Retiree Health Care Insurance Preliminary Report

Washington State Law Enforcement Officers' and Fire Fighters' Plan 2 Retirement Board

September 13, 2006

Key Issues

- Access to retiree health care is “patchwork”
- Increasing retirements, longevity, health care costs
- Erosion of benefits
- Frequently requested benefit

Option 1

- Provide all LEOFF Plan 2 retirees' access to PEBB
- All costs paid by retirees

Option 2

- Provide all LEOFF Plan 2 retirees' access to PEBB
- All or part of costs paid by a revenue source to be determined

Retiree Health Care Insurance

Questions?

LAW ENFORCEMENT OFFICERS' AND FIRE FIGHTERS' PLAN 2 RETIREMENT BOARD

Retiree Health Care Insurance

Preliminary Report

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1. Issue

The Board requested a briefing on Health Care Insurance for LEOFF Plan 2 retirees.

2. Staff

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3. Members Impacted

Retiree health care could impact all current and future LEOFF Plan 2 retirees. As of September 30, 2004 there were 14,754 active members and 432 retirees as reported in *The Office of the State Actuary's 2004 LEOFF 2 Actuarial Valuation Report.* It is projected that there will be nearly 9,000 retirees by 2021.

4. Current Situation

LEOFF Plan 2 does not currently provide retiree health care benefits. Access to retiree health care for LEOFF Plan 2 retirees may be provided through employers. Those retirees without employer-sponsored health care access must rely upon coverage available through labor and employer organizations, purchase an individual health care policy, rely on public programs such as Medicare and COBRA, or go without coverage.

5. Background Information and Policy Issues

As many workers struggle to get financially prepared for retirement some are overlooking the fact they may be ill-prepared to deal with health care issues as they age. LEOFF Plan 2 retirees and members have identified post-retirement health care as an area of significant concern.

Health care policy is often examined by looking at two key basic principles: access and cost. Access to retiree health care involves determining the ability for certain groups to obtain health care in retirement. After resolving access issues, attention can turn to determining how to fund the cost of retiree health care insurance.

Access to Retiree Health Care Insurance

While the general trend for retiree access to health care may be described as "declining", access to health care for LEOFF Plan 2 retirees is more aptly described as "patchwork". Access to retiree health care for LEOFF Plan 2 retirees varies from employer to employer; some retirees have access to health care through their employers and some do not. The variation in bargaining units and employer size also results in varying benefits across membership, further adding to the patchwork nature of retiree health care benefits available to LEOFF Plan 2 members at retirement.

In general, the availability of employer-sponsored health insurance is much broader for active full-time employees than for retirees. According to the International City/County Management Association Retirement Corporation (ICMA-RC), 60 percent of local government employers across the country provide coverage for retiree health care for those under age 65, with 57 percent continuing coverage after age 65. Roughly one-third of employers providing coverage pay 100 percent of the cost, one-third require the retiree to bear the entire cost, and one-third share the cost with the retiree.

- Nationally, 60% of local government employers provide access to retiree health care insurance.
- Less than 50% of LEOFF Plan 2 employers provide access to health care for retirees.
- Approximately 8,180 active members (53.9%) would have access to retiree health care if they retired today.

In comparison, the results from the LEOFF Plan 2 Retirement Board 2005 Employer Survey showed that 176 of the 481 employers (36.6%) provide access to health care for their LEOFF Plan 2 retirees. With data from the Department of Retirement Systems it was calculated that 8,180 or 53.9% of the active members being reported at that time would have access to retiree health care if they were retired. Additionally, only 8 of the employers providing access to retiree health care contribute to the cost of those benefits. These 8 employers covered 374 or 2.5% of the reported active members.

For those retirees without employer-sponsored health care access, other options may exist. For example, health care benefits may also be available through labor and employer organizations such as the Fire Fighters' Health and Welfare Board or the Association of Washington Cities Employee Benefit Trust. Those who do not have access to health care through a labor or employer organization are left to purchase an individual health care policy, rely on public programs such as COBRA (see Appendix A: COBRA) and Medicare (see Appendix B: Medicare), or go without coverage.

Escalating costs will require that retirees spend an ever-increasing proportion of their retirement income on out-of-pocket post-retirement health care expenses, making access to affordable retiree health care insurance a key retirement planning consideration for members.

Retiree Health Care Insurance Access in Comparison Systems

Of the fourteen comparison systems reviewed, half of the systems provided retiree access to health care insurance provided by either the state or through the pension system itself. Six of the comparison systems indicated that retirees may have access to retiree health care through the employer by continuing on an employer's health care plan. However, this access was often contingent on the employer decision for health insurance to be carried after retirement. Lastly, one system specifically stated that no retiree health care insurance was available through the retirement system and did not have any indication that continuation through the employer was available. See Appendix C: Retiree Health Care Insurance Comparison for additional details.

Retiree Health Care Costs

Employers can generally provide workers with less costly insurance than the workers could purchase themselves because employment-based coverage generally offers access to group insurance plans, which charge lower premiums than individual plans. According to a 2005 Towers Perrin Health Care Cost Survey, retirees will contribute on average 40% of the total cost of employer-provided health care insurance.

A recent Segal Health Plan Cost Trend Survey reported an average per-participant cost for health care of $7,600 per year or $633 per month. However, survey participants also expect costs to rise in 2006 between 10 and 14 percent. To put such an increase in perspective, a 10 percent increase on the average cost would raise the per-participant cost to approximately $8,360 per year or $697 per month.

For those who do not have employer-sponsored health insurance and have not purchased health insurance on their own, cost is a major reason for lack of coverage. The 2004 Health Confidence study found that if employers stopped offering health insurance, fewer than 2 in 10 who currently have employment-based health benefits are extremely or very confident that they could afford to purchase it on their own. Moreover, while 46 percent report looking for health insurance on their own; more than 8 in 10 who found insurance say they did not purchase it due to the high cost.

Health care costs, which rose slowly in the mid-1990's, began increasing sharply at the start of this decade. Most research indicates that health care costs will likely continue to grow faster than workers' pay and retirees' pensions in the foreseeable future. The cost of providing health care has increased at a steady rate for the last five years.

Since 2000, premiums for family coverage have increased by 73%, compared with inflation growth of 14% and wage growth of 15%, according to a survey by the Kaiser Family Foundation and the Health Research and Education Trust. Between the spring of 2004 and spring of 2005, premiums for employer-sponsored health insurance rose by 9.2%, lower than the 11.2% increase in 2004, and the 13.9% increase in 2003. Despite this slowdown, premiums continued to increase much faster than overall inflation (3.5%) and wage gains (2.7%).

According to the "2005 Fiscal Wellness Survey" by Destiny Health, Americans are expressing worries about the looming retirement/health care situation. According to the new Destiny Health data, nearly two-thirds (65%) say they are concerned about health care expenses in retirement. However, their concerns are not backed by action:

- Only 54% of the survey respondents said they are saving anything at all to meet health care costs faced in retirement, but more than half said they expect Medicare to pay for their retirement health-care costs.
- In addition, respondents said they are currently allocating a mere 17% of their retirement savings for expected health care costs.
- More than half (51%) of those who are saving for retirement predict that, given the increased cost of health care, they will have enough when they retire, compared to 39 percent who don't think they will have enough.
- However, only 33% say they have increased the amount of their retirement saving they have allocated for health care costs.

Statistics from a variety of sources further paint a startling picture about the potential problems of health care in retirement for those without access to affordable health care insurance:

- A Kaiser Family Foundation report in 2003 says only 38% of firms offer health care coverage in retirement, vs. more than 66% in 1988. This represents a 28% decline in the number of employers offering health benefits in retirement, and that number continues to increase.
- The 2004 Health Confidence Survey (HCS), sponsored by the Employee Benefit Research Institute and Mathew Greenwald & Associates, reports one-quarter of the respondents have coped with increasing health care costs by decreasing contributions to retirement plans and other savings.

- A retirement study released by Prudential Financial, Inc. found that 7 in 10 workers feel rapidly rising health care costs in the recent past have hurt their prospects for a comfortable retirement.
- Individual medical care costs for Americans at or near retirement age could exceed $1 million, according to a recent survey conducted by the Employee Benefit Research Institute.
- The same study shows that a 55-year-old retiring today will need $83,000 to cover typical group insurance premiums, plus out-of-pocket expenses for 10 years just to get to age 65 when Medicare kicks in. The amount needed for individual coverage is even more staggering: as high as $256,000 for someone with a chronic condition requiring prescription drugs.
- A 65-year-old without employer coverage would need at least $116,000 for Medicare supplement and drug coverage through age 80, according to the Employee Benefit Research Institute.

As health care costs continue to increase they will erode the adequacy of pension benefits and thus become a significant factor in planning for a financially secure retirement. When considered with a looming increase in the LEOFF Plan 2 retiree population (see Appendix D: Projected LEOFF Plan 2 Retirees), and longer retiree life expectancy, there will be an increased need for access to affordable retiree health care insurance.

Public Employees' Benefit Board (PEBB)

PEBB purchases health care benefits for many subgroups composed of many members. By combining insurance purchasing for these groups, the higher costs for sicker and/or older members are somewhat offset by the lower costs for healthier and/or younger members.

PEBB has two distinct groups of members: (1) the state active employees and non-Medicare retirees and (2) Medicare retirees. Each group is referred to as a "risk pool." The insurance companies evaluate the risk involved to insure each group and establish rates based on the perceived risk of future claims. Retiree medical premiums are generally higher before age 65 and the beginning of Medicare coverage. Premiums for Medicare eligible retirees in PEBB are less than the premiums for non-Medicare retirees. There are two types of subsidies that affect the cost of PEBB benefits for retirees. These subsidies are the explicit subsidy and the implicit subsidy.

Explicit Subsidy

An explicit subsidy exists where the employer pays a specific part of the cost. For Medicare retirees in PEBB, there is an explicit subsidy of $131.87 per month (or 50 percent of the premium, whichever is less) for 2006.

Implicit Subsidy

An implicit subsidy exists where the cost of adding more expensive members is blended with the cost of the existing pool, resulting in a lower overall cost for the newly-added members. Enrolling more non-Medicare retiree enrollees in the risk pool, such as LEOFF Plan 2 Retirees, increases the implicit subsidy. The Fiscal Note for HB 2162 (2005), which would

have provided PEBB access to LEOFF Plan 2 retirees, assumed PEBB would increase the monthly rates for each person in the active/non-Medicare risk pool from $689.38 to $689.71 ($0.33 per person per month) . When converted to a fiscal year, the additional expenditure for the implicit subsidy would be $573,667 for fiscal year 2007.

Retiree Premiums

The PEBB premiums for 2006 ranged from $137 per month for a single subscriber who is already enrolled in Medicare parts A and B, to $1,345 per month for a full family not yet eligible for Medicare. The premiums vary by specific plan; See Appendix E for detailed information about monthly PEBB retiree rates in 2006.

Funding Approaches

There are two basic approaches for calculating and funding the member costs of health care: the pooled approach and the individual approach. Regardless of which approach is used, the cost must be paid by the employer or the employee. Depending on the agreement between the employer and employees, the employee may pay the entire cost of the health care, the employer may pay the entire cost of the health care, or the employer and employee share the cost.

Pooled Approach

Under the pooled funding approach, all of the projected retiree health liabilities for members of the pool are grouped together and the total cost is allocated among members so that each person pays the same cost for health care coverage. The pooled fund is used to pay for retiree health costs for all members. This approach is similar to the methodology used to determine pension contribution rates for LEOFF Plan 2, where the projected pension liabilities for all members are pooled together and used to calculate a uniform contribution for all members.

Individual Approach

Under the individual member funding approach, each person has their own individual retiree health savings account that they contribute to throughout their working career. The amount of contributions can vary from member to member under this approach and each member's individual account is only used to pay for their personal health expenses in retirement.

Employers providing retiree health benefits to those over age 65 usually integrate coverage with Medicare and treat Medicare as the primary payer. Most public sector employees, including LEOFF Plan 2 members, will be automatically eligible for Medicare at age 65.

Funding Vehicles

There are numerous vehicles available to assist in funding retiree health care costs. The following is intended as an overview of the major options available.

Consumer-Driven Health Accounts

Federal law permits the establishment of certain types of savings arrangements for health care. The options available vary as to tax treatment, who can contribute, and what expenses

can be covered. These options are commonly referred to as "consumer-driven health accounts". The basic principle behind these types of account is that consumers will be more cost conscious if responsible for making health care spending decisions from their own account, which will lead to better consumption habits and overall lower costs. Four types of accounts which can be used to help fund health care expenses are:

- Health Reimbursement Arrangements (HRA)
- Health Savings Accounts (HSA)
- Flexible Spending Accounts (FSA)
- Medical Savings Accounts (MSA)

Health Reimbursement Arrangements (HRA) are medical care reimbursement plans established by employers that can be used by employees to pay for health care. HRAs are funded solely by employers. Employers typically commit to make up to a specified amount of money available in the HRA for expenses incurred by employees or their dependents. HRAs are accounting devices, and employers are not required to expend funds until an employee incurs expenses that would be covered by the HRA. Employees may use the HRA to pay for medical expenses and premiums. Unspent funds in the HRA usually can be carried over to the next year (sometimes with a limit). Employees cannot take their HRA balances with them if they leave their job, although an employer can choose to make the remaining balance available to a former employee to pay for health care. HRAs are often offered along with a high deductible health plan (HDHP). In such cases, the employee pays for health care first, out of his or her HRA and then, out-of-pocket until the health plan deductible is met. Sometimes certain preventive services are paid for by the plan before the employee meets the deductible.

Health Savings Accounts (HSA) are savings accounts created by individuals to pay for health care. An individual may establish an HSA if he or she is covered by a "qualified health plan", which is a plan with a high-deductible (i.e., a deductible of at least $1,000 for single coverage and $2,000 for family coverage) that also meets other requirements. Employers can encourage their employees to create HSAs by offering an HDHP that meets federal requirements. Employers in some cases also may assist their employees by identifying HSA options, facilitating applications or negotiating favorable fees from HSA vendors.

Both employers and employees can contribute to a HSA, up to an annual limit equal to the lesser of the deductible in the HSA qualified health plan or a statutory cap. Employee contributions to the HSA are made on a pre-income tax basis, and some employers arrange for their employees to fund their HSAs through payroll deduction. Employers are not required to contribute to employee established HSAs, but if they elect to do so, their contributions are not taxable to the employee. Interest and other earnings on amounts in an HSA are not taxable. Withdrawals from the HSA by the account owner to pay for qualified health care expenses are not taxed. The savings account is owned by the individual who creates the account, so employees retain their HSA balances if they leave their job.

Flexible Spending Accounts (FSA) are employer-established benefit plans that reimburse employees for specified medical expenses as they are incurred. The employee contributes funds to the account through a salary reduction agreement and is able to withdraw the funds set aside to pay for medical bills. The salary reduction agreement means that any funds set aside in a flexible spending account escape both income tax and Social Security tax. Employers may contribute to these accounts as well.

There is no statutory limit on the amount of money that can be contributed to health care flexible spending accounts. However, limits can be imposed by the employer. By law, the employee forfeits any unspent funds in the account at the end of the year. There have been proposals introduced in Congress to ease this "use it or lose it" rule. Flexible spending accounts are not portable. Funds can be used for un-reimbursed medical expenses such as health care deductibles, co-payments, eligible non-prescription medications, and other items not covered by insurance, but exclude premiums for health insurance coverage and long-term care expenses.

Medical Savings Accounts (MSA) are savings accounts used to pay for un-reimbursed health care expenses. These accounts can accumulate tax-deferred interest similar to individual retirement accounts (IRAs). Funds are controlled and owned by the account holder. The employee or the employer--never both--makes contributions. In order to qualify, the employee must be covered by a HDHP and must be self-employed or employed by a firm with 50 or fewer employees.

The maximum contribution to a medical savings account for single coverage is 65 percent of the deductible on the employee's health plan and 75 percent of the deductible for family coverage. Savings are rolled over every year and are portable, regardless of employment status. Funds can accumulate earnings, which are not taxed unless funds are withdrawn for non-medical expenses. Funds can be used on a pretax basis to pay for un-reimbursed medical care expenses, long-term care insurance premiums, health insurance premiums paid while unemployed, and COBRA premiums. If withdrawn for non-medical purposes, savings are considered taxable income and are subject to income taxes in addition to a percentage penalty tax. If the employee becomes disabled or reaches Medicare eligibility age, however, distributions for non-medical expenses from the account are subject only to ordinary income tax, not the penalty tax.

Qualified Medical Sub-Account

A Section 401(h) Qualified Medical Sub-Account can be created as a component of a qualified retirement plan. It may take the form of a defined contribution plan, with individual accounts held for each employee, or a defined benefit account, with the funding pooled for investment. The defined benefit may be the promise of some specific benefit, for example health insurance coverage at whatever cost, or the promise of a specific dollar amount towards paying for health care costs; for example $250 per month towards medical costs, upon retirement. The assets may be invested with the pension assets but must be accounted for separately and not made available to fund pension benefits. Excess pension assets may be eligible to fund the qualified medical sub-account, but cannot be transferred back to later fund pension benefits. Contributions can be made by employers or employees

during employment or a combination of both. There is a great deal of flexibility in the funding structure and contribution rates may be adjusted from year to year. The plan does not have use-it-or-loose it restriction and can permit the carry over of balances from one year to the next. Payments to and distributions from the 401(h) account for medical expenses are not taxable.

Voluntary Employee Beneficiary Association (VEBA)

A VEBA (Section 501(c)(9) Trust) is an employee association trust that can integrate with existing health coverage. VEBAs are required to obtain IRS approval for tax-exempt status. It is funded with employer contributions, either prior to or after retirement. Unused sick, vacation, or severance amounts may be contributed to a VEBA to fund post-retirement benefits if contributions are a mandatory requirement and the employee cannot elect to receive cash. The employer and employees may also make after-tax contributions. There are a number of administrative and reporting requirements that may not apply to government entities.

Governmental Trust

A Section 115 Governmental Trust can be formed to provide medical benefits to retirees. This is a more free-form alternative available to governmental employers that has not been widely used and would require a private letter ruling to secure IRS approval of structure and tax treatment. Employer contributions and distributions to employees/retirees would not be taxable. After tax contributions by employees can be allowed. Account balances may be carried over from year to year. No cash out option is available.

Recent Legislation

The Legislature has considered several pieces of legislation during the last six years which addressed the access to, and in some cases funding of, health insurance through the Public Employees' Benefit Board (PEBB):

House Bill 1371 (2001) - Health care access for survivors of emergency service personnel killed in the line of duty.

This bill required the Public Employees' Benefits Board (PEBB) to provide access to health insurance to surviving spouses and dependent children of emergency service personnel killed in the line of duty on or after January 1, 1998, including those who died as a result of injuries sustained in the course of employment as determined by the Department of Labor and Industries under Title 51 RCW. "Emergency service personnel" means members of the Law Enforcement Officers' and Fire Fighters' Retirement system and members of the Volunteer Fire Fighters' and Reserve Officers' Relief and Pensions system. Under this bill, all benefit costs were paid by the surviving spouses and dependent children.

Senate Bill 5777 (2002) - Permitting retired and disabled employees to obtain health insurance.

In 2002, the Legislature enacted legislation requiring political subdivisions to offer PERS covered retirees and disabled employees access to group health insurance coverage. This bill required that PERS covered employees who are retired or disabled from local government,

who are not covered by the state Health Care Authority (HCA), to be allowed to continue participation in a health plan of their employer. Prior to this bill, local government employees in PERS not covered by HCA had no right under state law to continue to participate in the insurance plans of their employer after they retire or are disabled.

The bill provided exceptions and certain conditions under which the health care access must be provided. A local government could require a retired or disabled person who requires continued participation in its health plan to pay the full cost of such participation, including any amounts necessary for administration. Other conditions established in the bill included enrollment periods, coordination of benefits with a participant's other employer-based medical coverage and coverage of dependents if the retired or disabled employee dies.

The legislation took effect on January 1, 2003, but local government employers were allowed up to one year from the effective date to come into compliance. The legislation established a mandate for the local government employers to offer access to health coverage, but did not require health carriers to offer such coverage. Following the passage of the legislation many health carriers declined to offer group policies for public retirees and disabled employees, and local government employers were unable to offer any alternatives to their retirees or disabled employees.

House Bill 2985 (2004) - Providing for individual health insurance for retired and disabled public employees.

In 2004 local government employers requested that legislation passed in 2002 (see SB 5777 above) be repealed due to the inability to comply with the legislation. In collaboration with employee representatives, the employers and bill sponsors agreed to make the requirement for providing retiree health care access conditional upon the employers ability to provide the required access rather than repealing the legislation. The new condition stated that an employer who could not comply with the provisions of the legislation were required to "document a good faith effort" to provide access to a fully insured group health benefit plan.

This bill amended the 2002 legislation so that PERS and LEOFF Plan 2 covered employees who are retired or disabled from local government and who are not covered by the state Health Care Authority (HCA) be allowed to continue participation in a health plan of their employer. However, the bill provided that if a local government employer is unable to offer access to group health insurance for their PERS and LEOFF Plan 2 retirees and disabled employees, despite a "documented good faith effort", the local government employer's obligation only extends to assisting the retirees and disabled employees in applying for individual health benefit plans.

Assistance may include developing standardized information on the availability and cost of individual health benefit plans, application packages, and benefit fairs. The Office of the Insurance Commissioner is also required to make available health benefit plan information, including a list of carriers that offer individual coverage, rates and how to apply.

The legislation provided no guidance on what constitutes a documented good faith effort. Moreover, the legislation does not provide any frequency or timeframe requirements for

making a good faith effort. Although these issues were discussed in committee, no amendments were made to the bill. Thus, it may be unclear to employers what needs to be documented and whether or not they have met their statutory obligation after one attempt to provide access.

Senate Bill 5781 (2005) - Authorizing retired local government employees to receive benefits from the public employees' benefits board.

This bill would have provided access to health benefits for retirees of the Public Employees' Retirement System (PERS) Plan 1, 2, or 3 who were employed by a county, municipality, or other political subdivision of the state. The local government employers would have been required to remit the cost of premium subsidies (explicit and implicit) to the Health Care Authority.

Senate Bill 5781, similar to HB 2162, would have added additional retirees into the active/non-Medicare risk pool, creating an expected increase in the implicit subsidy and provided that the increased costs would be covered by the amount remitted by the local governments.

The estimated expenditures provided in the Washington State Health Care Authority Fiscal Note for Senate Bill 5781 were as follows:

2005-2007	2007-2009	2009-2011
$150,683,433	$200,598,787	$234,829,589

House Bill 2162 (2005) - Creating the retired law enforcement officer and fire fighter retirement system plan 2 retiree medical board.

This bill would have established a medical board to oversee the funding and provision of health insurance benefits for retired members of LEOFF Plan 2.

This bill would have also provided access to health benefits for current and future LEOFF Plan 2 retirees through the Public Employee's Benefit Board (PEBB), if coverage was selected immediately upon retirement. LEOFF Plan 2 retirees would have been grouped in the community-rate risk pool along with retired and disabled state, K-12, and higher education members. Retiree health benefits would have been funded through active member contributions and retiree premiums. In addition to the cost of benefits, the contributions and premiums would also be used to cover the additional cost of LEOFF Plan 2 retirees joining PEBB.

PEBB purchases health care benefits for many subgroups comprised of many members. By purchasing insurance for combined groups, the higher costs for older members are somewhat offset by the lower cost for younger members. This is referred to as an implicit subsidy. PEBB has two distinct groups: (1) the state active employees and non-Medicare retirees and (2) Medicare retirees. Each group is referred to as a "risk pool". The insurance companies

evaluate the risk involved to insure each group and establish rates based on the perceived risk of future claims.

The state active-non-Medicare risk pool consists of all state-active employees and non-Medicare retirees under the age of 65 who are not eligible for Medicare. This bill proposed to allow LEOFF Plan 2 members who will retire, or have retired, to join this risk pool. Because non-Medicare retirees have approximately a 50 percent higher risk factor than a state active enrollee, health plans would likely increase premiums to cover increased costs. As a result, enrolling more non-Medicare retirees from LEOFF Plan 2 in the risk pool increases the implicit subsidy. It was assumed in the Health Care Authority Fiscal Note that the contribution and premium rates would cover these additional expenses.

The Health Care Authority assumed that the rate charged to the medical board would cover these additional increases, so current PEBB members and K-12 school districts would not be charged additional expenses from retired LEOFF Plan 2 members joining PEBB. The new LEOFF Plan 2 members joining PEBB were estimated to increase the blended premium rate for a non-Medicare subscriber from $689.38 to $689.71.

The estimated expenditures provided in the Washington State Health Care Authority Fiscal Note for House Bill 2162 were as follows:

2005-2007	2007-2009	2009-2011
$2,194,366	$4,905,879	$5,526,693

Senate Bill 6723 (2006) - Determining the retirement allowance of a member who is killed in the course of employment.

This bill, passed by the 2006 Legislature on the recommendation of the LEOFF Plan 2 Retirement Board, reimburses the cost of Health Care Authority insurance premiums for surviving spouses and dependents of members of the LEOFF Plan 2 killed in the course of employment. It also extends the availability of Health Care Authority insurance to survivors of emergency service personnel and all LEOFF 2 members killed in the line of duty prior to January 1, 1998.

6. Policy Options

- **Option 1: Provide LEOFF Plan 2 retirees' access to PEBB; Cost paid by retirees.**
  This option would allow all LEOFF Plan 2 retirees the ability to purchase retiree health care benefits through the Public Employees' Benefit Board (PEBB). Under this option, the retirees would be required to pay all of the benefit costs (premiums, implicit subsidy increase) generated by adding LEOFF Plan 2 retirees into the active/non-Medicare risk pool.

- **Option 2: Provide LEOFF Plan 2 retiree's access to PEBB; Cost paid by a revenue source to be determined.**
  This option would provide all LEOFF Plan 2 retirees with retiree health care benefits through the Public Employees' Benefit Board (PEBB). Under this option, a revenue source (that is still to be determined) would pay for all or some of the the benefit costs (premiums, implicit subsidy increase) generated by adding LEOFF Plan 2 retirees into the active/non-Medicare risk pool.

7. Supporting Information

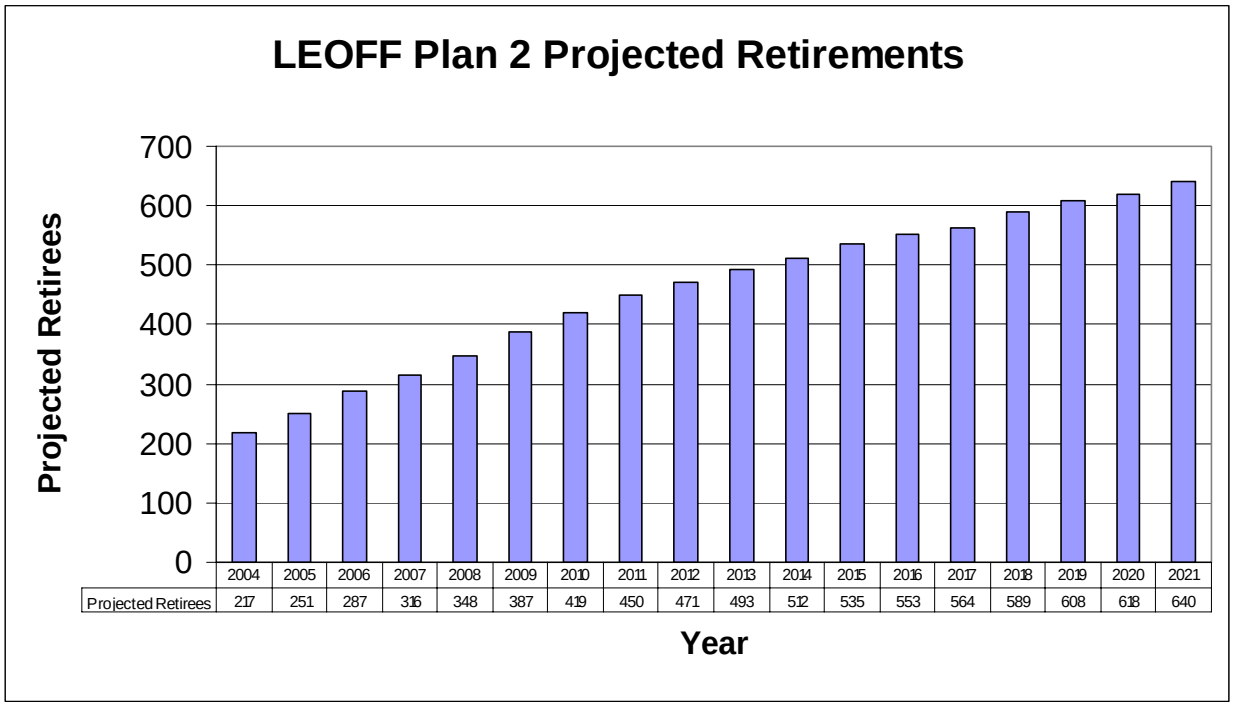
- **Appendix A: COBRA Summary**
- **Appendix B: Medicare Summary**
- **Appendix C: Retiree Health Care Comparison**
- **Appendix D: Projected LEOFF Plan 2 Retirees**
- **Appendix E: Monthly PEBB Retiree Rates in 2006**

Appendix A: COBRA Summary

The membership of LEOFF Plan 2 is stated as 14,754 in the 2004 Actuarial Valuation Report[1] from the Office of the State Actuary. The number of LEOFF Plan 2 retirees stated in that report is 432.

The Office of the State Actuary has projected that the number of LEOFF Plan 2 members who will retire each year will increase every year from 2004 to 2021. During this period, it is projected that 8,258 members will retire from LEOFF Plan 2.

The following chart shows the increase in retirements from year to year. This is a reflection of the aging baby boomer population coupled with LEOFF Plan 2 beginning to reach maturity.



[1] 2003 Actuarial Valuation Report prepared in October 2004.

Appendix B: Medicare Summary

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 provides for the continuation of group health coverage that otherwise might be terminated. COBRA generally requires that group health plans sponsored by covered employers, offer employees and their families the opportunity to temporarily continue health coverage.

Eligibility

There are three elements to qualify for COBRA benefits: (1) plan coverage, (2) qualified beneficiaries, and (3) qualifying events.

Plan coverage – Group health plans for employers with 20 or more employees are subject to COBRA coverage.

Qualified beneficiaries – A qualified beneficiary generally is an individual covered by a group health plan and is only available when existing coverage is lost due to certain specific qualifying events. Qualified beneficiaries can include employees, employee's spouse, employee's dependent child, retired employees, retired employee's spouse, and the retired employee's dependent child.

Qualifying events – Qualifying events are certain events that would cause an individual to lose health coverage. The type of qualifying event will determine who the qualified beneficiaries are and the amount of time that a plan must offer health coverage to them under COBRA. The following is a breakdown, by beneficiary, of the various qualifying events:

- **Employees:** Voluntary or involuntary termination of employment for reasons other than gross misconduct; Reduction in the number of hours of employment.
- **Spouses:** Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct; Reduction in the hours worked of the covered employee; Covered employee becoming entitled to Medicare; Divorce or legal separation of the covered employee; Death of the covered employee.
- **Dependent Children:** Loss of dependent status under the plan rules; Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct; Reduction in the hours worked of the covered employee; Covered employee becoming entitled to Medicare; Divorce or legal separation of the covered employee; Death of the covered employee.

Timeframes

Qualified beneficiaries must be given at least 60 days from the later of the coverage loss date or the date the COBRA election notice is provided by the employer or plan administrator. The election notice must be provided in person or by first class mail within 14 days after the plan administrator receives notice that a qualifying event has occurred.

If a claim for COBRA coverage is denied, written notice must be given within 90 days after the claim is filed. There is a 60-day window to appeal the decision and within 60 days after the receipt of the appeal, receive a decision.

COBRA establishes specific periods of coverage for continuation of health benefits, but employers may provide longer periods of coverage. Beneficiaries normally are eligible for group coverage up to 18 months. There is an 11 month extension for beneficiaries who qualify for disability. Under certain circumstances, coverage can be extended to 36 months.

Costs
In general, the monthly premiums for COBRA coverage are paid by the beneficiary. The premium cannot exceed 102 percent of the cost to the plan for similarly situated individuals who have not experienced a COBRA qualifying event.

For example, if the cost of providing health benefits coverage for a similarly situated employee is $400 per month, $100 of which is paid by the employee and $300 of which is paid by the employer, the plan may charge an individual a COBRA premium of $408 per month (102 percent times $400). The employer is not responsible for any portion of the individual's COBRA premium.

For qualified beneficiaries receiving the 11-month disability extension of coverage, the premium for those additional months may be increased from 102 percent to 150 percent of the plan's total cost of coverage.

Additional Information
There are many Web sites that offer information about COBRA coverage. Listed below are a couple of the more helpful sites:

Centers for Medicare and Medicaid Services at:
www.cms.hhs.gov/hipaa/hipaa1/cobra/default.asp

U.S. Department of Labor:
www.dol.gov/dol/topic/health-plans/cobra.htm

Appendix C: Retiree Health Care Comparison

Overview

Medicare is a health insurance program enacted in 1965. It covers people age 65 or older, people under age 65 with certain disabilities and people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). Medicare is broken down into two parts, Medicare Part A and Part B.

Enrollment

While Medicare enrollment may be automatic in many instances, it is not mandatory. If a person is not eligible for premium-free Medicare Part A, they can still purchase Medicare Part B without buying Medicare Part A. Conversely, if a person qualifies for premium-free Medicare Part A, they do not have to sign up for Medicare Part B. However, if a person delays signing up for Medicare Part B during their initial enrollment period, they can still sign up during the general enrollment period (January 1 – March 31) but there is a 10% increase in the premium for each 12-month period of delay.

Part A (Hospital Insurance)

Medicare Part A helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not unskilled or long-term care). It also covers hospice care and some home health care. Most people are enrolled automatically, without taking any action.

Most people do not have to pay a premium. Eligibility for premium-free Medicare Part A can come under three conditions:

- Under age 65, disabled, and are receiving benefits from Social Security or the Railroad Retirement Board for at least 24 months based on that disability.
- Age 65 or older and either they or their spouse worked at least 10 years under Medicare-covered employment.
- Eligible for Medicare because of End-Stage Renal Disease.

Part B (Medical Insurance)

Medicare Part B helps cover doctor's services, outpatient hospital care, and some other medical services that Medicare Part A does not cover, such as some of the services of physical and occupational therapists, and some home health care. Medicare Part B helps pay for these covered services and supplies when they are medically necessary. It also covers some preventive services.

Most people pay the monthly premium ($78.20 for 2005) for Medicare Part B. In addition to the premium there also is a deductible that must be met before Medicare starts to pay its share ($110.00 in 2005). In both cases the amounts (premiums and deductibles) can change year to year.

Benefit Integration

If someone has continuing health coverage in retirement it is necessary to contact the health insurance provider to see how the plan integrates with Medicare. Determining if Medicare

makes sense varies with how each plan fits with Medicare. For example, many plans will defer to Medicare as the primary payer for health care coverage and provide a lower monthly premium in exchange. However, this practice varies from plan to plan. Also, some health care plans may require participation in Medicare Part B in order to continue participating in the plan.

Additional Information
There are many publications and Web sites that offer information about Medicare coverage:

Medicare brochure provided by Social Security, www.socialsecurity.gov/pubs/10043.pdf

Enrolling in Medicare brochure provided by Centers for Medicare & Medicaid Services, www.medicare.gov/Publications/Pubs/pdf/11036.pdf

Centers for Medicare & Medicaid Services, www.medicare.gov

Social Security Administration, www.socialsecurity.gov

Appendix D: Projected LEOFF Plan 2 Retirees

Alaska Public Employees Retirement System (PERS)	Medical coverage is provided to disabilitants, regardless of age and benefit recipients over age 60 or police/fire members with 25 years of police/fire service The retirement system pays the retiree medical plan premium. Retirees and survivors under age 60 must pay the full premium cost if they want coverage. However, employees must accrue a minimum of 10 years of credited service, to have system-paid coverage at age 60. Employees with less than 10 years must pay the full premiums as long as they wish to continue medical coverage.
Arizona Public Safety Personnel Retirement System (PSPRS)	Retiree health insurance may be provided as an extension of the insurance offered by your employer, ie. City of Phoenix, Pima County, etc. This system also provides partially subsidized insurance through the Arizona State Retirement System Retiree Group Insurance Program.
Arkansas Local Police and Fire Retirement System	Each individual employer may decide if health insurance is to be carried after retirement
Colorado Fire and Police Pension Association	In 2003, legislation authorized FPPA to create the State Wide Health Care Plan. It is a defined benefit plan that provides a benefit to assist in paying for the costs of health care for each retired eligible member. Payments to and distributions from the account would not be taxable to member/retiree. Eligible members make a 1% contribution to the plan throughout their careers and upon retirement receive a monthly subsidy for a 10-year period to pay for qualified health insurance premiums. Plan still awaiting IRS approval before implementation.
Delaware County & Municipal Police/Fire Pension	Retirees are allowed to continue with coverage in health insurance plans. Pensioners of the County and Municipal Pension Plan (Police/Firefighters) must pay 100% of the cost of the health insurance plans described herein. It is necessary to have Part A and B to participate in the State's retiree health coverage.
District of Columbia Police Officers' and Firefighters' Retirement Plan	If you have had at least five years of continuous health and life insurance* coverage before you retire, you may continue your coverage for health benefits and life insurance benefits when you retire. Your surviving spouse may also be able to continue health benefits under certain circumstances when you die.
Kansas Police and Firemen's Retirement System (KP&F)	No insurance is provided through the retirement system.

Maryland Pension System for Local Fire Fighters and Police Officers	Each individual employer may decide if health insurance is to be carried after retirement.
N.J. Police and Firemen's Retirement System	Employees already covered by the State Health Benefits Program (SHBP) through their employer will be offered SHBP coverage when they retire. Some employers have agreed to pay for the cost of coverage for those with 25 years of service credit or those on disability retirements. Chapter 330, P.L. 1997, provides health benefits under the SHBP to local police officers and firefighters who retire after 25 years of service, or on a disability, and who do not receive any payment towards retiree health coverage from their employers. The State will pay 80 percent of the cost of the least expensive SHBP plan offered and the retiree will pay the remainder for the plan selected. The eligibility of retired police officers and firefighters for benefits under Chapter 330 will depend on the health benefits provided by the employer for retired police officers and firefighters as of the effective date of the law, July 1, 1998, as indicated in labor and other employment contracts, ordinances, and resolutions of the employers.
New York Police and Fire Retirement System (PFRS)	Health Insurance — We do not administer health insurance programs. However, if we are instructed by your former employer, we will deduct premiums from your monthly pension benefit to pay for your health insurance coverage.
Ohio Police and Fire Pension Fund	Upon your service or disability retirement, you and your eligible dependents may enroll in OP&F's health care program, which includes various plan options such as medical, prescription drug, dental and vision. In addition, these benefits are available to your eligible survivors upon your death. Retiree's pay from 25% to 62.5% of the premium depending on years or service and income. They will pay 50 to 75% of the premium for spouse and children coverage.
South Carolina Police Officers Retirement System (PORS)	Police and Fire members do have access to retiree insurance when they retire if they meet the eligibility requirements to continue the coverage. Also the employer has to be a member of the Employee Insurance Program. If the employer is a local sub-division they would set the funding of their retirees.
Rhode Island Employees Retirement System	Retired municipal employees receive health care benefits through their former municipal employer.
Utah Public Safety Retirement System Utah Firefighter Retirement System	**Health Insurance** after retirement is based on your employer's benefit package and should be reviewed carefully with your employer ***before*** you retire. A supplement to Medicare is available at age 65 to you and your spouse through Public Employees Health Program (PEHP).

Appendix E: Monthly PEBB Retiree Rates in 2006

Medical Rates (without Medicare)

Medical Plans	Subscriber	Subscriber & Spouse or SSDP	Subscriber & Child(ren)	Full Family
Community Health Plan of Washington	$430.26	$852.88	$747.23	$1,169.85
Group Health Cooperative	409.05	810.46	710.11	1,111.52
Group Health Options, Inc.	455.18	902.72	790.84	1,238.38
Kaiser Foundation Health Plan of the Northwest	412.53	817.42	716.20	1,121.09
PacifiCare of Washington, Inc.	488.82	970.00	849.71	1,330.89
Regence Blue Shield	493.87	980.10	858.54	1,344.77
UMP Neighborhood	369.51	731.38	640.91	1,002.78
Uniform Medical Plan PPO	371.69	735.74	644.73	1,008.78

Medical rates (with Medicare)

Medicare rates shown below have been reduced by the state-funded contribution of $131.87 per retiree per month.

Medical Plans	Sub-scriber	Subscriber & Spouse or SSDP		Subscriber & Child(ren)		Full Family		
		Number eligible for Medicare						
		1	2	1	2	1	2	3
Community Health Plan of WA	$228.53	$651.15	$449.42	$545.50	$449.42	$968.12	$766.39	$670.31
Group Health Cooperative	185.45	586.86	363.26	486.51	363.26	887.92	664.32	541.07
Group Health Options, Inc.	278.16	725.70	548.68	613.82	548.68	1,061.36	884.34	819.20
Kaiser Foundation Health Plan of the Northwest	137.41	542.30	267.18	441.08	267.18	845.97	570.85	396.95
PacifiCare of Washington, Inc.	165.43	646.61	323.22	526.32	323.22	1,007.50	684.11	481.01
Regence BlueShield	308.45	794.68	609.26	673.12	609.26	1,159.35	973.93	910.07
UMP Neighborhood	194.04	555.91	380.44	465.44	380.44	827.31	651.84	566.84
Uniform Medical Plan PPO	194.04	558.09	380.44	467.08	380.44	831.13	653.48	566.84