OLO Report 2026-16 October 16, 2026

Group Health Insurance Cost Drivers

for Montgomery County Government and Montgomery County Public Schools

Aron Trombka

OFFICE OF LEGISLATIVE OVERSIGHT

Office of Legislative Oversight Report 2026-16
Group Health Insurance Cost Drivers

Table of Contents

Executive Summary i

1. Report Assignment, Scope, and Structure 1
2. Group Health Insurance Overview 4
3. External Group Health Insurance Cost Drivers 8
4. Employer Group Health Insurance Policies 11
5. County Government and MCPS Group Health Insurance Data 19
6. Group Health Insurance Cost Containment Practices 46
7. Employer Self-Insurance 54
8. Discussion Questions 57
9. Stakeholder Comments 60

EXECUTIVE SUMMARY

Many employers in the United States, including the County Government and Montgomery County Public Schools (MCPS), provide employees and eligible family members with a group health insurance benefit. The County Council directed the Office of Legislative Oversight (OLO) to identify the factors that have driven County Government and MCPS active employee group insurance costs in recent years.

External Group Health Insurance Cost Drivers

OLO identified five external factors that have contributed to recent increases in group health insurance costs.

Prescription Drug Costs: Much of the recent increases in health care costs stem from growth in prescription drug spending. Several categories of drugs have contributed to the rise in group insurance spending both because of increased use and the high cost per dose. For example, use of GLP-1 medications originally approved by the FDA to treat Type-2 diabetes are now approved for weight loss. Other prescription drug categories that significantly affect group insurance costs include oncologic treatments and biological medications to treat immunology and inflammatory conditions such as rheumatoid arthritis, psoriasis, and Crohn's disease.

Aging of the Workforce: The aging of the U.S. population and workforce has increased utilization of health care coverage sponsored by employers. In general, older people make a greater number of medical provider visits and use more prescription drugs than younger people. In addition, as workers age, they are more likely to develop chronic conditions, such as heart disease and diabetes, that are costly to treat and control

Hospital and Medical Provider Consolidation: A recent report by the U.S. Department of Health and Human Services (DHHS) found that "over the last thirty years, the health care industry has experienced a dramatic and continuous trend of consolidation across the country." The report concluded that, "empirical research unambiguously shows that hospital system-led acquisitions and mergers are associated with higher prices for services charged to insurers and patients."

Private Equity Investment: The DHHS report cited above identifies private equity (PE) investment as another cause for rising health care costs. The report states the health care sector has experienced an influx of investment from PE investors in recent years and that "PE acquisitions lead to higher prices for insurers and patients in their pursuit of profits."

Labor Shortages: The supply of other medical professionals dropped markedly in recent years prompting hospitals and other medical providers to raise staff compensation levels to attract and retain qualified workers, prompting requests for higher reimbursement rates.

Employer Group Health Insurance Policies

Employer policies that directly affect group health insurance costs include:

Premium Cost Share and Incentives: The term, "cost share," refers to the percents of group insurance premium costs paid by the employer and the employee, respectively. Higher employer cost shares make group insurance more affordable for employees but also raise the amount of money the employer must set aside for this benefit. Some employers offer lower cost share percentages to employees who select insurance plans with lower overall costs. This approach incentivizes employees to select lower cost plans. However, establishing cost share differentials could be seen as placing a higher cost burden on employees who require more robust health insurance coverage.

Out-of-Pocket Costs: Out-of-pocket costs refer to the portion of health care expenses the employee must pay for specific health care events. The two most common forms of out-of-pocket health care expenses are co-payments and deductibles. In general, group health insurance plans with higher out-of-pocket costs have lower premium costs. As the employer pays for a portion of premium costs but does not contribute to out-of-pocket costs, plans with higher out-of-pocket costs often require lower employer contributions than plans with lower out-of-pocket costs.

Cost Share for Spouses and Dependents: Employers may contribute the same percentage of premium costs for all offered group insurance plans or may contribute different percentages of premium costs for self, self plus one, and family coverage. Some employers have introduced "unitized pricing" that adjusts the employee's contribution amount for a family plan based on the number of people covered by the plan. Setting employee cost contributions based on the number of people covered by an insurance plan may better align the benefit level with the cost incurred by the employer but may also be perceived as a bias against larger families.

Eligibility and Costs for Part-Time Employees: Employers who offer health insurance to part-time employees must decide how to share premium costs with these employees. Some employers offer part-time employees who work a specified number of hours (such as 20 hours per week) the same health insurance options as available to full-time employees. Other employers adjust the cost share for part-time employees, such as pro-rating the employer cost share based on the number of hours worked per week.

Salary-Based Charges: Traditionally, employers have provided a single menu of group health insurance plans and costs to all eligible employees, regardless of their salary. Some employers have adopted a policy to tie employees' contribution to salary. Under a salary-based model, employees with lower salaries pay a lower share of premium costs than employees with higher salaries. Advantages of salary-based charges include the ability of the employer to recover a greater share of premium costs and reduced risk that lower-paid employees may limit their medical care to avoid high out-of-pocket costs. Policy disadvantages include that salary may not reflect total household income and health care usage may not correlate with salary.

Opt-Out Programs: Some public sector employers offer a financial incentive to employees who elect to waive their employer-provided health insurance and enroll in a spouse's or other family member's health plan. The intent of these "opt-out programs" is to reduce an employer's health benefit spending while assuring all employees have access to health care. Employees who participate in opt-out programs must demonstrate they have enrolled in a health plan that meets specified coverage standards. In return, participating employees receive a cash payment in lieu of the health benefit.

County Government Cost Share and Eligibility Policies

The County Government offers employees a choice of four medical insurance plans, CareFirst High Option POS, CareFirst Standard Option POS, United Healthcare EPO, and Kaiser Permanente HMO. The Kaiser Permanente HMO plan also includes prescription coverage. For employees who elect to participate in a plan other than Kaiser Permanente, the County Government offers a Caremark prescription plan. The County Government currently contributes 80% of costs for all group health insurance plans; the employee pays the remaining 20% of premium costs through payroll deductions. The County Government currently does not offer any cost share incentives for employees to select lower-cost plans.

MCPS Cost Share and Eligibility Policies

Currently, MCPS offers a choice of five medical insurance plans, two Cigna OAP plans (one with "preferred care management" and one without) and two Cigna HMO/OAPIN plans (one with "preferred care management" and one without) and a Kaiser Permanente HMO plan. The Kaiser Permanente HMO plan also includes prescription, preventative dental, and vision coverage. For employees who elect to participate in a plan other than Kaiser Permanente, MCPS offers a Caremark prescription plan. The current group health cost share between MCPS and its employees varies by plan. For Calendar Year 2026, MCPS contributes between 75% and 87% of premium costs; employees contribute between 13% and 25% of cost depending on the plan. MCPS is currently in a two-year phase-in that will shift 2% of premium costs from the employer to employees. MCPS offers employees an economic incentive to select lower cost plans. MCPS currently contributes a higher percentage of premium costs for HMO medical plans than for POS medical plans.

County Government and MCPS Group Health Insurance Data

This report presents data on costs incurred by the County Government and MCPS to provide group health insurance benefits to active employees. OLO cautions the reader against drawing conclusions from comparison of the County Government and MCPS data. Many elements of plan design such as cost share, copays and deductibles, and utilization management practices are mostly controlled by the employer. However, many critical cost drivers are a function of the composition of the workforce. Factors such as size of the pool of insured persons, age distribution of the insured, average family size of the insured, and medical conditions of the insured lay beyond the control of the employer.

Differences between County Government and MCPS group insurance costs are likely to be related to a combination of employer policies and workforce demographics. As this report does not account for factors such as the age and medical conditions of insured County Government and MCPS employees, OLO cautions the reader not to attribute differences in the cost data solely to the policies and management practices of the two agencies.

County Government Group Health Insurance Data: OLO's review of County Government employee group health insurance data revealed the following points:

- Annual County Government expenditures on active employee group insurance (claims plus administrative costs) increased from $139.1 million in 2018 to $202.7 million in 2025, an increase of 45.8%, or an average annual rate of 5.5%.

- Part of the increase in County Government active employee group insurance costs is attributable to inflation. Adjusted for inflation, County Government expenditures on active employee group insurance increased from $165.0 million in 2018 to $202.7 million in 2025, an increase of 22.9%, or an average annual rate of 3.0%.

- In 2025, a total of 8,966 County Government employees enrolled in one of the medical group insurance plans, an increase of 7.6 percent above 2018 enrollment.

- In 2018, 83.9% of eligible employees enrolled in group medical insurance; in 2025, the percentage remained nearly the same at 84.1%.

- The average group insurance cost per enrolled County Government employee cost to the County Government in 2018 and 2019 was near $19,800 in inflation-adjusted dollars. From 2018 through 2025, average per enrolled employee costs increased from $19,802 to $22,614 (both in 2025 dollars), a 14.2% increase.

- Medical claims account for the largest share of health insurance costs. In 2025, the County Government paid, on average, $13,326 in medical claims per enrolled employee representing 63.1% of all claim costs. The County Government paid, on average, $6,748 in drug claims per enrolled employee in 2025, representing 31.9% of total claim costs.

- In recent years, drug claim costs have grown at a significantly faster rate than medical claim costs. Per enrollee drug claim costs increased by 54.0% (in inflation-adjusted dollars) from 2018 to 2025. In contrast, inflation-adjusted medical costs per enrollee increased by 14.2% during the same period. Drug claims comprised 25.7% of total claim costs in 2018 but grew to 31.9% of total claim costs in 2025.

- Pharmaceutical manufacturers often provide group insurance plan sponsors with rebates in exchange for favorable placement of specific drugs in the plan's formulary. When drug claim costs are offset by rebates, the 2018 to 2025 growth rate for employee drug claims (as measured in 2025 dollars) was 29.7%, more than double the growth rate for medical claims. However, when accounting for rebates, County Government drug claims as a percentage of

total claims have only increased slightly over the past seven years; drug claims comprised 21.3% of total claims in FY18 and 23.6% of claims in FY25.

- Three County Government medical plans – CareFirst High Option POS, CareFirst Standard Option POS, and United Healthcare HMO – provide medical coverage but exclude prescription coverage. The Kaiser Permanente HMO plan includes both medical and prescription coverage. In 2025, average cost to the County for the Caremark plan was $5,888 (including rebates). Employees who enrolled in the Kaiser Permanente HMO cost the County Government $14,248 in 2025, an amount of $4,339 (or 30.5%) less than the average combined cost to the County Government of the combined cost of the CareFirst Standard Option POS and Caremark prescription plans; $7,162 (or 50.3) less than the average combined cost of the United Healthcare HMO and Caremark prescription plans; and $10,355 less than the average combined cost of the CareFirst High Option POS and Caremark prescription plans.

- A smaller percentage of County Government employees enrolled in HMOs in 2025 than in 2018. In 2018, a combined 42.5% of employees participating in County Government medical insurance plans elected HMO coverage. By 2025, the percentage of employees enrolled in HMOs dropped to 35.5%. While this change may be a result of changing employee preferences, OLO notes the decline in HMO participation coincides with the elimination of the County Government's HMO pricing incentive.

- From 2018 through 2025, the County Government experienced a small shift in coverage levels with the percentage of employees selecting Self + Family coverage declining by 3.2 percentage points (from 42.3% to 39.0%) and the percentage of employees selecting Self coverage increasing by about 2.8 percentage points from (35.2% to 38.0%) during the same period. The percentage of employees selecting Self +1 coverage remains mostly constant with 22.5% selecting this coverage level in 2018 and 23.0% in 2025.

In sum, the combined and compounded effect of the 7.6% increase in the number of enrolled employees and a 14.2% increase in the inflation-adjusted cost per employee combined to produce a nearly 23% increase in County Government active employee group insurance costs from 2018 through 2025. Claims cost increases, particularly for prescription coverage, are a major driver of per employee costs. In addition, a moderate shift in enrollment from lower cost plans to higher cost plans has contributed to the rapid rise in County Government group insurance expenditures.[1] A small but measurable upward shift in the percentage of County Government employees who enroll in single coverage has mitigated increases in County Government expenditures.

[1] Employees with medical conditions that require greater levels of treatment may gravitate towards higher-cost plans while employees that expect only to use their insurance plan for infrequent preventative and emergency services may select lower-costs plans. As such, the cost per enrollee may reflect self selection of employees based on their medical needs and conditions.

MCPS Group Health Insurance Data: OLO's review of MCPS employee group health insurance data revealed the following points:

- Annual MCPS expenditures on active employee group insurance (claims plus administrative costs) increased from $312.0 million in FY18 to $438.9 million in FY25, an increase of 40.7%, or an average annual rate of 5.0%.

- Part of the increase in MCPS active employee group insurance costs is attributable to inflation. Adjusted for inflation, MCPS expenditures on active employee group insurance increased from $370.2 million in FY18 to $438.9 million in FY25, an increase of 18.6%, or an average annual rate of 2.5%.

- A total of 20,663 MCPS employees enrolled in one of the employer-provided medical group insurance plans in 2018. Seven years later, in FY25, a total of 21,280 MCPS employees enrolled in one of the medical group insurance plans, an increase of 3.0 percent above FY18 enrollment.

- In 2018, 92.0% of eligible employees enrolled in group medical insurance; in 2025, the percentage dropped to 82.6%.

- The average group insurance cost per enrolled MCPS employee (excluding retirees) in inflation-adjusted dollars. From 2018 through 2025, average per enrolled employee costs increased from $17,916 to $20,624 (both in 2025 dollars), a 15.1% increase.

- In FY25, MCPS paid, on average, $12,792 in medical claims per enrolled employee representing 61.4% of all claim costs. MCPS paid, on average, $7,188 in drug claims per enrolled employee in FY25, representing 34.5% of total claim costs.

- MCPS per enrollee drug claim costs increased by 64.4% (in inflation-adjusted dollars) compared to a medical claims growth rate of 20.8% during the same period. Moreover, drug claims have consumed an increasingly greater share of total claim costs in recent years. Drug claims comprised 27.7% of total claim costs in FY18 but grew to 34.5% of total claim costs in FY25.

- Pharmaceutical manufacturers often provide group insurance plan sponsors with rebates in exchange for favorable placement of specific drugs in the plan's formulary. When drug claim costs are offset by rebates, the 2018 to 2025 growth rate for MCPS employee drug claims (as measured in 2025 dollars) was 25.9%, about five percentage points higher than the growth rate for medical claims. Furthermore, when accounting for rebates, MCPS drug claims as a percentage of total claims have remained mostly steady over the past seven years; drug claims comprised 23.4% of total claims in FY18 and 24.3% of claims in FY25.

- Through 2025, MCPS offered employees a choice of three medical plans: a Cigna Open Access Plans (OAP), a Cigna Open Access Plan Plus In-Network (OAPIN) plan, and a Kaiser

Permanente HMO plan.[2] The Kaiser HMO plan includes prescription coverage; MCPS employees who enrolled in one of the other medical plans had to enroll in the Caremark plan to receive prescription coverage. MCPS paid an average of $13,749 per employee enrolled in one of the Cigna plans[3] and $15,002 per employee enrolled in the Kaiser Permanente HMO plan. In 2025, average cost to MCPS for the Caremark plan was $4,326 (including rebates). MCPS employees who enrolled in one of the Cigna medical plans plus the Caremark prescription plan cost MCPS, on average, $18,077 in FY25, or $3,075 (20.5%) more than the cost per employee enrolled in the Kaiser Permanente HMO.

- In 2025, about 44% of MCPS employees enrolled in the Cigna Open Access plan while about 41% enrolled in the Cigna Open Access Plus In-Network plan. About 15% of MCPS employees elected to participate in the Kaiser Permanente HMO plan.

- From 2018 through 2025, MCPS experienced a shift in coverage levels with the percentage of employees selecting Family coverage declining by 1.7 percentage points (from 46.9% to 45.2%) and the percentage of employees selecting Two-Party coverage decreasing by about 2.1 percentage points (from 23.3% to 21.2%). During this time, the percentage of employees selecting Single coverage increased by 3.7 percentage points (from 29.8% to 33.5%).

In sum, MCPS inflation-adjusted expenditures on active employee group insurance increased by 15.1 from FY18 through FY25. Claims cost increases, particularly for prescription coverage, are a major driver of per employee costs. A small but measurable upward shift in the percentage of MCPS employees who enroll in single coverage has mitigated expenditure increases. Another factor in the expenditure growth was the 3.0% increase during this period in the number of enrolled employees. However, the growth in expenditures seems to be tempered by the declining rate of employee participation in MCPS group insurance plans.

Group Health Insurance Cost Containment Practices

Many employers, including the County Government and MCPS undertake practices to control employee group health insurance costs. The most prominent of these practices is prescription utilization management. Prescription utilization management is a cost-containment strategy to ensure medications are both cost-effective and efficacious in treating the condition for which they were prescribed. Common utilization management techniques include:

[2] MCPS introduced the "preferred care management" options for Cigna medical plans in 2026. Today, MCPS offers employees a choice of five medical insurance plans, two Cigna Open Access Plans (OAP, one with "preferred care management" and one without) and two Cigna Health Maintenance Organization/Open Access Plan Plus In-Network (HMO/OAPIN) plans (one with "preferred care management" and one without), and a Kaiser Permanente HMO plan.

[3] MCPS's financial system tracks the combined costs for all Cigna plans covered by the agency's self-insurance fund; MCPS does not have disaggregated cost data for each of the Cigna plan types.

- Generic and Biosimilar Medications: Generics and biosimilar medications often are available at lower cost than the original treatments. A prescription insurance plan sponsor may seek to reduce costs by requiring use of generics and biosimilars for the treatment of certain conditions.

- Prior Authorization: Prior authorization requires a health care provider to obtain approval before prescribing certain medications to treat specific health conditions. This practice may control costs by assessing whether prescribed treatments are medically necessary, align with clinical guidelines, and include lower-cost alternatives.

- Step Therapy: Prescription step therapy requires patients to try lower-cost medications before a health plan covers a more expensive treatment. Step therapy often begins with a prescription for generic drugs or preferred brand-name alternatives.

- Quantity Limits: A prescription drug quantity limit is a practice in which a health insurance plan restricts coverage for a specific medication to a defined time period.

As detailed in Chapter 6 of this report, both the County Government and MCPS have undertaken multiple cost containments practices.

Discussion Questions

OLO suggests that Councilmembers ask County Government and MCPS group insurance managers to discuss the most effective and equitable means of controlling group health insurance costs. In addition, OLO suggests Councilmembers discuss with agency and labor representatives the following four policy-related questions:

1. *What is the optimal group insurance cost share arrangement between County agencies and their employees? Should agency cost-share policies incentivize employees to select lower-cost plans?*
2. *Should the County Government and MCPS consider alternative cost-share approaches such as salary-based charges and unitized pricing for family coverage?*
3. *Should the County Government and MCPS consider implementing group insurance opt-out programs?*
4. *How should County agencies assess potential prescription drug utilization management strategies to properly balance cost control with employee access to needed treatments?*

CHAPTER 1: REPORT ASSIGNMENT, SCOPE, AND STRUCTURE

This chapter summarizes the assignment given to the Office of Legislative Oversight (OLO) by the Montgomery County Council, discusses the scope of this report, and outlines the structure of the report. This chapter also includes a racial equity statement and acknowledges people who contributed to the development of this report.

A. Assignment

As part of the OLO Fiscal Year 2026 Work Program, the County Council directed OLO to collect data on annual County Government and Montgomery County Public Schools (MCPS) active employee group insurance costs over the past several years to identify the factors that have contributed to rising costs. This report summarizes policies and practices that directly affect group insurance costs.

OLO also conducted a literature review on the external factors that have affected employer-provided group insurance costs in the United States as well as practices intended to contain these costs. In addition, this report compares the advantages and disadvantages of an employer self-insurance model and a fixed premium insurance model.

B. Report Scope

As directed by the County Council, this report addresses the costs associated with group health insurance provided by the County Government and MCPS to active employees. The report does not consider group health insurance costs for retired employees.

This report presents data for the years 2018 through 2025.[4] The County Government has retained its current actuary since 2018 but lacks ready access to data prior to that year. Whenever possible, OLO adjusted past year cost data to account for inflation based on the U.S. Bureau of Labor Statistics Medical Care Consumer Price Index for All Urban Consumers (CPI-U) for the Washington-Arlington-Alexandria, DC-VA-MD-WV area.

[4] Several MCPS data sets reflect costs measured by fiscal year. For these data sets, this report presents cost information for Fiscal Year 2018 (FY18) through Fiscal Year 2025 (FY25).

C. Report Structure

This OLO report consists of nine chapters.

- Chapter 2, *Group Health Insurance Overview*, provides general background information about employer-provided group health insurance as well as an overview of group health insurance benefits offered by the County Government and MCPS. The chapter also includes definitions of group health insurance terms used in this report.

- Chapter 3, *External Group Health Insurance Cost Drivers*, describes external factors that have contributed to recent increases in health care costs in the United States.

- Chapter 4, *Employer Group Health Insurance Policies*, discusses policies adopted by plan sponsors that directly affect group health insurance costs paid both by the sponsor and plan participants.

- Chapter 5, *County Government and MCPS Group Health Insurance Data*, presents data on costs incurred by the County Government and MCPS to provide group health insurance benefits to active employees and identifies factors that contribute to growth in group insurance expenditures.

- Chapter 6, *Group Health Insurance Cost Containment Practices*, describes practices commonly used by employers to control expenditures on employee group insurance and presents information about the Maryland Prescription Drug Affordability Board.

- Chapter 7, *Employer Self-Insurance*, discusses the relative advantages and disadvantages of employer group health self-insurance as well as the predominant practices of large employers.

- Chapter 8, *Discussion Questions*, presents discussions questions based on the findings of this report for Councilmember consideration.

- Chapter 9, *Stakeholder Comments*, includes responses from the County Government and MCPS to the Chapter 8 discussion questions.

D. Racial Equity Statement

In 2019, the County Council established the Racial Equity and Social Justice Act. This law directs County departments and offices to apply a racial equity and social justice lens to their work. To apply a RESJ lens, OLO pays attention to race, ethnicity, and other social constructs when analyzing problems, looking for solutions, and defining success. Neither the County

Government nor MCPS have access to data on employee group health insurance enrollment decisions by racial or ethnic identities.

This report does not make recommendations regarding policies and practices that affect group health insurance costs. Any decision to retain or modify County Government or MCPS group health insurance policies or practices should consider whether those decisions reduce or increase racial or ethnic disparities in health care coverage.

E. Acknowledgements

OLO acknowledges the insights, support, guidance, and assistance provided for this report by:

- Traci L. Anderson, Montgomery County Office of Human Resources
- Karen Bass, Montgomery County Office of Human Resources
- Samuel Frushour, Montgomery County Office of Human Resources
- Richard C. Johnstone, Montgomery County Public Schools
- Karen Pecoraro, Office of Legislative Oversight
- Jennifer Shovlin, Montgomery County Office of Human Resources

CHAPTER 2: GROUP HEALTH INSURANCE OVERVIEW

This chapter provides general background information about employer-provided group health insurance as well as an overview of group health insurance benefits offered to employees of the Montgomery County Government (County Government) and Montgomery County Public Schools (MCPS). The chapter also includes definitions of group health insurance terms used in this report.

A. Employer-Provided Group Health Insurance

Many employers in the United States, including the County Government and MCPS, provide members of their workforce with a group health insurance benefit. Through this benefit, employees may access health insurance coverage through plans offered by their employer. In many cases, the employer allows employees to include coverage for eligible dependents under the group insurance benefit.

Instead of requiring workers to independently subscribe to individual health plans, the employer negotiates contracts with one or more insurance providers to cover workers who elect to participate in an employer-provided plan. Both employer and employee contribute to the cost of health insurance. As cost risk is spread across a large pool of people, employer-provided health insurance plans often are more affordable and provide better coverage than plans offered to an individual or a family.

Employer-provided health insurance comes in many forms. In addition to coverage for medical services such as doctor visits, emergency care, and hospital stays, some employers offer insurance plans that cover costs related to prescription drugs, dental care, and vision care. In addition, employer-provided group health insurance plans vary widely in terms of employee cost share, deductibles, co-payments, and other cost elements (see next section).

B. Definition of Group Health Insurance Terms

This section provides brief definitions of group health insurance terms used in this report.

- Co-payment: the fixed dollar amount the plan participant pays for a covered health care service.

- Cost Share: The percent of group insurance premium costs paid by employer and employee, respectively. The employer cost share plus the employee cost share total to 100%.

- Deductible: The amount a plan participant must pay at the beginning of the coverage year for health care services before the health insurance plan begins to pay.

- Dental Maintenance Organization (DMO): A dental care plan that has its own network of dentists that provides eligible medical coverage without charging the plan participant or the employer for individual claims.

- Exclusive Provider Organization (EPO): A health insurance plan that has its own specific network of doctors and hospitals that provide but generally does not require subscribers to obtain referrals to see specialists.

- Fully Insured Plan: A group health insurance plan in which the employer purchases health insurance coverage from a commercial insurer to provide coverage for its employees. The employer and employees pay premiums to the insurance provider which then assumes the financial risk plan participants' claims (see definition of "Self-Insured Plan").

- Health Maintenance Organization (HMO): A health plan that has its own network of health care providers, medical facilities, and pharmacies that provide eligible medical coverage without charging the plan participant or the employer for individual claims.

- Open Access Plan (OAP): A health insurance plan that allows members to visit both in-network and out-of-network specialists directly without a referral from a primary care physician.

- Open Access Plan Plus In-Network (OAPIN): A health insurance plan that allows members to visit in-network specialists directly without a referral from a primary care physician.

- Point-of-Service (POS) Plan: A managed group health insurance plan that requires plan participants to select a primary care physician for in-network referrals. Plan participants may seek care outside of the network at an additional cost.

- Preferred Provider Organization (PPO) Plan: A group health insurance plan that offers access to a network of health care providers and services at set rates, and usually with a referral requirement. Plan participants may seek care outside of the network at an additional cost.

- Self-Insured Plan: A group health insurance plan in which the employer assumes the financial risk for plan participants' claims (see definition of "Fully Insured Plan").

- Point-of-Service (POS) Plan: A managed group health insurance plan that requires plan participants to select a primary care physician for in-network referrals. Plan participants may seek care outside of the network at an additional cost.

C. Affordable Care Act

The Affordable Care Act (ACA) of 2010 governs the provision of health insurance in the United States including employer-provided health plans. In brief, the ACA prohibits insurance companies from denying coverage or imposing additional charges for pre-existing conditions (such as asthma, diabetes, or cancer). This law further requires most insurance plans to cover essential health benefits including emergency room visits, hospital stays, preventative care, pregnancy and newborn care, prescription drugs, and mental health services. In addition, the ACA allows adult children to remain on their parents' health insurance plans until age 26.

D. Montgomery County Government Employee Group Health Insurance Benefits

The County Government offers health insurance coverage for permanent full-time or part-time employees and (unless collectively bargained otherwise) work at least 20 hours per week. The County Government also provides coverage for employees' spouses as well as children, stepchildren, or others for whom the employee has legal custody who are: (a) under 26 years of age; or (b) who is incapable of self-support because of a mental or physical disability and who depends on the employee for financial support.

Currently, the County Government offers a choice of four medical insurance plans, CareFirst High Option POS, CareFirst Standard Option POS, United Healthcare EPO, and Kaiser Permanente HMO. The Kaiser Permanente HMO plan also includes prescription and vision coverage. For employees who elect to participate in a plan other than Kaiser Permanente, the County Government offers a Caremark prescription plan. The County also offers employees an option to enroll in a Cigna dental care plan and an EyeMed vision plan.

At present, the County contributes 80% of the premium costs for all group health insurance plans; the employee pays the remaining 20% of premium costs through payroll deductions. Current County Government health care rates appear here. Additional details about County Government employee health insurance benefits can be found in the Group Insurance Summary Description document prepared by the County's Office of Human Resources.

As described in Chapter 4 of this report, the terms of employee health insurance benefits offered by the County Government have been subject to change. Section 33-107 of the County Code lists "employee benefits such as insurance" as one of the items for which the County Executive has a duty to bargain with certified employee organizations. Nonetheless, a 2010 County Attorney opinion determined the law authorized the County Council to modify health benefits outside of the collective bargaining process.

E. MCPS Employee Group Health Insurance Benefits

MCPS offers health insurance coverage for permanent employees who work at least 20 hours per week and their spouses. MCPS also provides coverage for employees' children,

stepchildren, or others for whom the employee has legal custody who are: (a) under 26 years of age;[5] or who have a permanent disability.

Currently, MCPS offers a choice of five medical insurance plans, two Cigna OAP plans (one with "preferred care management" and one without) and two Cigna HMO/OAPIN plans (one with "preferred care management" and one without)[6] and a Kaiser Permanente HMO plan. The Kaiser Permanente HMO plan also includes prescription, preventative dental, and vision coverage. For employees who elect to participate in a plan other than Kaiser Permanente, MCPS offers a Caremark prescription plan. MCPS also offers employees the option to enroll in a CareFirst PPO dental plan, an Aetna DMO dental plan, and a Davis/CareFirst vision plan.

The current cost share between MCPS and employees varies by plan. Depending on the plan, MCPS contributes between 75% and 87% of premium costs; employees contribute between 13% and 25% of cost. Information about the cost share for each group health plan offered by MCPS appears in the next chapter. Current MCPS health care rates appear here. See Chapter 4 of this report for a brief history of changes to the MCPS employer/employee group insurance cost shares.

Additional details about MCPS employee health insurance benefits can be found in the 2026 Employee Benefit Summary document prepared by the MCPS Employee and Retiree Service Center.

As described in Chapter 4 of this report, the terms of employee health insurance benefits offered by MCPS are subject to change. The Board of Education is responsible for selecting group insurance providers and plans for MCPS. In addition, contract agreements between MCPS and its employee bargaining units stipulate that a Joint Employee Benefits Committee will periodically review the terms and performance of employee group insurance plans.

[5] MCPS offers dental and vision coverage for employees' adult children who are under 26 years of age.
[6] Under Cigna's Care Management program, an in-network physician and a nurse advocate manages the plan participant's care. Prior authorization is required before receiving in-network and out-of-network care. For more details, see Chapter 4 of this report.

CHAPTER 3: EXTERNAL GROUP HEALTH INSURANCE COST DRIVERS

This chapter briefly describes the external factors that have contributed to recent increases in health care costs in the United States. OLO defines external factors as those national health care, demographic and economic trends that impact medical spending but are beyond the control of an individual employer or health insurance sponsor.

Multiple factors influence the cost of health care. This chapter highlights five external factors that have contributed to recent increases for health care payers including employee insurance plan sponsors.

A. Prescription Drug Use and Costs

Much of the recent increases in health care costs stem from growth in prescription drug spending. In particular, the rapid introduction and prevalent use of new specialized pharmaceuticals is a major cost driver for group health insurance sponsors. As presented in a research article by the Journal of Managed Care and Specialty Pharmacy (JMCP), more than 50% of total drug spending in the United States comes from specialty drugs. Moreover, in recent years, the FDA has approved many new therapies targeting complex, chronic, and rare conditions. According to the National Insurance Services (NIS), nearly 80% of FDA approvals in 2025 were for specialty drugs.

Several categories of prescription drugs have contributed to the rise in group insurance spending both because of increased use and because of the high cost per dose. For example, use of GLP-1 medications originally approved by the FDA to treat Type-2 diabetes are now approved and widely used for weight loss. Research from the Kaiser Family Foundation found that "the number of claims for GLP-1s increased four-fold between 2019 and 2024, from 4.8 million to 21.8 million, with claims doubling between 2022 and 2024 alone." According to the National Insurance Services (NIS), GLP-1 costs average close to $1,000 per patient per month.

Oncologic treatments also are a major contributor to group health costs. As stated by the National Cancer Institute, "compared to a decade ago, patients with cancer are receiving increasingly expensive chemotherapy and biologics, both alone and in combination. The use of expensive supportive agents and hematopoietic growth factors has also increased. The list price of newly introduced systemic therapies and supportive drug-based treatments is growing, and prices of both infusion and oral drugs continue to increase after product launch…. Prices higher than $10,000 a month for individual drugs and biologic agents are common."

Another prescription drug category that significantly affects group insurance costs is a class of biological medications designed to treat Immunology and Inflammatory conditions such as rheumatoid arthritis, psoriasis, and Crohn's disease. A biological medication is a drug derived from living organisms (such as bacteria, yeast, or animal cells) rather than chemical synthesis. Biological treatments generally are more expensive to develop and manufacture than traditional

chemical-based drugs. According to a recent article posted by the National Library of Medicine, these biological treatments cost an average of $10,000 to $30,000 per patient per year.

B. Aging of the Workforce

The U.S. population and the U.S. workforce have aged measurably in recent years. Data from the U.S. Census Bureau confirm this trend. According to U.S. Census Bureau data, workers who are 55 years of age or above comprised 21.8% of all workers in the State of Maryland in the Year 2015. By the Year 2025, workers in Maryland aged 55 or above comprised 26.0% of the Maryland workforce.

The aging of the U.S. population and the concurrent aging of the workforce have increased utilization of health care coverage sponsored by employers. In general, older people make a greater number of medical provider visits and use more prescription drugs than younger people. In addition, as workers age, they are more likely to develop chronic conditions, such as heart disease and diabetes, that are costly to treat and control. As a result, the aging of the U.S. workforce has contributed to rising health insurance costs paid by employers.

C. Hospital and Medical Provider Consolidation

The structure and economics of the U.S. health care system also affects the cost of medical treatments borne by employers. One cause of health care cost escalation is the recent trend toward hospital and medical provider consolidation. In this context, the term "consolidation" refers to a shift from numerous providers of varying sizes to fewer and larger providers dominating the industry. A recent report by the U.S. Department of Health and Human Services (HHS) found that "over the last thirty years, the health care industry has experienced a dramatic and continuous trend of consolidation across the country." Health care provider consolidation often leads to higher costs. As stated in the HHS report, "empirical research unambiguously shows that hospital system-led acquisitions and mergers are associated with higher prices for services charged to insurers and patients." Large health networks that acquire independent physician practices or that merge with other networks achieve leverage to negotiate higher reimbursement rates from insurers. The HHS report further found that large health care systems with a large market share in a geographic region may steer referrals within their systems resulting in less competitive pricing for services. These practices contribute to driving up insurance premium costs paid by employers.

D. Private Equity Investment

The DHHS report cited in the previous section identifies private equity (PE)[7] investment another cause for rising health care costs. The report states that the health care sector has experienced an influx of investment from PE investors in recent years and cites research that found the PE-

[7] Private equity is a type of private fund that pools money from institutional investors and high-net-worth individuals to acquire or invest in established private companies that are not publicly traded.

backed companies own more than 30% of physician practices and more than 40% of emergency rooms in the United States as of 2024. As stated in the report, "an emerging body of literature also shows that PE acquisitions lead to higher prices for insurers and patients in their pursuit of profits. Hospitals acquired by PE firms increase prices by 7-16% … and PE-acquired physicians' practices increase prices 4-20%." The HHS report cites studies that suggest PE-backed firms disproportionately engage in up-coding, provide unnecessary services, and order more high margin tests and procedures. These increased costs are borne by both insurance plan sponsors and patients.

E. Labor Shortages

The cost of labor is a significant component of total medical costs. For example, the American Hospital Association estimates that labor comprised 56% of total hospital expenses in 2024. The supply of physicians, nurses, and other medical professionals dropped markedly during the Covid pandemic and staffing shortages continue today. This labor shortage has prompted hospitals and other medical providers to raise staff compensation levels to attract and retain a sufficient supply of qualified workers. As a result, many health care providers have sought to negotiate higher reimbursement rates from insurance companies to offset increased employee compensation costs. Much of these higher costs have been passed on to insurance plan sponsors.

CHAPTER 4: EMPLOYER GROUP HEALTH INSURANCE POLICIES

The previous chapter discussed group health insurance cost drivers that are mostly out of the control of plan sponsors (such as employers). This chapter discusses cost drivers controlled by group insurance plan sponsors, that is, policies adopted by plan sponsors that directly affect group health insurance costs paid both by the sponsor and plan participants (employees). The first section of this chapter introduces a series of expense sharing and eligibility policies that impact the group insurance financial burden borne by employers and employee, respectively. The next two sections describe the specific group health insurance expense sharing and eligibility policies adopted by the County Government and MCPS.

A. Group Health Insurance Cost Share and Eligibility Policies

As group insurance plan sponsors, employers implement policies that directly affect the costs they incur, as well as costs paid by employees. The combined effect of each of these policy decisions shape the "richness" of the group insurance plan offerings. In the context of group insurance, the term "richness" refers to allocation of cost burden between a plan sponsor and plan participants. A plan is considered "richer" to the extent the plan sponsor assumes greater costs than plan participants. This section discusses seven policies that affect the distribution of costs between the plan sponsor (the employer) and plan participants (employees).

1. Employer/Employee Premium Cost Share

As it relates to group insurance, the term, "cost share,'" refers to the percents of group insurance premium costs paid by the employer and the employee, respectively. The employer cost share plus the employee cost share total to 100%. Higher employer cost shares make group insurance more affordable for employees but also raise the amount of money the employer must set aside for this benefit.

According to a 2025 report by the U.S. Bureau of Labor Statistics, on average, state and local government employers with 500 or more employees assume 86% of medical group insurance premium costs for employees with single coverage and 71% of premium costs for employees with family coverage. (See subsection 4 below for a discussion of coverage of employees' spouses and dependents.)

Table 1. Average Employer and Employee Medical Group Insurance Premium Cost Share State and Local Government with 500 or More Employees

Type of Coverage	Employer Premium Cost Share	Employee Premium Cost Share
Single Coverage	86%	14%
Family Coverage	71%	29%

Source: US Bureau of Labor Statistics

2. Cost Share Incentives

Some employers set different cost shares for different group health insurance plans. These employers offer lower cost share percentages to employees who select insurance plans with lower overall costs. This approach incentivizes employees to select lower cost plans and so reduces costs for both the employer and for employees who select the lower cost plans. However, establishing cost share differentials could be seen as placing a higher cost burden on employees who require more robust – and thereby most costly – health insurance coverage.

3. Out-of-Pocket Costs

Beyond premium cost shares, employers and employees divide group health costs through other "out-of-pocket" payment requirements. Out-of-pocket costs refer to the portion of health care expenses the employee must pay for specific health care events. The two most common forms of out-of-pocket health care expenses are co-payments and deductibles. A co-payment is a fixed dollar amount the plan participant pays for a covered health care service. A deductible is the amount a plan participant must pay for health care services at the beginning of the coverage year before the health insurance plan begins to pay.

In general, group health insurance plans with higher out-of-pocket costs have lower premium costs. As the employer pays for a portion of premium costs but does not contribute to out-of-pocket costs, plans with higher out-of-pocket costs often require lower employer contributions than plans with lower out-of-pocket costs. For the employee, plans with higher out-of-pocket costs benefit workers with low health care usage but raise costs for workers with high health care usage.

Many employers offer employees a choice of health care plans with different premium costs and different levels of out-of-pocket costs. Plans referred to as "high option," or a similar title, have a higher premium cost but lower out-of-pocket costs than plans referred to as "standard option" or a similar title.

4. Cost Share for Spouses and Dependents

The Affordable Care Act (ACA) requires large employers to provide health insurance coverage to full-time employees and dependents (up to the age of 26 or with certain certified disabilities). The ACA does not mandate that employee health insurance plans also include coverage for spouses. Nonetheless, many large employers offer health insurance plans with different coverage levels, some of which include coverage for spouses and dependents. Plan coverage options include coverage for the employee alone (often referred to as "single" coverage), for the employee plus one other family member (a spouse or child, referred to as a "self plus one" plan), or for the employee and all eligible family members ("family coverage"). Employers may offer the same or different cost shares for each coverage level. That is, the employee may

contribute the same percentage of premium costs for all offered group insurance plans or may contribute different percentages of premium costs for self, self plus one, and family coverage.

Some employers have introduced "unitized pricing" that adjusts the employee's contribution amount for a family plan based on the number of people covered by the plan. Setting employee cost contributions based on the number of people covered by an employer-provided insurance plan may better align the benefit level with the cost incurred by the employer but may also be perceived as a bias against larger families.

As shown in Table 1 above, data from a 2025 report by the U.S. Bureau of Labor Statistics indicate that, on average, state and local governments with 500 or more employees cover a greater share of premium costs for single coverage than for family coverage.

5. Eligibility and Costs for Part-Time Employees

The ACA does not require large employers to provide health insurance coverage to part-time employees. For the purposes of ACA insurance mandates, a part-time employee is defined as an employee who works fewer than 30 hours per week. Some employers do not offer any group health insurance benefit to employees not subject to the ACA mandate. Nonetheless, employers may choose to offer group health insurance benefits to employees who work fewer than 30 hours per week. Employers who offer health insurance to part-time employees must decide how to share premium costs with these employees. Some employers offer part-time employees who work a specified number of hours (such as 20 hours per week) the same health insurance options as available to full-time employees. Other employers adjust the cost share for part-time employees, such as pro-rating the employer cost share based on the number of hours worked per week.

As shown in Table 2, data from a 2025 report by the U.S. Bureau of Labor Statistics indicate that, on average, state and local governments cover a greater share of premium costs for full-time employees than for part-time employees.

Table 2. Average Employer and Employee Medical Group Insurance Premium Cost Share State and Local Government Full-Time and Part-Time Employees

Type of Coverage	Employer Premium Cost Share	Employee Premium Cost Share
Full-Time Employee, Single Coverage	87%	13%
Full-Time Employee, Family Coverage	72%	28%
Part-Time Employee, Single Coverage	83%	17%
Part-Time Employee, Family Coverage	68%	32%

Source: US Bureau of Labor Statistics

6. Salary-Based Charges

Traditionally, employers have provided a single menu of group health insurance plans and costs to all eligible employees, regardless of their salary. Some employers have adopted a policy to tie employees' contribution to salary. Under a salary-based model, premium cost shares vary within specified salary bands; employees with lower salaries pay a lower share of premium costs than employees with higher salaries. For example, for Fiscal Year 2026, State of Illinois employees who earn below $30,200 annually contribute between $112 and $152 per month for medical insurance (depending on the plan) while employees who earn more than $125,000 annually contribute between $274 and $314 per month.

Employers who implement salary-based group insurance charges must ensure their pricing structure complies with ACA and other Federal requirements for all employees. Under the ACA, employers must assure health insurance plans remain "affordable" for employees of all salary levels. In general, the Federal affordability test requires that the employee's share for single coverage does not exceed a designated percentage of household income.

Advantages of salary-based charges include the ability of the employer to recover a greater share of premium costs and the establishment of a more equitable benefit program that reduces the risk that lower-paid employees may limit their medical care to avoid both premium and high out-of-pocket costs. Disadvantages of this policy include that an employee's salary may not reflect total household income and health care usage may not correlate with salary.

7. Opt-Out Programs

Some public sector employers offer a financial incentive to employees who elect to waive their employer-provided health insurance and enroll in a spouse's or other family member's health plan. The intent of these "opt-out programs" is to reduce an employer's health benefit spending while assuring that all employees have access to health care. Employees who participate in opt-out programs must demonstrate they have enrolled in a health plan that meets specified coverage standards. In return, participating employees receive a cash payment in lieu of the health benefit. For example, New York State employees who participate in the Opt-out Program are eligible for a 2026 payment of $1,000 for single coverage and $3,000 for family coverage. Similarly, State of California employees who participate in the Cash Option program are eligible for a 2026 payment of up to $1,680 for opting out of their employer's health and dental benefit plans.

B. County Government Cost Share and Eligibility Policies

This section discusses current and past County Government group health insurance cost share and eligibility policies.

1. Current and Past Cost Shares / Cost Share Incentive

The County Government currently contributes 80% of costs for all group health insurance plans; the employee pays the remaining 20% of premium costs through payroll deductions. The County Government currently does not offer any cost share incentives for employees to select lower-cost plans (such as HMO or standard option POS plans).

Prior to FY12, the County Government contributed between 68% and 80% of group health insurance premiums costs. Most employees contributed 20% of premium costs for most health plans. Non-represented employees hired after October 1994 contributed 24% of premium costs. In addition, any employee who selected a high option plan contributed an additional 8% of premium costs.

In response to significant revenue shortfalls associated with the Great Recession, the County Executive proposed in his FY12 operating budget two modifications to the health insurance cost sharing. First, the Executive recommended adjusting the employee group insurance cost share to 30% for all plans. In addition, the Executive proposed the County Government implement a new salary-based group insurance charge that would have imposed a $910 per year charge on employees who earned between $50,000 and $89,999 per year and a $1,560 per year charge on employees who earned $90,000 per year.[8]

During consideration of the FY12 operating budget, the County Council rejected the Executive's proposal. Instead, the Council approved a cost share of 75% employer/25% employee for POS plans. To incentivize employee selection of less costly HMO plans, the Council retained the 80% employer/20% employee cost share for HMO plans.

In approving the FY23 operating budget, the Council set the cost share at 80% employer/20% employee for all group insurance plans, thus eliminating any incentive for employees to select a lower-cost plan.

2. Premium vs. Out-of-Pocket Costs

The County Government offers employees health care plans that offer trade-offs between premium costs and out-of-pocket costs. Within the POS plans, the standard option has lower premium costs but higher out-of-pocket cost than the high option plan. For example, the standard option POS plan requires a $15 co-payment for doctor office visits and a $35 co-payment for emergency room visits while the high option POS plan requires a $10 co-payment

[8] All dollar amounts reflect FY12 dollars.

for doctor office visits and a $25 co-payment for emergency room visits. The HMO plans offered by the County Government generally have lower out-of-pocket costs than PPO plans.

3. Spouses, Dependents, and Part-Time Employees

The County Government offers Self +1 as well as Self + Family group health insurance coverage to its employees. While premium costs are greater for Self +1 and Self + Family coverage than for single coverage, the percentage cost share (20% of total premium cost) is the same for all coverage levels.

Most County Government employees who work at least 20 hours per week are eligible for employer-provided group health insurance coverage with a 20% employee cost share. In addition, County collective bargaining agreements may designate employees in certain positions who work fewer than 20 hours per week as eligible for group insurance. For example, crossing guards who work at least ten hours per week are eligible to enroll in County Government group health insurance with a 20% employee cost share.

4. Salary-Based Charges and Opt-Out Program

The County Government does not vary group health insurance options and costs based on an employee's salary.

The County Government does not offer an option for an employee (who is eligible for health insurance coverage through a family member) to receive a cash incentive to opt out of County-provided insurance coverage.

C. MCPS Cost Share and Eligibility Policies

This section discusses current and past MCPS group health insurance cost share and eligibility policies.

1. Current and Past Cost Shares / Cost Share Incentive

The current group health cost share between MCPS and its employees varies by plan. For Calendar Year 2026, MCPS contributes between 75% and 87% of premium costs; employees contribute between 13% and 25% of cost depending on the plan. As shown in Table 3, MCPS is currently in a two-year phase-in that will shift 2% of premium costs from the employer to employees.

Table 3. Calendar Year 2025, 2026 and 2027 MCPS Group Insurance Cost Shares

Group Insurance P*lan*	2025 MCPS Share	2026 MCPS Share	2027 MCPS Share	2025 Employee Share	2026 Employee Share	2027 Employee Share
Cigna Medical POS with Care Management	83%	82%	81%	17%	18%	19%
Cigna Medical POS without Care Management	N/A	75%	74%	N/A	25%	26%
Cigna HMO with Care Management	88%	87%	86%	12%	13%	14%
Cigna HMO without Care Management	N/A	80%	79%	N/A	20%	21%
Kaiser Permanente Medical, Rx, Dental, Vision HMO	88%	87%	86%	12%	13%	14%
Caremark Prescription	83%	82%	81%	17%	18%	19%
CareFirst Dental PPO	83%	82%	81%	17%	18%	19%
Aetna Dental DMO	83%	82%	81%	17%	18%	19%
Davis/Caremark Vision	83%	82%	81%	17%	18%	19%

MCPS offers employees an economic incentive to select lower cost plans. As shown in the table above, MCPS currently contributes a higher percentage of premium costs for HMO medical plans than for POS medical plans. In addition, MCPS contributes a higher premium cost share for Cigna enrollees who participate in "Care Management." Under Cigna's Preferred Care program, an in-network physician and a nurse advocate manage the plan participant's care. Prior authorization is required before receiving in-network and out-of-network care, including for hospital admissions and certain outpatient services such as computed tomography (CT) scans, magnetic resonance imaging (MRI) pain management, medical oncology, and private duty nursing.

2. Premium and Out-of-Pocket Costs

Within the POS plan category, the MCPS group insurance plan with the Preferred Care Management option offers employees both lower premium and lower out-of-pocket costs than the non-care management option. For example, in 2026 the Cigna POS plan with Preferred Care Management has no in-network annual deductible while the Cigna POS Plan without Preferred Care Management has an annual deductible of $200 for individual plans and $400 for family

plans. The HMO plans offered by MCPS generally have lower out-of-pocket costs than the PPO plans.

3. Spouses, Dependents, and Part-Time Employees

MCPS offers self plus one as well as family group health insurance coverage to its employees. While premium costs are greater for self plus one and family coverage than for single coverage, the percentage cost share is the same for all coverage levels with a single plan (see Table 3 for plan specific cost shares).

MCPS employees who work at least 20 hours per week are eligible for employer-provided group insurance coverage. All employees who work at least 20 hours per week contribute the same amount to their group health coverage.

4. Salary-Based Charges and Opt-Out Program

MCPS does not vary group health insurance options and costs based on an employee's salary.

MCPS does not offer an option for an employee (who is eligible for health insurance coverage through a family member) to receive a cash incentive to opt out of MCPS-provided insurance coverage.

CHAPTER 5: COUNTY GOVERNMENT AND MCPS GROUP HEALTH INSURANCE DATA

This chapter presents data on costs incurred by the County Government and MCPS to provide group health insurance benefits to active employees. This chapter further contains data on the employment group health enrollment by plan and coverage level. This chapter identifies factors that contribute to growth in County Government and MCPS group insurance expenditures.

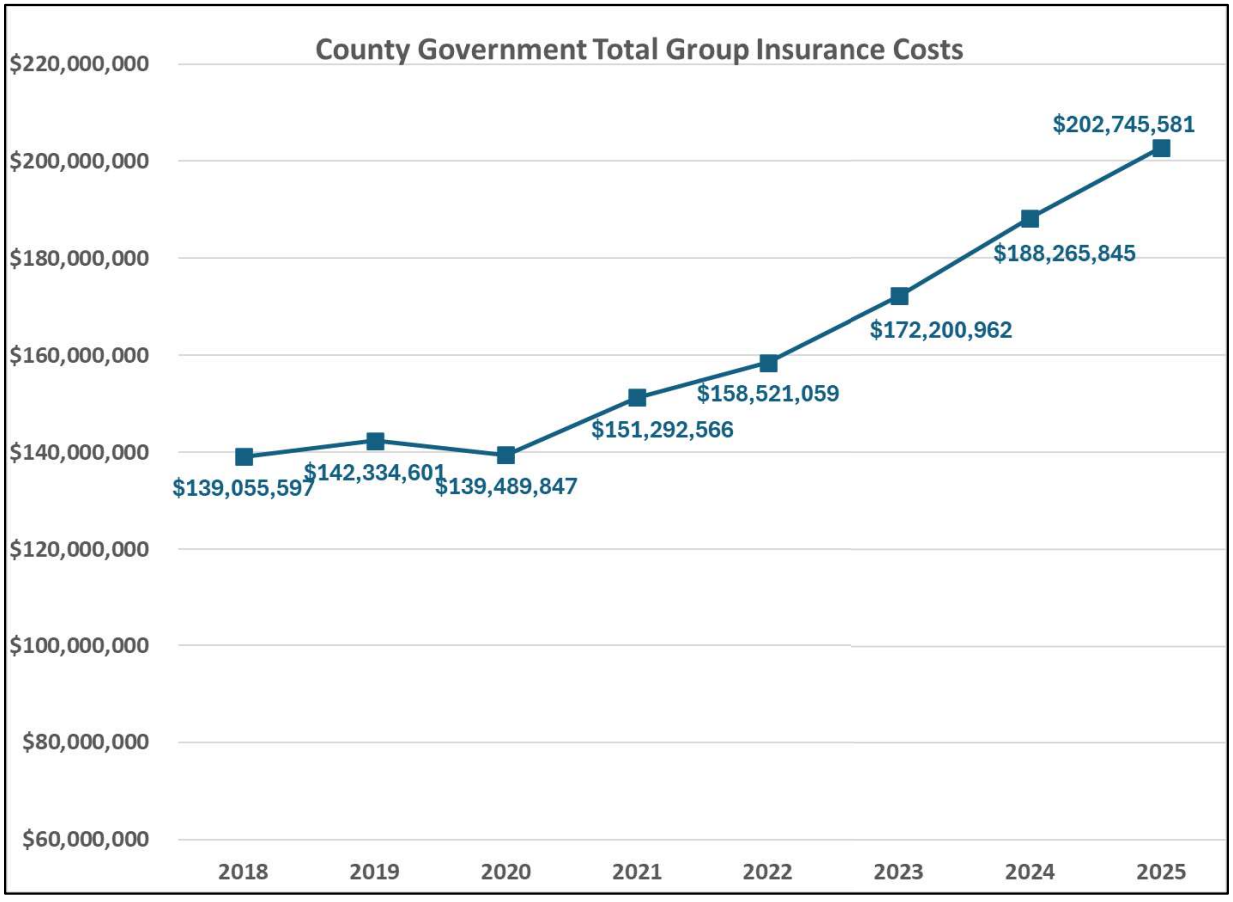
A. County Government Group Health Insurance Data

Section A of this chapter presents employee group insurance data for the County Government.

1. Total Active Employee Group Insurance Costs

Annual County Government expenditures on active employee group insurance (claims plus administrative costs) increased from $139.1 million in 2018 to $202.7 million in 2025, an increase of 45.8%, or an average annual rate of 5.5%. As shown in Chart 1, costs remained mostly stable from 2018 through 2020 (the year of the Covid-19 pandemic). However, these costs rose more sharply from 2020 through 2025. The growth in costs from $188.3 million in 2024 to $202.7 million in 2025 represents a one-year increase of 7.7%.

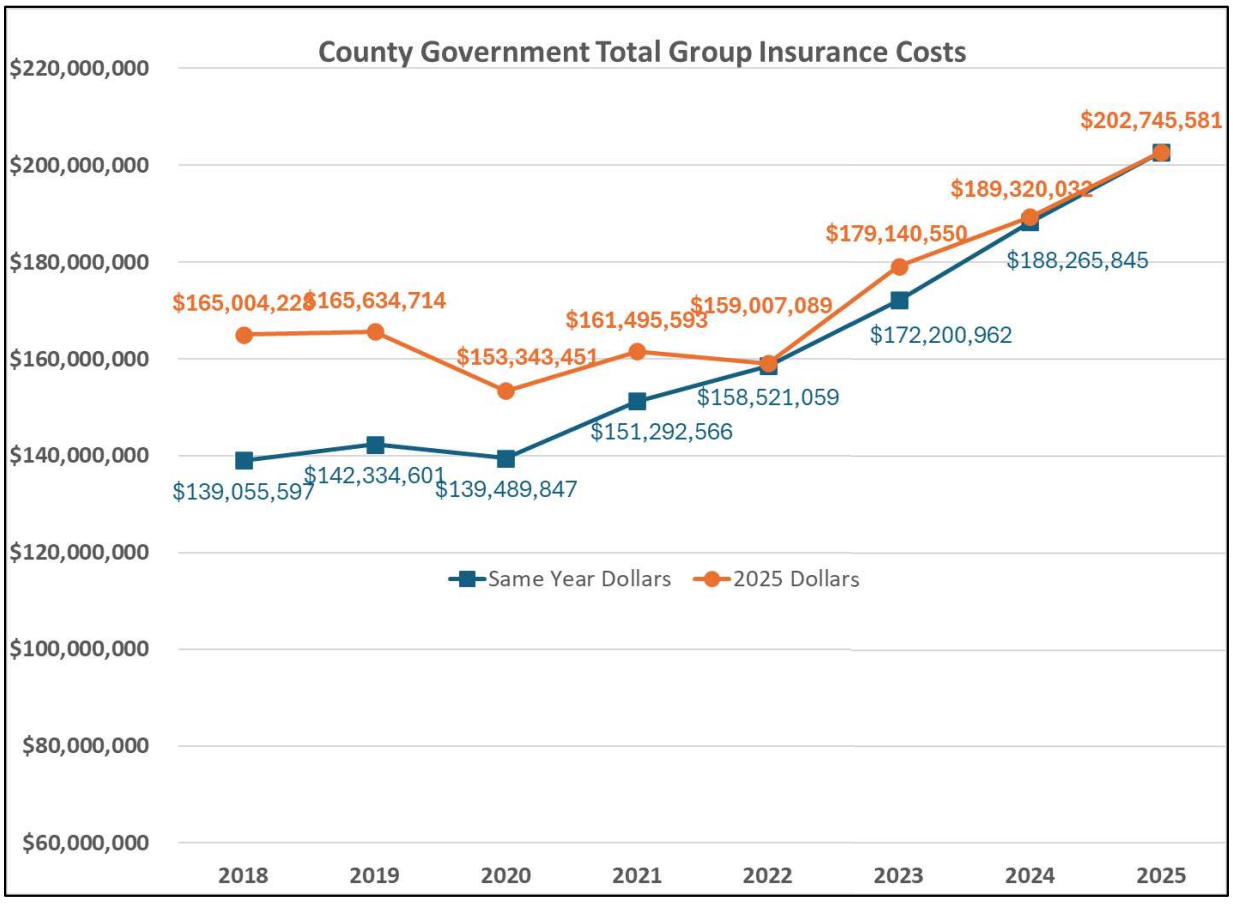
Chart 1



Part of the increase in County Government active employee group insurance costs is attributable to inflation. To account for inflation, OLO adjusted past year group insurance costs into 2025 dollars based on the U.S. Bureau of Labor Statistics Medical Care Consumer Price Index for All Urban Consumers (CPI-U) for the Washington-Arlington-Alexandria, DC-VA-MD-WV area.

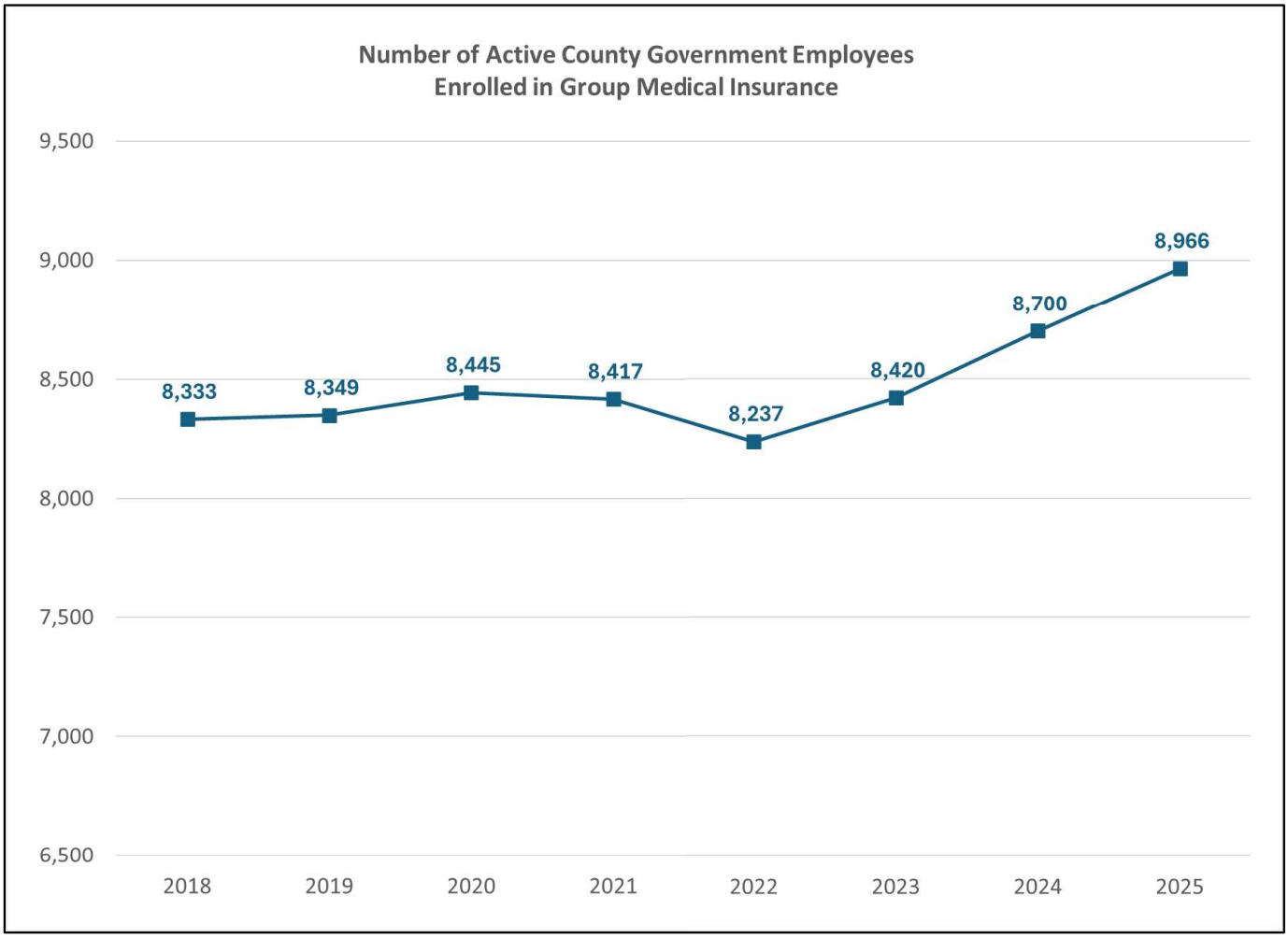
Chart 2 displays two sets of County Government active employee group insurance costs: (a) in unadjusted dollars expended in each year ("Same Year Dollars" shown in blue); and (b) in infaltion-adjusted dollars equivalent to 2025 dollars ("2025 Dollars" shown in orange). Adjusted for inflation, County Government expenditures on active employee group insurance increased from $165.0 million in 2018 to $202.7 million in 2025, an increase of 22.9%, or an average annual rate of 3.0%. The growth in inflation-adjusted costs from $189.3 million in 2024 to $202.7 million in 2025 represents a one-year increase of 7.0%.

Chart 2



Another factor that affects employer group insurance costs is the number of employees enrolled in group insurances plans. As displayed in Chart 3, a total of 8,333 County Government employees enrolled in one of the County-provided medical group insurance plans in 2018. Seven years later, in 2025, a total of 8,966 County Government employees enrolled in one of the medical group insurance plans, an increase of 7.6 percent above 2018 enrollment.[9] This increase in the number of enrolled employees is a significant factor driving up County Government group insurance expenditures.

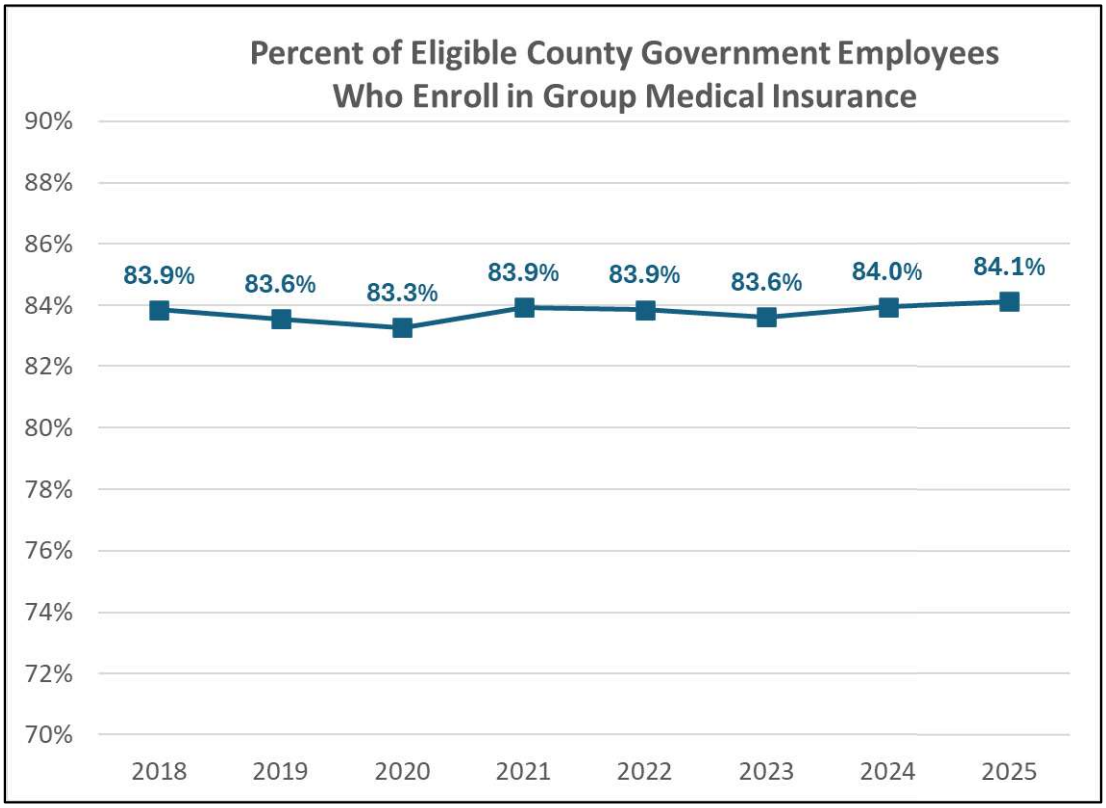
Chart 3



[9] Annual enrollment counts are the average of the monthly enrollment counts for each fiscal year.

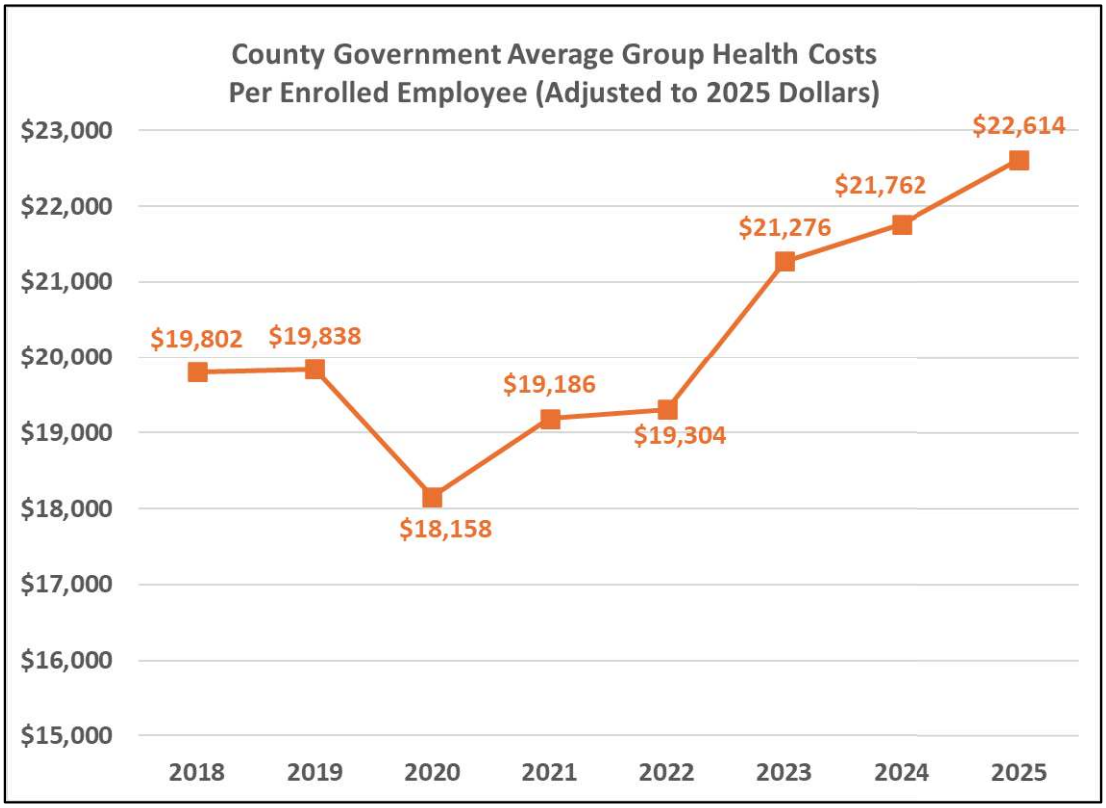
A possible cause for growth in County Government group health insurance enrollment might have been a change in the percentage of employees who elected to sign up for employer-provided health plans. However, as shown in Chart 4, the County Government experienced little change in the percentage of active employees enrolled in group medical insurance. In 2018, 83.9% of eligible employees enrolled in group medical insurance; in 2025, the percentage remained nearly the same at 84.1%. As such, enrollment rate cannot be characterized as a major contributor to increased County costs.

Chart 4



A key driver of County Government group insurance costs is the cost per covered employee. Chart 5 shows the average group insurance cost per enrolled County Government employee (excluding retirees) in inflation-adjusted dollars. The average cost to the County Government in 2018 and 2019 was near $19,800 per enrolled employee. Medical claims dropped precipitously in the Covid pandemic years of 2020 through 2022 but then rebounded significantly in 2023 through 2025. From 2018 through 2025, average per enrolled employee costs increased from $19,802 to $22,614 (both in 2025 dollars), a 14.2% increase.

Chart 5



In sum, the combined and compounded effect of a 7.6% increase in the number of enrolled employees and a 14.2% increase in the inflation-adjusted cost per employee combined to produce a nearly 23% increase in County Government active employee group insurance costs from 2018 through 2025.

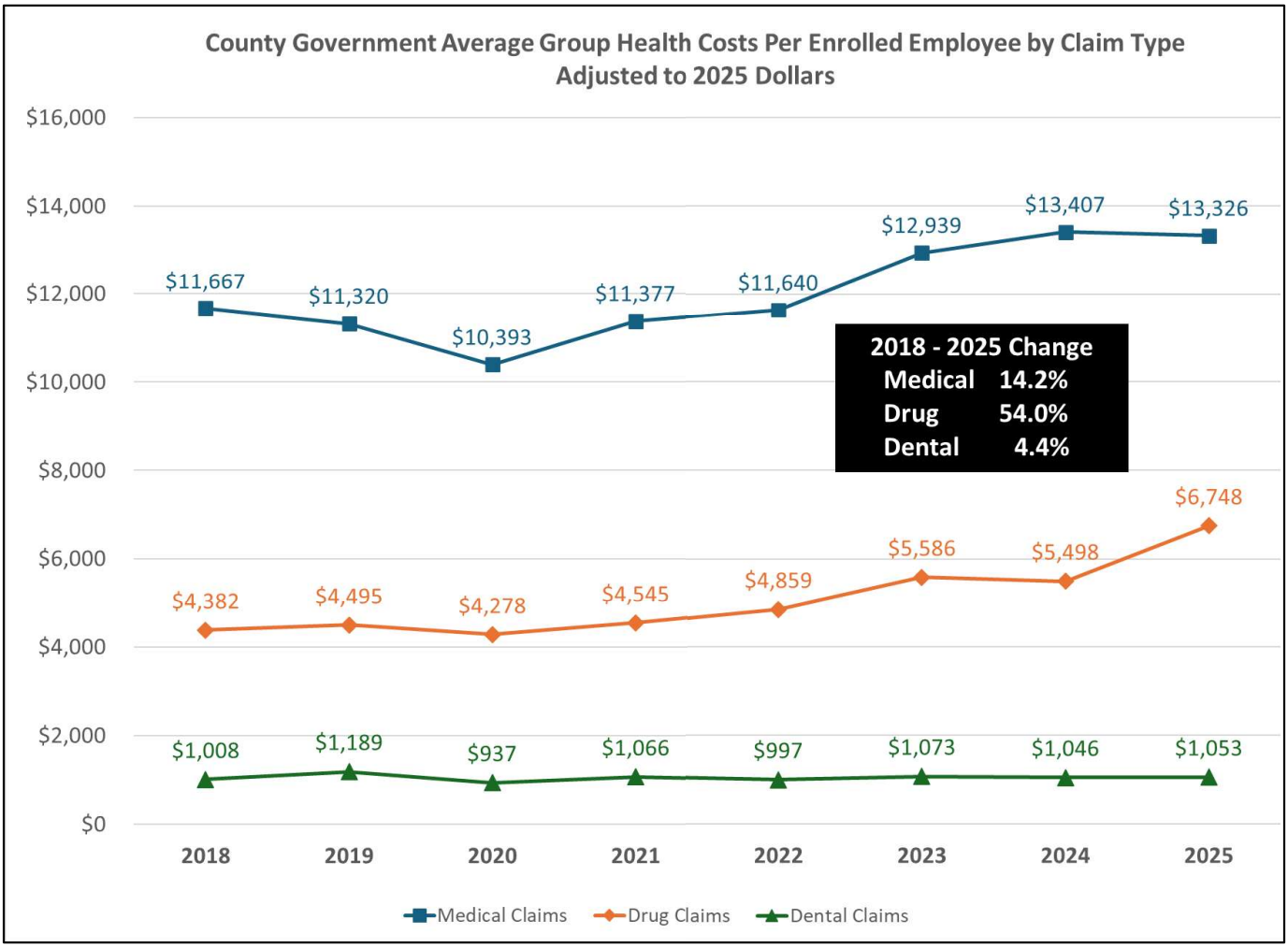
2. Active Employee Costs by Claim Type

As the County Government is a self-insured employer, the dominant component of its group insurance costs are health care claims. Health care claims comprised more than 93% of total County Government group insurance costs in 2025; administrative costs accounted for the remaining 7% of costs. The County Government pays three types of health care claims:

- Medical claims: claims for payment of medical services such as medical provider visits, laboratory work, diagnostic services, procedures, and hospital care.
- Drug claims: claims for payment of prescription medications and treatments.
- Dental claims: claims for payment of dental care provider visits and procedures.

Medical claims account for the largest share of County Government health insurance costs. Chart 6a shows the average medical claim, drug claim, and dental claim costs to the County Government per enrolled employee as measured in inflation-adjusted dollars. In 2025, the County Government paid, on average, $13,326 in medical claims per enrolled employee representing 63.1% of all claim costs. The County Government paid, on average, $6,748 in drug claims per enrolled employee in 2025, representing 31.9% of total claim costs. At $1,053 per enrolled employee, dental claims accounted for only 5.0% of total claim costs.

Chart 6a

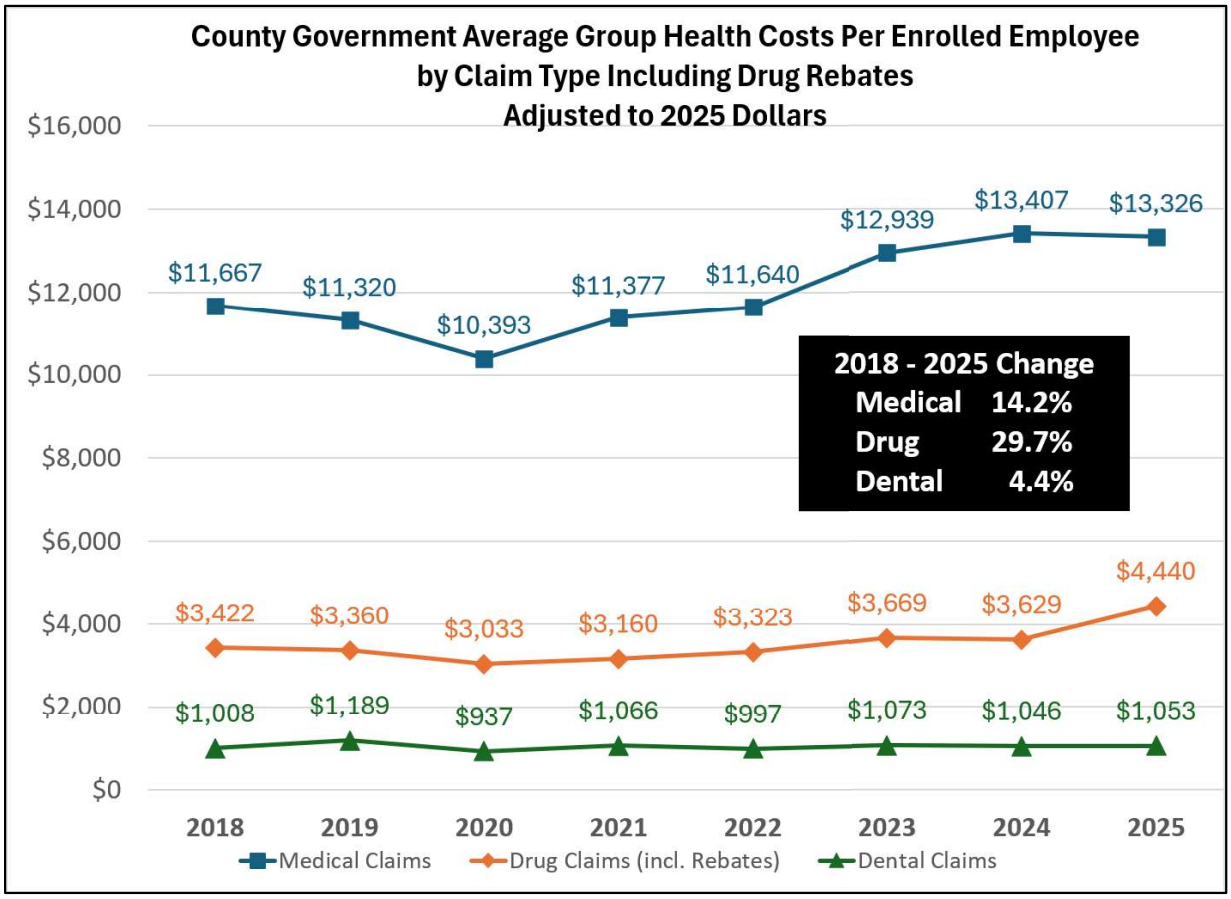


In recent years, drug claim costs have grown at a significantly faster rate than medical claim costs. As shown in Chart 6a, per enrollee drug claim costs increased by 54.0% (in inflation-adjusted dollars) from 2018 to 2025. In contrast, inflation-adjusted medical costs per enrollee increased by 14.2% during the same period. Moreover, drug claims have consumed an increasingly greater share of total claim costs in recent years. Drug claims comprised 25.7% of total claim costs in 2018 but grew to 31.9% of total claim costs in 2025.

Chart 6a above displays County Government expenditures for employee drug claims. However, a significant portion of these costs are later offset when the County Government receives rebates from pharmaceutical manufacturers. Pharmaceutical manufacturers often provide group insurance plan sponsors with rebates in exchange for favorable placement of specific drugs in the plan's formulary. Rebates are typically calculated as a percentage of the plan sponsor's spending on specific drugs.

Chart 6b below shows County Government per enrollee drug claims cost adjusted to account for pharmaceutical manufacturer rebates. When drug claim costs are offset by rebates, the 2018 to 2025 growth rate for employee drug claims (as measured in 2025 dollars) was 29.7%, more than double the growth rate for medical claims. However, when accounting for rebates, County Government drug claims as a percentage of total claims have only increased slightly over the past seven years; drug claims comprised 21.3% of total claims in FY18 and 23.6% of claims in FY25.

Chart 6b



In sum, the data presented above demonstrate that claim cost increases are a major driver of the rapid growth in County Government group insurance expenditures.

3. Active Employee Costs by Medical Plan

County Government employees have an option to enroll in one of four medical insurance plans: CareFirst High Option POS, CareFirst Standard Option POS, United Healthcare HMO, and Kaiser Permanente HMO.

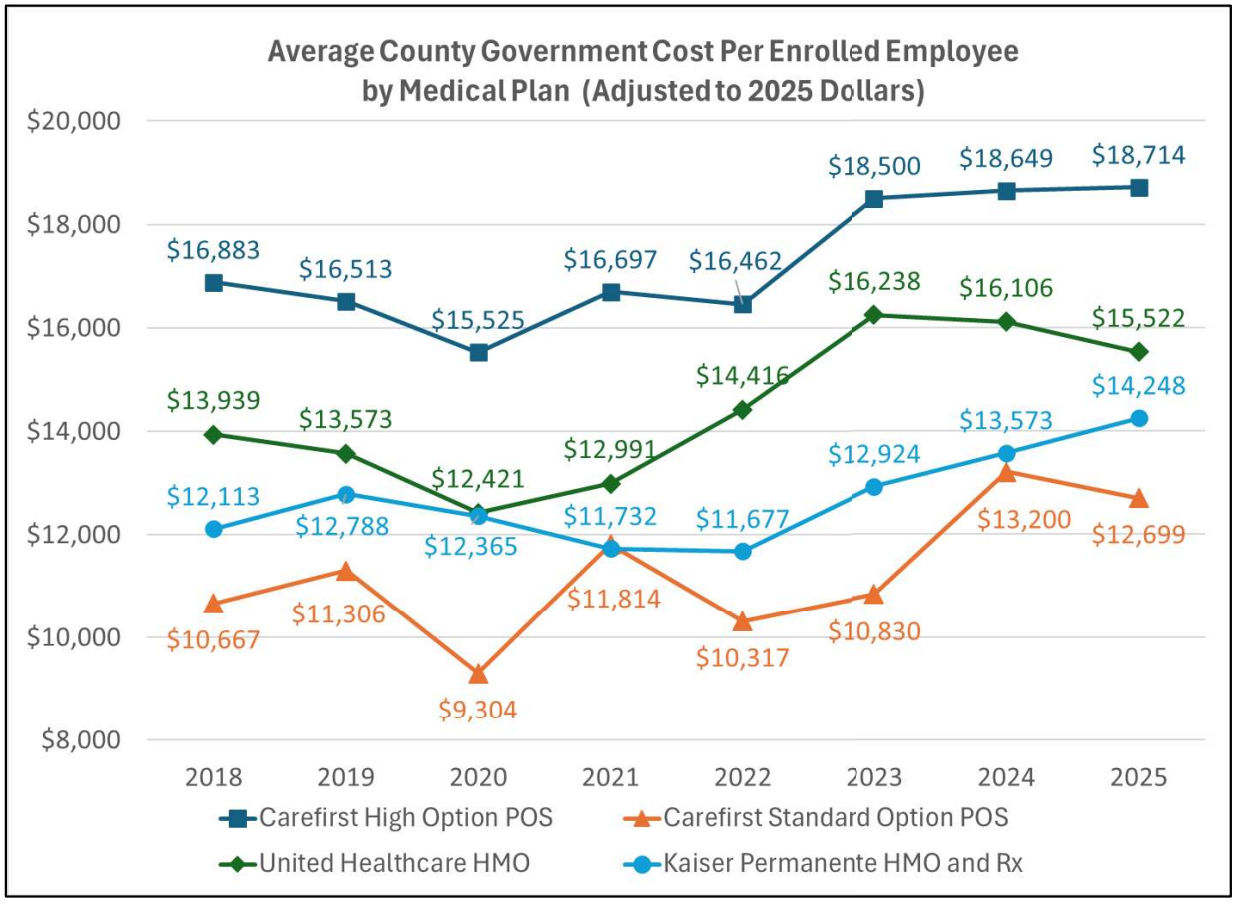
The Kaiser Permanente HMO medical plan differs from other County Government plans in two important ways. First, the Kaiser Permanente HMO plan includes prescription coverage; employees who enroll in one of the other medical plans must also enroll in the Caremark plan to receive prescription coverage. Secondly, County Government self-insurance applies to the CareFirst High Option POS, CareFirst Standard Option POS, and United Healthcare HMO plans. For these three plans, claims costs comprise the bulk of County Government expenditures.[10] In

[10] Claims costs comprise about 95% of County Government group health insurance expenditures; administrative costs comprise the remaining 5%.

contrast, County Government costs for Kaiser Permanente consist entirely of the employer share of premium costs; actual plan usage does not affect the cost to the County Government.

The County Government incurs markedly different costs to insure an employee through the different plans. As shown in Chart 7, in 2025, the County Government paid an average of $18,714 per employee enrolled in the CareFirst High Option POS plan; $15,522 per employee enrolled in the United Healthcare HMO plan; $14,248 per employee enrolled in the Kaiser Permanente HMO plan; and $12,699 per employee enrolled in the CareFirst Standard Option POS plan.

Chart 7



In inflation-adjusted dollars, the per enrolled employee cost increased between 10% and 20% for all plans from 2018 through 2025. The CareFirst Standard Option POS plan had the highest rate of increase, 19.1%, among the four plans during this time period. The CareFirst High Option POS plan had the lowest rate of increase at 10.8%.

A significant difference exists among the four medical plans offered to County Government employees. Three plans – CareFirst High Option POS, CareFirst Standard Option POS, and United Healthcare HMO – provide medical coverage but exclude prescription coverage. The

Kaiser Permanente HMO plan includes both medical and prescription coverage. About 92% of employees enrolled in the CareFirst High Option POS, CareFirst Standard Option POS, and United Healthcare HMO plans also enroll in Caremark prescription coverage. In 2025, average cost to the County for the Caremark plan was $5,888 (including rebates). Table 4 shows the average combined medical and prescription cost per employee in 2025 including both medical and prescription coverage.

Table 4
2025 Average Cost Per County Government Employee
Combined Medical and Prescription Costs

CareFirst High Option POS + Caremark Rx	$24,603
CareFirst Standard Option POS + Caremark Rx	$18,587
United Healthcare HMO + Caremark Rx	$21,410
Kaiser Permanente HMO and Rx	$14,248

Employees who enrolled in the Kaiser Permanente HMO (that includes prescription coverage) cost the County Government $14,248 in 2025, an amount $4,339 (or 30.5%) less than the average combined cost to the County Government of the combined cost of the CareFirst Standard Option POS and Caremark prescription plans; $7,162 (or 50.3) less than the average combined cost of the United Healthcare HMO and the Caremark prescription plans; and $10,355 less than the average combined cost of the CareFirst High Option POS and the Caremark prescription plans;

OLO notes that differences in plan costs per enrolled employee may be influeneced by the populations choosing particular plans. Employees with medical conditions that require greater levels of treatment may gravitate towards plans such as the Carefirst high option while employees that expect only to use their insurance plan for infrequent preventative and emergency services may select lower-costs plans. As such, the cost per enrollee shown above may reflect self selection of employees into different plans based on their medical needs and conditions.

A moderate shift in County Government employee medical insurance selection occurred during the past seven years. As shown in Charts 8a and 8b, a smaller percentage of employees enrolled in HMOs in 2025 than in 2018. In 2018, a combined 42.5% of employees participating in County Government medical insurance plans elected HMO coverage. By 2025, the percentage of employees enrolled in HMOs dropped to 35.5%. While this change may be a result of changing employee preferences, OLO notes the decline in HMO participation coincides with the elimination of the County Government's HMO pricing incentive (see Chapter 4 of this report). As the County incurs significantly lower costs for employees enrolled in the Kaiser

Permanente HMO plan, the moderate shift of employees away from this plan further contributes to the trend of rising County Government group insurance expenditures.

Chart 8a

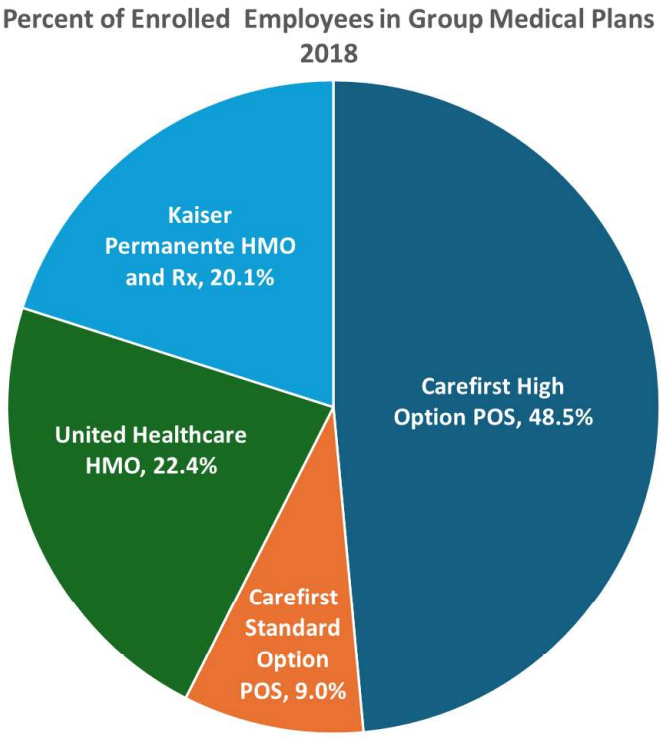
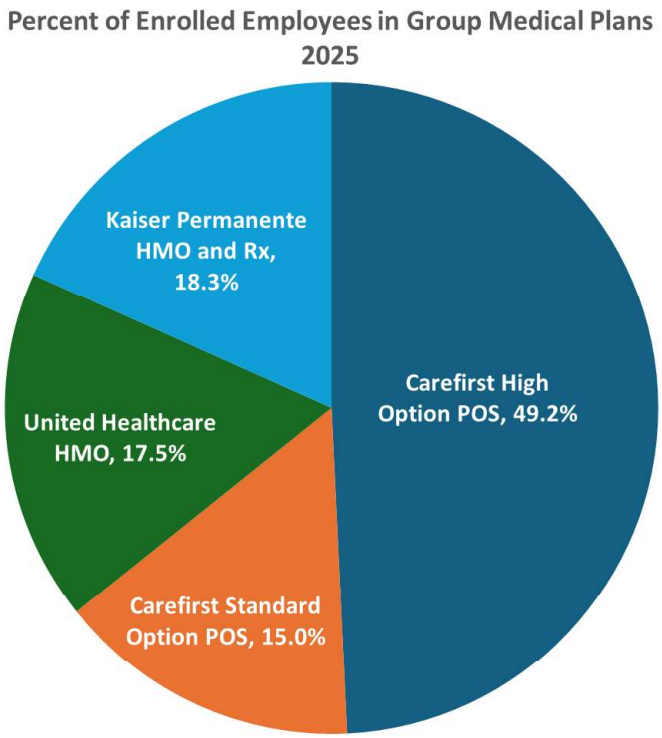


Chart 8b



4. Active Employee Coverage Levels

The County Government offers employees a choice of three group health insurance coverage levels. Employees may select "Self" coverage (for the employee alone), "Self +1" coverage (for the employee plus one other family member), or "Self + Family" coverage (for the employee and all eligible family members).

As evident by comparing Charts 9a and 9b, from 2018 through 2025, the County Government experienced a small shift in coverage levels with the percentage of employees selecting Self + Family coverage declining by 3.2 percentage points (from 42.3% to 39.0%) and the percentage of employees selecting Self coverage increasing by about 2.8 percentage points (from (35.2% to 38.0%) during the same time period. The percentage of employees selecting Self +1 coverage remains mostly constant with 22.5% selecting this coverage level in 2018 and 23.0% in 2025.

Changes in the demographic composition of the County Government workforce are the likely cause for the 3% shift from Self + Family to Self coverage. As the County Government spends less per employee for Self coverage than Self + Family coverage, this shift mitigated overall increases in County Government group insurance expenditures.

Chart 9a

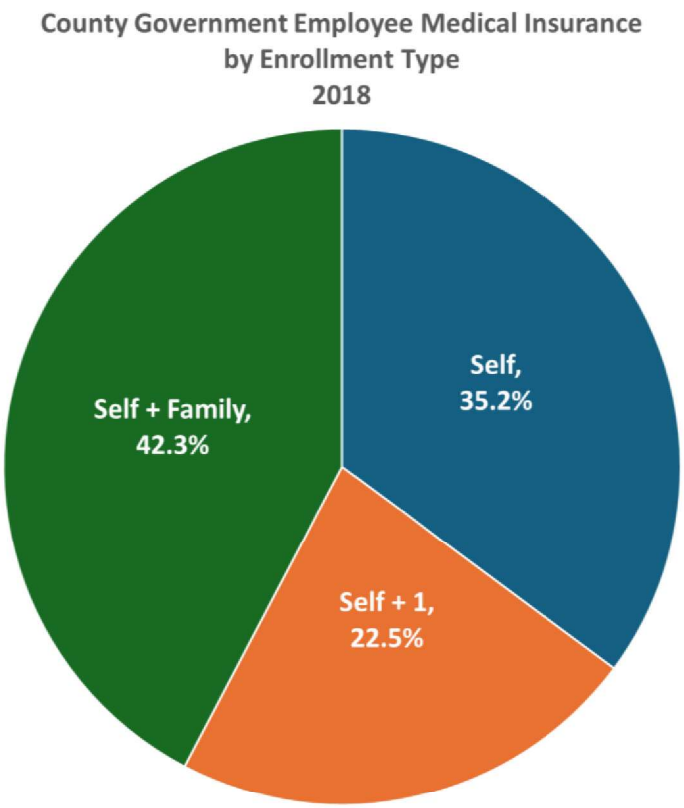
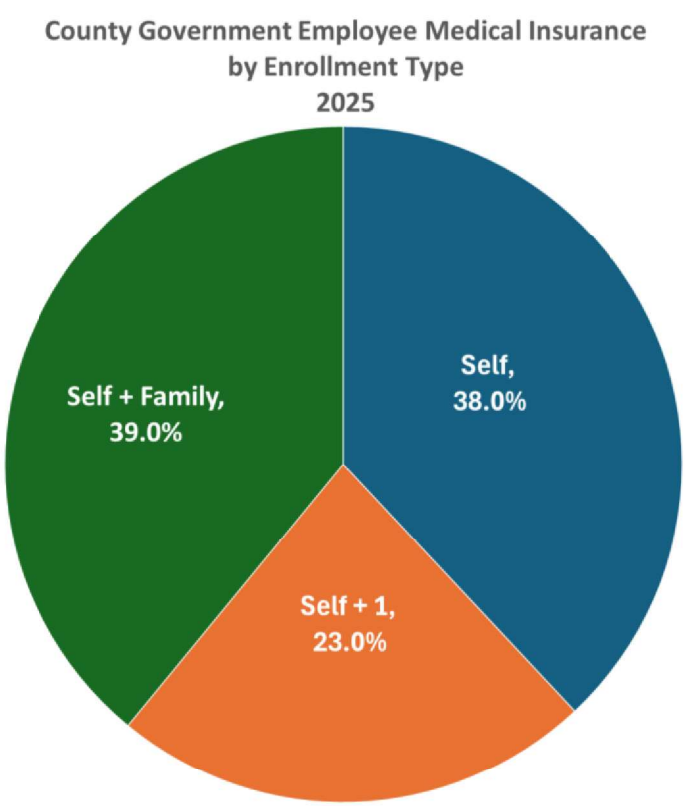


Chart 9b



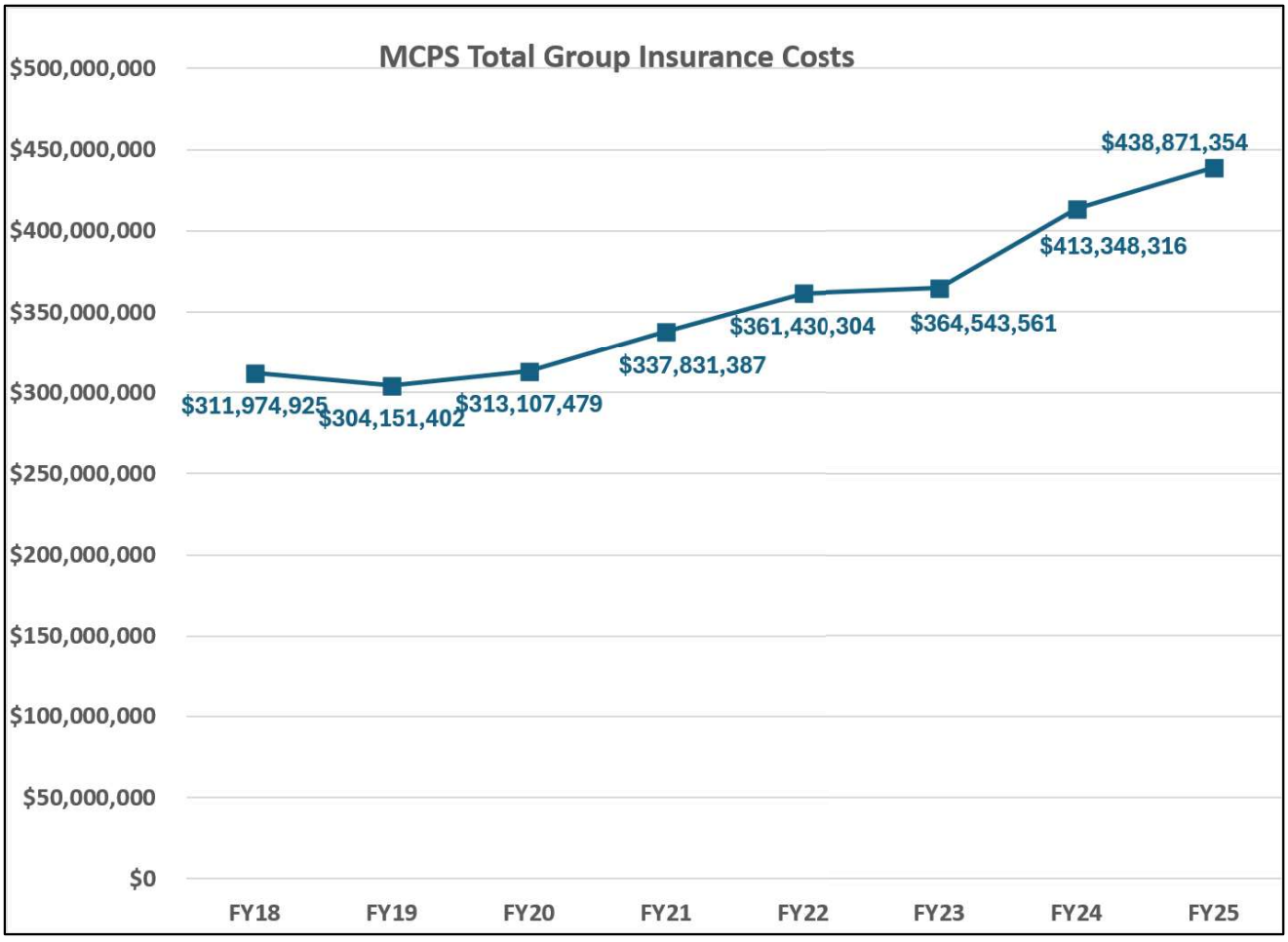
B. MCPS Group Health Insurance Data

Section B of this chapter presents employee group insurance data for Montgomery County Public Schools (MCPS).

1. Total Active Employee Group Insurance Costs

Annual MCPS expenditures on active employee group insurance (claims plus administrative costs) increased from $312.0 million in FY18 to $438.9 million in FY25, an increase of 40.7%, or an average annual rate of 5.0%. As shown in Chart 10, costs remained mostly stable from FY18 through FY21 (including the initial years of the Covid-19 pandemic). However, these costs rose more sharply from FY21 through FY25. The growth in costs from $364.6 million in FY23 to $413.3 million in FY24 represents a one-year increase of 13.4%.

Chart 10

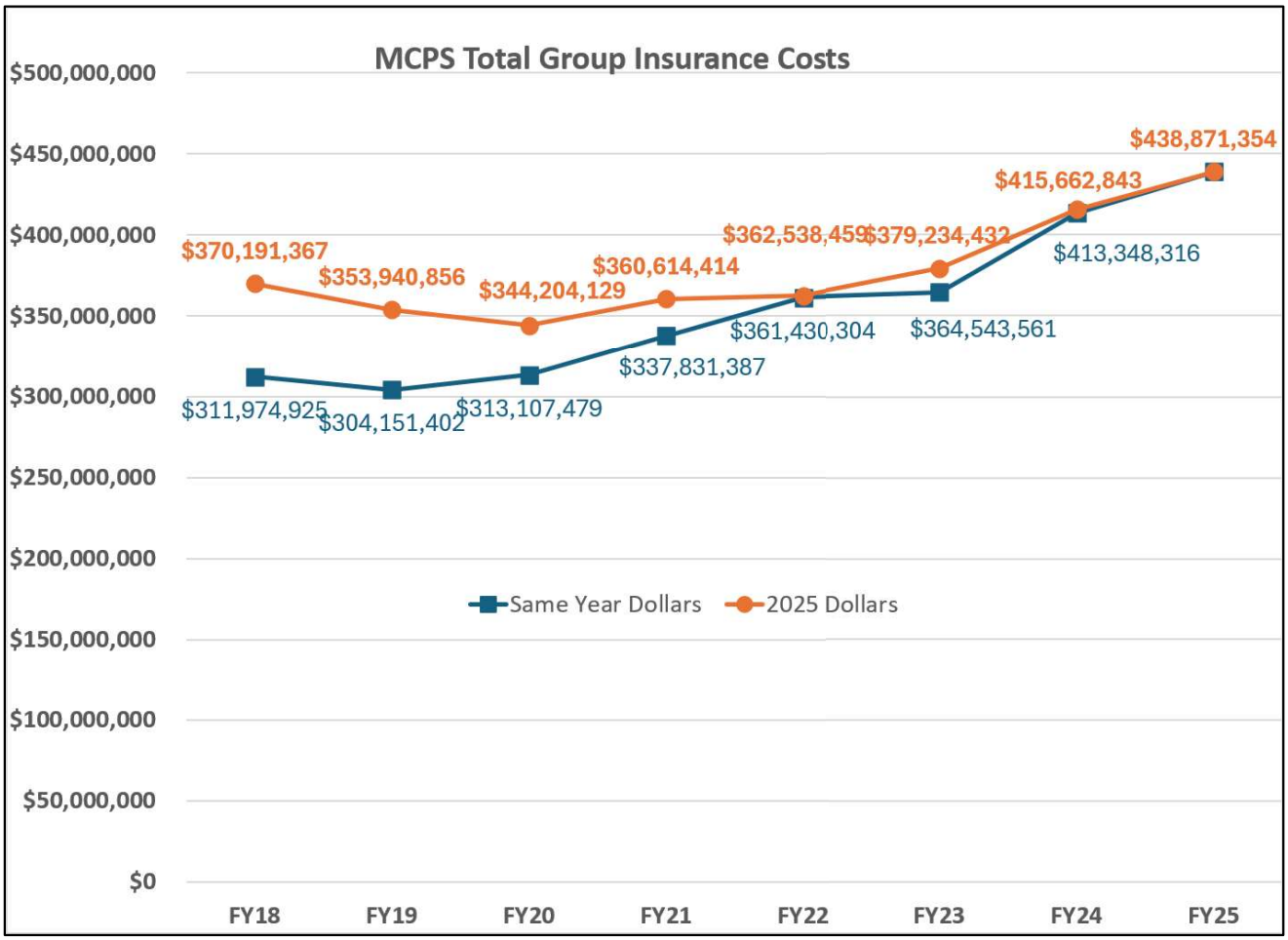


Part of the increase in MCPS active employee group insurance costs is attributable to inflation. To account for inflation, OLO adjusted past year group insurance costs into 2025 dollars based

on the U.S. Bureau of Labor Statistics Medical Care Consumer Price Index for All Urban Consumers (CPI-U) for the Washington-Arlington-Alexandria, DC-VA-MD-WV area.

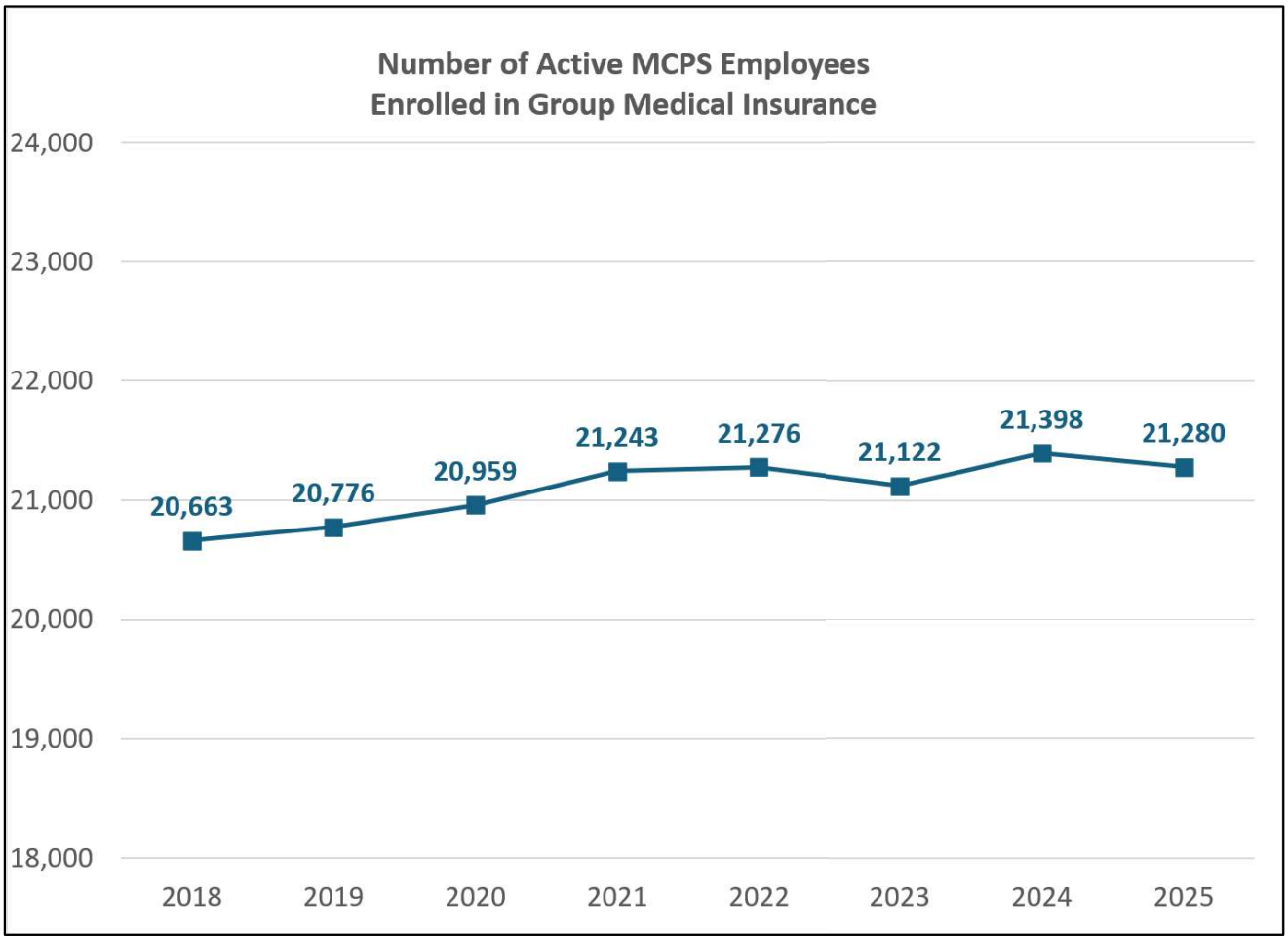
Chart 11 displays two sets of MCPS active employee group insurance costs: (a) in unadjusted dollars expended in each year ("Same Year Dollars" shown in blue); and (b) in infaltion-adjusted dollars equivalent to 2025 dollars ("2025 Dollars" shown in orange). Adjusted for inflation, MCPS expenditures on active employee group insurance increased from $370.2 million in FY18 to $438.9 million in FY25, an increase of 18.6%, or an average annual rate of 2.5%. The growth in inflation-adjusted costs from $379.2 million in FY24 to $415.7 million in FY25 represents a one-year increase of 9.6%.

Chart 11



Another factor that affects employer group insurance costs is the number of employees enrolled in group insurances plans. As displayed in Chart 12, a total of 20,663 MCPS employees enrolled in one of the employer-provided medical group insurance plans in 2018. Seven years later, in FY25, a total of 21,280 MCPS employees enrolled in one of the medical group insurance plans, an increase of 3.0 percent above FY18 enrollment.[11] This increase in the number of enrolled employees contributed to increases in MCPS group insurance expenditures.

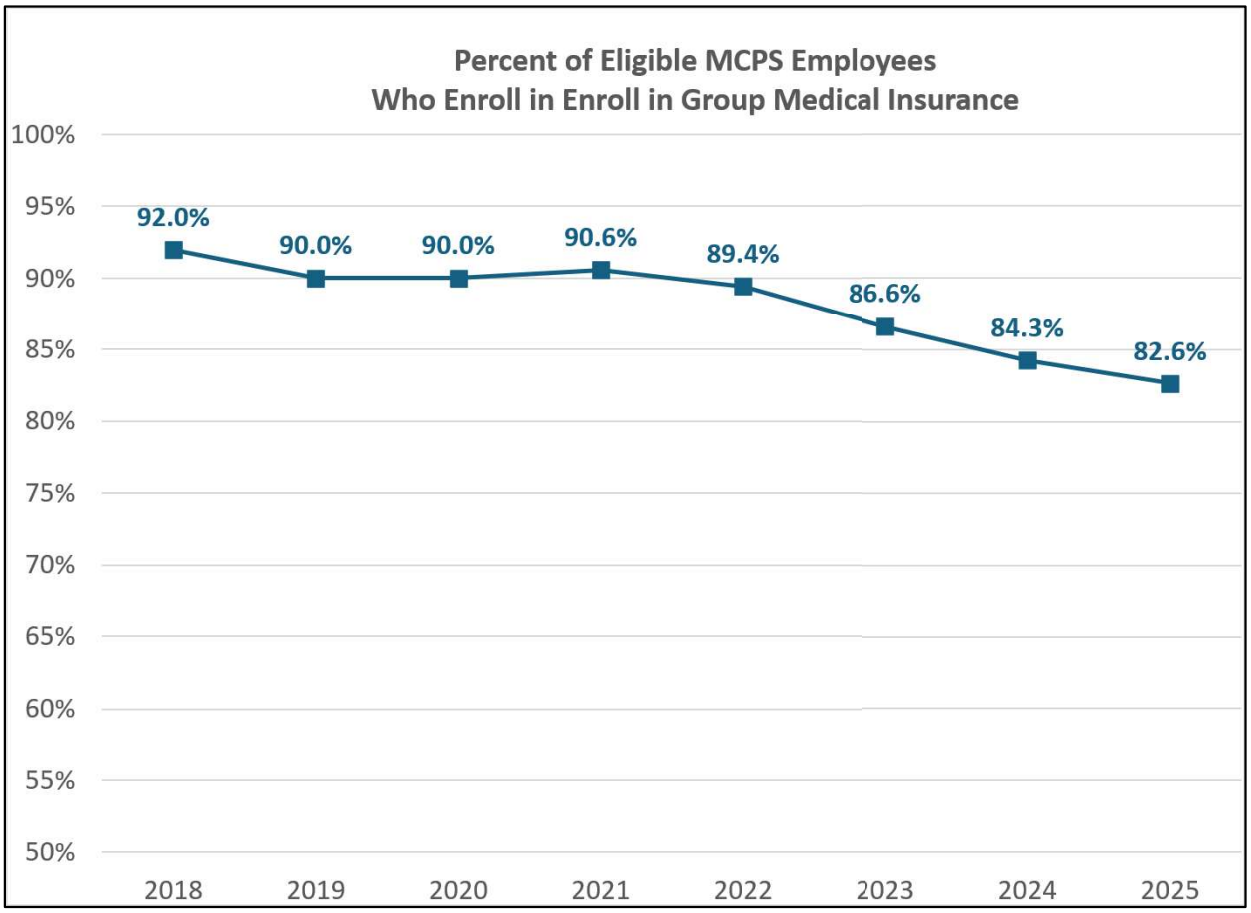
Chart 12



[11] Enrollment counts for January of each year, the mid-point of the fiscal year.

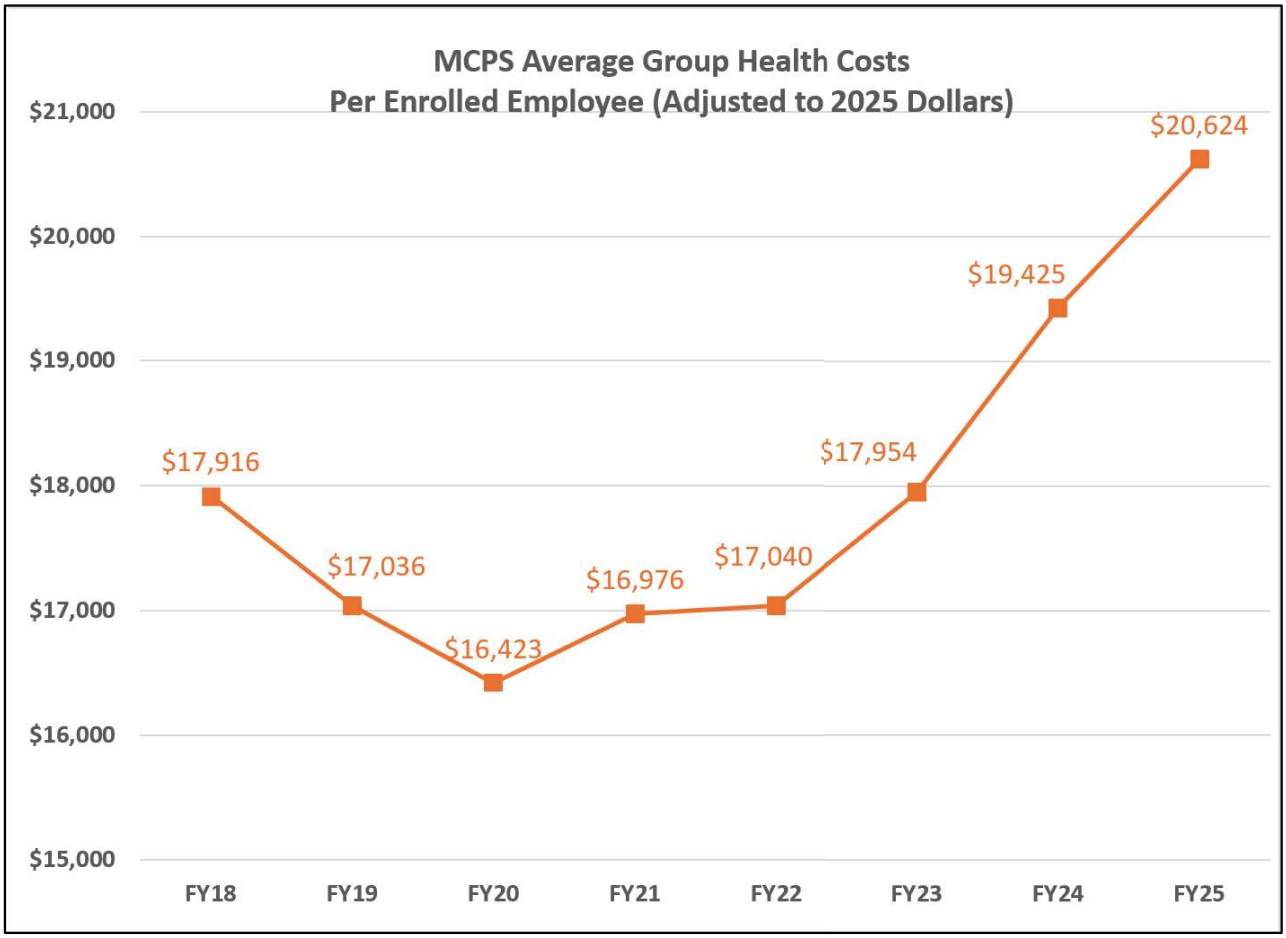
As shown in Chart 13, MCPS experienced a marked decrease in the percentage of active employees enrolled in group medical insurance. In 2018, 92.0% of eligible employees enrolled in group medical insurance; in 2025, the percentage dropped to 82.6%. MCPS has not identified a cause for this decline. Nonetheless, the drop in enrollment participation mitigated increases in MCPS employee group health spending. Had the participation rate remained mostly stable, then MCPS' costs would have increased at a greater rate.

Chart 13



A key driver of group insurance costs is the cost per covered employee. Chart 14 shows the average group insurance cost per enrolled MCPS employee (excluding retirees) in inflation-adjusted dollars. The average cost to MCPS in FY18 was $17,916 per enrolled employee. Medical claims dropped preciptiously in the Covid pandemic years of FY20 and FY21 but then rebounded significantly in FY23 through FY25. From 2018 through 2025, average per enrolled employee costs increased from $17,916 to $20,624 (both in 2025 dollars), a 15.1% increase.

Chart 14



In sum, MCPS inflation-adjusted expenditures on active employee group insurance increased by 15.1%, or an average annual rate of 2.0%, from FY18 through FY25. One factor in the expenditure growth was the 3.0% increase during this period in the number of employees enrolled in one of the MCPS medical group insurance plans. However, the growth in expenditures seems to be tempered by the declining rate of employee participation in MCPS group insurance plans which fell from 92.0% to 82.6% of eligible employees during this seven-year period. As detailed in the following sections, factors other than enrollment played a dominant role in MCPS group insurance cost increase.

2. Active Employee Costs by Claim Type

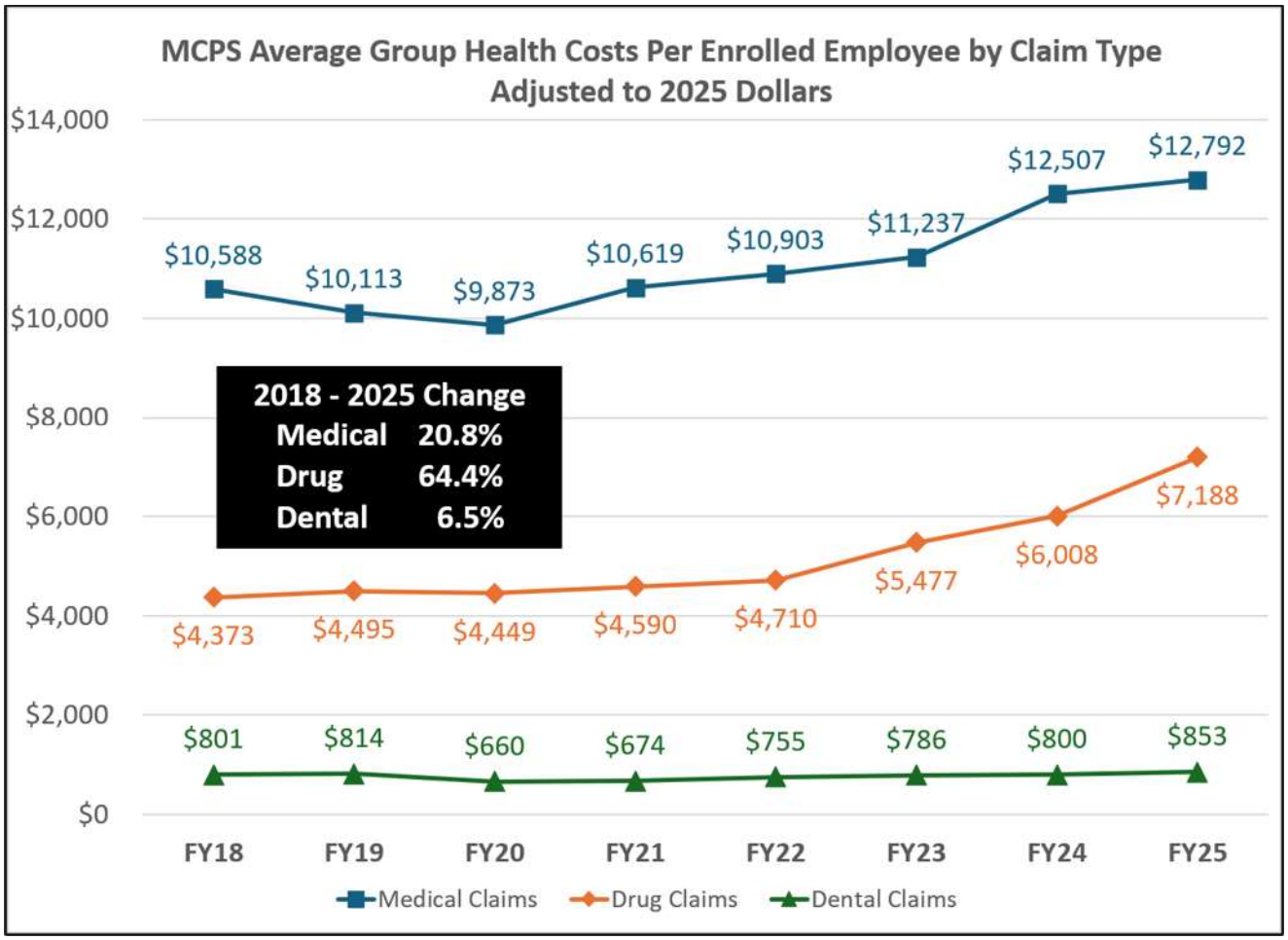
As MCPS is a self-insured employer, the dominant component of its group insurance costs are health care claims. Health care claims comprised 87% of total MCPS group insurance costs in 2025; administrative costs accounted for the remaining 13% of costs. MCPS pays three major types of health care claims:[12]

- Medical claims: claims for payment of medical services such as medical provider visits, laboratory work, diagnostic services, procedures, and hospital care.
- Drug claims: claims for payment of prescription medications and treatments.
- Dental claims: claims for payment of dental care provider visits and procedures.

Chart 15a shows the average medical claim, drug claim, and dental claim costs per enrolled MCPS employee as measured in inflation-adjusted dollars. In FY25, MCPS paid, on average, $12,792 in medical claims per enrolled employee representing 61.4% of all claim costs. MCPS paid, on average, $7,188 in drug claims per enrolled employee in FY25, representing 34.5% of total claim costs. At $853 per enrolled employee, dental claims accounted for only 4.1% of total claim costs.

[12] MCPS also pays claims for employer vision coverage, but the dollar amount of these claims is relatively negligible and so not included in this analysis.

Chart 15a



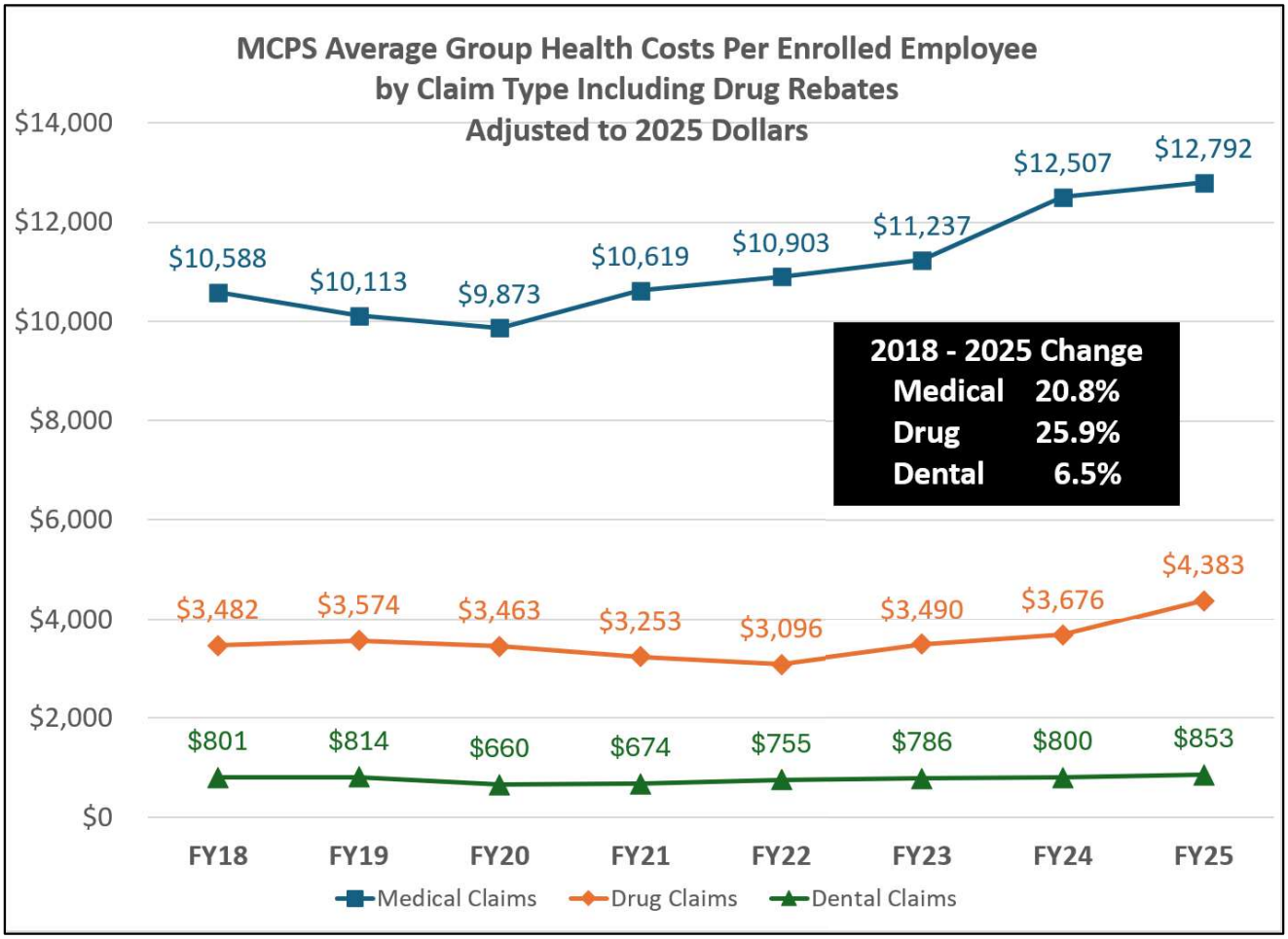
In recent years, drug claim costs have grown at a significantly faster rate than medical claim costs. As shown in Chart 15a, per enrollee drug claim costs increased by 64.4% (in inflation-adjusted dollars) compared to a medical claims growth rate of 20.8% during the same period. Moreover, drug claims have consumed an increasingly greater share of total claim costs in recent years. Drug claims comprised 27.7% of total claim costs in FY18 but grew to 34.5% of total claim costs in FY25.

Chart 15a above displays MCPS expenditures for employee drug claims. However, a significant portion of these costs are later offset when MCPS receives rebates from pharmaceutical manufacturers. Pharmaceutical manufacturers often provide group insurance plan sponsors with rebates in exchange for favorable placement of specific drugs in the plan's formulary. Rebates are typically calculated as a percentage of the plan sponsor's spending on specific drugs.

Chart 15b below shows MCPS per enrollee drug claims cost adjusted to account for pharmaceutical manufacturer rebates. When drug claim costs are offset by rebates, the 2018 to 2025 growth rate for MCPS employee drug claims (as measured in 2025 dollars) was 25.9%,

about five percentage points higher than the growth rate for medical claims. Furthermore, when accounting for rebates, MCPS drug claims as a percentage of total claims have remained mostly steady over the past seven years; drug claims comprised 23.4% of total claims in FY18 and 24.3% of claims in FY25.

Chart 15b



In sum, the data presented above clearly demonstrate that claim cost increases are a major driver of the rapid growth in MCPS group insurance expenditures.

3. Active Employee Costs by Medical Plan

This section shows MCPS group insurance cost data through 2025. Through 2025, MCPS offered employees a choice of three medical plans: a Cigna Open Access Plans (OAP), a Cigna Open Access Plan Plus In-Network (OAPIN) plan, and a Kaiser Permanente HMO plan.[13]

The Kaiser Permanente HMO medical plan differs from the other plans in two important ways. First, the Kaiser HMO plan includes prescription coverage; employees who enroll in one of the other medical plans must also enroll in the Caremark plan to receive prescription coverage. Secondly, MCPS self-insurance applies to the Cigna plans alone. For these plans, claims costs comprise the bulk of MCPS expenditures.[14] In contrast, MCPS costs for the Kaiser Permanente HMO consist entirely of the employer share of premium costs; actual plan usage does not affect MCPS' costs.

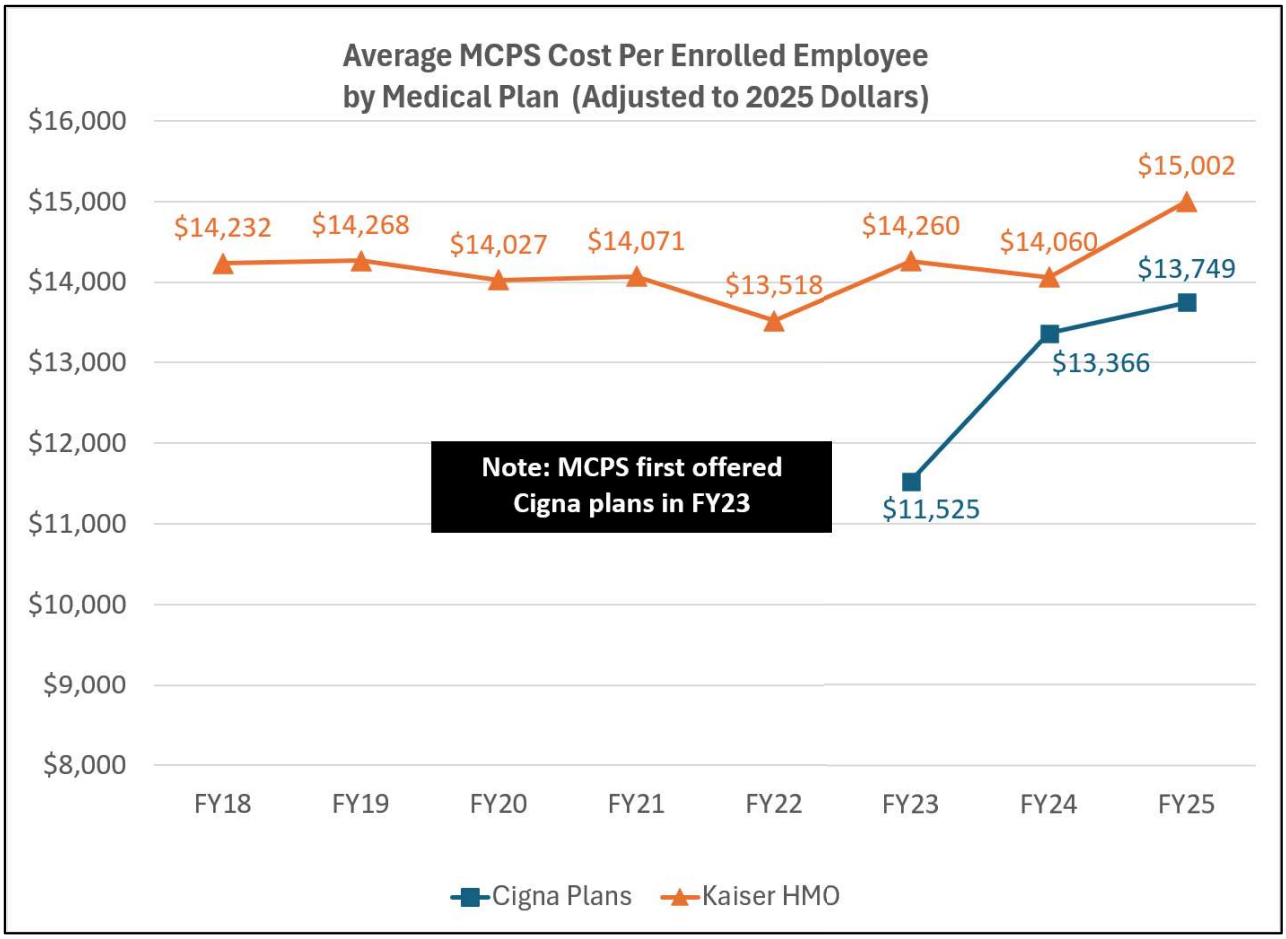
Of note, MCPS's financial system tracks the combined costs for all Cigna plans covered by the agency's self-insurance fund; MCPS does not have disaggregated cost data for each of the Cigna plan types. MCPS has cost data unique to the fully insured Kaiser Permanente HMO plan.

As shown in Chart 16, in FY25, MCPS paid an average of $13,749 per employee enrolled in one of the Cigna plans and $15,002 per employee enrolled in the Kaiser Permanente HMO plan.

[13] MCPS introduced the "preferred care management" options for Cigna medical plans in 2026. Today, MCPS offers employees a choice of five medical insurance plans, two Cigna Open Access Plans (OAP, one with "preferred care management" and one without) and two Cigna Health Maintenance Organization/Open Access Plan Plus In-Network (HMO/OAPIN) plans (one with "preferred care management" and one without), and a Kaiser Permanente HMO plan.

[14] Claims costs comprise about 88% of MCPS group health insurance expenditures; administrative costs comprise the remaining 12%.

Chart 16



In inflation-adjusted dollars, the cost to MCPS per employee enrolled in a Cigna plan increased from $11,525 to $13,749 (or 19.3%) from FY23 through FY25. During the same time period, the cost per employee for the Kaiser HMO plan increased from 14,260 to $15,002 (or 5.2%).

A significant difference exists among the medical plans offered to MCPS employees. The Cigna plans provide medical coverage but exclude prescription coverage. The Kaiser Permanente HMO plan includes both medical and prescription coverage. In 2025, average cost to MCPS for the Caremark plan was $4,326 (including rebates). Table 5 shows the average combined medical and prescription cost per employee in 2025 including both medical and prescription coverage.

Table 5
FY25 Average Cost Per MCPS Employee
Combined Medical and Prescription Costs

Cigna Plans (combined average for OAP and OAPIN plans) plus Caremark Rx	$18,077
Kaiser Permanente HMO and Rx	$15,002

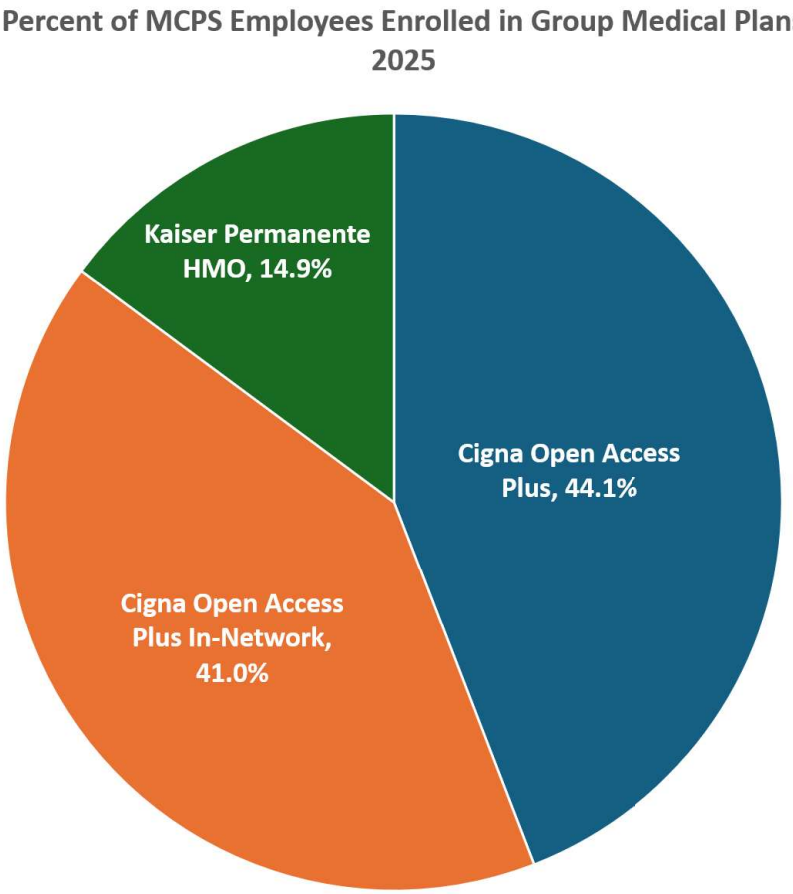
MCPS employees who enrolled in one of the Cigna medical plans[15] plus the Caremark prescription plan cost MCPS, on average, $18,077 in FY25, or $3,075 (20.5%) more than the cost of an employee who enrolled in the Kaiser Permanente HMO (that includes prescription coverage).

As noted in the section of this chapter on County Government group insurance costs, differences in plan costs per enrolled employee may be influeneced by the populations choosing particular plans. MCPS employees with medical conditions that require greater levels of treatment may gravitate, for example, toward a Cigna open access plan while employees that expect only to use their insurance plan for infrequent preventative and emergency services may select a lower-cost plan such as the Kaiser Permanente HMO. As such, the cost per enrollee shown above may reflect self selection of employees into different plans based on their medical needs and condtions.

[15] As previously mentioned, MCPS does not have disaggregated cost data for each of the Cigna plan types.

In 2025, the two Cigna plans each enrolled more than 40% of participating MCPS employees. More than 44% of employees enrolled in the Cigna Open Access plan while about 41% enrolled in the Cigna Open Access Plus In-Network plan. Near 15% of MCPS employees elected to participate in the Kaiser Permanente HMO plan. Under both past and current cost share policies, MCPS provides a pricing incentive for employees to select lower cost group health insurance plans (see details in Chapter 4 of this report).

Chart 17



4. Active Employee Coverage Levels

MCPS offers employees a choice of three group health insurance coverage levels. Employees may select "Single" coverage (for the employee alone), "Two-Party" coverage (for the employee plus one other family member), or "Family" coverage (for the employee and all eligible family members).

As evident by comparing Charts 17a and 17b, from 2018 through 2025, MCPS experienced a shift in coverage levels with the percentage of employees selecting Family coverage declining by 1.7 percentage points (from 46.9% to 45.2%) and the percentage of employees selecting Two-Party coverage decreasing by about 2.1 percentage points (from 23.3% to 21.2%). During this time, the percentage of employees selecting Single coverage increased by 3.7 percentage points (from 29.8% to 33.5%). Changes in the demographic composition of the MCPS workforce are the likely cause for this shift. As MCPS spends less per employee for Single coverage than for Family and Two-Party coverage, this shift mitigated overall increases in MCPS group insurance expenditures.

Chart 18a
MCPS Medical Insurance Enrollment by Coverage Type
Fiscal Year 2018

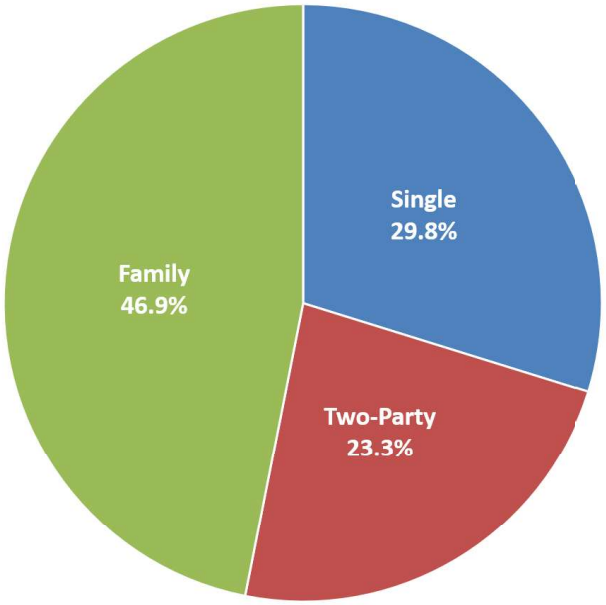
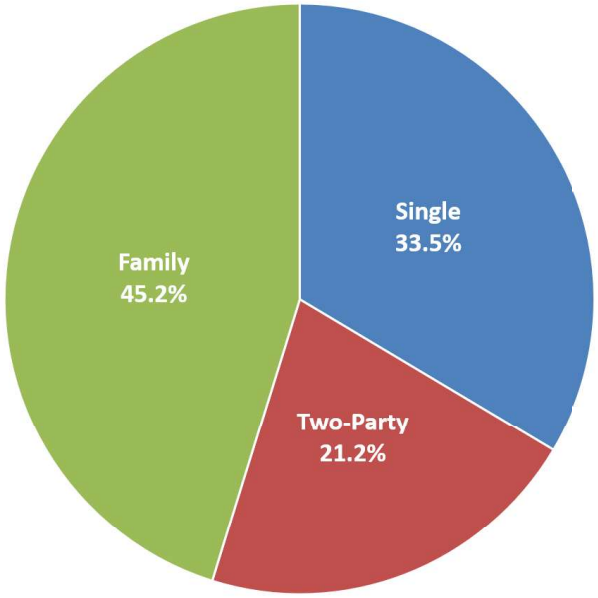


Chart 18b
MCPS Medical Insurance Enrollment by Coverage Type
Fiscal Year 2025



C. A Cautionary Summary

OLO presents two tables that summarize key 2025 group insurance data points for the County Government and MCPS. OLO cautions the reader to be wary of drawing conclusions from comparison of the County Government and MCPS data. Group Insurance costs are a function of multiple factors. Certainly, many elements of plan design such as cost share, copays and deductibles, and utilization management practices are mostly in the control of the employer. However, many critical cost drivers are a function of the demographic composition of the workforce and are difficult to control while maintaining non-discriminatory hiring practices. Factors such as the size of the pool of insured persons, the age distribution of the insured, the average family sizes of the insured, and the medical conditions of the insured lay beyond the control of the employer.

Differences between County Government and MCPS group insurance costs are likely to be related to a combination of employer policies and workforce demographics. As this report does not (and cannot) account for factors such as the age and medical conditions of insured County Government and MCPS employees, OLO cautions the reader not to attribute differences in the cost data solely to the policies and management practices of the two agencies.

Summary of Select 2025 County Government Group Insurance Cost Data	
Number of Employees Enrolled in Group Medical Insurance	8,966
Percent of Eligible Employees Enrolled in Group Medical Insurance	84.1%
Average Group Health Insurance Cost Per Enrolled Employee (Claims + Administrative Costs)	$22,614
Medical Claims Costs as a Percent of Total Claims Costs	63.1%
Drug Claims Costs as a Percent of Total Claims Costs	31.9%
Cumulative Seven-Year Inflation Adjusted Per Employee Medical Claims Growth Rate	14.2%
Cumulative Seven-Year Inflation Adjusted Per Employee Drug Claims Growth Rate (Net of Drug Rebates)	29.7%
Range of Average Claims Cost per Enrolled Employee by Medical Plan (including Rx)	$14,248 - $24,603
Percent of Employees Enrolled in Single (Self) Medical Coverage	38.0%

Summary of Select 2025 MCPS Group Insurance Cost Data	
Number of Employees Enrolled in Group Medical Insurance	21,280
Percent of Eligible Employees Enrolled in Group Medical Insurance	82.6%
Average Group Health Insurance Cost Per Enrolled Employee (Claims + Administrative Costs)	$20,624
Medical Claims Costs as a Percent of Total Claims Costs	64.4%
Drug Claims Costs as a Percent of Total Claims Costs	27.7%
Cumulative Seven-Year Inflation Adjusted Per Employee Medical Claims Growth Rate	20.8%
Cumulative Seven-Year Inflation Adjusted Per Employee Drug Claims Growth Rate (Net of Drug Rebates)	25.9%
Range of Average Claims Cost per Enrolled Employee by Medical Plan (including Rx)	$15,002 - $18,077[16]
Percent of Employees Enrolled in Single (Self) Medical Coverage	33.5%

[16] The $18,077 amount represents the average of the per enrollee cost for the Cigna OAP and OAPIN plans (plus the cost of the Caremark prescription plan). The average cost for the OAP plan should be higher than this amount; the average cost for the OAPIN plan should be lower than this amount.

CHAPTER 6: GROUP HEALTH INSURANCE COST CONTAINMENT PRACTICES

This chapter describes practices commonly used by employers to control expenditures on employee group health insurance. The chapter further describes cost containment practices employed by the County Government and MCPS. In addition, this chapter presents information about the Maryland Prescription Drug Affordability Board.

A. Cost Containment Practices

This section discusses three commonly used practices to control spending on employer-provided group insurance.

1. Employee Wellness Programs

Employee wellness programs are employer-implemented initiatives designed to support and improve the physical and mental health and well-being of employees. Wellness programs may include a series of components such as:

- preventive health screenings;
- workplace vaccinations;
- fitness challenges;
- subsidized gym memberships;
- smoking cessation programs; and
- mental health workshops.

The intent of wellness programs is to foster a healthier and more productive workforce as well as to control group insurance costs by promoting preventive care and chronic disease management.

2. Prescription Utilization Management

Prescription utilization management is a health care cost-containment strategy to monitor drug use to ensure medications are both cost-effective and efficacious in treating the condition for which they were prescribed. Utilization management practices derive from evaluation of the clinical necessity of drug treatments against evidence-based guidelines with the objective of controlling prescription drug costs while maintaining an acceptable standard of care. Common utilization management techniques include:

- Generic and Biosimilar Medications: A generic drug is a medication created to provide the same clinical benefit as a previously marketed brand-name drug. A biosimilar medication is made from the same source materials and achieves a similar benefit as another biological medication. The U.S Food and Drug Administration (FDA) verifies generic drugs work in the same way and provides the same clinical benefit as brand-

name drugs and that biosimilars have similar effectiveness and risks as the original medication. Generics and biosimilars often are available at lower cost than the original treatments. A prescription insurance plan sponsor may seek to reduce costs by requiring use of generics and biosimilars for the treatment of certain conditions.

- Prior Authorization: Prior authorization is a practice in which a health care provider must obtain approval from the patient's health insurance plan before prescribing certain medications to treat specific health conditions. This practice may control costs by assessing whether prescribed treatments are medically necessary, align with clinical guidelines, and include, where appropriate, lower-cost alternatives, such as generic drugs and biosimilars. Prior authorization may also prevent spending on drugs for purposes not specifically listed by the FDA for a specific medical condition.

- Step Therapy: Prescription drug step therapy is a practice that requires patients to try one or more lower-cost medications before a health plan will cover the cost for a more expensive treatment. Step therapy often begins with a prescription for generic drugs or preferred brand-name alternatives considered clinically effective to treat the patient's condition. The health care provider may prescribe more costly drugs only after demonstrating that the lower-cost medication did not adequately address the patient's needs.

- Quantity Limits: A prescription drug quantity limit is a practice in which a health insurance plan restricts coverage for a specific medication to a defined timeframe (such as 30 or 90 days). Frequently, quantity limits are based on FDA-approved dosing guidelines. Quantity limits help control plan sponsor costs by preventing over-utilization, misuse, stockpiling, and waste of prescription drugs.

3. Dependent Eligibility Audits

A dependent eligibility audit is a process to verify that all employees' dependents enrolled in a group health plan indeed are eligible for coverage. During the audit process, employees are asked to provide documentation (such as marriage licenses, birth certificates, and adoption papers) to prove that a family member meets the eligibility criteria of the insurance plan. The intent of dependent eligibility audits is to identify individuals who inappropriately receive a health plan benefit. By revoking coverage for ineligible plan participants, an employer pays for health insurance benefits exclusively for eligible employees and family members.

B. County Government Cost Containment Practices

This section presents information about group insurance cost containment practices undertaken by the County Government.

1. County Government LiveWell Program

In 2015, the County Government established an employee wellness initiative, currently known as the "LiveWell" program. The LiveWell program is intended to support the physical, emotional, financial, intellectual, occupational, and social well-being of County Government employees. All insurance-eligible County Government employees are eligible to participate in LiveWell activities and services.

The County Government offers eligible employees free access to multiple wellness benefits. LiveWell activities and services related to physical and mental health include:

- Personify Health Platform: Employees may connect the Personify Health application to their phone or other device. The application offers a fitness tracker, personalized health and nutrition information and tips, healthy habit challenges as well as opportunity to earn up to $350 per year for undertaking certain health-promoting activities.

- Employee Assistance ComPsych Guidance Program: Employees and their family members receive access to confidential mental health counseling and a mental health awareness toolkit through the County's relationship with ComPsych Guidance Resources.

- Discounts: Eligible County Government employees receive discounts for use of County Recreation Department facilities such as swimming pools and exercise rooms as well as discounted membership for Capital Bikeshare. CareFirst BlueCross BlueShield, Kaiser Permanente and United HealthCare each offer their plan participants discounts on certain gym memberships and fitness equipment.

- Outreach and Education: The County's Office of Human Resources (OHR) sends employees bi-weekly "Wellness Wednesday" emails that contain healthy living guidance as well as information about wellness webinars and in-person and virtual fitness classes.

2. County Government Prescription Utilization Management

The County Government currently employs a series of prescription utilization management practices designed to contain prescription drug costs while maintaining an acceptable standard of care. At present, these practices include:

- Prior Authorization: Requires physicians to obtain approval from the insurer before prescribing certain high-cost drug classes to treat specific health conditions.

- Generic Step Therapy: Requires that plan participants use generic alternatives within the same therapeutic class as the first line of therapy before brand name prescriptions are covered.

- Mail-Order Generic Substitution: Allows CVS Caremark to contact prescribers or plan participants to inquire about switching mail-order prescriptions from a brand name to a generic medication.

- Advanced Control Formulary: Establishes a preferred drug list that prioritizes generics as first-line options, requires prior authorization for certain medications.

- Specialty Guideline Management: Requires plan participants to meet specified criteria before the first dispensation of certain specialty medications.

- Exclusive Specialty: Requires plan participants to obtain certain specialty medications exclusively from designated pharmacies.

- Drug Savings Review: Identifies plan participants who may be taking unnecessary medication that pose a risk for drug-induced conditions and identifies opportunities to reduce or simplify plan participants' therapy.

- GLP-1 for Weight Loss: Requires prior authorization with approval criteria including Body Mass Index (BMI) of 30 or greater (obese) or a BMI of 27 (overweight) with at least one weight-related comorbidity (such as high blood pressure or high cholesterol); documented participation in a comprehensive weight management program for at least six months prior to starting medication; and documentation showing at least a 5% loss of baseline body weight, or maintenance of initial weight loss to be eligible for continued therapy.

- GLP-1 for Weight Loss (Kaiser Permanente members): Requires a 50% copayment for GLP-1 medications prescribed for weight loss.

- GLP-1s for Diabetes: Requires prior authorization to ensure GLP-1s approved to type-2 diabetes are not used for weight management.

- New Opioid Prescription Limits: Limits the supply of a first opioid prescription to seven days for immediate release, new, acute prescriptions for plan members who do not have a history of prior opioid use (unless a physician submits a prior authorization request stating that a greater supply is medically indicated).

- Opioid Potency Limits: Limits the quantity of opioid products prescribed to no more than 90 MME (morphine milligram equivalents) per day, consistent with the Centers for

Disease Control and Prevention (CDC) guidelines; prescribers may submit a prior authorization request for up to 200 MME per day.

- Opioid Supply Limits for Young Patients: Limits plan participants and dependents who are 19 years of age or younger to a three-day supply for new short-acting opioid prescriptions (with an exemption for cancer, sickle cell disease, hospice, or palliative care patients) consistent with the CDC guidelines.

- Limits on Erectile Dysfunction Medications: Limits coverage for each plan participant to a maximum of six doses of an FDA-approved medication per month.

- Topical Analgesic Patch Exclusion: Disallows coverage for topical analgesics prescribed as an alternative to the multi-ingredient compounds that are unapproved by OHR's Compound Management program.

3. County Government Eligibility Audits

In 2021 and 2022, a contractor retained by OHR conducted a group insurance eligibility audit (called Dependent Eligibility Recertification) of County Government employees. The purpose of the audit was to recertify the eligibility of employees' dependents to receive employer-sponsored health insurance and to discontinue coverage for dependents found to be ineligible. The audit identified a total of 469 dependents deemed ineligible for County Government-provided health insurance. The contractor estimated the audit reduced County Government group insurance expenditures by about $2,368,000 per year. The cost of the audit was $485,000.

C. MCPS Cost Containment Practices

This section presents information about group insurance cost containment practices undertaken by MCPS.

1. MCPS Well Aware Program

In 2010, MCPS established an employee wellness initiative, currently known as the "Well Aware" program. MCPS offers eligible employees free access to multiple wellness benefits, including:

- Biometric Health Screenings: MCPS employees who enroll in group medical insurance are eligible to receive a one percent reduction in their cost share by completing a biometric health screening of blood pressure, blood sugar, body mass index, and cholesterol.

- Health Risk Assessments: MCPS employees who enroll in group medical insurance are eligible to receive an additional one percent reduction in their cost share by completing

an online health risk assessment administered by their medical plan (Cigna or Kaiser Permanente).

- Free Classes: MCPS employees are eligible to enroll in free exercise stress reduction, and mindfulness classes

- Webinars: MCPS offers monthly webinars on health and wellness related topics.

- Employee Assistance Program: Employees receive access to no-cost short-term confidential counseling with a licensed mental health professional.

- Discounts: Permanent MCPS employees receive free access to County recreation facilities and are eligible for a 20 percent discount on an annual pool pass for family members. Employees also are eligible for discounts on select weight loss plans and nutrition programs. In addition, MCPS employees are eligible for discounts arranged by their medical plan (Cigna or Kaiser Permanente) for certain health-related services such as massage therapy, acupuncture, and chiropractic care.

- Outreach and Education: MCPS sends employees monthly Well Aware emails that contain healthy living guidance as well as information about upcoming webinars, fitness classes, and events.

2. MCPS Prescription Utilization Management

MCPS currently employs a series of prescription utilization management practices designed to contain prescription drug costs while maintaining an acceptable standard of care. At present, these practices include:

- Generic Drug Step Therapy: Requires that plan participants use generic alternatives within the same therapeutic class as the first line of therapy before brand name prescriptions are covered.

- Specialty Drug Coverage: Requires the patient's physician to coordinate with CVS/Caremark to fill prescriptions for certain specialty drugs as specified by the Specialty Guideline Management Program.

- Specialty Drug Management: Employs a third-party specialty medication program called PrudentRx that partners with CVS Caremark to enroll plan participants in manufacturer copay assistance programs that shift a significant portion of specialty drug expenses from the plan to pharmaceutical manufacturers and often results in no out-of-pocket costs for plan participants.

- GLP-1 Management: Screens out diabetes patients and identifies requests that are likely off-label for weight management; requires a prior authorization case review for patients who do not meet coverage requirements.

- Primary Preferred Drug List: Requires certain prescriptions for drugs not subject to the specialty guideline management program or the generic drug step therapy program to be filled from the CVS/Caremark Primary Preferred Drug List. The medicines on the Primary Preferred Drug list are not equivalents of non-preferred brand name medicines but are medicines in the same therapeutic category used to treat the same condition.

- Compound Drug Preauthorization: Requires pre-authorization from Caremark for any compound drug costing $300 or more before the prescription is dispensed.

- Opioid Potency Limits: Limits the quantity of opioid products prescribed to no more than a specified MME (morphine milligram equivalents) per day, consistent with the CDC guidelines; prescribers may submit a prior authorization request for prescriptions that exceed the allowed limit.

- Maintenance Medications: Requires most refills of maintenance medications be dispensed by a CVS pharmacy or the CVS/Caremark Mail Service Pharmacy.

3. MCPS Eligibility Audits

MCPS conducted a dependent eligibility audit in 2009 at a cost of approximately $120,000. The audit identified approximately 500 dependents who were ineligible for coverage. At approximately the same time, the Affordable Care Act (ACA) came into effect which raised the group health age limit for dependent children to age 26. As a result, approximately 700 dependent children became eligible again for MCPS group insurance coverage. According to MCPS, the additional cost associated with dependents returning under the ACA negated the cost savings derived from the eligibility audit.

D. Maryland Prescription Drug Affordability Board

In 2019, the Maryland General Assembly approved legislation that established the Prescription Drug Affordability Board (PDAB). As stated in State law, the "purpose of the Board is to protect State residents, State and local governments, commercial health plans, health care providers, pharmacies licensed in the State, and other stakeholders within the health care system from the high costs of prescription drug products." Notably, State law authorizes the PDAB conduct prescription drug cost reviews to determine "whether use of the prescription drug product that is fully consistent with the labeling approved by the United States Food and Drug Administration or standard medical practice has led or will lead to affordability challenges for the State health care system or high out–of–pocket costs for patients."

To identify and evaluate prescription medications that may present affordability challenges, the PDAB analyzes data pertaining to specific drugs and biologics including the wholesale acquisition costs of a year of treatment, the rate of change in wholesale acquisition costs, and the availability of generic or biosimilar alternative treatments. The PDAB also solicits input from a 29-member Stakeholder Council that consists of representatives of brand-name drug manufacturers, generic drug manufacturers, biotechnology companies, health care providers, pharmacists, health care advocates, and advocates for seniors as well as researchers, members of the public, and others.

After reviewing the research findings and stakeholder input, the PDAB makes a determination on a drug's affordability. If a drug is deemed unaffordable, the PDAB may recommend policy actions or establish an upper payment limit to mitigate costs. As stipulated in State law, an upper payment limit sets maximum prices for specific medications purchased or paid for by: (a) the State Government or local governments; (b) a health benefit plan of the State Government or local government, including a county, bi-county, or municipal employee health benefit plan; or (c) the Maryland State Medical Assistance Program. To date, the PDAB has conducted cost reviews for six drugs: Farxiga (dapagliflozin), Jardiance (empagliflozin), Ozempic (semaglutide), Trulicity (dulaglutide), Dupixent (dupilumab), and Skyrizi (risankizumab). For additional details, see the PDAB 2025 Annual Report.

PDAB upper payment limits will not take effect until Calendar Year 2027 at the earliest.

CHAPTER 7: EMPLOYER SELF-INSURANCE

Both the County Government and MCPS are self-insured for most employer-provided medical and prescription plans.[17] A self-insured plan is a group health insurance plan in which the employer directly pays for employee health care claims. Self-insured employers assume the financial risk of covering employee health care claims, and so, in effect, act as their own insurers. Most typically, self-insured employers pay a fee to an insurer to administer a group insurance plan.

The alternative to self-insurance is fully insured health insurance. Under a fully insured plan, the employer purchases health insurance coverage from a commercial insurer to provide coverage for its employees. The employer and employees pay fixed premiums to a third-party insurance provider that assumes financial risk for employees' medical claims.

This chapter discusses the relative advantages and disadvantages of employer group health self-insurance as well as the predominant practices of large employers.

A. Advantages of Self-Insurance

Employers may find self-insurance more advantageous than subscribing to fully insured plans for several reasons. For many employers, self-insurance provides greater control over health care expenditures than can be achieved under fully insured plans. For fully insured plans, the insurer establishes the premium costs (shared by employers and employees). Premium rates cover the estimated claim costs, administrative costs, risk contingencies, and profit margin regardless of the level of patient health care utilization. Self-insured employers pay for actual not estimated claims costs, thus reducing exposure to higher than needed utilization rates that may be built into fully insured premiums. When actual claims fall below projections, the employer receives the financial benefit rather than forfeiting surplus premium payments to the insurer.

An employer who directly pays health insurance claims may have access to data that could help control costs. A self-insured employer can review claims costs and identify specific types of medical care and prescription drug use that have the greatest effect on total health care expenditures. Employers may use this utilization information to determine cost drivers and to implement targeted cost-containment strategies.

In addition, self-insured group health plans provide an opportunity for the employer to customize coverage design in a manner not available through the fixed options offered by fully insured plans. Self-insured employers have the autonomy to tailor group health plan design elements such as deductibles, copays, and utilization management requirements to best meet the specific needs of the employer and the workforce.

[17] Both the County Government and MCPS offer employees medical and prescription coverage through Kaiser Permanente, a fully insured plan.

B. Disadvantages of Self-Insurance

Employer self-insurance also has some disadvantages compared to fully insured group health plans. Most notably, self-insurance exposes the employer to financial risk stemming from the unpredictability of claims costs. As discussed in Chapter 2 of this report, the introduction of new high-cost treatments can greatly increase claims costs over a relatively short period of time. Moreover, a small number of employees with serious and complicated medical conditions may generate catastrophically costly claims that may raise expenditures significantly above budgeted dollars.

To shield themselves from the risk of severely high-cost claims, many self-insured employers pay for "stop-loss coverage." Stop-loss coverage is a third-party insurance policy that reimburses a self-insured employer for unusually high-cost claims. Stop-loss coverage may protect the employer against either catastrophically high claims by individual plan members or against catastrophically high claims by employees in the aggregate.

The volatility of claims can generate additional challenges for self-insured employers. Employees do not necessary seek health care treatment uniformly throughout the year; as such, claims may peak and ebb during certain months of the year resulting in uneven monthly cash flow demands.

While self-insurance grants employers access to utilization data, analysis of this data does not come without costs. Oversight of health care data requires administrative oversight performed by internal staff and/or by outside actuarial contractors.

C. Self-Insurance for Large Employers

An employer offering health insurance benefits must weigh the relative advantages and disadvantages of self-insurance versus subscribing to fully insured health care plans. For most employers, the determining factor is level of exposure to catastrophic risk. Risk exposure is a function of the size of the pool of insured employees. A large pool of insured employees is more protected from catastrophic risk than a smaller pool. As such, large employers generally steer toward self-insurance while small employers are more likely to provide fully insured group insurance plans. As stated in the U. S. Department of Labor 2026 Report to Congress: Annual Report on Self-Insured Group Health Plans:

> *Self-insurance is more common among larger group health plan sponsors, in part because the health expenses of larger group health plans are more predictable, and therefore, larger plan sponsors can better manage those risks internally…*

A recent survey by the Kaiser Family Foundation found that 87 percent of employers that offer group health insurance for 5,000 or more employees are self-insured. The County Government provides group health insurance to approximately 9,000 employees and their dependents;

MCPS provides insurance to approximately 21,000 employees and their dependents. Both agencies are self-insured for group health plans covering the majority of their participating employees.

CHAPTER 8: DISCUSSION QUESTIONS

Based on the findings of this report, OLO presents discussion questions for Councilmember consideration. First, **OLO suggests that Councilmembers ask County Government and MCPS group insurance managers to discuss what, in their opinions, are the most effective and equitable means of controlling agency group health insurance costs. Councilmembers may also wish to discuss the relationship between growth in group health insurance costs and other compensation costs and their impact on current agency budget sustainability challenges.**

In addition, OLO suggests Councilmembers discuss with agency and labor representatives the following four policy-related questions:

Policy Question 1. ***What is the optimal group insurance cost share arrangement between County agencies and their employees? Should agency cost share policies incentivize employees to select lower cost plans?***

The term, "cost share,'" refers to the percent of group insurance premium costs paid by the employer and the employee, respectively. Employers set, and at times modify, their employer/employee group health insurance cost share formula in an attempt to balance support for the workforce with fiscal responsibility. Higher employer cost shares make group insurance more affordable for employees but also raise the amount of money the employer must set aside for this benefit.

In recent years, the County Government and MCPS have modified their employer/employee group health insurance cost share formulas multiple times. In some cases, the agency raised the employee cost share; in other cases, the agency lowered the cost share. Councilmembers may wish to discuss with agency and labor representatives how to optimally balance the goal of providing workers with affordable and robust health coverage with the goal of responsibly managing finite public resources.

Some employers offer lower cost share percentages to employees who select insurance plans with lower overall costs. This approach incentivizes employees to select lower cost plans and so reduces costs for both the employer and for employees who select the lower cost plans. However, establishing cost share differentials could be seen as placing a higher cost burden on employees who require more robust – and thereby most costly – health insurance coverage.

For many years, the County Government offered lower employee cost shares for lower cost medical insurance plans. The County Government discontinued the incentives in FY23. MCPS currently offers lower employee cost shares for lower cost medical plans. Councilmembers may wish to discuss whether, or to what extent, County agencies should incentivize employees to select lower cost medical plans.

Policy Question 2. Should the County Government and MCPS consider alternative cost share approaches such as salary-based charges and unitized pricing for family coverage?

Both the County Government and MCPS offer group health insurance with three coverage levels: for the employee alone (called "Self" coverage by the County Government and "Single" coverage by MCPS), for the employee plus one family member (called "Self+1" by the County Government and "Two-Party" by MCPS), and for the employee and all eligible family members (called "Self+Family" by the County Government and "Family" by MCPS). Employees pay the lowest cost for Self/Single coverage, a higher cost for Self+1/Two-Party coverage, and the highest cost for Self+Family/Family coverage. The difference in cost paid by the employee is based on the different total premium cost for each of the three coverage levels. The County Government and MCPS do not employ any other method for differentiating the employee contribution for a particular insurance plan.

Other methods exist to differentiate the amount paid by different employees for employer-provided group insurance coverage. Some employers have introduced "unitized pricing" that adjusts the employee's contribution amount for a family plan based on the number of people covered by the plan. Setting employee cost contributions based on the number of people covered by an employer-provided insurance plan may better align the benefit level with the cost incurred by the employer but may also be perceived as a bias against larger families.

In addition, some employers have adopted a policy to tie employees' contribution to salary. Under a salary-based model, premium cost shares vary within specified salary bands; employees with lower salaries pay a lower share of premium costs than employees with higher salaries. Advantages of salary-based charges include the ability of the employer to recover a greater share of premium costs and a potentially reduced risk that lower paid employees may limit their medical care to avoid both premium and high out-of-pocket costs. Disadvantages of this policy include that an employee's salary may not reflect total household income and that health care usage may not correlate with salary.

Councilmembers may wish to discuss with agency and labor representatives the advantages and disadvantages of alternative cost share approaches such as salary-based charges and unitized pricing for family coverage.

Policy Question 3. Should the County Government and MCPS consider implementing group insurance opt-out programs?

Some public sector employers offer a financial incentive to employees who elect to waive their employer-provided health insurance and enroll in a spouse's or other family member's health plan. The intent of these "opt-out programs" is to reduce an employer's health benefit spending while assuring that all employees have access to health care. Employees who participate in opt-out programs must demonstrate they have enrolled in a health plan that meets specified coverage standards. In return, participating employees receive a cash payment

in lieu of the health benefit. California and New York each offer opt-out programs for State employees. Councilmembers may wish to consider whether a similar program would be appropriate for employees of County agencies.

Policy Question 4. ***How should County agencies assess potential prescription drug utilization management strategies to properly balance cost control with employee access to needed treatments?***

Prescription utilization management is a health care cost-containment strategy to monitor drug use to ensure that medications are both cost effective and efficacious in treating the condition for which they were prescribed. Utilization management practices derive from evaluations of the clinical necessity of drug treatments against evidence-based guidelines to control prescription drug costs while maintaining an acceptable standard of care. Councilmembers may wish to discuss with County Government and MCPS representatives how they evaluate potential utilization management measures to achieve the proper balance between controlling costs and providing employees access to needed treatments?

CHAPTER 9: STAKEHOLDER COMMENTS

OLO shared a draft of this report with the County Government Chief Administrative Officer (CAO) and the MCPS Superintendent. OLO appreciates the time taken by staff in each agency to review the draft report and provide comments. This final report incorporates technical corrections and feedback from these stakeholders.

In addition, the CAO and Superintendent each provided written comments addressing the discussion questions presented by OLO in Chapter 8 of this report. The CAO's comments begin on page 61. The Superintendent's comments begin on page 63.

OFFICE OF THE COUNTY EXECUTIVE

Marc Elrich
County Executive

Richard S. Madaleno
Chief Administrative Officer

MEMORANDUM

October 2, 2026

TO: Chris Cihlar, Director
Office of Legislative Oversight

FROM: Richard S. Madaleno, Chief Administrative Officer

SUBJECT: Draft OLO Report 2026-16: *Group Health Insurance Cost Drivers*

Thank you for the opportunity to comment on the Office of Legislative Oversight's (OLO) Draft Report 2026-16: *Group Health Insurance Cost Drivers*.

We appreciate the report's analysis of the factors driving increases in our group health plan costs, and we recognize that many of these pressures, including medical inflation, rising specialty drug utilization, and a growing share of spending tied to chronic conditions and high-cost claimants, are affecting public and private employers alike. Rather than absorbing these increases passively or shifting them onto employees, the County has been taking a proactive, data-informed approach to slow cost growth while protecting the quality and accessibility of care our workforce depends on.

The County approaches cost management as ongoing rather than a single renewal-cycle response. That means regular review of plan performance against benchmarks, vendor accountability through performance guarantees, periodic verification of dependent eligibility, and monitoring of emerging trends so we can adjust before they become significant cost pressures. Through these combined efforts, we aim to keep the health plan financially sustainable while continuing to offer competitive benefits that support recruitment, retention, and the overall well-being of our workforce.

Additionally, the County has implemented a robust, award-winning wellness program designed to support employees across all dimensions of their wellbeing journey. Wellness programs, particularly those that combine lifestyle support, mental health resources, and chronic disease management, enhance employee health, reduce costs, strengthen productivity, and improve overall engagement. While meaningful outcomes can take time to fully develop, well-structured,

evidence-based wellness initiatives deliver strong returns and significantly enhance workforce well-being.

Further, the County has also recently expanded programs to help employees manage chronic conditions. Disease management programs provide substantial benefits for both employees and employers. These programs, which focus on diabetes, cardiovascular disease, asthma, arthritis, and other long-term conditions, have produced measurable improvements with a strong return on investment, including:

- Improved health outcomes
- Reduced healthcare utilization and costs
- Increased productivity and engagement
- Coordinated, patient-centered care
- Early intervention and prevention of chronic disease
- Alignment with evidence-based practices (e.g., annual wellness visits, standard immunizations, cancer screenings like routine mammograms and colonoscopies)

That said, the County's current health insurance plan designs have remained largely unchanged for more than thirty years, with no adjustments to copayments, deductibles, or structural elements.

We look forward to continued dialogue and partnership as the County evaluates these critical issues and charts a path toward a more efficient and financially resilient group insurance program.

RM/kb

cc: Fariba Kassiri, Deputy Chief Administrative Officer, Office of the County Executive
Tricia Swanson, Director of Strategic Partnerships, Office of the County Executive
Traci Anderson, Director, Office of Human Resources
Dr. Lolita Weedon, Deputy Director, Office of Human Resources
Jennifer Shovlin, Chief of Administrative Services, Office of Human Resources
Samuel Frushour, Chief of Policy, Practice & Strategic Engagement, Office of Human Resources
Karen Bass, Health Insurance Manager, Office of Human Resources

October 5, 2026

The Honorable Natali Fani-González, President
and Members of the Montgomery County Council
Montgomery County Council
Stella B. Werner Council Office Building
100 Maryland Avenue, 6th Floor
Rockville, Maryland 20850

Dear President Fani-González and Members of the Montgomery County Council:

Montgomery County Public Schools (MCPS) appreciates the opportunity to provide comments on the October 16, 2026, Office of Legislative Oversight (OLO) report, *Group Health Insurance Cost Drivers for Montgomery County Government and Montgomery County Public Schools*. We appreciate the report's thorough analysis and its focus on an issue that is critically important to our school system. Access to high-quality, affordable health benefits remains a cornerstone of MCPS' ability to recruit, retain, and support a highly effective workforce. At the same time, rising health care costs have created significant financial pressures that must be addressed to ensure both the continued well-being of our employees and the long-term fiscal sustainability of the school system.

MCPS has been transparent in the past three fiscal years regarding the growing deficits in both its active employee and retiree health benefit trust funds. Increasing health care costs are certainly one of the factors impacting our benefit trust funds. However, we must be frank and acknowledge that the extent and scope of these deficits are the result of a series of prior funding decisions that did not prioritize the fund's long-term health. These included budgetary reductions in employer benefit contributions to support other organizational priorities; the implementation of premium holidays for employees; and, more recently, the use of one-time funding from the Other Post-Employment Benefits (OPEB) Trust to address revenue shortfalls in the MCPS Operating Budget.

While these actions addressed budget and fund balance concerns at the time, they also contributed to structural funding challenges that have compounded year after year. As a result, the current leadership of MCPS is faced with the difficult but critically necessary task of restoring the long-term financial health of its benefit trust funds while continuing to provide comprehensive and competitive benefits.

Notable actions by MCPS to address this challenge began during the 2024 collective bargaining process, in which several significant changes to the employee health benefit programs were negotiated to generate additional revenue and help mitigate the rising cost of health care. As noted

15 West Gude Drive Suite 400 240-740-3020 Rockville, Maryland 20850 montgomeryschoolsmd.org

in the OLO report, these changes included a phased increase in the employee premium cost share of two percentage points throughout a two-year period, the implementation of preferred managed care plan options, and targeted strategies to address the rapidly increasing costs associated with GLP-1 medications. In addition to these plan design changes, MCPS pursued cost-containment measures during negotiations with its insurance providers. As existing contracts came up for renewal, MCPS successfully negotiated administrative fee holidays and other cost-saving provisions to help offset the increasing health care expenditures and reduce financial pressures on the employee and retiree benefit trust funds.

These actions demonstrate MCPS' proactive approach to addressing the structural challenges facing its health benefits program. While no single measure fully will resolve the long-term funding gap, the steps taken through collective bargaining and vendor negotiations represent meaningful efforts by the district to strengthen the financial sustainability of the benefits program and mitigate the compounding impact of prior budget decisions, coupled with a volatile health market.

Additionally, as reflected in the report, MCPS' cost-share position relative to other Montgomery County agencies has changed significantly over time. While MCPS historically maintained the lowest employee premium cost-sharing requirements and incurred the highest employer health benefit costs among County agencies, that no longer is the case. Today, MCPS employees contribute a higher average share of premium costs than employees in several other County agencies, while the average employer cost per covered employee is less than that of many peer agencies.

It also is important to recognize the scale of the MCPS health benefits program when evaluating cost trends and funding challenges. As the second-largest employer in the County, surpassed only by the federal government, the insured population served by MCPS, including active employees and retirees, is more than twice the size of the combined covered populations of all other County agencies. This creates a level of scale and complexity that is unmatched within County government and presents both opportunities and challenges, requiring careful consideration when comparing benefit costs, plan design, and funding strategies across agencies. As we have experienced in recent years, when the healthcare market experiences significant cost increases and shifts in utilization of services or prescriptions, the short-term fiscal effects can be severe and must be met with strategic and nimble action to address the long-term impacts.

Consequently, direct comparisons between MCPS and smaller County agencies should be made with appropriate context. The size, demographics, utilization patterns, and complexity of the MCPS-covered population create unique operational and financial considerations that influence both health care costs and the strategies available to manage them. As discussions continue regarding the long-term financial sustainability of employee health benefits, it is essential that these distinctions are recognized to ensure that policy recommendations are equitable, practical, and responsive to the realities of the MCPS workforce.

The policy questions raised in the report regarding incentivizing lower-cost plan options, alternative cost share structures, opt-out programs, and prescription utilization strategies will be an important subject of discussion with our employee associations, as MCPS has reopened collective bargaining related to employee benefits.

MCPS already has implemented policies that encourage employees to select lower-cost health plan options while still providing employees and retirees with meaningful choices and comprehensive coverage. This is a strategy the district will continue to review to help mitigate the rising cost of health care.

The concept of a salary-banded cost-sharing strategy is worth exploring as the concept warrants further evaluation. The benchmarking data, collected by our consultant AON, from 1,289 employers indicates that while approximately 30 percent utilize a salary-banded cost-sharing model, these employers are primarily within the private sector. This approach is generally more effective in organizations where significant disparities in compensation levels create meaningful salary bands. The applicability of this approach to MCPS would require careful consideration of workforce demographics, compensation structures, and collective bargaining obligations.

With respect to insurance opt-out programs, one of the primary challenges is determining an incentive amount that generates actual savings for MCPS or any County agency. Government-sponsored health insurance plans generally provide employees with lower costs and more comprehensive benefits than many private-sector alternatives. As a result, employees considering an opt-out option likely would need access to alternative health insurance coverage, and any incentive would need to be sufficient to offset those costs while still producing savings for the employer.

The rising cost of prescription medications, particularly the introduction of new and increasingly expensive drug therapies, continues to be a significant driver of health care cost increases. Determining the appropriate balance among copay structures, plan design, and cost-sharing provisions will require ongoing evaluation and discussion. We anticipate that this will remain a key topic of conversation throughout the next several years.

In conclusion, MCPS believes it would be important for the Council to consider establishing a policy regarding appropriate fund balance levels for employee benefit trust funds. A clearly defined funding policy would provide a framework for maintaining the financial stability of these funds and minimizing the need for significant corrective actions during periods of economic uncertainty or rapid cost escalation.

Such a policy is particularly important as health care costs continue to rise nationwide due to factors identified in the report, including increasing prescription drug expenditures, an aging workforce, consolidation among hospitals and medical providers, private equity investment in health care, and ongoing labor shortages. While MCPS has taken meaningful steps to strengthen

the financial position of its benefits program through collective bargaining, plan design changes, and vendor negotiations, these broader market forces will continue to place pressure on employer-sponsored health plans.

Moving forward, sustained collaboration among MCPS, employee associations, County leaders, and other stakeholders will be critical to balancing affordability, competitiveness, and fiscal responsibility. By maintaining a focus on proactive planning and prudent funding practices, MCPS can continue to provide high-quality health benefits while ensuring the long-term viability of its employee and retiree benefit programs.

Sincerely,

Thomas W. Taylor, Ed.D., M.B.A.
Superintendent of Schools

TWT:IAW:lsh

Copy to:
Mrs. Alfonso-Windsor
Ms. McGuire