RETIREE HEALTH CARE ISSUES BRIEF

Perspective

At the same time as public officials across the nation are grappling with unfunded public pension liabilities, so too are policy makers taking note of the increasing costs of retirement health care benefits. Many of the big questions are similar for both pension and health care benefits:

What role, if any, should the government play in ensuring public sector retirement health care?
What should this coverage look like?
How should states fund—or alter—coverage for current and future retirees?
What contribution should be expected from employees/retirees, if any?

Lawmakers also need to consider one of the fundamental questions surrounding health care coverage in general—what are the unintended consequences and costs of underfunding health care coverage for our aging population? Additionally, PERA is currently exploring the impacts of the recently passed national health care legislation on retiree health care plans.

Resources

Primary resources for this brief include: Midwest Council of State Governments, National Conference of State Legislatures (NCSL), Colorado PERA, PEW Center on the States, Moody's.

What the States are Doing

According to a 2010 Pew Center on the States study, close to 95 percent of the $587 billion in states' liabilities for current and future non-pension retiree benefits is unfunded.

A key factor contributing to liability stems from who pays the health insurance premium: the employer or the retired worker. For those states who don't pay for most or any of the premiums, their liabilities largely stem from an "implicit subsidy," i.e. the retired workers' premiums would be higher if they were unable to access a state health plan that includes younger, active employees with less-costly insurance claims. In turn, the states, which contribute to premiums of active workers, pay more because the claims of both active and retired employees determine the cost of the premium.
(Source: Midwest Council of State Govts.)

Some of the reform measures states are taking to address pension liabilities in general may also impact retiree health care (e.g. raising retirement age). Additionally, some states have taken measures to specifically address health coverage. See below for a summary table of recent initiatives—some of which lower retiree health care liability, and others which actually increase health care liability (generally done in order to incentivize early retirement and gain immediate budgetary savings):
(Sources: MWCSG and NCSL)

State	Principle/Action
Connecticut	New state employees required to contribute 3% of their compensation to offset cost of retiree health benefits. Current employees with less than 5 years service required to contribute until they have 10 years of service.

Kentucky	Increases employee contribution to 3% for most members. Retirees will pay Medicare Part B premium (or the equivalent amount if under 65). Employers will pay an additional contribution equal to that paid by active members. State will pay net cost of medical insurance for new retirees who are not Medicare eligible (to encourage early retirement).
Michigan	Creates irrevocable trusts for purpose of holding, investing and distributing assets for certain postemployment health care benefits. Adds 3% contribution requirement, which is being legally challenged for "violation of contract." Eliminated option for retirees to choose "alternative coverage" options.
New Hampshire	Requires that group II state employees have 20 years of creditable service with the state in order to receive retiree health and surgical benefits. Legislature also adopted a resolution endorsing the establishment of a statewide retiree medical trust.
New Jersey	After any "binding collective negotiations agreement," employees will contribute 1.5% of base salary to health care coverage. Retirees required to pay 1.5% of pension. Limits participation in health benefits program to full time employees (25+ hours, 35+ for elected/appointed).
Texas	Approved retiree health care cost increases aimed to encourage "low-cost options," such as generic drugs and primary physicians vs. specialists.
Vermont	Reduces coverage for new hires/those with fewer than 10 years service (1-14 years of service=no subsidized coverage). For current employees with more than 10 years of service, increases number of years required to be eligible for coverage.
Wisconsin	Wisconsin allows retired workers to apply unused sick leave to premiums, which has increased liability. In 2003, the legislature issued $600M in bonds to pay off much of this unfunded liability.
Iowa	Recently, Iowa increased their health care liability in exchange for immediate budgetary savings by offering state-funded premiums for early retirement.
Minnesota	Provides early retirement incentives by way of adding to retiree's Health Care Savings Plan" accounts (pre-tax money for post-employment health expenses).
Indiana	Created retirement medical savings accounts for state workers. State is required to make contributions to accounts (amount varies for each employee depending on age) through a retiree health trust fund, funded by cigarette tax revenues and other sources.
North Dakota	In 2009 ND increased the state's monthly contribution to retiree health care trust fund from 1 percent of total payroll to 1.14 percent. This increased the retirees' health care credit to offset health insurance costs from $4.5 to $5 per year of service.

Ohio	Implemented Health Care Preservation Plan, which split retirees into three different groups (each with its own set of eligibility standards and benefit levels) and gave retired state employees a choice among different health plans. Retirees are given a monthly health care credit to pay the premium of the plan of their choosing. Ohio pays 100 percent of the costs of premiums for retired workers with at least 30 years of service. However, for an employee with limited years of service who chooses a more expensive health plan, his or her health care credit might not pay for the entire premium. Also, retirees in 2010 are paying higher out-of-pocket maximums, deductibles and co-payments. NOTE that Ohio has had a trust fund since 1974 and is considered one of the most effective states in funding both pensions and retiree health care (PEW)

Colorado

As of November 2009, Colorado ranked 17th lowest among all states for its total unfunded retiree health care liability. In 2009 CO had an unfunded liability of $1.5B and an annual required contribution of $77.8M.

The Pew Center on the states rated Colorado as one of only nine "solid performers" when it came to setting aside funds to meet this long-term liability for retiree health care funds. Despite this rating, at the end of 2009, the PERA Health Care Trust Fund was only 14.8% funded, with an amortization period of 53 years. The average funding level for states is 7.1%, and 20 states have not funded any of their liability.

In Colorado, it is voluntary for retirees to enroll in PERACare. There are currently 106,829 covered lives (health, dental, vision plans). Open enrollment occurs annually (which is not the case in all states).

Retirees who are enrolled pay their own premiums via deduction from their monthly PERA benefits. However, Colorado created a Health Care Trust Fund (HCTF) in 1985 and began paying a subsidy to offset the cost of premiums for participants in the PERACare plan in 1986.

The maximum subsidy paid to enrollees by the HCTF is $115/month for Medicare-eligible participants, and $230/month for pre-Medicare participants (i.e. under 65). For retirees with less than 20 years of service, premium subsidies are reduced by 5% per year of service less than 20.

Subsidy amounts are set in state statute, and have not been changed since 2000. Note that most states set a percentage of their subsidies in statute rather than dollar amount.

1.02% of the state's employer contribution is used to fund the HCTF.