



Montgomery County Government

A STUDY OF RETIREE GROUP INSURANCE BENEFITS TABLE OF CONTENTS

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EXECUTIVE SUMMARY

Rising medical costs, increased longevity, the growing number of retirees and fiscal constraints are causing many public and private sector employers to take a serious look at the future of group insurance benefits offered to retirees. This report by the Office of Legislative Oversight examines the health and life insurance benefits provided to retirees of the five major County and bi-County agencies: County Government, Montgomery County Public Schools (MCPS), Montgomery College, the Maryland-National Park and Planning Commission (M-NCPPC), and the Washington Suburban Sanitary Commission (WSSC).

Major Findings The present and future costs of providing health and life insurance benefits to agency retirees are substantial. The total cost increased from \$21.5 million in FY 92 to \$38.1 million in FY 95; the total cost is projected to increase to \$67.2 million by FY 2000. In FY 95 there are 8,434 retirees across the five agencies; by FY 2000, this number is projected to increase by 26% to 10,622 retirees.

The funding of retiree group insurance benefits is shared between the agencies and the retirees themselves, and each agency takes a somewhat different approach to pricing benefits. Overall, the agencies paid for 78% of total costs in FY 95, with the employer/retiree premium split ranging from 50/50 to 85/15.

There are both similarities and differences to how each of the five agencies structure retiree group insurance benefits. The factors which vary include: eligibility requirements; health plan options; the calculation of retiree life insurance benefits; the pricing and financing of benefits; and policies regarding transfer season and out-of-area retirees. Across the five agencies, more than 95% of eligible retirees elect to participate in the agencies' health and life insurance benefit plans.

Montgomery College is the only agency currently setting-aside funds each year to prefund the future cost of retiree group insurance benefits. MCPS had established trust funds for prefunding health and life insurance benefits, but annual contributions to the trust funds were discontinued during the 1980's; the remaining trust fund balance continues to serve as a source of funding.

Several national surveys indicate that only a small percent of employers are eliminating retiree health benefits altogether, especially for current retirees. Instead, many public and private sector employers are acting to limit their future group insurance costs by making changes to eligibility, pricing, plan design, plan options, and funding arrangements.

Recommendations OLO's major recommendation is for the Council to endorse a process of deliberate review and discussion of strategies to contain the future costs of providing group insurance benefits to agency retirees. To be successful, the process of developing cost containment strategies should involve the Council, the County Executive, representatives from the five agencies, employees, retirees, and providers.

OLO also recommends that efforts be made to ensure clear and timely communication to employees and retirees about the terms of post-retirement group insurance benefits. In addition, OLO recommends that as part of their annual budget submission, the five agencies should consistently report actual, budgeted, and projected costs of group insurance benefits for retirees.

I. AUTHORITY, SCOPE, AND METHODOLOGY

A. Authority

Council Resolution No. 13-223, FY 96 Work Program of the Office of Legislative Oversight.

B. Scope

This project was designed to address the following issues:

- (1) What are the group insurance benefits provided to retirees of the County Government, Montgomery County Public Schools (MCPS), Montgomery College, the Maryland-National Park and Planning Commission (M-NCPPC), and the Washington Suburban Sanitary Commission (WSSC)? Specific questions included:
 - How does each agency define eligibility for retiree group insurance benefits?
 - What are the health plan options available to retirees under-65 and over-65?
 - What are each of the agency's provisions for: survivor and dependent coverage, retiree participation in transfer season, and health plan options for out-of-area retirees?
- (2) What are the current and projected costs of providing group insurance benefits to retirees of the five agencies? How does each agency approach the pricing and funding of retiree group insurance benefits?
- (3) How do other area local governments and school systems, the Federal Government, and the State of Maryland approach the provision of group insurance for retirees?
- (4) What are the different strategies being used by public and private sector employers to manage the future costs of retiree group insurance benefits? What are the major legal issues involved?

In describing the benefits available to over-65 retirees, this report includes some discussion of how the five agencies coordinate their retiree medical benefits with Medicare. However, because of the complexities of this highly technical issue, additional work will be required to fully understand how medical benefits provided through agency-sponsored plans are integrated with Medicare benefits.

C. Methodology

This project was conducted by Karen Orlansky, Director, Office of Legislative Oversight, with assistance from OLO Public Administration Interns Christina Kim and Christopher Reeve.

The research design included: document and file reviews; library research of journal and newspaper articles; quantitative analysis of program data; multiple interviews with agency staff; and a phone survey of area local governments and school systems.

OLO also used information on retiree group insurance benefits published by the Government Finance Officers Association (GFOA) and several private employee benefits consulting firms. In particular, the report cites data from three surveys:

- The Government Finance Officers Association (GFOA) surveyed its members in 1994 concerning retiree health care benefits. 1,020 jurisdictions participated in the survey: 40% with a population of less than 25,000, 33% with a population between 25,000 and 100,000, and 26% with a population of more than 100,000. 68% of respondents were municipalities, 14% were counties, 8% were special districts, and 10% were other categories.
- The Wyatt Comparison on Retiree Medical Benefits surveyed 684 private sector employers in 1992. Wyatt's data base included information on more than 7.9 million employees. Of the firms surveyed, the median size of the workforce was 3,234 employees and the average (mean) was 11,605 employees.
- The Foster Higgins National Survey of Employer Sponsored Plans surveyed 2,097 employers in 1994. The firms were selected based upon a stratified random sample of private employers and government agencies with between 10 and 25,000 employees. A distinction between large and small employers was made at 500 employees.

Throughout the report, these surveys will be referenced as the 1994 GFOA survey, the 1992 Wyatt comparison survey and the 1994 Foster Higgins survey. Additional information on the private sector surveys is contained in Appendix A.

D. Acknowledgements

The Office of Legislative Oversight acknowledges the full cooperation and support from the human resources and budget staff members of the five County and bi-County agencies who spent time working with us throughout the study period. Special thanks are owed to: Charles Thompson, Linda Thall, Marshall Spatz, Joy Lawson, and Rebecca Pugh from the County Government; Larry Bowers, Wes Girling, and Alan Kaplan from MCPS; Robert Keller, Donna Dimon, Lynda Sturges, and Kenneth Mullinix from the College; John Derwart and Rita Hubbard from WSSC; and Edward Navarre, Vivienne McGettigan, Robert Seubert, Judy Opel, Doug Sherwood, and William Serelis from M-NCPPC.

II. ORGANIZATION OF REPORT

The report is organized as follows:

Chapter III, OVERVIEW OF RETIREE GROUP INSURANCE BENEFITS, describes the health and life insurance benefits provided by the five agencies. The chapter is divided into four sections:

- A. Eligibility requirements
- B. Health plan options for retirees
- C. Approaches to Medicare integration
- D. Life insurance benefits for retirees

Chapter IV, FINANCING POST-RETIREMENT GROUP INSURANCE BENEFITS, presents data on the agency costs of retiree group insurance (current and projected), and discusses how each of the five agencies approach the pricing and funding of retiree group insurance benefits.

Chapter V, COMPARATIVE INFORMATION, summarizes the results of OLO's survey of area local governments and school systems, the Federal Government, and the State of Maryland, concerning group insurance benefits for retirees.

Chapter VI, APPROACHES TO CONTROLLING COSTS, describes the different approaches being used by employers to control the costs of providing post-retirement group insurance benefits, and summarizes the major legal issues to consider when making changes.

Chapter VII, SUMMARY OF FINDINGS AND RECOMMENDATIONS, summarizes the major findings of this report and sets forth OLO's recommendations.

Chapter VIII, AGENCY COMMENTS ON DRAFT REPORT, contains the written comments received from the five agencies on a final draft of this report.

Chapter III. OVERVIEW OF RETIREE GROUP INSURANCE BENEFITS

Employer-sponsored plans are an important source of health care coverage for retirees, especially for under-65 retirees who are not yet eligible for Medicare coverage. Public sector employers are more likely than private sector employers to offer group insurance benefits to retirees. However, factors such as the increasing costs of health care, increased longevity, the changing ratio of active to retired employees, and fiscal constraints are affecting the ability of both public and private sector employers to offer the same level of retiree benefits in the future.

The 1992 Bureau of Labor Statistics survey of employee benefits reported that employer-financed retiree health coverage was available for 51% of full-time public sector employees. This compared to 45% of full-time employees of medium and large private sector establishments. Other surveys concerning the availability of retiree benefits show that larger employers are more likely to provide health benefits to retirees:

- The 1994 GFOA survey reported that 60% of the 1,020 responding jurisdictions provided some form of retiree health benefits to their employees. The percent varied by size of jurisdiction with 77% of jurisdictions with over 100,000 population providing retiree health benefits, compared to only 47% of jurisdictions with populations under 25,000.
- The 1992 Wyatt Comparison survey found that the availability of retiree coverage in the private sector varied significantly by employer size, with 82% of employers with 5,000 or more employees providing retiree medical benefits compared to only 55% of employers with fewer than 500 employees.

How to define eligibility, what benefits to offer, and how to integrate employer-sponsored benefits with Medicare are issues confronting both public and private sector employers. This chapter provides an overview of the group insurance benefits provided to retirees of the County Government, Montgomery County Public Schools (MCPS), Montgomery College, Maryland-National Capital Park and Planning Commission (M-NCPPC), and Washington Suburban Sanitary Commission (WSSC). The chapter is divided into four sections:

- A. Eligibility requirements
- B. Health plan options for retirees
- C. Approaches to Medicare integration
- D. Life insurance benefits for retirees

Each section begins with some general information, including relevant survey results from the 1994 GFOA survey, the 1992 Wyatt Comparison survey, and the 1994 Foster Higgins survey. The general information is followed by specific data about the five agencies.

A. Eligibility Requirements

A1. General

Defining who is eligible for post-retirement benefits is a fundamental policy issue for any group insurance program. In addition to being a key variable for determining current and future costs, eligibility requirements can influence employee behavior, including whether active employees decide to participate in group insurance and when an employee decides to retire.

The majority of employers use the same age and service requirements for retiree medical benefits as for pension benefits. However, according to the 1994 Foster Higgins survey, one third of employers who offer retiree medical benefits have now imposed additional eligibility requirements for participation in their retiree medical plan. Specifically, the survey found that:

- 59% of employers require participation in the employer medical plan as an active employee for a specific number of years directly prior to retirement as a prerequisite for receiving retiree medical benefits.
- 60% of employers have a minimum years of service requirement (most common requirement is 10 years).
- 55% of employers have a minimum age requirement (most common requirement is 55 years old).
- 19% of employers have plans that require some combination of age and years of service minimum.

The 1994 GFOA survey found that public sector employers that provide retiree health coverage tend to make this benefits available to most groups of employees and tend to also offer these benefits to early retirees and disabled retirees. Specifically, of employers that offer retiree health benefits, 89% extend these benefits to early retirees, and 95% extend them to disabled retirees.

The availability of retiree medical benefits can influence when an employee retires. The Foster Higgins 1994 survey reported that for large employers that offered retiree group insurance benefits, the median age at retirement was 62 with two-thirds of employees retiring before the age of 65. Among large employers not offering coverage, the median age at retirement was 64.

A2. Eligibility requirements by agency

The County Government, MCPS, Montgomery College, M-NCPPC, and WSSC (the five agencies) all offer group insurance benefits to eligible retirees. Across the five agencies, more than 95% of retirees who are eligible to receive retiree health and life insurance benefits elect to participate in agency-sponsored programs. The similarities and differences among the eligibility requirements established by the five agencies are described below.

Connection between retiree group insurance and receipt of pension.

Similar to most employers, all five agencies link eligibility for retiree group insurance to receipt of a retirement pension benefit. Each of the five agencies also have some requirements concerning participation in a health insurance program as an active employee. Four of the five agencies have separate requirements for retiree participation in health vs. life insurance.

Consistent with the practice of most other public sector employers, all five agencies include employees who take early retirement and those who take a disability retirement as eligible to participate in retiree group insurance. The benefits are generally the same, except that the formula for declining life insurance benefits may vary.

At this time, almost all employees across the five agencies are enrolled in the agencies' defined benefit retirement plans. Although the specifics vary, all of the agencies' defined benefit retirement plans require a certain combination of age and years of service plus a vesting requirement of having participated in the retirement benefit plan for a minimum number of years (typically 5 years). Because of the link between receiving a pension and eligibility for retiree group insurance, the age and service requirements for receipt of a defined benefit pension serve as prerequisites for participation in retiree group insurance plans.

Only the College and the County Government have a portion of their employees currently enrolled in a defined contribution retirement plan. To be eligible for the College's retiree group insurance plan, an employee in the defined contribution retirement plan must meet the same age and years of service requirements established for employees in the College's defined benefit retirement plan. The County Government has not yet defined the eligibility requirements for retiree group insurance for those employees who participate in the defined contribution retirement plan (the Retirement Savings Plan), which was introduced for non-public safety employees hired since October 1, 1994.

At all of the agencies except WSSC, an employee must be eligible to begin receiving a pension at the time of retirement in order to participate in the retiree group insurance plan. In other words, you are not eligible for retiree group insurance benefits if you leave agency service as a vested member of the retirement plan and qualify for collection of a deferred pension at some later date. WSSC is the only one of the five agencies to allow a qualified, vested employee to re-enroll in the group insurance plan when he/she begins to collect a deferred pension; since April 1994, the employer/retiree cost sharing in these cases is based on years of service (see page 27).

Additional requirements concerning participation as active employee in agency's group insurance plan. To be eligible for retiree health insurance benefits, all five agencies also require a retiree to have been enrolled in the agency's health insurance plan as an active employee for a minimum number of years, except that the County Government's requirement only applies to employees hired since January 1, 1987. In addition to being an eligibility requirement, the years of enrollment can also determine the employer/retiree cost sharing formula (see discussion of pricing that begins on page 24). The eligibility requirement for a minimum years of health plan enrollment ranges from one to five years:

- MCPS requires at least one year of enrollment directly before retirement;

- WSSC requires at least two years of enrollment directly before retirement (except for qualified, vested employees who collect a deferred retirement);
- M-NCPPC requires at least three years of enrollment directly before retirement; and
- The County Government and the College require at least five years of enrollment directly before retirement. (For County Government, this requirement applies only to employees hired since January 1, 1987; employees hired before that date are required only to be receiving a pension.)

The County Government, MCPS, and WSSC extend the minimum number of years requirement to dependents who are going to be covered by the retiree's plan. However, both the College and M-NCPPC provide that dependents who were covered by a comparable plan for the same minimum number of years may transfer into the retiree's coverage at the time of retirement.

Special requirements for life insurance. The special eligibility requirements for retiree life insurance vary among the five agencies. The following requirements apply to employees who take early or regular (not disability) retirement:

- The County and the College require five years of continuous participation in the agency's life insurance plan directly prior to retirement.
- MCPS requires that an employee participated in the MCPS life insurance plan for one year directly prior to retirement.
- WSSC provides life insurance to all active employees and retirees at no premium charge and there is no minimum years of plan participation at WSSC for retiree life insurance..
- At M-NCPPC, retirees who are members of the Employees Retirement System (ERS) are eligible to receive a death benefit of \$10,000. In addition, at the time of retirement, an employee may convert his/her life insurance benefit (which is an optional benefit) to an individual plan through M-NCPPC's carrier of life insurance.

Eligibility for coverage of dependents/survivors. While all five agencies provide group insurance benefits to the survivors and dependents of retirees, the details of eligibility are not identical.

All five agencies provide survivors and dependents of retirees with lifetime group insurance coverage at the same group insurance and pricing structure as the retiree. For County Government, MCPS, Montgomery College, and M-NCPPC, participation can continue even if the survivor/dependent no longer receives a pension payment, e.g., pension is exhausted, lump-sum payment option was selected. For WSSC, participation can continue only if the retiree's survivor/dependent continues to receive a pension check.

M-NCPPC and WSSC retirees can add or delete dependents after retirement during transfer seasons. County Government retirees may add and delete dependents after retirement only if they had selected family coverage at the time of retirement. MCPS and the College do not allow retirees to add any dependents after retirement; only deletions to plan coverage are allowed.

County Government, WSSC, and M-NCPPC discontinue coverage for a surviving spouse if he/she remarries. The College and MCPS do not have re-marriage exceptions.

Where is eligibility defined? The eligibility requirements for retiree group insurance are outlined in different documents.

The County Code (Chapter 33) defines a retiree for County Government defined benefit pension plan participants¹. State law defines a retiree for MCPS and Montgomery College defined benefit plan participants. The retirement plan documents for the College define retiree for the College's defined contribution plan participants. Plan documents for MCPS and M-NCPPC also define retiree. WSSC defines retiree in the agency's Personnel Policy and Benefits Program document.

For the County Government, the College, and M-NCPPC, the eligibility requirements for retiree group insurance are contained in the agencies' respective insurance plan documents. For MCPS and WSSC, the requirements are set forth in agency regulation and policy documents.

B. Health plan options for retirees

B1. General

For employers who offer retiree group insurance benefits, it is typical to provide retirees under age 65 with health plan options and levels of coverage similar to active employees. Once retirees becomes eligible for Medicare benefits (currently age 65), the employer-provided coverage is usually modified.

The 1994 GFOA survey reported that of the jurisdictions that provide retiree health benefits: 60% offer indemnity plans (of which approximately half are self-insured plans); 39% offer health maintenance organization (HMO) plans; and 34% offer preferred provider organizations (PPO) plans. The totals sum to more than 100% because almost half (49%) of public sector employers offer more than one plan option to retirees.

The GFOA survey also found that the types of retiree health plans offered vary by the size of jurisdiction: 64% of jurisdictions with populations over 100,000 offer more than one health plan option, compared to 34% of smaller jurisdictions.

The 1994 Foster Higgins survey reported that traditional indemnity plans saw an abrupt drop in enrollment in 1994. Consistent with the GFOA results, Foster Higgins reported that approximately 60% of large employers continue to offer an indemnity plan. However, enrollment decreased from 43% of eligible employees in 1993 to 34% in 1994. Foster Higgins also found that the number of large employers only offering an indemnity plan dropped from 31% in 1993 to 19% in 1994.

1. As indicated above, a "retiree" is not defined for Retirement Savings Plan participants.

A factor frequently cited as contributing to increasing indemnity plan costs is the changing demography of indemnity plan members. Active employees are leaving indemnity plans much more quickly than retirees, and as the portion of active employees in the indemnity plans declines, per employee costs increase. Most studies show that retirees want to remain in indemnity plans because they are familiar with and continue to value unrestricted choice, and because they are more likely to move out of the geographic range of their previous employer's managed care network.

B2. Health plan options by agency

Table 1 (page 9a) outlines the health care plan options available to retirees of the five agencies for the 1995 benefit year. In sum:

- Three agencies continue to provide a traditional indemnity (fee for service) medical plan. For County Government and MCPS, enrollment in the indemnity plan is restricted. M-NCCPC discontinued its indemnity plan in 1986, and WSSC discontinued its indemnity plan as of January 1995.
- The County Government and MCPS offer a point-of-service (POS) plan option with provisions for 80% reimbursement for non-network services; the College offers a POS plan with provisions for 70% reimbursement for non-network services. WSSC's POS plan provide for 70% reimbursement for non-network services for participants who reside within a service area, and 80% reimbursement for non-network services for participants who reside outside a service area.
- M-NCPPC is the only agency to offer a preferred provider organization (PPO) option; M-NCPPC's PPO provides for 70% reimbursement for non-network services.
- All five agencies offer at least one health maintenance organization (HMO) option, and most offer both staff model and network model HMOs.

Table 1 also shows the availability of additional health plan components (i.e., dental, vision, and prescription drug insurance) to retirees. How the options available to retirees differ from those offered to actives are discussed later in this section. Many of the plan design changes implemented during recent years by the agencies for active employees have been similarly implemented for retirees, including increases in deductibles, co-payments, employee contribution to premiums, etc.

Across the five agencies, the pre-tax health spending accounts available to active employees are not available to retirees, and retirees are not eligible to participate in a pre-tax dependent care assistance program. Restricting participation in these programs to active employees is linked to how the federal government defines "compensation" and is not a local government decision.

Tables 2 and 2a (pages 9b and 9c) show retiree enrollment by type of medical plan for the 1995 benefit year. The data indicate that for the three agencies that continue to offer a traditional indemnity medical plan, the overwhelming majority of participating retirees are indemnity plan members:

- 88% of County Government retirees belong to the indemnity plan;
- 85% of College retirees belong to the indemnity plan; and
- 82% of MCPS retirees belong to the indemnity plan.

Table 1

County and Bi-County Agencies Health Plan Options for Retirees

1995 Benefit Year					
	County Govt	MCPS	College	M-NCPPC	WSSC
Medical Insurance:					
• Indemnity Plan	1	1	1		
• Point of Service Plan (POS)	1	1	1		1
• Preferred Provider Organization (PPO)				1	
• Health Maintenance Organizations (HMO)	3	6	2	5	5
Dental Insurance	A,B	B	C	C	C
Vision Insurance	A	B	not available	A,C	A
Prescription Drug Insurance	A	B	A, C	C	A

A = routine, basic, and/or discounted services and coverage included as a part of one or more of the medical plans

B = participation in a separate plan is required and additional premium is bundled with the participation in any medical plan

C = retirees are also eligible to participate in a stand-alone plan that require separate premiums and offers more generous benefits beyond the basic level

County Government: Retirees are not eligible to participate in the stand-alone prescription drug and vision plans that are offered to active employees. Dental insurance is bundled with the choice of any medical plan for both active and retired employees. Participation in the indemnity plan is limited to all employees/retirees (except FOP members) who were enrolled before the 1994 benefit year, and to FOP members who were enrolled before January 1, 1995.

MCPS: Participation in the indemnity plan is limited to employees hired before 1/1/94. Over-65 retirees are not eligible to participate in the POS plan. As of 12/31/95, one HMO (Humana Group Health) plan will be eliminated; another HMO (Columbia FreeState) is already frozen to new enrollment. There will be only 4 HMOs available to employees/retirees during transfer seasons for the 1996 benefit year.

College: The indemnity plan offers two options, comprehensive and basic. Over 65 retirees are not eligible to participate in the POS plan. Enrollment in MD-IPA is limited to active and retired employees hired before 8/8/88. Participation in the stand-alone prescription drug plan is only available to retirees enrolled in the indemnity plan.

WSSC: There are two stand-alone dental plans to choose from.

Table 2
Retiree Participation by Medical Plan Options
1995 Benefit Year

<u>Number of Retirees</u>	<u>County Govt</u>	<u>MCPS</u>	<u>College</u>	<u>M-NCPPC</u>	<u>WSSC</u>	<u>Total</u>
Indemnity Plan	2659	3365	192	0	0	6216
POS Plan	154	7	0	0	450	611
HMO	221	739	33	53	145	1191
PPO Plan	0	0	0	87	0	87
Total	3034	4111	225	140	595	8105

<u>Percentage of Retirees</u>	<u>County Govt</u>	<u>MCPS</u>	<u>College</u>	<u>M-NCPPC</u>	<u>WSSC</u>	<u>Total</u>
Indemnity Plan	87.6	81.9	85.3	0	0	76.7
POS Plan	5.1	0.2	0	0	75.6	7.5
HMO	7.3	18	14.7	37.9	24.4	14.7
PPO Plan	0	0	0	62.1	0	1.1
Total	100	100	100	100	100	100

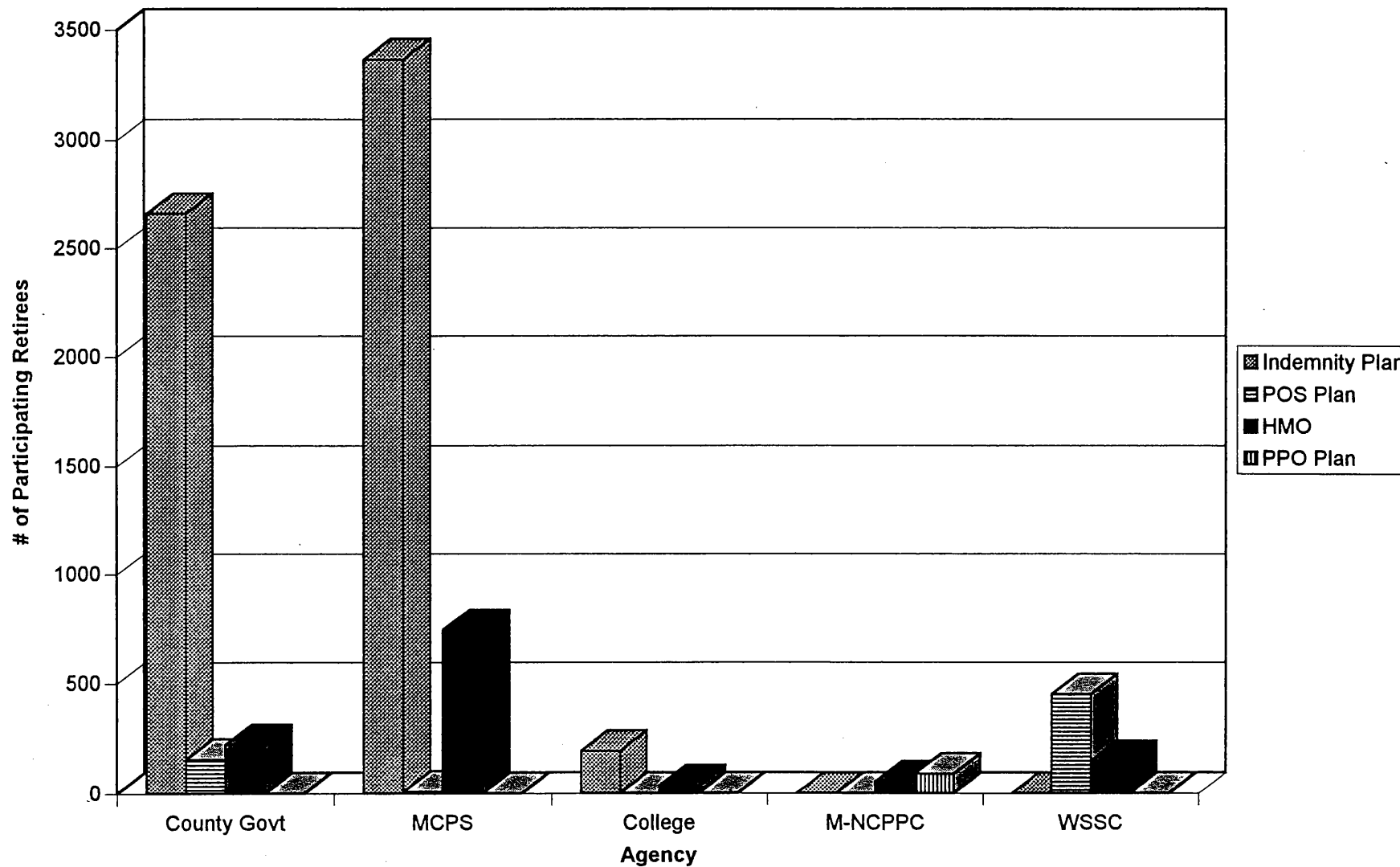
POS=Point of Service

PPO=Preferred Provider Organization

HMO=Health Maintenance Organization

Note: M-NCPPC data are only for Montgomery County portion of Commission retirees

Table 2a
Retirees Participation by Medical Plan Option
1995 Benefit Year



For the two agencies that no longer offer an indemnity plan option, the majority of participating retirees belong to the POS or PPO option with the remainder belonging to an HMO:

- 76% of WSSC retirees belong to the point-of service (POS) plan and the other 24% belong to an HMO.
- 62% of M-NCPPC retirees belong to the preferred provider organization (PPO) plan and the other 38% belong to an HMO.

The health plan options available to retirees of each of the five agencies are described in more detail below. Each description includes the agency's practice of including or excluding retirees from the annual transfer season for active employees, and the agency's policy regarding health plan options for out-of-area retirees. A summary of each agency's approach is contained in Table 3 (page 10a).

County Government

Retirees hired before July 1, 1993 (under 65 and over 65) have the same medical plan options as active employees hired before that date: an indemnity plan, a point-of-service (POS) plan, and three HMOs. Participation in the indemnity plan is limited to employees and retirees (except FOP members) enrolled in the indemnity plan before January 1994, and to FOP members enrolled before January 1, 1995. For the 1996 benefit year, transfer choices for all active employees and retirees will be limited to the point-of-service plan and three HMOs.

Table 2 (page 9b) shows the 1995 medical plan enrollment choices for the approximately 3,000 participating County Government retirees:

- 2,659 (88%) belong to the indemnity plan;
- 221 (7%) belong to an HMO; and
- 154 (5%) belong to the County's POS plan.

County Government retirees are not eligible to participate in either the County's stand-alone prescription drug card plan or vision insurance plan. Retirees receive prescription drug and vision benefits to the extent routine coverage and/or discounts are included in the medical plan selected. Retirees over-65 who are in the indemnity plan receive prescription drug coverage as part of their Medicare Supplement plan (see page 14).

At present, participation in the County's separate dental insurance plan is required for all health plan members (active and retired), except for non-represented employees hired since October 1, 1994, who are enrolled in the Select Plan, the County's flexible benefits plan. Except for employees enrolled in the Select Plan, the premium for participation in the County's dental insurance plan is bundled with the medical plan premium for all employees and retirees. Because no employees hired since October 1, 1994 are as yet eligible for retirement, the changes for this group of employees do not yet apply to any retirees.

Table 3

County and Bi-County Agencies
Transfer Season Policy for Retirees and Out-of-Area Provisions

	County Govt ¹	MCPS	College ²	M-NCPPC	WSSC ³
Transfer Season Policy:					
• Annual transfers				X	X
• No transfers except - Periodically at agency discretion			X		
Offered in 1995	X	X			
Intend to offer in 1996	X	X			
Out-of-Area Provisions:					
• Indemnity plan		X	X		
• PPO				X	
• POS	X				X
• HMO where available	X	X	X	X	X

1. County Government: Retirees who moved out of the area before 1/1/94 were placed in the indemnity plan. Since January 1, 1994, retirees who move out of the area have the choice of enrolling in the point-of-service plan (which now has 80% out of network reimbursement provisions) or in an HMO where available.

2. College: Retirees are offered the opportunity to transfer medical plans during the first annual transfer season that occurs after their retirement. Additional opportunities to transfer are offered to retirees periodically depending on the type and extent of plan changes being implemented. The College's POS plan provides for 70% reimbursement for non-network services.

3. WSSC: The POS plan provides for 80% reimbursement for retirees who relocate out of a service area; this compares to 70% reimbursement for participants who live in a service area, but who use non-network services.

In terms of future medical plan choices for active and retired employees, it should be noted that Section 21.10 of the 1995-97 agreements negotiated between the County Government and Montgomery County Government Employees Organization states that it is the employer's intent to discontinue the Prudential Indemnity Plan by January 1, 1998, and that the parties agree to pursue alternatives to the Indemnity Plan for implementation by January 1, 1998; an excerpt from the 1995-97 County Government/MCGEO agreement is included as Appendix B. A similar provision was negotiated between the County Government and the International Association of Firefighters (IAFF) in a sidebar agreement.

Transfer policy: Retirees are enrolled in the medical plan they were enrolled in on their final day of work as an active employee. For many years, the County did not offer retirees the opportunity to change plans unless they were relocating out of the Washington metropolitan area. However, the 1995 transfer season was opened up to retirees and the Office of Human Resources plans to allow retirees to participate in the transfer season for the 1996 benefit year.

Out-of-area retirees: Until January 1, 1994 (when enrollment in the indemnity plan was frozen), retirees who were relocating outside the Washington metropolitan area were offered the opportunity to transfer to the indemnity plan. Since January 1994, retirees planning to relocate are offered the opportunity to transfer to the point-of-service plan (which now has provisions for 80% reimbursement for non-network services), or during transfer season to an available HMO.

Montgomery County Public Schools (MCPS)

MCPS retirees under-65 have the same options as active MCPS employees. For the 1995 plan year, MCPS offered: an indemnity plan, a point-of-service plan, and six HMOs (with participation in the Columbia and Humana HMOs being limited to those previously enrolled). Participation in the indemnity plan is limited to active and retired employees hired before January 1, 1994. For the 1996 benefit year, the Humana HMO option is being discontinued and enrollment in Columbia will continue to be limited to those already enrolled. Retirees over-65 have the same options as under-65 retirees except that they are not eligible to participate in the POS plan.

Table 2 (page 9b) shows the 1995 medical plan enrollment choices for the approximately 4,000 MCPS retirees:

- 3,365 (81.9%) belong to the indemnity plan;
- 739 (18%) belong to an HMO; and
- 7 (0.1%) belong to the point-of-service plan.

Provisions for dental, vision, and prescription drug benefits are not included in MCPS' HMO and point-of-service provider contracts. Instead, MCPS has stand-alone dental, vision, and prescription drug insurance plans and participation in these plans is bundled with participation in any medical plan for both active and retired employees. The levels of coverage are identical for retired and active employees, except that certain dental coverage (e.g., orthodontia) is not available to retirees.

Transfer policy: MCPS retirees are enrolled in the medical plan that they belong to at the time of retirement. For many years, retirees were not eligible to participate in the annual transfer season held for active employees. However, MCPS opened up the 1995 benefit year transfer season to retirees and intends to do the same for the 1996 benefit year.

Out-of-area retirees: MCPS retirees (hired before 1/1/94) who are already enrolled in a MCPS medical plan and who are relocating outside the Washington metropolitan service area are offered the option of transferring to the indemnity plan, the POS plan, or an available HMO. The POS plan provides for 80% reimbursement for non-network services. The indemnity plan will not be an out-of-area option for retirees who were hired after 1/1/94.

Montgomery College

College retirees under-65 have the same options as active College employees. For the 1995 plan year, the medical plan options are: two levels of indemnity plan coverage (comprehensive and basic); a point-of-service plan with provisions for 70% out-of-network reimbursement; and two HMOs. Enrollment in one of the HMOs (MD-IPA), including transfers is limited to active and retired employees hired before August 1, 1988. College retirees over-65 have the same options, except that they cannot enroll in the point-of-service plan.

Table 2 (page 9b) shows the 1995 medical plan enrollment choices for the 225 participating College retirees:

- 192 (85%) belong to the indemnity plan; and
- 33 (15%) belong to an HMO.

In addition to medical insurance, the College offers employees and retirees the option of participating in a stand-alone dental plan. While some prescription drug benefits are offered as part of the point-of-service and HMO medical plans, a separate prescription drug insurance plan is only available to retirees in combination with the indemnity plan.

Transfer policy: College retirees are enrolled in the medical plan they belong to at the time of retirement unless they are enrolled in an HMO and are relocating from the service area. Retirees are offered the opportunity to transfer medical plans during the first annual transfer season that occurs after their retirement. Although the annual transfer season is not usually open to retirees, the College periodically provides retirees with the opportunity to change plans, especially when significant plan design changes are implemented.

Out-of-area retirees: Retirees relocating out of the Washington metropolitan service area are offered the opportunity to transfer to the indemnity plan (comprehensive level) or to an available HMO.

Maryland-National Capital Park & Planning Commission (M-NCPPC)

M-NCPPC retirees (under-65 and over-65) have the same medical plan options as active M-NCPPC employees. For the 1995 benefit year, the medical plan options are: one PPO (with 70% reimbursement for non-network services) and 5 HMOs. M-NCPPC discontinued its comprehensive indemnity plan in 1986.

Table 2 (page 9b) shows the 1995 medical plan enrollment choices for the 140 participating M-NCPPC retirees: (Note: These numbers reflect only the Montgomery County portion of M-NCPPC retirees.)

- 87 (62%) belong to the PPO plan; and
- 53 (38%) belong to an HMO.

Active and retired employees are also eligible to participate in stand-alone dental, vision, and prescription drug insurance plans that require separate premiums. The medical plans include some routine or discounted dental and vision benefits, but all prescription drug benefits have been carved out of the M-NCPPC's HMO and PPO contracts.

Transfer season: Retirees are eligible to participate in the annual transfer season held for active employees.

Out-of-area retirees: Retirees who relocate out of the Washington metropolitan service area are offered the opportunity to transfer to the PPO plan (which provides for 70% reimbursement for non-network services), or to an available HMO.

Washington Suburban Sanitary Commission (WSSC)

WSSC retirees (under-65 and over-65) have the same medical plan options as active WSSC employees. For the 1995 benefit year, the plan options are one point-of-service (POS) plan and five HMOs. WSSC discontinued its indemnity plan as of January 1, 1995.

Table 2 (page 9b) shows the 1995 medical plan enrollment choices for the approximately 600 participating WSSC retirees:

- 450 (76%) belong to the POS plan; and
- 145 (24%) belong to an HMO.

WSSC offers active and retired employees the opportunity to participate in a stand-alone dental insurance plan (two dental plans to choose from). Routine vision benefits are included in the medical plans offered, and participation in a stand-alone prescription drug insurance plan is bundled with the selection of any medical plan.

Transfer season: Retirees are eligible to participate in the annual transfer season held for active employees.

Out-of-area retirees: Retirees who relocate out of the Washington metropolitan area can transfer to the POS plan or to an available HMO. The applicable provision for reimbursement in the POS plan will depend on whether the retiree moves to an area that is a service area for the POS. The POS plan provides for 70% reimbursement for non-network services for participants who live in a service area, and 80% reimbursement for non-network services for participants who relocate to a place that is not within a service area.

C. Approaches to Medicare Integration

The approach taken by employers to recognize the benefits paid by Medicare has a significant impact on the total cost of providing health insurance to retired employees. This section provides an introduction to the different ways employer-sponsored plan can be integrated with Medicare followed by a summary of how the five County and bi-County agencies approach Medicare integration.

The details of Medicare integration are highly technical and beyond the scope of this OLO study. The whole issue of how "best" to integrate retiree health benefits with Medicare is identified in the recommendation section as an issue that deserves additional examination.

C1. The four major approaches

Medicare is the primary payer of medical benefits for retirees age 65 and over. Appendix C contains an excerpt from the 1995 Guide to Health Insurance for People with Medicare; this excerpt summarizes what Medicare is and explains Medicare Part A (hospital insurance) and Part B (medical insurance).

"Medicare integration" is the term used to describe how medical costs not covered by Medicare are divided between retirees and employers. There are four major approaches that employer-sponsored plans have toward Medicare integration:

- Medicare supplement
- Medicare carve-out
- Maintenance of benefits, and
- Coordination of benefits.

Medicare supplement. A Medicare supplement plan covers defined services such as prescription drugs, eyeglasses, and other services that are not covered by Medicare. There is no cost sharing between the employer plan and Medicare because they cover different benefits. Most employer-sponsored Medicare supplement plans are modeled after standardized private insurance policies called "Medigap" policies; these standardized plans are identified by the letters A through J.

Medicare carve-out. Under the carve-out method, the amount the employer pays for a given claim is reduced directly by the Medicare payment. With a carve-out plan, the deductibles, co-payments, and other cost control methods remain the same. From the retiree's perspective, the total benefit from Medicare plus the employer's plan is equal to the benefit that was provided to the retiree before age 65.

Maintenance of benefits. Under the maintenance of benefits method, the amount the employer pays for a given claim is limited to those amounts not paid by Medicare and considered eligible expenses under the employer's plan. This means that the covered charge after Medicare payments is subject to the plan's deductible and co-payment provisions. Maintenance of benefits is generally considered a middle ground between carve-out and coordination of benefits.

Coordination of benefits. Under the coordination of benefits method, the plan's payment is calculated assuming no other coverage is available and then limited to the total claim minus the amount Medicare will pay. Medicare benefits are first used to reduce the retiree's obligations, including deductibles and co-insurance, with the amount remaining used to reduce the obligations of the employer's plan.

The 1994 GFOA survey found that among government employers offering retiree health benefits, the approach used for Medicare integration was as follows:

- 32% use the Medicare supplement method;
- 31% use the carve-out method;
- 27% use the coordination of benefits method; and
- 10% use another method.

According to the 1994 Foster Higgins survey, of public and private sector employers that provide retiree health insurance to retirees over-65:

- 21% use a Medicare supplement;
- 40% use the carve-out method;
- 21% use maintenance of benefits; and
- 18% use coordination of benefits.

Further explanation and examples of these four methods are contained in an excerpt from an April 1993 report prepared by the Wyatt Company Research and Information Center, attached at Appendix D.

Employer-sponsored medical plans for retirees are likely to be profoundly affected if the federal government implements some of the structural changes to Medicare that are currently being discussed by Congress. Many of the proposals under consideration would reduce the federal government's contribution and raise the issue of whether the remaining costs will be passed along to employer-sponsored plans and/or retirees. Proposals for change under discussion include:

- Raise the age of Medicare eligibility from 65 to 67 years old;
- Increase the premium contributions of beneficiaries;
- Re-structure Medicare to require greater use of managed care;
- Fund future cost increases in the form of higher deductibles and co-payments; and
- Shift some of the cost burden of paying for Medicare from the federal government to state and local governments.

C2. Medicare integration by agency

The health plans of the five agencies are designed on the assumption that over-65 retirees are enrolled in Medicare Part A (hospital insurance) and Part B (medical insurance). See Appendix C for additional explanation of Part A and Part B.

Medicare eligible retirees of the five agencies qualify for premium-free Part A benefits, and are advised to enroll in Part B when they become entitled to premium-free Part A. Retirees of all five agencies are responsible for paying the Part B premium, and agency calculations of benefits assume that the retiree has enrolled in Part B. In 1995, the monthly premium for Part B is \$46.10, and most enrollees have it deducted directly from their monthly Social Security check.

Beyond assuming participation in Medicare Part A and Part B, each agency takes a somewhat different approach to integrating their retiree medical benefits with Medicare. The approaches to integrating Medicare benefits with those offered under a traditional fee-for-service (indemnity) arrangement also vary from integrating Medicare benefits with those offered under managed care arrangements.

Table 4 (page 16a) summarizes how the agencies approach Medicare integration. For the three agencies that continue to maintain an indemnity plan option:

- The County Government uses a modified carve-out approach for over-65 retirees hired before January 1, 1987; and a Medicare supplement approach (equivalent to Medigap Policy A) for over-65 retirees hired since January 1, 1987. Under the modified carve-out, after Medicare picks up its authorized amount of the claim the County pays the balance except that the deductible requirement must be met. However, the County will pay the balance including money that would be subject to copayment if Medicare were not involved. The total monthly premium paid by over-65 retirees is lower than that paid by under-65 participants.
- MCPS uses a Medicare supplement approach. Retirees pay for Medicare Part B, but MCPS pays 100% of the premium for the Medicare supplement. Over-65 retirees continue to be participants in MCPS' stand-alone dental, vision, and prescription drug insurance plans, but the employer/employee premium split changes from 70/30 to 30/70. Currently, the bottom-line premium charged to over-65 retirees is lower than that for under-65 retirees.
- The College uses a coordination of benefits approach, which means that the indemnity plan's payment is calculated assuming no other coverage is available and then limited to the total claim minus the amount Medicare will pay.

A coordination of benefits approach is also used by M-NCPPC for its over-65 retirees enrolled in the PPO, and by WSSC and the County for its over-65 retirees enrolled in a POS plan. MCPS and College retirees who are over-65 are no longer eligible to participate in the agency's POS plan and must transfer to the indemnity plan or an HMO.

In most cases, over-65 retirees who belong to HMOs pay a lower rate than under-65 HMO participants because the HMO is able to submit certain expenses to Medicare for reimbursement. In some instances, however, an over-65 retiree enrolled in an HMO will pay more than an under-65 retiree enrolled in an HMO (see MCPS comments in Chapter VIII).

Two of the HMO plans offered by M-NCPPC since January 1994 have a federally qualified Medicare contract to provide health coverage to post-65 retirees enrolled in Medicare Part A and Part B at a zero monthly premium cost. Additional information about one of these plans, "HealthPlus 65", is included as Appendix E. A special report from Hewitt Associates on expanded managed care options for Medicare insurance is included as Appendix F.

Table 4

County and Bi-County Agencies
Approaches to Health Plan Integration with Medicare

	County Govt¹	MCPS²	College	M-NCPPC³	WSSC
Assumes retiree enrolls in Medicare Part A and Part B	yes	yes	yes	yes	yes
Agency pays for Part B	no	no	no	no	no
Approach to Medicare Integration*:					
• Carve-out	X				
• Medicare Supplement/Medigap	X	X			
• Coordination of Benefits			X	X	X

* For County Government, MCPS, and the College, the X indicates how the agency approaches Medicare integration with its indemnity plan.

1. **County Government:** For indemnity plan members, over-65 retirees hired before 1/1/87 are provided with carve-out plan to integrate with Medicare. Retirees hired after 1/1/87 are provided with Medicare supplement plan equivalent to Medigap Policy A (policy includes prescription drug coverage).

2. **MCPS:** Although retirees must pay the Medicare Part B premium, the employer/retiree premium split for the Medicare Supplement is 100/0. All POS participants must transfer to another plan upon turning 65.

3. **M-NCPPC:** Effective 1/1/94, two HMO (Health Plus 65 and Humana Gold) plans had federally qualified Medicare contracts to provide health coverage to post-65 retirees at no cost. While M-NCPPC retirees may avail themselves of this contract, this is not a benefit offered by the Commission itself.

D. Life Insurance Benefits for Retirees

For active employees, an employer-sponsored life insurance benefit is typically defined in terms of the employee's salary, e.g., 1X or 2X the annual salary. Although some employers discontinue life insurance benefits for retirees, it is more common to allow retirees to continue to participate but adjust the level of life insurance benefit upon retirement.

Typically, employer-sponsored life insurance plans for retirees are structured to provide a declining benefit, which means that the level of benefit continues to be reduced over a pre-established period of time and then remain at a minimum level for the lifetime of the retiree. The life insurance benefits available to retirees of the five agencies are described below.

County Government

For active employees, the life insurance benefit for full-time employees is equal to twice the employee's salary and participation is bundled with the choice of any medical plan.¹ For part-time employees, the life insurance benefit is one time the employee's salary. For retirees, the life insurance benefit is a declining benefit that depends on the age of the retiree and the number of years that the retiree participated in the County's life insurance plan as an active employee.

If the retiree is under age 65 at retirement: the life insurance benefit is equal to 5% of the last active amount for each full year the employee was insured prior to retirement date, up to 100% of the active employee benefit (for employees with 20 or more years of participation). On the fifth anniversary of the retirement date and each following anniversary of that date, the benefit reduces by 10% of the initial amount, until the benefit is reduced to 25% of the initial retiree life amount where it remains for the lifetime of the retiree.

For employees who receive a service-connected disability retirement, the life insurance benefit remains at 2x the employee's final annual salary until the individual reaches the age at which he/she would have been eligible for normal retirement. After that year, it declines in accordance with the schedule for all other retirees.

If the retiree is age 65 or older at retirement: the life insurance amount immediately reduces to 25% of the amount which would have been in force had the retiree not yet reached age 65.

Montgomery County Public Schools

For active employees, the life insurance benefit is equal to twice the employee's salary. The life insurance benefit is bundled with the choice of any MCPS medical plan, but is also available separately to employees who do not participate in a MCPS medical plan. For retirees, the life insurance benefit declines with the number of years after retirement.

1. This applies to all employees except non-represented employees since October 1, 1994, who are enrolled in the County's cafeteria benefits plan. Under the SELECT plan, there is mandatory enrollment in a life insurance plan that provides a benefit equal to 1X salary and employees have the option of purchasing additional life insurance equal to 3X salary.

Upon retirement, the life insurance benefit is reduced to 42.5% of the active benefit, or 85% of the retiree's final salary. For each year between one to four years after retirement, the benefit is reduced by 7.5% until the benefit reaches 25% of the retiree's final salary where it remains for the lifetime of the retiree.

Montgomery College

For active employees, the life insurance benefit is an optional benefit equal to twice the employee's salary. For retirees, the life insurance benefit declines with the number of years after retirement.

Upon retirement, the life insurance benefit becomes 50% of the active benefit, which makes it equal to 100% of the retiree's final annual salary. On the first anniversary of the retirement date and each following anniversary of that date, the benefit is reduced by 10% of the initial amount. On the fifth anniversary of the retirement date, the benefit amount is set at \$5,000, where it remains for the lifetime of the retiree.

For employees who take a disability retirement, the life insurance benefit does not begin to decline until the individual reaches the age of 60.

Maryland-National Capital Park & Planning Commission (M-NCPPC)

For active employees, the life insurance benefit is an optional benefit equal to 1.8 times the employee's base salary, with a maximum benefit of \$125,000. At the time of retirement, an employee may convert his/her life insurance to an individual plan through M-NCPPC's carrier of life insurance and pay the full premium.

M-NCPPC employees who are members of the Employees' Retirement System (ERS) are automatically eligible to receive a death benefit of \$10,000. This benefit is funded by the ERS and included in its actuarial projections.

Washington Suburban Sanitary Commission (WSSC)

For active employees, the life insurance benefit is provided to all employees at zero premium charge and is equal to 1.75 times the employee's salary. For retirees, the life insurance benefit declines with the number of years after retirement.

Upon retirement, the life insurance benefit becomes equal to one times the retiree's final annual salary rounded to the next higher \$1,000 less 15%. For each year between the first and fourth year after retirement, the benefit reduces by the same dollar amount of the original 15% decrease, until the benefit reaches 25% of the retiree's final annual salary or \$5,000 (whichever is greater), where it remains for the lifetime of the retiree.

In addition, active WSSC employees can purchase a supplemental life insurance benefit in increments of \$10,000 up to a maximum of \$100,000. Retirees can continue to participate in the supplemental life insurance plan, although the benefit reduces to 50% of the active employee amount, not to exceed \$20,000. When the retiree reaches age 70, the supplemental life insurance plan is canceled.

IV. FINANCING RETIREE GROUP INSURANCE BENEFITS

The national costs of post-retirement group insurance benefits increased significantly during the past decade, due to multiple of factors including: increases in the costs of medical care, increased longevity, and the increasing number of retirees. Since December 1992, the annual expense for retiree medical benefits also increased for private sector employers due to new accounting requirements that require accrual of the expected cost of future retiree medical benefits.

In FY 92, the cost of providing group insurance benefits to retirees of the five agencies was \$21.5 million. This amount increased to \$38.1 million in FY 95 and is projected to increase to \$67.2 million by FY 2000. In total, the cost of providing retiree group insurance benefits is shared between the agencies and the retirees themselves, with the agencies' funding approximately 78% of the total cost in FY 95.

This chapter is organized into three sections:

- A. The Costs of Providing Retiree Group Insurance Benefits, reviews the five-agency costs of providing retiree health and life insurance benefits.
- B. Approaches to Funding, describes the different approaches that the five agencies have taken to financing retiree group insurance.
- C. Employer/Retiree Cost Sharing, examines in more detail how the costs of retiree group insurance benefits are shared between the agencies and retirees.

A. The Costs of Providing Retiree Group Insurance Benefits

A1. Total costs

Table 5 (page 19a) summarizes the historical and projected costs of group insurance benefits for retirees of the five agencies.¹ The agency projections outlined below and detailed in Appendix G were based on the best information available during the summer of 1995. These projections are subject to revision as more current data are obtained.

In FY 92, there were 6,823 agency retirees; this increased to 8,434 retirees in FY 95 and is projected to increase to 10,622 retirees by FY 2000. The cost data show that:

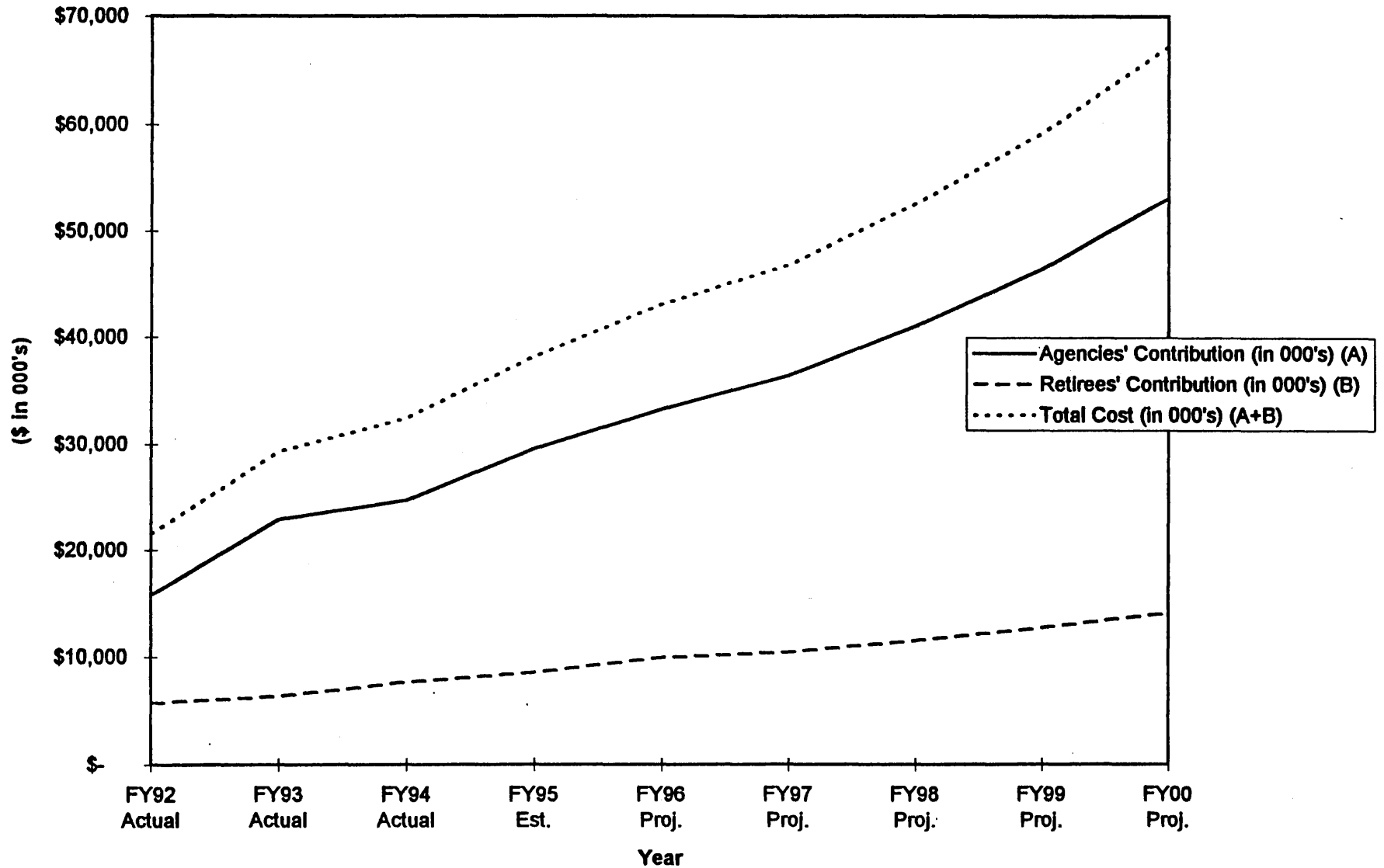
- In FY 95, the cost of providing group insurance benefits to retirees of the five agencies totaled \$38.1 million. This total cost was shared between the agencies and the retirees themselves, with the agencies contributing \$29.5 million, (78% of the total), and the retirees' contributing \$8.6 million (22% of the total).

1: M-NCPPC costs include Montgomery County portion only; calculated as 50% of total M-NCPPC costs for retiree group insurance.

Table 5
Cost of Retiree Group Insurance: All Agencies

Year	Agencies' Contribution (in 000's) (A)	Retirees' Contribution (in 000's) (B)	Total Cost (in 000's) (A+B)	Number of Retirees
FY92 Actual	\$ 15,743	\$ 5,779	\$ 21,522	6,823
FY93 Actual	\$ 22,886	\$ 6,385	\$ 29,271	7,143
FY94 Actual	\$ 24,712	\$ 7,682	\$ 32,394	7,960
FY95 Est.	\$ 29,553	\$ 8,578	\$ 38,131	8,434
FY96 Proj.	\$ 33,182	\$ 9,928	\$ 43,110	8,860
FY97 Proj.	\$ 36,378	\$ 10,482	\$ 46,860	9,293
FY98 Proj.	\$ 41,038	\$ 11,546	\$ 52,584	9,781
FY99 Proj.	\$ 46,464	\$ 12,760	\$ 59,224	10,186
FY00 Proj.	\$ 53,142	\$ 14,083	\$ 67,225	10,622

Table 5a
Cost of Retiree
Group Insurance: All Agencies



County Government, MCPS, Montgomery College, M-NCPPC (Montgomery County portion only), and WSSC

- The total FY 95 cost of \$38.1 million was 77% higher than the total FY 92 cost of \$21.5 million. Between FY 95 and FY 2000, the total cost is projected to increase another 76%. The annual projected increases range between \$3.8 million and \$8 million.
- Between FY 95 and FY 2000, total agency contributions are projected to increase from \$29.5 million to \$53.1 million (80%). During this time period, the retirees' collective contributions (including contributions from new retirees) are projected to increase from \$8.6 million to \$14 million (64%).

Table 6 (page 20a) shows the cost per retiree by agency for FY 95 compared to the cost per retiree projected for FY 2000. Per retiree costs are projected to increase by 55% for County Government, 37% for MCPS, 11% for the College, 12% for M-NCPPC; and 31% for WSSC. Additional cost data by agency are summarized below.

A2. Cost data by agency

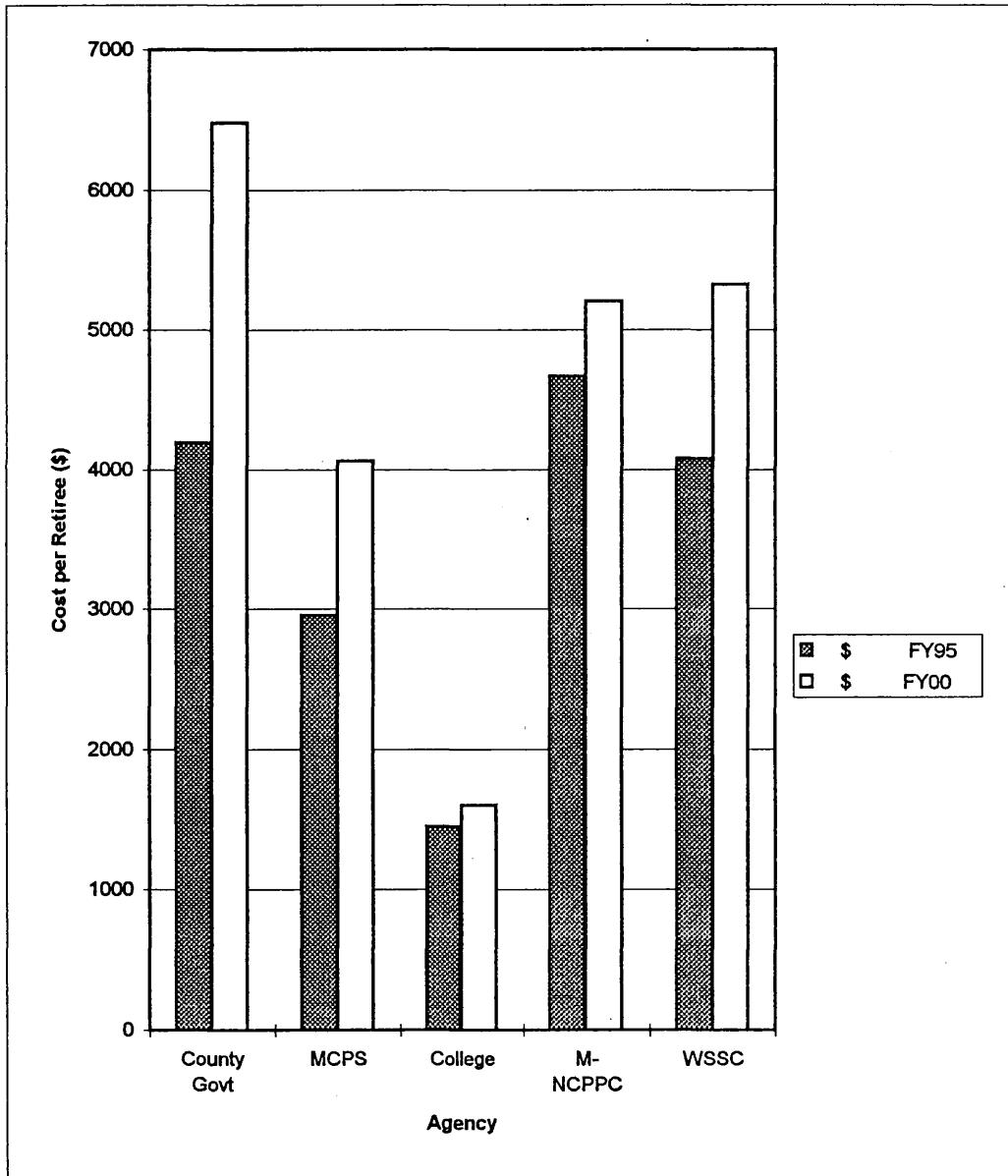
Cost data for each agency are summarized in tables and graphs contained in Appendix G. While all five agencies project substantial increases in the costs of retiree group insurance between FY 95 and FY 2000, the projected rates of increase vary significantly. For example, the projected percent increases in agency contributions between FY 95 and FY 2000 range from 32% (M-NCPPC) to 96% (County Government); the projected increases in retiree contributions, which include the contributions from new retirees, range from 32% (M-NCPPC) to 80% (MCPS).

Factors that contribute to the range of agency projections include: the assumptions used to estimate medical inflation in future years; the agency approach to pricing benefits; the number of retirees and projected increase in number of retirees; the medical plan choices available to retirees and percent of retirees that continue to belong to traditional fee-for-service plans; and the number of retirees under-65 and over-65.

By agency, the projected increases between FY 95 and FY 2000 can be summarized as follows:

- County Government projects that the total cost of retiree group insurance will increase from \$15.9 million in FY 95 to \$29.7 million by FY 2000. The agency contribution is projected to increase from \$13 million to \$25.5 million (96%), and the retiree contribution is projected to increase from \$2.9 million to \$4.2 million (45%).
- MCPS projects that the total cost of retiree group insurance will increase from \$16.7 million in FY 95 to \$29.5 million by FY 2000. The agency contribution is projected to increase from \$12 million to \$21.1 million (76%); and the retiree contribution is projected to increase from \$4.7 million to \$8.4 million (80%).

Table 6
Agency Cost per Retiree in FY95 and Projected for FY00



Agency	\$ FY95	\$ FY00	\$ Change	% Change
County Govt	4194	6480	2286	55%
MCPS	2955	4063	1108	37%
College	1450	1604	154	11%
M-NCPPC	4669	5206	537	12%
WSSC	4079	5324	1245	31%

- Montgomery College projects that the total cost of retiree group insurance will increase from \$659,000 in FY 95 to approximately \$1 million by FY 2000. The agency contribution is projected to increase from \$0.4 million to \$0.6 million (52%); and the retiree contribution is projected to increase from \$262,300 to \$398,300 (52%).
- M-NCPPC projects that the total cost of retiree group insurance (Montgomery County portion only) will increase from \$764,000 in FY 95 to \$1 million by FY 2000. The agency contribution is projected to increase from \$649,000 to \$859,000 (32%); and the retiree contribution is projected to increase from \$115,000 to \$152,000 (32%).
- WSSC projects that the total cost of retiree group insurance will increase from \$4.1 million in FY 95 to \$6 million by FY 2000. The agency contribution is projected to increase from \$3.5 million to \$5.1 million (46%); and the retiree contribution is projected to increase from \$616,000 to \$898,000 (46%).

B. Approaches to Funding

The 1994 Government Finance Officers Association survey of state and local governments that provide retiree health benefits found that:

- 32% provide retiree health benefits free of charge to retirees;
- 32% provide retiree health benefits that are financed 100% by the retirees themselves; and
- The remaining 36% share the costs between the employer and the retirees.

Of those government employers who finance some portion of their retiree health benefits, 16% reported that they prefund some of their future liability and an additional 25% indicated that they are considering prefunding.

B1. Private Sector Financial Accounting Standards (FAS 106)

Post-retirement group insurance benefits were traditionally funded in the public and private sector on a pay-as-you-go basis. Since 1992, however, private sector employers have been subject to a new accounting standard (Financial Accounting Standards 106), which requires employers to accrue the expected cost of future retiree medical benefits.

The governing principle of FAS 106 is that the expense of benefits must be fully recognized during the period of service when the benefits are earned. While changing how retiree medical benefits are accounted for does not necessarily increase the annual cost of those benefits, it can have a profound impact on an entity's financial statements.

FAS 106 is frequently cited as a major reason that private sector employers are reexamining the provision of retiree medical benefits. Largely resulting from the issuance of FAS 106, techniques for prefunding retiree health benefits are being used more frequently. Examples of prefunding alternatives being used primarily in the private sector are:

- 501 (c)(9) Voluntary Employee Beneficiary Association (VEBA): is where an employer sponsors a trust in which workers can make regular contributions that the employer may match in whole or in part. Employee contributions go into the trust after taxes are paid, and the trust earnings and payments for health premiums are then tax free. VEBAs must be based on voluntary membership.
- 401(h) retiree medical account: is where a qualified pension plan provides funding for retiree health expenses by contributing to a separate account under the plan. Contributions are tax-deductible, and earnings are tax-free. Medical benefits must be subordinate to the plan's retirement pensions and non-pension contributions cannot exceed 25% of the aggregate contributions made to the pension plan.
- 401(k) pension plan: is where a portion of the funds contributed to a 401(k) pension plan are set-aside for retiree health benefits. In retirement, distributions to the retiree are taxable and can then be used to pay for retiree health benefits.
- Corporate Owned Life Insurance (COLI): is where an employer purchases life insurance on the active work force and later collects the life insurance proceeds (tax-free) and/or borrow the maximum cash surrender value to derive a positive cash flow in later years.

B2. Funding approaches of the five agencies

For now, the accounting standards for the public sector issued by the Government Accounting Standards Board (GASB) do not require that retiree medical benefits be recognized during the period of service when the benefits are earned. There is discussion of imposing some of the principles of FAS 106 on the public sector at some point in the future; according to the independent auditors for the County Government, some change in the government accounting standards governing post-retirement group insurance benefits is expected to occur in two to three years. (See letter from KPMG Peat Marwick LLP included as Appendix H.)

All five agencies use a combination of agency and retiree contributions to fund the annual cost of retiree group insurance benefits. The source of funds for the agency contribution is general revenue for the County Government, MCPS, M-NCPPC, and Montgomery College, and water and sewer fund revenue for WSSC.

At present, the College is the only one of the five agencies that is setting-aside funds each year to fund the liability of group insurance benefits for future retirees. At one time, MCPS was prefunding health and life insurance benefits, but annual contributions to the health and life insurance trust funds were discontinued during the 1980's. The different agency approaches are discussed below.

County Government

The County Government also funds retiree group insurance entirely on a pay-as-you-go basis except that the County and active employees contribute each pay period to a fund entitled "pre-funding of retiree life insurance". The amount contributed is a fixed amount per employee and does not vary according to the employee's salary. In total, approximately \$4 is deducted each year from each employee's paycheck for this purpose; and this amount is matched by a contribution of the County Government of \$16 per year per employee.

In FY 95, active employees contributed a total of approximately \$23,000 and the County contributed approximately \$101,000 for the "pre-funding of retiree life insurance." Although this money is tracked in a separate account, it is OLO's understanding that, in practice, it is used simply as another source of funds for the total costs of group insurance and is not set aside exclusively to fund actual life insurance costs for retirees. The prefunding practice is, however, linked to the policy that County Government retirees age 65 or older no longer have to contribute toward a life insurance premium.

Montgomery County Public Schools (MCPS)

MCPS began prefunding retiree health and life insurance benefits in 1960. Annual contributions (a combination of agency and employee contributions) were made to a retiree health insurance trust fund account until 1980, and contributions to a retiree life insurance trust fund account were made until 1987. In accordance with the Board of Education's policy during those years, the Board's share of retiree health and life insurance benefits were paid 70% from the operating budget and 30% from the trust fund.

Although annual MCPS contributions to the trust fund accounts stopped during the 1980's, the trust fund has continued to be a source of revenue to offset the agency share of retiree group insurance benefits paid out of the annual operating budget. By FY 94, funds in the health insurance trust account were depleted and \$13 million was transferred from the life insurance account to the health insurance account. In FY 96, the two accounts were merged into a single trust fund account. As of June 1995, the trust fund balance was approximately \$31.3 million; the use of this trust fund will depend upon future budget and policy decisions of the Board of Education.

Montgomery College

Montgomery College funds the current costs of retiree group insurance on a pay-as-you-go basis. However, since FY 94, the College began to set-aside funds from the current operating budget to pay for future group insurance benefits for retirees.

Prior to FY 94, the College followed the guidelines set forth by the Financial Accounting Standards Board (FASB). In 1993, to satisfy the requirements of FAS 106, the College conducted an actuarial study to estimate the College's liabilities and expense for providing post-retirement medical, dental, and life insurance benefits. A schedule of payments to prefund this future liability, amortized over 20 years was developed.

Since FY 94, the College has been under the guidelines established by the Government Accounting Standards Board (GASB). However, the College has continued to adhere to the prefunding schedule developed when the College was following FAS 106. In accordance with that schedule, the following payments have been made to a restricted account for post-retirement benefit costs:

\$1,685,000 in FY 94
\$1,750,000 in FY 95
\$1,750,000 in FY 96.

Exactly when and at what rate funds from this restricted account will be used to help pay for retiree group insurance benefits has not yet been determined.

Maryland-National Capital Park & Planning Commission (M-NCPPC) and Washington Suburban Sanitary Commission (WSSC)

M-NCPPC and WSSC fund retiree group insurance on an entirely pay-as-you-go basis. The total projected cost for the fiscal year (agency share plus retiree share) is included in each agency's annual appropriation request.

C. Employer/Retiree Cost Sharing

C1. General

There are many different approaches that employers take to sharing the cost of post-retirement group insurance with retirees. In general, premium costs are either split between the employer and the retiree on a percentage basis (e.g., 80/20, 70/30), or the employer contributes a fixed dollar amount toward the cost (e.g., \$100/month). Almost all employers use a different pricing approach for retirees once they reach 65 and are eligible to receive Medicare benefits.

Some employers also vary the pricing schedule according to the retiree's years of service and/or years of participation in the employer's health insurance program. Other employers vary the pricing schedule according to a formula that combines years of service with the age of the employee at the time of retirement.

The pricing schedule for retirees under 65 can be the same or different than that for active employees, but almost all employers have different pricing for retirees once the retirees become Medicare eligible. Costs for health insurance for retirees under age 65 are substantially higher than coverage for retirees age 65 and over because Medicare pays much of the cost. The impact on employers' costs could be substantial if the federal government changes the Medicare eligibility requirements or modifies what Medicare does and does not cover (see pages 14-16).

The 1994 Foster-Higgins survey indicated that for retirees under age 65, of the large employers (5,000 or more employees) surveyed-

- the average premium split between employers and retirees (on a percentage basis) was 68/32 for individual coverage and 62/38 for family coverage; and
- the average dollar contribution for retirees under age 65 was \$109 per month for individual coverage and \$204 per month for family coverage.

For Medicare-eligible retirees age 65 and over:

- 23% paid 100% of the premiums for retiree-only coverage; 41% shared the cost; and 36% required retirees to pay the full cost;
- the average split was 62/38 for individual coverage and 63/37 for family coverage premiums; and
- the average contribution for Medicare-eligible retirees was \$89 per month for individual coverage and \$154 per month for family coverage.

The approach to pricing life insurance also varies, especially because the life insurance benefits for retirees are often different than the life insurance benefits for active employees, with a sizable number of employers not offering any life insurance benefits to retirees. Some employers apply the same employer/retiree premium split used in health insurance to life insurance, although it is not uncommon for life insurance benefits to be provided to retirees either on a employer/retiree premium split of 100/0 (retiree pays zero) or 0/100 (retiree pay entire premium).

C2. Employer/retiree cost sharing by agency

Health insurance pricing: Each agency has a somewhat different approach to pricing health insurance for its retirees. In general, for retirees not yet eligible for Medicare:

- The County Government's pricing schedule varies according to when the employee was hired and the number of years of participation in the County's group insurance plan as an active employee.
- MCPS's pricing schedule varies according to the number of years of participation in MCPS' group insurance plan as an active employee.

- Montgomery College's pricing schedule varies according to the employee's years of service with the College.
- WSSC's pricing schedule depends on when the employee was first hired and the years of service with the agency.
- M-NCPPC's pricing is independent of participation in group insurance or years of service.

MCPS is the only one of the five agencies that calculates health insurance premiums for under-65 retirees separately from premiums for active employees. The other four agencies calculate health insurance premiums based upon the group of participants, including active employees and under-65 retirees together.

For all five agencies, the actual contribution of the retiree also varies depending upon the plan options offered and selected, i.e., indemnity, point-of-service, HMOs, etc. The pricing schedules for all five agencies also change for retirees once they become eligible for Medicare.

The different approaches for pricing health insurance for retirees under age 65 are discussed below. For the previous discussion of eligibility requirements, see pages 5-8; for an explanation of how agency-sponsored medical benefits are coordinated with Medicare, see pages 14-16.

County Government: For County employees hired on or after January 1, 1987, the employer/retiree premium split for health insurance is 50/50 for employees with five years of participation in the County's group insurance plan as an active employee. (Employees with fewer than five years of participation directly before retirement are not eligible to participate.) The County's contribution increases 2% for every additional year of participation up to a maximum employer/retiree premium split of 70/30 (for employees with 15 years or more of participation).

Employees hired before January 1, 1987 have the option of keeping the same premium split that they had as active employees (currently set at 80/20) for the number of years and months they were covered in the group insurance program as an active employee. For example, if an employee had 15 years of participation at the time of retirement, then he/she could continue health insurance participation at the 80/20 rate for 20 years. At the end of 20 years, the retiree could continue to participate but would have to begin paying the entire premium.

The change in pricing options effective for employees hired since January 1987 was outlined in Council Resolution 10-2233, Insurance Benefits for Retirees, adopted October 16, 1986. A copy of this resolution is included as Appendix I.

Montgomery College: For Montgomery College retirees, the employer/retiree premium split depends on the years of College service. For retirees with five to ten years of service, the employer/retiree premium split for health insurance is 40/60. (Employees with fewer than five years of service directly before retirement are not eligible to participate.) For employees with more than 10 years of service, the premium split is 60/40.

MCPS: For MCPS retirees, the employer/retiree premium split is based on a formula that combines age and years of enrollment in a MCPS health plan as an active employee. For retirees with 1-5 years of enrollment at the time of retirement, the employer/retiree premium split is 50/50. For retirees with more than 5 years of enrollment, the employer/retiree premium split is 70/30.

M-NCPPC: For M-NCPPC employees, the employer/retiree premium split is 85/15 for medical and dental insurance, and 80/20 for vision insurance. The pricing schedule does not depend on either the age or years of service of the employee at the time of retirement. (Employees with fewer than three years of participation directly before retirement are not eligible to participate.)

WSSC: For WSSC employees hired before April 1, 1994, the employer/retiree premium split for all health benefits is on a sliding scale depending on the years of WSSC service. The ratio ranges from 21.25/78.75 for five years of service up to 85/15 for 20 years of service. A table showing the cost sharing formula is included in Appendix J.

For WSSC employees hired before April 1, 1994, the employer/retiree premium split is 85/15 for medical, vision, and prescription drug and 0/100 for dental insurance. The sliding scale of cost sharing does not apply to employees/retirees hired before April 1, 1994.

C3. Life insurance pricing:

For a summary of the retiree life insurance benefit offered by each agency, see page 17. Life insurance benefits are provided to retirees of MCPS, WSSC, and M-NCPPC, and over-65 retirees of County Government at no cost to the retiree. Specifically:

County Government: The employer/retiree premium split for life insurance is 80/20 for retirees under age 65 and 100/0 (no cost to the retiree) for retirees 65 and older. As explained earlier, active employees contribute to the "pre-funding of retiree life insurance" (see page 23).

MCPS: The employer/retiree premium split for life insurance is 100/0 (no cost to the retiree).

College: The employer/retiree premium split for life insurance is 80/20.

M-NCPPC: M-NCPPC employees who are members of the Employees' Retirement System receive a \$10,000 death benefit at no premium cost to the retiree.

WSSC: The employer/retiree premium split for life insurance is 100/0 (no cost to the retiree); in addition, WSSC retirees can purchase supplemental life insurance at a premium split of 1/100 (no cost to WSSC)

V. COMPARATIVE INFORMATION

A. General

OLO conducted a phone survey of area local governments and schools systems to find out basic information about the group insurance benefits available to their retirees. Information was also obtained about post-retirement group insurance benefits offered by the Federal government and the State of Maryland. The summary of the information was subsequently verified by representatives of the survey participants.

The local governments surveyed were:

- Alexandria City Government
- Anne Arundel County Government
- Arlington County Government
- Baltimore County Government
- Fairfax County Government
- Howard County Public Schools
- Prince George's County Government

The school systems surveyed were:

- Alexandria City Public Schools
- Anne Arundel County Public Schools
- Arlington County Public Schools
- Fairfax County Public Schools
- Howard County Public Schools
- Prince George's County Public Schools

This chapter summarizes the survey findings in terms of: eligibility requirements, health plan options, approach to handling out-of-area retirees, life insurance benefits, pricing, and funding. Appendix K contains additional details about each of the systems included in the survey.

B. Summary of Findings

B1. Eligibility requirements

For all 15 systems surveyed, a retiree must be receiving a pension in order to be eligible for retiree group insurance benefits. In addition, the following 10 systems require that a retiree participated in the employer's medical plan prior to retirement in order to enroll in retiree group insurance:

- Alexandria City Government
- Alexandria City Public Schools
- Anne Arundel County Public Schools
- Arlington County Government
- Fairfax County Government
- Howard County Public Schools
- Prince George's County Government
- Prince George's County Public Schools
- Federal Government

Six of the 15 systems surveyed have some re-enrollment provision that allows retirees (under certain conditions) to participate in a medical plan after the retiree has previously chosen not to participate; specific re-enrollment restrictions and qualifications vary by jurisdiction:

- Anne Arundel County Public Schools
- Baltimore County Government
- Fairfax County Public Schools
- Howard County Government
- Howard County Public Schools
- Prince George's County Public Schools

In addition, Alexandria City Government offers retirees a one-time re-enrollment option and Anne Arundel County Government's re-enrollment option is scheduled to terminate next year. Prince George's County Government has a re-enrollment option for police and fire retirees only.

Four of the 15 systems surveyed allow deferred retirees to participate in group insurance upon collecting a pension:

- Anne Arundel County Public Schools
- Baltimore County Government
- Howard County Government
- State of Maryland

Eleven of the systems surveyed provide life insurance benefits to retirees. Of these, two (Baltimore County Government, Prince George's County Public Schools) have additional life insurance requirements for participation in the retiree life insurance program.

B2. Health insurance plan options

Eleven of the 15 plans surveyed offer dental, vision, and prescription drug benefits to retirees either as part of regular medical plans that are offered or available as stand-alone plans:

- Alexandria City Government
- Alexandria City Public Schools
- Anne Arundel County Government
- Anne Arundel County Public Schools
- Arlington County Government
- Arlington County Public Schools
- Fairfax County Government
- Howard County Public Schools
- Prince George's County Government
- Prince George's County Public Schools
- State of Maryland

The exceptions are:

- Baltimore County Government - dental and vision insurance is unavailable except in one HMO plan
- Fairfax County Public Schools - vision is unavailable except for minor coverage with the 2 HMO plans
- Howard County Government - dental insurance is unavailable
- Federal Government - vision insurance is offered in only a few plans

All 15 plans surveyed integrate employer-sponsored medical benefits with Medicare and assume retirees will enroll in Medicare Part B upon turning 65 years of age, except that the Federal Government does not require Medicare Part B participation.

Five of the 15 systems surveyed offer special medical plan options for out-of-area retirees:

- Alexandria City Government pays the first \$99.62 on premiums and retirees pay the remainder (the same plan for in area retirees).
- Anne Arundel County Government
- Arlington County Government
- Fairfax County Government
- Fairfax County Public Schools

Four of the 15 systems surveyed prevent or limit retirees from transferring health plan options after retirement:

- Alexandria City Public Schools
- Arlington County Public Schools allows coverage to be decreased only.
- Fairfax County Government allows transfer to current plan option only, FairChoice (the triple plan option).
- Howard County Public Schools allows transfer of medical insurance plans only

Seven of the 15 systems surveyed place limits on survivor coverage. In three systems, survivors must pay the full cost of the retiree premium:

- Alexandria City Government
- Arlington County Public Schools
- Howard County Public Schools

In the other four, survivors must receive a pension/retirement annuity check to receive benefits:

- Anne Arundel County Government
- Anne Arundel County Public Schools
- Fairfax County Government
- Federal Government

B3. Life insurance benefits

Four of the 15 systems surveyed do not offer life insurance to their retirees:

- Anne Arundel County Government
- Anne Arundel County Public Schools
- Howard County Government
- State of Maryland

Eight of the 11 systems that provide retiree life insurance benefits offer this benefit at zero premium cost to the retirees:

- Alexandria City Government
- Alexandria City Public Schools
- Arlington County Public Schools (for basic life insurance only)
- Fairfax County Public Schools (for full-time administrators and educators only)
- Howard County Public Schools
- Prince George's County Government
- Prince George's County Public Schools

Six of the 11 systems that provide life insurance benefits to retirees offer a declining benefit that reduces to 50% of the retiree's final annual salary:

- Alexandria City Public Schools
- Arlington County Public Schools
- Baltimore County Government
- Fairfax County Public Schools (for full-time administrators and educators only)
- Prince George's County Government
- Prince George's County Public Schools

Two systems also offer supplemental (optional) life insurance benefits to retirees:

- Arlington County Government
- Federal Government

B4. Pricing

Five of the 15 systems surveyed share the costs of providing retiree medical benefits using a percentage basis with the following employer/retiree premium split:

- Anne Arundel County Government (80:20)
- Anne Arundel County Public Schools (80:20 for hospital costs; 50:50 for major medical)
- Prince George's County Government (80:20 for HMOs; 75:25 for POS)
- Prince George's County Public Schools (70:30 for medical; 50:50 for dental and vision)
- Federal Government (averages 75:25)

For retirees of Fairfax County Government and Fairfax County Public Schools, the medical benefit is defined as continuing to participate in the group plans provided by the employer. The employer/retiree premium split is 0/100, but for retirees age 62 and older, the agency provides a \$45/month subsidy.

Six of the 15 systems surveyed use a sliding scale pricing schedules for their retirees:

- Arlington County Government
- Arlington County Public Schools
- Baltimore County Government
- Howard County Government
- Howard County Public Schools
- State of Maryland

In five systems, the pricing schedule depends on the retiree's years of service. In two systems, the pricing schedule depends on the plan options chosen (In Baltimore County Government, the pricing depends on both criteria.)

Two of the 15 systems surveyed use a fixed dollar contribution approach to pricing:

- Alexandria City Government
- Alexandria City Public Schools

B5. Funding approach

All 15 systems surveyed fund their retiree health insurance program on a pay-as-you-go basis.

Seven of the 11 systems surveyed that provide life insurance also fund their life insurance programs on a pay-as-you-go basis:

- Alexandria City Government
- Arlington County Government
- Baltimore County Government
- Fairfax County Government
- Howard County Public Schools
- Prince George's County Government
- Prince George's County Public Schools

The other four systems that provide life insurance prefund their life insurance benefits for retirees:

- Alexandria City Public Schools
- Arlington County Public Schools
- Fairfax County Public Schools
- Federal Government

The three Virginia jurisdictions listed above prefund their retiree life insurance through the Virginia State Retirement System. The Federal Government funds its basic life insurance program only through a trust fund.

VI. APPROACHES TO CONTROLLING COSTS

A. Methods for Controlling Future Costs

A1. General.

Rising medical costs, increased longevity, and the increasing number of retirees are factors causing both public and private sector employers to take a serious look at the future of retiree benefits. Many of the initiatives being used to control retiree health costs are consistent with employers' efforts to manage benefit costs for active employees.

It appears that only a small percent of employers are eliminating retiree health benefits altogether, especially for current retirees. A 1993 General Accounting Office study indicated that less than 1% of approximately 1,400 employers surveyed planned to terminate health benefit plans for their current retirees, and only 3-5% were considering total elimination of their health plans for future retirees.

Instead of terminating coverage altogether, many public and private sector employers are acting to limit their future retiree group insurance costs by making changes to eligibility, pricing, plan design, plan options, and funding arrangements. The 1994 GFOA survey reported that 53% of the respondents (including 66% of the larger jurisdictions) are attempting to reduce their costs or liabilities for retiree health care. The survey found that of all public sector employers attempting to reduce retiree health costs:

- 68% reported using managed care arrangements;
- 47% reported increasing cost sharing with retirees; and
- 20% reported reducing benefits.

As indicated by the percentages above (which sum to more than 100%), many employers are utilizing more than one method to reduce their costs and liabilities.

The 1994 Foster Higgins survey indicated that 44% of employers made changes to their retiree medical plan between 1992 and 1994. The survey showed that 30% of the employers increased the retiree's premium contribution; 16% raised deductible amounts, co-payments, and/or out of pocket maximums; 14% added a managed prescription drug card plan; 13% tightened eligibility requirements; 3% changed from a defined benefit plan to a defined contribution plan; and 7% terminated the retiree medical benefits for future retirees.

This chapter examines a number of these changes in more detail and outlines a number of the legal issues involved with making changes to retiree group insurance benefits.

A2. Changes to eligibility requirements

One approach to controlling employer costs is to tighten eligibility requirements for post-retirement group insurance benefits. While a majority of employers still use the same age and service requirements for retiree medical benefits as for their pension plan, many are introducing special eligibility requirements for the retiree medical plan. Examples include:

- Establishing or increasing a minimum years of service requirement (typically 10 years);
- Establishing or increasing a minimum number of years of participation in the employer's group insurance plan;
- Establishing a minimum age requirement (typically 55 years);
- Establishing a minimum age and years of service requirement.

Another area being examined for future cost savings is coverage for spouses and dependents. Methods for limiting employer costs include:

- Limiting coverage to the spouse and dependents identified at the time of retirement;
- More carefully investigating the eligibility of dependents to continue coverage;
- More aggressively pursuing coordination of benefits if a spouse or dependent is also covered by his/her employer; and
- Discontinuing coverage of a surviving spouse if he/she remarries.

A3. Changes to financing arrangements

Employers are using a variety of approaches to decrease their share of group insurance costs. Changes range from increasing the retiree's contributions to wholesale restructuring how benefits are provided and funded. Changes can be implemented all at once or phased in over several years. Some examples are described below.

- The retiree's contribution toward the cost of group insurance benefits can be increased by: increasing deductibles, premiums, and co-payments; establishing higher out-of-pocket maximums; and/or reducing annual and/or lifetime maximums.
- The employer's contribution can be changed from a percent of total costs to a fixed dollar amount per retiree. For example, the employer-provided benefit can be changed from a commitment to pay 80% of the total cost to a commitment to provide a fixed payment per month, e.g., \$100 per month for retirees under 65 and \$50 per month after age 65. The remaining premium amounts are paid by the retiree.
- The employer's contribution can be established on a sliding scale, which varies depending on the retiree's years of service. For example, the employer/employee premium split might be 80/20 for a retiree with 20 years of service, but 40/60 for a retiree with only 10 years of service. The remaining premium amounts are paid by the retiree.¹

1: This type of approach has been adopted by WSSC for employees hired since April 1994, see page 27.

- The employer can continue to allow retirees to participate in the employer's group insurance plans but establish premiums so that the entire cost of the plan is paid for by the plan participants. In this example, the benefit becomes defined as the availability of guaranteed coverage with the advantage of a group premium.
- The employer can increase pension benefits by a fixed dollar amount and discontinue a separate retiree medical benefit. In this example, the employer's contribution is fixed at the increased pension amount; and the retiree receives additional pension income, which can be used to purchase post-retirement health benefits.
- The employer can establish a plan under which active employees contribute to a retiree flexible spending account. The employer can decide how much to match each employee's contributions. Although the contribution is in after-tax dollars, the funds invested accumulate income on a tax-deferred basis. Upon retirement, the funds built up in the retiree flexible spending account can be used to purchase health insurance (in which case they remain tax-free) or can be taken out as an annuity, in which case taxes are paid on the amounts withdrawn.

A4. Change in plan options and plan design

For many years, almost all retiree medical plans were structured as traditional indemnity (fee for service) plans. Reasons for retaining this model have included: retirees' preference and familiarity with plans that do not restrict an individual's choice of health care providers; the relocation of retirees can take them outside the area served by an employer's managed care plan; and employers' approaches to Medicare integration have been generally designed for coordination with an indemnity plan arrangement.

However, many employers (including the five County and bi-County agencies) are implementing forms of managed care for their retirees. The 1994 GFOA survey reported that the use of managed care arrangements is the principal method of cost reduction, reported by 67% of employers who finance some portion of their retiree health benefits. Specific examples include:

- Introducing managed prescription drug benefit plans, which can control costs through negotiating discounts on drug prices, provide incentives for use of generic drugs, lower dispensing fees, increase use of lower cost mail order dispensing, and employ pharmacy benefit case management techniques.
- Offering incentives for retirees to migrate from traditional indemnity plan arrangements to managed care networks, ranging from preferred provider organization (PPO) plans to health maintenance organization (HMO) plans. The incentives are typically in the form of lower premiums and lower out-of-pocket expenses.
- Discontinuing the availability of a traditional indemnity plan.¹ In 1994, as noted earlier in this report, only 60% of large employers continued to offer their employees and retirees a traditional indemnity plan. Indemnity plan enrollment dropped from 43% of all eligible employees in 1993 to only 34% of all eligible employees in 1994.

1: WSSC and M-NCPPC have discontinued the availability of a traditional indemnity plan; and the County Government has indicated its intent to do so by 1998.

A5. Additional examples

Appendix L contains a June 1994 article from Plan Sponsor that describes additional examples of how private sector employers are using different methods to control future costs and liabilities associated with retiree group insurance benefits. Appendix M describes a proposal to limit the federal government's cost of health care for retired federal employees, as set forth in the Congressional Budget Office's 1995 Report to the Senate and House Budget Committees reducing the deficit.

B. Legal Issues

During the past decade, there have been numerous court cases around the country concerning the rights of an employer to modify or terminate retiree medical benefits. These cases raise difficult issues, often placing the rights and obligations of employers trying to control increasing costs of employee benefits versus the rights and financial needs of retired employees.

According to the Office of the County Attorney, there is no Maryland case law at this time which definitively addresses the rights of a governmental employer in Maryland to modify or terminate retiree health care benefits. However, based upon a review of information related to changes being made to retiree group insurance plans, a number of the major legal issues to be considered are listed below.

Who will the changes apply to? Changes can be implemented to affect one or more of the following groups of retirees and employees:

- employees who have already retired;
- active employees who are already eligible to retire and receive retiree group insurance benefits but who have not yet retired;
- active employees who do not yet meet the requirements to retire and receive retiree group insurance benefits; and
- future employees.

The factors to consider are different depending upon which group(s) an employer wants changes to apply to.

Does the employer have a contract with its employees and/or retirees to provide retiree group insurance benefits, and if so, what are the terms of that contract? In assessing whether a contractual commitment exists, the information distributed to employees and retirees is an important factor. Specifically, the court test appears to be whether the employer unambiguously reserved the right to make unilateral changes to the terms of retiree group insurance benefits and/or to terminate coverage entirely.¹ The record of how benefits were communicated to employees and retirees, either orally or in writing, contributes to whether an employer indicated that retiree group insurance benefits are or are not subject to modification in the future.

1: The employee benefits books provided to WSSC and MCPS employees both contain explicit language stating that the benefit plan described in the book is subject to change. An excerpt from WSSC's handbook is attached as Appendix N.

Are the changes under consideration substantial, reasonable, and necessary? If a court were to determine that a contract had been established, then the question becomes whether the changes under consideration constitute a "substantial impairment" of that contract. For example, making changes to co-payments and deductibles is not likely to be viewed as a substantial impairment, while terminating coverage altogether could be viewed as a substantial impairment. Even if a change was determined to be substantial, then another court test appears to be whether the change was "reasonable and necessary to serve an important public purpose".

Relationship of post-retirement group insurance benefits to collective bargaining. Retiree group insurance benefits are not included in the current collective bargaining agreements bargained by any of the County and bi-County agencies. There is no authority in the County's collective bargaining law and the Police labor relations act for the unions to bargain on behalf of retired employees.

VII. SUMMARY OF FINDINGS AND RECOMMENDATIONS

This chapter is organized into two parts. Part A summarizes the major findings of this report; Part B sets forth OLO's recommendations.

A. SUMMARY OF FINDINGS

Employer-sponsored plans are an important source of health care coverage for retirees, especially for under-65 retirees who are not yet eligible for Medicare coverage. The increasing costs of health care, increased longevity, the changing ratio of active to retired employees, and fiscal constraints are causing many public and private sector employers to take a serious look at the future of health and life insurance benefits offered to retirees.

There are both similarities and differences to how each of the County and bi-County agencies structure retiree group insurance benefits. The factors which vary among agencies include: eligibility requirements; health plan options available to retirees; the calculation of retiree life insurance benefits; the pricing of benefits, whether the annual transfer season is open to retirees; and policies regarding out-of-area retirees.

Eligibility Requirements

- Across the five agencies, more than 95% of eligible retirees elect to participate in the agencies' post-retirement health and life insurance benefit plans.
- Similar to many other public and private sector employers who provide retiree group insurance benefits, the five agencies: link receipt of retiree health benefits to receipt of a pension; provide group insurance benefits to the survivors and dependents of retirees; and extend the availability of retiree health benefits to early retirees and disabled retirees.
- All five agencies have additional eligibility requirements concerning enrollment in the agency's health insurance plan as an active employee, with requirements from one to five years of enrollment. (Years of enrollment can also affect the employer/retiree cost sharing formula.) These requirements parallel the practice of almost 60% of other employers who offer post-retirement health insurance benefits.

Health Plan Options for Retirees

- Consistent with the practice of many other employers, the five agencies generally provide under-65 retirees with health plan options and levels of coverage similar to active employees. Once retirees become eligible for Medicare, the employer-provided coverage is modified.

- Similar to the practice of almost half of public sector employers who provide retiree health benefits, agency retirees are offered more than one health plan option. The availability of additional health plan components (i.e., dental, vision, and prescription drug insurance) varies among the agencies, as do the policies concerning the ability of retirees to participate in the agency's annual transfer season.
- For the 1995 benefit year, all five agencies offered retirees the option of at least one health maintenance organization (HMO) and a managed care network (point-of-service plan or preferred provider organization), with reimbursement of 70-80% for non-network services. Three agencies (County Government, MCPS, College) also continue to provide an indemnity plan, although for County Government and MCPS, enrollment in the indemnity plan is restricted.
- For the agencies that continue to offer an indemnity medical plan, the overwhelming majority (82-88%) of retirees are indemnity plan members. For M-NCPPC and WSSC (the two agencies that no longer offer an indemnity plan option), the majority of retirees belong to the managed care network (POS or PPO).
- A factor frequently cited as increasing indemnity plan costs is the changing demography of indemnity plan members. As active employees leave indemnity plans more quickly than retirees and the portion of active employees in indemnity plans decline, per participant medical costs tend to increase.
- Retirees who already belong to an agency medical plan and who re-locate out of the Washington metropolitan service area have the following health plan options: MCPS retirees hired before 1/1/94 and College retirees can transfer to the agencies' indemnity plans; County Government and WSSC retirees can transfer to the agencies' point-of-service plans; and out-of-area M-NCPPC retirees can transfer to the agency's preferred provider organization plan.

Approaches to Medicare integration

- Medicare is the primary payer of medical benefits for retirees age 65 and over. "Medicare integration" is the term used to describe how medical costs not covered by Medicare are divided between retirees and employers.
- The health plans of the five agencies are designed on the assumption that over-65 retirees are enrolled in Medicare Part A (hospital insurance) and Part B (medical insurance). Beyond this assumption, each agency takes a somewhat different approach to integrating retiree medical benefits with Medicare. Medicare integration with indemnity plans also varies from Medicare integration with managed care arrangements.
- Employer-sponsored medical plans for retirees, including those offered by the five agencies, will be profoundly affected if the federal government implements some of the structural changes to Medicare currently under discussion. Most of the proposals (e.g., raising the age of Medicare eligibility, higher deductibles and co-payments) would reduce the federal government's contribution. This in turn raises the question of whether the remaining costs will be passed along to employer-sponsored plans or retirees.

Life Insurance Benefits for Retirees

- Similar to many other employers, the County Government, MCPS, College, and WSSC offer a declining life insurance benefit to retirees. This means that the level of the benefit (which is calculated based on the retiree's final salary as an active employee) continues to be reduced over a pre-established period of time and then remains at a minimum level for the lifetime of the retiree.
- For County Government retirees, the life insurance benefit declines over time to 25% of the initial retired life amount; for WSSC and MCPS retirees, it declines over time to 25% of the retiree's final annual salary; and for College employees it eventually declines to \$5,000.
- At M-NCPPC, retirees who are members of the Employees' Retirement System (ERS) are eligible to receive a death benefit of \$10,000. In addition, at the time of retirement, employees who participated in M-NCPPC's optional life insurance benefit plan can opt to convert their life insurance benefit (calculated as 1.8X base salary with a maximum amount of \$125,000) to an individual plan.

The Costs of Providing Benefits

- In FY 92, the total cost of providing health and life insurance benefits to 6,823 retirees of the five agencies was \$21.5 million. This increased to \$38.1 million for 8,434 retirees in FY 95, and is projected to increase to \$67.2 million for 10,622 retirees by FY 2000.
- The total cost of providing group insurance benefits to retirees is shared between the agencies and the retirees themselves. In FY 95, the agencies contributed \$29.5 million (78% of the total) and the retirees contributed \$8.6 million (22% of the total). Agency projections indicate that by FY 2000, the agencies will contribute \$53.1 million (80% of total costs) and the retirees will contribute \$14.1 million (20% of total costs).
- In FY 95, the agency contribution per retiree by agency averaged: \$4,194 for County Government; \$2,955 for MCPS; \$1,450 for Montgomery College; \$4,669 for M-NCPPC; and \$4,079 for WSSC.
- Agency costs for retiree group insurance per retiree are projected to increase between FY 95 and FY 2000 by: 55% for County Government; 37% for MCPS; 11% for the College; 12% for M-NCPPC; and 31% for WSSC. Factors that contribute to this significant range of agency projections include: the assumptions used for medical inflation; the agency approach to pricing benefits; the number of retirees and projected increases in retirees; the medical plan choices available to retirees and the agency approach to Medicare integration; and the number of under-65 vs. over-65 retirees.

Approaches to Funding

- Since 1992, private sector employers have been subject to a new accounting standard (Financial Accounting Standards 106), which requires employers to accrue the expected cost of future retiree medical benefits. FAS 106 is frequently cited as a major reason that private sector employers are reexamining the provision of retiree medical benefits.
- For now, the accounting standards for the public sector issued by the Government Accounting Standards Board (GASB) do not require that retiree medical benefits be recognized during the period of service when the benefits are earned. There is discussion of imposing some of the principles of FAS 106 on the public sector at some point in the future. According to the independent auditors for the County Government, some change in the government accounting standards governing post-retirement group insurance benefits is expected to occur within two to three years.
- At present, Montgomery College is the only agency setting-aside funds each year to prefund the future cost of retiree group insurance benefits. MCPS had established a trust fund for prefunding retiree health and life insurance benefits, but annual contributions to the trust fund accounts were discontinued during the 1980's; the remaining MCPS trust fund balance continues to serve as a source of funding.

Employer/Retiree Cost Sharing

- The 1994 Government Finance Officers Association survey of state and local governments that provide retiree health benefits found that: 32% provide retiree health benefits free of charge to retirees; 32% provide retiree health benefits that are financed 100% by the retirees themselves; and the remaining 36% share the costs between the employer and the retirees.
- There are many different ways that employers share the cost of post-retirement group insurance with retirees. In general, premium costs are either split between the employer and the retiree on a percentage basis (e.g., 80/20, 70/30), or the employer contributes a fixed dollar amount toward the cost (e.g., \$100/month). Almost all employers use a different pricing approach for retirees once they reach 65 and are eligible to receive Medicare benefits.
- For all five agencies, the actual dollar contribution of the retiree varies depending upon the plan options offered and selected, i.e., indemnity, point-of-service, HMOs, etc. The pricing schedules for all five agencies change for retirees once they become eligible for Medicare. Beyond these similarities, each agency has a somewhat different approach to pricing health insurance for its retirees.
- In FY 95, the portion of total retiree group insurance costs paid for by the agencies were: 82% for County Government; 72% for MCPS; 60% for the College; 85% for M-NCPPC; and 85% for WSSC. The employer/retiree cost sharing formulas vary by agency:

- The County Government's pricing schedule varies according to when the employee was hired and the number of years of enrollment in the County's group insurance plan as an active employee.
- MCPS's pricing schedule varies according to whether the retiree participated in the agency's medical plan as an active employee for one to five years or more than five years.
- Montgomery College's pricing schedule varies according to the employee's years of service with the College.
- WSSC's pricing schedule depends on when the employee was first hired and the years of service with the agency.
- M-NCPPC's pricing is independent of participation in group insurance or years of service.

Methods for Controlling Future Costs

- Several national surveys indicate that only a small percent of employers are eliminating retiree health benefits altogether, especially for current retirees. Instead, many public and private sector employers are acting to limit their future group insurance costs by making changes to eligibility, pricing, plan design, plan options, and funding arrangements.
- The 1994 Foster Higgins survey indicated that 44% of employers made changes to their retiree medical plan between 1992 and 1994. The survey showed that 30% of the employers increased the retiree's premium contribution; 16% raised deductible amounts, co-payments, and/or out of pocket maximums; 14% added a managed prescription drug card plan; 13% tightened eligibility requirements; 3% changed from a defined benefit plan to a defined contribution plan; and 7% terminated the retiree medical benefits for future retirees.
- Many employers (including the five County and bi-County agencies) are implementing forms of managed care for their retirees. The 1994 GFOA survey reported that the use of managed care arrangements is the principal method of cost reduction, reported by 67% of employers who finance some portion of their retiree health benefits.
- Examples of tightening eligibility requirements include: establishing or increasing a minimum years of service requirement; establishing or increasing a minimum number of years of participation in the employer's group insurance plan; establishing a minimum age requirement; and/or establishing a minimum age and years of service requirement.

- Methods for limiting coverage for spouses and dependents include: limiting coverage to the spouse and dependents identified at the time of retirement; more carefully investigating the eligibility of dependents to continue coverage; more aggressively pursuing coordination of benefits if a spouse or dependent is also covered by his/her employer; and/or discontinuing coverage of a surviving spouse if he/she remarries.
- Employers are using a variety of approaches to decrease their share of group insurance costs. Changes range from increasing the retiree's contributions (by increasing deductibles, premiums, and co-payments; establishing higher out-of-pocket maximums; and/or reducing annual and/or lifetime maximums) to wholesale restructuring how benefits are provided.
- Examples of restructuring how retiree health benefits are financed include: changing the employer's contribution from a percent of total costs to a fixed dollar amount per retiree; increasing pension benefits by a fixed dollar amount and discontinuing a separate retiree medical benefit; and establishing a plan under which active employees contribute to a retiree medical spending account.

Legal Issues

- During the past decade, there have been numerous court cases concerning the rights of an employer to modify or terminate retiree medical benefits. These difficult cases often place the rights and obligations of employers trying to control increasing benefit costs versus the rights and financial needs of retired employees.
- According to the Office of the County Attorney, there is no Maryland case law at this time which definitively addresses the rights of a governmental employer in Maryland to modify or terminate retiree health care benefits.
- Retiree group insurance benefits are not included in the current collective bargaining agreements bargained by any of the County and bi-County agencies. There is no authority in the County's collective bargaining law and the Police labor relations act for the unions to bargain on behalf of retired employees.

B. RECOMMENDATIONS

Recommendation #1: The Council should endorse a process of deliberate review and discussion that leads to the development of strategies to contain the future costs of group insurance benefits for retirees of the County and bi-County agencies.

The costs associated with providing group insurance benefits to retirees of the five County and bi-County agencies are substantial. With increasing medical inflation, increased longevity, and a growing number of retirees, the future liability of the five agencies to provide post-retirement health and life insurance benefits is projected to increase significantly in the years ahead.

Given the magnitude of the financial commitment combined with the complexity of the issues involved with making changes to how retiree benefits are structured and funded, OLO recommends that the Council endorse a process of deliberate review and discussion of strategies to manage the future costs of providing group insurance benefits to agency retirees.

To be successful, the process of developing cost containment strategies should involve the Council, the County Executive, the County Attorney, and other appropriate decision-makers and staff from the five agencies. The process should also allow for input from employees, retirees, service providers, and other interested parties. The approach taken could be similar to that adopted in 1991 with the formation of the Working Group on Health Benefits, with the focus being this time on post-retirement group insurance benefits.

OLO recommends that one result of the process endorsed by the Council be the development of policy guidance to the five agencies concerning the future of group insurance benefits for retirees. This policy guidance, in the form of a Council resolution, would serve as a logical follow-up to earlier Council resolutions concerning employee benefits, i.e., Council Resolution 12-872, Policy Guidance on the Collective Bargaining Process and Employee Benefits, adopted October 1992; and Council Resolution 12-1439, Policy Guidance on Group Insurance, adopted December 1993.

Specifically, OLO recommends that the review and decision-making process proceed as follows:

- The Council should request each of the agencies to submit a "white paper" that responds to specific policy questions related to the structure and funding of retiree group insurance benefits. Other interested parties (e.g., employees, retirees, service providers) should also be encouraged to submit their comments and reactions. A list of recommended policy questions is presented below (see page 45).
- Combined with the background and factual information contained in this OLO report, the agency white papers and additional comments received should form the basis for discussion by the Council, the County Executive, and representatives from the other agencies of strategies for controlling future increases in retiree group insurance costs.
- The Council should retain a benefits consultant to assist with developing specific cost containment options. In particular, OLO recommends that outside expertise be retained for advising the Council on the technical issues related to Medicare integration.

Below are listed policy questions to guide the dialogue about possible changes to how the County and bi-County agencies structure and fund health and life insurance benefits for agency retirees in the future. As indicated above, combined with the background and factual information contained in this OLO report, responses to these questions should form the basis for Council, Executive, and agency discussion about specific strategies for controlling future increases in retiree group insurance costs.

Macro Council questions

- (a) Should a Council goal be for the five agencies to provide retiree group insurance benefits that are similar or equivalent in structure and/or cost?
- (b) When budgeting and projecting costs of retiree group insurance benefits, is there a set of uniform assumptions that make sense for the five agencies to follow or are all assumptions unique to each agency's benefit structure and demographics?
- (c) Should a Council goal be for the five agencies to adopt similar accounting treatment and similar strategies for the future funding of retiree group insurance? Specifically, should future retiree group insurance costs be funded on a pay-as-you-go basis, or should the agencies (in addition to the College) begin to prefund future retiree group insurance costs in accordance with actuarially determined estimates of future liabilities?

Eligibility requirements for retiree group insurance benefits:

- (d) Should participation as an active employee in each agency's pension, health insurance, and/or life insurance plan be a prerequisite for participation in the agency's retiree group insurance plan? If so, should there be a minimum years of participation requirement?
- (e) Should there also be an age and/or years of agency service requirement? What age and how many years?
- (f) Should there be provisions to allow or disallow employees who are vested in the retirement plan and leave agency service to resume participation in the agency's retiree group insurance plan when the employee begins to collect his/her pension?
- (g) What should be the eligibility requirements for retiree group insurance benefits for employees who participate in a defined contribution pension plan?
- (h) Should eligibility requirements be the same for early and regular retirees? How about for employees retiring under a disability retirement provision?

- (i) Should eligibility requirements for post-retirement health and life insurance be different?
- (j) What should be the eligibility requirements for survivors/dependents of the retiree? Should there be limits on the addition of dependents after retirement? Should the remarriage of a surviving spouse affect participation?
- (k) Where should eligibility requirements be defined, e.g., by law, in official plan documents, in employee handbooks?

Post-retirement health and life insurance plan options

- (l) Should retirees be offered the same medical plan options as active employees? Should retirees be eligible to participate in other stand-alone health plans available to active employees, e.g., dental, vision, prescription drug?
- (m) What should be the health plan options available to out-of-area retirees? If an agency's indemnity plan is discontinued, then how should health benefits be handled for retirees who no longer reside within the geographic area of the agency's managed care network?
- (n) Should retirees be eligible to participate in the annual transfer season held by agencies for active employees?
- (o) How should life insurance benefits for retirees be calculated? Should there be a minimum level of coverage with supplemental life insurance available for an additional cost? If the benefit declines, what should the formula be? Should the level of coverage be linked to the retiree's final annual salary as an active employee or offered as a fixed dollar amount of a death benefit?

Financing post-retirement group insurance benefits

- (p) Should the formula for agency/retiree cost sharing be identical for all retirees or vary by employee according to factors such as:
 - number of years that the employee worked for the agency?
 - number of years that the employee participated in the group insurance plan as an active employee?
 - when the employee was first hired by the agency?
 - age of employee?
 - health plan options selected?
 - selection of individual or family coverage?

- (q) Should the agency contribution continue to be calculated as a percent of the premium or should an alternative approach (such as a fixed dollar amount) be considered?
- (r) Should the pricing schedules be identical or different for the various components of group insurance, i.e., medical, dental, prescription drug, vision benefits?
- (s) How should the agency contributions be adjusted when the retiree becomes eligible to receive Medicare benefits? (See related issues under coordination with Medicare.)
- (t) Should health insurance premiums for retirees be calculated based upon the experience of retirees alone or combined with the experience of active employees? Should the experience of under-65 retirees be combined with the experience of over-65 retirees?
- (u) Should there be annual out-of-pocket maximum for retirees? Should there be annual or lifetime maximum contributions for each agency?

Coordination with Medicare

- (v) What health plan options should be available to retirees who are eligible to receive Medicare benefits?
- (w) How should the health benefits provided through agency medical plans be integrated with Medicare benefits? (This question needs to be addressed for each model of health plan available, e.g., indemnity, POS, PPO, and HMOs, etc.)
- (x) How should potential changes at the federal level to the structure of Medicare be reflected in how agency-sponsored health plans operate?

Recommendation #2: Ensure that there is clear and timely communication to employees and retirees about the terms of post-retirement group insurance benefits.

Clear and timely communication to active employees about the terms of post-retirement group insurance benefits is essential. Clear communication becomes even more important when employers are considering making changes to the benefits provided. It is essential that the written material provided to employees of the County and bi-County agencies explicitly reserve the agencies' right to make changes to the terms of group insurance benefits provided.

Several of the agencies have recently updated and improved the written materials provided to employees about retiree group insurance benefits. The availability of a separate booklet that clearly explains retiree group insurance benefits appears to be a particularly effective technique. This compares to including information on retiree group insurance as part of material designed primarily for active employees.

In addition to preparing well written and up to date written material, it is important for the agencies to have trained staff available that can explain post-retirement benefits to active and retired employees.

Recommendation #3: As part of their annual budget submission, the five agencies should report actual and budgeted costs of group insurance benefits for retirees separately from group insurance for active employees. At regular intervals, the agencies should also conduct actuarial projections of future costs of post-retirement group insurance benefits.

At present, the reporting of group insurance costs for retirees varies among the agencies. The annual budget request from each agency should include data on the actual and budgeted costs of group insurance benefits for retirees separately from group insurance costs for active employees. It would be useful for the budget requests to also include agency projections of retiree group insurance costs for the next five years and a list of agency assumptions that accompany those projections, e.g., increase in number of retirees, medical inflation, etc.

To allow for additional analysis of retiree group insurance benefits, it would also be useful for the agencies to annually provide data on:

- costs of retiree group insurance benefits by type of medical plan (e.g., indemnity, POS, HMO) and insurance plan component (e.g., medical, dental, vision, prescription drug, life);
- group insurance costs for retirees under-65 separated from group insurance costs for retirees over-65;
- the number of retirees participating in group insurance by type of medical plan (e.g., indemnity, POS, HMO), including data on the number who changed plans during the year; and
- the number of out-of-area retirees.

At regular intervals (i.e., every three years), the Council should request each agency to conduct an actuarial projection of the agency's future costs of post-retirement group insurance benefits. The projection should be conducted for an agreed-upon future time period, such as 15 or 20 years, and a listing of assumptions used should accompany the findings that are shared with the Council.

VIII. AGENCY COMMENTS ON DRAFT OF REPORT

On September 18, 1995, OLO circulated a draft of this report to the five agencies for review and comment. Written comments received by October 18 are attached beginning on the next page, with circle references as follows:

<u>Agency</u>	<u>Circle Number</u>
County Government	1
Montgomery County Public Schools	7
Montgomery College	9
Washington Suburban Sanitary Commission	11
Maryland-National Capital Park and Planning Commission	13

This final report incorporates all technical corrections received either orally or in writing. OLO particularly appreciates the many individuals who contributed their time and effort to help ensure that the many complex details contained in this report are factually correct.



OFFICES OF THE COUNTY EXECUTIVE

Douglas M. Duncan
County Executive

MEMORANDUM

October 16, 1995

To: Karen Orlansky, Director
Office of Legislative Oversight

From: Bruce Romer, Chief Administrative Officer

Subject: Office of Legislative Oversight DRAFT Report 96-2: A Study of Retiree Group Insurance Benefits

Thank you for the opportunity to comment on the DRAFT OLO Report 96-2: A Study of Retiree Group Insurance Benefits. This thorough and comprehensive report will serve as the foundation for future analysis. We find no significant problems with the overall reporting nor with the three broad recommendations. Our brief comments on each of these recommendations are as follows:

- We concur with the need for a deliberate review and discussion of strategies to manage the future costs of providing group insurance benefits to retirees. We recommended a flexible approach that recognizes limited staff resources and competing priorities. Also, while the draft alludes to coordination with the Executive branch in the process, it would be of value to have a more explicit mention of Council discussion of strategies with the Executive. We recommend the County Attorney's Office be represented on the working group. We presume the phrase "involve many interested and impacted parties, including retirees and services providers" does not refer to inclusion of non-government parties as regular members of the working group. Input from these parties is valuable, however it would be best garnered through their attendance at selected forums or other appropriate venues. Finally, with regard to the selection of a benefits consultant, we recommend the participation of all members of the working group in the selection process.
- We believe effective communication is critical and concur with OLO's recommendation. A senior staff member in the Office of Human Resources has been assigned the responsibility to develop all employee related communications with special emphasis on benefit issues. Specific information on post retirement insurance benefits is currently being developed.

Karen Orlansky, Director
Office of Legislative Oversight
October 16, 1995
Page 2

- We concur that further improvements in understanding and reporting are worthy objectives and intend to pursue such data in order to make better cost containment and management decisions. Through the use of a capable actuarial firm, the Office of Management & Budget has increased its understanding of costs, trends, fund management and causality among the numerous variables in the County group insurance fund fiscal environment. Reporting has become more detailed, accurate and comprehensive. In particular, we now receive and publish detailed six-year fiscal projections on the fund balance as a regular component of the annual actuarial rate setting recommendation, including extrapolations of the County's contributions to the fund for retiree group insurance. A copy of the actuary's projections are attached so that the updated figures can be incorporated into the OLO report.
- The County Attorney in his role of legal advisor to the Council will respond directly to you on the legal issues presented in this draft report.

I appreciate the opportunity to comment on this draft report. We look forward to participating with the Council in the process to develop an uniform set of assumptions, the accounting treatment and strategies for the future funding of group insurance benefits for retirees.

BR:rsd

Attachment: Actuary's six-year projections from CY96 group health rate setting report
Updated table from actuary for six-year projections of County cost per retiree

Distribution:

Robert K. Kendal, Director, Office of Management and Budget
Marta Brito Perez, Director, Office of Human Resources
Timothy Firestine, Director, Department of Finance
Charles W. Thompson Jr., County Attorney
CAO Chron File
OLO Report File

OLO\RETIREE

Montgomery County Government Group Insurance Projections

Group Insurance Projections	FY 94	7-12/94	1-6/95	FY 95	7-12/95	1-6/96	FY 96	7-12/96	1-6/97	FY 97
	Actual (6,066)	Estimate	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
Prior Year Fund Balance				420			3,693			7,370
Revenues										
County Contribution - Actives	35,833	18,388	17,101	35,489	17,101	16,825	33,926	16,825	17,834	34,659
County Contribution - Retirees	10,250	6,500	6,500	13,000	7,500	7,500	15,000	7,500	8,500	16,000
Employee Contribution - Actives	7,487	3,797	4,322	8,119	4,322	4,254	8,576	4,254	4,509	8,762
Employee Contribution - Retirees	2,596	1,341	1,585	2,926	1,585	1,630	3,216	1,630	1,728	3,359
Outside Agencies Contribution - all	3,159	1,758	1,691	3,449	1,691	1,699	3,390	1,699	1,801	3,500
Other Contributions	37	17	44	61	44	44	88	44	47	91
Pre-Funding Contributions	135	68	68	136	68	68	136	68	68	136
Dividends	1,699	0	0	0	0	0	0	0	0	0
Interest/Return Premiums	598	251	192	443	0	0	0	0	0	0
Total Revenues	61,794	32,120	31,504	63,624	32,312	32,020	64,332	32,020	34,487	66,507
Total Funds Available	55,728	32,120	31,504	64,044	32,312	32,020	68,025	32,020	34,487	73,878
Expenditures										
Claims cost - Active	32,550	14,165	15,694	29,859	16,165	16,488	32,653	17,478	18,177	35,654
Claims cost - Retirees	12,026	5,936	6,562	12,498	6,759	7,240	13,999	7,530	8,380	15,910
Carrier Administration - Active	2,235	1,112	1,256	2,368	1,212	1,237	2,449	1,311	1,363	2,674
Carrier Administration - Retirees	897	456	525	981	507	543	1,050	565	629	1,193
HMO premiums - Active	6,966	3,631	3,965	7,586	3,965	4,044	8,009	4,044	4,246	8,290
HMO premiums - Retirees	671	365	432	797	432	454	886	454	500	954
In-house expenses	510	198	259	457	500	500	1,000	500	500	1,000
LTD Premium	224	255	300	555	300	309	609	309	315	624
Interest Expense	30	0	40	40	0	0	0	15	15	30
Total Expenses	56,109	26,118	29,033	55,151	29,840	30,815	60,655	32,205	34,126	66,331
Results										
Balance	(381)	6,002		8,893	2,472	1,205	7,370	(185)		7,547
Return County Deficit Pay't				(5,200)						
End balance				3,693			7,370			7,547
		CY Rate Chg			CY Result		CY Rate Chg		CY Result	
		8%			4,943		0%		1,021	
									6%	

¹ EOY balance increased for \$1,201 K dividend and reduced to reflect life insurance IBNR and estimate of prepaid employee premiums for retiree life insurance.

Montgomery County Government Group Insurance Projections

Prior Year Fund Balance

Revenues

County Contribution - Actives
County Contribution - Retirees
Employee Contribution - Actives
Employee Contribution - Retirees
Outside Agencies Contribution - all
Other Contributions
Pre-Funding Contributions
Dividends
Interest/Return Premiums

Total Revenues

Total Funds Available

Expenditures

Claims cost - Active
Claims cost - Retirees
Carrier Administration - Active
Carrier Administration - Retirees
HMO premiums - Active
HMO premiums - Retirees
In-house expenses
LTD Premium
Interest Expense

Total Expenses

Results

Balance
Return County Deficit Pay't

End balance

7-12/97	1-6/98	FY 98	7-12/98	1-6/99	FY 99	7-12/99	1-6/00	FY 00
<u>Projected</u>	<u>Projected</u>	<u>Projected</u>	<u>Projected</u>	<u>Projected</u>	<u>Projected</u>	<u>Projected</u>	<u>Projected</u>	<u>Projected</u>
		7,547			7,279			7,130
17,834	19,439	37,274	19,439	20,995	40,434	20,995	22,674	43,669
9,000	9,500	18,500	10,500	11,000	21,500	12,500	13,000	25,500
4,509	4,915	9,423	4,915	5,308	10,222	5,308	5,732	11,040
1,728	1,884	3,612	1,884	2,034	3,918	2,034	2,197	4,232
1,801	1,963	3,765	1,963	2,120	4,084	2,120	2,290	4,410
47	51	97	51	55	106	55	59	114
68	68	136	68	68	136	68	68	136
0	0	0	0	0	0	0	0	0
0	0	0	10	10	20	20	20	40
34,987	37,820	72,807	38,830	41,590	80,420	43,100	46,041	89,141
34,987	37,820	80,354	38,830	41,590	87,699	43,100	46,041	96,271
18,904	19,660	38,564	20,446	21,264	41,711	22,115	22,999	45,114
8,883	9,887	18,770	10,381	11,555	21,936	12,132	13,503	25,635
1,418	1,474	2,892	1,533	1,595	3,128	1,659	1,725	3,384
666	742	1,408	779	867	1,645	910	1,013	1,923
4,246	4,501	8,747	4,501	4,816	9,317	4,816	5,153	9,969
500	557	1,057	557	626	1,183	626	703	1,329
500	500	1,000	500	500	1,000	500	500	1,000
315	321	637	321	328	649	328	334	662
0	0	0	0	0	0	0	0	0
35,433	37,643	73,075	39,019	41,550	80,569	43,085	45,931	89,016
		7,279			7,130			7,255
		7,279			7,130			7,255
CY Result	Rate Chg		CY Result	Rate Chg		CY Result	Rate Chg	
(84)	9%		(12)	8%		55	8%	

Montgomery County Government Group Insurance Projections

Prior Year Fund Balance

Revenues

County Contribution - Actives
County Contribution - Retirees
Employee Contribution - Actives
Employee Contribution - Retirees
Outside Agencies Contribution - all
Other Contributions
Pre-Funding Contributions
Dividends
Interest/Return Premiums

Total Revenues

Total Funds Available

Expenditures

Claims cost - Active
Claims cost - Retirees
Carrier Administration - Active
Carrier Administration - Retirees
HMO premiums - Active
HMO premiums - Retirees
In-house expenses
LTD Premium
Interest Expense

Total Expenses

Results

Balance
Return County Deficit Pay't

End balance

7-12/00 Projected	1-6/01 Projected	FY 01 Projected	7-12/01 Projected	1-6/02 Projected	FY 02 Projected
		7,255			7,806
22,674	24,715	47,389	24,715	27,186	51,901
14,500	15,500	30,000	15,500	16,500	32,000
5,732	6,248	11,981	6,248	6,873	13,121
2,197	2,395	4,592	2,395	2,634	5,029
2,290	2,496	4,786	2,496	2,746	5,242
59	65	124	65	71	136
68	68	136	68	68	136
0	0	0	0	0	0
20	20	40	20	20	40
47,541	51,507	99,048	51,507	56,099	107,606
47,541	51,507	106,303	51,507	56,099	115,412
23,919	24,876	48,795	25,871	26,906	52,777
14,178	15,781	29,959	16,570	18,442	35,011
1,794	1,866	3,660	1,940	2,018	3,958
1,063	1,184	2,247	1,243	1,383	2,626
5,153	5,514	10,667	5,514	5,900	11,414
703	790	1,493	790	887	1,677
500	500	1,000	500	500	1,000
334	341	676	341	348	689
0	0	0	0	0	0
47,646	50,851	98,497	52,769	56,384	109,153
		7,806			6,259
		7,806			6,259
CY Result 5	Rate Chg 9%		CY Result (606)	Rate Chg 10%	

Montgomery County Government

BI Weekly Rates - Non Flex 1997

Estimates based on current budget projections

Rate Chgs

9% Pru Indemnity
7% Pru Choice
5% Dental
15% Drug
0% Vision
0% Life

Plan	Proposed 1996						Preliminary 1997					
	Individual			Family			Individual			Family		
	Total	County	Employee	Total	County	Employee	Total	County	Employee	Total	County	Employee
Pru Indem	\$118.55	\$93.24	\$23.31	\$313.90	\$251.12	\$62.78	\$127.04	\$101.63	\$25.41	\$342.15	\$273.72	\$68.43
Pru Choice	\$92.76	\$74.21	\$18.55	\$249.84	\$199.87	\$49.97	\$99.25	\$79.40	\$19.85	\$267.33	\$213.86	\$53.47
Dental	\$11.10	\$8.88	\$2.22	\$28.39	\$22.71	\$5.68	\$11.66	\$9.33	\$2.33	\$29.81	\$23.85	\$5.96
Drug	\$26.85	\$21.48	\$5.37	\$55.47	\$44.38	\$11.09	\$30.88	\$24.70	\$6.18	\$63.79	\$51.03	\$12.76
Vision	\$0.94	\$0.75	\$0.19	\$2.33	\$1.88	\$0.47	\$0.94	\$0.75	\$0.19	\$2.33	\$1.88	\$0.47
Life /\$1,000 oov	\$0.12	\$0.10	\$0.02	\$0.12	\$0.10	\$0.02	\$0.12	\$0.10	\$0.02	\$0.12	\$0.10	\$0.02
AD&D /\$1,000 oov	\$0.03	\$0.02	\$0.01	\$0.03	\$0.02	\$0.01	\$0.03	\$0.02	\$0.01	\$0.03	\$0.02	\$0.01
BTA /Ee	\$0.09	\$0.07	\$0.02	\$0.09	\$0.07	\$0.02	\$0.09	\$0.07	\$0.02	\$0.09	\$0.07	\$0.02
Dep Life /Ee	\$0.23	\$0.18	\$0.05	\$0.23	\$0.18	\$0.05	\$0.23	\$0.18	\$0.05	\$0.23	\$0.18	\$0.05

Dollar Change

Plan	Individual			Family		
	Total	County	Employee	Total	County	Employee
Pru Indem	\$10.49	\$8.39	\$2.10	\$28.25	\$22.80	\$5.65
Pru Choice	\$9.40	\$7.19	\$1.30	\$17.49	\$13.89	\$3.50
Dental	\$0.66	\$0.45	\$0.11	\$1.42	\$1.14	\$0.28
Drug	\$4.03	\$3.22	\$0.81	\$8.32	\$6.66	\$1.66
Vision	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Life /\$1,000 oov	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
AD&D /\$1,000 oov	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
BTA /Ee	\$0.00	(\$0.00)	\$0.00	\$0.00	(\$0.00)	\$0.00
Dep Life /Ee	\$0.00	\$0.00	(\$0.00)	\$0.00	\$0.00	(\$0.00)

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WILLIAM M MERCER

2022960909

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850 Hungerford Drive * Rockville, Maryland * 20850-1747

Telephone (301) 279-3381

October 18, 1995

Ms. Karen Orlansky, Director
Office of Legislative Oversight
Montgomery County Council
Stella B. Werner Council Building
Rockville, Maryland 20850

Dear Ms. Orlansky:

Thank you for the opportunity to review and comment on the draft report on Retiree Group Insurance Benefits. This is an extremely complex area, and you are to be commended for your efforts to bring focus to an important issue facing all county agencies.

Your report was thorough and we concur that ongoing interagency discussions are needed to review options and develop alternative strategies. Montgomery County Public Schools looks forward to participating in that effort.

While the report was thorough, we would like you to consider incorporating the following changes:

Page 6 - The final bullet on the page is technically correct, but does not reflect the typical situation. Retirees who had one to five years of participation in the health plan as active employees have a 50/50 cost sharing arrangement. Retirees who had more than five years of participation in the health plan as active employees have a 70/30 cost sharing arrangement. The vast majority of MCPS retirees have had more than five years of participation in the health plan.

Page 16 - The final paragraph does not clearly reflect the MCPS practice. The cost sharing arrangement for retirees over age 65 is different than for retirees under age 65. Specifically, retirees under age 65 pay 30 percent of plan cost. A retiree who is over age 65 and enrolled in the indemnity plan receives the medicare supplement benefit free of charge. At the same time, the retiree pays 70 percent of the dental, vision and prescription drug plan cost. A retiree at age 65 who is enrolled in an HMO pays nothing up to the medicare supplement plan cost, and 100 percent of the HMO cost in excess of the medicare supplement rate. In some instances, a retiree over age 65 enrolled in an HMO will pay more than a retiree under age 65 enrolled in an HMO.

October 18, 1995

- Page 17 - The final paragraph needs to reflect that life insurance is bundled whenever an employee elects to participate in a health plan. However, employees can elect life coverage even if they do not participate in a health plan.
- Page 23 - The second sentence of the first paragraph under the MCPS heading should reflect that contributions to the pre-funded accounts were made from both the operating budget and employees.
- Page 23 - Final paragraph. There has always been only one "Trust Fund" with separate retiree health and retiree life accounts. This past spring, the two accounts were merged into a single account.
- Page 27 - The first paragraph states that eligibility is tied to "years of service." Actually, eligibility is tied to years of enrollment in a health plan.

Please contact Mr. G. Wesley Girling at 279-3611 if you have any questions about these suggestions.

Sincerely,


Paul L. Vance
Superintendent of Schools

PLV:sz

Copy to:

Mrs. Gemberling
Mr. Bowers
Mr. Girling



Montgomery
College

October 18, 1995

Ms. Karen Orlansky, Director
Office of Legislative Oversight
County Office Building
100 Maryland Avenue, #509
Rockville, MD 20850

Re. Draft Report on Retiree Group Insurance Benefits

Dear Ms. Orlansky:

I am responding to your letter dated September 18, 1995 to Dr. Parilla regarding the draft OLO report on retiree group insurance benefits.

I am particularly pleased that your study recognizes and documents the long-standing efforts of the College to manage retiree group insurance costs in a responsible way. We believe that retiree group insurance benefits are an important component of our overall human resources policy. At the same time, we recognize that the costs of these benefits must be managed very prudently, particularly when all signs for the future point to an increasingly restrictive fiscal climate in the public sector.

The draft study notes that College costs per retiree in FY1995 (\$1,450) are significantly lower than costs at County agencies in the study--ranging from 38% to as much as 67% lower. This dramatic difference is associated with lower contribution levels, strong internal controls within the program, and comparatively lower group insurance costs. The study also reveals that the College has the lowest projected cost increase over the next five years (11%), and it recognizes that the College is the only institution among the group studied to set aside funds from the current operating budget to pay for future group insurance benefits for retirees.

I would also like you to be aware of a new action being considered by the College to further control retiree benefits costs. As noted on p. 22 of the draft study, 401(h) accounts may be established as part of qualified pension plans to fund retiree group insurance premiums. The Board of Trustees will be asked at its October 16 meeting to authorize such an account within the Aetna Supplemental Retirement Plan, a small plan established in 1968 to supplement retirement benefits for employees in certain State plans. If approved by the Trustees, the College will submit the revised Plan to the IRS for a determination letter. Subsequently, we expect to pay a portion of retiree medical insurance premiums from excess assets now held within the Plan.

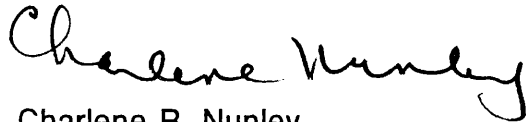
To Ms. Karen Orlansky
October 18, 1995
Page 2

With regard to the recommendations in the draft study, the College is already in substantial compliance with numbers 2 and 3. The implications of the first recommendation are of some concern to us. Certainly, the College would like to be part of the dialogue on broad policy issues regarding retiree group insurance issues. Based on the study results, I believe we could contribute to and benefit from such a dialogue. However, the recommendation also contemplates further extensive data collection and analysis, "white papers", a consultant review, and possibly a Working Group similar to the one on Health Benefits in 1991. This most probably would result in a great deal of staff time being devoted to a project that is of more limited benefit to the College than many other cost-efficiency options that we are investigating and pursuing.

As we strive to control our costs, our staff in Human Resources and Finance are increasingly overburdened. Any substantial additional administrative burdens on these staffs will have the effect of reducing our ability to control costs in areas such as group insurance--a result that none of us seeks. I am hopeful that you will take this into account in formulating your final recommendations.

Thanks again for sharing the draft study with us.

Sincerely,



Charlene R. Nunley
Acting for the President

FJT

cc: Board of Trustees
Ms. Dimon
Mr. Keller
Mr. Mullinix
Dr. Tusa

orlansky.doc



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GENERAL MANAGER
Cortez A. White

October 16, 1995

Ms. Karen Orlansky, Director
Office of Legislative Oversight
100 Maryland Avenue
Rockville, MD 20850

Dear Ms. Orlansky:

In response to your request to review the draft report, on Retiree Group Insurance Benefits, I understand that certain technical language issues have been resolved through telephone contact with John Derwart. In general, the report seems to give an accurate accounting of what Montgomery County and the various agencies are doing in the area of retiree benefits, which WSSC has seen as a significant cost concern for the years ahead. This is precisely why we have addressed it head on in the past few years, with the introduction of a Point-of-service health care plan for both active and retired employees, replacing the indemnity plan, and the change in the retiree cost sharing formula for employees hired after April 1, 1994.

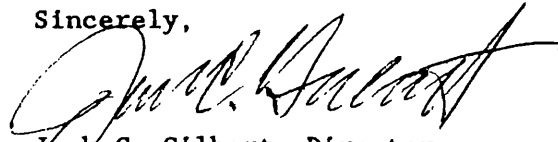
Although the intent of your recommendations is laudable, nonetheless, I believe any formal study of retiree benefits without a clear understanding of the objectives and potential value to each agency would be in our view premature. As you know, significant debate is now proceeding in Washington as to how to restructure the Medicare system. Although a Montgomery County Council study might help to focus on specific policy issues for the county and its agencies, until we know more about the affects of national policy changes, we could end up having to restudy this issue within the next twelve to twenty-four months. Our staff time at WSSC continues to be absorbed with normal responsibilities and we respectfully request that any possible participation in any future study or discussion take this into consideration.

Your recommendation to request that each agency submit a "white paper" to address certain policy issues might be a simple first step, which could provide the council with some of the thought processes that many of us have already gone through in addressing the area of retiree benefits. We suggest that this approach be taken before any more formal study proceeds.

Ms. Karen Orlansky, Director
Office of Legislative Oversight
October 16, 1995
Page 2

Thank you for the opportunity to review the draft report. We commend your office for the thoroughness and breadth in covering the subject matter.

Sincerely,



Jack C. Gilbert, Director
Human Resources Division

JCG/ppc

cc: Cortez White
Wayne Fallin
Richard Haddad
Thomas Street
John Derwart



THE MARYLAND-NATIONAL CAPITAL PARK AND PLANNING COMMISSION

6611 Kenilworth Avenue • Riverdale, Maryland 20737

MEMORANDUM

October 13, 1995

TO: Karen Orlansky, Director
Office of Legislative Oversight

FROM: Trudye Morgan Johnson, Executive Director
Maryland National Capital Park and Planning Commission

SUBJECT: Comments: Draft Report 96-2: A Study of Retiree Group Insurance Benefits

We appreciate the opportunity to comment on this report and offer for your consideration clarifying language and technical corrections to our initial submittal.

The Commission's review of the draft included William Serelis, Administrator of our Employees' Retirement System and staff previously involved with your office on this matter. We found the draft to be comprehensive and informative. We endorse the process of deliberate review that you are recommending to the County Council. Changes which would affect medical insurance availability could have significant impact on the health and wellness of our retirees.

We were pleased to note that the Commission's projected cost increase of 12% over the next five years for retiree medical insurance appears to be within reasonable bounds. As this project moves forward, we are ready to work with you and the County Council to explore long term cost containment measures.

Attachment

cc: William Hussmann
Betty Hewlett
Edward Navarre
William Serelis
Doug Sherwood
Judy Opel

COMPARATIVE DESCRIPTION OF TWO NATIONAL RETIREE HEALTH SURVEYS

FOSTER HIGGINS: The Foster Higgins National Survey of Employer Sponsored Plans (1994) consisted of a database of 2,097 employers. The sample included a combination of mailed surveys and telephone interviews of both private and public sector employees. The size of the employers ranged from 10 to over 20,000 employees. The cutoff between large and small employers was made at 500 employees.

WYATT: The Wyatt Comparison on Retiree Medical Benefits (April 1993) surveyed 684 employers in 1992. The size of the employers ranged from fewer than 10 to over 25,000 employees. The average size was 11,605 and the median was 3,234 employees per employer. The cutoff between large and small size employers was made at 1,000 employees.

According to the size of the employers, the findings between Foster Higgins 1994 survey differed slightly with the 1993 Wyatt survey results, although the two surveys clearly indicate that the larger the employer the more likely the employer will offer retiree group insurance. 29% surveyed by Foster Higgins with 500 to 999 employees offered retiree group insurance; 47% with 1,000-4,999 employees; 66.5% with 5,000-9,999. (Foster Higgins survey findings are based on the average between under-65 and over-65 retirees.) In the Wyatt survey, 60% with 500-999 employees offered retiree group insurance; 67% with 1,000-4,999; and 82% with 5,000 or more employees.

The two surveys focused on different aspects of the availability of retiree group insurance. Of large employers (500+), the Foster Higgins survey found that 43% offered coverage to under-65 retirees and 40% offered retiree group insurance to over-65 retirees. Wyatt found that 30% of its surveyed employers did not offer any insurance to retirees; 11% only offered coverage to retirees under 65, and 59% offered insurance coverage to retirees both before and after age 65.

Foster Higgins and Wyatt had similar results in the areas of Medicare integration and cost containment measures. Both surveys found the carve-out method to be most popular when coordinating with Medicare. 40% of those surveyed by Foster Higgins and 48% surveyed by Wyatt used this approach. Medigap or Medicare Supplement was the second most used method by 21% of Foster Higgins' respondents and 20% of Wyatt's. 18% of Foster Higgins' and 11% of Wyatt employers used the coordination of benefits to integrate with Medicare. Finally, 17% of Foster Higgins employers used HMOs or a managed care approach while 13% of Wyatt implemented the maintenance of benefits technique.

Both surveys also found that employers were utilizing the same methods to contain the rising costs for retiree health care. 30% of Foster Higgins and 37% of Wyatt employers increased retiree contributions to offset medical costs. Increasing cost sharing techniques such as raising the deductible and co-payments were the second most popular method with 16% of employers from both surveys. 13% of Foster Higgins employers and 10% of Wyatt employers tightened eligibility requirements.

Another similarity between the surveys was the trend of employers to reduce or terminate coverage for future employees. 7% of Foster Higgins employers were terminating coverage for future employees and 5% of Wyatt employers were reducing the level of benefits for future employees.

Montgomery County Government

Agreement

Between Montgomery County Government
Employees Organization, United Food and
Commercial Workers, Local 1994, AFL-CIO
and Montgomery County Government,
Montgomery County, Maryland

Office, Professional, and Technical (OPT)
Bargaining Unit



For the Years July 1, 1995 Through June 30, 1997

8. Prescription co-pays
9. Supplemental benefits for AIDS and Hepatitis B
10. Acupuncture and Chiropractic care benefits

21.5 The County shall also contribute 80% of the premiums determined for any calendar year for benefit plans other than the health plans included in Section 21.2 (a). The Employee Benefits Committee shall be provided with information (including but not limited to all actuarial and consultant reports) enabling it to review the premium determinations. The level of such benefits shall not be reduced.

21.6 Premiums for all plans shall be established using standard actuarial principles or actual rates being charged by the carrier or HMO. For any self-insured plans "cross subsidies" shall be eliminated for calendar year 1996.

21.7 Medical Spending Accounts

As of January 1, 1995 the County discontinued its contribution to the medical spending accounts. PruChoice premiums shall be calculated without regard to any contributions to the medical spending account. Employees shall continue to be permitted to contribute up to \$1,500 to such account as far as allowed by IRS Code.

21.8 Pre-tax Premiums

Employee contributions to Health Benefit Plans shall continue to be effected in a manner so that the premiums shall be pre-tax as far as allowed by IRS Code.

21.9 Bidding

The County has determined to obtain competing bids for existing HMOs and/or carriers for calendar years 1996 and 1997. The County shall assure that the same or lower costs and the same or improved benefit levels are maintained and that medical care shall be transitioned consistent with "industry standards" when health care providers are changed. The Union shall participate to the full extent allowed by law, rule, and regulation in the entire bidding process. Participation shall include, but not be limited to, consultation and provision of information.

21.10 Discontinuance of Indemnity Plan

Notwithstanding the provisions of Article 42, Duration, of this Agreement, it is the parties' understanding that it is the Employer's intent to discontinue the Prudential Indemnity Plan by January 1, 1998. Accordingly, the parties agree to pursue alternatives to the Indemnity Plan for implementation by

January 1, 1998. Furthermore, the parties agree that participants in the Prudential Indemnity Plan will be scheduled to attend a joint Labor/Management educational seminar during the term of the Agreement to educate them regarding alternatives to the Indemnity Plan. Indemnity Plan participants shall be granted up to two hours administrative leave to do so.

ARTICLE 22

TRANSFER

22.1 Definition

Transfers for the purpose of this agreement shall have the same meaning as provided in Section 21-1 of the Montgomery County Personnel Regulations, effective July 1, 1986. Transfers usually involve one or more of the following factors:

- (a) A change from one merit system position to another;
- (b) A change in physical location of the job or position;
or
- (c) A change in duty assignment but within the same occupational class.

22.2 Reasons for Transfer

The following while not inclusive, may be reason for transferring an employee:

- (a) A voluntary request;
- (b) A lack of funding resulting from budgetary limitations or loss of federal/state funds;
- (c) A change in the approved work program/plan/design;
- (d) An administrative reorganization;
- (e) A technological change or advancement that impacts on work force needs;
- (f) A change in an employee's physical or mental condition;
- (g) The resolution of a grievance or other problems affecting the operational efficiency of a unit or organization; or
- (h) For training or development.

ARTICLE 42

DURATION

This contract embodies the whole agreement of the parties and may not be amended during its term except by mutual written agreement. This Agreement shall become effective July 1, 1995 and terminate June 30, 1997. Renegotiation of this Agreement shall begin no later than November 1, 1996 and shall proceed pursuant to the County Collective Bargaining Law.

ARTICLE 43

TRANSPORTATION/AIR QUALITY COMMITTEE

The parties hereby establish a Transportation/Air Quality Committee for the purposes of developing recommendations to the parties regarding but not limited to transportation subsidies, County vehicle use, alternative commuting methods, and employee parking policies and other ways the County can achieve improvements in air quality to assist in meeting Federal regional air quality standards. The Committee shall consist of three (3) members appointed by the County, and three (3) members appointed by the Union. Either party may remove or replace its appointees at any time. The Chair of the Committee will rotate each January 1 from a County designee to a Union designee, and vice versa each July 1. The initial Chair shall be a County designee.

ARTICLE 44

DEFINED CONTRIBUTION PLAN

44.1 Defined Contribution Retirement Plan

The parties have submitted legislation to the County Council that would establish a Defined Contribution Retirement Plan for non-public safety employees hired on or after July 1, 1994, and any other employee who desires to transfer to the new system from the existing retirement system.

44.2 Contributions

Employees must contribute three (3) percent of base salary up to the FICA maximum, and six (6) percent of base salary above the FICA maximum. The Employer will contribute an amount equal to six (6) percent of the employees' regular earnings.

1995

GUIDE

To Health Insurance for People with Medicare

- ★ WHAT MEDICARE PAYS AND DOESN'T PAY
- ★ 10 STANDARD MEDIGAP INSURANCE PLANS
- ★ YOUR RIGHT TO MEDIGAP INSURANCE
- ★ MEDIGAP CHANGES AFFECTING DISABLED BENEFICIARIES
- ★ TIPS ON SHOPPING FOR PRIVATE HEALTH INSURANCE

Developed jointly by the
National Association of Insurance Commissioners
and the
Health Care Financing Administration of the U.S. Department of Health and Human Services

rectory of state insurance departments and agencies on aging beginning on page 27.

Before discussing Medigap and the other types of private insurance available to supplement Medicare, it will be helpful to review your Medicare benefits and identify the payment gaps.

WHAT IS MEDICARE?

Medicare is a federal health insurance program for:

- people 65 or older,
- people of any age with permanent kidney failure, and
- certain disabled people under 65.

Medicare is administered by the Health Care Financing Administration. The Social Security Administration provides information about the program and handles enrollment. If you are receiving Social Security or Railroad Retirement Board benefits when you turn 65, you are enrolled in Medicare automatically and will receive your Medicare card in the mail. If you are not receiving benefits when you turn 65, you must contact a Social Security Administration office or, if appropriate, the Railroad Retirement Board. If you are disabled, you will automatically get a Medicare card in the mail when you have been a disability beneficiary under Social Security or Railroad Retirement for 24 months.

Two Parts of Medicare

The Medicare card shows the Medicare coverage you have—Hospital Insurance (Part A), Medical Insurance (Part B), or both—and the date your coverage started. If you have only one part of Medicare, you can get information about getting the other part from any Social Security Administration office.

Part A. Medicare Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers, and by part of the Self-Employment Tax paid by self-employed persons. If you or your spouse is entitled to benefits under either the Social Security or Railroad Retirement systems or worked long enough in federal, state or

local government employment to be insured, you do not have to pay any premium for Part A. Your Part A coverage generally starts in the month you turn 65 or shortly thereafter, depending on when you apply.

Buying Part A: If you do not qualify for premium-free Part A benefits, you may buy the coverage if you are at least 65 years old and meet certain requirements. You also may buy Part A if you are under age 65, were previously entitled to Medicare under the disability provisions and you still have the same disabling impairment but your disability benefits were terminated because of your work and earnings. The monthly Part A premium in 1995 is \$183 if you had at least 30 quarters of Medicare-covered employment but fewer than 40 quarters. It is \$261 if you had fewer than 30 quarters or no quarters of covered employment.

Part B: Medicare Part B is paid for in part by the premiums from persons who enroll in the program. The monthly premium in 1995 is \$46.10, and most enrollees have it deducted from their monthly Social Security check. You are automatically enrolled in Part B when you become entitled to premium-free Part A unless you state that you don't want it. Although you do not have to buy Part B, it is generally a good deal because the federal government subsidizes about 75 percent of the program costs. Even if you do not qualify for premium-free Part A, you generally can buy Part B if you are 65 or older.

Medicare Enrollment Periods: The initial enrollment period for Part B and premium Part A runs for seven months beginning three months before the month in which you turn 65. If you do not enroll during your initial 7-month enrollment period, you will have to wait until the next "general enrollment period." These enrollment periods occur each year, from January 1 through March 31. Coverage begins the following July 1.

Premiums for both Part A and Part B generally will be higher if you wait to enroll during a general enrollment period. The Part B premium goes up 10 percent for each 12 months after you were first eligible. So, if you wait 24 months to enroll in Part B,

your premium will always be 20 percent higher. The increase in the Part A premium (if you have to pay a premium) is limited to 10 percent no matter how late you enroll for the coverage.

Under certain circumstances you can delay your Medicare enrollment without penalty. If after turning 65 you have group health plan coverage based on your current employment or the current employment of a spouse, you will have a special enrollment period. You may enroll in Part B or premium Part A at any time you are covered under the group health plan or you may wait and enroll during the eight-month period beginning with the month you or your spouse stops working or when you are no longer covered under the employer plan, whichever comes first. If you do not enroll during this special enrollment period, you will have to wait until the next general enrollment period.

Medigap Warning: Be aware that your Medigap open enrollment period, which is a period of time during which you can buy the Medigap policy of your choice, starts as soon as you enroll in Part B and are 65 or older (see page 16).

MEDICARE HOSPITAL INSURANCE BENEFITS (PART A)

When all program requirements are met, Medicare Part A helps pay for medically necessary inpatient care in a general hospital, skilled nursing facility, psychiatric hospital or hospice care. In addition, Part A pays the full cost of medically necessary home health care and 80 percent of the approved cost for wheelchairs, hospital beds, and other durable medical equipment (DME) supplied under the home health care benefit. Coverage is also provided for whole blood or units of packed cells, after the first three pints, when furnished by a hospital or skilled nursing facility during a covered stay.

Benefit Periods

Medicare hospital and skilled nursing facility benefits are paid on the basis of benefit periods. A benefit period begins the first day you receive a Medicare-covered service in a qualified hospital. It ends when you have been out of a hospital or other facility that primarily provides skilled nursing or reha-

bilitation services for 60 days in a row. It also ends if you remain in a facility (other than a hospital) that primarily provides skilled nursing or rehabilitation services but do not receive any skilled care there for 60 days in a row.

If you enter a hospital again after 60 days, a new benefit period begins. With each new benefit period, Part A hospital and skilled nursing facility benefits are renewed except for any lifetime reserve days or psychiatric hospital benefits you used. There is no limit to the number of benefit periods you can have for hospital or skilled nursing facility care.

Inpatient Hospital Care

If you are hospitalized, Medicare will pay for all covered hospital services during the first 60 days of a benefit period, except for the deductible. The Part A deductible in 1995 is \$716 per benefit period. You are responsible for the deductible.

In addition to the deductible, you are responsible for a share of the daily costs if you are hospitalized for more than 60 days in a benefit period. For the 61st through the 90th day, Part A pays for all covered services except for coinsurance of \$179 a day in 1995. You are responsible for the coinsurance.

Under Part A, you also have a lifetime reserve of 60 days for inpatient hospital care. These lifetime reserve days may be used whenever you are in the hospital for more than 90 days in a benefit period. When a reserve day is used, Part A pays for all covered services except for coinsurance of \$358 a day in 1995. Again, the coinsurance is your responsibility. Once used, reserve days are not renewed.

Gaps In Inpatient Hospital Coverage

You Pay:

- \$716 deductible on first admission to hospital in each benefit period.
- \$179 daily coinsurance for days 61 through 90.
- All charges for coverage after 90 days in any benefit period unless you have "lifetime reserve" days available and use them. (over)

- \$358 daily coinsurance for each lifetime reserve day used.
- For the first three pints of whole blood or units of packed cells used in each year in connection with covered services unless the blood is replaced. To the extent the blood deductible is met under one part of Medicare, it does not have to be met under the other part.
- For a private hospital room, unless medically necessary, and for a private duty nurse.
- For personal convenience items, such as a telephone or television in a hospital room.
- For non-emergency care in a hospital that does not participate in the Medicare program.
- For care received outside the United States and its territories, except under limited circumstances in Canada and Mexico.

Psychiatric Hospital Care

Medicare Part A helps pay for no more than 190 days of inpatient care in a Medicare-participating psychiatric hospital in your lifetime. Once you have used 190 days, Part A doesn't pay for any more inpatient care in a psychiatric hospital. However, psychiatric care provided in a general hospital, rather than in a psychiatric hospital, is not subject to the 190-day limit.

If you are a patient in a psychiatric hospital on the first day of your entitlement to Medicare, there are additional limitations on the number of hospital days that Medicare will pay for. Inpatient psychiatric care is subject to the same terms and conditions as other Medicare inpatient hospital care.

Gaps In Inpatient Psychiatric Hospital Coverage

You Pay:

- For all care after you have received 190 days of such specialized treatment in your

lifetime (even if you have not yet exhausted your coverage for inpatient care in a general hospital).

- The gaps in general hospital coverage also apply to psychiatric hospital coverage.

Skilled Nursing Facility Care

To qualify for Medicare-covered skilled nursing facility (SNF) benefits, you must:

- ☑ Require daily skilled care which, as a practical matter, can only be provided in a skilled nursing facility on an inpatient basis.
- ☑ Be in the hospital for at least three consecutive days (not counting the day of discharge) before entering a skilled nursing facility that is certified by Medicare.
- ☑ Be admitted to the skilled nursing facility for the same condition for which you were treated in the hospital.
- ☑ Generally be admitted to the facility within 30 days of your discharge from the hospital.
- ☑ Be certified by a medical professional as needing skilled nursing or skilled rehabilitation services on a daily basis.

Medicare Part A can help pay for up to 100 days of skilled care in a skilled nursing facility during a benefit period. All covered services for the first 20 days of care are fully paid by Medicare. All covered services for the next 80 days are paid by Medicare, except for a daily coinsurance amount. The daily coinsurance in 1995 is \$89.50. You are responsible for the coinsurance. If you require more than 100 days of care in a benefit period, you are responsible for all charges beginning with the 101st day.

A skilled nursing facility is different from a nursing home. It is a special kind of facility that primarily furnishes skilled nursing and rehabilitation services. It may be a separate facility or a distinct part of another facility such as a hospital.

Medicare will not pay for your stay if the services you receive are primarily personal care or custodial services, such as assistance in walking, getting in and out of bed, eating, dressing, bathing and taking medicine.

Gaps In Skilled Nursing Facility Coverage

You Pay:

- \$89.50 daily coinsurance for days 21 through 100 in each benefit period.
- All costs for care after 100 days in a benefit period.
- All costs for care that is less than the level of care Medicare covers in a SNF.
- All costs if you were not transferred to the SNF in a timely manner after a qualifying hospital stay.
- For care in a general nursing home, or in a SNF not approved by Medicare, or for just custodial care in a Medicare-approved SNF.
- The 3-pint blood deductible (see list of gaps under inpatient hospital care on page 4).

Home Health Care

Medicare pays the full cost of medically necessary home health visits by a Medicare-approved home health agency. A home health agency is a public or private agency that provides skilled nursing care, physical therapy, speech therapy and other therapeutic services in the patient's home. These services are usually provided on a periodic basis by a visiting nurse and/or home health aide.

To qualify for coverage, you have to need intermittent skilled nursing care, physical therapy, or speech therapy, be confined to your home, and be under a physician's care. You do not have to pay a deductible or coinsurance (except for durable medical equipment), and no prior hospitalization is required for home health care benefits. Coverage is also provided for a portion of the cost of wheelchairs, hospital beds and other durable medical equipment (DME) provided under a plan-of-care set up and periodically reviewed by a physician.

Gaps in Home Health Coverage

You Pay:

- For full-time nursing care.
- For meals delivered to your home and for drugs.
- Twenty percent of the Medicare-approved amount for durable medical equipment, plus charges in excess of the approved amount on unassigned claims.
- For homemaker services that are primarily to assist you in meeting personal care or house-keeping needs.

Hospice Care

Medicare pays for hospice care for terminally ill beneficiaries who choose to receive hospice care rather than regular Medicare benefits for management of their illness. Under Medicare, hospice is primarily a program of care generally provided in the patient's home by a Medicare-approved hospice. The focus is on care, not cure. Hospice services covered under Medicare Part A include:

- ☒ Physician services
- ☒ Nursing care
- ☒ Medical appliances and supplies
- ☒ Drugs (for pain and symptom relief)
- ☒ Short-term inpatient care
- ☒ Medical social services
- ☒ Physical therapy, occupational therapy and speech/language pathology services
- ☒ Dietary and other counseling

There is no deductible for these hospice care benefits. Copayments are, however, required for the following two benefits:

1. Prescription drugs for pain relief and symptom management, for which patients can be charged 5% of the reasonable cost, but no more than \$5 for each prescription.

(over)

2. Respite care, for which the patient can be charged about \$5 per day, depending on the area of the country. Inpatient respite care provides some time off for the person who regularly provides care in the home. Each stay is limited to no more than five days.

If you need medical services for a condition unrelated to the terminal illness, regular Medicare benefits are available. When regular benefits are used, you are responsible for the applicable Medicare deductible and coinsurance amounts.

Gaps In Hospice Coverage

You Pay:

- Limited charges for inpatient respite care and outpatient drugs.
- Deductibles and coinsurance amounts when regular Medicare benefits are used for treatment of a condition other than the terminal illness.

MEDICARE MEDICAL INSURANCE BENEFITS (PART B)

Medicare pays for a wide range of medical services and supplies, but the most significant coverage is for your doctor's bills. Medically necessary physician services are covered no matter where you receive them—at home, in the doctor's office, in a clinic, in a nursing home, or in a hospital. Part B also covers:

- ☒ Outpatient hospital services
- ☒ X-rays and laboratory tests
- ☒ Certain ambulance services
- ☒ Durable medical equipment, such as wheel chairs and hospital beds, used at home
- ☒ Services of certain specially qualified practitioners who are not physicians
- ☒ Physical and occupational therapy
- ☒ Speech/language pathology services

- ☒ Partial hospitalization for mental health care
- ☒ Mammograms and Pap smears
- ☒ Home health care if you do not have Part A

While Part B generally does not cover outpatient prescription drugs, it does cover some oral anti-cancer drugs, certain drugs for hospice enrollees, and non-self administrable drugs provided as part of a physician's services. Certain drugs furnished during the first year after an organ transplantation and epoetin for home dialysis patients are also covered, as well as antigens, and flu, pneumococcal, and hepatitis B vaccines. Coverage is also provided for blood after you meet the 3-pint annual deductible.

Part B Deductible And Coinsurance

When you use your Part B benefits, you will be required to pay the first \$100 each calendar year. This is called the deductible. It must be based on the Medicare-approved amount for covered services and supplies, not the actual charges billed by your physician or medical supplier.

After you meet the deductible, Part B generally pays 80 percent of the Medicare-approved amount for all covered services you receive during the rest of the year. You are responsible for the other 20 percent. Your 20 percent share is called coinsurance. If you require home health services under Part B, you do not have to pay a deductible or coinsurance. You do, however, have to pay 20 percent of the Medicare-approved amount for any durable medical equipment supplied under the home health benefit.

Besides the deductible and coinsurance, you may also have other out-of-pocket costs if your physician or medical supplier does not accept assignment of your Medicare claim and charges more than Medicare's approved amount. The difference to be paid is called the "excess charge."

Medicare-Approved Amount

The Medicare-approved amount for physician services covered by Part B is based on the lesser of the physician's actual charge or the fee schedule amount. The fee schedule assigns a dollar value to each physician service based on work, the cost of running a

practice and malpractice insurance costs. Medicare generally pays 80 percent of the approved amount.

Here's how the payment system works. Let's suppose you go to a physician who accepts assignment of your Medicare claim and the approved amount for the services you receive is \$100. Let's also assume that you have met your \$100 deductible for the year. Medicare would pay the doctor \$80 and you would be responsible for the \$20 balance.

If you went to a physician who does not accept assignment, you would have to pay more. Using the \$100 example above, the approved amount would be \$95 because the approved amount for physicians that do not accept assignment is 95 percent of the amount for those that do. Also, non-participating physicians can bill an excess charge up to 15 percent of the approved amount. Therefore, you would have to pay 20 percent of the approved amount, or \$19, plus the excess charge of \$14.25. This means that you would pay \$13.25 more by using a physician that does not accept assignment.

Accepting Assignment

To avoid having to pay excess charges, always ask your physicians and medical suppliers whether they accept assignment. Some do on a case-by-case basis while others sign participation agreements with Medicare and accept the Medicare-approved amount as full payment on all Medicare claims. They are called participating physicians and suppliers and they are listed in *The Medicare Participating Physician/Supplier Directory*.

The directory is distributed to senior citizen organizations, all Social Security and Railroad Retirement Board offices, hospitals, and all state and area offices of the Administration on Aging. It also is available free by writing or calling the insurance company that processes Medicare Part B claims for your area. The names, addresses and telephone numbers of the companies, which are called Medicare "carriers," are listed in the back of *The Medicare Handbook*, available from any Social Security Administration office.

Besides avoiding excess charges, another advantage of using physicians or suppliers who accept assignment is that they are paid directly by Medicare, ex-

cept for the deductible and coinsurance amounts that you must pay. Those who do not accept assignment collect the full amount of the bill from you. Medicare then reimburses you its share of the approved amount for the services or supplies received. Regardless of whether your physicians and suppliers accept assignment, they must file your Medicare claim for you.

In certain situations non-participating physicians and suppliers who do not normally accept assignment are required by law to do so. For instance, all physicians and qualified laboratories must accept assignment for clinical diagnostic laboratory tests covered by Medicare. Physicians also must accept assignment for covered services provided to beneficiaries with incomes low enough to qualify for Medicaid payment of their Medicare cost-sharing requirements (see page 23).

Physician Charge Limits

While physicians who do not accept assignment of a Medicare claim can charge more than physicians who do, there is a limit to the amount they can charge for services covered by Medicare. They are permitted to charge you only 15 percent more than the Medicare-approved amount, and you must pay that extra amount. This is called the "limiting charge" and you do not have to pay more than this amount.

To determine the limiting charge for a particular service, contact the Medicare carrier for your area. Limiting charge information also appears on the Explanation of Medicare Benefits (EOMB) form generally sent to you by the carrier after you receive a Medicare-covered service. If your physician has exceeded the charge limit, contact the physician and ask for a reduction in the charge, or a refund if you have paid the bill. If you cannot resolve the issue with the physician, call your Medicare carrier.

Under a new law all Medicare carriers are required to screen physician bills for overcharges and notify the physician and the patient within 30 days of any overcharge. The physician is then required to refund the overcharge within 30 days or credit your account for it. Physicians who knowingly, willfully and repeatedly charge more than the legal limit are subject to sanctions.

Some states have also enacted charge limit laws. Currently, Connecticut, Massachusetts, Minnesota, New York, Ohio, Pennsylvania, Rhode Island and Vermont have such laws. If you live in one of these states, or if you want to find out whether your state has a law limiting physician charges, contact your state insurance department counseling program or office on aging (see listings beginning on page 27).

Other Charge Limits

Physicians who do not accept assignment for elective surgery are required to give you a written estimate of your costs before the surgery if the total

charge will be \$500 or more. If you are not given a written estimate, you are entitled to a refund of any amount you paid in excess of the Medicare-approved amount. Additionally, any non-participating physician who provides you with services that he or she knows or has reason to believe Medicare will determine to be medically unnecessary and thus will not pay for, is required to tell you that in writing before performing the service. If written notice is not given, and you did not know that Medicare would not pay, you cannot be held liable to pay for that service. However, if you did receive written notice and signed an agreement to pay for the service, you will be held liable to pay.

Gaps In Doctor and Medical Supplier Coverage

You Pay:

- \$100 annual deductible.
- Generally, 20% coinsurance and permissible charges in excess of Medicare-approved amount.
- 50% of the Medicare-approved amounts for most outpatient mental health treatment.
- All charges in excess of Medicare's maximum yearly payment of \$720 for independent physical or occupational therapists.
- All charges for most services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury.
- All charges for most self-administerable prescription drugs and immunizations, except for pneumococcal, influenza and hepatitis B vaccinations.
- All charges for routine physicals and other screening services, except for mammograms and Pap smears.
- All charges for routine eye examinations or eyeglasses, except prosthetic lenses after cataract surgery.
- All charges for acupuncture treatment.
- All charges for most dental care and dentures.
- All charges for hearing aids or routine hearing loss examinations.
- All charges for care outside the United States and its territories, except in certain instances in Canada and Mexico.
- All charges for routine foot care except when a medical condition affecting the lower limbs (such as diabetes) requires care by a medical professional.
- All charges for services of naturopaths, Christian Science practitioners, immediate relatives, or charges imposed by members of your household.
- Unless replaced, all charges for the first 3 pints of whole blood or units of packed cells used in each year in connection with covered services. To the extent the 3-pint blood deductible is met under Part A, it does not have to be met under Part B.

Medicare Benefit Charts

The charts on pages 9 and 10 describe Medicare benefits only. The "You Pay" column itemizes expenses you are responsible for and must pay out of your own pocket or through the purchase of some type of private insurance as described in this booklet.

MEDICARE (PART A): HOSPITAL INSURANCE COVERED SERVICES FOR 1995

Services	Benefit	Medicare Pays	You Pay
HOSPITALIZATION Semiprivate room and board, general nursing and other hospital services and supplies. (Medicare payments based on benefit periods; see pg.3.)	First 60 days	All but \$716	\$716
	61st to 90th day	All but \$179 a day	\$179 a day
	91st to 150th day*	All but \$358 a day	\$358 a day
	Beyond 150 days	Nothing	All costs
SKILLED NURSING FACILITY CARE Semiprivate room and board, skilled nursing and rehabilitative services and other services and supplies. ** (Medicare coverage based on benefit periods; see pg. 3.)	First 20 days	100% of approved amount	Nothing
	Additional 80 days	All but \$89.50 a day	Up to \$89.50 a day
	Beyond 100 days	Nothing	All costs
HOME HEALTH CARE Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies and other services.	Unlimited as long as you meet Medicare requirements for home health care benefits.	100% of approved amount; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
HOSPICE CARE Pain relief, symptom management and support services for the terminally ill.	For as long as doctor certifies need.	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
BLOOD When furnished by a hospital or skilled nursing facility during a covered stay.	Unlimited during a benefit period if medically necessary.	All but first 3 pints per calendar year.	For first 3 pints.***

* 60 reserve days may be used only once.

** Neither Medicare nor Medigap insurance will pay for most nursing home care.

*** To the extent the three pints of blood are paid for or replaced under one part of Medicare during the calendar year, they do not have to be paid for or replaced under the other part.

Appendix D

Special Issue
April 1993

COMPARISON



Wyatt

Retiree Medical Benefits

Who Are the 1992 Wyatt COMPARE Employers?

Data Digest

Employer-provided Benefits and Medicare

The method used by an employer-provided retiree medical plan to integrate the plan benefits with Medicare can affect the plan's cost significantly. Employer-provided coverage, and other private insurance, is designed to fill in the gaps left by Medicare. Medicare has been estimated to pay approximately two-thirds of an average retiree's medical claims.

Medicare Supplement Plans

Such plans pay for charges that Medicare does not cover, such as the Medicare inpatient hospitalization deductible. These plans are modeled after individual insurance policies, termed Medigap policies. Medicare supplement plans most often provide for scheduled benefits, so the employer retains control of the cost of the plan. Because scheduled benefit plans do not increase automatically with increases in medical care costs, the FAS 106 expense for such plans can be dramatically lower than the expense for a plan that provides a similar given level of benefits.

Three Other Methods of Integrating with Medicare

The three other methods of integrating with Medicare are the Medicare carve-out, the maintenance of benefits, and the coordination of benefits. In addition to the brief descriptions provided below, Figure A on page 11 demonstrates how a claim would be divided among Medicare, the plan, and the retiree. This example uses a plan with a \$200 deductible and 20 percent retiree copayment. The total claim is \$2,200 and the payment from Medicare is \$1,300.

Medicare carve-out. Under a Medicare carve-out, the amount that the employer pays for a given claim is reduced directly by the Medicare payment. This approach calculates the retiree share first, using the deductible and copayment provisions of the employer's benefit program. The retiree's share of the cost is \$600 (\$200 plus 20 percent of \$2,000). The plan's payment, before considering the Medicare payment, is \$1,600 (\$2,200 total claim less the retiree's share). The actual payment from the plan is \$300 after subtracting the amount paid by Medicare.

Maintenance of benefits. Only those amounts not paid by Medicare are considered eligible expenses under the employer plan. So the covered charge after Medicare payments is subject to the plan's deductible and copayment provisions. This approach represents a middle ground between the carve-out and coordination approaches in terms of employer expense, benefit levels, and cost control. The eligible expense in this example is \$900 (\$2,200 total claim less the Medicare payment). The retiree's share is \$340 (\$200 deductible plus 20 percent of \$700). The employer share is \$560 (\$900 minus the retiree's share).

Coordination of benefits. Using this approach, the plan's payment is calculated assuming no other coverage is available and then limited to the total claim, minus the amount that Medicare will pay. This often results in 100 percent reimbursement of the claim, which negates the impact of the deductible and copayment provisions of the employer's plan. This method is now the least popular Medicare integration method because it is often the most expensive. The retiree's share, according to the plan provisions, is \$600 (\$200 deductible plus 20 percent of \$2,000). The plan's share is the lesser of \$1,600 (the total claim minus the retiree's share) or \$900 (the \$2,200 total claim minus the \$1,300 Medicare payment). In this example, the plan's share of \$900 plus the Medicare payment of \$1,300 is equal to the total claim of \$2,200. So the retiree will not have to pay any part of the cost. ■

Figure A

Allocation of a \$2,200 Claim under Three Medicare Integration Provisions

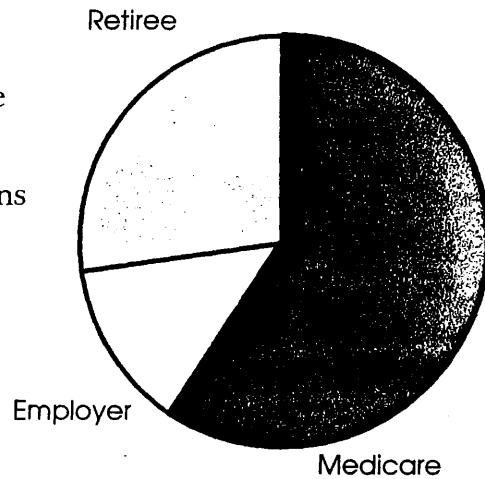
Plan Provisions: \$200 Deductible and 20 Percent Retiree Copayment

Medicare Carve-out

Retiree share is calculated first, using the \$200 deductible and 20 percent copayment of the remaining \$2,000.

Plan share is remainder after Medicare and retiree portions are subtracted from the total claim.

Payer:	
Medicare	\$1,300
Employer	\$ 300
Retiree	\$ 600

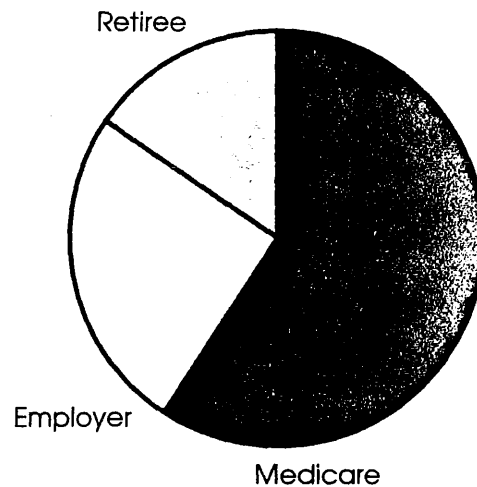


Maintenance of Benefits

Medicare pays \$1,300 of the claim, leaving \$900 of the claim covered by the plan. Retiree share is \$200 deductible plus 20 percent copayment of \$700.

Plan share is remainder after Medicare and retiree portions are subtracted from the total claim.

Payer:	
Medicare	\$1,300
Employer	\$ 560
Retiree	\$ 340

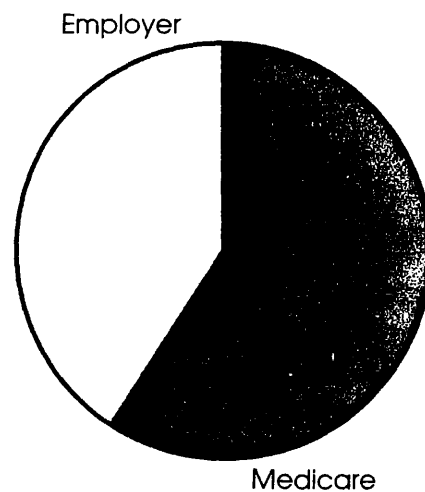


Coordination of Benefits

Plan share is calculated ignoring Medicare and then limited to the total claim minus the Medicare portion.

Retiree share is zero, since the entire claim has been paid by Medicare and the plan.

Payer:	
Medicare	\$1,300
Employer	\$ 900
Retiree	\$ 0



Source: The Wyatt Company, 1993.

Now Extra Health Care Doesn't Have To Cost Extra

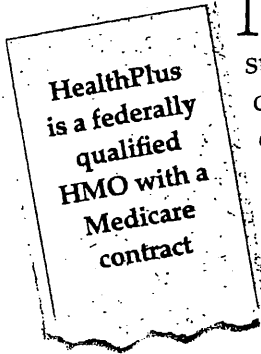


*A Federally-Approved Health Plan That
Offers Extra Benefits For Medicare Beneficiaries*

NEW YORK LIFE HEALTHPLUS 65

HealthPlus is a subsidiary of Sanus Corp. Health Systems, a New York Life company.

Introducing HealthPlus65

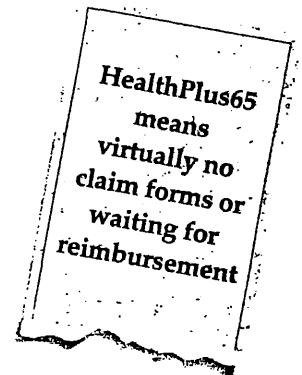


Now you can have more health coverage than you can get from Medicare alone — *without* the expense of costly supplemental insurance policies. HealthPlus is a federally qualified Health Maintenance Organization (HMO) that offers you a new option to Medicare.

This new option — HealthPlus65 — gives you extra coverage with no additional premiums beyond the regular Medicare Part B premiums already deducted each month from your Social Security check.

There are virtually no claim forms — or waiting for reimbursement.

HealthPlus65 helps you contain your health care costs and gives you access to a broad range of quality health care designed to help you maintain your health.



Who Is HealthPlus?

HealthPlus65 is offered by HealthPlus, Inc., one of the largest, most experienced and financially strong health plans in the metropolitan Washington, D.C. area.

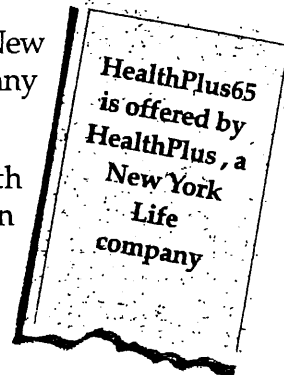
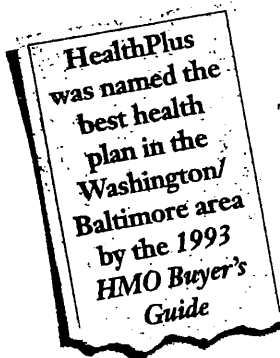
We are a subsidiary of Sanus Corp. Health Systems, a New York Life company. New York Life Insurance Company is the nation's fifth largest life insurance carrier.

For 10 years HealthPlus has offered quality health care plans to hundreds of thousands of people in Maryland, Virginia and Washington D.C.

You can take comfort in the fact that HealthPlus is a federally qualified HMO that has proven it is:

- Experienced
- Financially stable
- Proficient in selecting quality health care providers

That is why HealthPlus was selected as the best health plan in the Washington/Baltimore area by the 1993 *HMO Buyer's Guide*.



HealthPlus65 Brings You Extra Coverage

HealthPlus65 provides all of the benefits of Medicare *plus* these important advantages: *

Physician's Office Visits	Just \$5 per visit
Lab Tests and X-rays <i>(in radiology or laboratory facility)</i>	No charge
Preventive Care	Just \$5 per visit
Hospitalization	No deductibles
Emergency Care	\$50 emergency room copayment
Home Health Services	Just \$5 per visit
Outpatient Surgery	\$50 copayment in ambulatory facility
Annual Vision Exam	Just \$35
Prescription Drugs	Discount program
Prescription Eyeglasses	Discount program

**Limitations and exclusions apply; see HealthPlus65 Schedule of Benefits. Benefits apply to covered medical services obtained in accordance with HealthPlus65 procedures.*

**Refer to the
enclosed
Comparison
of Benefits
to see how
HealthPlus65
offers you
benefits beyond
Medicare**

HealthPlus65 Keeps Your Costs Low

So that Medicare beneficiaries like you can enjoy increased benefits, HealthPlus has contracted with the federal government which pays us to provide *all* of your Medicare benefits *plus* important additional benefits. HealthPlus serves a large number of members so our purchasing power helps us contain health care costs – and gives you access to a broad range of quality health care.

HealthPlus65
recognizes that
Medicare
beneficiaries
often have
fixed incomes

This approach makes it possible for HealthPlus65 to eliminate Medicare deductibles and cover more services than regular Medicare without requiring any premium payment from you beyond the Medicare Part B premium deducted from your monthly Social Security check.

The enclosed Comparison of Benefits highlights some of the important features of HealthPlus65.

With
HealthPlus65
there are no
deductibles and
no premiums
beyond your
regular
Medicare Part B
deduction



Why You Need HealthPlus65

As a Medicare beneficiary, you're probably well aware of the limitations of Medicare coverage. You must pay deductibles — which can mean *a lot of money* when you need health care services, especially if you're hospitalized. You also have to pay for preventive care, since it is not covered by Medicare.

With regular Medicare alone, one hospitalization can cost you hundreds of dollars

Supplemental insurance policies (sometimes called "Medigap") can be one alternative — but the premiums are expensive. The broader the coverage, the higher the price. Your premium costs may increase. And you may face a lot of paperwork with every claim.

As you'll see in this brochure, HealthPlus65 can do away with these costs and complications.

In addition, with HealthPlus65, you won't have the frustration of locating physicians who will accept Medicare assignment (not all physicians do). Instead, HealthPlus65 gives you a choice of quality, private practice physicians with offices close to where you live.

With HealthPlus65 there's no charge for pre-authorized hospitalization and no limit on hospital days



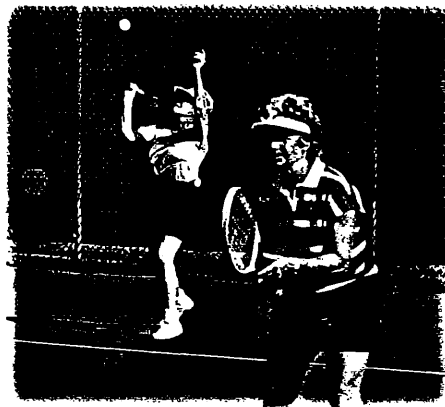
How HealthPlus65 Works

Receiving your health care through HealthPlus65 is easy. Here's how it works:

- When you enroll, choose a Primary Care Physician who will coordinate all your covered health care needs.
- Receive all your health care from providers who participate with HealthPlus65. When you become a member of the HealthPlus65 Health Plan, you agree to receive all non-emergency health care from physicians, hospitals, and other medical providers that contract with HealthPlus65.
- Present your HealthPlus65 membership ID card when you receive covered medical services *instead of* your Medicare card. When you do, we'll take care of the bills ... and the paperwork.

Except for emergencies and urgent care when you're away from home, you'll receive care from providers who contract with HealthPlus65

Present your HealthPlus65 membership ID card instead of your Medicare card



Your HealthPlus65 Providers

Physicians, hospitals, labs and other medical providers in your area have contracted with HealthPlus65 to provide your health care.

As a member of HealthPlus65, you'll have an important responsibility to receive your routine and specialty care from the private practice physicians and other providers who are part of the HealthPlus65 network.

HealthPlus65
offers you a
choice of
respected health
care providers
in convenient
locations
throughout
the area

If you go outside the HealthPlus65 provider network and receive non-emergency routine or specialty services from a provider who does not contract with HealthPlus65, neither HealthPlus65 nor Medicare will pay for those services.





Hewitt Associates

A Special Report

to Clients

July 12, 1995

Expanded Managed Care Options for Medigap Insurance

On July 7, the President signed legislation that extends for three years a pilot program (called Medicare SELECT) that provides a Medigap policy option with managed care features. It also expands the program to all 50 states. The program would have expired June 30 without legislative action.

This expanded availability will give employers the opportunity to use managed care Medigap insurance as an alternative strategy for managing their retiree medical obligation.

Background

Under federal Medigap rules, insurance policies that supplement Medicare coverage must fit one of several specific plan designs. The Medicare SELECT program was set up in 1990 legislation as an experimental managed care option for Medigap policies. These managed care policies mirror one of the standard Medigap designs, except that full benefits are paid only when network providers are used. If nonnetwork providers are used, the policies pay lower benefits or may provide no coverage. Premiums for Medicare SELECT policies are generally lower than for comparable Medigap policies.

Under the original demonstration project, Medicare SELECT policies could be sold in the following 15 states: Alabama, Arizona, California, Florida, Illinois, Indiana, Kentucky, Massachusetts, Minnesota, Missouri, North Dakota, Ohio, Texas, Washington, and Wisconsin. (To date, only the State of Massachusetts has chosen not to authorize the sale of these policies, pending extension of the program.) The plans may be sold by insurance companies and by HMOs.

New Law

Under the new law, Medicare SELECT policies may now be authorized by any state. In addition, the program has been extended until at least June 30, 1998, contingent on the findings of a study by the Secretary of Health and Human Services (HHS).

At that time, the program will become permanent unless the HHS study finds that when comparing cost, quality, and access to care under Medicare SELECT to standard Medigap policies:

- Medicare SELECT premiums are not lower than those of other Medigap plans providing comparable coverage,
- The Medicare SELECT program has resulted in significant additional expenditures under the Medicare program, or
- Beneficiaries' access to and quality of care has been significantly diminished under Medicare SELECT.

The HHS study is to be completed by June 30, 1997 and the Secretary of HHS is to make a determination by December 31, 1997. If the Secretary finds any of the above conditions to be true, further congressional action would be needed to extend the program beyond June 30, 1998. (If the program is not extended, beneficiaries covered by existing Medicare SELECT policies would remain covered, but no new enrollees would be accepted after June 30, 1998.)

The legislation also requires the General Accounting Office to study whether problems exist for Medicare beneficiaries who are continuously covered by a Medigap policy and wish to switch policies without medical underwriting. If such problems are found, the study will include options for modifying the Medigap market to address the situation. (Under current law, beneficiaries may choose a Medigap policy without medical underwriting during the 6-month period following their date of initial Medicare eligibility. Thereafter, the policies may be subject to underwriting in the event a beneficiary wishes to change policies.)

Hewitt Associates Comment: For employers interested in using Medigap insurance to manage their retiree medical obligation, this legislation provides expanded opportunities for using managed care as part of that strategy. The legislation will increase the choices of Medigap coverage available to Medicare-eligible individuals, most of whom were previously ineligible for Medicare SELECT managed care. While individuals residing in one of the states included in the demonstration project may already be familiar with Medicare SELECT, individuals in the remaining states may now be able to choose a less expensive, network-based Medicare SELECT policy.

Enactment of this legislation also signals the interest of Congress and the Administration in the broader issue of expanding managed care options for Medicare benefits. We will likely see more consideration of Medicare managed care as the Medicare reform debate unfolds in Congress this summer and fall. On the Administration side, the Health Care Financing Administration has a new demonstration project to expand the range of Medicare managed care options available in selected markets.



Hewitt Associates

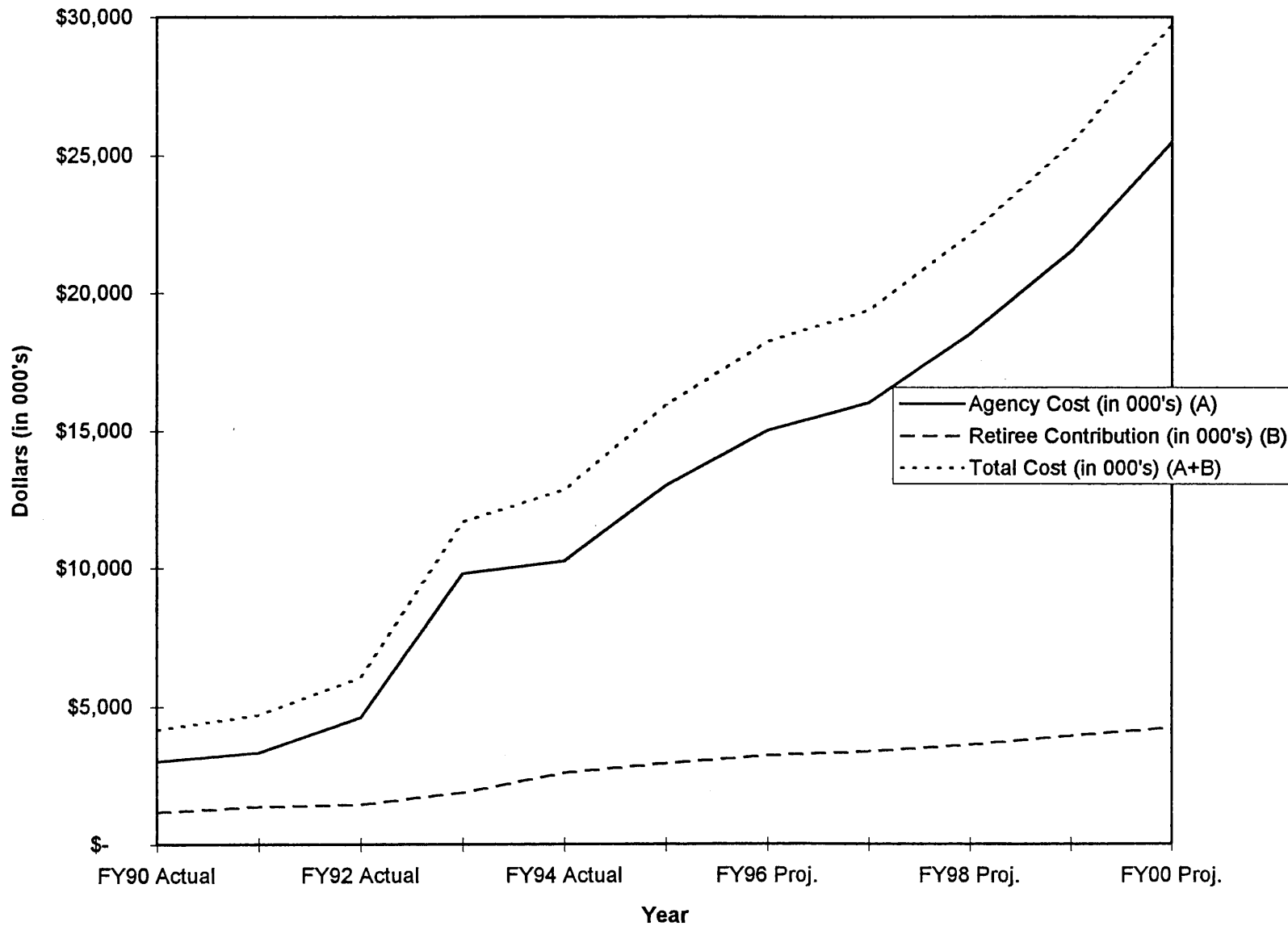
100 Half Day Road Lincolnshire, Illinois 60069 (708) 295-5000

County Government Retiree Group Insurance Costs: FY90-FY00

Year	Agency Cost (in 000's) (A)	Retiree Contribution (in 000's) (B)	Total Cost (in 000's) (A+B)	Number of Participating Retirees (C)	Agency Cost per Retiree (A/C)	Average Retiree Contribution (B/C)
FY90 Actual	\$ 3,000	\$ 1,163	\$ 4,163	2000	\$ 1,500	\$ 582
FY91 Actual	\$ 3,320	\$ 1,374	\$ 4,694	2100	\$ 1,581	\$ 655
FY92 Actual	\$ 4,600	\$ 1,447	\$ 6,047	2234	\$ 2,059	\$ 648
FY93 Actual	\$ 9,800	\$ 1,869	\$ 11,669	2280	\$ 4,298	\$ 820
FY94 Actual	\$ 10,250	\$ 2,596	\$ 12,846	2900	\$ 3,534	\$ 895
FY95 Est.	\$ 13,000	\$ 2,926	\$ 15,926	3100	\$ 4,194	\$ 944
FY96 Proj.	\$ 15,000	\$ 3,216	\$ 18,216	3255	\$ 4,608	\$ 988
FY97 Proj.	\$ 16,000	\$ 3,359	\$ 19,359	3418	\$ 4,681	\$ 983
FY98 Proj.	\$ 18,500	\$ 3,612	\$ 22,112	3589	\$ 5,155	\$ 1,006
FY99 Proj.	\$ 21,500	\$ 3,918	\$ 25,418	3768	\$ 5,705	\$ 1,039
FY00 Proj.	\$ 25,500	\$ 4,232	\$ 29,732	3935	\$ 6,480	\$ 1,075

Source: Operating Budgets and County Government Staff

County Government Retiree Group Insurance Costs: FY90-FY00



Source: Operating Budgets and County Government Staff

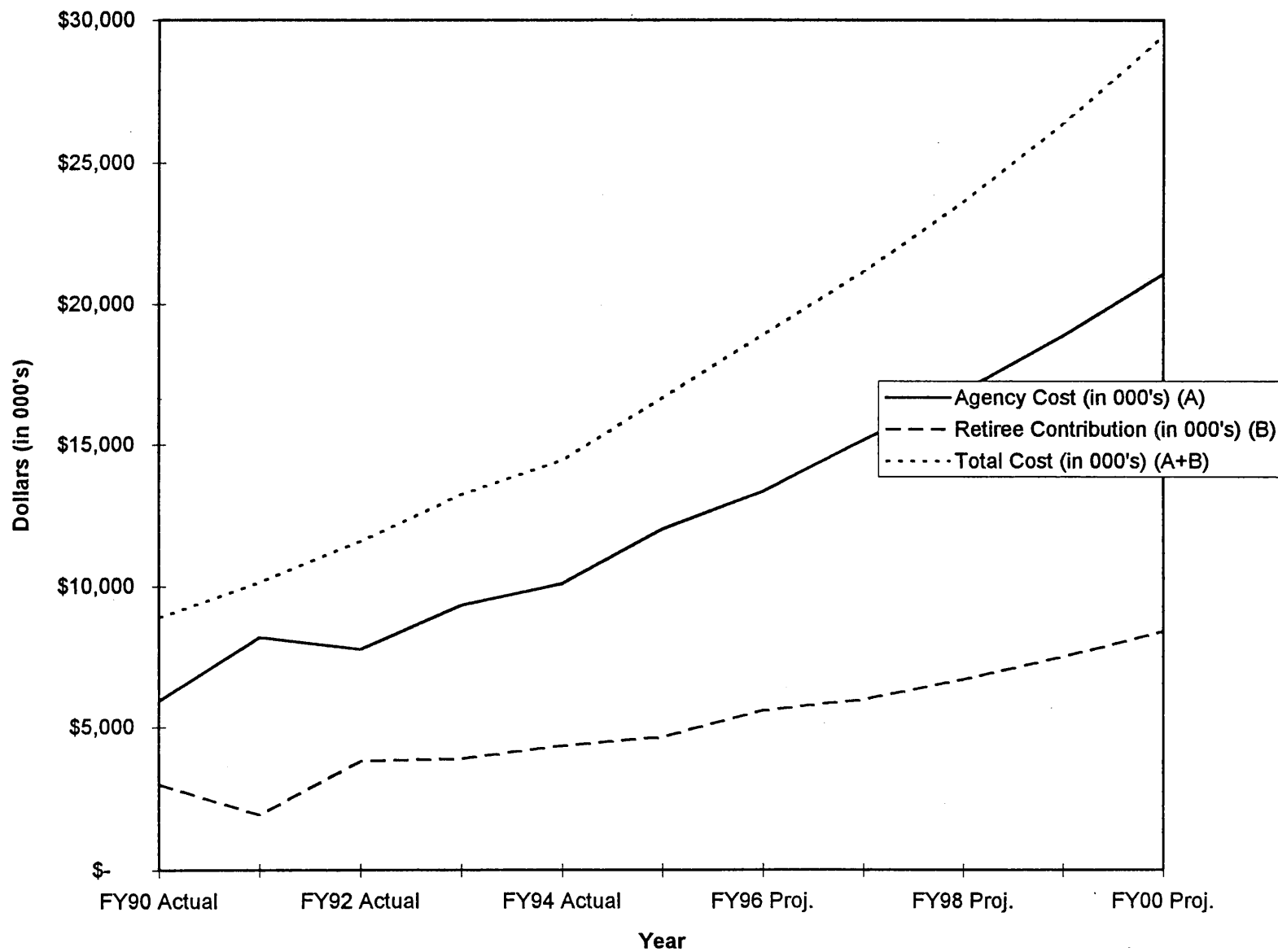
Montgomery County Public School Retiree Group Insurance Costs: FY90-FY00

Year	Agency Cost (in 000's) (A)	Retiree Contribution (in 000's) (B)	Total Cost (in 000's) (A+B)	Number of Participating Retirees (C)	Agency Cost per Retiree (A/C)	Average Retiree Contribution (B/C)
FY90 Actual	\$ 5,921	\$ 2,973	\$ 8,894	N/A	N/A	N/A
FY91 Actual	\$ 8,184	\$ 1,934	\$ 10,118	3,259	\$ 2,511	\$ 594
FY92 Actual	\$ 7,769	\$ 3,784	\$ 11,553	3,487	\$ 2,228	\$ 1,085
FY93 Actual	\$ 9,323	\$ 3,888	\$ 13,211	3,696	\$ 2,523	\$ 1,052
FY94 Actual	\$ 10,089	\$ 4,344	\$ 14,433	3,827	\$ 2,636	\$ 1,035
FY95 Est.	\$ 12,007	\$ 4,659	\$ 16,666	4,063	\$ 2,955	\$ 1,147
FY96 Proj.	\$ 13,325	\$ 5,600	\$ 18,925	4,288	\$ 3,108	\$ 1,306
FY97 Proj.	\$ 15,158	\$ 5,981	\$ 21,139	4,513	\$ 3,359	\$ 1,325
FY98 Proj.	\$ 16,917	\$ 6,699	\$ 23,616	4,738	\$ 3,571	\$ 1,414
FY99 Proj.	\$ 18,883	\$ 7,502	\$ 26,385	4,963	\$ 3,805	\$ 1,512
FY00 Proj.	\$ 21,080	\$ 8,403	\$ 29,483	5,188	\$ 4,063	\$ 1,620

N/A=data not available

Source: Operating Budgets and Montgomery County Public School Staff

MCPS Retiree Group Insurance Costs: FY90-FY00

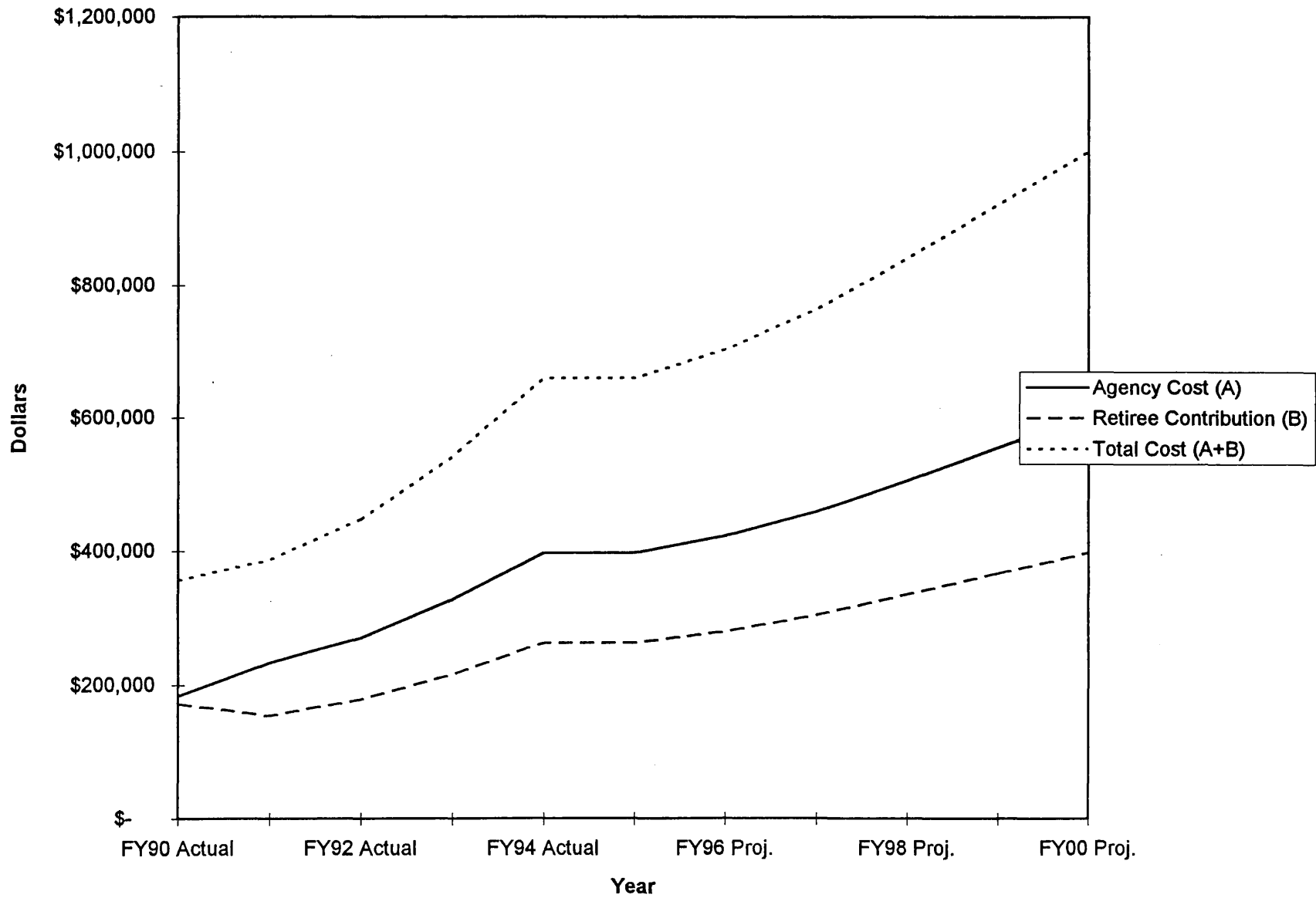


Montgomery College Retiree Group Insurance: FY90-FY00

Year	Agency Cost (A)	Retiree Contribution (B)	Total Cost (A+B)	Number of Participating Retirees (C)	Agency Cost per Retiree (A/C)	Average Retiree Contribution (B/C)
FY90 Actual	\$ 183,391	\$ 172,114	\$ 355,505	177	\$ 1,036	\$ 972
FY91 Actual	\$ 232,916	\$ 153,751	\$ 386,667	194	\$ 1,201	\$ 793
FY92 Actual	\$ 269,892	\$ 178,160	\$ 448,052	209	\$ 1,291	\$ 852
FY93 Actual	\$ 326,896	\$ 215,476	\$ 542,372	233	\$ 1,403	\$ 925
FY94 Actual	\$ 396,896	\$ 261,997	\$ 658,893	260	\$ 1,527	\$ 1,008
FY95 Est.	\$ 397,312	\$ 262,272	\$ 659,584	274	\$ 1,450	\$ 957
FY96 Proj.	\$ 423,090	\$ 279,367	\$ 702,457	292	\$ 1,449	\$ 957
FY97 Proj.	\$ 460,322	\$ 303,951	\$ 764,273	312	\$ 1,475	\$ 974
FY98 Proj.	\$ 506,814	\$ 334,651	\$ 841,465	334	\$ 1,517	\$ 1,002
FY99 Proj.	\$ 555,469	\$ 366,777	\$ 922,246	356	\$ 1,560	\$ 1,030
FY00 Proj.	\$ 603,239	\$ 398,320	\$ 1,001,559	376	\$ 1,604	\$ 1,059

Source: Operating Budgets and Montgomery College Staff

Montgomery College Retiree Group Insurance Costs: FY90-FY00



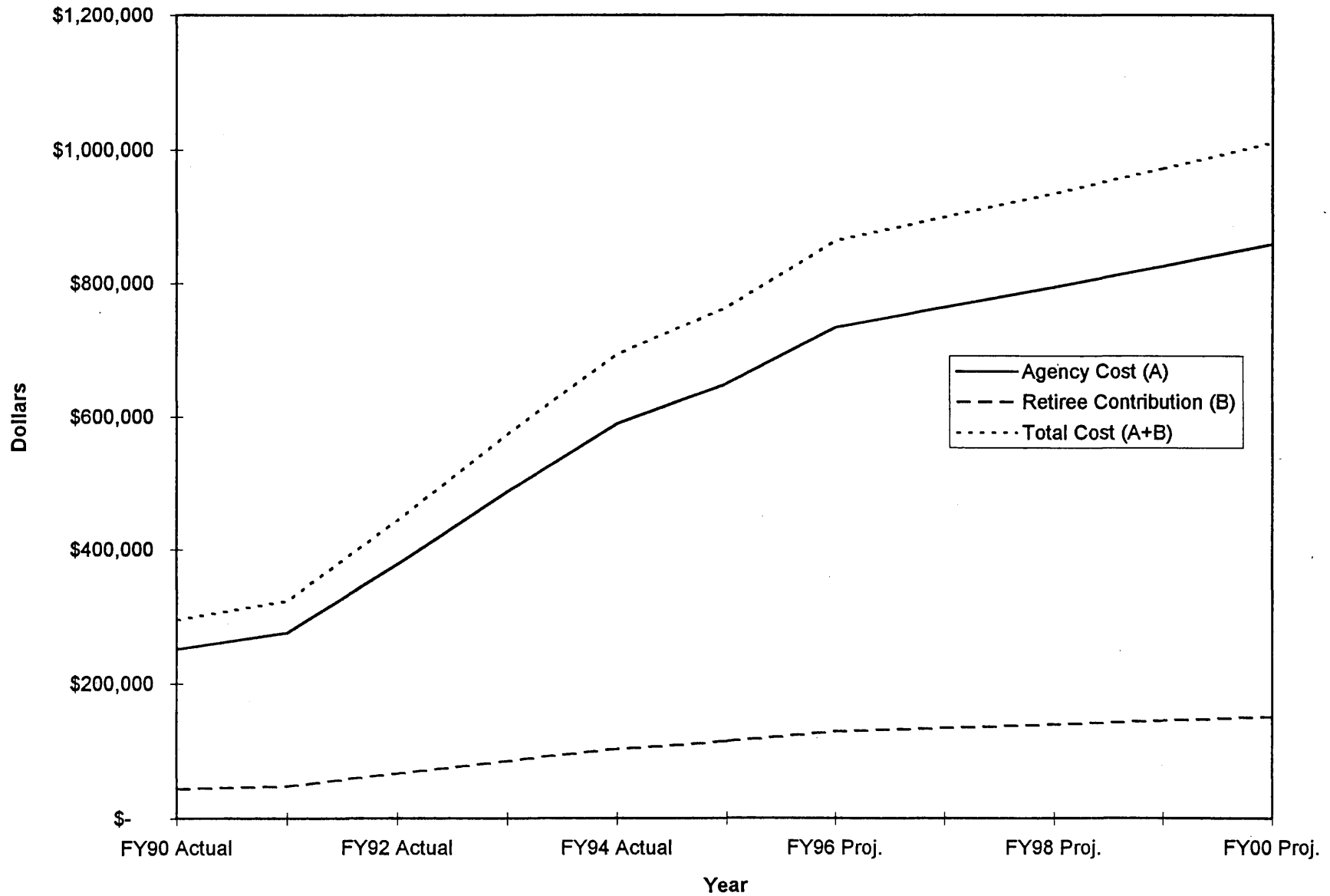
M-NCPPC Retiree Group Insurance Costs: FY90-FY00

Year	Agency Cost (A)	Retiree Contribution (B)	Total Cost (A+B)	Number of Participating Retirees (C)	Agency Cost per Retiree (A/C)	Average Retiree Contribution (B/C)
FY90 Actual	\$ 250,000	\$ 44,000	\$ 294,000	109	\$ 2,294	\$ 404
FY91 Actual	\$ 274,000	\$ 48,000	\$ 322,000	116	\$ 2,362	\$ 414
FY92 Actual	\$ 377,000	\$ 67,000	\$ 444,000	120	\$ 3,142	\$ 558
FY93 Actual	\$ 488,000	\$ 86,000	\$ 574,000	127	\$ 3,843	\$ 677
FY94 Actual	\$ 589,000	\$ 104,000	\$ 693,000	140	\$ 4,207	\$ 743
FY95 Est.	\$ 649,000	\$ 115,000	\$ 764,000	139	\$ 4,669	\$ 827
FY96 Proj.	\$ 734,000	\$ 130,000	\$ 864,000	145	\$ 5,062	\$ 897
FY97 Proj.	\$ 764,000	\$ 135,000	\$ 899,000	150	\$ 5,093	\$ 900
FY98 Proj.	\$ 794,000	\$ 140,000	\$ 934,000	155	\$ 5,123	\$ 903
FY99 Proj.	\$ 826,000	\$ 146,000	\$ 972,000	160	\$ 5,163	\$ 913
FY00 Proj.	\$ 859,000	\$ 152,000	\$ 1,011,000	165	\$ 5,206	\$ 921

Source: Operating Budgets and M-NCPPC Staff

Note: Data are for Montgomery County portion only, calculated as 50% of total Commission costs.

M-NCPPC Retiree Group Insurance Costs: FY90-FY00



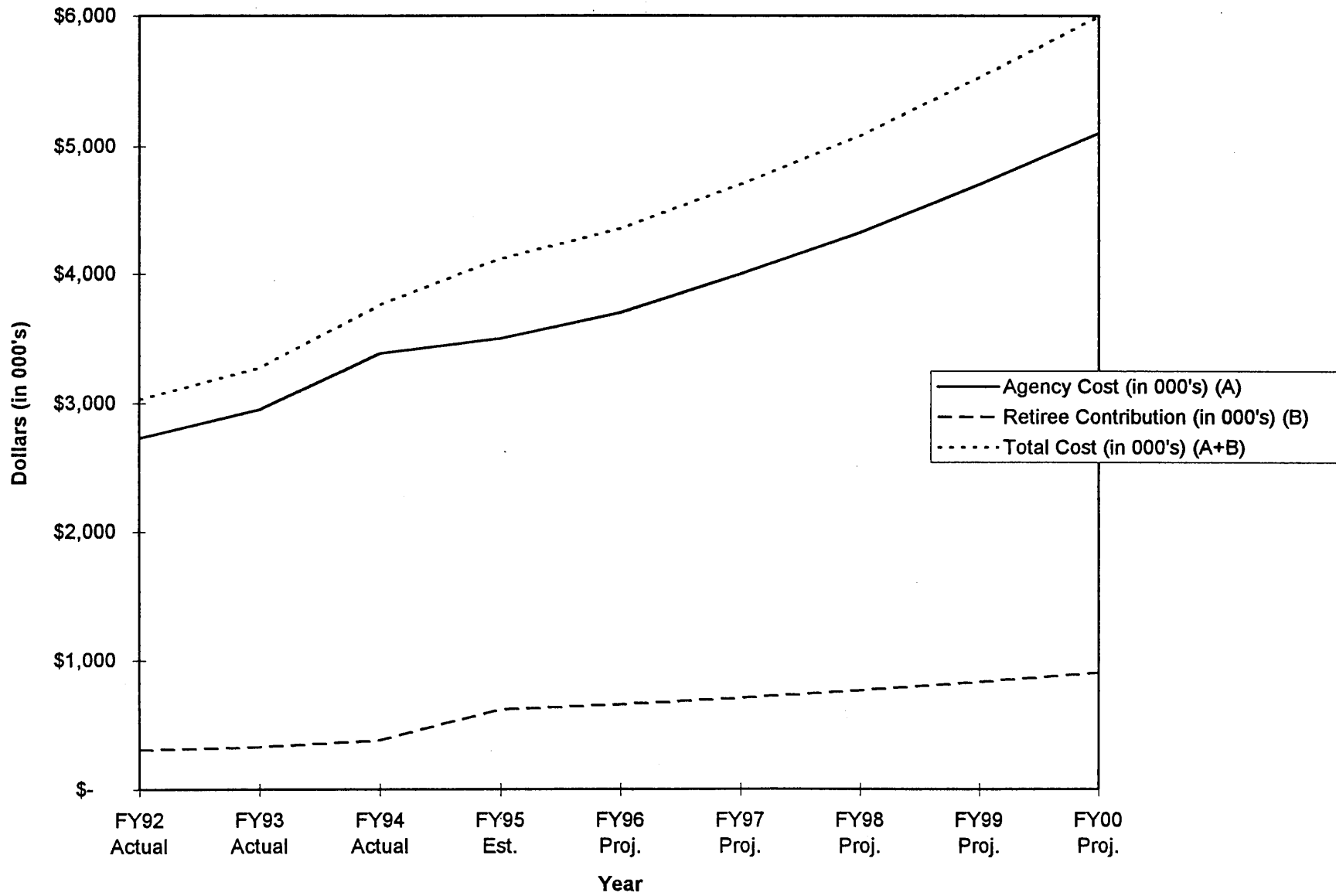
WSSC Retiree Group Insurance Costs: FY90-FY00

Year	Agency Cost (in 000's) (A)	Retiree Contribution (in 000's) (B)	Total Cost (in 000's) (A+B)	Number of Participating Retirees (C)	Agency Cost per Retiree (A/C)	Average Retiree Contribution (B/C)
FY90 Actual	N/A	N/A	N/A	638	N/A	N/A
FY91 Actual	N/A	N/A	N/A	690	N/A	N/A
FY92 Actual	\$ 2,727	\$ 303	\$ 3,030	773	\$ 3,528	\$ 392
FY93 Actual	\$ 2,948	\$ 327	\$ 3,275	807	\$ 3,653	\$ 405
FY94 Actual	\$ 3,387	\$ 376	\$ 3,763	833	\$ 4,066	\$ 451
FY95 Est.	\$ 3,500	\$ 616	\$ 4,116	858	\$ 4,079	\$ 718
FY96 Proj.	\$ 3,700	\$ 651	\$ 4,351	880	\$ 4,205	\$ 740
FY97 Proj.	\$ 3,996	\$ 703	\$ 4,699	900	\$ 4,440	\$ 781
FY98 Proj.	\$ 4,320	\$ 760	\$ 5,080	920	\$ 4,696	\$ 826
FY99 Proj.	\$ 4,700	\$ 827	\$ 5,527	939	\$ 5,005	\$ 881
FY00 Proj.	\$ 5,100	\$ 898	\$ 5,998	958	\$ 5,324	\$ 937

N/A=data not available

Source: Operating Budgets and WSSC Staff

WSSC Retiree Group Insurance Costs: FY90-FY00





Peat Marwick LLP

Appendix H

2001 M Street, N.W.
Washington, D.C. 20036

Telephone 202 467 3000

Telefax 202 833 1350

September 8, 1995

Ms. Karen A. Orlansky
Director, Office of Legislative Oversight
Montgomery County
100 Maryland Avenue
Rockville, MD 20850

Dear Ms. Orlansky:

You requested in your memorandum dated August 10, 1995, an update on the status of GASB requirements for post-retirement group insurance benefits, either applicable today or expected to be applicable in the foreseeable future, with emphasis on GASB's position on prefunding post-retirement group insurance benefits.

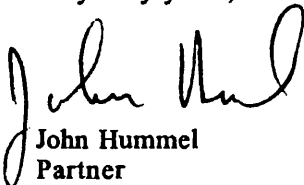
To date, GASB has issued two statements addressing these matters. They are:

- **GASB Statement No. 12. *Disclosure of Information on Post-Employment Benefits Other than Pension Benefits of State and Local Government Employers.*** This statement is effective for periods beginning after June 15, 1990. It requires minimum financial statement disclosures, such as plan coverage, eligibility, statutory or contractual obligations to contribute, accounting and financing or funding policies, and actuarially determined bases for funding; and
- **GASB Statement No. 26. *Financial Reporting for Post-Employment Health Care Plans Administered by Defined Benefit Plans.*** This statement is effective for periods beginning after June 15, 1996. Based upon our preliminary review, this statement is not applicable to the County or its component units because post-employment health care plans are not administered through the County's defined benefit plans.

Additionally, discussions that we held with Tom Strayer, a project manager with GASB, indicated that one of the GASB's current projects addresses the accounting and financial reporting of post-employment benefits by employers and by plans or the entities that administer them. With respect to funding issues, Mr. Strayer stated that the GASB is precluded from issuing guidance on funding, since the GASB is not empowered to do so. He anticipated that his project will begin deliberations in September 1995, and that an Exposure Draft and a final Statement are expected in the fourth quarters of 1996 and 1997, respectively.

There is currently no other outstanding information issued by the GASB on post-retirement group insurance benefits. Please do not hesitate to contact me at (202) 467-3139 or Vince Loiacono at (202) 467-3013, if you have any further questions.

Very truly yours,


John Hummel
Partner



Member Firm of
Klynveld Peat Marwick Goerdeler

Resolution No. 10-2233

Introduced: October 16, 1986

Adopted: October 16, 1986

COUNTY COUNCIL
FOR MONTGOMERY COUNTY, MARYLAND

By: County Council

Subject: Insurance Benefits for Retirees

Background

- (1) The Compensation Task Force in its June 1985 Report recommended that the health and life insurance benefits provided to retirees be made uniform across all County-funded agencies, and that this include lifetime coverage for medical and life insurance.
- (2) The Task Force also recommended that life insurance be provided for all retirees in an amount equal to \$10,000 or 25% of salary at retirement, whichever is higher.
- (3) The County Executive in his September 12, 1986 memorandum recommended a retiree health insurance program for County Government employees as follows:
 - ° maintain the present benefit plan up to age 65;
 - ° at age 65, provide a lifetime Medicare Supplement plan similar to the school system's plan, but with the following differences:
 - a. exclude the drug-card plan and the vision-care benefit;
 - b. add a \$1,500 stop-loss benefit;
 - ° a lifetime cost-sharing of 70% County/30% retiree;
- (4) The Personnel Committee at its meeting of September 29, 1986 reviewed the Executive's proposal and recommended the following changes:
 - ° add coverage for prescription drugs using an 80% coinsurance plan with a \$25 annual deductible;
 - ° have a lifetime cost-sharing formula that recognizes years of service:
 - a. 70% County/30% retiree for those with 10 or more years of service;
 - b. 50% County/50% retiree for those with less than 10 years of service.

- ° the new Medicare Supplement plan should be the one offered to all persons hired on or after January 1, 1987.
- ° current employees and current retirees should be offered an option to choose this new lifetime coverage or the existing insurance coverage. These persons must make a selection by May 31, 1987.


Action

The County Council for Montgomery County, Maryland, approves the following resolution:

With regard to insurance benefits for retirees, the Council's policy is as follows --

- ° before age 65, the health insurance benefits will be the same as for active employees;
- ° at age 65, the County will offer a lifetime Medicare Supplement plan to include a Stop-Loss benefit of \$1,500 per year, and 80% coinsurance for prescription drugs, after a \$25 annual deductible; the \$25 annual deductible shall be indexed annually using an appropriate cost index.
- ° the cost-sharing formula will be:
 - 50% County/50% retiree for those with 5 years of plan participation as an active employee;
 - for each additional year above 5, the County's share will be increased two percentage points up to a maximum County share of 70%.
- ° for the transition period for County Government employees:
 - all employees hired after January 1, 1987 will be eligible only for the new plan described herein;
 - those employed prior to January 1, 1987 will be given the option of choosing this new plan;
 - those currently retired and with lapsed coverage will be offered the new plan.

This is a correct copy of Council action.


Kathleen A. Freedman, Secretary
County Council

**WSSC
RETIREE HEALTH CARE**

Retirement health care cost sharing for employees hired after March 31, 1994 .

The cost sharing formula for these employees when they retire from WSSC will be based on total full years of WSSC service at the time they retire and the cost sharing formula in effect at that time. Years of service will determine what the retiree will have to pay toward health care premiums.

The following chart is presented to explain the concept, with the current cost sharing formula (85/15) used as an example.

YEARS OF WSSC SERVICE	% OF WSSC BENEFIT	X	CURRENT WSSC COST SHARING	=	ADJUSTED WSSC COST SHARING	RESULTING RETIREE COST SHARING
20	100 %	X	85 %	=	85.00 %	15.00 %
19	95 %	X	85 %	=	80.75 %	19.25 %
18	90 %	X	85 %	=	76.50 %	23.50 %
17	85 %	X	85 %	=	72.25 %	27.75 %
16	80 %	X	85 %	=	68.00 %	32.00 %
15	75 %	X	85 %	=	63.75 %	36.25 %
14	70 %	X	85 %	=	59.50 %	40.50 %
13	65 %	X	85 %	=	55.25 %	44.75 %
12	60 %	X	85 %	=	51.00 %	49.00 %
11	55 %	X	85 %	=	46.75 %	53.25 %
10	50 %	X	85 %	=	42.50 %	57.50 %
9	45 %	X	85 %	=	38.25 %	61.75 %
8	40 %	X	85 %	=	34.00 %	66.00 %
7	35 %	X	85 %	=	29.75 %	70.25 %
6	30 %	X	85 %	=	25.50 %	74.50 %
5	25 %	X	85 %	=	21.25 %	78.75 %
1 - 4	COBRA Coverage Only					

Retiree Group Insurance
of Area Local Governments and School Systems
Survey Results - July 28, 1995

ELIGIBILITY REQUIREMENTS

Name of County	Participation in Medical Plan Requirement	Years of Service Requirement	Life Insurance Requirements	Re-enrollment Opportunities+	Deferred Retirees*
Alexandria City Government	yes - directly before retirement	yes - minimum of 5 years	same as medical	yes - one-time only option	no
Alexandria City Public Schools	yes - directly before retirement	yes - minimum of 5 years	same as medical	none	no
Anne Arundel County Government	no	yes - minimum of 5 years	life insurance not available to retirees	yes - but it is scheduled to terminate next year (last opening is May 1996)	none offered
Anne Arundel County Public Schools	yes - minimum of 2 years	yes - minimum of 5 years	life insurance is not available to retirees	yes - if meet medical plan requirement	yes
Arlington County Government	yes - directly before retirement	yes - minimum of 5 years	same as medical Optional Supplemental Life insurance is also available	none	no
Arlington County Public Schools	yes - directly before retirement	yes - continuously employed for a minimum of 5 years	same as medical	none	no
Baltimore County Government	no	yes - minimum of 5 years	must be enrolled in County's life insurance plan for at least 18 months before retirement	yes - applies to health insurance	yes - applies to health insurance only
Fairfax County Government	yes - directly before retirement	yes - minimum of 5 years	same as medical	none	no

+ Re-enrollment refers to the option to participate in retiree group insurance again after the retired employee has chosen to previously discontinue membership in the group insurance programs.

* Are employees who are eligible to collect deferred retirement permitted to participate in the system's retiree group insurance program when they begin to collect a pension?

**Retiree Group Insurance
of Area Local Governments and School Systems
Survey Results - July 28, 1995**

ELIGIBILITY REQUIREMENTS

Name of County	Participation in Medical Plan Requirement	Years of Service Requirement	Life Insurance Requirements	Re-enrollment Opportunities+	Deferred Retirees*
Fairfax County Public Schools	no	yes - minimum of 5 years	same as medical	yes - permitted during open seasons annually	no
Howard County Government	no	yes - minimum of 10 years	life insurance is not available to retirees	yes - applies to health insurance only	yes - applies to health insurance only
Howard County Public Schools	yes - for a minimum of 1 year	yes - minimum of 10 years	same as medical	yes - permitted during open seasons annually	no
Prince George's County Government	yes - directly before retirement	yes - minimum of 5 years	same as medical	yes - permitted for police and fire retirees only	no
Prince George's County Public Schools	yes - if hired before 10/1/86, directly before retirement; if hired on or after 10/1/86, minimum of 12 years	yes - if hired before 10/1/86, minimum of 5 years; if hired on or after 10/1/86, minimum of 12 years	similar to health insurance program - if hired before 9/1/79, same requirements as medical for retirees hired before 10/1/86; if hired on or after 9/1/79, same requirements as medical for retirees hired on or after 10/1/86	yes - permitted under specific times and qualifying events	no

+ Re-enrollment refers to the option to participate in retiree group insurance again after the retired employee has chosen to previously discontinue membership in the group insurance programs.

* Are employees who are eligible to collect deferred retirement permitted to participate in the system's retiree group insurance program when they begin to collect a pension?

**Retiree Group Insurance
of Area Local Governments and School Systems
Survey Results - July 28, 1995**

ELIGIBILITY REQUIREMENTS

Name of County	Participation in Medical Plan Requirement	Years of Service Requirement	Life Insurance Requirements	Re-enrollment Opportunities+	Deferred Retirees*
State of Maryland	no	yes - minimum of 5 years	life insurance is not available to retirees	yes - permitted for retirees with a minimum of 10 years of service and who receive their annuity within 5 years of deferment	yes - permitted during open seasons annually
Federal Government	yes - minimum of 5 years	yes - minimum of 5 years	same as medical Optional Supplemental Life insurance is also offered	yes - permitted for FEHBP participants who transferred to HCFA's Medicare Pre-paid Program only	no

+ Re-enrollment refers to the option to participate in retiree group insurance again after the retired employee has chosen to previously discontinue membership in the group insurance programs.

* Are employees who are eligible to collect deferred retirement permitted to participate in the system's retiree group insurance program when they begin to collect a pension?

Retiree Group Insurance
of Area Local Governments and School Systems
Survey Results - July 28, 1995

HEALTH INSURANCE

Name of County	Estimated Number of Participating Retirees	Types of Plans/Coverage	Medicare		Pricing*
			Part A and B	Supplement	
Alexandria City Government	350 total	<u>Medical</u> : 5 HMOs <u>Dental</u> : included with medical <u>Vision</u> : included with medical <u>Prescription drug</u> : included with medical	both required	offered	fixed dollar contribution
Alexandria City Public Schools	150 total	<u>Medical</u> : 1 plan that contains HMO and indemnity parts <u>Dental</u> : included with medical <u>Vision</u> : included with medical <u>Prescription drug</u> : included with medical	both required	offered - Medigap Plan E and Managed Care plans	fixed dollar contribution
Anne Arundel County Government	750 total and in the health program only	<u>Medical</u> : 2 HMOs, 1 POS, 1 PPO <u>Dental</u> : purchase separately <u>Vision</u> : purchase separately <u>Prescription drug</u> : purchase separately	both required	offered	80:20
Anne Arundel County Public Schools	1,900 total and in the health program only	<u>Medical</u> : 1 indemnity, 2 HMOs <u>Dental</u> : purchase separately <u>Vision</u> : purchase separately <u>Prescription drug</u> : included with medical	both required	offered - Carve-out	hospital costs are 80:20; major medical benefits are 50:50
Arlington County Government	1,030 total and in the health program only	<u>Medical</u> : triple plan option that offers features from an indemnity, PPO, and HMO <u>Dental</u> : included with medical <u>Vision</u> : included with medical <u>Prescription drug</u> : included with medical	both required	offered	sliding scale depending on years of service
Arlington County Public Schools	1,000 total	<u>Medical</u> : 1 indemnity, 2 HMOs, and 2 PPOs <u>Dental</u> : included in HMOs and PPOs only <u>Vision</u> : included in HMOs and PPOs only <u>Prescription drug</u> : included in all medical plans	both required	offered	sliding scale depending on plans and options chosen

* Unless otherwise noted, pricing schedule contains the employer:retiree premium split.

**Retiree Group Insurance
of Area Local Governments and School Systems
Survey Results - July 28, 1995**

HEALTH INSURANCE

Name of County	Estimated Number of Participating Retirees	Types of Plans/Coverage	Medicare		Pricing*
			Part A and B	Supplement	
Baltimore County Government	3,000 total	Medical: 1 indemnity, 1 PPO, 6 HMOs Dental: unavailable except by 1 HMO Vision: unavailable except by 1 HMO Prescription drug: included with HMOs, separate for PPO and indemnity	both required	offered	sliding scale depending on years of service and the plan chosen
Fairfax County Government	2,300 total	Medical: triple plan option that offers features from an indemnity, HMO, PPO Dental: included with medical Vision: included with medical Prescription drug: included with medical	both required	offered	0:100 at age 62+, County provides \$45 subsidy
Fairfax County Public Schools	3,800 total	Medical: 2 HMOs, 1 PPO Dental: DMO offered beginning 11/1/94 Vision: unavailable except for minor coverage with HMOs Prescription drug: included with medical	both required	offered - Carve-out	0:100 at age 62+, County provides \$45 subsidy
Howard County Government	140 total and in the health program	Medical: 1 indemnity, 3 HMOs Dental: not available Vision: purchase separately Prescription drug: purchase separately	both required	offered	sliding scale of 50:50 to 90:10 depending on years of service
Howard County Public Schools	550 total	Medical: 2 indemnity, 5 HMOs Dental: purchase separately Vision: purchase separately Prescription drug: purchase separately	both required	offered	sliding scale of 50:50 to 90:10 depending on years of service

* Unless otherwise noted, pricing schedule contains the employer:retiree premium split.

Retiree Group Insurance
of Area Local Governments and School Systems
Survey Results - July 28, 1995

HEALTH INSURANCE

Name of County	Estimated Number of Participating Retirees	Types of Plans/Coverage	Medicare		Pricing*
			Part A and B	Supplement	
Prince George's County Government	1,600 total	<u>Medical</u> : 3 HMOs, 1 POS <u>Dental</u> : purchase separately <u>Vision</u> : purchase separately <u>Prescription drug</u> : included with medical	both required	offered	80:20 for HMOs 75:25 for POS
Prince George's County Public Schools	4,000 total	<u>Medical</u> : 1 indemnity, 6 HMOs <u>Dental</u> : purchase separately <u>Vision</u> : purchase separately <u>Prescription drug</u> : included with medical	both required	offered - Carve-out	70:30 for Medical 50:50 for Dental and Vision
State of Maryland	20,000 total and in the health program only	<u>Medical</u> : 1 indemnity, 7 HMOs <u>Dental</u> : purchase separately <u>Vision</u> : purchase separately <u>Prescription drug</u> : purchase separately	both required	offered	sliding scale depending on years of service
Federal Government	1.6 million total	<u>Medical</u> : over 350 various plans and dependent on factors such as geographic location, union membership, occupation, retiree may have as many as 20 options; <u>Dental</u> : provided at a minimal level <u>Vision</u> : offered in only a few plans <u>Prescription drug</u> : included with medical	Part B is not required	offered - optional and managed by separate agency	averages 75:25

* Unless otherwise noted, pricing schedule contains the employer:retiree premium split.

Retiree Group Insurance
of Area Local Governments and School Systems
Survey Results - July 28, 1995

LIFE INSURANCE

Name of County	Approximate Number of Participating Retirees	Pricing*	Initial Benefit Level at Retirement	Schedule of Declining Benefit	Minimum Benefit Level
Alexandria City Government	350 total	100:0	1X annual salary rounded to next higher \$1,000	at age 65, declines 25% and declines for 10% for next 5 years	25% of annual salary
Alexandria City Public Schools	150 total	100:0	2X annual salary	declines 2% each month	50% of annual salary
Anne Arundel County Government	LIFE INSURANCE NOT AVAILABLE TO RETIREES				
Anne Arundel County Public Schools	LIFE INSURANCE NOT AVAILABLE TO RETIREES				
Arlington County Government	1,030 total	Basic-100:0 Optional-smoker = \$1.40 per \$1,000 of coverage; non-smoker= \$1.22 per \$1,000 of coverage	2 kinds: Basic - before age 60 retirees receive \$10,000; age 60+, retirees receive \$5,000 Optional Supplemental before age 60, retirees may receive \$10,000, 1X or 0.5X annual salary; age 60+, retirees receive \$5,000		2 kinds: basic - before age 60, retirees receive \$10,000; age 60+, retirees receive \$5,000. optional supplemental - before age 60, retirees may receive \$10,000, 1X or 0.5X annual salary; at age 60+, retirees receive \$5,000.
Arlington County Public Schools	1,000 total	100:0	2X annual salary	declines 2% each month	50% of annual salary
Baltimore County Government	3,000 total	90:10	2X annual salary rounded to next higher \$1,000	declines by 15% of initial benefit for 4 years	50% of annual salary

*Pricing indicates the employer:retiree ratio split for premium cost sharing.

**Retiree Group Insurance
of Area Local Governments and School Systems
Survey Results - July 28, 1995**

LIFE INSURANCE

Name of County	Approximate Number of Participating Retirees	Pricing	Initial Benefit Level at Retirement	Schedule of Declining Benefit	Minimum Benefit Level
Fairfax County Government	2,300 total	retirees pay \$0.24 monthly per \$1,000 of coverage; County pays \$0.26 monthly per \$1,000 of coverage	2 levels - 1.5X or 3X annual salary	at retirement or 65, whichever is first, benefit declines 65% of initial amount; at age 70, benefit declines by 30% of initial amount	30% of 1.5X or 3X annual salary
Fairfax County Public Schools	3,800 total	f/t admin. & educators pay 100:0; p/t workers pay 50:50	2 kinds: full-time administrators/educators - 2X annual salary; part-time employees, food service workers, bus drivers - 1.5X or 3X annual salary	at retirement and under age 65, declines by 35% of initial benefit; at age 70, declines another 15% of initial benefit level	50% of initial benefit
Howard County Government	LIFE INSURANCE NOT AVAILABLE TO RETIREES				
Howard County Public Schools	550 total	100:0	1X annual salary	declines 10% each year for 4 years	50% of annual salary
Prince George's County Government	1,600 total	100:0	2X annual salary	declines 15% each year for 4 years	50% of annual salary
Prince George's County Public Schools	4,000 total	100:0	2X annual salary	declines 15% each year for 4 years	50% of annual salary
State of Maryland	LIFE INSURANCE NOT AVAILABLE TO RETIREES				

*Pricing indicates the employer:retiree ratio split for premium cost sharing.

Retiree Group Insurance
of Area Local Governments and School Systems
Survey Results - July 28, 1995

LIFE INSURANCE

<u>Name of County</u>	<u>Approximate Number of Participating Retirees</u>	<u>Pricing</u>	<u>Initial Benefit Level at Retirement</u>	<u>Schedule of Declining Benefit</u>	<u>Minimum Benefit Level</u>
Federal Govern- ment	1.6 million total	Basic- \$0.185 per \$1,000 of coverage (optional life is available also)	Basic: annual salary + \$2,000	Basic: reduction may be 0%, 25%, 50% or 75% depending on plan options chosen	Basic: depends on plan options chosen

*Pricing indicates the employer:retiree ratio split for premium cost sharing.

Retiree Group Insurance
of Area Local Governments and School Systems
Survey Results - July 28, 1995

MISCELLANEOUS

Name of County	Funding	Lifetime Coverage	Survivor Coverage	Annual Transfer Season	Out-of-Area Provisions
Alexandria City Government	pay-as-you-go for both health and life	yes	A or survivors receive COBRA	yes	same as for in-area retirees: City pays the first \$99.62 of benefit and retiree pays the remainder (see pricing sheet)
Alexandria City Public Schools	pay-as-you-go for health; prefunding for life under the Virginia State Retirement System (VRS)	yes	yes	no	indemnity plan
Anne Arundel County Government	pay-as-you-go for the available health plan only	B	B	yes	special indemnity plan for out-of-area retirees only
Anne Arundel County Public Schools	pay-as-you-go for the available health plan only	B	B	yes	indemnity plan
Arlington County Government	pay-as-you-go for both health and life	yes	yes	yes with limited choices	special indemnity plan for out-of-area active and retired employees
Arlington County Public Schools	pay-as-you-go for health; prefunding for life under the Virginia State Retirement System (VRS)	yes	A	yes	indemnity plan
Baltimore County Government	pay-as-you-go for both health and life	C	C	yes	PPO plan
Fairfax County Government	pay-as-you-go for both health and life	yes	B and D	yes with limited choices	special indemnity plan for out-of-area active and retired employees

CODES:

- A - Survivors may continue participation in health insurance program only if they pay the full cost of the premium
- B - Survivors must receive a pension check to continue participation in health insurance program
- C - Options depend on retirement plans chosen
- D - Survivors must remain unmarried to continue participation in health insurance program

Retiree Group Insurance
of Area Local Governments and School Systems
Survey Results - July 28, 1995

MISCELLANEOUS

Name of County	Funding	Lifetime Coverage	Survivor Coverage	Annual Transfer Season	Out-of-Area Provisions
Fairfax County Public Schools	pay-as-you-go for health; life insurance for administrators, educators and other full-time employees is prefunded under the Virginia State Retirement System (VRS) and life insurance for bus drivers, food service workers and part-time employees is pay-as-you-go under SRS	yes	yes	yes with limited choices	special indemnity plan for out-of-area active and retired employees
Howard County Government	pay-as-you-go for the available health only	C	C	yes	indemnity plan
Howard County Public Schools	pay-as-you-go for both health and life	yes	A	yes with limited choices	indemnity plan
Prince George's County Government	pay-as-you go for both health and life	yes	yes	yes	POS plan
Prince George's County Public Schools	pay-as-you-go for both health and life	yes	D and survivors may not hold full-time jobs	yes	indemnity plan
State of Maryland Government	pay-as-you-go for the available health only	yes	yes	yes	indemnity plan
Federal Government	pay-as-you-go for health and Optional Supplement life; prefunding for basic life in a trust fund	yes	B	yes	not applicable

CODES:

- A - Survivors may continue participation in health insurance program only if they pay the full cost of the premium
- B - Survivors must receive a pension check to continue participation in health insurance program
- C - Options depend on retirement plans chosen
- D - Survivors must remain unmarried to continue participation in health insurance program

Radical surgery

The cost to prefund retiree medical benefits is soaring. To deal with the problem, most companies are drastically downsizing their benefits packages.

Lynn Brenner

When US employers first introduced the post-retirement medical benefit, it looked to them like an almost costless way to reward former employees. Some 25 years later, many of those same employers feel a bit like the smiling lady who rode a tiger in the children's limerick: "They returned from the ride, with the lady inside, and the smile on the face of the tiger."

Few employers will claim that their promised post-retirement health care benefits have swallowed them whole. But the additional costs to which they committed themselves in the late 1960s and early 1970s now represent a serious threat to many companies' financial performance.

How serious? Last year, the General Accounting Office estimated post-retirement medical coverage as a \$412 billion corporate liability. "For some companies, this is a snowball on a mountaintop, gathering momentum, threatening everything in its path," says Fred Schick, a consultant at Sedgwick Noble Lowndes.

Twenty years ago, the big US manufacturing, steel, and fuel companies that pioneered this benefit had fewer retirees than active employees, so the cost of retiree medical care was small relative to total corporate income and budget. And most important, companies covered the cost on a pay-as-you-go basis. "No one realized how big it was," says Richard Ostuw, chief actuary for health and welfare at Towers Perrin, "because they weren't measuring it as a long-term commitment."

But health care costs have soared over the last



decade and a half. At many companies, so have the number of retirees—augmented by downsizing due to technological innovation and by generous early retirement incentive programs. "In the auto and steel industries, some companies now have more retirees than active workers," says Ostuw. Then, last year, FAS 106's requirement that plan sponsors prefund their long-term post-retirement health care costs puts a high price on pay-as-you-go schemes.

The result: retiree medical expenses turned into an avalanche tumbling straight to the bottom line—\$2.2 billion at IBM, \$4.8 billion at DuPont, \$7 bil-

lion at AT&T, and \$22.3 billion at General Motors, as of 1993. Wall Street analysts predicted that FAS 106 would slash corporate profits by \$1 trillion in the first few years after its implementation.

A few corporations, including AT&T and Schering-Plough, consider themselves sufficiently healthy to shoulder the burden, and have prefunded their FAS 106 liabilities. But for most others, the price of prefunding is simply unacceptable. These companies are scrambling to shrink their liabilities by cutting the cost of their benefits package.

Foster Higgins found in a 1992 survey that 69% of employers had made or intended to make major changes in their benefits plans to reduce the cost of retiree medical coverage. Twenty-two percent of the respondents to a William Mercer survey the same year had decided to eliminate the coverage entirely for future retirees. And several dozen companies have stepped into a legal minefield by reducing the health care benefits of their current retirees (see "See you in court!" below).

The trend shows every sign of continuing. Foster Higgins found late last year that only 17% of employers provided free coverage to retirees under age 65, while 42% share the cost and 41% require

retirees to pay it all themselves. The survey found employers more likely to provide free coverage to Medicare-eligible retirees—23% provide free coverage, 41% share the cost with retirees, and 36% require them to pay the full cost.

Most tellingly, 35% of employers said they intend to make further changes in their retiree medical benefit programs by the end of 1995. Large employers' FAS 106 burden would be much lighter under the health care reform package originally proposed by the Clinton Administration, which includes an early retiree subsidy and the extension of Medicare coverage to prescription drugs and long-term care. But the legislation that ultimately emerges from the health care debate is likely to be much less generous.

And whatever its provisions, they will be phased in over the remainder of the decade or longer. Meantime, the cost of retiree medical continues to climb. Foster Higgins says in 1993 employers paid an average \$2,735 per retiree, a 7.9% increase from 1992. Employers who can separate costs for retirees by age category report they incurred average costs of \$5,216 for retirees under age 65, and \$1,786 for those age 65 and over, for whom Medicare is the

See you in court!

Cutting current retirees' benefits can create a legal minefield.

Until recently, few employers were ready to risk a class-action lawsuit by cutting current retirees' benefits. But today, companies desperate to trim their FAS 106 liability are increasingly willing to brave litigation, benefits consultants say. "Clients that five years ago would have said, 'We'll get sued if we cut back,' now are saying, 'We'll take the chance,'" says Fred Schick, a consultant at Sedgwick Noble Lowndes. "They simply can't afford to meet the commitments made in the early '70s."

Some very big companies—among them General Motors, Navistar, Primerica, and Unisys—have been sued by retirees alleging broken promises. Some of these employers have lost. In February, a federal judge in Detroit ruled in favor of 50,000 GM retirees who sued the automaker after it tried to make them pay for their medical coverage. US District Court Judge John Feikens said the company had induced the employees to take early retirement by promising free lifetime medical coverage, and had violated that agreement when it later

imposed a deductible and copayments.

The Employee Retirement Income Security Act does not give employees automatic vesting rights in medical benefits, as it does in pensions. But in the 1970s many companies promised lifetime medical coverage—often without appreciating the size of the promise, says James Waters, a principal at consultant Towers Perrin. Even ones that made no explicit promises can face a tough time in court, because any ambiguity in benefit plan documents is likely to be interpreted in the retirees' favor, adds David Glaser, a partner at Patterson, Belknap, Webb & Tyler, a New York law firm.

Last November, for example, the US District Court for the Eastern District of Pennsylvania refused to dismiss a retirees' suit against Unisys after the company unveiled a new post-retirement medical plan, under which they would have to pay the full cost of coverage beginning in 1995. The reason for the court's ruling: Some of the relevant benefit plan documents had internal contradictions. They reserved the employer's right to terminate the plan, but also guaranteed employees lifetime health insurance coverage.

"Any company that wants any chance at all to

primary carrier. These represented rises of 7.5% and 8.7%, respectively, for 1992.

No wonder, then, that most benefits sponsors are opting for quicker, more decisive methods of cost control than simply prefunding retiree medical—only the biggest, best-capitalized companies can access the cash to prefund the costs all at once. “Restructuring benefits leads to immediate relief,” explains Steven Ferruggia, director of group actuarial practice at Buck Consultants. But, for most, “with prefunding, it takes a long time to accumulate assets meaningful enough to reduce the liability.”

“What’s the payback?”

In deciding whether and how far to cut their retiree health benefits, companies are posing some basic questions—often for the first time in decades—about the nature of the benefit itself and their reasons for providing it. “Employers should



start by examining why they offer this benefit in the first place,” says Patricia Wilson, president of Associates & Wilson, a Rosemont, Pennsylvania benefits consulting firm. “What’s the payback? Retiree medical is really about managing your workforce. The benefit package influences when and if people retire.”

For companies that intend to downsize, for example, drastically reducing retiree medical coverage would be counterproductive, Wilson says. Employees present-

ed with an early retirement scheme under which they would have to buy their own health insurance, with limited support from the boss, will not be quick to sign up. “This can become an issue if it’s in the company’s interest to have people exit in their late 50s to create opportunities for younger people,” notes James Waters, a principal with Towers Perrin.

On the other hand, companies that fear a shortage of skilled workers later in the decade may want to avoid offering too rich a retirement package that

modify benefits for existing retirees should state to employees upfront that what you have isn’t what you’ll get forever,” warns William Arnone, director of pre-retirement and financial planning services at Buck Consultants. In the last few years, employers have begun to do that, says Waters. A 1993 survey by Buck found 87% of employers who responded had stated in writing that retiree benefits are not guaranteed, and can be changed or terminated.

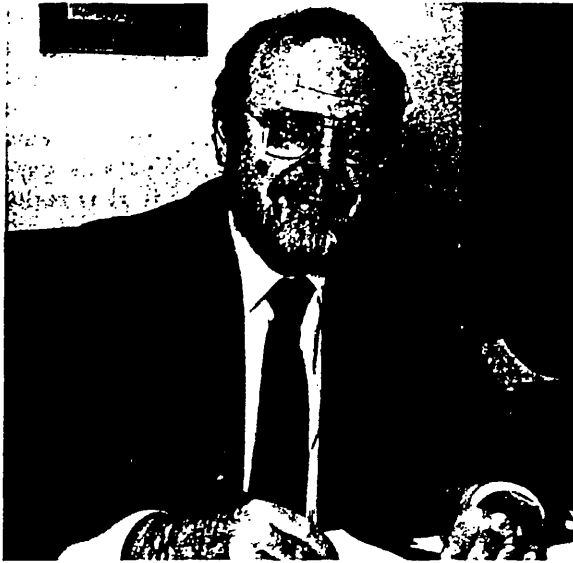
But that may not be enough. Late last year, a federal appeals court ruled that Curtiss-Wright, a defense-related manufacturer based in New Jersey, could not eliminate the medical benefits of some of its retirees (see “Termination blues,” *Plan Sponsor*, May 1994) even though the company’s plan documents explicitly reserved the right to do so. The court said the documents must spell out a procedure for amending the plan to terminate benefits. This must identify the person or persons with authority to make the change, by job title or description, rather than simply reserving the right for the company.

While other courts may disagree with the Third Circuit’s decision on Curtiss-Wright, the conservative approach would be for employers to amend

their plans and then ratify and reapprove prior changes, he says. “We’re already seeing plaintiffs raise this issue as an additional argument in some cases where it wasn’t part of their original complaint,” Boies warns.

The biggest problem for many companies may be employees who retired five or 10 years ago, often with incomplete written communications from employers about what they could expect, says Waters. In the absence of clear-cut written evidence, courts consider verbal assurances. “In the Bethlehem Steel case, for example, the summary plan description didn’t really address termination of benefits,” says Brian O’Hare, an attorney at Patterson, Belknap, “so the court used exit interviews. It decided in favor of the retirees.”

The bottom line? Do not plan to trim retiree medical benefits before examining every piece of paper that might be relevant, including collective bargaining agreements, insurance contracts, newsletters, and employee handbooks, says Norman Newman, a partner at Chicago law firm Winston & Strawn. “The alternative is to have this come out in depositions,” he says. “You can be sure the affected employee has the letter you sent him.” —LB



PSE&G's Quinn: "Sure, not everyone was happy, but everyone understood the issues"

will entice skilled workers to retire. And companies primarily interested in attracting young employees can probably safely dispense with a retiree health program, says Waters.

One of the most obvious ways to reduce the employer's liability is to increase retirees' share of the cost—by raising deductibles and copays, or by capping the employer contribution. TREbase 2000, an on-line national employee benefits database developed by William Mercer, shows that in the past three years, 50% of 588 participating companies have increased retirees' contribution to the cost of their medical coverage. On average, the Mercer data shows that future retirees whose coverage has not been eliminated face 17% higher deductibles and 15% higher out-of-pocket maximums as a result of benefit plan restructuring prompted by FAS 106.

Introducing an unprecedented deductible in an acceptable manner takes planning, however. Until last year, Public Service Electric & Gas, a New Jersey-based utility with 12,500 employees and 6,000 retirees, had always provided first-dollar medical coverage to retirees, says benefits manager Richard Quinn. But last year, PSE&G negotiated a new deal with its unions under which future retirees will pay a \$250 deductible and have only 70% of their medical expenses reimbursed, unless they use a managed care network.

Retirees who use the network will get 80% reimbursement, and have no deductible. Future retirees will also contribute to premium costs for the first time, according to a formula based on their salary at retirement and their years of service.

"It took us three years to do that," says Quinn. "We have a health care committee made up of our union presidents, our industrial relations people, and myself. For three years, we met monthly to discuss every piece of relevant data, every dollar we spent. Those meetings were absolutely critical to making these changes."

PSE&G also distributed benefits publications to all employees, explaining its FAS 106 problems. "Everyone knew the areas where we thought we had to make changes, and why," says Quinn. "Sure, not everyone was happy, but everyone understood the issues."

To PSE&G, reducing its FAS 106 liability was part of an overall strategy to contain the absolute dollars the company spends on health care. But as part of the same negotiation, PSE&G agreed to improve the union's savings plan. "We tried to balance the changes in retiree medical coverage by putting more dollars into the defined contribution plan, where we have a better opportunity to predict future costs," says Quinn.

Companies have also started tying new eligibility requirements to the retiree medical benefit, based on length of service—a process that has as much to do with fairness as it does with belt-tightening. "It used to be that you could be hired at age 62, leave at age 65, and get this benefit, which is stupid," says Wilson. "Nobody thought about it."

In fact, even today, Waters contends that relatively few companies link their commitment to provide retiree health care to length of service and age of retiree. As a result, younger retirees typically receive more valuable benefits from the company than do retirees age 65 or older, for whom Medicare is the primary insurer (see table, page 23).

Some are changing, however. General Electric, for example, now requires at least 10 years of service to qualify for any post-retirement medical coverage. Chrysler no longer pays the full cost of medical benefits for any retiree under age 60 with fewer than 30 years of service. Neither does New England Electric Company—its early retirees now pay the same contribution to medical benefits as active workers.

But the effectiveness of service-weighting retiree medical benefits can depend on your company's demographics. "I know one employer that initially

had a very strong attraction to the idea of changing its cost-sharing of retiree health care based on length of service," says Buck Consultants' Ferruggia. "This is a plan change that's easily accepted by employees because it's widely perceived as equitable. But when we looked at the demographics, we found this company had a workforce with a very low turnover. We projected retirees with maximum years of service. The change would actually have been more expensive than the plan they already had."

401(k) trade-offs, defined dollar matches

Another option is to drop medical coverage for future retirees altogether, but soften the blow by doing as PSE&G did—offer an increase in the corporate match to a 401(k) or employee stock ownership plan. Boise-Cascade, for example, created an ESOP in 1989, after it decided to gradually eliminate its subsidy of retiree health costs. The company makes an annual ESOP contribution for employees based on their years of service, but is not committed to contribute a specific amount.

Boise-Cascade's ESOP contribution has ranged from \$1,500 to \$2,000 a year per employee for those with 20 years of service, and half that amount for those with 10 years of service, says Stuart Larimore, manager of benefits planning. And now, these are costs that can easily be kept under control.

Another way to achieve the same result is to make the corporate health care cost subsidy a fixed dollar amount instead of a percentage of plan cost, effectively transferring the burden of health care cost inflation from employer to employee. With the "defined dollar benefit," the employer pays a specific dollar amount, instead of picking up the tab for a specific number of hospital days, for example. If the cost exceeds the employer's contribution, the retiree pays the difference.

The DDB is also easily linked to length of service. At New England Electric, new employees are now credited with a flat dollar amount per month, per year—representing the company's future contribution towards the cost of their health care as retirees—says vice president Don Goodwin. The most commonly used DDB, according to Towers Perrin, is a specific annual dollar benefit—\$2,000 a year for retirees

under age 65, say, and \$800 a year for those older.

The DDB can initially equal the full cost of coverage, for example. But if health care costs rise 10% a year, and the DDB contribution is increased by 5% a year, retirees will be paying 50% of the cost in 15

Comparison of Medical and Pension Benefits

Age of Retirement	Years of Service	Medical Benefit (PV)	Pension Benefit (PV)	Ratio of Medical to Pension
55	10	\$60,000	\$30,000	200%
65	30	25,000	140,000	18

Because they are not yet covered by Medicare, employees who retire at 55 cost the employer far more in benefits than their colleagues who retire at 65.

Source: Towers Perrin

years.

IBM used a variation on this approach, capping its retiree health cost at twice its current contribution. In 1991, IBM announced that it would continue increasing its contribution to medical care for employees who retire after December 31 of that year, until that contribution reaches \$7,000 per employee.

"We don't expect that cap will be reached until late in the decade," explains an IBM spokesperson. "But by announcing it, we can avoid virtually unlimited growth. We haven't said what we'll do when we reach the cap. Our options remain open."

The DDB approach is not yet widely followed—a Hewitt Associates survey of employers last year found only 20% of respondents limited current or future cost this way for early retirees, and only 21% for retirees over age 65. But consultants predict its use will increase, in part because it preserves corporate flexibility.

"You can periodically update your contribution if you want to get more people to retire, for example," notes Wilson. By the time the company faces the issue of whether to update the contribution, says Waters, the problem may have been solved by the federal government through health care reform. Meanwhile, "a defined dollar amount based on per capita cost of coverage really caps the employer's FAS 106 liability," Waters adds.

Carve-outs and Medigap

Many companies have also saved money by changing the way they integrate their medical benefits with Medicare coverage for retirees over 65.



Towers Perrin's Waters: Who will sign up for reduced retiree medical coverage?

The integration method determines how retiree and employer will split the remaining expenses after Medicare benefits are paid—which can have significant impact on employer liability.

Traditionally, employers have followed a "coordination of benefits" method under which retirees receive 100% of their medical expenses through a combination of Medicare and employer plan benefits. "Let's say the medical expense is \$1,000, and the employer's plan normally would pay 80%, or \$800," says Ed Winterbauer, a principal at Apex Management Group, a Princeton, New Jersey-based consultant. "Let's assume Medicare pays 60%. Under the coordination of benefits method, because Medicare pays \$600, the employer pays \$400. Together, they've covered the \$1,000 expense."

But today, companies are increasingly switching to the "carve-out" method, in which the plan benefit is reduced by whatever amount Medicare pays. This makes a real difference. "Take the same \$1,000 medical expense," says Winterbauer. "With the carve-out approach, the employer pays its regular \$800 benefit minus Medicare's \$600 payment—in other words, \$200. The retiree winds up with 80% of the expense covered. This method preserves the integrity of the employer's plan."

Employers do not typically reduce their cost by the 50% that Winterbauer describes. But using the carve-out clearly can result in hefty savings over the

coordination of benefits method.

Winterbauer says it is generally easier for an employer that self-insures to switch to a Medicare carve-out than for one that buys insurance from a third party. Self-insurers are exempt from state insurance laws, many of which require coordination of benefits.

A handful of employers use a third approach—buying specific Medigap coverage to supplement Medicare. This is done, for example, with prescription drugs, which Medicare does not cover. General Electric's prescription drug plan pays \$8 of the first \$10 for prescriptions and refills purchased over the counter at local pharmacies, says Chuck Welch, benefits manager. "But if you use the mail-order option, we give 80% coverage up to \$40—the plan pays \$32, the retiree pays \$8." Anything above \$40 is paid by the retiree.

GE also pays a flat dollar supplement to Medicare for retiree hospitalization costs, with a \$50,000 lifetime maximum per covered retiree and spouse combined. For a small premium, retirees can purchase an additional \$20,000 per individual of this hospitalization coverage themselves. "And we have a Travelers Medigap policy specifically tailored for us," says Welch. "It covers part B of Medicare," which pays for doctors' fees and out-patient services. Retirees pay for this policy themselves.

"There are some real financial advantages to buying stand-alone supplemental coverage," says Winterbauer. "You're in a much better position to predict your future costs year by year than if you're trying to coordinate with Medicare." While a stand-alone Medigap plan's costs will rise as general medical costs increase, since these plans are not designed to complement Medicare directly, the employer's costs do not change if Medicare changes. So the employer does not have to try to predict how much Medicare will cover.

"If Medicare is reduced over time, and your coverage is wrapped around it, your exposure will increase," adds Waters. "If you've uncoupled your promise from Medicare and provided a true supplemental policy, it can be a very specific, defined benefit—like paying the Medicare deductible, for example."

The Medigap approach is a significant departure, says Winterbauer: "With the carve-out and the coordination-of-benefits approaches, one has the sense that employers have attempted to provide a retiree medical plan that resembles the active employees' medical plan as much as possible. Medigap doesn't do that."

Most employers' retiree benefits plans still tend to mimic active workers' far too closely, says Patricia Wilson. The result, sometimes, is that the benefits administrator fails to track costs the company ultimately must pay, and carefully follows costs that Medicare covers. When Foster Higgins surveyed employers late last year, only 51% said they could measure the cost of retiree medical benefits separately from active workers' benefits.

Employers pay for retirees' prescription drugs. Yet only 2% of Foster Higgins' survey respondents required a prospective review of prescriptions to check for adverse side-effects, appropriate dosage, and potential drug interactions before drugs are dispensed.

On the other hand, the year before, the consultant found that 50% of survey respondents required pre-certification of hospital admissions, case management of catastrophic illness, and second surgical opinions for retirees' coverage—just as they do for active workers. This is in spite of the fact that Medicare, not the employer, pays for hospitalization and surgery of retirees over age 65.

The best thing employers can do for retirees, Wilson says, is provide them with good information about Medicare "and focus on adding benefits that provide catastrophic protection. For very, very long hospital stays, for example, you can run out of Medicare coverage. The employer can provide that catastrophic coverage cheaply, because very few people will in fact run out of Medicare."

Ultimately, the most effective way to reduce the cost of retiree medical care may be to manage its delivery. Employers are increasingly managing retirees' prescription drug coverage, for example, by establishing mail-order drug programs (see "Overdose!" *Plan Sponsor*, October 1993). But it is harder to sell a managed care network to retirees than to active workers—US government data shows that at the end of last year, less than 7% of the elderly were enrolled in health maintenance organizations.

Increasingly, employers like PSE&G are nudging their future retirees into managed care networks. A 1993 employer survey by Buck Consultants found that 13% of respondents were considering adopting an HMO or a preferred provider organization as an alternate care option for their plan participants over age 65, as well as for younger employees.

"A significant number of companies with point-of-service arrangements are making those programs

their primary retiree medical plan until Medicare kicks in," says Ostuw. POS plans cover employees both inside and outside a managed care network, but give financial incentives to stay in-network.

No time to wait

The extent to which any or all of these trends will continue depends partly on the success or failure of Washington's efforts at health care reform. Under the original Clinton Administration proposal, the government would pick up 80% of the bill for early retirees. It would also provide prescription drug coverage to early retirees and Medicare recipients,

With the "defined dollar benefit," the employer pays a specific dollar amount, instead of picking up the tab.

plus some long-term care insurance.

But the early retiree subsidy is likely to be eliminated now that "the ivory tower plan is being translated into retail politics," says Henry Saveth, a partner at Foster Higgins. "At this point, the Clinton plan and maybe even the Cooper and Stark plans are viewed more as theories or outlines to be negotiated than as contenders for ultimate passage," he explains. "And there's a realization that whatever passes is going to be strapped for revenue."

Besides, he adds, "there's no public policy reason that justifies an early retiree subsidy. It was originally suggested for political reasons, to get the rust-belt industries to buy into the plan." The proposal to add prescription drug and long-term care coverage to Medicare also had a political motivation—to secure the support of the elderly. Keeping either one in the final bill will be difficult, notes Saveth, since they would be very expensive.

In any case, tailoring benefits to legislation that has not even passed is always risky—especially when changes are already urgently needed. "Federal health care reform is an environmental factor," says GE's Welch, philosophically, "but as an employer, you can't base decisions on pending changes." This time, most companies are not waiting for Washington to move before they make changes they already know will reduce their expenses. P5

CONGRESS OF THE UNITED STATES
CONGRESSIONAL BUDGET OFFICE

Reducing the Deficit: Spending and Revenue Options

A Report to the Senate and House Committees on the Budget

As required by Public Law 93-344



FEBRUARY 1995

184 REDUCING THE DEFICIT: SPENDING AND REVENUE OPTIONS

February 1995

DOM-50 LIMIT THE GOVERNMENT'S SHARE OF THE COST FOR THE FEHB PROGRAM
TO A FIXED AMOUNT PER EMPLOYEE

	Annual Savings (Millions of dollars)					Cumulative Five-Year Savings
	1996	1997	1998	1999	2000	
Discretionary Spending						
Budget Authority	100	200	400	700	900	2,300
Outlay	100	200	400	700	900	2,300
Direct Spending						
Budget Authority	100	200	400	600	900	2,200
Outlays	100	200	400	600	900	2,200

NOTES: Estimates do not include any savings realized by the U.S. Postal Service.

In order to show the effect of the specific programmatic changes in this option, savings are calculated relative to spending that has been projected under the assumption that current laws and policies affecting this activity remain unchanged. Those current-law estimates differ from projections that are not based on any programmatic assumptions and simply assume that the 1995 level of spending for this activity (or that amount adjusted for inflation) is provided in every year.

The Federal Employees Health Benefits (FEHB) program provides health insurance coverage for over 4 million active federal employees and annuitants, as well as their 4.6 million dependents and survivors, at an annual cost to the government of about \$13 billion. Two important differences exist between the FEHB program and the health insurance coverage provided by private employers. First, participants in the FEHB program choose from among many health insurance plans offering varying levels of benefits and premiums; they can also switch plans during an annual open-enrollment period. In contrast, many private-sector employees are offered no choice among plans, although larger firms tend to provide several alternatives. Second, in the FEHB program, the government and participants jointly finance the coverage through insurance premiums. In 1995, the government is expected to pay, on average, about 72 percent of the premiums for active employees and 73 percent for annuitants. Many large private employers pick up the entire cost of covering an individual employee and roughly 75 percent of the additional cost of family coverage.

Although health insurance costs have risen sharply over the past decade, premiums for FEHB

plans have, on average, risen more slowly than those for private-sector employers. Over the past five years, FEHB plan premiums have increased an average of 6.8 percent a year, whereas the premiums paid by medium and large firms surveyed by Hay/Huggins Company, a benefits consulting firm, increased by 10.8 percent a year. Furthermore, FEHB premiums are expected to decline by 3.3 percent in 1995; the Congressional Budget Office (CBO) projects, however, that aggregate private health premiums are likely to rise by about 5 percent. Much more so than private-sector employees, federal employees have been able to switch from high-cost to lower-cost plans to blunt the effects of rising premiums. The dollar cap in the cost-sharing structure of FEHB (see below) encourages that efficient behavior and intensifies competitive pressures on all participating plans to hold down premiums.

Here is how that cost sharing works. For both employees and retirees, the government contributes 75 percent of the premium for the particular option selected by the enrollee, up to a cap of \$1,600 per year for individuals (\$3,490 for families). The dollar cap is set at 60 percent of the average high-option premiums for individuals and families in the "Big

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Six" plans--five large plans and a phantom plan that acts as a placeholder for a former participating insurer. (Employer costs are higher under the U.S. Postal Service collective bargaining agreement.) Employees have an incentive not to choose plans with premiums above \$2,133 (\$4,653 for family coverage) because they pay 100 percent of the added cost of the premium. Thus, the dollar cap helps to control program costs.

By contrast, the requirement that enrollees pay 25 percent of the premium in plans with costs below \$2,133 gives employees only a weak incentive for price-conscious selection among those health plans and also blunts price competition among plans to attract participants. Under the current arrangement, if an employee switched from a plan costing \$2,100 to one costing only \$1,800, his or her annual cost would be reduced by only \$75. The provision requiring employees to pay at least 25 percent of premiums potentially affects an increasing proportion of enrollees. Between 1987 and 1992, the number of enrollees paying 25 percent of the premium while the government contributes less than the maximum dollar amount rose from 28 percent of total enrollment to 69 percent.

Budgetary savings and better cost-reducing incentives would be gained by revising the FEHB program so that the government simply paid the first \$1,535 of an employee's premium (\$3,430 for family coverage). Those amounts are based on the average government contributions in 1995 and would increase annually by the rate of inflation rather than by the rate of change in the Big Six premiums. Because those premiums are expected to rise faster than inflation, the government's savings would be considerable. In addition, the government would have more control over its premium contributions because they would be more predictable. Federal employees and retirees would also have the opportunity--by choosing low-cost plans--to reduce their share of the total premium below the 25 percent minimum under current law.

Compared with current law, savings in discretionary spending from reduced payments for *current employees* and their dependents would total \$2.3 billion over five years. Yet despite those savings, government spending for FEHB premiums for current

employees would still be growing each year. If the goal was to hold government payments constant over time, additional policy actions would be required. Savings in direct spending, relative to current-law spending, from reduced benefits for *retirees* would reach \$2.2 billion over five years. CBO's estimate does not include any savings from potential reductions in premiums as a result of increased competition among insurance plans.

This option would require the roughly two-thirds of all enrollees who currently choose a plan with a premium in the range of \$1,535 (\$3,430 for family coverage) to \$2,133 (\$4,653 for family coverage) to pay all of the premium above the new cap--not just one-quarter of it, as at present. The 31 percent of participants enrolled in the Blue Cross-Blue Shield high-option plan and other plans with premiums above \$2,133 (\$4,653) would also continue to pay all of that extra cost. With all consumers subject to paying all of those incremental costs, the incentive to select a lower-cost plan would be strengthened. Because purchasers would be more price-conscious, many plans would have a greater incentive to economize and offer lower premiums to retain their participants. Almost all plans currently have premiums above \$1,535 (\$3,430 for family coverage), and there would be no incentive to offer a premium below that amount. In the lowest-cost plans, which include the standard options under the Mail Handlers and the George Washington University Hospital plans, enrollees could look forward to having the government pay the entire premium, with no cost to them.

The health care sector is currently undergoing dramatic changes. After several years of extremely rapid growth, spending slowed in the early 1990s. Employers and employees, in sorting out some new health insurance options, have stirred up a nascent price competition among health plans--historically, a weak force. A variety of new plans, commonly grouped under the managed care category, are attempting to capitalize on the new price consciousness of consumers and are rapidly claiming a share of the market from traditional fee-for-service plans. In 1994, about 40 percent of federal employees were enrolled in managed care plans.

This proposal would accelerate the changes currently under way in the health care market by intensi-

fyng competition among FEHB plans. The FEHB program is often held up as a model of managed competition. If that approach works as theorists have predicted, the program changes in this option could reduce the growth of health premium costs. Many FEHB plans, especially the managed care plans, have a significant ability to control their premium costs. Further, enrollees would receive the full benefit if their premiums rose more slowly than inflation.

On the downside, this option would result in enrollees' paying an increasing share of their premiums when premium rates rose faster than inflation. Currently, the government bears most of that risk; large private-sector employers bear essentially all of it. The added cost to workers would amount to about \$500 per worker in 2000 and more in later years. Asking employees and retirees to pay more would have a number of consequences. Although it could encourage participants to select more cost-efficient plans, it could also place more participants in plans

with inferior benefits. Because the added costs to employees amount to a reduction in compensation, the government might find it harder to attract and retain high-quality employees. Finally, for current retirees and long-time federal workers, cuts in promised benefits amount to a retroactive change in the terms of their employment that lowers their standard of living. (For further discussion of the pros and cons of such cuts, see DOM-60 and ENT-50.)

The option has an additional drawback in that it would strengthen the existing incentives for FEHB plans to seek out healthy people and for healthy people to select cheap plans. Those patterns isolate sick people in selected plans that then experience increases in costs and risk financial instability. The Office of Personnel Management, which administers the FEHB program, can review plans to try to limit that form of adverse selection. However, its effectiveness in limiting all adverse selection is doubtful.



Washington Suburban Sanitary Commission

Personnel Policy and Benefit Programs

Appendix N

FOREWORD

7/93

This manual contains the personnel policies and procedures of the Washington Suburban Sanitary Commission. The WSSC reserves the right to change or eliminate its policies and procedures at any time without notice. This handbook is not a contract and is not an implied contract. The Manager, Human Resources Division is responsible for interpretation of the text of this manual.

