LEOFF Plan 2 Retiree Health Care

Initial Consideration

WASHINGTON STATE
Law Enforcement Officers' and Fire Fighters'
Plan 2 Retirement Board

September 28, 2005

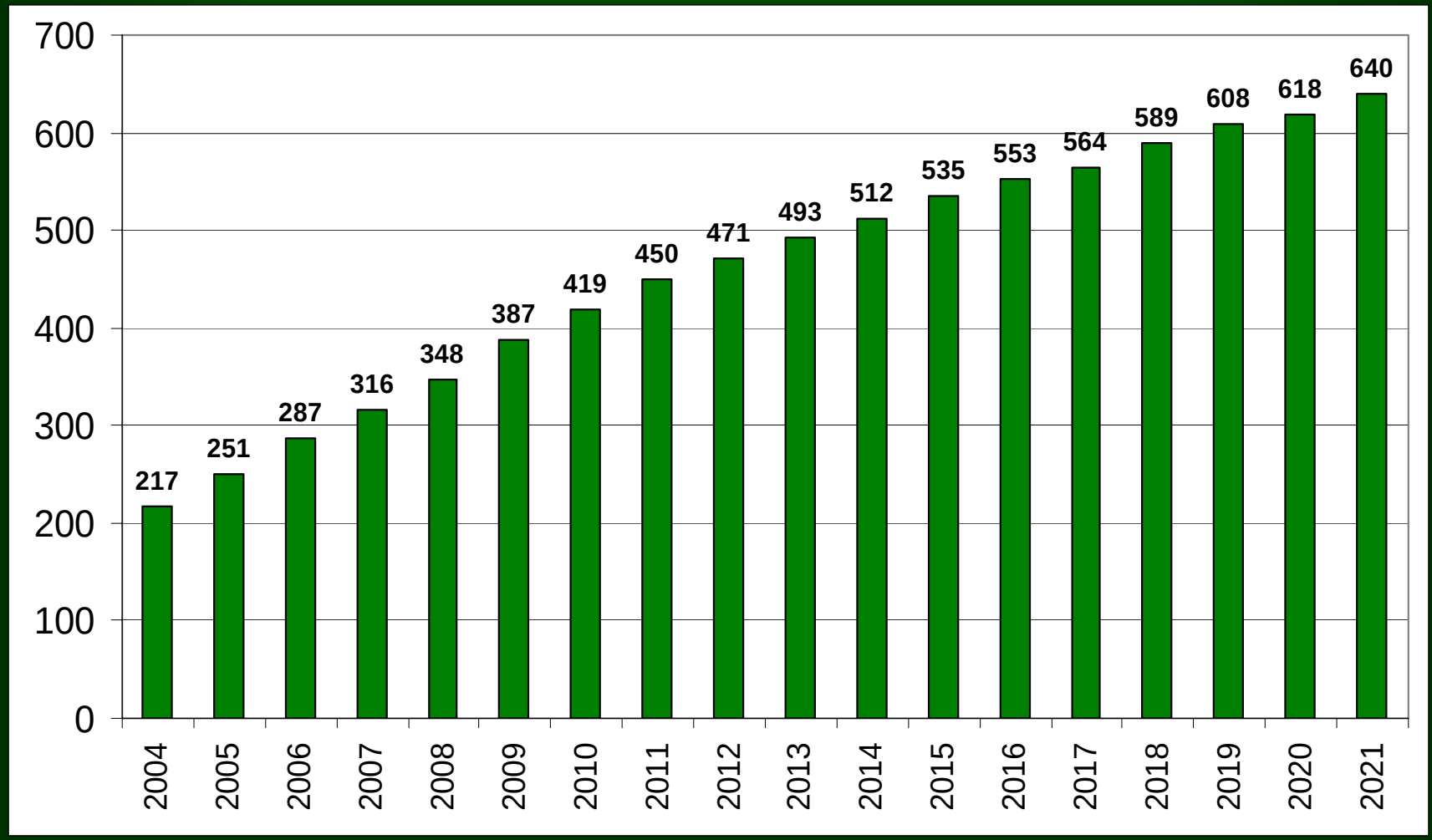
Current Situation

- Access and benefits vary from employer to employer for LEOFF Plan 2 retirees
- Retiree health care not a part of LEOFF Plan 2 pension benefits

General State of Retiree Health Care

- Retiree health care expenses take up large piece of pension
- Increasing number of retirees
- Increasing health care cost
- Longer life expectancy

LEOFF Plan 2 Retiree Projections



Increasing Health Care Costs

- Health care costs growing faster than pensions
- Towers Perrin: $5,400 yr/$450 mo
- Segal: $7,600 yr/$633 mo
  - Projected: $8,360 yr/$697 mo
- Cost a major reason for no coverage

Health Care Policy

Two Primary Components

- Access
- Cost

Access

- Nationally
  - 60% of local government provide access to retire health care
  - 66% of local government providing access contribute to cost

  Source: ICMA-RC
- LEOFF Plan 2
  - 47% of members work for employers who provide access to retiree health care
  - 5% of employers providing access contribute to cost

Access

- Access varies by employer
- Variation in benefits
  - Employer size and bargaining unit
- Alternative access
  - Labor and multi-employer organizations

Cost

- Funding Approaches
  - Pooled
  - Individual
- Numerous vehicles for funding costs

Cost - Pooled Approach

- Projected health liabilities pooled
- Cost allocated among all members
- All members contribute same percentage of pay
- Member contributions go into health care fund
- Health care fund pays for benefits

Cost - Individual Approach

- Individual has own account
- Contribute through working career
- Contributions may vary person to person
- Account used to pay individual health care expenses in retirement

Cost – Funding Vehicles

- Individual Accounts
  - Health Reimbursement Arrangements (HRA)
  - Health Savings Accounts (HSA).
  - Flexible Spending Accounts (FSA)
  - Medical Savings Accounts (MSA)
- Qualified Medical Sub-Account
- Voluntary Employee Benefit Association
- Section 115 Governmental Trust

Questions?

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

Retiree Health Care

Initial Consideration

September 28, 2005

1. Issue

In light of 2005 legislation, the Board requested a briefing on Health Care for LEOFF Plan 2 retirees for the September 28, 2005 Board Meeting.

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, 2003 there were 316 retirees and 14,560 members in the plan. 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

Introduction

LEOFF Plan 2 retirees and members have identified post-retirement health care costs as a significant concern. Health care costs, which include medical expenses as well as health insurance premiums, have been escalating at rate of more than 11% to 15% per year. These escalating costs require that retirees spend an ever-increasing proportion of their retirement income on out-of-pocket post-retirement health care expenses. As a result, retiree health care is a key retirement planning consideration for workers.

As workers struggle to get financially prepared for retirement, many overlook the fact that they may be ill-prepared to deal with health care issues and costs as they age. A Destiny Health survey found that workers were setting aside just 17% of their retirement savings for the health care costs they expect to encounter in retirement, and more than half of current workers said they expect Medicare to pay for their retirement health-care costs. A third of the respondents in the survey expect to fund health care expenses in retirement on their own, but 32% admit to saving nothing at all. A retirement study released by Prudential Financial, Inc. found that seven in 10 workers feel rapidly rising health care costs in the recent past have hurt their prospects for a comfortable retirement. In the 2004 Health Confidence Survey (HCS), sponsored by the Employee Benefit Research Institute and Mathew Greenwald & Associates, one-quarter of the respondents have coped with increasing health care costs by decreasing contributions to retirement plans and other savings.

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

Health care policy is often examined by looking at two key basic principles: access and cost. Access to retiree health care involves determining the need and ability for certain groups to obtain health care in retirement. After resolving access issues, focus can then turned to determining how to pay for the retiree health care.

Access to Retiree Health Care

The availability of employer-sponsored health insurance is much broader for current full-time employees than for retirees and varies by employer. According to the International City/County Management Association Retirement Corporation (ICMA-RC), 60 percent of local government employers 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 requires the retiree to bear the entire cost and one-third share the cost with the retiree.

In comparison, the preliminary results from the LEOFF Plan 2 Retirement Board 2005 Employer Survey show just over 47 percent (176) of the employers indicated that they provide access to health care for their LEOFF Plan 2 retirees. Based on current retirement data from the Department of Retirement Systems, 7,042 members (47 percent) would have access to retiree health care if they retired today. Also, about five percent of the employers providing access to retiree health care contribute to the cost of those benefits.

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 LEOFF Plan 2 retiree health care benefits.

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 that 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 B: COBRA) and Medicare (see Appendix C: Medicare), or go without coverage.

Cost of Retiree Health Care

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 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%).

Employers can generally provide workers with less costly insurance than they could purchase themselves because employment-based coverage generally offers access to group insurance plans, which charge lower premiums than individual plans.

According to the 2005 Towers Perrin Health Care Cost Survey, retirees will contribute on average 40% of the total cost of employer-provided health care insurance. For employer provided/subsidized health care, retirees under age 65 are expected to pay an average of $2,160 per year or $180 a month for retiree-only coverage. Without employer subsidy, this means total per-participant cost of $5,400 per year or $450 per month.

The most 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 that 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.

Funding Approaches for Retiree Health Care

There are two basic approaches for calculating and funding the member costs of health care: the pooled approach and the individual 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.

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.

Regardless of whether the cost is determined through a group or individual approach, 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 will share the cost.

Most employers providing retiree health benefits to those over age 65 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.

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 balance 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. VEBA's 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

There were two bills in the 2005 Legislative Session which sought to provide health care benefits to retirees. House Bill 2162 would have provided benefits for LEOFF Plan 2 retirees and Senate Bill 5781 would have provided benefits for PERS retirees who retire from local government.

House Bill 2162

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 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 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 5781

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, like HB 2162, would have added additional retirees into the active/non-Medicare risk pool creating an expected increase in the implicit subsidy and provides 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

6. Supporting Information

Appendix A: Projected LEOFF Plan 2 Retirees

Appendix B: COBRA Summary

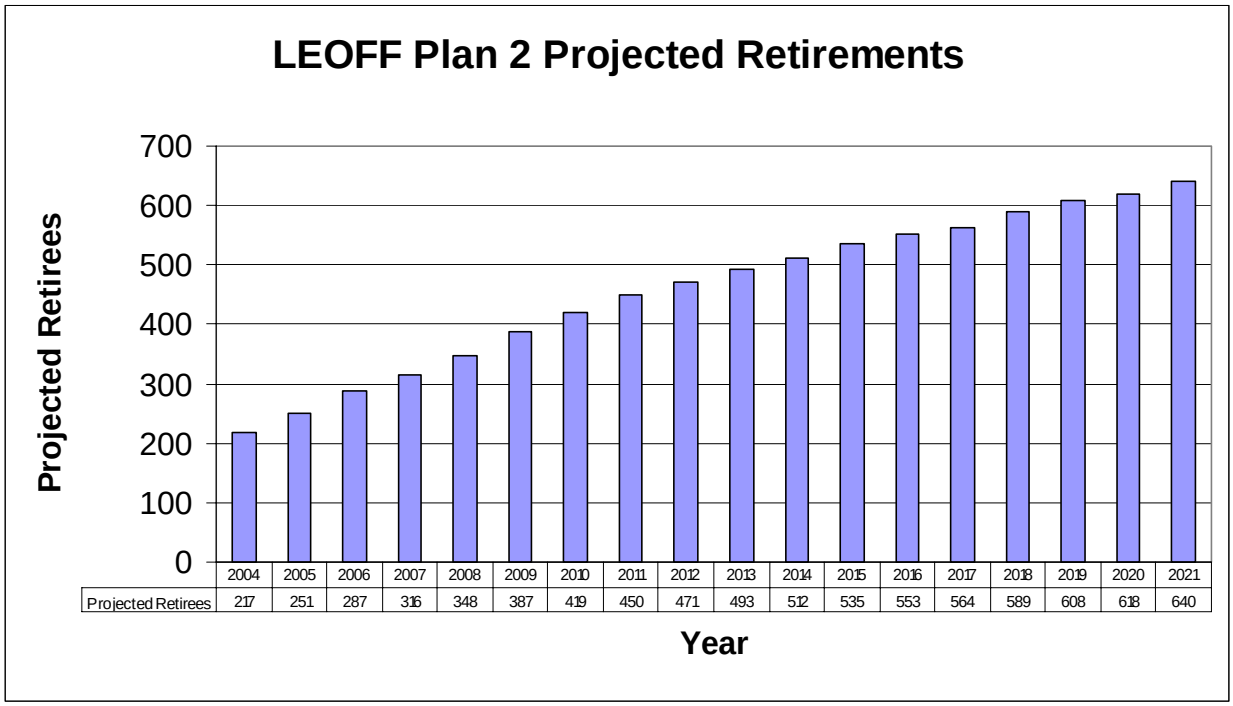
Appendix C: Medicare Summary

Appendix A: Projected LEOFF Plan 2 Retirees

The membership of LEOFF Plan 2 is stated as 14,560 in the 2003 Actuarial Valuation Report[1] from the Office of the State Actuary. The number of LEOFF Plan 2 retirees stated in that report is 316.

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: COBRA 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 of 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 that 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: Medicare Summary (Part A and B)

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.

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.

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.

Integration

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

BILL SUMMARY
HB 2162

Title: Creating the retired law enforcement officers' and fire fighters' retirement system plan 2 retiree medical board.

Sponsors: Representatives Curtis, O'Brien, Haler, P. Sullivan, Anderson, Miloscia, McCune, Strow, Lovick, Cox, Sells, Campbell, Rodne

Legislative History: 2005 Regular Session -- Feb 21, First reading, referred to Appropriations

Brief Summary of Bill:

- Creates the retired law enforcement officers' and fire fighters' retirement system plan 2 retiree medical board.
- Provides LEOFF Plan 2 retirees with access to retiree health care coverage through the Public Employee Benefit Board (PEBB) and groups LEOFF Plan 2 retirees in the community-rate risk pool along with retired and disabled state, K-12, and higher education members.
- Requires the cost of the retire health care to funded by contributions from the active membership and premiums from retirees, including the additional cost of LEOFF Plan 2 retirees joining PEBB.

Background:

- Currently retired or disabled state, K-12, and higher education employees are eligible for continuation of coverage under the Public Employees' Benefits Board insurance programs.
- Retired LEOFF Plan 2 employees may be eligible to continue in insurance programs offered by their employers (if available), through labor or employer organizations, through the purchase of individual health care policy, or through public programs such as Medicare and COBRA.

Summary of Bill:

HB 2162 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 also would have 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. Members who were retired or are close to retirement would pay less cumulative dollars for the same benefits as a member just starting in his or her career. In addition to the basic cost of benefits, the contributions and premiums would have been 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.

Fiscal Note: Available

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

BILL SUMMARY
SB 5781

Title: Authorizing retired local government employees to receive benefits from the public employees' benefits board.

Sponsors: Senators Fraser, Benton, Pflug, Regala, Zarelli, Rasmussen, Keiser, Kline, Haugen, Roach, Prentice, Jacobsen, Kohl-Welles

Legislative History: 2005 Regular Session -- Feb 7, First reading, referred to Ways & Means.

Brief Summary of Bill:

- Creates a definition of "retired local government employee".
- Provides retired local government employees with access to retiree health care coverage through the Public Employee Benefit Board (PEBB) in the community-rate risk pool along with retired and disabled state, K-12, and higher education members.

Background:

- Currently retired or disabled state, K-12, and higher education employees are eligible for continuation of coverage under the Public Employees' Benefits Board insurance programs.
- Retired or disabled county, municipality, or other political subdivision PERS Plan 1 and PERS Plan 2 employees, and their dependents, are eligible to continue in insurance programs offered by their employers (if available).
- Separated county, municipality, or other political subdivision PERS Plan 3 employees who are at least age 55 and have at least 10 years of service are eligible to continue in insurance programs offered by their employers (if available).

Summary of Bill:

Senate Bill 5781 would have provided access to health benefits for "retired local government employees" of the Public Employees' Retirement System (PERS) Plan 1, 2, or 3. The bill defines a "retired local government employee" to mean:

- Persons who separated from employment with a county, municipality, or other political subdivision of the state and are receiving a retirement allowance from PERS as of July 1, 2005;
- Persons who separate from employment with a county, municipality, or other political subdivision of the state on or after July 1, 2005, and immediately upon separation receive a retirement allowance from PERS; or

- Members of PERS Plan 3 who are at least fifty-five years of age and who have at least ten years of service credit and who separate from employment with a county, municipality, or other political subdivision of the state on or after July 1, 2005, and immediately upon separation elect to continue health insurance coverage with their employer or coverage provided by the public employees' benefits board.

The local government employers would have been required to remit the cost of premium subsidies (explicit and implicit) to the Health Care Authority.

The bill 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.

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 retired local government employee 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 retired local government employees in the non-Medicare 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.

Fiscal Note: Available

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