claims cost				
	2008 Projected Cost Under this Recommendation		2008 Cost Reported in 12/31/07 Valuation	
	Current Retirees in Old Plans	Active 80/20 Plan Participants	Current Retirees in Old Plans	Active 80/20 Plan Participants
Pre-Medicare	$12,744	$10,605	$13,273	$10,605
Medicare	$4,458	$3,719	$5,143	$3,719
Medicare Part D Subsidy	$540	$550	$600	$550

Change coordination of benefits with Medicare for existing and future retirees

For plan participants that are Medicare eligible, this alternative would change the type of Medicare Integration from a standard "Coordination" methodology to a "Carve-Out" methodology. This change is assumed to apply to the current grandfathered Traditional Indemnity, retiree PPO and HMO plans, as well as to the active "80/20" PPO plan. A summary comparison of the Group 1 annual starting costs (including administrative fees) at age 65 before and after the plan change is displayed below:

Annual average age 65 adult per capita medical & prescription drug claims cost				
	2008 Projected Cost Under this Recommendation		2008 Cost Reported in 12/31/07 Valuation	
	Current Retirees in Old Plans	Active 80/20 Plan Participants	Current Retirees in Old Plans	Active 80/20 Plan Participants
Pre-Medicare	$13,273	$10,605	$13,273	$10,605
Medicare	$4,707	$3,109	$5,143	$3,719
Medicare Part D Subsidy	$600	$550	$600	$550

Replace pre-08 retiree plans with a modified PPO for existing retirees (no OOP limit on Rx)

Elimination of the current grandfathered Traditional Indemnity, retiree PPO and HMO plans would require all current grandfathered participants in those plans to migrate to the Modified PPO plan in order to maintain medical coverage. The Modified PPO plan is assumed to have the following plan design: $100 deductible; 20% coinsurance; $1,000 medical Out of Pocket Maximum; prescription drug copayments of $5 Generic, $15 Brand, and $30 Non-formulary. For this alternative, no member annual Prescription Out of Pocket Maximum is assumed. All other plan features are assumed to be the same as the current grandfathered retiree PPO plan. A summary comparison of the Group 1 annual starting costs (including administrative fees) at age 65 before and after the plan change is displayed below:

Annual average age 65 adult per capita medical & prescription drug claims cost

	2008 Projected Cost Under this Recommendation		2008 Cost Reported in 12/31/07 Valuation	
	Current Retirees in Old Plans	Active 80/20 Plan Participants	Current Retirees in Old Plans	Active 80/20 Plan Participants
Pre-Medicare	$11,268	$10,605	$13,273	$10,605
Medicare	$4,199	$3,719	$5,143	$3,719
Medicare Part D Subsidy	$540	$550	$600	$550

Replace pre-08 retiree plans with a modified PPO for existing retirees ($1,000 OOP limit on Rx)

This alternative is the same as the alternative immediately above, with the exception that the prescription drug plans includes a $1,000 member annual Out of Pocket Maximum for prescription drug copayments. A summary comparison of the Group 1 annual starting costs (including administrative fees) at age 65 before and after the plan change is shown below:

Annual average age 65 adult per capita medical & prescription drug claims cost

	2008 Projected Cost Under this Recommendation		2008 Cost Reported in 12/31/07 Valuation	
	Current Retirees in Old Plans	Active 80/20 Plan Participants	Current Retirees in Old Plans	Active 80/20 Plan Participants
Pre-Medicare	$11,326	$10,605	$13,273	$10,605
Medicare	$4,247	$3,719	$5,143	$3,719
Medicare Part D Subsidy	$540	$550	$600	$550

(A) Replace pre-08 retiree plans with a modified PPO for existing retirees ($1,000 OOP limit on Rx) ***and***
(B) Change coordination of benefits with Medicare for existing and future retirees in all plans

Highlights of this alternative:

- Elimination of the current grandfathered Traditional Indemnity, retiree PPO and HMO plans for current retirees at all ages. Participants in those plans to migrate to the Modified PPO plan in order to maintain medical coverage.

- The Modified PPO plan is assumed to have the following plan design:
  - $100 per member deductible;
  - 20% member coinsurance
  - $1,000 annual medical Out of Pocket Maximum (including deductible)
  - Prescription drug copayments of $5 Generic, $15 Brand, and $30 Non-formulary. A $1,000 member annual Out of Pocket Maximum for prescription drug copayments.
  - All other plan features are assumed to be the same as the current grandfathered retiree PPO plan.

- For plan participants that are Medicare eligible, this alternative would change the type of Medicare Integration from a standard "Coordination" methodology to a "Carve-Out" methodology. This change is assumed to apply to the Modified PPO described above as well as to the active "80/20" PPO plan.

A summary comparison of the Group 1 annual starting costs (including administrative fees) at age 65 before and after the plan change is displayed below:

Annual average age 65 adult per capita medical & prescription drug claims cost

	2008 Projected Cost Under this Recommendation		2008 Cost Reported in 12/31/07 Valuation	
	Current Retirees in Old Plans	Active 80/20 Plan Participants	Current Retirees in Old Plans	Active 80/20 Plan Participants
Pre-Medicare	$11,326	$10,605	$13,273	$10,605
Medicare	$3,650	$3,109	$5,143	$3,719
Medicare Part D Subsidy	$540	$550	$600	$550

Attachment J

Market Alternatives for Medicare eligible retirees & dependents Medical Coverage

Medicare Advantage (MA) Plans

- MA Plans
  - Fully insured programs that provide the same or better benefits of Original Medicare for typically a lower total premium rate
  - Medicare does not pay any claims
  - Medicare pays carrier. Carrier takes risk on utilization.

- Most MA plans have a network of providers
  - HMO plan – cannot access an out of network provider (unless emergency)
  - PPO – out of network providers typically have a larger member cost sharing
  - PFFS – no network

- If prescription drug coverage is provided, called an MA-PD plan

- Benefit levels/premium rates
  - Can be customized and rates can be negotiated for group plans
  - Can be offered with other non MA plans

- Market is quickly evolving and future plan design alternatives, premium changes unknown. Current legislative discussions regarding reimbursement methodology

Market Considerations for Medicare eligible retirees & dependents Prescription Drug Coverage

As alternatives to the City's current Retiree Drug Subsidy (RDS) approach

- Employer Rx secondary to Medicare Part D
  - Similar to secondary concept of Medicare Parts A & B but more complicated from a member's perspective
  - Savings can be higher than RDS

- Prescription Drug Plan (PDP)
  - A private insurance company that offers the same benefit as the original Part D plan
  - Can be linked to an MA plan (then called a MA-PDP)
  - Member must enroll in the PDP
  - Vendor drug formulary may be restrictive
  - Premium reduction typically larger than RDS, but for tax paying entities no tax savings

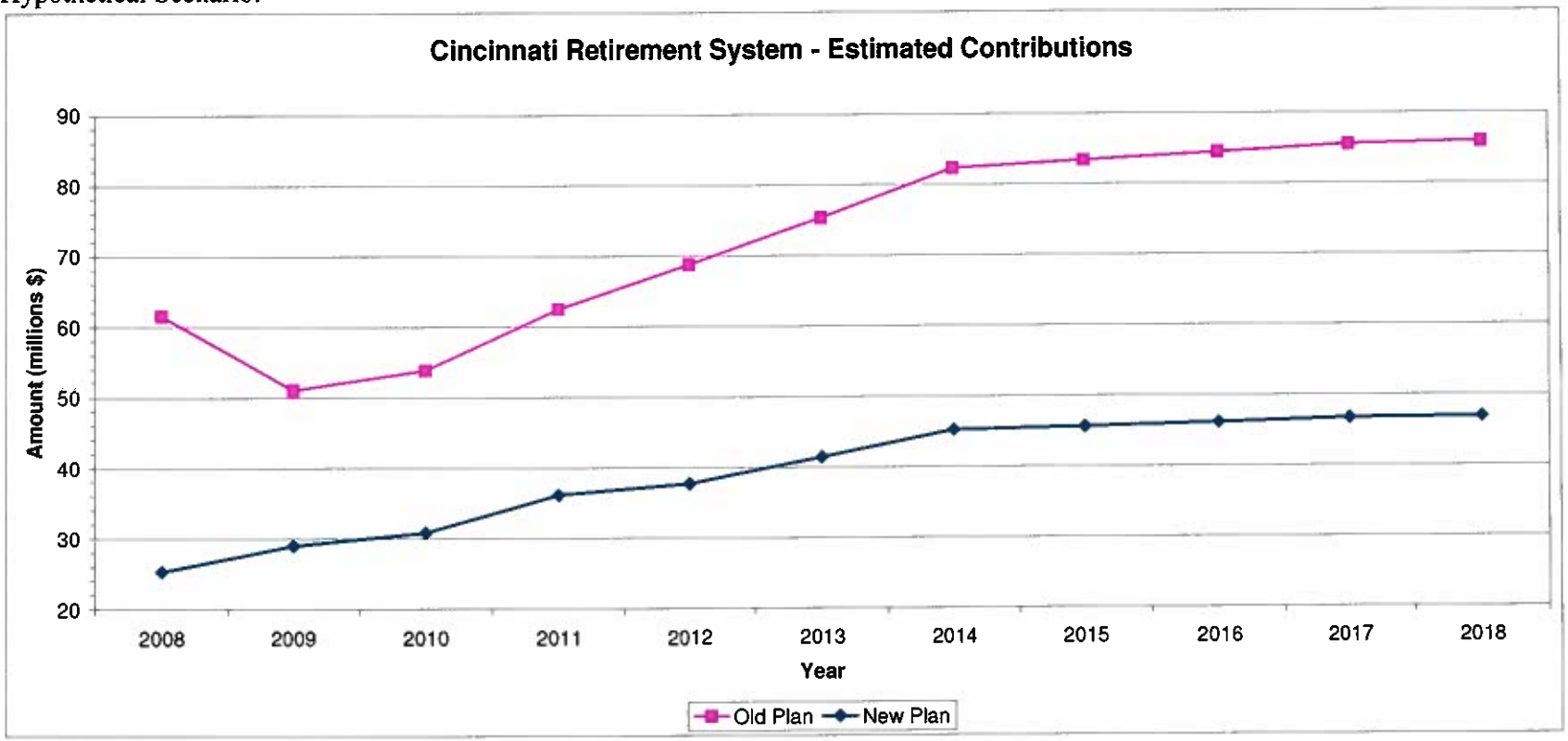
- Enhanced PDP
  - More generous benefits than standard PDP
  - Savings are less than a standard PDP, as benefit design is enhanced
  - Enhanced PDP savings reduce the plan premium rate
  - Premium reduction typically less than RDS, and no tax savings

Market Considerations for all retirees & dependents
Other/Miscellaneous items

- Account based plans (primarily pre-65)
- Limited benefit plans (primarily pre-65)
- Retiree health/expenses continues to be a popular topic on the political and legislative front

Attachment K

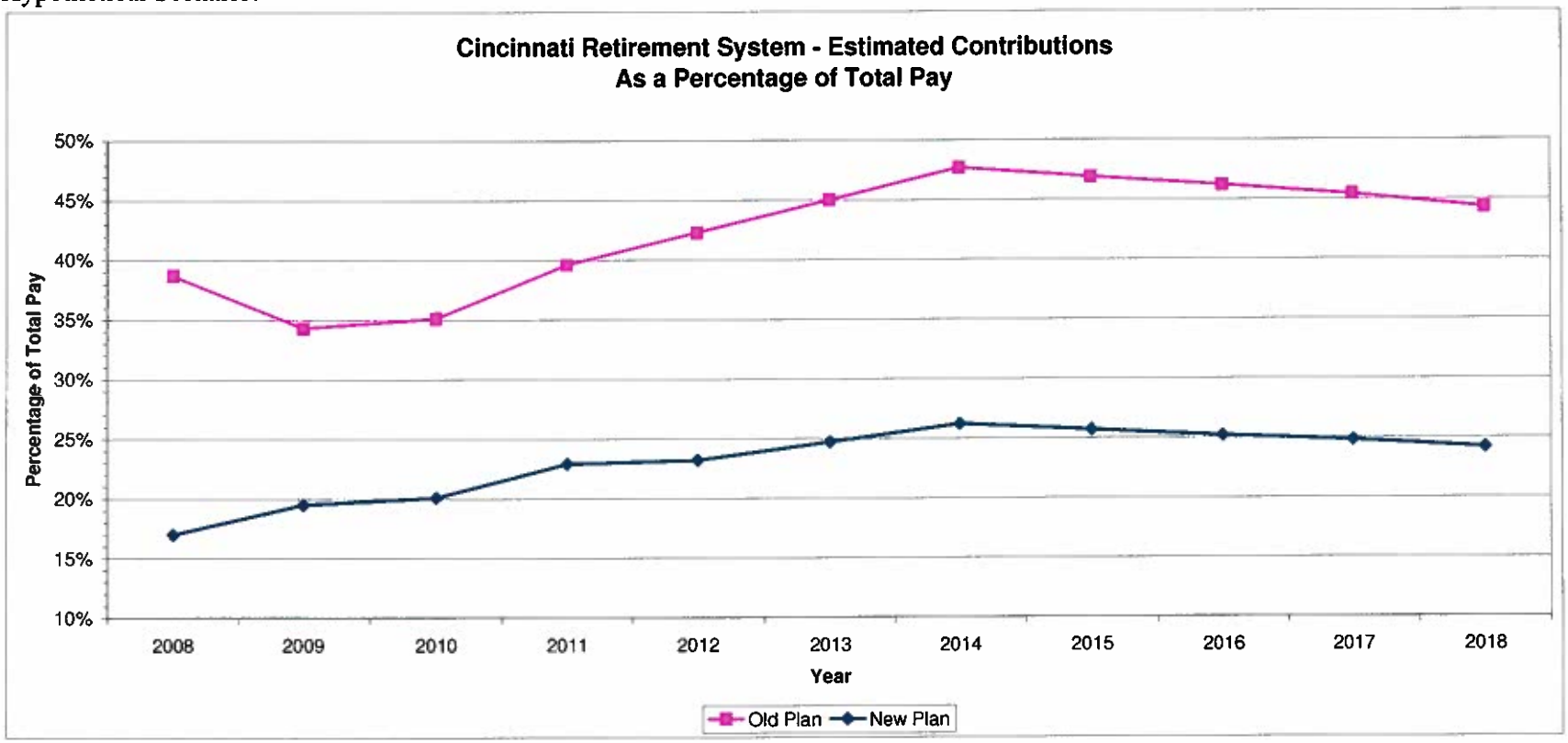
Hypothetical Scenario:



	Year Ending									
	12/31/2008	12/31/2009	12/31/2010	12/31/2011	12/31/2012	12/31/2013	12/31/2014	12/31/2015	12/31/2016	12/31/2017
Actual Asset Return	0.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%

This is a hypothetical scenario- the CRS earns 0% on assets in 2008 and 8.0% through 2017. The chart shows the impact of 5-year smoothing of actuarial losses on the City's contribution. The City's required contribution, under the current plan, would increase to $82 million in 2013. If Task Force recommendations are implemented, 2013 contribution would be $45 million.

Hypothetical Scenario:



	Year Ending									
	12/31/2008	12/31/2009	12/31/2010	12/31/2011	12/31/2012	12/31/2013	12/31/2014	12/31/2015	12/31/2016	12/31/2017
Actual Asset Return	0.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%

This is a hypothetical scenario- the CRS earns 0% on assets in 2008 and 8.0% through 2017. This chart shows the impact of 5-year smoothing of gains and losses on the City's contribution. The City's required contribution, under the current plan, would increase to 45% of payroll. If Task Force recommendations are implemented, 2013 contribution would be 26% of payroll.