GRAND JUNCTION CITY COUNCIL
MONDAY, MAY 2, 2016

WORKSHOP, 5:00 P.M.
CITY HALL AUDITORIUM
250 N. 5TH STREET

To become the most livable community west of the Rockies by 2025

1. **Vulnerability Index Study** — ***Supplemental Documents***

2. **Retiree Health** — ***Supplemental Documents***

3. **Committee and Board Reports**

4. **Other Business** — ***Supplemental Documents***

GRAND JUNCTION REGISTRY WEEK
EXECUTIVE SUMMARY

Overview: The Grand Junction Registry Week took place between Tuesday, March 1 at 8:00 am and Wednesday, March 2 at 4:00 pm, and included two parts: identifying and surveying individuals and families who were sleeping unsheltered as well as surveying those who were residing in emergency shelter or transitional housing programs. Approximately 30 volunteers were trained on the data collection requirements/forms/process and assisted with the surveying. Over the 2 day period, different geographic areas within Grand Junction were surveyed. A group of providers, relying heavily on the Grand Junction Police Department, developed a list of "hot spots" where they believed those sleeping unsheltered were likely to be found, and focused their efforts on those areas. All of the individuals who identified as homeless and provided their consent had the survey administered to them. However, refusals were not captured, so these numbers should definitely be seen as a low estimate.

The Survey: The survey tool used during this Registry Week was the Vulnerability Index Service Prioritization Decision Assistance Tool (VI-SPDAT). This tool is used to prescreen individuals for services that might be available to them, and to determine who is in need of immediate assistance. In addition to the VI-SPDAT, a short series of localized questions capturing military background were asked. For each person surveyed, the VI-SPDAT generates an acuity score—a numeric assessment of the severity of a respondent's needs. The VI-SPDAT is divided into four domains, and assesses a person's history of housing and homelessness, their involvement in risky situations, their level of socialization and ability to function on a day-to-day basis, and their level of wellness, including physical and mental health as well as substance use.

Limitations: Because data was not captured on everyone experiencing homelessness, the quality of the data is not the highest possible. Many volunteers reported back that individuals who were likely sleeping unsheltered refused to take the survey, and it is unclear to what degree we were able to obtain surveys on those sleeping in emergency shelters or transitional housing.

Results:

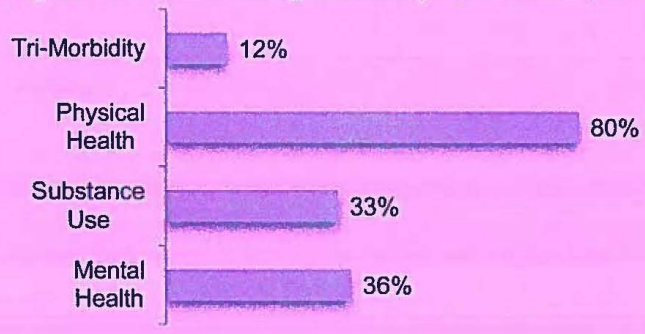
- 212 households surveyed
- 146 households experiencing chronic homelessness

Risks: The experience of being homeless is associated with numerous increased risks, which were measured during the Registry Week. Risks can take a variety of forms; 16% said that they do things that may be considered to be risky like exchange sex for money, run drugs for someone, have unprotected sex with someone they don't know, share a needle, etc. Furthermore, 12% reported that they get forced or tricked into doing things they don't want to do. Note that some activities, like exchanging sex for money or running drugs, may be included in both categories.

Service Utilization in the Past 6 Months:

Times	0	1	2	3	4+
Ambulance Rides	72%	17%	5%	1%	5%
ER Visits	43%	19%	15%	8%	15%
Hospitalizations	79%	13%	3%	1%	4%
Crisis Service	79%	8%	6%	3%	4%
Police Interactions	52%	21%	7%	4%	15%
Jail Nights	58%	24%	7%	2%	8%

Wellness: Overall, 13% of respondents reported no problems related to wellness. The remaining 87% reported having at least one health issue. "Tri-morbidity" refers to the co-occurrence of a physical health problem, a mental health problem, and a substance use problem. It is linked with a higher risk of death among homeless persons. Overall, 12% of respondents had tri-morbidity.



Recommendations

Recommendation 1:

Develop a 30-40 unit single site Permanent Supportive Housing (PSH) project targeting chronically homeless single individuals who are medically fragile and/or have substance abuse and/or mental health issues. Based on the data 68 households (47% of the 146 people experiencing chronic homelessness) are in need of PSH, a proven, cost effective solution to ending chronic homelessness. This housing must be managed and services provided using a Housing First and Harm Reduction model and building and service design should be based on trauma informed care principals.

Process: Because these projects are complicated and the funding sources are highly competitive there must be strong support from the community including the City Council, Mayor's Office and Police department. A local service provider with experience with Housing First and Harm Reduction should be the local lead and through an RFP process, partner with a developer, owner and property manager who has experience with these types of projects. PSH for this specific population needs to be structured with 0 debt and have 100% project based vouchers. The service provider must commit to on-going training on Housing First, Harm Reduction and Trauma informed care and be willing to fully embrace a model where sobriety, medication compliance and utilizing services are not a condition of tenancy.

Design: PSH requires a level of consideration taking in the design of the site and building above and beyond what affordable housing requires, therefore the service provider should be part of the development team giving input into design throughout the process. Design considerations should include: single point of entry, 24 hour front desk coverage, security cameras, office space for case managers and outside service partners, community space, community kitchen and dining area and a space for a visiting nurse and/or mental health professional.

Recommendation 2:

Create a Homeless Coordinating Committee – This is chaired by an elected official with a vice chair and membership includes all who serve and are impacted by your homeless citizens. This would include, but limited to, the Continuum of Care agencies/leaders, State employees who have resources that serve homeless citizens, Faith Based leaders, Housing Authority, Emergency Service providers, police, hospital leaders, business leaders, community advocates, and others. This committee is to:

a. Identify and engage champions for the homeless cause.
b. Review the present homeless delivery system and implement improvements to effectively identify and assess homeless citizens and match them with appropriate resources, such as permanent supportive housing for the chronically homeless individuals, rapid rehousing for families, veterans with VA services, homeless youth with transitional housing, etc.
c. Support the development of additional permanent supportive housing and affordable housing.
d. Identify gaps in services and funding and identify and obtain needed resources.
e. Increase the collaboration among all agencies serving the homeless citizens.

Engage the public in providing service to your homeless brothers and sisters.

Recommendation 3:

Public Education Strategy- Work with community partners to develop a two page document with talking points which address the economic impacts of the current system, cost savings generated by housing homeless and the humanitarian impact of homelessness.

Recommendation 4:

Implement a technical assistance program for developers who want to develop affordable and permanent supportive housing in Grand Junction.

Recommendation 7:

Re-prioritize local affordable housing resources/funding to permanent supportive housing projects to take advantage of the current priority in the State of Colorado on state and federal dollars being invested in permanent supportive housing.

Grand Junction 2016 Registry Week

OrgCode Consulting, Inc.

This document provides an overview of the data collection process and results from the March 1-4, 2016 Grand Junction Registry Week.

Prepared by Katie Raines of OrgCode Consulting, Inc.

March 18, 2016

Grand Junction 2016 Registry Week

Background

Registry Weeks were made popular throughout the United States during the 100,000 Homes Campaign organized by Community Solutions. A Registry Week is when a community comes together and mobilizes over a few days to identify the most vulnerable individuals experiencing homelessness through the use of a survey tool. This process helps providers determine who is likely to die on the streets with no housing intervention. Communities use the results from this process to prioritize individuals for permanent supportive housing, and other housing resources that may be available in the community.

Methods

This Registry Week included two parts: identifying and surveying individuals and families who were sleeping unsheltered as well as those who were housed in emergency shelter or transitional housing programs.
The surveying took place between Tuesday, March 1 at 8:00 am and Friday, March 4 at 4:00 pm.
Approximately 50 volunteers assisted with data collection, who were trained on the data collection requirements/forms/process.

Street Count

Over the 4-day period, different geographic areas within Grand Junction were surveyed. A group of providers, relying heavily on the Grand Junction Police Department, developed a list of "hot spots" where they believed those sleeping unsheltered were likely to be found, and focused their efforts on those areas.
All individuals who identified as homeless, and agreed to taking a survey, had the VI-SPDAT administered. However, the decision was made to not keep track of those who refused to take they survey, so these numbers should very much be seen as a low estimate.

Sheltered Count

An attempt was made to survey individuals at each agency in the area that provides emergency shelter or transitional housing. Most agencies obliged with this request. Additionally, individuals who were homeless prior to entering Mesa County Jail were surveyed.

The Survey

The survey tool used during this Registry Week was the Vulnerability Index Service Prioritization Decision Assistance Tool (VI-SPDAT). This tool is used to prescreen individuals for services that might be available to them, and to determine who is in need of immediate assistance. In addition to the VI-SPDAT, a short series of localized questions capturing military background were asked.

The VI-SPDAT

In order to conduct a needs assessment for the homeless population as a whole, the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) was used. The VI-SPDAT is a short survey, jointly created by Community Solutions and OrgCode Consulting, Inc., that is intended to be used by anyone with basic training on the survey, including service providers or volunteers. Although he VI-SPDAT was first developed to enable service providers to make quick, informed decisions about the prioritization of clients and resources based on individual needs, it was used in Grand Junction to collect aggregate data about the prevalence of various risk factors associated with homelessness among the homeless population in Grand Junction.

For each person surveyed, the VI-SPDAT generates an acuity score—a numeric assessment of the severity of a respondent's needs. Three versions of the tool were used during this process: VI-SPDAT v.2 for Single Individuals, VI-SPDAT v.2 for Families, and the TAY-VI-SPDAT v.1, the "Next Step Tool for Homeless Youth". The higher the score, the higher the respondent's acuity. In general, homeless persons with high acuity would be best served with a Housing First intervention, while individuals and families with moderate acuity would best be served with a Rapid ReHousing intervention. However, this is a generalization, and a full assessment is recommended on a case-by-case basis.

The VI-SPDAT is divided into four domains, and assesses a person's history of housing and homelessness, his or her involvement in risky situations, their level of socialization and ability to function on a day-to-day basis, and their level of wellness which includes physical and mental health as well as substance use.

Limitations

Because data was not captured on everyone experiencing homelessness, the quality of the data is not the highest possible. Many volunteers reported back that individuals who were likely sleeping unsheltered refused to take the survey, and it is unclear to what degree we were able to obtain surveys on those sleeping in emergency shelters or transitional housing.

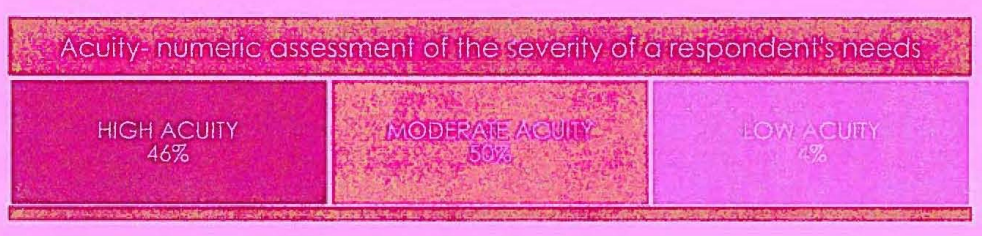
Grand Junction 2016 Registry Week

213 Surveys Administered

178 Single Individuals

16 Families

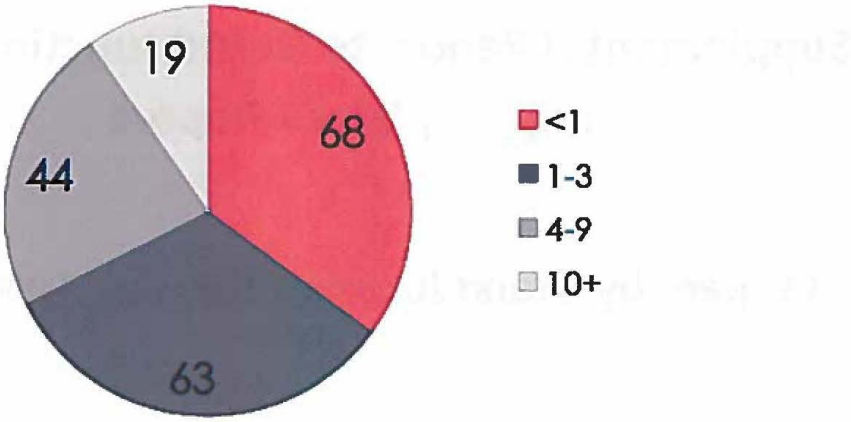
19 Transition Aged Youth



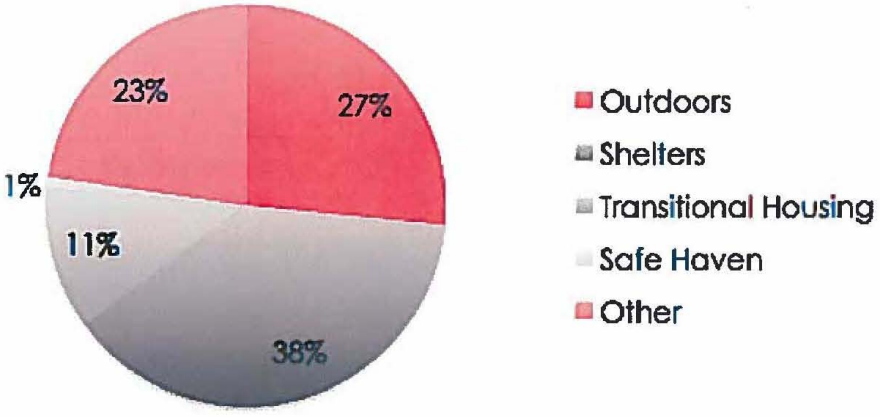
- 98 surveys indicated that respondents had high acuity. In general, homeless persons with high acuity would be best served with a **Housing First** intervention.
- 106 surveys indicated that respondents had moderate acuity, and would best be served with **Rapid ReHousing.**
- 9 surveys showed that respondents will likely **self-resolve** their own homelessness

Grand Junction 2016 Registry Week

Length of Homelessness in Years



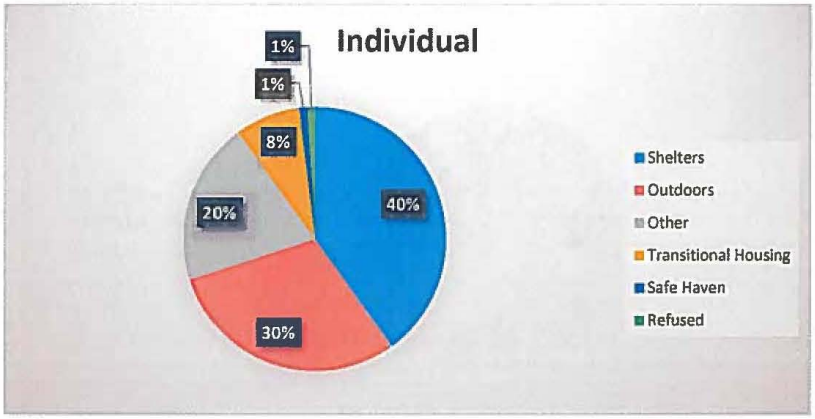
Where do you sleep most frequently?

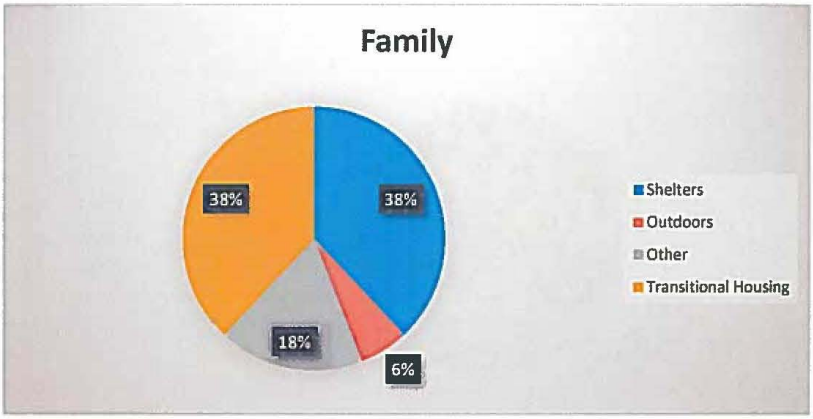


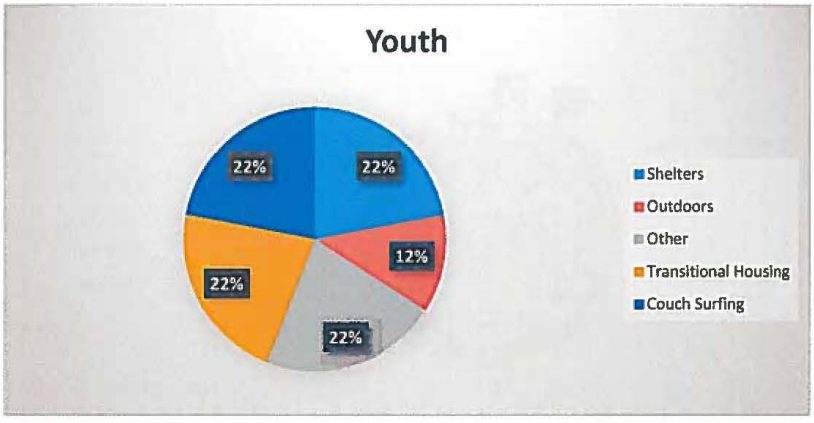
Supplemental Report to Grand Junction 2016 Registry Week Report

Prepare by Grand Junction Housing Authority

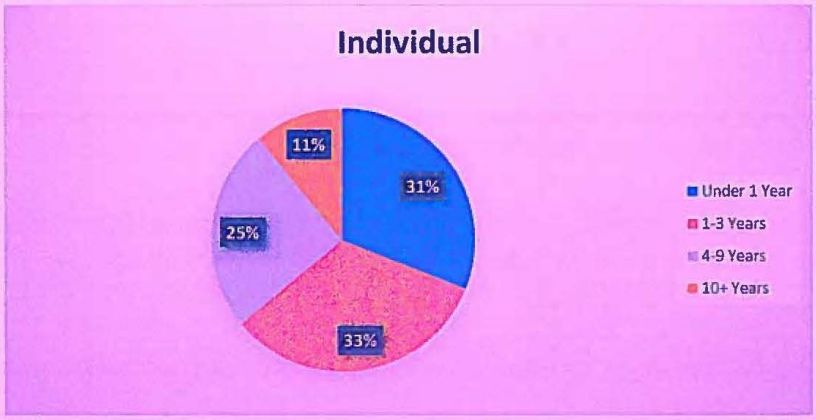
Where do you most frequently sleep?

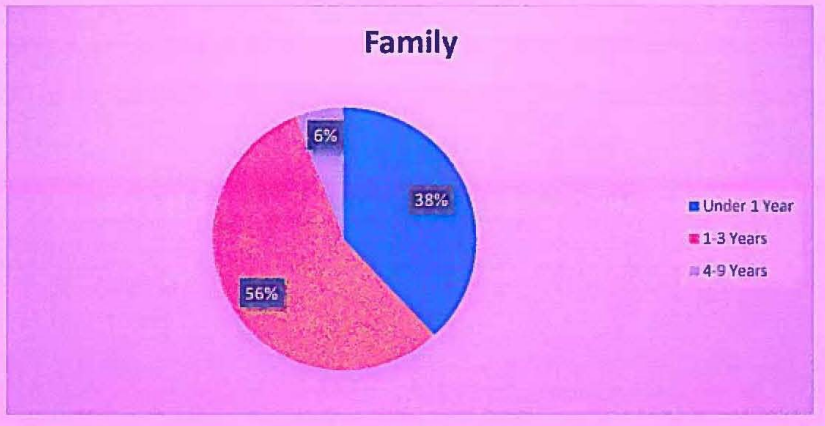


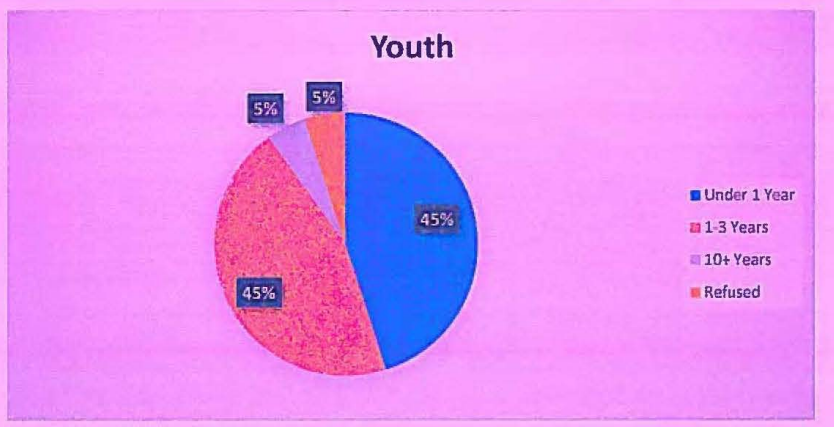




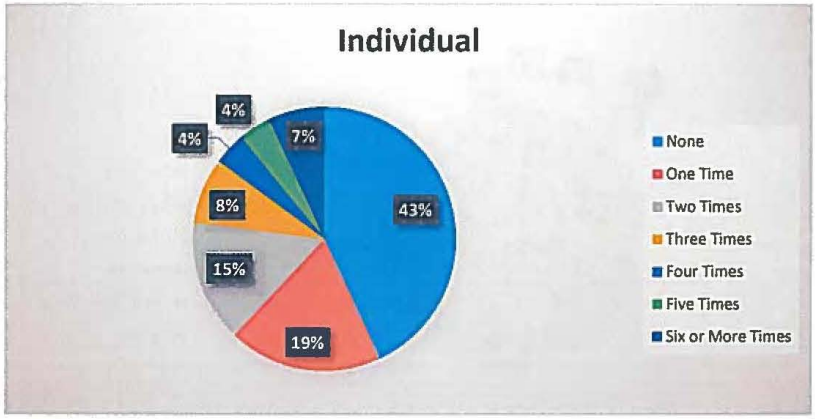
How long has it been since you've had permanent stable housing?

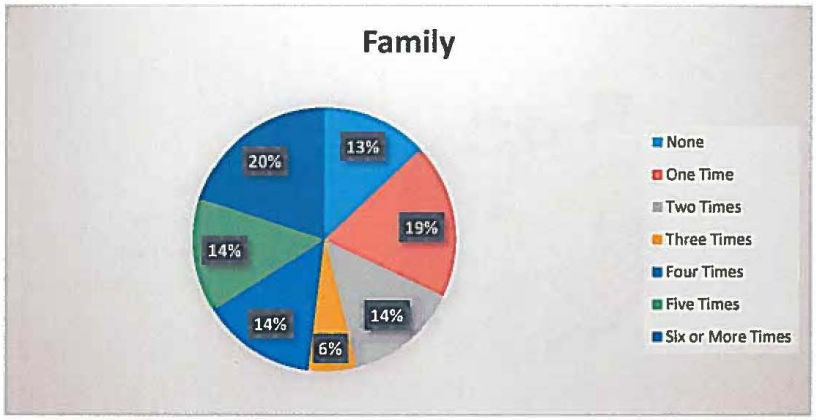


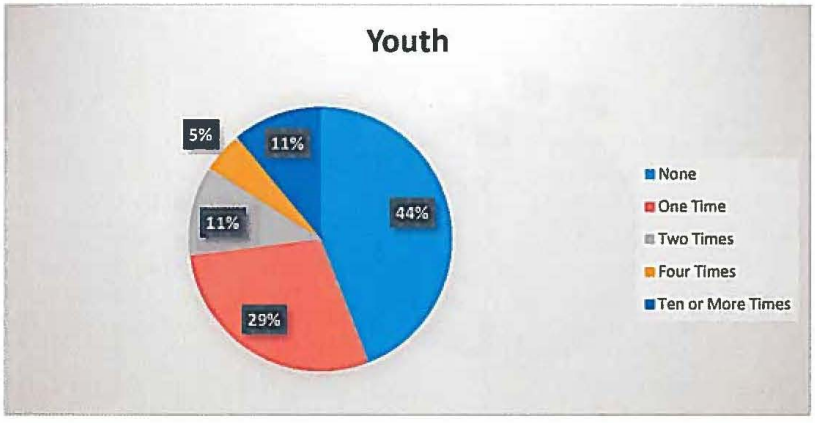




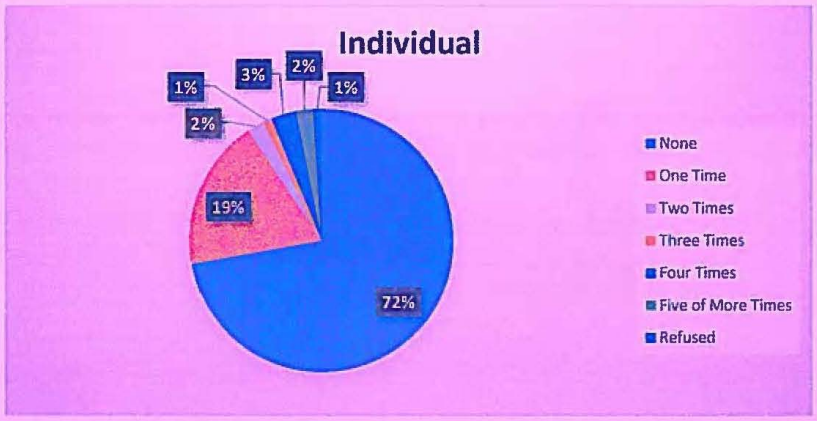
In the past 6 months how many times have you received healthcare at an emergency department/room?

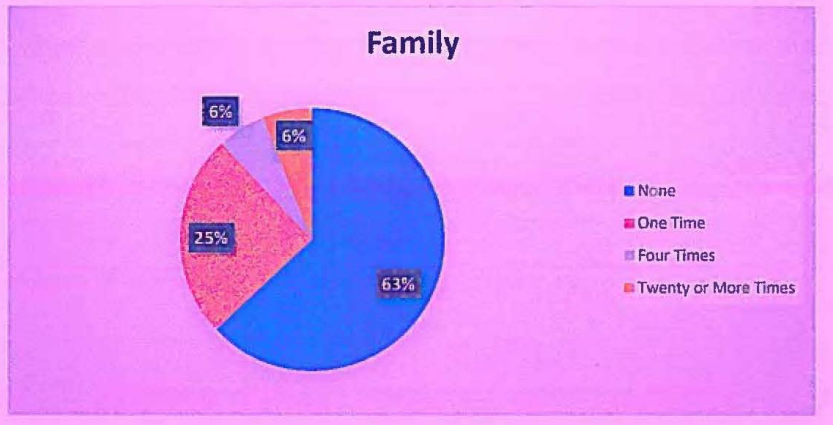


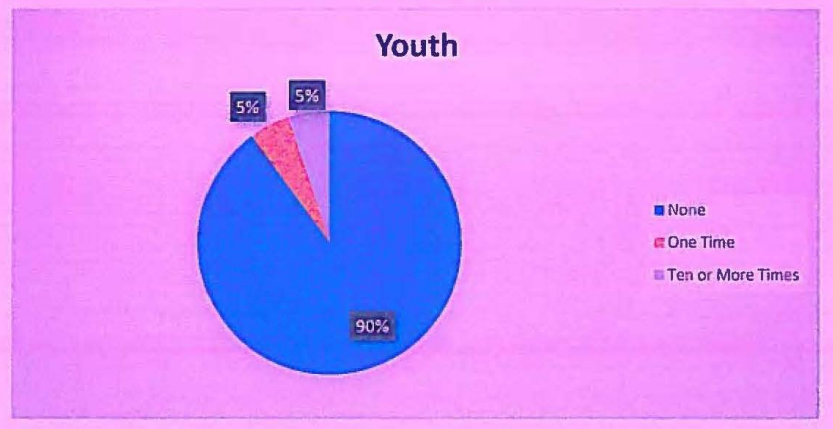




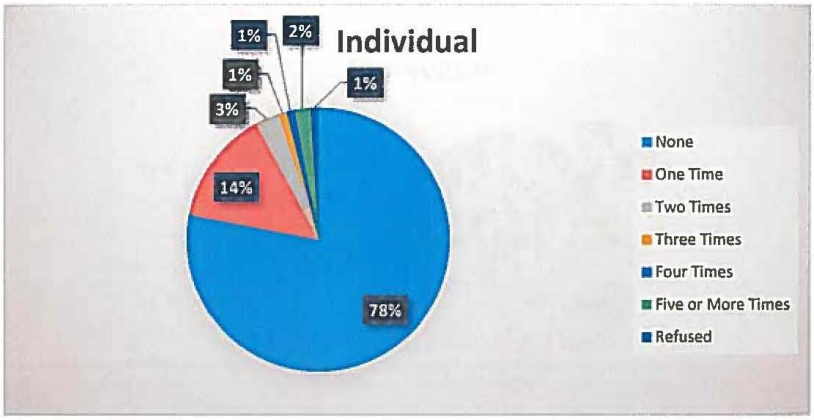
In the past 6 months how many times have you taken an ambulance to the hospital?

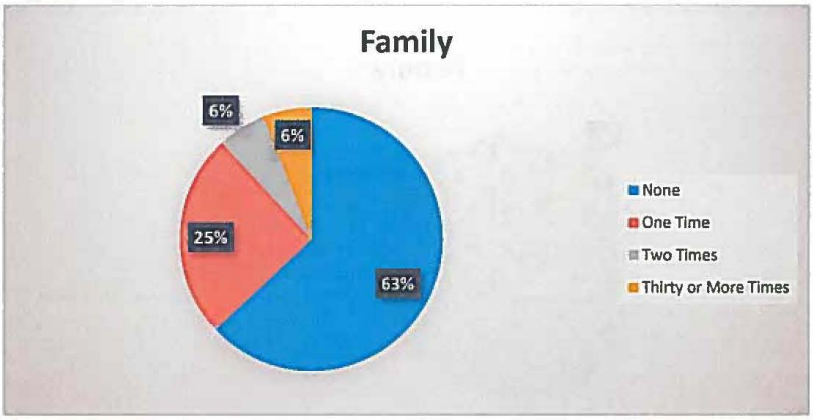


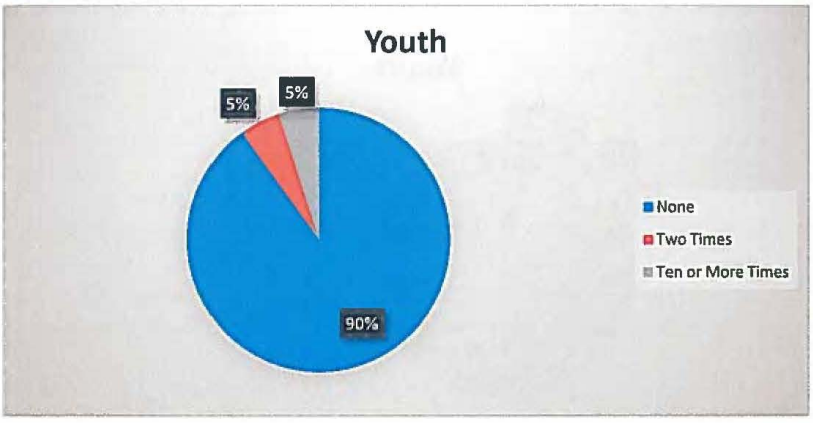




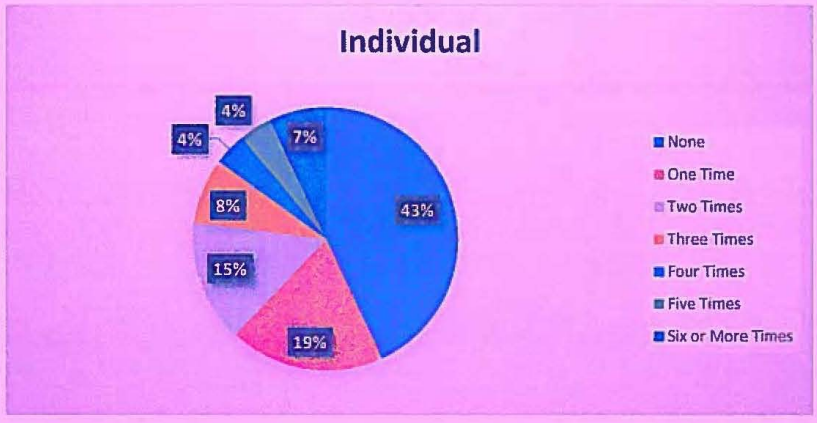
In the past 6 months how many times have you been hospitalized as an inpatient?

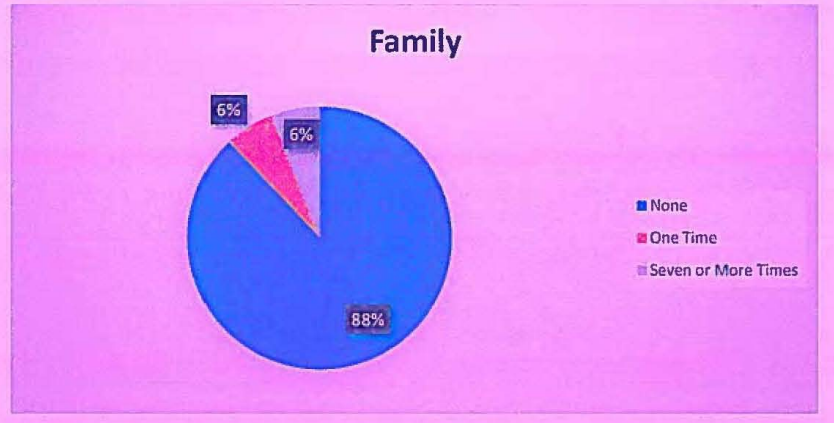


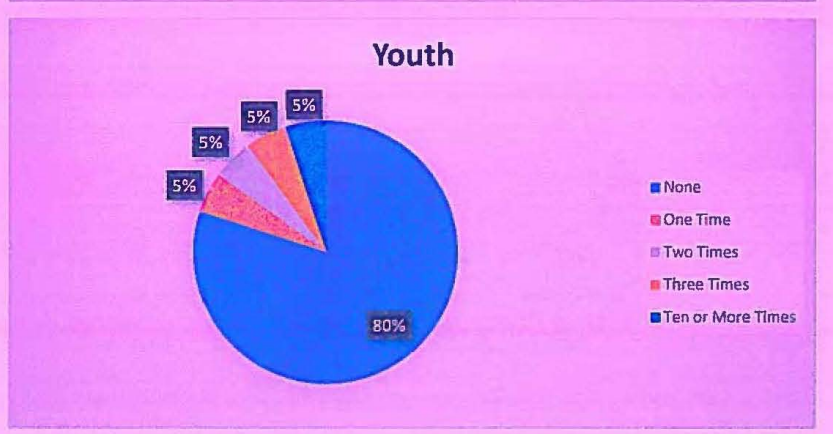




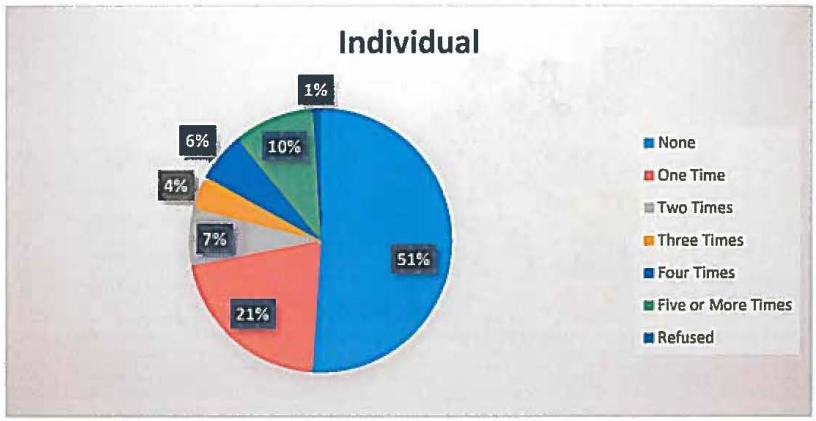
In the past 6 months how many times have you used a crisis service, including sexual assault crisis, mental health crisis, family/intimate health crisis, distress centers, and suicide prevention hotlines?

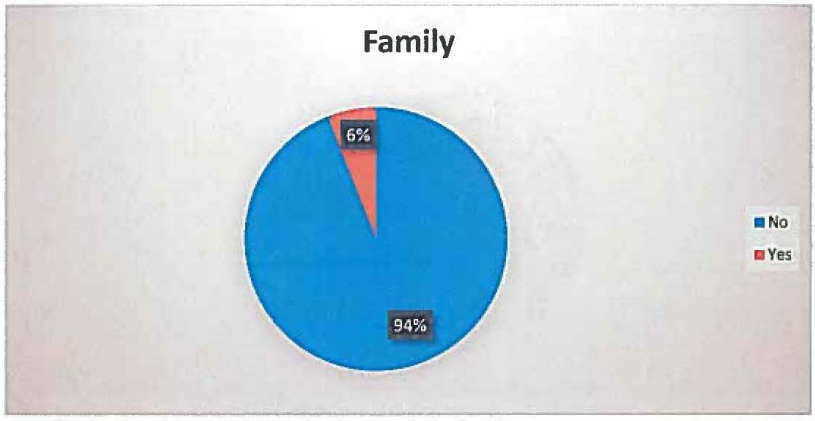


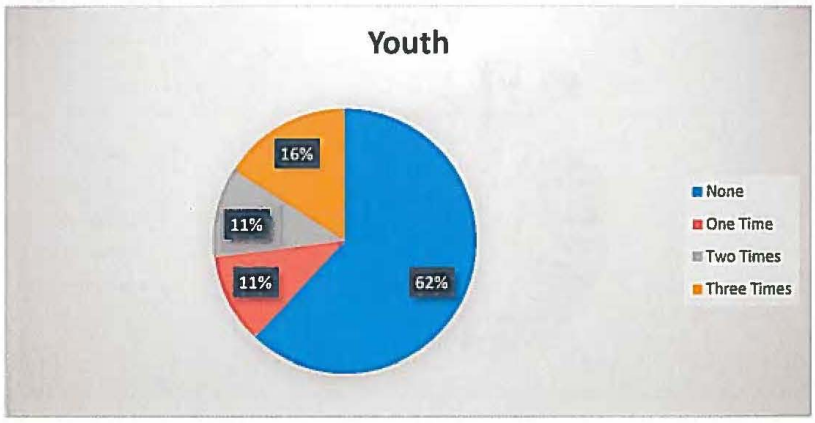




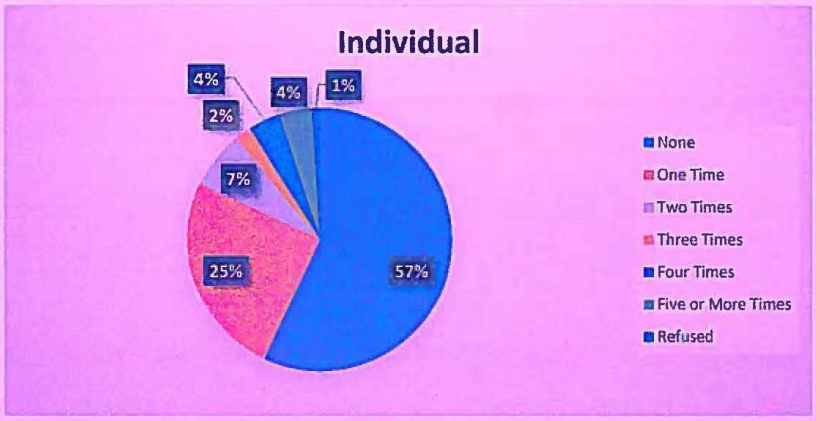
In the past 6 months how many times have you talked to police because you witnessed a crime, were the victim of a crime, or the alleged perpetrator of a crime or because the police told you that you must move along?

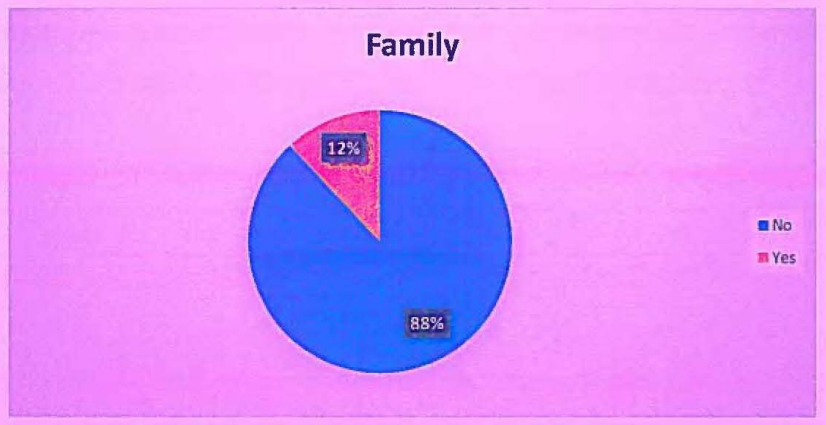


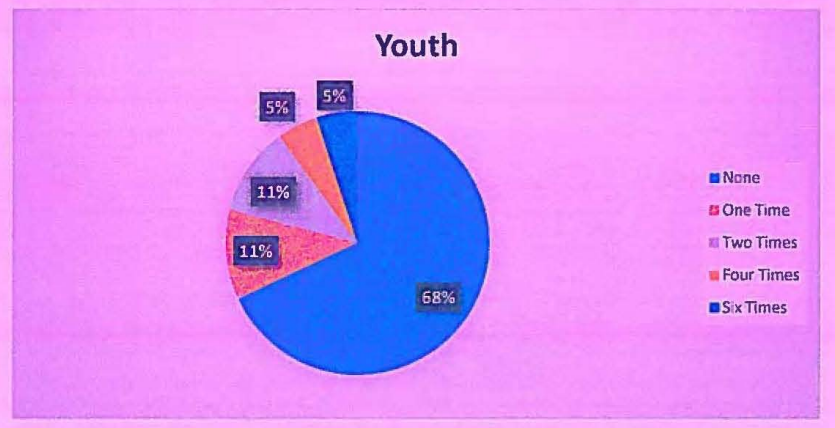




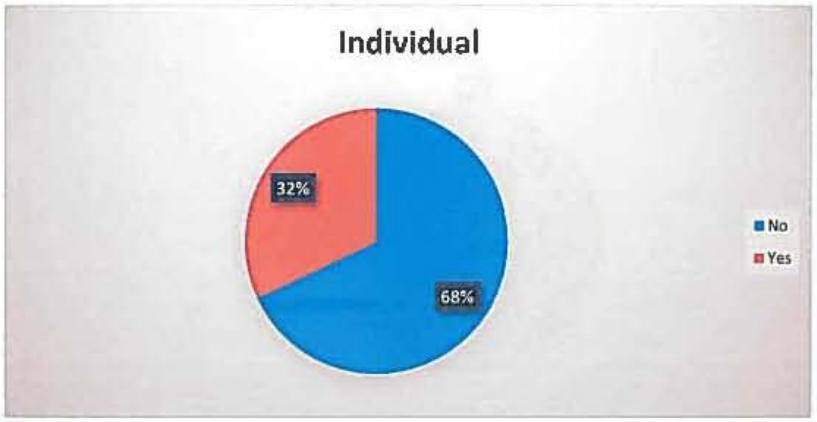
In the last 6 months how many times have you stayed one or more night in a holding cell, jail or prison (or juvenile detention) whether that was a short term stay like the drunk tank, a longer stay for a more serious offense or anything like that?

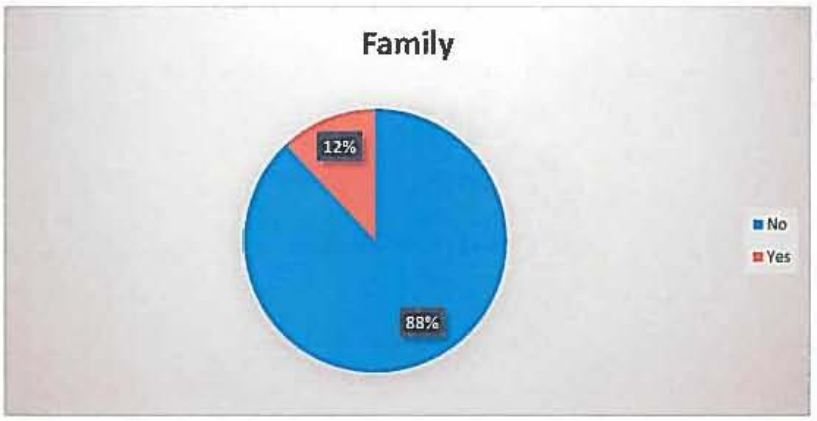


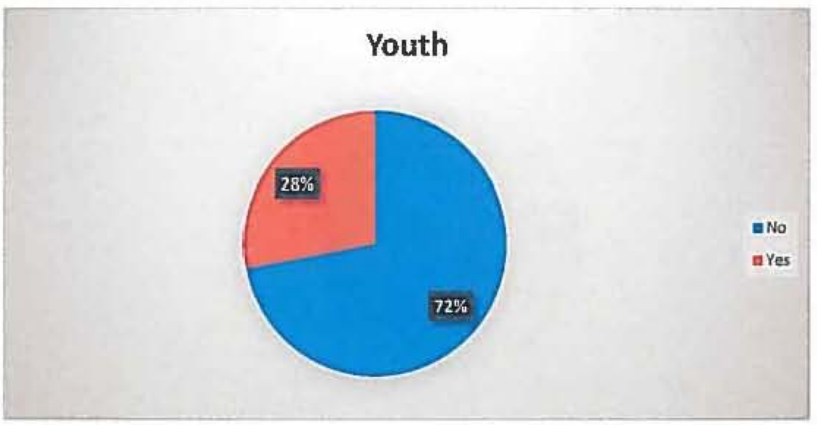




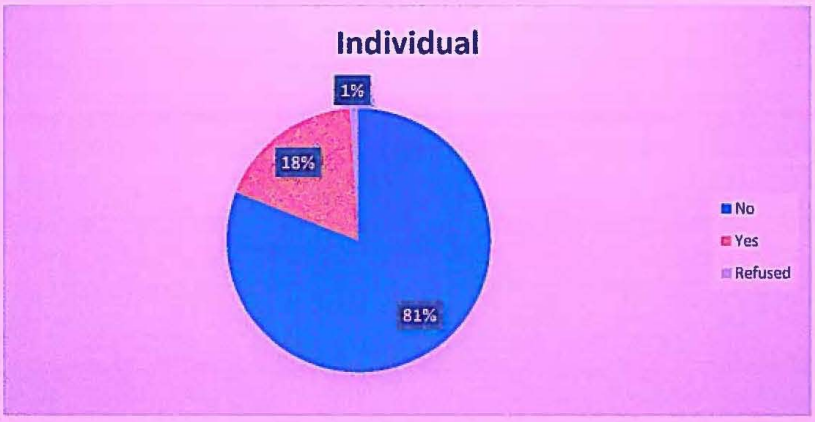
Have you been attacked or beaten up since you've been homeless?

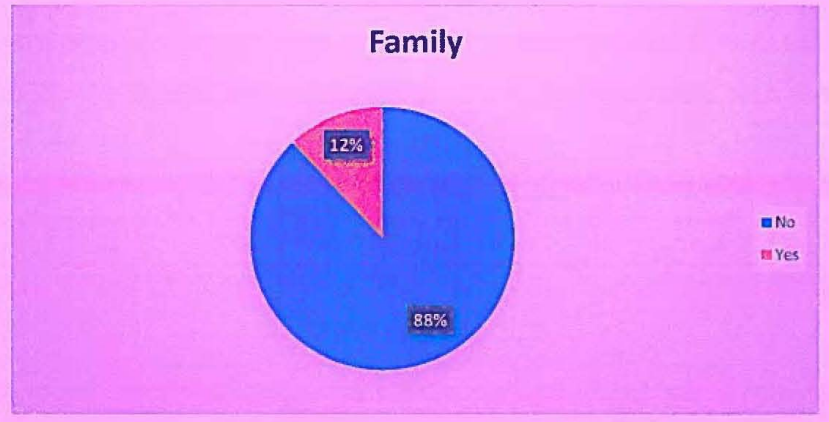


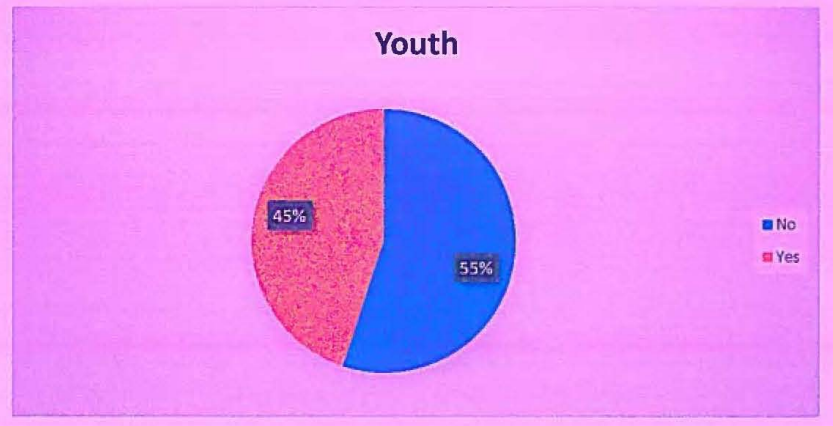




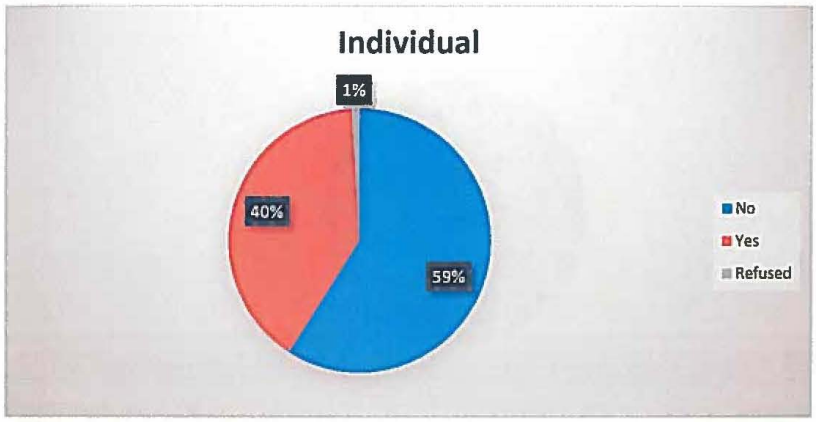
Have you threatened to or tried to harm yourself or anyone else in the last year?

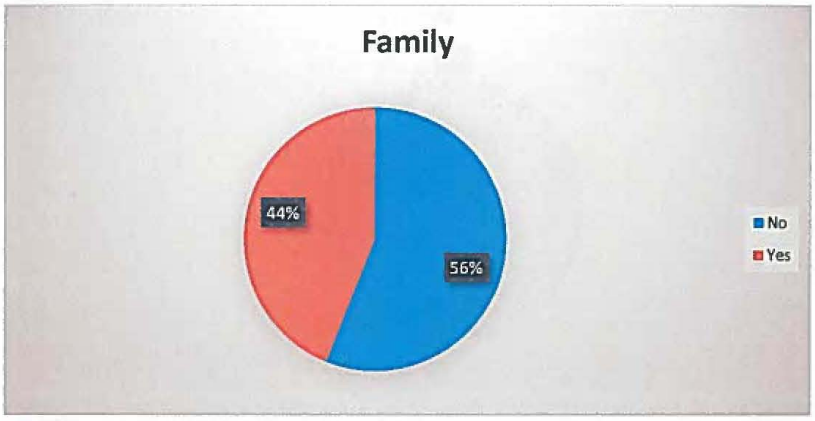


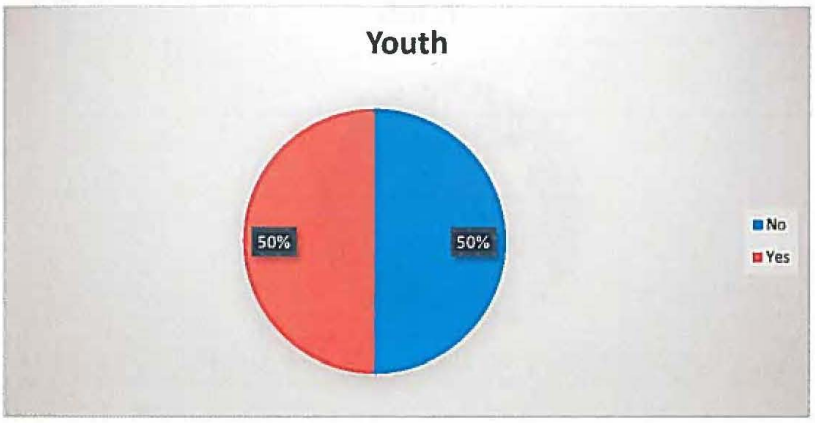




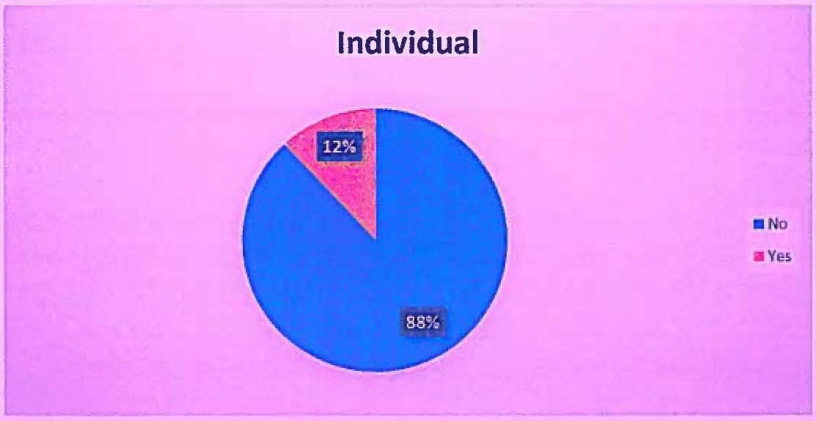
Do you have any legal stuff going on right now that may result in you being locked up, having to pay fines, or that make it more difficult to find a place to live?

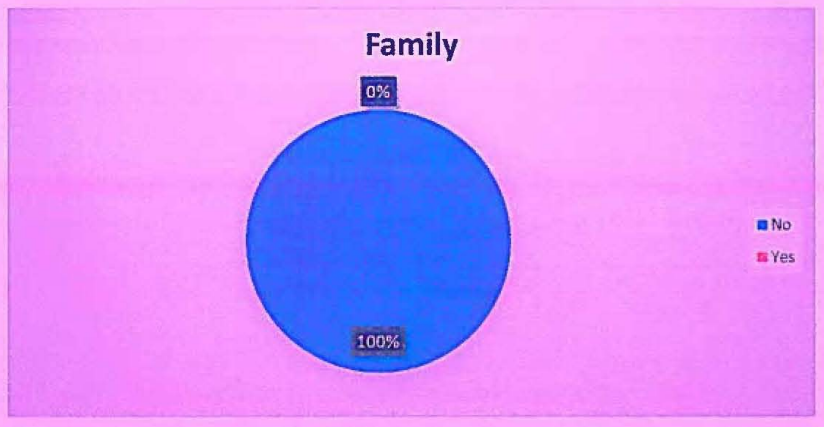


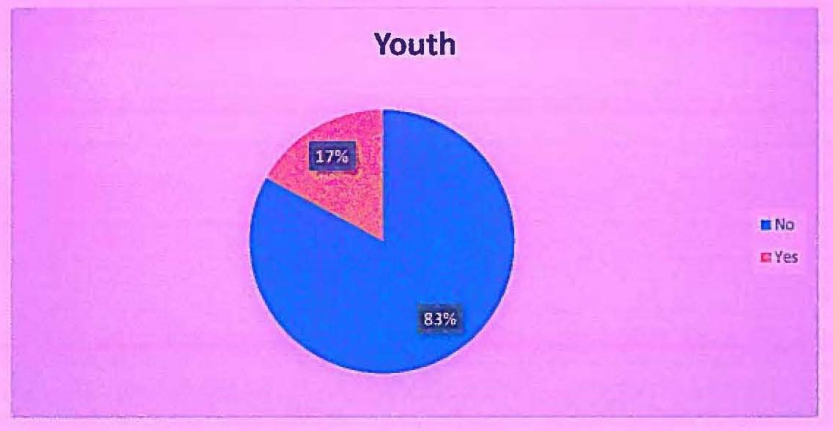




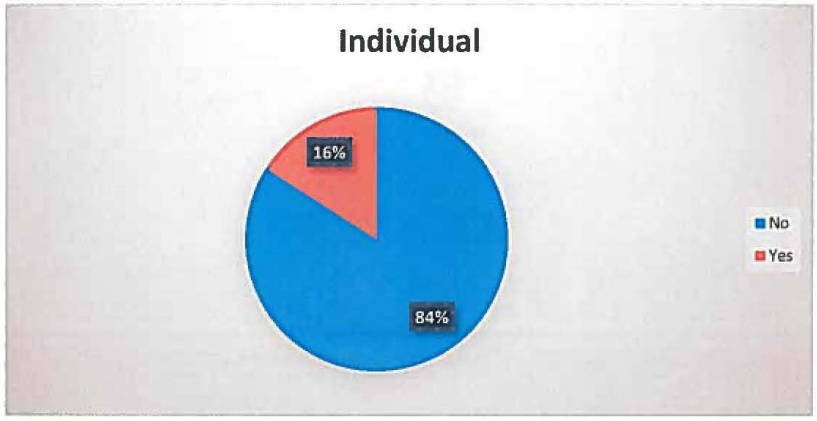
Does anybody force or trick you to do things that you do not want to do?

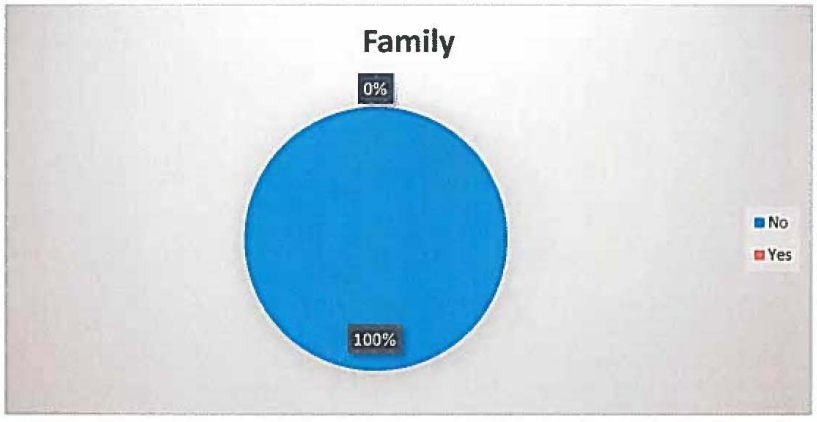


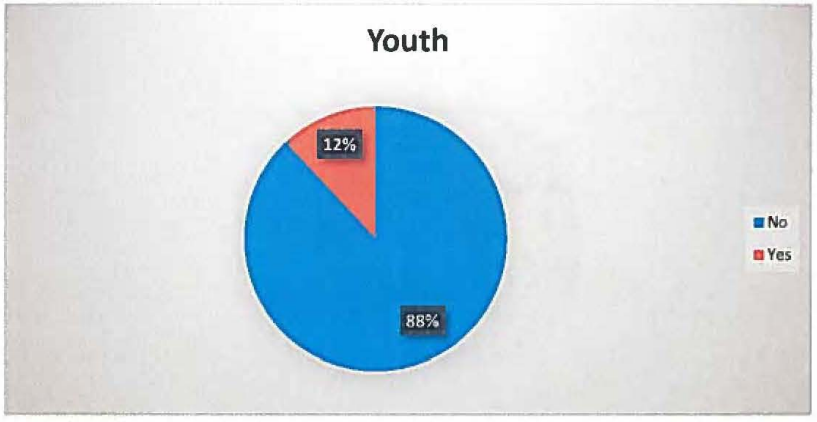




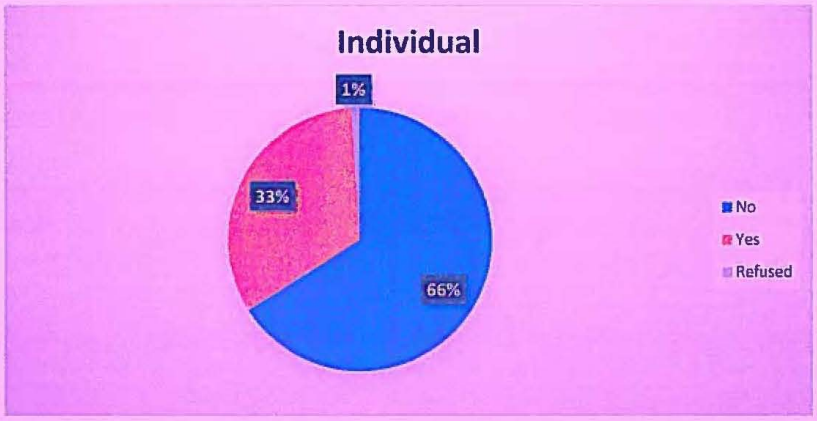
Do you ever do things that may be considered risky like exchange sex for money, run drugs for someone, have unprotected sex with someone you don't know, share a needle or anything like that?

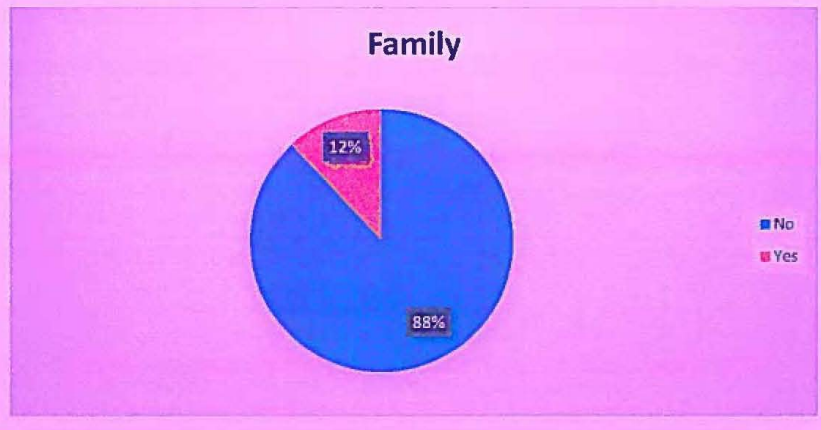


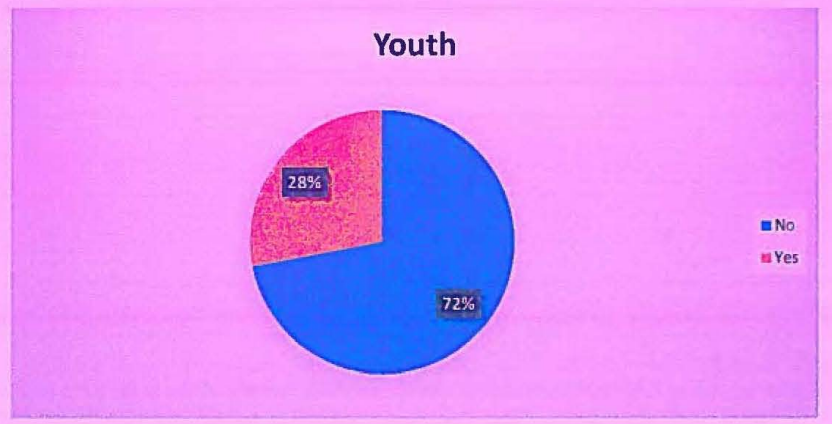




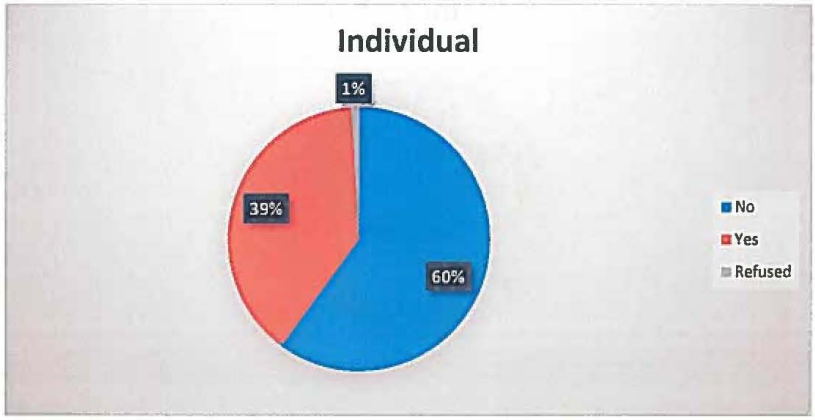
Is there any person, past landlord, business, bookie, dealer, or government group like the IRS that thinks you owe them money?

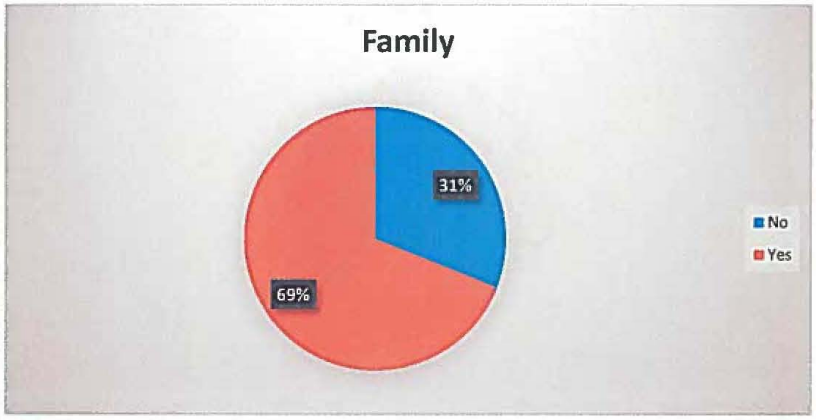


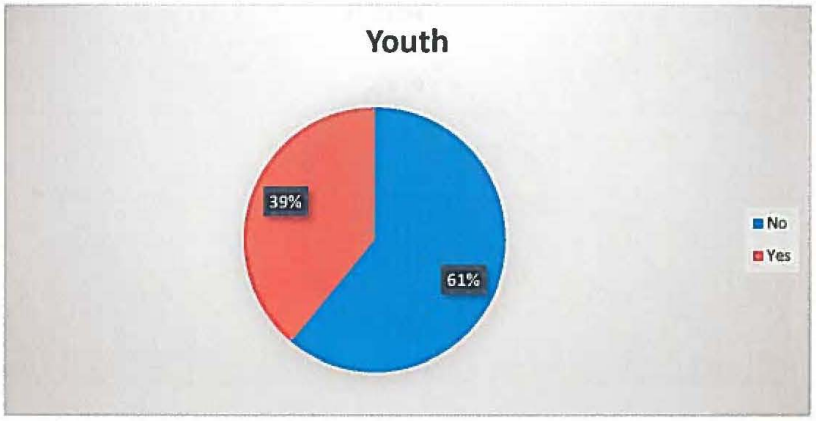




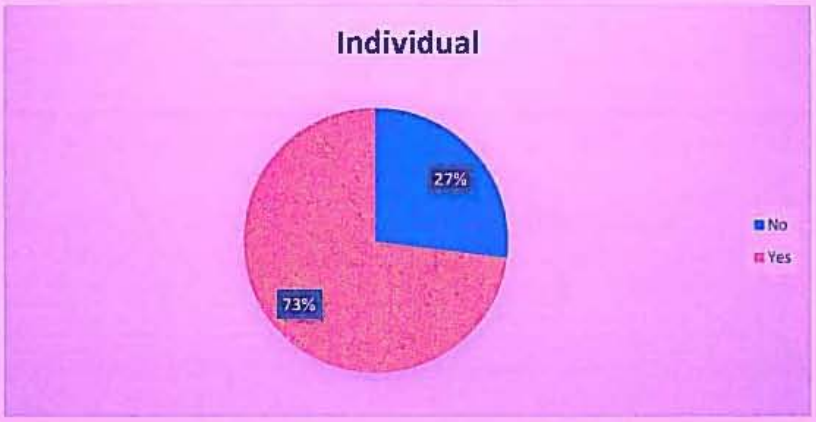
Do you get any money from the government, a pension, an inheritance, working under the table, a regular job, or anything like that?

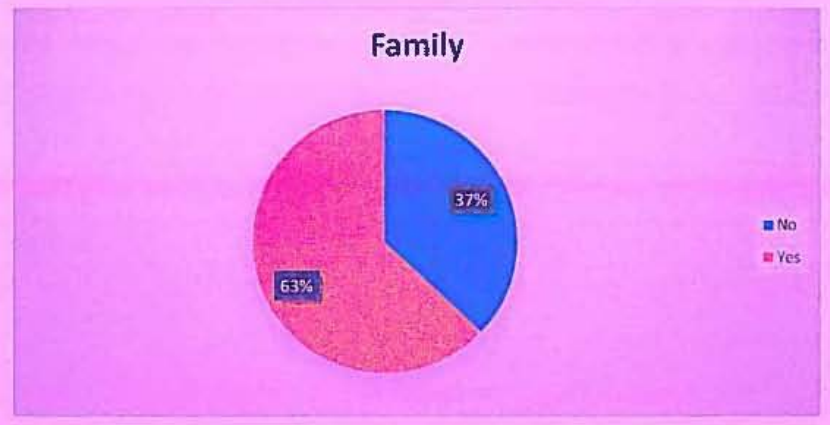


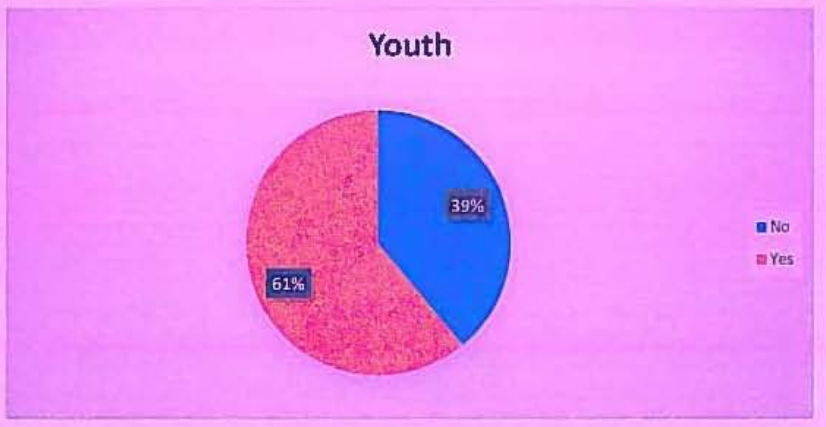




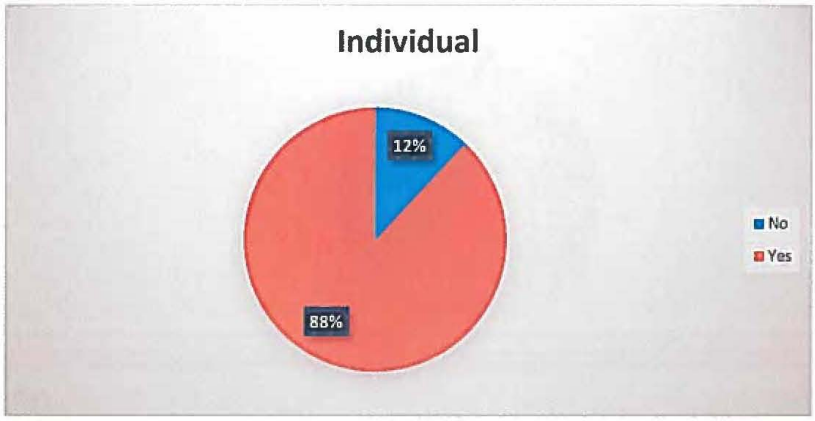
Do you have planned activities, other than just surviving, that make you feel happy and fulfilled?

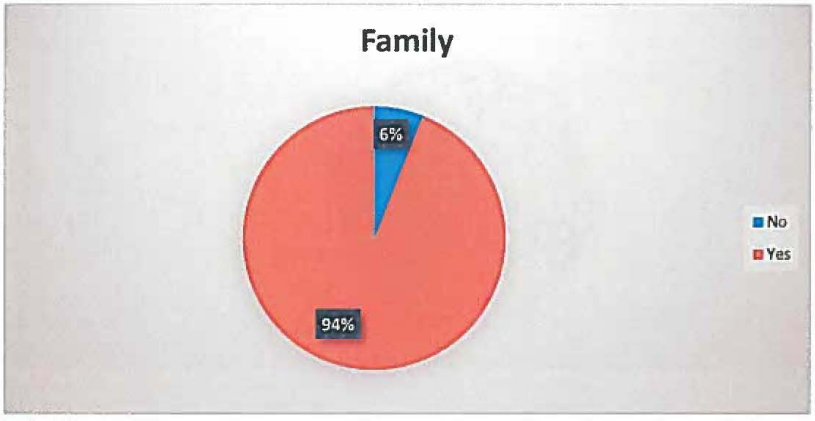


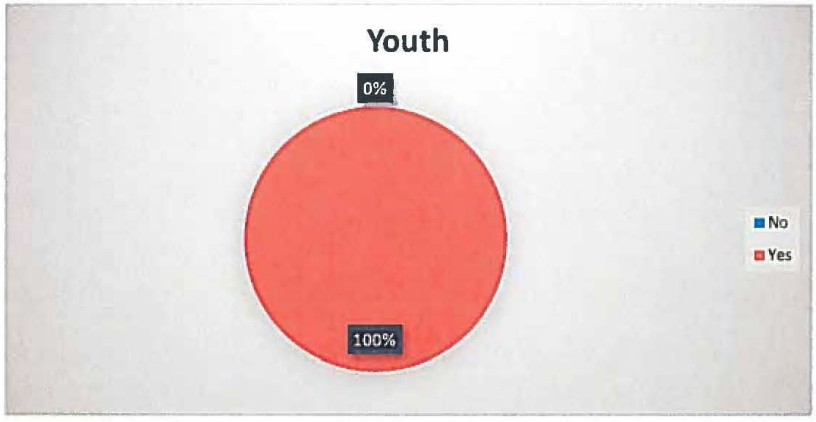




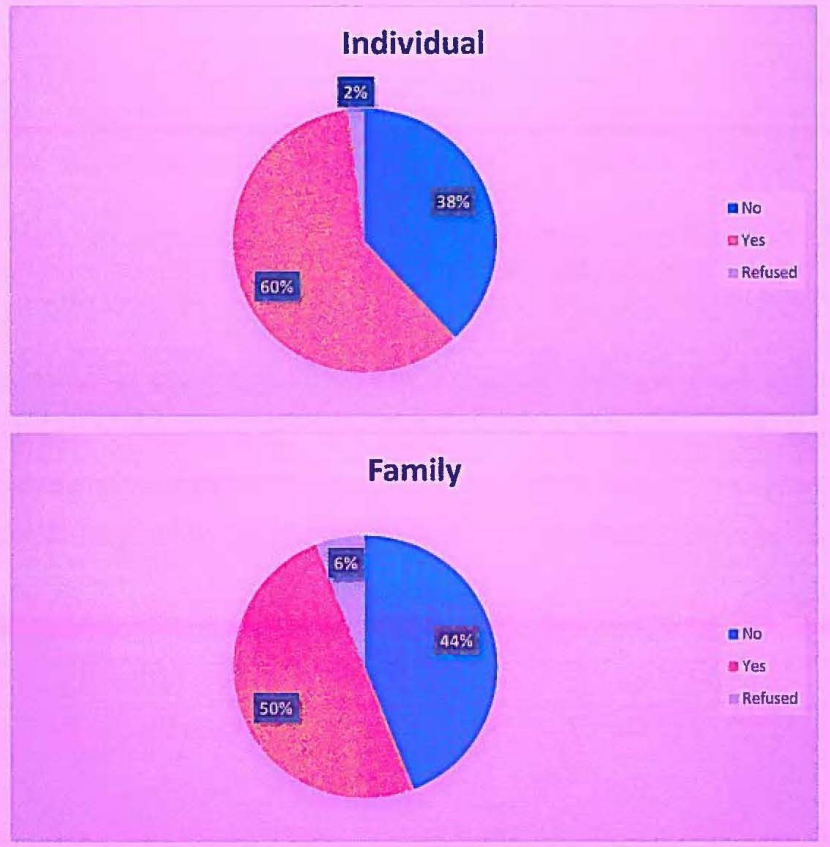
Are you currently able to take care of basic needs like bathing, changing clothes, using a restroom, getting food and clean water and other things like that?



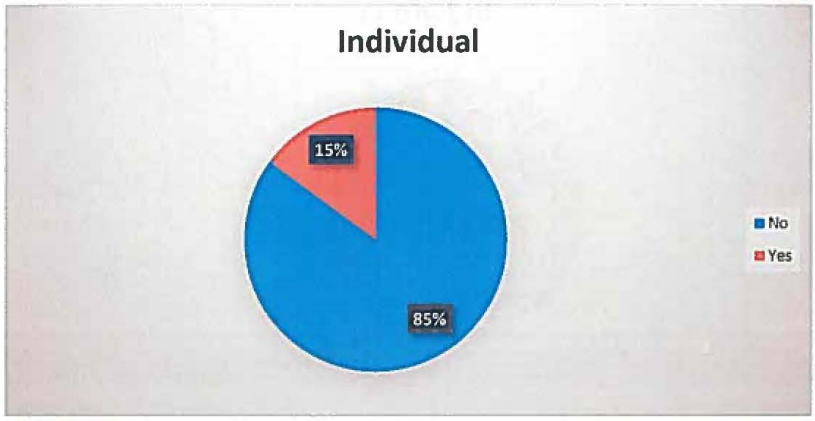


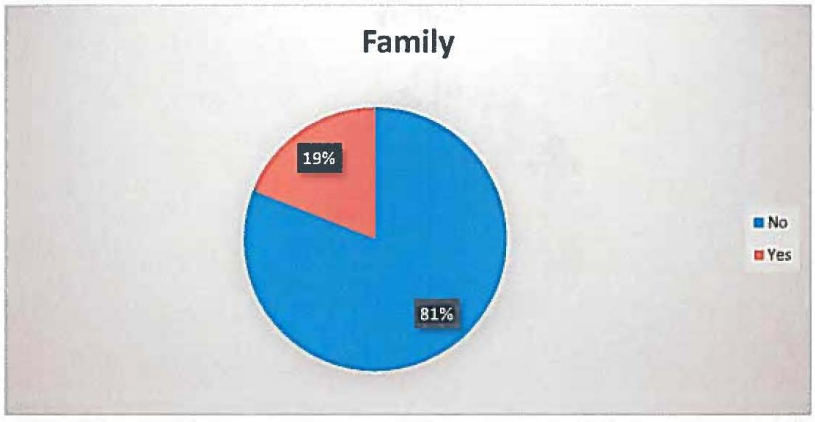


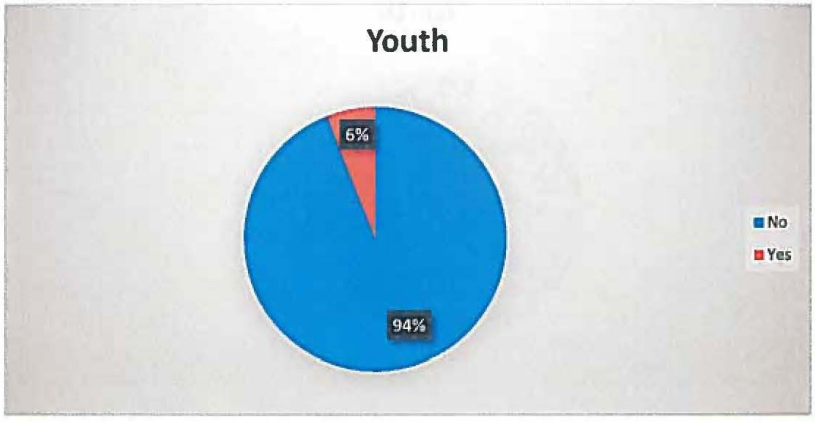
Is your current homelessness in any way caused by a relationship that broke down, an unhealthy or abusive relationship, or because family or friends caused you to become homeless?



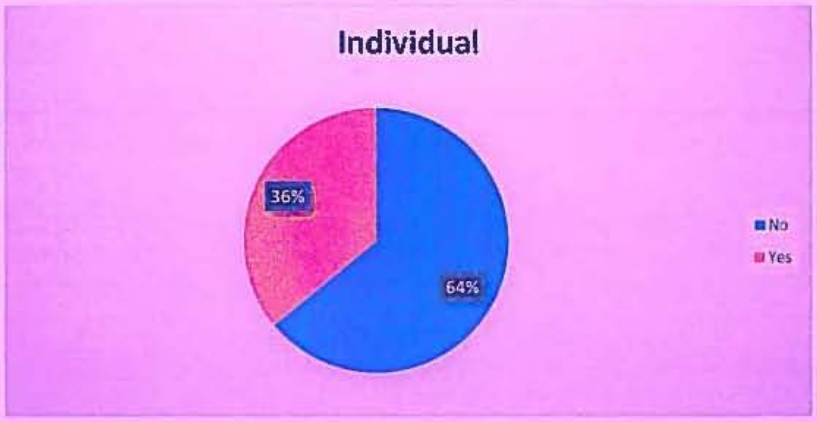
Have you ever had to leave an apartment, shelter program, or other place you were staying beacause of your physical health?

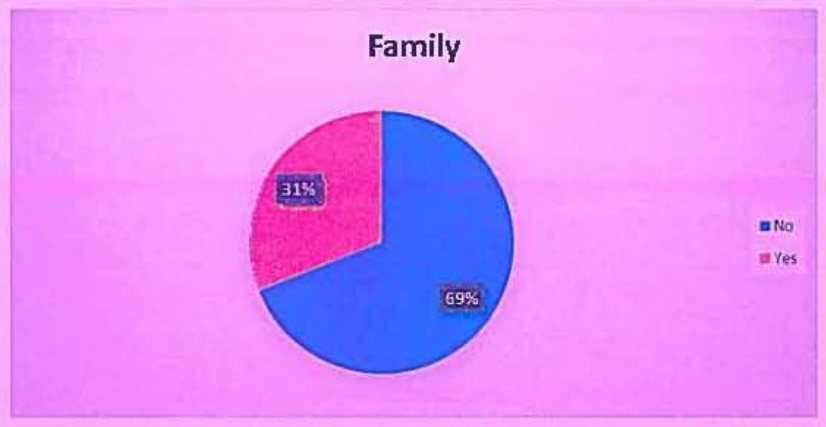


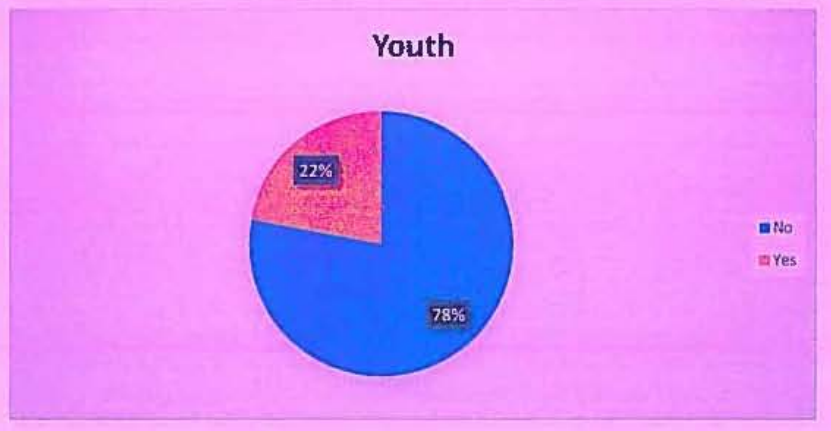




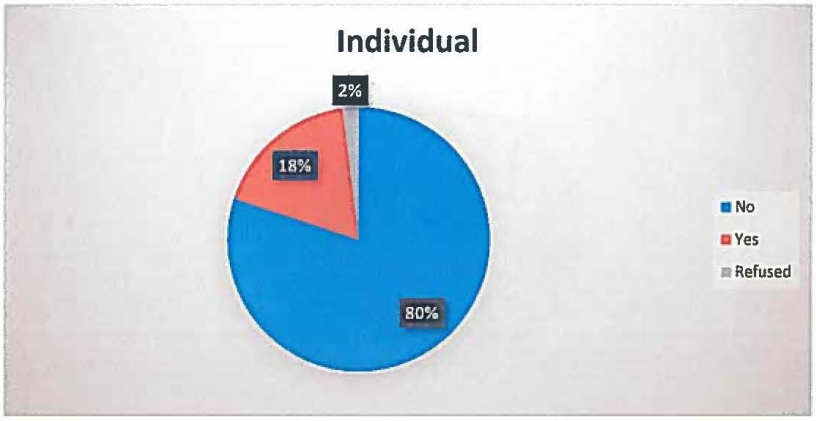
Do you have chronic health issues with your liver, kidneys, stomach, lungs, or heart?

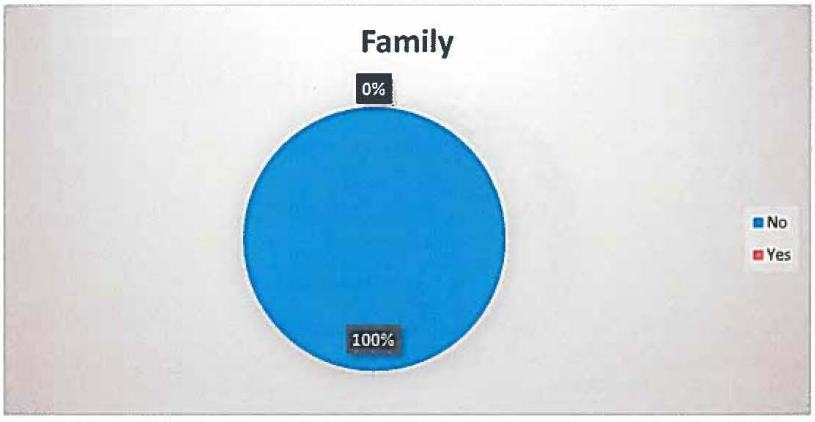


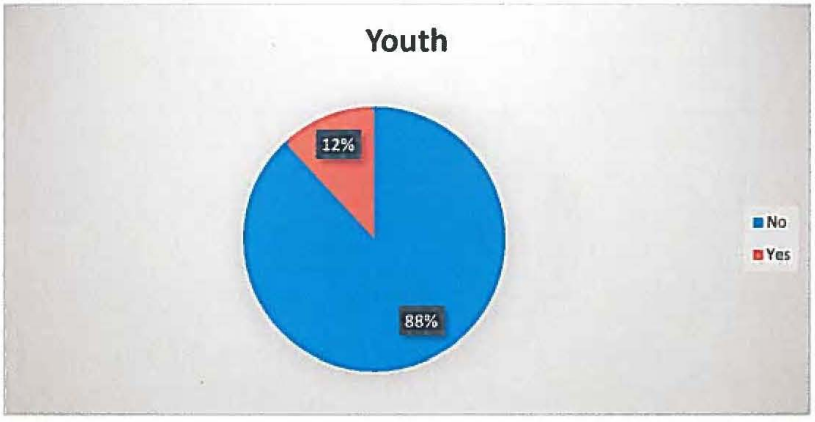




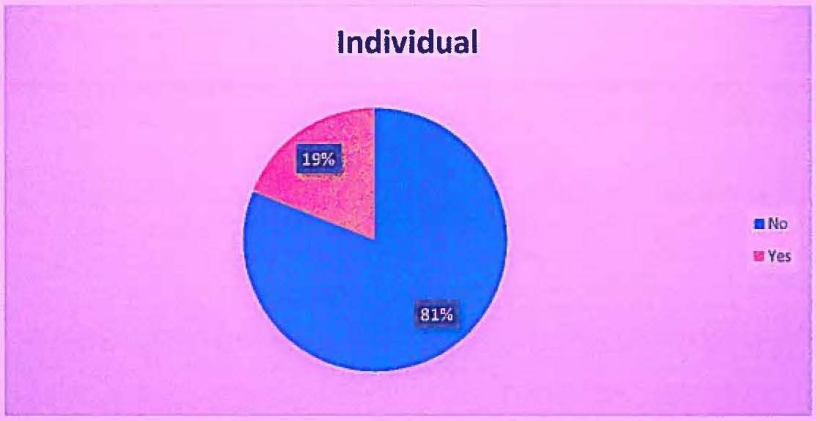
If there were space available in a program that specifically assists people that live with HIV or AIDS, would that be of interest to you?

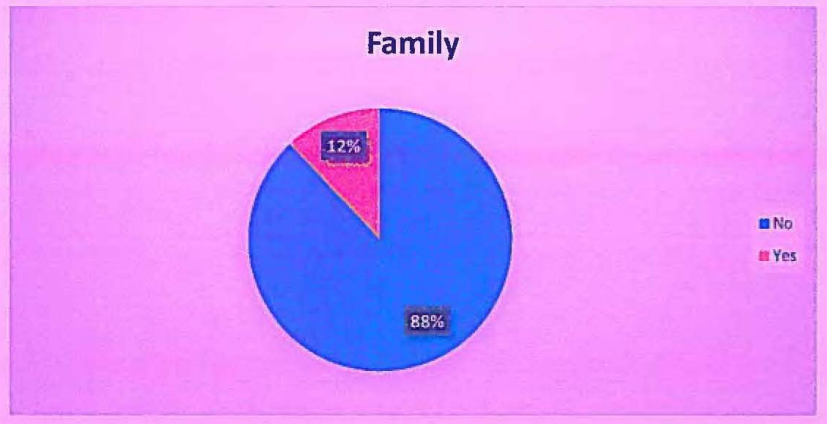


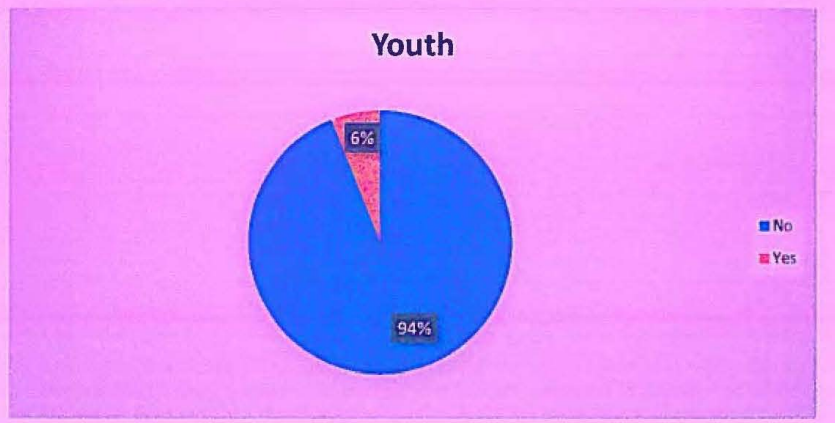




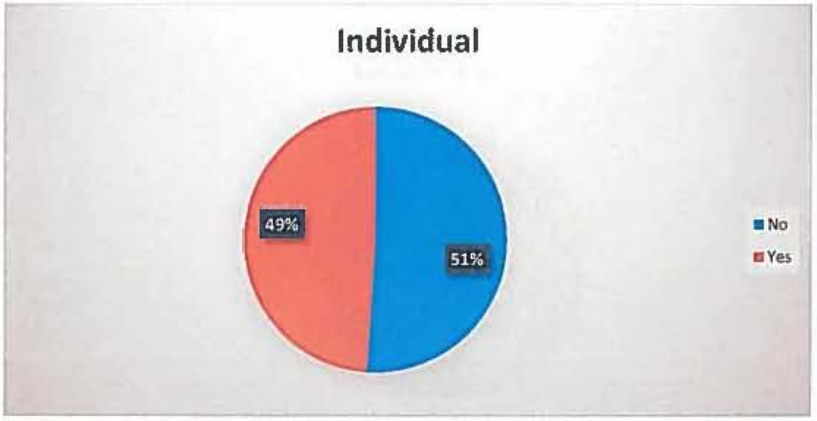
Do you have any physical disabilities that would limit the type of housing you could access, or would make it hard to live independently because you'd need help?

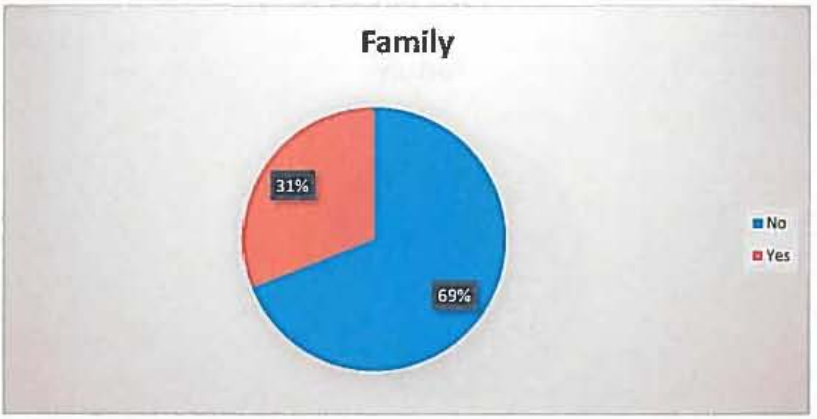


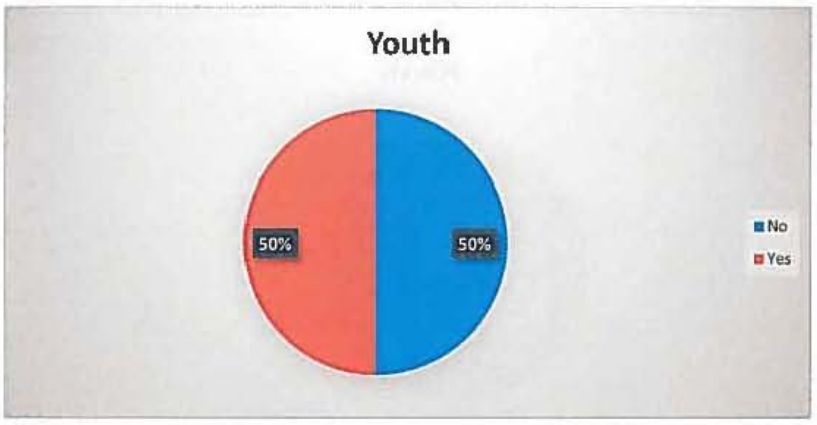




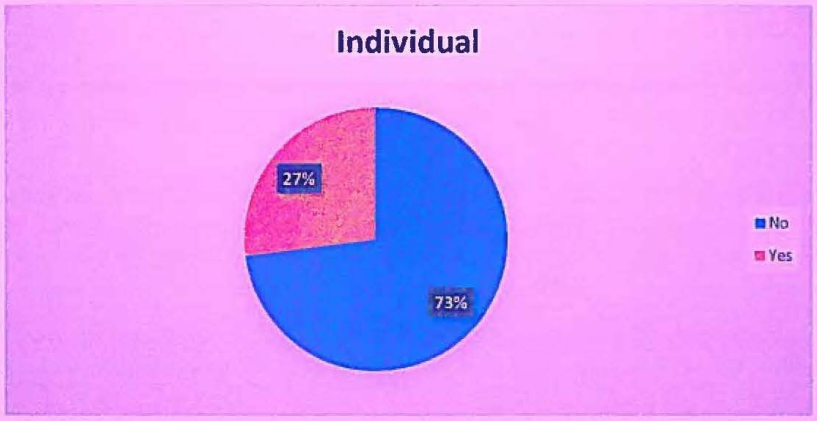
When you are sick or not feeling well, do you avoid getting help?

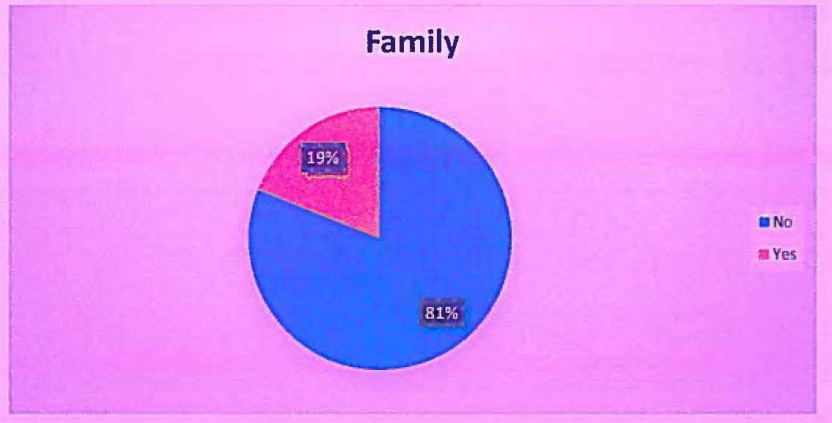


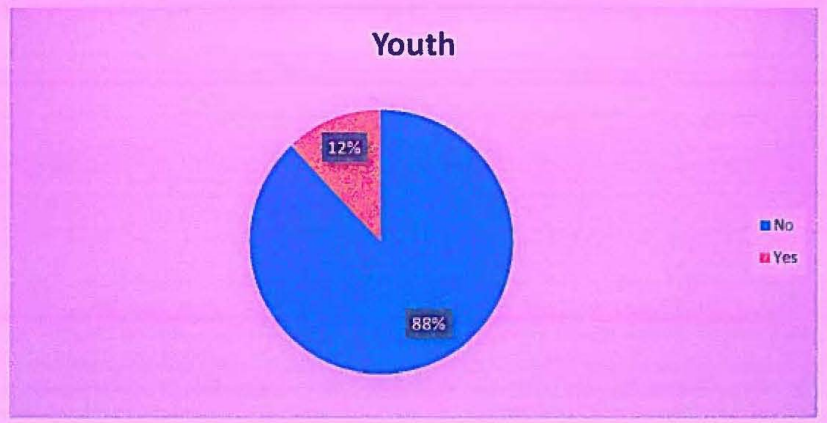




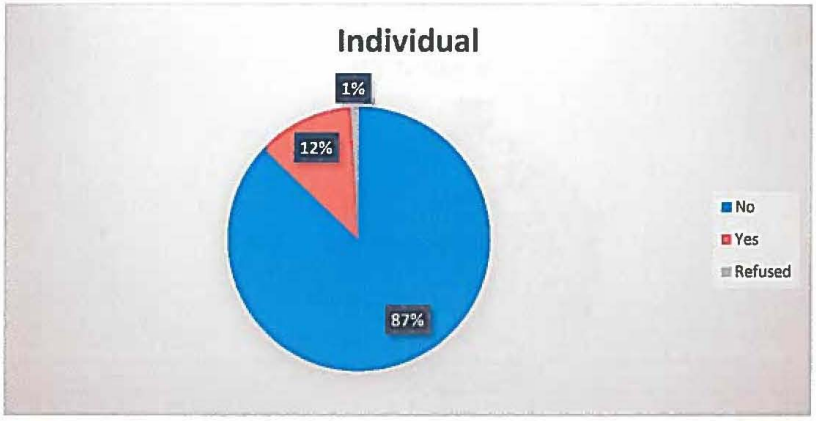
Has your drinking or drug use led you to being kicked out of an apartment or program where you were staying in the past?

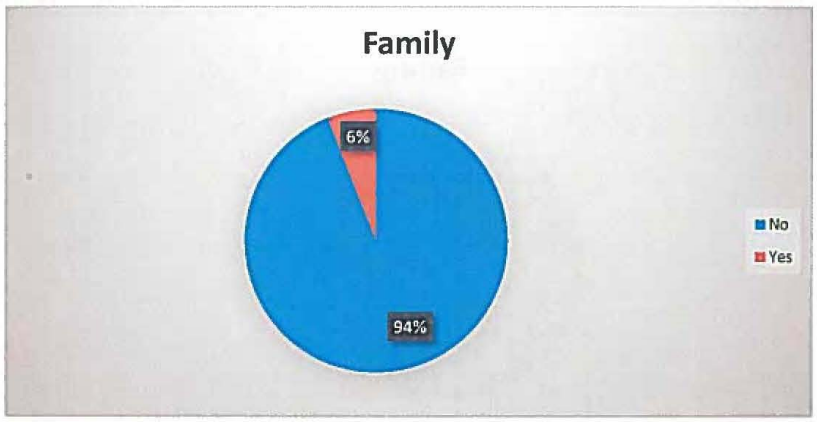


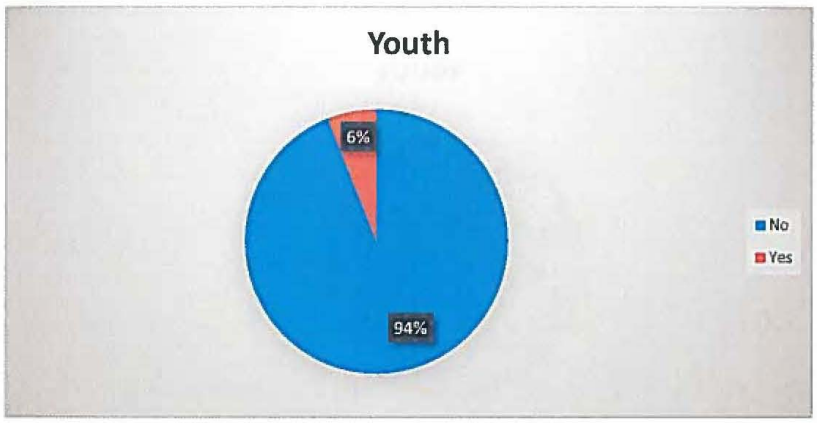




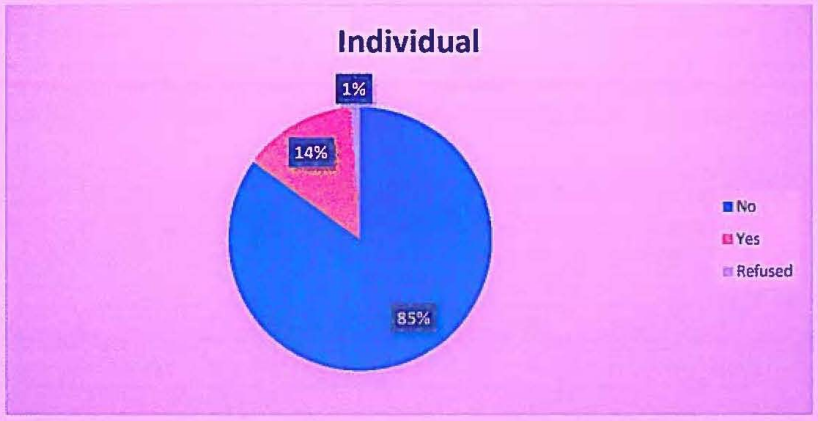
Will drinking or drug use make it difficult for you to saty housed or afford your housing?

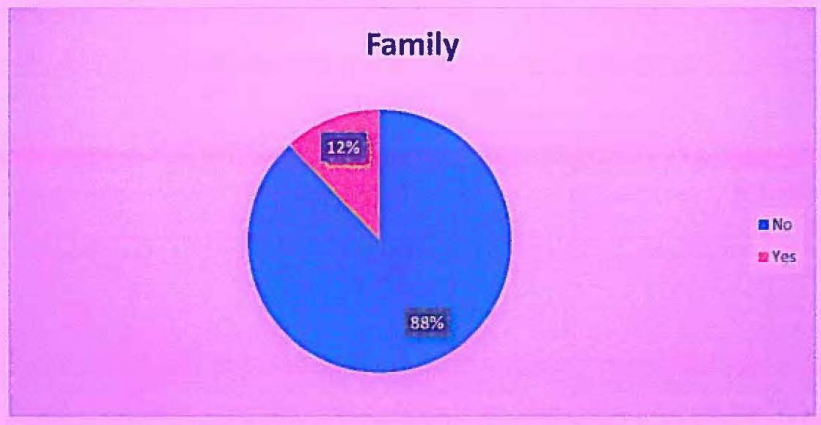


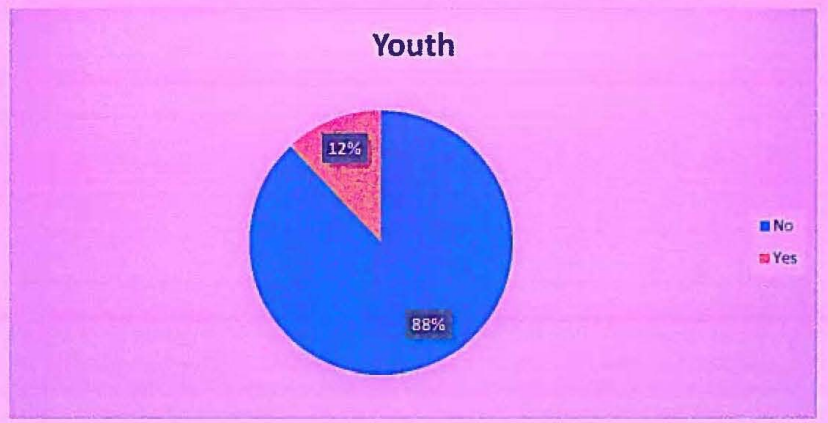




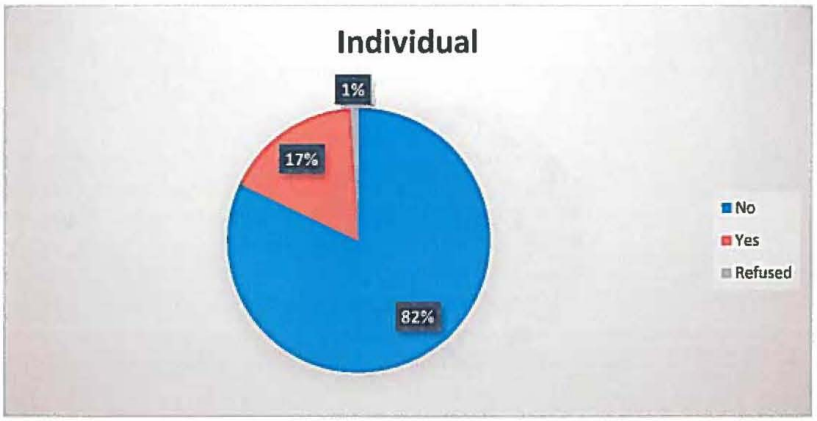
Have you ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying because of a mental health issue or concern?

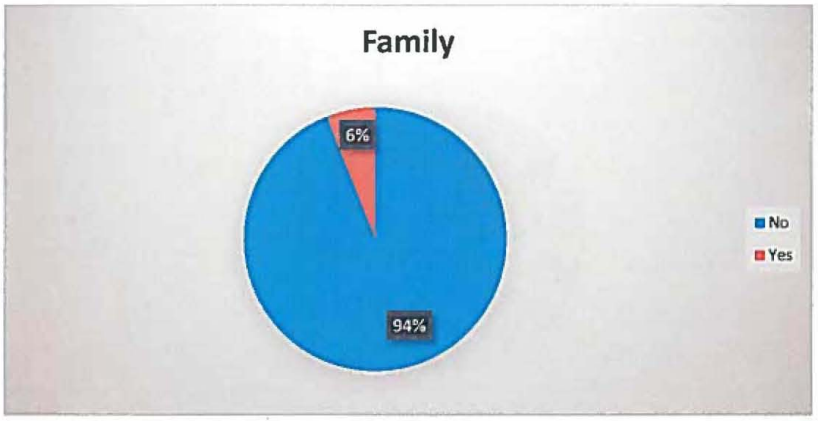


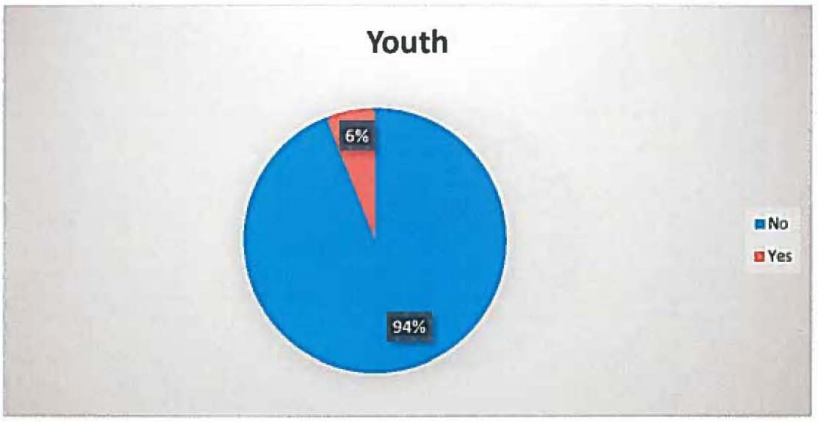




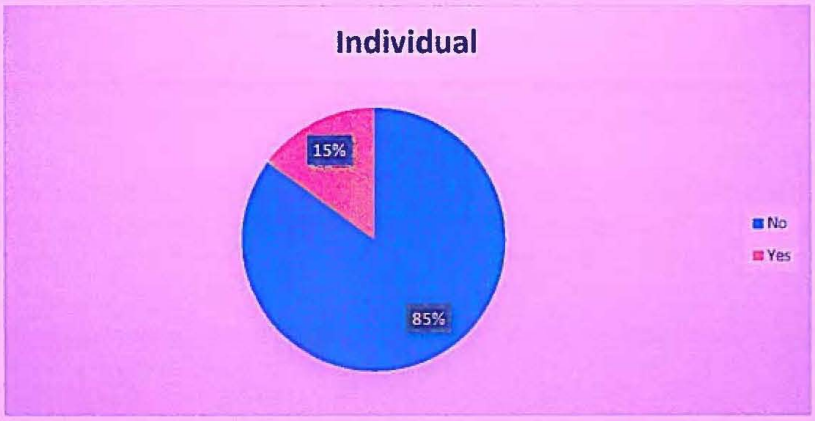
Have you ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying because of a past head injury?

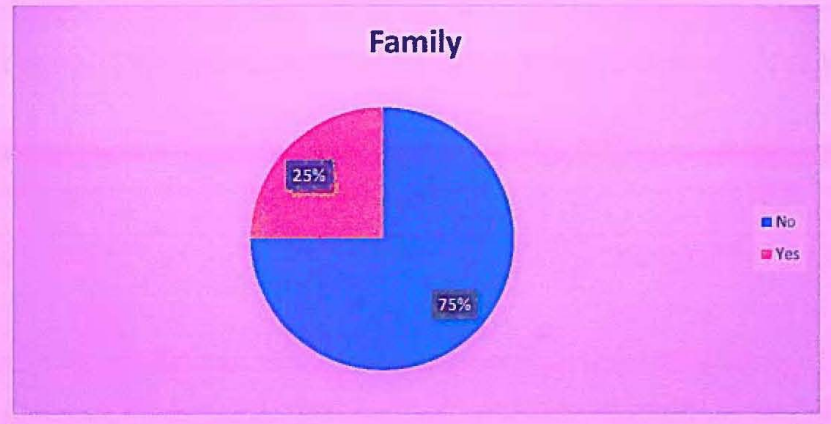


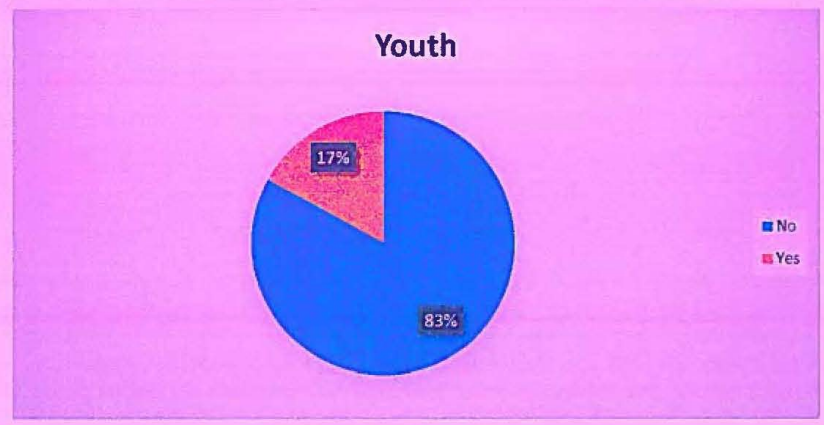




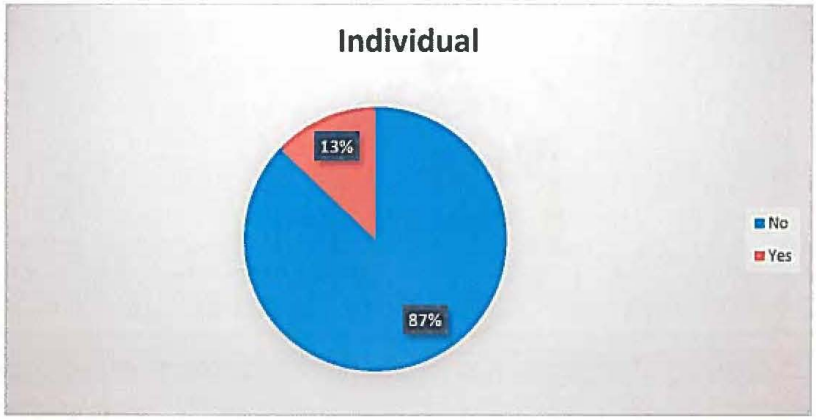
Have you ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying because of a learning disability, developmental disability, or other imapairment?

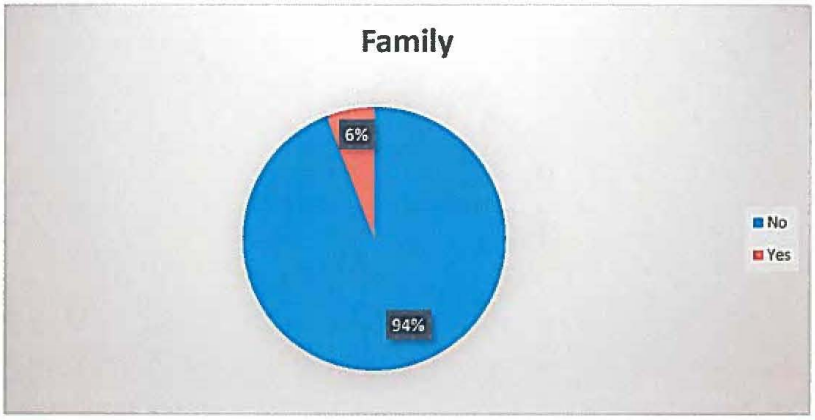


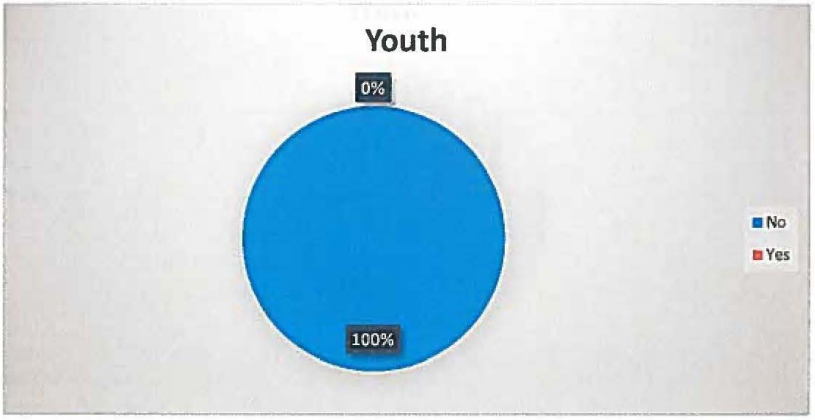




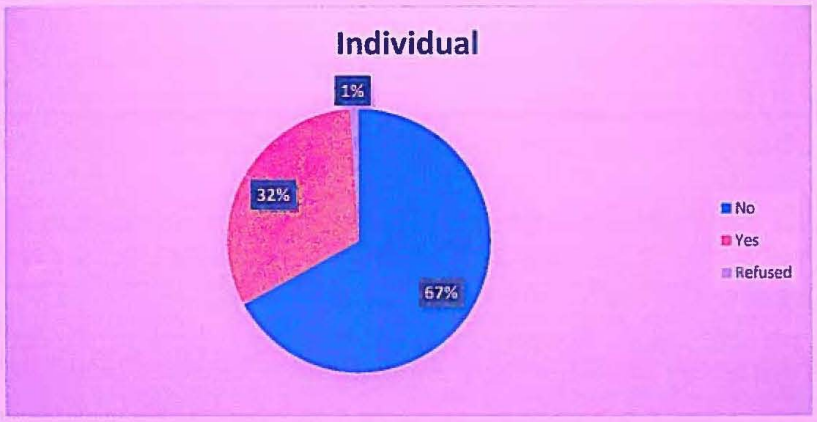
Do you have any mental health or brain issues that would make it hard for you to live independently because you'd need help?

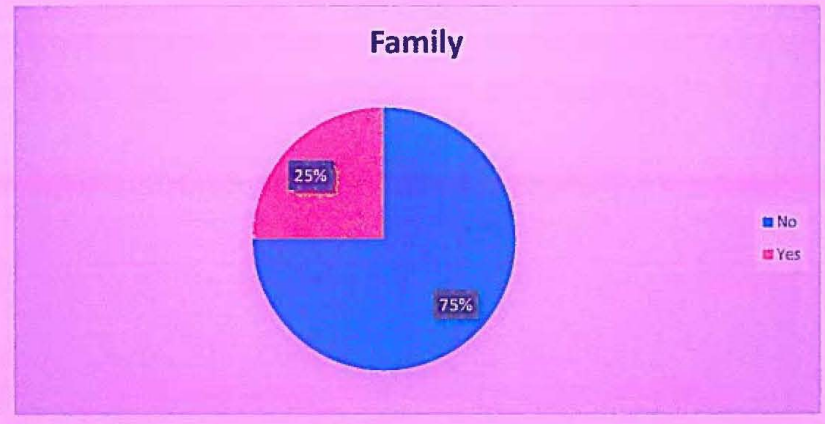


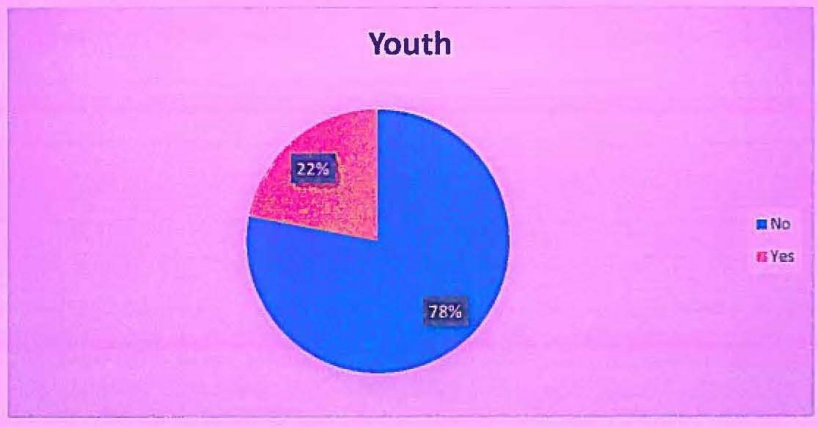




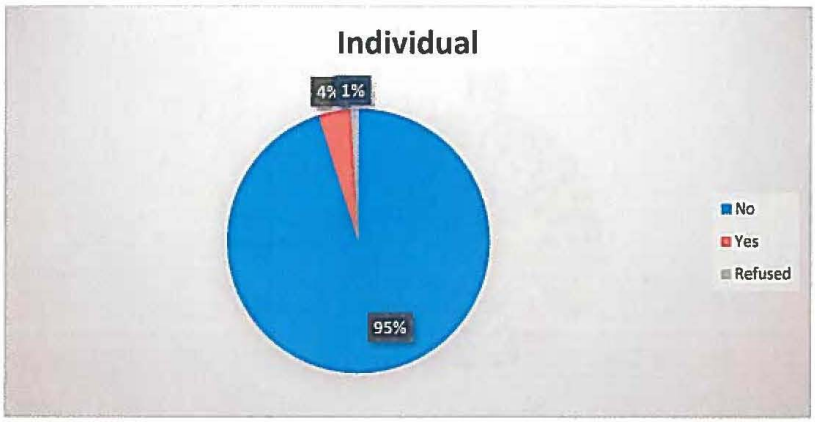
Are there any medications that a doctor said you should be taking that, for whatever reason, you are not taking?

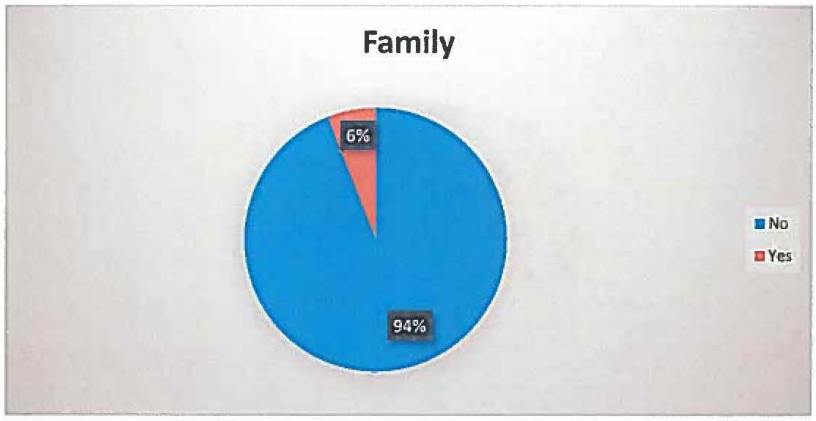


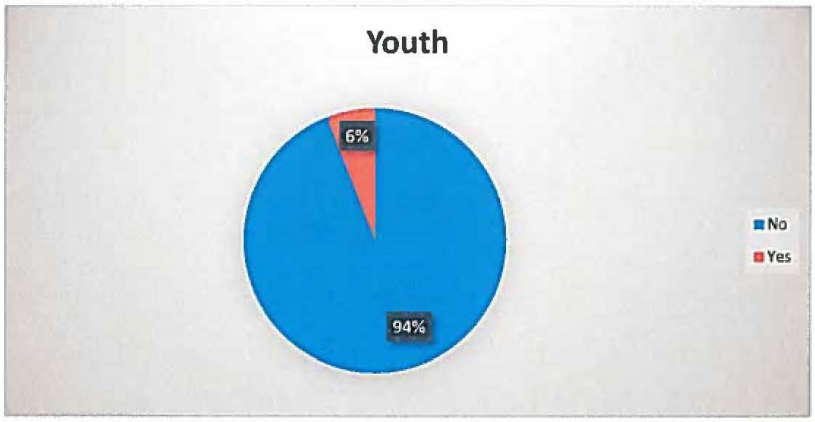




Are there any medications like painkillers that you don't take the way the doctor prescribed or where you sell the medications?



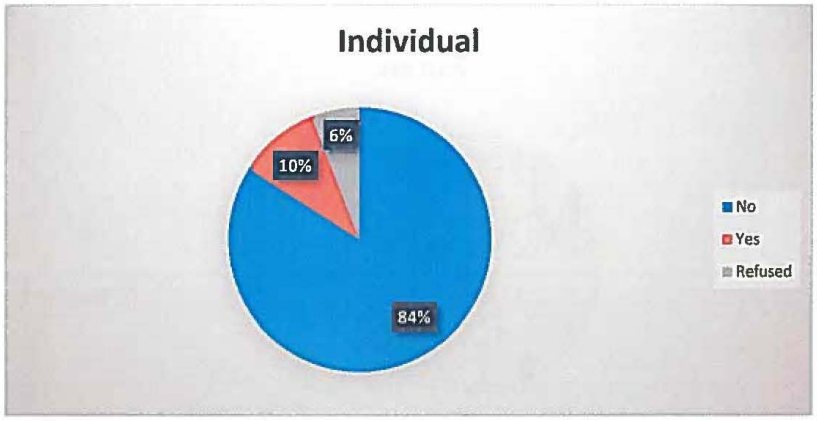




Has your current period of homelessness been caused by an experience of emotional, physical, psychological, sexual, or other type of abuse, or by any other trauma you have experienced?

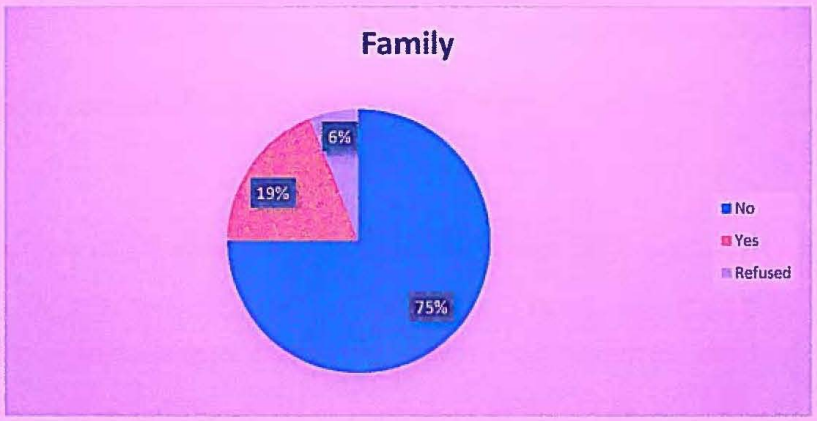
Individual Specific Questions

Are you currently pregnant? (Out of 49 women surveyed)

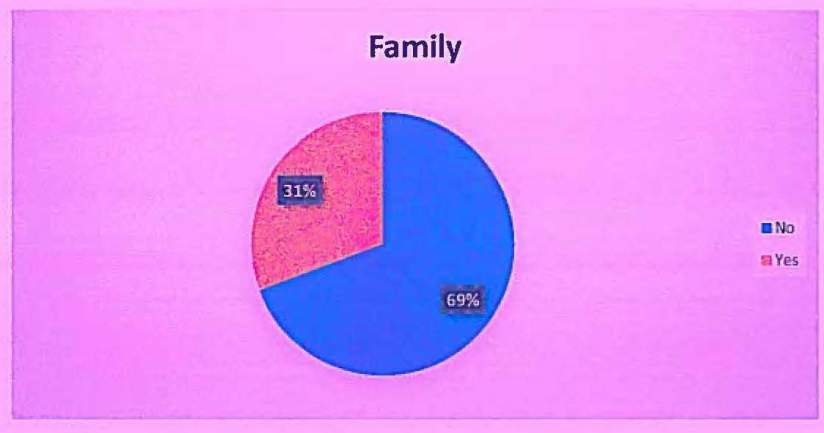


Family Specific Questions

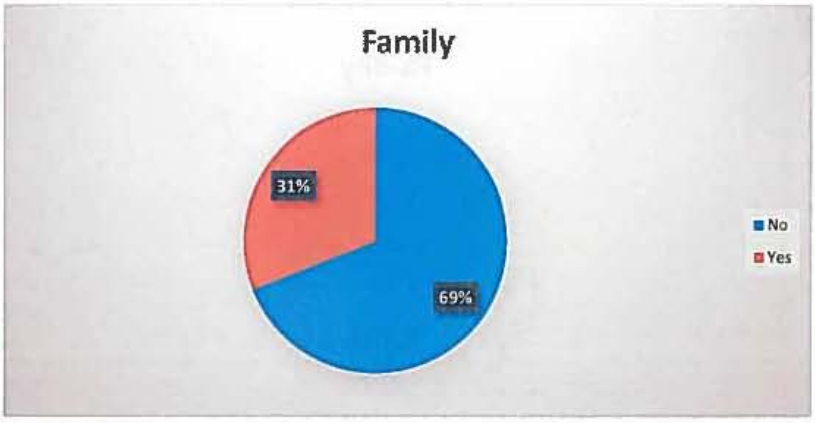
Does any single member of your household have a medical condition, mental health concerns, and experience problematic substance abuse?



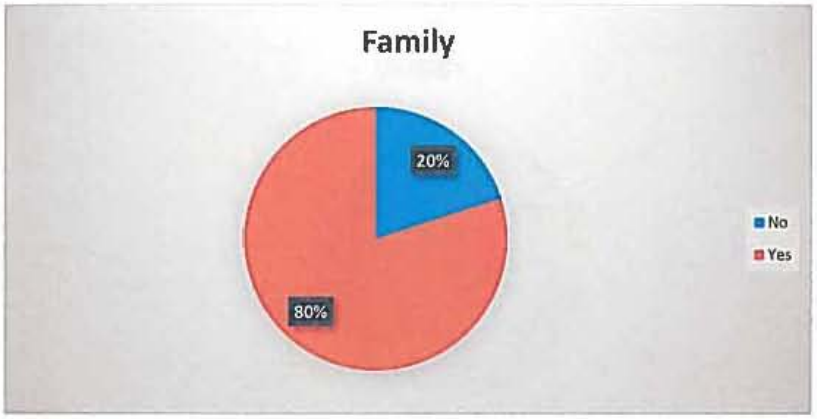
Do you have any legal issues that are being resolved in court or need to be resolved in court that would impact your housing or who may live within your housing?



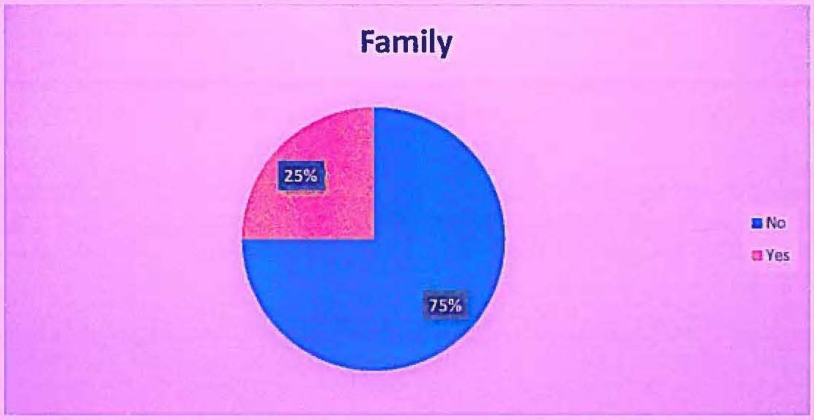
In the last 180 days have any children lived with family or friends because of your homelessness or housing situation?



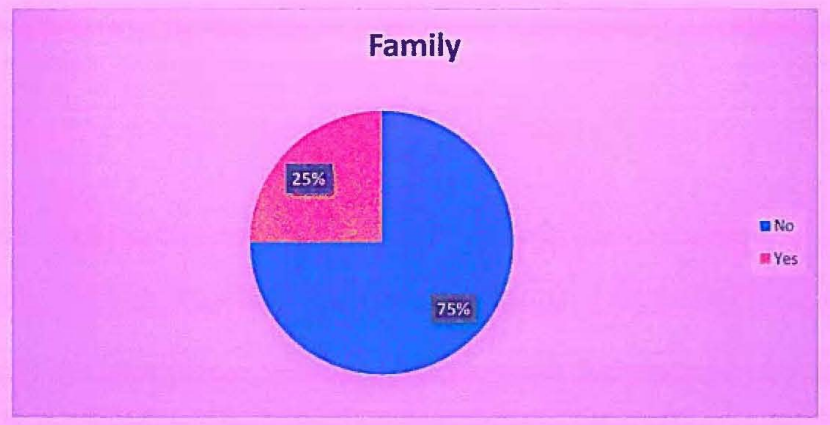
Do your children attend school more often than not each week? (Out of 10 families with school age children)



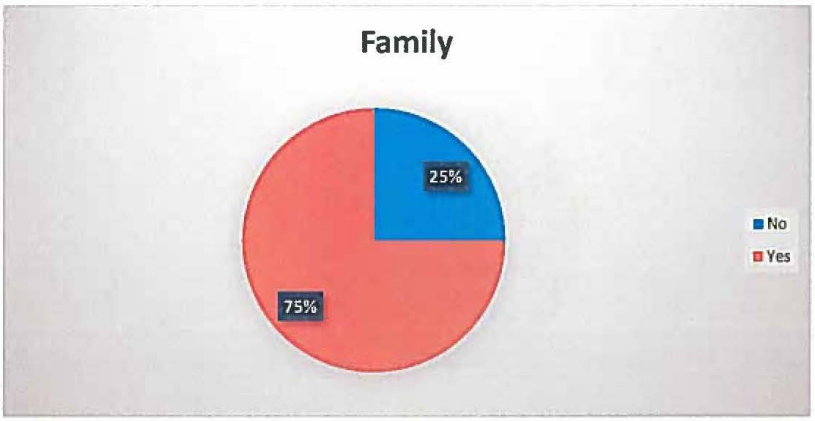
Have the membersof your familt changed in the last 180 days due to things like divorce, your kids coming back to live with you, someone leaving for military service or incarceration, a relative moving in, or anything like that?



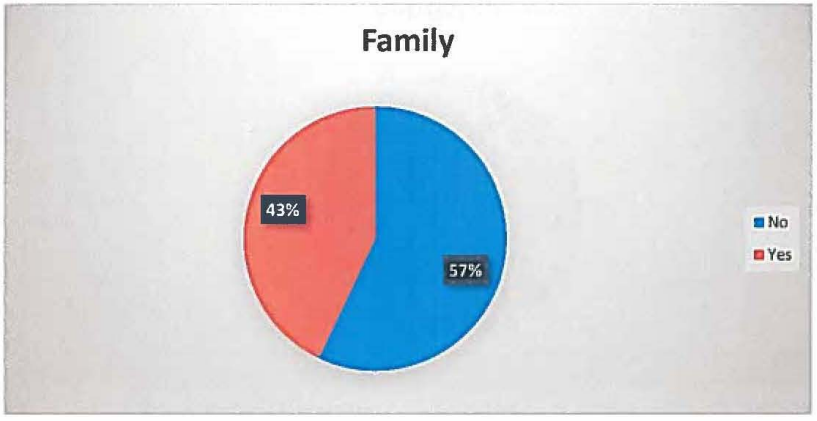
Do you anticipate any other adults or children coming to live with you within the first 180 days of being housed?



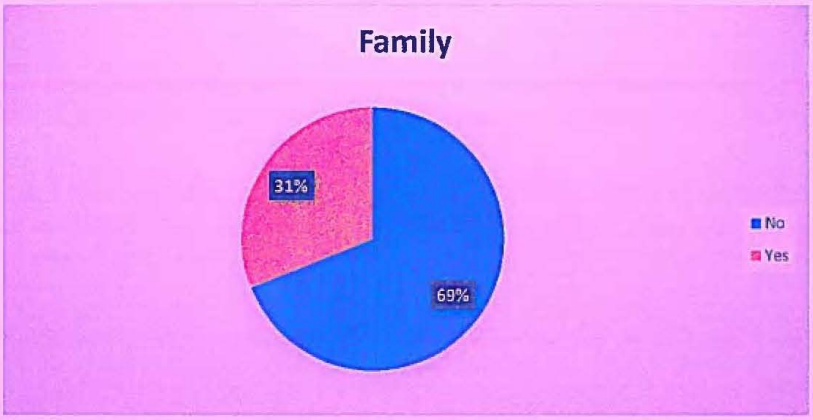
Do you have two or more planned activities each week as a family such as outings to the park, going to the library, visiting other family, watching a movie, or anything like that?



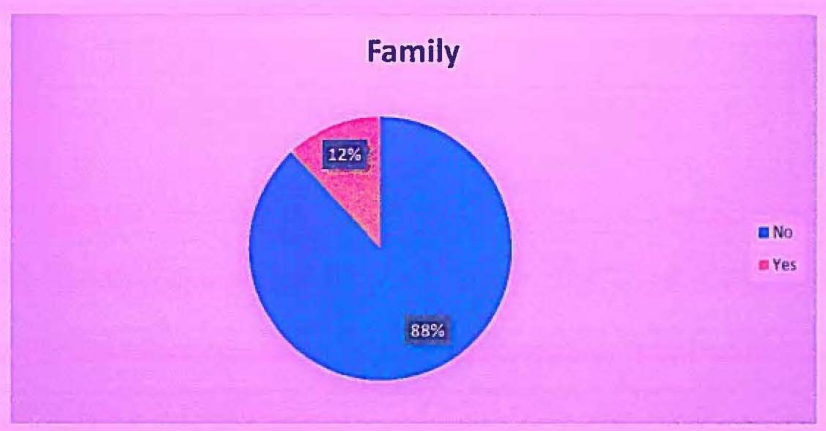
Do your older kids spend 2 or more hours on a typical day helping their younger siblings with things like getting ready for school, helping with homework, making them dinner, bathing them or anything like that? (Out of 7 families with children 12 or younger AND children 13 or older)



After school, or on weekends or days when there isn't school, is the total time children spend each day where there is no interaction with you or another adult three or more hours per day for children 13 or older?



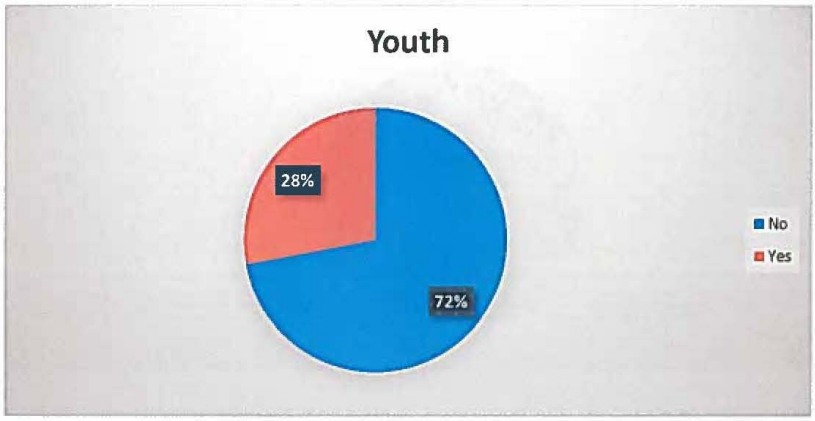
After school, or on weekends or days when there isn't school, is the total time children spend each day where there is no interaction with you or another adult two or more hours per day for children 12 or younger?



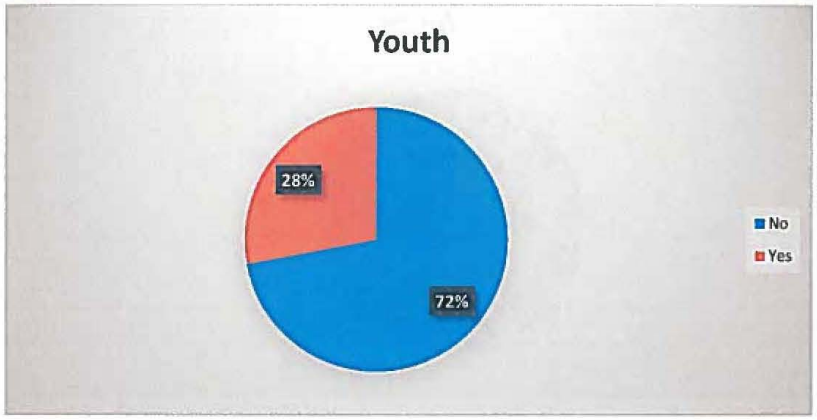
- **67% have children under the age of 18 currently living with them**
- **28% will have children under 18 coming to live with them once they find housing**
- **6% have had children removed by Child Protective Services in the last 180 days**
- **12% have had a child experience abuse or trauma in the last 180 days**
- **25% (out of 12 that responded) are currently pregnant**

Youth Specific Questions

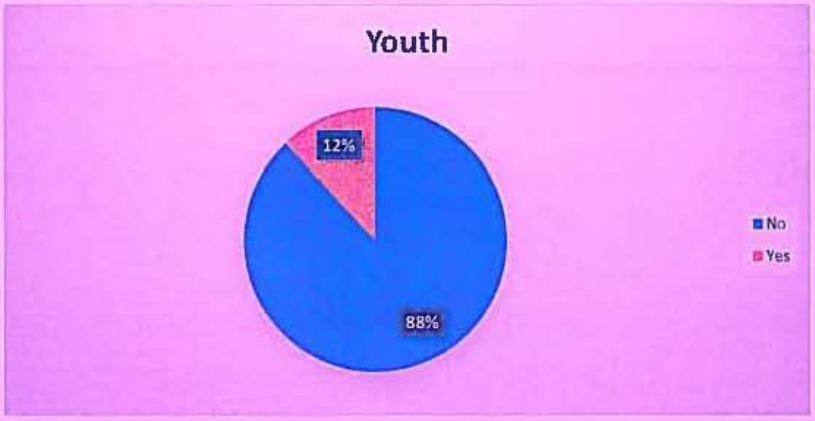
Were you ever incarcerated when you were younger than 18?



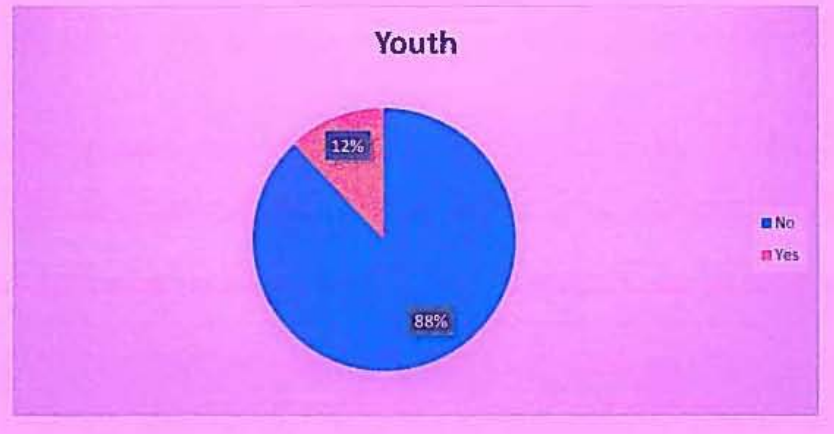
Are you currently pregnant, have you ever been pregnant, or have you ever gotten someone pregnant?



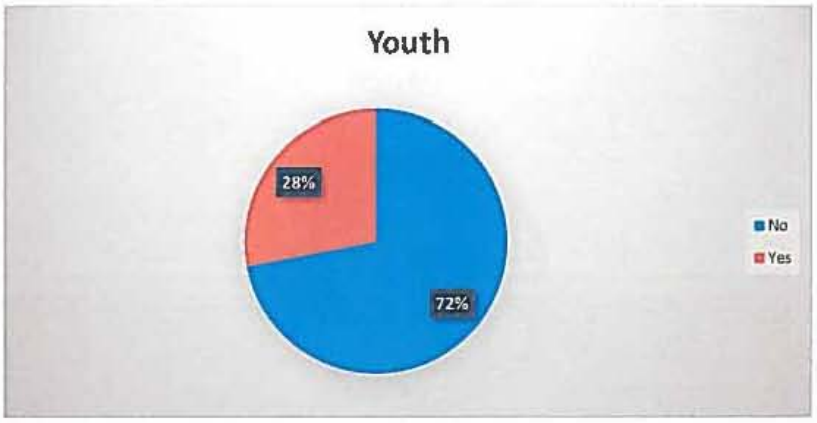
Is your current lack of stable housing because you ran away from your family home, a group home or foster home?



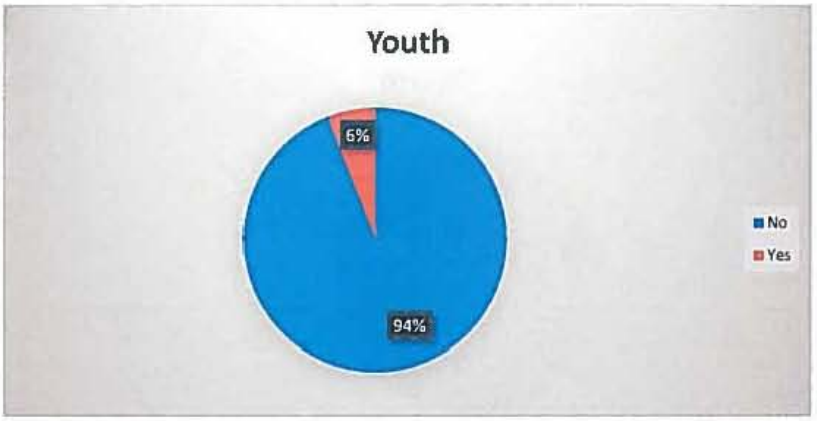
Is your current lack of stable housing because of a difference in religious or cultural beliefs from your parents, guardians or caregivers?



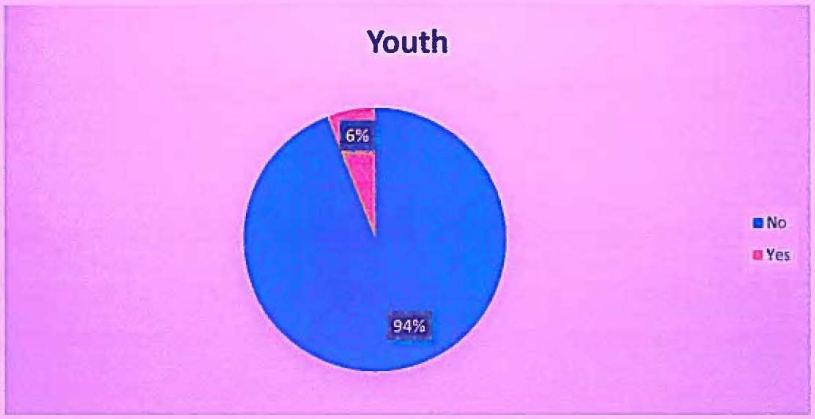
Is your current lack of stable housing because your family of friends caused you to become homeless?



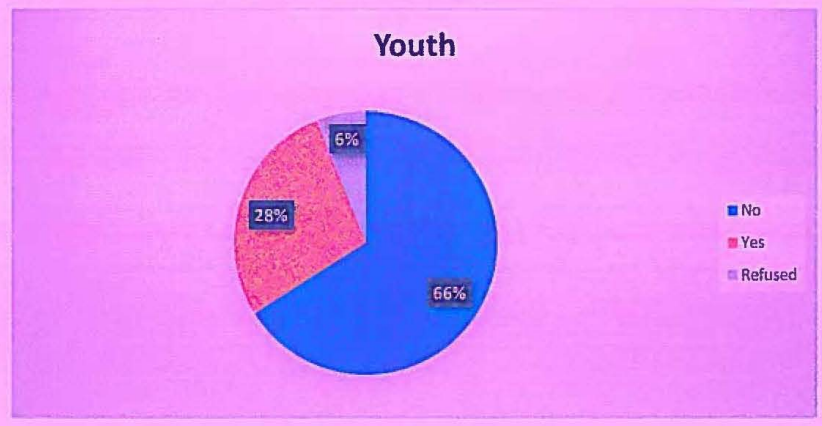
Is your current lack of stable housing because of conflicts around gender identity or sexual orientation?



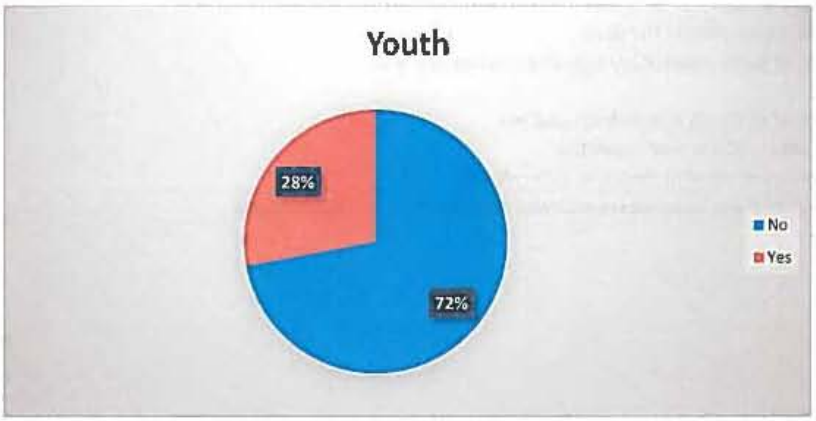
Is your current lack of stable housing because of violence at home between family members?



Is your current lack of stable housing because of an unhealthy or abusive relationship, either at home or elsewhere?



If you've ever used marijuana, did you ever try it at age 12 or younger?



Military Information

Have you served in the military?

- **17% of all Individual respondents said yes**
- **Of those, 19% served in combat**
- **35% are enrolled in the GJVA**
- **91% of those enrolled are receiving services at the VA**

- **25% of all Family respondents said yes**
- **Of those, 25% served in combat**
- **25% are enrolled in the GJVA, 25% refused**
- **100% of those enrolled are receiving services at the VA, 25% refused**

CITY OF Grand Junction COLORADO

Employee Retiree Health Plan
City Council Workshop-May 2nd, 2016

Executive Summary

The employee funded Retiree Health Plan ("Plan") has been a benefit to City of Grand Junction employees and the organization for 18 years. Because many of the jobs in the organization are physically as well as mentally demanding, City employees frequently need to retire earlier than the Medicare eligibility age of 65. The benefit to employees is affordable health care coverage to bridge the age gap between retirement (or disability) and Medicare. The benefit to the organization is an improved ability to manage aging workforce issues. Workers comp exposure, risk of disability and the personal and organizational costs related to injury claims can all be associated with managing an older workforce. These risks and costs can be reduced by employees being able to retire instead of remaining on the job only to retain health insurance coverage. The Plan is underwritten so that the number of participants would be a small portion of the active employees with health insurance. Since inception there have been over 1,300 employee participants contributing an average of 7 years into the Plan. Of those, 10% have reached eligibility and retired on the Plan. Public Works and Public Safety employees have comprised the strong majority of these. Currently there are 69 retirees on the Plan.

The Plan is funded by active employee contributions, retirees' portion of premiums, retiree buy-ins, and interest earned on the fund balance. The premiums to Rocky Mountain Health Plans ("RMHP") are then paid out of these resources. In 2011 and 2012 the Plan was successful in receiving Early Retirement Reinsurance Program (ERRP) funding. The terms of the funding required that other Plan design components were not changed while receiving funding. Also during the recession, in order to minimize the impact of wage reductions on active employees (3% wage reduction in 2010 and 2011), the contributions were not increased. At the same time the City reduced its workforce by 12% thereby cutting the number of active employees contributing to the Plan. Because of recessionary pressures on active employee contributions, the cost of insurance increasing, and investment returns being limited, the total outflow of the Plan has exceeded the inflow since 2012.

To re-establish the financial solvency of the Plan will require the formation of a Trust, infusion of a portion of refunds received from our health insurance carrier as a result of employees' responsible and positive utilization of the health benefit, and some Plan design changes. Establishing a formal Trust provides a long term investment strategy for the Plan with higher rates of return than are available through more restrictive City investments. The Trust will be managed by the Board of Trustees (the "Board") who will have fiduciary responsibility over the Plan including communication to and representation of plan participants, and administration of the Plan including design changes to ensure ongoing solvency. The Board will be comprised of seven members and the composition will be consistent with the existing employee boards (Fire, Police, and General Employee) for our ICMA retirement plans. Three employee representatives from the existing boards, one retiree, and the City Manager, Finance Director, and Human Resources Director will be on the board.

The proposed financial model for the Plan contains several assumptions and because this is a long term projection, the assumptions are averaged in order to smooth out the variability in the rates. The model will be used by the Board moving forward to adjust assumptions based on current and new projected economic conditions in order to make plan changes as required each year that ensure the affordability

and sustainability of the Plan. The necessary financial strategy is based on the following assumptions; employee growth rate of .5% (based on 5 year past average growth); some increase in active employee contributions; increase in retiree's portion of premium to 22% (consistent with premium cost share of active employees health insurance); medical inflation of 5% per year; fund rate of return of 4.5% per year; and participation rates based on historical experience by age band and number of eligible years on the Plan. The projected net benefits and cash flows (two options provided) based on these assumptions stabilize the plan by providing positive cash flow and adding to the fund balance each year. The two assumptions in the Plan which make the most impact on financial solvency are the contributions of active employees and the sharing of the refunds which are a direct result of good claims experience due to employees' management of their own health.

In conclusion, in order to continue this long term benefit to the City employees and the organization as a whole, and to ensure the financial viability of the Plan in the future, we need to move forward with implementing the steps discussed above. The following analysis provides detail documentation of the concepts reviewed in this executive summary and two options have been provided for consideration.

Employee Retiree Health Plan

***Historical* Net Benefits and Cash Flows:**

The City Retiree Health Plan ("Plan") was initiated in 1998. Under the current Plan, retiring employees are eligible to enroll at age fifty or older if they have at least fifteen years of service with the City or upon disability at any age with at least five years of service with the City. Currently, the Employee Retiree Health Fund pays 90% of the premium for retirees until the age of sixty-five or becoming Medicare eligible, whichever comes first. Retirees are responsible for 10% of the premiums associated with their coverage and 100% of the premiums associated with spouse and other dependent coverage.

The Plan has been partially funded through regular deductions from the payroll of those active employees participating in the Plan. In 2016, payroll deductions were increased by 5% to $17.60 per pay period, $457.60 per year. The deductions have been deposited into the Employee Retiree Health Fund which is maintained by the City for the payment of explicitly subsidized retiree health care benefits. Additionally, the Employee Retiree Health Fund has been financed by one-time, buy-in payments made by employees at the time the employee enrolls in the Plan. The buy-in payment amount has been defined by the City and is based upon the date and age at retirement. In addition, the fund also received Early Retirement Reinsurance Program (ERRP) funding in 2011 (see column E). The receipt of this funding limited plan changes until the funding was fully spent at the end of 2013. A summary of the Plan's historical net benefits and cash flows are provided below. The balance of the Fund as of January 1, 2016 is $1,021,201.

Year	Retiree Premiums Paid to RMHP (A)	Premiums Paid By Retiree (B)	Buy-In Payments (C)	Net Benefit Provided (A) + (B) + (C)
2006	$182,697	($77,628)	($18,112)	$86,957
2007	250,531	(95,484)	(6,456)	148,591
2008	357,859	(107,832)	(6,883)	143,144
2009	323,348	(103,946)	(23,750)	195,652
2010	443,969	(121,957)	(102,372)	219,640
2011	452,075	(144,033)	(33,155)	274,887
2012	482,664	(163,234)	(12,305)	307,125
2013	467,118	(147,717)	(19,464)	299,937
2014	469,642	(128,676)	(31,009)	309,957
2015	463,559	(101,222)	(29,541)	332,796

Year	Fund Balance as of January 1 (A)	Active Employee Contributions (B)	Net Benefit Payments (C)	Interest Earned (D)	Other (E)	Net Cash Flow (B)+(C)+(D)+(E)
2006	$799,605	$162,194	($86,957)	$33,891	$0	$109,128
2007	908,733	205,705	(148,591)	40,685	(640)	97,159
2008	1,005,892	271,074	(243,144)	39,698	0	67,628
2009	1,073,520	248,375	(195,652)	24,135	(518)	76,340
2010	1,149,860	242,126	(219,640)	14,677	32	37,195
2011	1,187,055	228,944	(274,887)	6,560	126,865	87,482
2012	1,274,537	232,597	(307,125)	6,139	7,882	(60,507)
2013	1,214,030	230,675	(299,937)	5,494	38	(63,730)
2014	1,150,300	244,357	(309,957)	5,091	36	(60,473)
2015	1,089,827	264,109	(332,796)	5,257	(5,196)	(68,626)

Employee Retiree Health Plan

Assumptions and Methodology for Projected:

Employee Growth Rate

Year	Full Time Employees	Growth Rate
2011	628	
2012	629	0.16%
2013	647	2.9%
2014	642	(0.77%)
2015	641	(0.15%)

The 5-year average growth rate used for the purposes of future cash flow projections is .5%.

Active Employee Contributions

Active employee contributions of $17.60 per pay period are anticipated to increase, per annum, at some level depending upon the option considered for the purposes of future cash flow projections.

Shared Funding Agreement

The City's medical and prescription drug plans are experience rated with a shared funding agreement with our health care provider. If health care utilization is above or below expected losses, the City or RMHP pays that difference to the other party. It is assumed that year-to-year gains and losses under the shared funding arrangement will sum to zero over an extended time period. A summary of the shared funding arrangement for the last ten years is provided below.

RMHP Shared Funding Agreement			
Year	Total Premiums	Total Claims	Refund/(Payment)
2006	4,218,860	4,208,134	10,726
2007	5,167,711	4,954,635	213,076
2008	6,027,891	5,889,612	138,279
2009	6,664,622	5,873,946	790,676
2010	6,658,340	7,198,893	(540,553)
2011	6,805,036	6,231,862	573,174
2012	7,368,359	7,391,619	(23,260)
2013	8,010,880	6,684,032	1,326,848
2014	8,840,463	8,132,344	708,119
2015 Estimate	9,059,722	8,600,138	459,584
		Total Refund	3,656,669

The City has devoted a great deal of time and effort in educating our employees to be responsible health care consumers. While some costs simply cannot be avoided, it is our belief that the positive experience the City has had under our shared funding arrangement is a direct result of an array of health insurance products to fit the varied needs of our workforce and of our employees being informed consumers. It is recommended to transfer a portion of these refunds based on the share of employee contributions rates to the Employee Retiree Health Trust in order to re-establish financial solvency for the plan. These contributions have been included for the purpose of future cash flow projections.

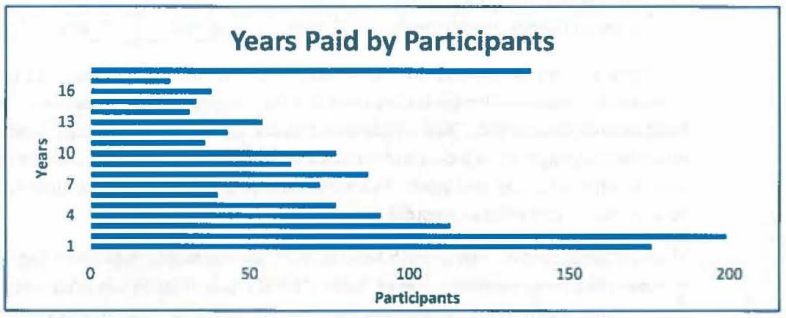
Employee Retiree Health Plan

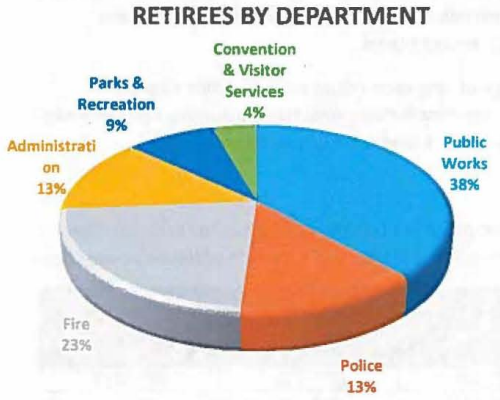
Retiree Premium Rates:

As of January 1, 2016, the City offers two medical and prescription drug plans for active employees and two medical and prescription drug plans for retirees. Retirees are to be billed the same composite premium as active employees in the most expensive plan if enrolled in the RMHP Good Health Classic 3000 Plan and the same composite premium as active employees if enrolled in the RMHP Good Health HMO HSA 3250B Plan. It is assumed the City will maintain this strategy regardless of the retiree medical and prescription drug plan designs used to provide health care benefits. Revised Retiree premium contribution rates have been used for the purposes of future cash flow projections.

Anticipated Plan Participation

Since the plan was initiated in 1998, there have been over 1,300 active employee participants contributing into the Employee Retiree Health Fund. Participants contributed for an average of 7 years.

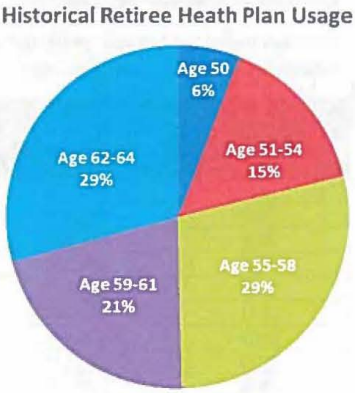




Based on historical participation rates by age band, the probability of future use has been projected. There is a 5% probability that eligible employees will be able to retire and use the Plan at age 50 compared to a 37% probability that they eligible employees will retire and use the Plan from age 59-64.

Of the 1,300 active employee participants, 201 employees reached eligibility, and 137 of those individuals retired on the Plan from various departments as shown to the left.

A summary of historical retirements by age bands is demonstrated in the chart below.



Medical Inflation

Actual medical cost inflation for the period 2009 - 2014, after receipt of RMHP rebates, estimates 5% per year. Therefore, medical inflation rate of 5% per annum is applied to both active employee and retiree premiums. If and when, inflation exceeds projections additional plan design and/or contribution changes will be made.

Fund Rate of Return

ICMA Balanced Asset Allocation for QTR Ended 12/31/15				
Fund Name	1 Year	3 Year	5 Year	10 Year
VT Vantagepoint MP Cons Growth	(1.75%)	4.02%	4.38%	4.27%
VT Vantagepoint MP Trad Growth	(2.10%)	6.41%	5.90%	4.89%

The Vantagepoint MP Cons Growth Fund invests in a combination of other Vantagepoint Funds and one or more third party exchange-traded funds ("ETFs") to seek to obtain exposure to approximately 61% fixed income investments, 30% equity investments, and 9% multi-strategy investments. Multi-strategy investments generally include asset classes and strategies that seek to provide additional diversification from traditional stocks and bonds. Examples may include convertible securities, derivative-based strategies and real estate investment trusts (REITs), among others.

The Vantagepoint MP Trad Growth Fund invests in a combination of other Vantagepoint Funds and one or more third party exchange-traded funds ("ETFs") to seek to obtain exposure to approximately 34% fixed income investments, 54% equity investments, and 12% multi-strategy investments. Multi-strategy investments generally include asset classes and strategies that seek to provide additional diversification from traditional stocks and bonds. Examples may include convertible securities, derivative-based strategies and real estate investment trusts (REITs), among others.

To remain conservative, a 4.5% per annum (average of long term return on both funds above), compounded annually is used for the purposes of future cash flow projections, assuming that the retiree health funds available are placed into a trust allowing for a long-term investment strategy.

***Projected* Net Benefits and Cashflows:**

Provided below are ten year projections of the anticipated net benefit payments and Fund cash flows reflecting the participation, contribution, growth, medical inflation, and fund rate of return assumptions.

Year	Retiree Premiums Paid to RMHP (A)	Premiums Paid By Retiree (B)	Buy-In Payments (C)	Net Benefit Provided (A) + (B) + (C)
2016	$522,850	($132,876)	($30,361)	$359,613
2017	581,965	(163,816)	(15,706)	402,443
2018	663,860	(200,903)	(26,112)	436,845
2019	684,330	(220,743)	(14,323)	449,264
2020	674,651	(228,956)	(43,412)	402,283
2021	699,366	(246,698)	(38,328)	414,340
2022	736,438	(263,576)	(37,265)	435,597
2023	787,621	(286,342)	(37,404)	463,875
2024	820,043	(302,675)	(33,333)	484,035
2025	814,765	(305,901)	(35,333)	473,531

Employee Retiree Health Plan

Assumes infusion of employee share of 10 year refunds from health insurance carrier mid-year 2016 as well as continued share of future refunds and an annual increase in active employee contributions of 2.5% per year ($17.60 per pay period in 2016, by 2025 $21.98 per pay period). Employee Retiree Trust Fund Balance at the end of 2025 projected as $2,265,803.

Year	Fund Balance as of January 1 (A)	Active Employee Contributions (B)	Net Benefit Payments (C)	Interest Earned (D)	Employee Share Refunds (E)	Net Cash Flow (B)+(C)+(D)+(E)
2016	$1,021,201	$270,712	($359,613)	$21,685	$761,613	$694,397
2017	1,715,598	278,867	(402,443)	76,671	100,000	53,096
2018	1,768,693	287,268	(436,845)	78,476	100,000	28,899
2019	1,797,592	295,922	(449,264)	79,691	100,000	26,349
2020	1,823,942	304,836	(402,283)	82,135	100,000	84,688
2021	1,908,630	314,020	(414,340)	85,881	100,000	85,561
2022	1,994,191	323,479	(435,597)	89,466	100,000	77,348
2023	2,071,539	333,224	(463,875)	92,530	100,000	61,878
2024	2,133,417	343,263	(484,035)	95,086	100,000	54,315
2025	2,187,732	353,603	(473,531)	98,000	100,000	78,072

Assumes infusion of employee share of 10 year refunds from health insurance carrier mid-year 2016 and an annual increase in active employee contributions of 11% for 2017, 2018, 2019 ($17.60 per pay period in 2016, and up to $24.07 beginning in 2020). Fund Balance at the end of 2025 projected as $2,114,327.

Year	Fund Balance as of January 1 (A)	Active Employee Contributions (B)	Net Benefit Payments (C)	Interest Earned (D)	Employee Share Refunds (E)	Net Cash Flow (B)+(C)+(D)+(E)
2016	$1,021,201	$293,161	($359,613)	$21,938	$761,613	$717,098
2017	1,738,299	327,036	(402,443)	76,527	- 0 -	1,120
2018	1,739,419	364,825	(436,845)	76,653	- 0 -	4,634
2019	1,744,053	406,980	(449,264)	77,531	- 0 -	35,247
2020	1,779,300	409,015	(402,283)	80,220	- 0 -	86,952
2021	1,866,253	411,060	(414,340)	83,908	- 0 -	80,628
2022	1,946,880	413,116	(435,597)	87,104	- 0 -	64,622
2023	2,011,502	415,181	(463,875)	89,422	- 0 -	40,727
2024	2,052,230	417,257	(484,035)	90,848	- 0 -	24,071
2025	2,076,300	419,343	(473,531)	92,214	- 0 -	38,026

Employee Retiree Health Plan

The chart below demonstrates the flow of Employee Retiree Health Funds and the City's shared funding agreement.