Catastrophic Disability Retirement Medical Insurance

Preliminary Report

LEOFF Plan 2 Retirement Board

December 17, 2008

Issue

- Members who suffer catastrophic duty-related disabilities may not have access to health care insurance

Background

- Limited employer sponsored retiree coverage
- Coverage through other programs
- Confusing State/Federal regulations, critical timelines, and providers
- Protections can be missed/lost

Follow-Up Issue

- Dependent Coverage
  - Workers' Compensation – No (Worker Only)
  - COBRA – Yes ("Qualified Beneficiary")
  - WSHIP – Yes (Dependent Children)

Follow-Up Issues

- Overlapping Coverage
  - Workers' Compensation –Injury Cost Only
  - COBRA – Secondary Payer
  - WSHIP – Last Payer of Benefits

Option 1

- Pay for catastrophic disability retiree health care insurance from pension fund
  - Access to PEBB health care insurance for member and family
  - PEBB health care insurance costs paid from L2 pension fund

- Cost: Employee 0.25%
  Employer 0.15%
  State 0.10%

Catastrophic Disability
Retirement Medical Insurance

Questions?

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

Catastrophic Disability Retirement Medical Insurance

Preliminary Report

December 17, 2008

1. Issue

Members who suffer catastrophic duty-related disabilities may not have access to health care insurance.

2. Staff

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3. Members Impacted

This issue could affect all 16,099 active members and four of the 924 retirees and members with total disabilities incurred in the line of duty.

4. Current Situation

A catastrophic disability benefit is established for a member who is totally disabled in the line of duty. The combined benefits from LEOFF Plan 2, Social Security disability, and Workers' Compensation cannot exceed 100% of the member's final average salary. Any amount that exceeds 100% will be offset from the LEOFF Plan 2 benefit. The LEOFF Plan 2 benefit cannot be offset below the member's accrued retirement benefit. LEOFF Plan 2 may pay a benefit up to 70% of final average salary. A member receiving a catastrophic disability benefit will be required to submit necessary financial documents reporting any earnings from employment, payments from Social Security disability and payments from Workers' Compensation.

LEOFF Plan 2 does not provide access to or pay for any health care insurance for any disability retirees. A disability retiree may have access to health care insurance through their employer, union or associations, or the open market. LEOFF Plan 2 does pay for PEBB benefits for survivors of members that were killed in the course of employment.

5. Background Information and Policy Issues

The purpose of a disability retirement benefit is to replace a portion of income for a retiree who cannot work because of a job-related injury or illness, which is expected to be permanent or to last indefinitely. The cost of living for people with disabilities is generally higher than for most due to higher medical costs, paying for disability aids and home adaptations, the cost of transport, help with care and higher costs on day to day living. Extensive medical bills are the top reason for personal bankruptcies, accounting for about half of all cases filed in the United States.

LEOFF Plan 2 members who are catastrophically disabled may lose employer sponsored health care insurance. According to the 2005 Employer Survey conducted by the Board, only 46.8% of LEOFF 2 members have access to employer sponsored retirement health care. Those without employer-sponsored health care access must rely upon coverage that may be available through Workers' Compensation and COBRA. After that an individual may seek to purchase an individual health care policy or qualify for the state high risk pool.

The varying programs require disabled members, or those assisting them, to navigate a confusing minefield of State/Federal regulations, critical timelines, and providers. Important protections can be lost if appropriate and timely actions are not taken. This report identifies and explains some of the areas of complexity that catastrophically disabled members face in seeking health care insurance.

Catastrophic Disability

Legislation enacted in 2006 created the Catastrophic Duty Disability Benefit. This legislation created a disability allowance equal to 70 percent of final average salary, which receives favorable tax treatment and is not actuarially reduced for early retirement, for a LEOFF Plan 2 member who is catastrophically disabled in the course of employment.

A catastrophic disability is defined as a member's inability to perform any substantial gainful activity due to a physical or mental condition that may be expected to result in death or last for at least 12 months. Substantial gainful activity is defined as average earnings of more than $940 per month (2008), adjusted annually based on Federal Social Security standards.

The total disability benefit is reduced to the extent that in combination with certain workers' compensation payments and Social Security disability benefits, the disabled member would not receive more than 100 percent of final average salary.

Workers' Compensation Benefits

If a worker is injured on the job and files a workers' compensation claim which is approved, Labor and Industries (L&I) or the Self Insured employer will cover medical bills directly related to the injury. This coverage may continue until a doctor certifies that the injury has stabilized and reached a point where further recovery is not expected. If the member qualifies, they will be awarded a Workers' Compensation disability pension.

Coverage for medical treatment ends on the date that a workers' compensation pension goes into effect. An exception is made in some cases where continued treatment is needed to protect an injured worker's life. If this kind of discretionary coverage is approved, a statement of the coverage limits will be included on the notice of the pension award. There is also no provision in the law for providing medical coverage for dependents through workers' compensation.

If objective medical evidence shows the condition caused by the injury or disease has worsened and requires additional health care attention, the claim may be reopened. If applying for medical coverage only, the request can be made at any time. In most cases, a decision will be made within 90 days.

COBRA Benefits

At the point which medical coverage under Workers' Compensation ends and employer sponsored health insurance coverage ends COBRA (Consolidated Omnibus Budget Reconciliation Act) is usually the next alternative for continuing health care coverage.

COBRA is a federal law that allows individuals working in companies of 20 or more employees to continue their health insurance benefits for up to 18 months after their employment terminates for any reason, excluding gross misconduct. During the time that an individual is covered by COBRA, they are responsible for paying 102 percent of the total health insurance premium, including any portion of the premium that may have been paid by the employer. If an individual has a Social Security-approved disability (Appendix A) that started within 60 days of when COBRA benefits were elected, the individual is then eligible to use OBRA (see below) to continue health insurance benefits for an additional 11 months, for a total of 29 months.

OBRA

OBRA is a federal law that allows individuals to extend their COBRA coverage for an additional 11 months. Only individuals who elected to use COBRA because of a Social Security approved disability are eligible for OBRA. During the time that an individual is covered by OBRA, they are responsible for paying 150 percent of the total health insurance premium, including any portion of the premium that may have been paid by the employer. If still disabled once OBRA coverage expires, the individual will be eligible for Medicare, which provides health coverage for people who have been disabled for 29 months and are approved for Social Security.

Individual Health Care Coverage

After COBRA coverage is exhausted, an individual may need to shop for individual health care coverage. Common concerns under the circumstance of catastrophic disability are the ability to obtain health care coverage in light of certain pre-existing conditions. Both Federal and State laws ensure that individuals, such as catastrophically disabled members, will have

reasonable access to health care coverage. The process usually starts with the Standard Health Questionnaire.

Standard Health Questionnaire

Most people buying individual health insurance in Washington state need to complete a standardized health screen questionnaire. This questionnaire identifies eligibility for the Washington State Health Insurance Pool (WSHIP) (Appendix B). If an individual fails the questionnaire, they automatically qualify for WSHIP. Premiums for WSHIP coverage are higher than commercial health plans. However, WSHIP offers some high deductible plan options with lower premiums.

There are several exemptions where the standard health questionnaire does not have to be completed. An individual is *not* required to fill out the health screen questionnaire when applying for individual insurance if they:

- will exhaust COBRA coverage or will lose it because the former employer closed its business.
- have 24 months of continuous coverage through a small employer.
- have moved out of the individual's existing plan's service area within Washington state.
- are staying with a primary care doctor who left the individual's existing plan.
- are losing coverage with the state Basic Health Plan and have 24 months of continuous coverage under the plan.
- have received a notice about the discontinuation of your conversion plan. This is a limited benefit policy an individual may have a right to convert to after their group insurance ends.
- are adding a newborn or newly adopted or soon-to-be adopted child to the health plan.

In the case where an individual exhausts COBRA coverage and is seeking an individual health benefit plan, the provider *must* accept the application for coverage (guaranteed issuance)[1].

Pre-existing Conditions

A "preexisting condition exclusion" is a limitation or exclusion of health benefits based on the fact that a physical or mental condition was present before the first day of coverage. However, the Health Insurance Portability and Accountability Act (HIPAA) (Appendix C) limits the extent to which a plan or issuer can apply a pre-existing condition exclusion.

A pre-existing condition exclusion is limited to a physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 month period ending on the enrollment date in a plan or policy.

[1] RCW 48.43.018(1)(c)

During the pre-existing condition exclusion period, the plan or issuer may opt not to cover or pay for treatment of a medical condition based on the fact that the condition was present prior to an individual's enrollment date under the new plan or policy. (The plan or insurer must, however, pay for any *unrelated* covered services or conditions that arise once coverage has begun.) The enrollment date is the first day of coverage, or if there is a waiting period before coverage takes effect, the first day of the waiting period.

The HIPAA limitation is usually referred to as "Creditable Coverage" and is discussed in more detail in the next section.

Creditable Coverage

The concept of creditable coverage is that an individual is given credit for previous health coverage against the application of a pre-existing condition exclusion period when moving from one group health plan to another, from a group health plan to an individual policy, or from an individual policy to a group health plan.

An individual will receive credit for previous coverage that occurred *without a break of 63 days or more*. However, any coverage occurring prior to a break in coverage of 63 days or more would not have to be credited against a pre-existing condition exclusion period.

For example, if an individual had nine months of coverage under a prior plan, an insurance company with a 9 month pre-existing condition exclusion would waive your waiting period. If the individual had four months prior coverage, they would have to wait five months for the new insurance to cover a pre-existing condition.

Most health coverage is creditable coverage, including prior coverage under:

- a group health plan (including a governmental or church plan)
- health insurance coverage (either group or individual)
- Medicare
- Medicaid
- military-sponsored health care program such as CHAMPUS
- a program of the Indian Health Service
- a State high risk pool
- the Federal Employees Health Benefit Program
- a public health plan established or maintained by a State or local government and
- a health benefit plan provided for Peace Corps members.

Follow-Up Issues

Additional information was requested regarding dependent coverage and the coordination of benefits that overlap with the various benefit programs a member may utilize. The following addresses dependent coverage and treatment of overlapping coverage with respect to Workers' Compensation, COBRA, and Washington State Health Insurance Pool.

Dependent Coverage

Workers' Compensation

Workers' Compensation benefits do not provide any medical insurance benefits to dependents of an injured worker. Workers' Compensation medical insurance will only pay for claims directly related to the worker's injury.

COBRA

Qualified beneficiaries must be given an election period during which each qualified beneficiary may choose whether to elect COBRA coverage. Each qualified beneficiary may independently elect COBRA coverage. A covered employee or the covered employee's spouse may elect COBRA coverage on behalf of all other qualified beneficiaries.

Qualified beneficiaries must be offered coverage identical to that available to similarly situated beneficiaries who are not receiving COBRA coverage under the plan (generally, the same coverage that the qualified beneficiary had immediately before qualifying for continuation coverage). A change in the benefits under the plan for the active employees will also apply to qualified beneficiaries. Qualified beneficiaries must be allowed to make the same choices given to non-COBRA beneficiaries under the plan, such as during periods of open enrollment by the plan.

A qualified beneficiary generally is an individual covered by a group health plan on the day before a qualifying event who is an employee, the employee's spouse, or an employee's dependent child. In certain cases, a retired employee, the retired employee's spouse, and the retired employee's dependent children may be qualified beneficiaries. In addition, any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary. Agents, independent contractors, and directors who participate in the group health plan may also be qualified beneficiaries.

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 the health coverage to them under COBRA. A plan, at its discretion, may provide longer periods of continuation coverage.

Qualifying Events for Spouses:

- Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct
- Reduction in the hours worked by the covered employee
- Covered employee's becoming entitled to Medicare
- Divorce or legal separation of the covered employee
- Death of the covered employee

Qualifying Events for Dependent Children:

- Loss of dependent child 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 by the covered employee
- Covered employee's becoming entitled to Medicare
- Divorce or legal separation of the covered employee
- Death of the covered employee

Washington State Health Insurance Pool (WSHIP)

Coverage for Dependent Children is available under a separate policy. Coverage may be obtained for Dependent Children at the time of application for coverage or after coverage begins any time a qualifying event occurs. A qualifying event is limited to the birth or adoption of a Dependent Child or a Dependent Child's loss of health insurance coverage due to a parent's loss of such coverage. The Dependent Child must meet the eligibility requirements for coverage and benefits are subject to payment of the applicable premium and all other provisions of the applicable policy. Coverage will include the necessary care and Treatment of medically diagnosed congenital defects and birth abnormalities.

For a Dependent Child who lost coverage under a parent's policy, coverage will begin on the first day of the month following receipt of complete enrollment information and premium payment. A newborn or adopted Dependent Child will be covered automatically for 31 days from the moment of birth for a newborn or placement in the home for an adopted Dependent Child. Coverage after the 31st day will be under the policy applicable to the Dependent Child and is subject to receipt within the 31-day period of: (1) written notification of the birth or adoption; (2) enrollment information for the child; and (3) the applicable premium.

A child is deemed adopted when the child is physically placed, for the purpose of adoption under the laws of the state, in the parent's custody and financial responsibility is assumed for the medical expenses of the child. Evidence of adoption will be required as a condition of enrollment of the child. The Dependent Child's coverage will terminate upon attainment of age 19, except that coverage may be continued beyond age 19 while the Dependent Child is:

1. incapable of self-sustaining employment by reason of developmental disability or physical handicap; and
2. chiefly dependent upon the parent for support and maintenance, provided that proof of such incapacity and dependence is furnished to Us within 31 days of the Dependent Child's 19th birthday.

Proof may be required of continuing incapacity and dependence from time to time, but not more often than annually after the two-year period following the Dependent Child's 19th birthday.

If death occurs during the Policy period and there are Dependent Children covered, those Dependent Children may elect, if such election is done in writing within 30 days of the date of the parents death, to continue coverage.

Overlapping Medical Insurance Coverage

Workers' Compensation

Workers' Compensation medical insurance will pay for claims directly related to the worker's injury on a first payer basis. Any medical insurance claims not related to the injury will not be paid by Workers' Compensation and may be paid by other coverage which the worker may have.

COBRA

An individual who is covered under another group health plan or who is entitled to Medicare may elect and retain COBRA continuation coverage for the maximum period of coverage if the other group health plan coverage or Medicare entitlement begins on or before the date on which the individual elects COBRA continuation coverage.

Also, if other group health plan coverage begins after the date on which the individual elects COBRA continuation coverage, the individual is entitled to retain COBRA coverage for the maximum period if under the other group health plan coverage the individual is subject to any exclusion or limitation with respect to any pre-existing condition.

Washington State Health Insurance Pool

The WSHIP is the last payer of benefits whenever any other benefit is available, even if a claim for such benefits is not properly submitted or pursued. Benefits otherwise payable under WSHIP are reduced by all amounts paid or payable for health care through any other insurance, health insurance or health benefit plans, including but not limited to self-insured plans and by all Hospital and medical expense benefits paid or payable under any workers compensation coverage, automobile medical payment or liability insurance (including Personal Injury Protection coverage and Uninsured/Underinsured Motorist coverage), and any Hospital or medical benefit paid or payable under or provided pursuant to any state or federal law or program.

6. Policy Options

Policy Option 1: Pay for catastrophic disability retiree health care insurance from pension fund.

This option would provide Catastrophic Disability Retirees with paid health care insurance from the Public Employees' Benefit Board (PEBB). The health care insurance cost would be paid for from the LEOFF Plan 2 pension fund. Under this option, only the costs of the PEBB health care insurance will be paid; Costs for health insurance from other sources will not be paid. This option would include all (4) Catastrophic Disability retirees covered by the 2006 legislation and any future Catastrophic Disability Retirees.

7. Supporting Information

Appendix A: Social Security Disability and Medicare

Appendix B: Washington State Health Insurance Pool

Appendix C: HIPPA – Title 1

Appendix D: Insurance Commissioner Publications

Appendix A:

Social Security

The Social Security Administration (SSA) oversees two programs that pay disability income benefits to individuals who are legal United States residents, Social Security Disability Insurance (SSDI) and SSI.

Social Security Disability Insurance (SSDI) provides a benefit based on an individual's FICA contributions. This program requires that an individual pay into Social Security for at least 20 of the last 40 quarters (five of the last 10 years) for individuals age 31 or older. SSDI requires a full and unpaid five-month waiting period. Eligibility begins in the sixth month, and payment is received at the beginning of the seventh month to cover the previous month. This program has no asset limits and is solely based on contributions to FICA and medical eligibility.

Supplemental Security Income (SSI) provides a minimum monthly income for those without other resources. To receive SSI an individual must apply for other disability benefits if eligible, such as SSDI. Assets must add up to $2,000 or less. However, assets may include an individual's home as long as they live in it, and may include a car as long as it is valued at or below $4,500. The value of the car can be above $4,500 if it is used to get to and from medical appointments. An individual should apply for SSI as soon as possible after becoming disabled so as to establish an "onset date" and to start an application. Social Security's Definition of Disability is defined as a physical or emotional impairment which is severe enough to keep a person from doing work for a continuous period of not less than 12 months or which can be expected to result in death.

Medicare

Medicare provides health coverage for people who qualify for Social Security. Most people become eligible when they reach the age of 65, or if they have been disabled for 29 months. Medicare covers hospitalization, skilled nursing, home health and hospice care, but requires certain deductibles, premiums and co-payments. If receiving outpatient care, Medicare will cover 80 percent of allowable outpatient medical services after a $100 deductible. The individual is responsible for 20 percent of the charge, regardless of the cost. Medicare does not cover outpatient prescription drugs unless they are administered in a doctor's office or an outpatient clinic. Because of this, many patients choose to enroll in Medicare HMOs or to buy relatively inexpensive private health insurance supplements to reduce their out-of-pocket costs.

Appendix B:

Washington State Health Insurance Pool (WSHIP)

The Washington State Health Insurance Pool (WSHIP) was created by the Washington State Legislature to provide access to health insurance coverage to all residents of the state who are denied individual health insurance. To be eligible for WSHIP, an individual must be a resident of Washington state; must have been rejected for coverage by an insurance carrier based upon the results of the Standard Health Questionnaire, or live in a Washington state county where individual health benefit plans are not offered; and must not be eligible for Medicare coverage.

WSHIP provides comprehensive coverage, including a prescription drug benefit. WSHIP bases premiums on age and type of plan selected. WSHIP provides some discount rates to people age 50-64 with low income, people continuously insured with their previous plan, and people who have been in WSHIP for more than three years.

WSHIP bases premiums on age and type of plan selected. Premiums for WSHIP coverage are higher than commercial health plans. However, WSHIP offers some high deductible plan options with lower premiums. There are two WSHIP options available for people who are not on Medicare:

- ✓ **The Standard Plan (Plan 1)**, which is fee-for-service, allows individuals to go to the doctor of their choice.
- ✓ **The Network Plan (Plan 3)** uses providers from the First Choice network.

WSHIP also has a separate plan that is only available for people on Medicare (the Basic Plan.) This plan has different eligibility criteria. WSHIP provides some discount rates to people with low income, people continuously insured with their previous plan, and people who have been in WSHIP for more than three years.

Appendix C:

HIPAA Title I: Health Care Access, Portability, and Renewability[2]

Title I of HIPAA regulates the availability and breadth of group health plans and certain individual health insurance policies. It amended the Employee Retirement Income Security Act, the Public Health Service Act, and the Internal Revenue Code.

Title I also limits restrictions that a group health plan can place on benefits for preexisting conditions. Group health plans may refuse to provide benefits relating to preexisting conditions for a period of 12 months after enrollment in the plan or 18 months in the case of late enrollment.[a] However, individuals may reduce this exclusion period if they had group health plan coverage or health insurance prior to enrolling in the plan. Title I allows individuals to reduce the exclusion period by the amount of time that they had "creditable coverage" prior to enrolling in the plan and after any "significant breaks" in coverage.[b] "Creditable coverage" is defined quite broadly and includes nearly all group and individual health plans, Medicare, and Medicaid.[c] A "significant break" in coverage is defined as any 63 day period without any creditable coverage.[d]

Some health care plans are exempted from Title I requirements, such as long-term health plans and limited-scope plans such as dental or vision plans that are offered separately from the general health plan. However, if such benefits are part of the general health plan, then HIPAA still applies to such benefits. For example, if the new plan offers dental benefits, then it must count creditable continuous coverage under the old health plan towards any of its exclusion periods for dental benefits.

However, an alternate method of calculating creditable continuous coverage is available to the health plan under Title I. That is, 5 categories of health coverage can be considered separately, including dental and vision coverage. Anything not under those 5 categories must use the general calculation (e.g., the beneficiary may be counted with 18 months of general coverage, but only 6 months of dental coverage, because the beneficiary did not have a general health plan that covered dental until 6 months prior to the application date). Unfortunately, since limited-coverage plans are exempt from HIPAA requirements, the odd case exists in which the applicant to a general group health plan cannot obtain certificates of creditable continuous coverage for independent limited-scope plans such as dental to apply towards exclusion periods of the new plan that does include those coverages.

Hidden exclusion periods are not valid under Title I (e.g., "The accident, to be covered, must have occurred while the beneficiary was covered under this exact same health insurance contract." Such clauses must not be acted upon by the health plan and also must be re-written so that they comply with HIPAA.

To illustrate, suppose someone enrolls in a group health plan on January 1, 2006. This person had previously been insured from January 1, 2004 until February 1, 2005 and from August 1,

[2] http://en.wikipedia.org/wiki/HIPAA, 10/7/08

2005 until December 31, 2005. To determine how much coverage can be credited against the exclusion period in the new plan, start at the enrollment date and count backwards until you reach a significant break in coverage. So, the five months of coverage between August 1, 2005 and December 31, 2005 clearly counts against the exclusion period. But the period without insurance between February 1, 2005 and August 1, 2005 is greater than 63 days. Thus, this is a significant break in coverage, and any coverage prior to it cannot be deducted from the exclusion period. So, this person could deduct five months from his or her exclusion period, reducing the exclusion period to seven months. Hence, Title I requires that any preexisting condition begin to be covered on August 1, 2006.

a) 29 U.S.C. § 1181(a)(2)
b) 29 U.S.C. § 1181(a)(3)
c) 29 U.S.C. § 1181(c)(1)
d) 29 U.S.C. § 1181(c)(2)(A)

Appendix D:

Insurance Commissioner Publications

Health Insurance: Frequently Asked Questions
http://www.insurance.wa.gov/publications/health/health_insurance_faq.pdf

Shopping for individual health care coverage
http://www.insurance.wa.gov/publications/health/individual_health_care_coverage.pdf

A consumers guide to health care coverage
http://www.insurance.wa.gov/publications/health/consumers_guide_health_care.pdf

Losing your employer-sponsored health insurance
http://www.insurance.wa.gov/publications/shiba_helpline/Losing_employer_insurance.pdf

Your rights under COBRA
http://www.insurance.wa.gov/publications/health/cobra.pdf

Catastrophic Disability Medical Insurance Bill Draft

(Amending RCW 41.26.470, RCW 41.05.080, RCW 41.05.195)

Sec. 1. RCW 41.26.470 Earned disability allowance — Cancellation of allowance — Reentry — Receipt of service credit while disabled — Conditions — Disposition upon death of recipient — Disabled in the line of duty — Total disability.

(1) A member of the retirement system who becomes totally incapacitated for continued employment by an employer as determined by the director shall be eligible to receive an allowance under the provisions of RCW 41.26.410 through 41.26.550. Such member shall receive a monthly disability allowance computed as provided for in RCW 41.26.420 and shall have such allowance actuarially reduced to reflect the difference in the number of years between age at disability and the attainment of age fifty-three, except under subsection (7) of this section.

(2) Any member who receives an allowance under the provisions of this section shall be subject to such comprehensive medical examinations as required by the department. If such medical examinations reveal that such a member has recovered from the incapacitating disability and the member is no longer entitled to benefits under Title 51 RCW, the retirement allowance shall be canceled and the member shall be restored to duty in the same civil service rank, if any, held by the member at the time of retirement or, if unable to perform the duties of the rank, then, at the member's request, in such other like or lesser rank as may be or become open and available, the duties of which the member is then able to perform. In no event shall a member previously drawing a disability allowance be returned or be restored to duty at a salary or rate of pay less than the current salary attached to the rank or position held by the member at the date of the retirement for disability. If the department determines that the member is

able to return to service, the member is entitled to notice and a hearing. Both the notice and the hearing shall comply with the requirements of chapter 34.05 RCW, the Administrative Procedure Act.

(3) Those members subject to this chapter who became disabled in the line of duty on or after July 23, 1989, and who receive benefits under RCW 41.04.500 through 41.04.530 or similar benefits under RCW 41.04.535 shall receive or continue to receive service credit subject to the following:

(a) No member may receive more than one month's service credit in a calendar month.

(b) No service credit under this section may be allowed after a member separates or is separated without leave of absence.

(c) Employer contributions shall be paid by the employer at the rate in effect for the period of the service credited.

(d) Employee contributions shall be collected by the employer and paid to the department at the rate in effect for the period of service credited.

(e) State contributions shall be as provided in RCW 41.45.060 and 41.45.067.

(f) Contributions shall be based on the regular compensation which the member would have received had the disability not occurred.

(g) The service and compensation credit under this section shall be granted for a period not to exceed six consecutive months.

(h) Should the legislature revoke the service credit authorized under this section or repeal this section, no affected employee is entitled to receive the credit as a matter of contractual right.

(4)(a) If the recipient of a monthly retirement allowance under this section dies before the total of the retirement allowance paid to the recipient equals the amount of the accumulated contributions at the date of retirement, then the balance shall be paid to the member's estate, or such person or persons, trust, or organization as the recipient has nominated by written designation duly executed and filed with the director, or, if there is no such designated person or persons still living at the time of the recipient's death, then to the surviving spouse, or, if there is neither such designated person or persons still living at the time of his or her death nor a surviving spouse, then to his or her legal representative.

(b) If a recipient of a monthly retirement allowance under this section died before April 27, 1989, and before the total of the retirement allowance paid to the recipient equaled the amount of his or her accumulated contributions at the date of retirement, then the department shall pay the balance of the accumulated contributions to the member's surviving spouse or, if there is no surviving spouse, then in equal shares to the member's children. If there is no surviving spouse or children, the department shall retain the contributions.

(5) Should the disability retirement allowance of any disability beneficiary be canceled for any cause other than reentrance into service or retirement for service, he or she shall be paid the excess, if any, of the accumulated contributions at the time of retirement over all payments made on his or her behalf under this chapter.

(6) A member who becomes disabled in the line of duty, and who ceases to be an employee of an employer except by service or disability retirement, may request a refund of one hundred fifty percent of the member's accumulated contributions. Any accumulated contributions attributable to restorations made under RCW 41.50.165(2) shall be refunded at one hundred percent. A person in receipt of this benefit is a retiree.

(7) A member who becomes disabled in the line of duty shall be entitled to receive a minimum retirement allowance equal to ten percent of such member's final average salary. The member shall additionally receive a retirement allowance equal to two percent of such member's average final salary for each year of service beyond five.

(8) A member who is totally disabled in the line of duty is entitled to receive a retirement allowance equal to seventy percent of the member's final average salary. The allowance provided under this subsection shall be offset by:

(a) Temporary disability wage-replacement benefits or permanent total disability benefits provided to the member under Title 51 RCW; and

(b) Federal social security disability benefits, if any; so that such an allowance does not result in the member receiving combined benefits that exceed one hundred percent of the member's final average salary. However, the offsets shall not in any case reduce the allowance provided under this subsection below the member's accrued retirement allowance.

A member is considered totally disabled if he or she is unable to perform any substantial gainful activity due to a physical or mental condition that may be expected to result in death or that has lasted or is expected to last at least twelve months. Substantial gainful activity is

defined as average earnings in excess of eight hundred sixty dollars a month in 2006 adjusted annually as determined by the director based on federal social security disability standards. The department may require a person in receipt of an allowance under this subsection to provide any financial records that are necessary to determine continued eligibility for such an allowance. A person in receipt of an allowance under this subsection whose earnings exceed the threshold for substantial gainful activity shall have their benefit converted to a line-of-duty disability retirement allowance as provided in subsection (7) of this section.

Any person in receipt of an allowance under the provisions of this section is subject to comprehensive medical examinations as may be required by the department under subsection (2) of this section in order to determine continued eligibility for such an allowance.

A retirement allowance provided under the provisions of this section shall include reimbursement for any payments of premium rates to the Washington state health care authority pursuant to RCW 41.05.080.

Sec. 2. RCW 41.05.080 Participation in insurance plans and contracts — Retired, disabled, or separated employees — Certain surviving spouses and dependent children. (Effective January 1, 2009.)

(1) Under the qualifications, terms, conditions, and benefits set by the board:

(a) Retired or disabled state employees, retired or disabled school employees, retired or disabled employees of county, municipal, or other political subdivisions, or retired or disabled employees of tribal governments covered by this chapter may continue their participation in insurance plans and contracts after retirement or disablement;

(b) Separated employees may continue their participation in insurance plans and contracts if participation is selected immediately upon separation from employment;

(c) Surviving spouses and dependent children of emergency service personnel killed in the line of duty and surviving spouses and dependent children of Law Enforcement Officers and Fire Fighters who are totally disabled in the line of duty and receiving a retirement allowance as provided under RCW 41.26.470(8) may participate in ((~~insurance plans and contracts~~)) health insurance.

(d) Law Enforcement Officers' and Fire Fighters' who are totally disabled in the line of duty and receiving a retirement allowance as provided under RCW 41.26.470(8) and their dependents may participate in health insurance.

(2) Rates charged surviving spouses of emergency service personnel killed in the line of duty, Law Enforcement Officers' and Fire Fighters' who are totally disabled in the line of duty and receiving a retirement allowance as provided under RCW 41.26.470(8) and their dependents, retired or disabled employees, separated employees, spouses, or dependent children who are not eligible for parts A and B of medicare shall be based on the experience of the community rated risk pool established under RCW 41.05.022.

(3) Rates charged to surviving spouses of emergency service personnel killed in the line of duty, Law Enforcement Officers' and Fire Fighters' who are totally disabled in the line of duty and receiving a retirement allowance as provided under RCW 41.26.470(8) and their dependents, retired or disabled employees, separated employees, spouses, or children who are eligible for parts A and B of medicare shall be calculated from a separate experience risk pool

comprised only of individuals eligible for parts A and B of medicare; however, the premiums charged to medicare-eligible retirees and disabled employees shall be reduced by the amount of the subsidy provided under RCW 41.05.085.

(4) Surviving spouses and dependent children of emergency service personnel killed in the line of duty, Law Enforcement Officers' and Fire Fighters' who are totally disabled in the line of duty and receiving a retirement allowance as provided under RCW 41.26.470(8) and their dependents, and retired or disabled and separated employees shall be responsible for payment of premium rates developed by the authority which shall include the cost to the authority of providing ((~~insurance coverage~~)) health insurance including any amounts necessary for reserves and administration in accordance with this chapter. These self pay rates will be established based on a separate rate for the employee, the spouse, and the children.

(5) The term "retired state employees" for the purpose of this section shall include but not be limited to members of the legislature whether voluntarily or involuntarily leaving state office.

Sec. 3. RCW 41.05.195 Medicare supplemental insurance policies. (Effective January 1, 2009.)

Notwithstanding any other provisions of this chapter or rules or procedures adopted by the authority, the authority shall make available to retired or disabled employees who are enrolled in parts A and B of medicare one or more medicare supplemental insurance policies that conform to the requirements of chapter 48.66 RCW. The policies shall be chosen in consultation with the public employees' benefits board. These policies shall be made available to retired or

disabled state employees; retired or disabled school district employees; retired employees of county, municipal, or other political subdivisions or retired employees of tribal governments eligible for coverage available under the authority; or surviving spouses of emergency service personnel killed in the line of duty((.)); or Law Enforcement Officers' and Fire Fighters' who are totally disabled in the line of duty and receiving a retirement allowance as provided under RCW 41.26.470(8) or their dependents.

DRAFT
ACTUARY'S FISCAL NOTE

RESPONDING AGENCY:	CODE:	DATE:	PROPOSAL [NAME or Z-NUMBER]:
Office of the State Actuary	**035**	**12/03/08**	**LEOFF 2 Catastrophic Disability Retirement Medical Insurance**

WHAT THE READER SHOULD KNOW

The Office of the State Actuary ("we") prepared this draft fiscal note based on our understanding of the proposal as of the date shown above. We intend this draft fiscal note to be used by the Law Enforcement Officers' and Fire Fighters' (LEOFF) Retirement System Plan 2 Board throughout the 2008 Interim only. If a legislator introduces this proposal as a bill during the next legislative session, we will prepare a final fiscal note based on that bill language. The actuarial results shown in this draft fiscal note may change when we prepare our final version for the Legislature.

We advise readers of this draft fiscal note to seek professional guidance as to its content and interpretation, and not to rely upon this communication without such guidance. Please read the analysis shown in this draft fiscal note as a whole. Distribution of or reliance on only parts of this draft fiscal note could result in its misuse, and may mislead others.

SUMMARY OF RESULTS

This proposal would expand eligibility for insurance plans and contracts offered by the Public Employees' Benefits Board (PEBB) to LEOFF Plan 2 retirees who were totally disabled in the line of duty and are receiving a monthly retirement benefit. The retirees' monthly benefit would be increased to reimburse the cost of the insurance premiums.

Impact on Pension Liability

(Dollars in Millions)	Current	Increase	Total
Today's Value of All Future Pensions	$6,149	$76.7	$6,226
Earned Pensions Not Covered by Today's Assets	($974)	$40.8	($933)

Impact on Contribution Rates: (Effective 9/1/2009)

2009-2011 State Budget	LEOFF
Employee (Plan 2)	0.25%
Employer:	
Current Annual Cost	0.15%
State	0.10%

Budget Impacts

(Dollars in Millions)	2009-2011	2011-2013	25-Year
General Fund-State	$2.9	$3.3	$60.6
Total Employer	$7.1	$8.2	$151.6

See the Actuarial Results section of this draft fiscal note for additional detail. See the OPEB attachment of the final fiscal note for the impact to the GASB 45 liability.

WHAT IS THE PROPOSED CHANGE?

Summary Of Benefit Improvement

This proposal impacts the LEOFF Plan 2 by expanding the eligibility for insurance plans or contracts offered by the PEBB to retirees of LEOFF Plan 2 who were totally disabled in the line of duty and are receiving a retirement allowance under RCW 41.26.470(8). The monthly benefit provided to these retirees would be increased to reimburse the full cost of the premiums paid to the Health Care Authority.

Assumed Effective Date: 90 days after session.

What Is The Current Situation?

Members of LEOFF Plan 2 who participate in PEBB offered insurance plans or contracts as active members can purchase insurance from the PEBB when they retire. The retirees pay the necessary premiums. Members of LEOFF Plan 2 who don't participate in PEBB offered insurance plans or contracts as active members cannot purchase insurance from the PEBB as retirees. They must purchase retiree health insurance on their own, or through their former employer, if retiree coverage is offered.

Who Is Impacted And How?

We estimate this proposal could affect all 16,099 active members and four of the 924 retirees and members with total disabilities incurred in the line of duty of LEOFF Plan 2 through improved benefits. Furthermore, we expect approximately 16 members per year will actually receive improved benefits.

We estimate this proposal will increase the benefits for a typical member by the cost of a family premium in a PEBB health plan. In 2007, the monthly cost of a family in Regence Classic was $1,386.55 before age 65 and $1,089.53 after age 65 for medical insurance. In addition, the Regence BlueShield dental plan costs an additional $136.89 per month for dental coverage.

WHY THIS PROPOSL HAS A COST AND WHO PAYS FOR IT

Why This Proposal Has A Cost

This proposal has a cost because the pension system pays for the PEBB premiums of the members affected.

Who Will Pay For These Costs?

These costs will be paid under the standard LEOFF Plan 2 funding method through increased contribution rates for the members, employers, and the state.

HOW WE VALUED THESE COSTS

Assumptions We Made

We assumed that members affected by this bill would select the most expensive PEBB coverage. In addition we assume the member would elect to cover themselves and a spouse for the member's entire life, as well as children for the first ten years after becoming totally disabled. For more detail please see Appendix A.

How We Applied These Assumptions

There are currently four members (retirees) who qualify for this proposal. In addition current active members will become eligible in the future. For active members we assumed a rate of total disablement in the future.

After members incur a total disablement in the line of duty, we value both active and inactive members the same way. We value them by calculating the cost of PEBB premiums over their future lifetimes. For more detail please see Appendix B.

Special Data Needed

The Department of Retirement Systems identified the four members who currently qualify for benefits under this proposal.

We developed these costs using the same assets and data as disclosed in the 2007 Actuarial Valuation Report (AVR).

ACTUARIAL RESULTS

How The Liabilities Changed

This proposal will impact the actuarial funding of LEOFF Plan 2 by increasing the present value of future benefits payable under the system as shown below.

	Impact on Pension Liability		
(Dollars in Millions)	**Current**	**Increase**	**Total**
Actuarial Present Value of Projected Benefits *(The Value of the Total Commitment to all Current Members)*			
LEOFF 2	$6,149	$76.7	$6,226
Unfunded PUC Liability *(The Value of the Total Commitment to all Current Members Attributable to Past Service that is not covered by current assets)*			
LEOFF 2	$(974)	$40.8	$(933)

Note: Totals may not agree due to rounding.

How Contribution Rates Changed

The rounded increase in the required actuarial contribution rate results in the supplemental contribution rate shown below that applies in the current biennium. However, we will use the unrounded rate increase to measure the fiscal budget changes in future biennia.

Impact on Contribution Rates: (Effective 9/1/2009)

System/Plan	LEOFF
Current Members	
Employee (Plan 2)	0.249%
Employer:	
Normal Cost	0.149%
State	0.100%
New Entrants*	
Employee (Plan 2)	0.156%
Employer:	
Normal Cost	0.094%
State	0.062%

**Rate change applied to future new entrant payroll and used to determine budget impacts only. Current members and new entrants pay the same contribution rate.*

How This Impacts Budgets And Employees

Budget Impacts	
(Dollars in Millions)	**LEOFF**
2009-2011	
General Fund	$2.9
Non-General Fund	0.0
Total State	**$2.9**
Local Government	4.3
Total Employer	**$7.1**
Total Employee	**$7.1**
2011-2013	
General Fund	$3.3
Non-General Fund	0.0
Total State	**3.3**
Local Government	4.9
Total Employer	**$8.2**
Total Employee	**$8.2**
2009-2034	
General Fund	$60.6
Non-General Fund	0.0
Total State	**$60.6**
Local Government	91.0
Total Employer	**$151.6**
Total Employee	**$151.6**

Note: Totals may not agree due to rounding.

The analysis of this proposal does not consider any other proposed changes to the system. The combined effect of several changes to the system could exceed the sum of each proposed change considered individually.

As with the costs developed in the actuarial valuation, the emerging costs of the system will vary from those presented in the AVR or this draft fiscal note to the extent that actual experience differs from the actuarial assumptions.

HOW THE RESULTS CHANGE WHEN THE ASSUMPTIONS CHANGE

To determine the sensitivity of the actuarial results to the best-estimate assumptions or methods selected for this pricing we varied the following assumptions and methods:

- The member selects the most expensive coverage.

Instead, we also priced the circumstance where the member selects the least expensive coverage so that we can see the full variability due to this assumption. The least expensive PEBB coverage in 2007 was Group Health Value pre-65 and Kaiser Permanente Value post-65. Also, Deltacare was the least expensive dental plan.

If the members select the least expensive coverage, the increase in actuarial present value of projected benefits would decrease from $77 million to $49 million. The resulting rate changes and fiscal costs would decrease by the same proportion.

ACTUARY'S CERTIFICATION

The undersigned hereby certifies that:

1. The actuarial cost methods are appropriate for the purposes of this pricing exercise.
2. The actuarial assumptions used are appropriate for the purposes of this pricing exercise.
3. The data on which this draft fiscal note is based are sufficient and reliable for the purposes of this pricing exercise.
4. Use of another set of methods and assumptions may also be reasonable, and might produce different results.
5. This draft fiscal note has been prepared for the Law Enforcement Officers' and Fire Fighters' Retirement System Plan 2 Board.
6. This draft fiscal note has been prepared, and opinions given, in accordance with Washington State law and accepted actuarial standards of practice as of the date shown on page 1 of this draft fiscal note.

This draft fiscal note is a preliminary actuarial communication and the results shown may change. While this draft fiscal note is meant to be complete, the undersigned is available to provide extra advice and explanations as needed.

Matthew M. Smith, FCA, EA, MAAA
State Actuary

APPENDIX A – ASSUMPTIONS WE MADE

We assumed that members would select the most expensive health and dental plan in PEBB. We assumed that the member would elect to cover themselves, their spouse, and children (maximum of ten years) for the life of the member. We assumed 100 percent spouse and child coverage. The assumed medical costs and inflation are outlined below:

Annual Costs Before Medical Inflation		
	Expected	Low Cost
Medical Costs		
Pre-65		
Member and Spouse	$12,124	$9,109
Children	$4,514	$3,383
Post-65		
Member and Spouse	$8,560	$2,821
Children	$4,514	$3,545
Dental		
All Ages		
Member and Spouse	$1,095	$801
Children	$548	$400

Medical and Dental Inflation		
Year	Pre-65	Post-65
2007	12.0%	12.5%
2008	11.0%	11.5%
2009	10.0%	10.5%
2010	9.0%	9.5%
2011	8.0%	8.5%
2012	7.0%	7.5%
2013	6.0%	6.5%
2014	5.5%	5.5%
2015 +	5.0%	5.0%

The rate of incidence of total disablement is consistent with the AVR, and the medical inflation is consistent with the 2007 Other Post-Employment Benefits (OPEB) AVR.

Otherwise, we developed these costs using the same assumptions as disclosed in the AVR.

APPENDIX B – HOW WE APPLIED THESE ASSUMPTIONS

We used our valuation software to create a new benefit for this proposal. The benefit uses an assumption for total disablement (incidence) in the future (approximately 18 percent of the full disability rates). This key assumption is already in place, consistent with the 2007 AVR.

Upon incidence, we value both active members and the four currently eligible inactive members the same way. The member and children (for ten years) are paid a life annuity equal to the annual premiums of the most expensive PEBB plan. The member is paid a life annuity equal to the most expensive subscriber and spouse coverage in PEBB. Also, the member is paid a ten-year temporary life annuity equal to the most expensive child coverage in PEBB.

We used the 2007 PEBB premiums and started with 2007 medical inflation consistent with the 2007 OPEB AVR. We included total disabilities after retirement eligibility.

Also, we did not value the possibility that the addition of these members to PEBB would affect the PEBB risk pool.

Otherwise, we developed these costs using the same methods as disclosed in the AVR.

We used the Entry Age Normal Cost Method to determine the fiscal budget changes for future new entrants. We used the Aggregate Actuarial Funding Method to determine the fiscal budget changes for current plan members.

GLOSSARY OF ACTUARIAL TERMS

Actuarial Accrued Liability: Computed differently under different funding methods, the actuarial accrued liability generally represents the portion of the present value of fully projected benefits attributable to service credit that has been earned (or accrued) as of the valuation date.

Actuarial Present Value: The value of an amount or series of amounts payable or receivable at various times, determined as of a given date by the application of a particular set of actuarial assumptions (i.e., interest rate, rate of salary increases, mortality, etc.).

Aggregate Funding Method: The Aggregate Funding Method is a standard actuarial funding method. The annual cost of benefits under the Aggregate Method is equal to the normal cost. The method does not produce an unfunded liability. The normal cost is determined for the entire group rather than on an individual basis.

Entry Age Normal Cost Method (EANC): The EANC method is a standard actuarial funding method. The annual cost of benefits under EANC is comprised of two components:

- Normal cost.
- Amortization of the unfunded liability.

The normal cost is determined on an individual basis, from a member's age at plan entry, and is designed to be a level percentage of pay throughout a member's career.

Normal Cost: Computed differently under different funding methods, the normal cost generally represents the portion of the cost of projected benefits allocated to the current plan year.

Projected Unit Credit (PUC) Liability: The portion of the Actuarial Present Value of future benefits attributable to service credit that has been earned to date (past service).

Projected Benefits: Pension benefit amounts which are expected to be paid in the future taking into account such items as the effect of advancement in age as well as past and anticipated future compensation and service credits.

Unfunded PUC Liability: The excess, if any, of the Present Value of Benefits calculated under the PUC cost method over the Valuation Assets. This is the portion of all benefits earned to date that are not covered by plan assets.

Unfunded Actuarial Accrued Liability (UAAL): The excess, if any, of the actuarial accrued liability over the actuarial value of assets. In other words, the present value of benefits earned to date that are not covered by plan assets.