Approved February 16, 1988
Date

MINUTES OF THE SENATE COMMITTEE ON WAYS AND MEANS.

The meeting was called to order by SENATOR AUGUST "GUS" BOGINA at
Chairperson

11:10 a.m./~~p.m.~~ on February 9, 1988 in room 123-S of the Capitol.

All members were present except:

Committee staff present:

Research Department: Ed Ahrens, Alan Conroy, Russ Mills
Revisor's Office: Norman Furse
Committee Staff: Judy Bromich, Pam Parker

Conferees appearing before the committee:

John P. Mackin, Ph.D., Senior Vice President, Martin E. Segal Company

Dr. Mackin reviewed the report on the study of health care benefits for retirants of the Kansas Public Employees Retirement System (KPERS) which he presented to the Special Committee on Ways and Means during the 1987 Interim. He explained that the report provides information regarding present health benefit coverage for the more than 32,000 KPERS retirants; actuarial liabilities and funding costs for post-retirement health benefits for KPERS retirants; options for consideration by the Kansas Legislature, including legislation mandating access to continuing group coverage and/or legislation establishing a health benefits plan for all KPERS retirants; retiree medical costs and Medicare benefits; and special public sector issues that may influence the design and financing of a health benefits plan for some or all KPERS retirants. (Attachment 1)

In answer to questions, Dr. Mackin stated that the extension of the minimum continuation period for coverage under the Kansas health benefits plan to age 65 involves modest costs for local employers, however the exact impact is difficult to project.

He noted that SB 463 needs modification, especially in Section 3 where the language is open ended. He pointed out that he emphasized to the Special Committee on Ways and Means, and he was emphasizing again, the importance of employer money participation in order to substantially reduce the adverse selection. In his estimation two reasons to proceed cautiously with this bill this session would be in hopes the discussion involved with the state employees on health benefits might settle down a bit by the next session. Also, it is likely that Congress will pass a catastrophic coverage bill which will be a very important extension of the Medicare program. If that passes, this bill might be looked at again in order to better design a program with the knowledge that if there was federal catastrophic coverage the budget and actuarial projections would be much better.

MINUTES

Senator Werts moved, Senator Harder seconded, for the approval of the minutes from the February 5, 1988 meeting. The motion carried on a voice vote.

The meeting was adjourned.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

GUEST LIST

COMMITTEE: SENATE WAYS AND MEANS DATE: 2/9/88

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Bernie Hayen	112 W 7TH	League of Ks Municipalities
Judy Harder	400 SW 8th	KPERS
Ron Bluidissel	✓	KPERS
John Machin	New York	Martin Segal Co.
Craig Grant	Topeka	K-NEA
Marshall Crowther	Lawrence	KPERS
Walt Darling	Topeka	Division of Budget
Harold Pitts	Topeka	KCOA
Barb Reinert	"	KPOA
Dick Koerth	Topeka	DoB
		SWAM 2-9-88

ATTACHMENT 1
SWAM ... /88

HEALTH CARE BENEFITS FOR KPERS RETIRANTS

Report to:

LEGISLATIVE COORDINATING COUNCIL AND
SPECIAL COMMITTEE ON WAYS AND MEANS
KANSAS LEGISLATURE

Submitted by
Martin E. Segal & Company, Inc.
November, 1987

ATTACHMENT 1
SWAM 2-9-88

MARTIN E. SEGAL COMPANY
CONSULTANTS AND ACTUARIES

730 FIFTH AVENUE
NEW YORK, NEW YORK 10019
(212) 586-5600

November 13, 1987

Legislative Coordinating Council and
Special Committee on Ways and Means
Kansas Legislature
State Capitol Building
Topeka, Kansas 66612

Dear Council and Committee Members:

We are pleased to submit this report on our study of health care benefits for retirants of the Kansas Public Employees Retirement System (KPERS).

The Legislative Coordinating Council (LCC) authorized this important study to provide a basis for evaluating the cost and other implications of possible legislation relating to health care benefits for KPERS retirants. Our report on the study provides the LCC and the Special Committee on Ways and Means with information regarding:

- Present health benefit coverage for the more than 32,000 KPERS retirants;

- Actuarial liabilities and funding costs for post-retirement health benefits for KPERS retirants;

- Options for consideration by the Kansas Legislature, including legislation mandating access to continuing group coverage and/or legislation establishing a health benefits plan for KPERS retirants;

- Retiree medical costs and Medicare benefits; and

- Special public sector issues that may influence the design and financing of a health benefits plan for some or all KPERS retirants.

The sections of the report are as follows:

I. EXECUTIVE SUMMARY 1
II. PRESENT COVERAGE FOR KPERS RETIRANTS 6
III. LIABILITIES FOR KPERS RETIRANTS HEALTH BENEFITS 14
IV. OPTIONS FOR KANSAS LEGISLATURE 22
V. RETIREE MEDICAL COSTS AND MEDICARE 28
VI. RETIREE PLAN DESIGN AND PUBLIC SECTOR ISSUES 36

ATLANTA / BOSTON / CHICAGO / CLEVELAND / DALLAS / DENVER / HARTFORD / HOUSTON / LOS ANGELES
NEW ORLEANS / NEW YORK / PHOENIX / SAN FRANCISCO / WASHINGTON, D.C / EDMONTON / TORONTO

We look forward to meeting with you to review this report and to discuss options for providing health care benefits for KPERS retirants.

Sincerely,

MARTIN E. SEGAL COMPANY

By: John P. Mackin
John P. Mackin, Ph.D.
Senior Vice President

JPM/js

I. EXECUTIVE SUMMARY

Post-retirement health care is perhaps the hottest topic in the employee benefits field today. The broad subject of post-retirement health care encompasses all the issues related to the design and financing of health benefit plans; it can also be viewed essentially as a retirement issue rather than a health benefits issue.

Medical care protection for the retired population is an issue of national concern. Recently, several factors have focused attention on retiree health benefits: the rapid escalation in medical care costs; the growth in the size of the retired population, both in absolute numbers and in relation to the working population; the increases in life expectancies; the shifting of costs to employer-sponsored health benefit plans; and the precarious financial condition of Medicare.

For retirees 65 and over, Medicare is the primary source of medical care protection. Medicare, however, requires substantial cost sharing and currently pays less than half the total medical care costs of the elderly. Recent studies of Medicare benefits and financing conclude that fundamental changes will be needed to maintain the financial solvency of the Medicare program.

For retirees under age 65, employer-sponsored health benefit plans are the major source of medical care protection. Significant gaps in protection exist for retirees under 65 without employer-sponsored coverage. Some early retirees are unable to purchase satisfactory coverage on an individual basis, regardless of the price they are willing to pay.

Most retirees have access to coverage under an employer-sponsored health benefits plan, but an increasing number feel they cannot count on their plans to continue to provide benefits in the future. In the private sector, a substantial majority of large employers offer retiree health benefits and about half of the private employers that offer coverage pay the full premiums for retirees.

In the public sector, many retirees must pay for the full cost of coverage if they continue to participate in the group plan. Martin E. Segal Company's 1987 survey of state employee health benefit plans indicates that over half the states currently make no contributions toward the cost of retiree health care benefits. At the other end of the scale, 14 states pay for the full cost of coverage for a single retiree age 65 or over with Medicare.

The growing number of politically-effective retired public employees will continue to lobby for legislation providing for payment by public employers of a larger portion of their health care premiums. Over the next decade, it is likely that several states will increase their share of total premium costs for retirees and that some states will establish programs to start funding post-retirement health benefits on a level-cost actuarial basis during the employees' working years.

With few exceptions, post-retirement health benefits are financed on a pay-as-you-go basis. Reserves have not been accumulated to help meet future increases in costs for current retirants or for active employees who expect to become eligible for benefits when they retire. The aggregate unfunded liability for retiree health benefits is enormous, with current estimates ranging from a mere $100 billion to $2.4 trillion. Because of the unfunded nature of retiree health benefit plans, there is a serious concern that many employers will not have the financial resources to meet these long-term benefit commitments. The cumulative effect of substantial cost increases, court decisions involving retiree health benefits, the imposition of federal regulations, and new accounting rules may be to discourage employers from maintaining their present retiree health benefit plans and also discourage the creation of new plans.

The State of Kansas is <u>not</u> in the same position as many other large employers. Kansas is <u>not</u> presently faced with a large and rapidly growing liability for post-retirement health benefits. If the Kansas Legislature passed a bill providing that the State will pay the full cost of health benefit coverage for all 32,000 KPERS retirants, Kansas would incur a sizable unfunded liability for KPERS retirants health benefits.

As discussed in Section II, about 10,000 or less than one-third of the 32,000 KPERS retirants are covered under employer-sponsored health benefit plans. Most of the covered retirants - about 7,000 of the 10,000 - are enrolled in the Kansas Health Benefits Plan. Unlike the State, a substantial majority of the more than 1,000 local employers that participate in KPERS do not allow retired employees to continue coverage under the employer-sponsored group plan (except for the mandatory continuation required by COBRA).

KPERS retirants who participate in the Kansas Health Benefits Plan pay a large portion of their total benefit costs. Covered retirees who are 65 and over pay for essentially the full cost of coverage. Retired State employees who are under age 65 and not eligible for Medicare benefits can also continue coverage udner the State Plan. They have the same benefits and pay the same premium rates as the average total rates paid for active employees. Because the under-65 retirees covered by the State Plan have much higher average per-capita claims than the 36,000 covered active employees, the State Plan in effect provides a "subsidy" to these retirees by allowing them to continue coverage and pay the same premium rates as the composite rates paid for all covered employees.

Section III presents the results of our actuarial calculations of the liabilities and funding costs for KPERS retirants health benefits. The actuarial liability for post-retirement health benefits varies considerably depending on the assumptions used in the calculations, especially the assumed rate of inflation in medical care costs. Because of the uncertainty regarding the average rate of increase in medical costs in the future, we determined the actuarial liabilities for post-retirement health benefits based on three assumed rates of medical cost inflation: 6%, 8% and 10% per year.

If a KPERS Retirants Health Benefits Plan had been established and the Plan's premium costs were similar to the State Plan's premium costs for retirees, the total actuarial liability for the 32,000 current KPERS

retirants would be approximately $337.8 million based on an assumed medical cost inflation rate of 8% per year. The total liability for current retirants would be $286.6 million based on a 6% medical cost inflation rate, and $404.6 million if it is assumed that medical costs will increase at an average rate of 10% per year.

If a Plan is established to provide post-retirement health benefits for both current retirants and active members of KPERS and KP&F who retire in the future, the total projected actuarial liabilities for active employees and retirants could be funded on a level-cost actuarial reserve basis. Funding costs were calculated as percentages of the total payrolls of employees covered by KPERS and KP&F, based on the same funding method and 15-year amortization period used in our actuarial valuation of KPERS as of January 1, 1987. The actuarially-determined total contribution rates, based on an assumed medical cost inflation rate of 8%, are 2.85% of payroll for KPERS and 5.14% of payroll for KP&F. If the medical cost inflation rate is assumed to average 10% per year, the total funding costs are 3.46% of payroll for KPERS and 6.25% of payroll for KP&F.

Section IV, Options For Kansas Legislature, examines possible legislative actions relating to health benefits for KPERS retirants. The options considered include mandating access to continuing group coverage and establishing a health benefits plan for some or all KPERS retirants. Of course, the cost and other implications of adopting a particular option or combination of options will vary significantly depending on the specific provisions of any legislation passed by the Kansas Legislature.

The Special Committee on Ways and Means will want to consider many interrelated policy and technical issues before proposing that a health benefits plan be established for some or all KPERS retirants. Three key policy questions that need to be addressed are: Who will be eligible for coverage under the KPERS Retirants Health Benefits Plan? How will the Plan be financed? Who will be responsible for managing and administering the Plan?

Medical care is expensive for everyone, and especially for older Americans. For persons 65 and over, per-capita medical expenditures are triple the per-capita expenditures for the total U.S. population. Section V, Retiree Medical Costs and Medicare, points out that Medicare currently pays about 45% of the total medical care costs for persons 65 and over, but the Medicare reimbursement percentage differs greatly depending on the type of service. For the more than 30 million Medicare beneficiaries, the hospital deductible and co-insurance charges - and the monthly premium for medical insurance benefits - have increased substantially; nevertheless, the Medicare hospital insurance trust fund is projected to be exhausted shortly after the turn of the century.

Section VI discusses retiree plan design and public sector issues. The design of a health benefits plan for a particular group of retirees - like some or all KPERS retirants - will depend on the decisions made regarding numerous and sometimes conflicting issues. Special public sector issues that may influence the design and financing of a retiree health plan include the relatively large number of employees who retire before age 65 and the structure or scope of coverage under health benefit plans and public employee retirement systems.

II. PRESENT COVERAGE FOR KPERS RETIRANTS

KPERS is currently paying retirement benefits to a total of more than 32,000 retirants. As of December 31, 1986, there were about 31,000 KPERS retirants, 1,000 KP&F retirants, and 43 retired members of the Judges System.

Table 1 shows the number of KPERS retirants under age 65 and 65 and over as of December 31, 1986, by retirement system and coverage groups. The age distribution of retirants varies substantially by retirement system and coverage groups. Approximately 2,000 or 6.4% of the 31,000 retirants receiving benefits under KPERS are under age 65, whereas almost 70% of the 1,000 KP&F retirants are under age 65.

Health benefit coverage is especially important for retirees under age 65, because they generally are not eligible for Medicare benefits. Many of the 2,700 KPERS retirants who are under age 65 are not covered by an employer-sponsored health benefit plan. For those pre-65 retirees who purchase individual coverage, or convert coverage under a group plan into an individual policy, the cost is substantially higher than the cost of coverage for a retiree 65 or over.

As a rough estimate, about 10,000 or less than one-third of the 32,000 KPERS retirants are covered under employer-sponsored health benefit plans. Most of the covered retirants - about 7,000 of the 10,000 - are covered by the State of Kansas Health Benefits Plan. Although detailed data is not available on the age distribution of KPERS retirants covered by the State Plan, it is estimated that about 1,000 are under age 65 and 6,000 are age 65 and over.

Table 1

KPERS Retirants as of December 31, 1986
by Retirement System and Coverage Groups

	Under age 65	Age 65 and over	Total	Percent under 65
KPERS retirants	1,950	24,649	26,599	7.3%
Former KSRS annuitants	13	3,942	3,955	0.3
KPERS-TIAA retirants	17	545	562	3.0
Total KPERS	1,980	29,136	31,116	6.4%
KP&F retirants	699	308	1,007	69.4
Judges retirants	2	41	43	4.7
Total retirants	2,681	29,485	32,166	8.3%

Note: In addition to the 32,166 retirants, there were 1,975 beneficiaries receiving benefits as of December 31, 1986 (KPERS - 1,587, KP&F - 369, and Judges - 19). There are also approximately 1,300 disabled KPERS members who are receiving long-term disability benefits.

Unlike the State, a substantial majority of the local employers participating in KPERS do not allow retired employees to continue to participate in the employer-sponsored health benefit plan (except for the mandatory continuation of coverage required under COBRA). Over half of the cities of the first class, 85% of the counties, and almost all of the school districts do not permit retirees to continue coverage under the group plan after the expiration of COBRA coverage - even if the retiree is willing to pay for the full cost of coverage.

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA), enacted on April 7, 1986, requires employers of 20 or more employees to make group health benefit coverage available to certain former employees and their dependents. Since July 1986, almost all employers with health benefit plans have been required by federal statute to provide for the continuation of coverage to certain former employees and dependents for specified periods.

Under COBRA, coverage at group rates must be extended for at least 18 months to employees who retire or terminate employment, and to those who switch from full-time to part-time status and would otherwise lose their plan coverage. The same coverage must be extended for 36 months to an employee's spouse and dependents if the employee dies or becomes entitled to Medicare benefits, or in the event of a divorce or legal separation.

Continuing coverage must be identical to that provided to other plan participants, and may not be conditioned on evidence of insurability. After the required continuation period, a "qualified beneficiary" must be offered any conversion option generally available under the plan. Extension of coverage may cease before the end of the continuation period only if: (1) the employer ceases to maintain any group health plan for any employee, (2) the qualified beneficiary fails to make required premium payments on a timely basis, (3) the qualified beneficiary becomes covered under another group health plan, or (4) the qualified beneficiary becomes entitled to Medicare benefits.

A retired employee or other qualified beneficiary who elects to continue coverage may be required to pay up to 102% of the plan's premium cost for other similarly situated employees. Continuing coverage may be terminated if the qualified beneficiary does not make timely premium payments. An employer may pay for part or all of the cost of continuing health care coverage for qualified beneficiaries.

COBRA will increase the cost of most employer-sponsored health benefit plans. Additional administrative expenses will be incurred for new recordkeeping and premium collection procedures, and for communication of the new COBRA continuation requirements. Benefit costs will also rise because the average claims of those former employees who elect to continue coverage are likely to be significantly higher than the average claims for the active employee group. For example, the average claims of retirees under age 65 who elect to continue coverage may be more than double the average claims of all covered active employees. Even if the plan charges all individuals who continue coverage 102% of the premium, the plan's benefit costs are likely to increase because of this adverse selection.

Prior to the enactment of COBRA in 1986, almost half the states had enacted legislation requiring continuation of health insurance coverage for certain former employees who became unemployed - and 40 states mandated continuation and/or conversion of coverage into an individual policy for certain qualifying events. COBRA, however, generally required access to coverage for substantially longer periods, invoked a broader group of qualifying events, and applied to almost all employer-sponsored health benefit plans. State and local government employers that maintain health benefit plans are subject to the parallel continuation of coverage requirements which COBRA added to the Public Health Service Act.

As a result of COBRA, the State of Kansas and all local employers that maintain health benefit plans must provide employees who retire with access to continuing coverage at group rates for at least 18 months after retirement. The State Health Benefits Plan allows retirees to continue coverage after the mandatory COBRA extension period, provided they are receiving KPERS benefits and pay the required premiums. As noted, how-

ever, most local employers participating in KPERS do not allow retirees to continue to participate in the group plan after the expiration of the required COBRA continuation period.

State Health Benefits Plan

Retired State employees can continue to participate in the Kansas Health Benefits Plan if they are receiving KPERS benefits and pay the required premiums. Retirants under age 65 who continue coverage have the same benefits as covered active employees. The benefits provided for retirants 65 and over are coordinated with Medicare benefits.

Retirants under age 65 pay the same premium rates as the average total rates paid for active employees. The additional 2% permitted by COBRA does not apply. For 1988 the monthly Blue Cross-Blue Shield rates, including dental premiums, are $112.47 for single coverage and $173.06 for dependents coverage. The monthly rate for single coverage will increase 21.5%, from $92.55 in 1987 to $112.47 in 1988. For 1988 the annual cost of single coverage for a retiree under age 65 will be $1,349.64.

For retirants 65 and over and totally disabled KPERS members who are eligible for Medicare benefits, the Blue Cross-Blue Shield premium rate under the State Plan will be $59.71 a month for calendar year 1988. The monthly premium for a retiree 65 or over will increase 35.3% (from $44.13 in 1987 to $59.71 in 1988), primarily because of the addition of the stand-alone prescription drug program. For 1988 the annual cost of coverage for a retiree 65 or over will be $716.52

The Kansas Health Benefits Plan currently covers some 7,000 retirants, or over 70% of the 9,600 retired State employees receiving benefits under KPERS. Approximately 2,800 or 40% of the covered retirants have the required premiums deducted from their KPERS benefit checks, and about 4,200 make direct premium payments to the State. An estimated 1,000 retirants, or about 14% of the 7,000 covered retirants, are under age 65 and not eligible for Medicare benefits.

Cities and Counties

Based on a survey conducted by the Kansas Legislative Research Department in December 1984, over half of the cities of the first class and 85% of Kansas counties do not allow retired employees to continue coverage under the group health benefit plan after the expiration of the required COBRA coverage.

The findings of the Legislative Research Department's December 1984 survey are summarized below:

- Of the 24 cities of the first class, 14 indicated that health insurance coverage was not provided for retired employees. The 14 cities that did not permit retirees to continue as part of the health insurance coverage group were: Dodge City, Emporia, Fort Scott, Garden City, Hutchinson, Junction City, Lawrence, Liberal, Manhattan, Olathe, Overland Park, Parsons, Pittsburg, and Shawnee.

- Nine of the 24 cities of the first class responded that retired employees were permtited to continue coverage under the group plan, but that the retirant had to pay 100% of the health insurance costs. These nine cities were: Atchison, Coffeyville, Kansas City, Leavenworth, Lenexa, Newton, Prairie Village, Salina, and Topeka.

- Out of the 24 cities and 105 counties surveyed, only one city - Wichita - reported that it paid a portion of the health care costs for retirants. As of the December 1984 survey date, Wichita paid 75% of the premium costs for single retirants - the same percentage as the City paid for active employees. Spouses of retirees were also permitted to continue coverage under the Wichita Plan until age 65, but they had to pay the full health insurance costs.

- Of the 105 counties surveyed, 89 reported they did not provide health insurance coverage for retired employees and that retirees were not permitted to remain part of the coverage group.

- In the 16 counties that allowed retirees to continue to participate in the group plan, the retirees who continued coverage had to pay the full costs. The 16 counties where retirees could remain part of the health insurance group were: Atchison, Clark, Clay, Cloud, Crawford, Doniphan, Douglas, Edwards, Johnson, Lyon, Osborne, Rice, Saline, Seward, Trego, and Wallace.

The December 1984 survey indicated that the 9 first class cities and 16 counties that permitted retirees to remain part of the health insurance coverage group were generally the larger cities and counties. As a result, it appears reasonable to assume that roughly two-thirds of retired city employees and about one-fifth of retired county employees could continue to participate in the group plan, even though only 42% of the cities and 15% of the counties allowed retirees to continue coverage.

School Districts

A substantial majority of Kansas school districts do not allow retired employees to continue coverage in the group plan after the expiration of the mandatory COBRA continuation period. A few school districts have made continuing coverage available to those employees who elected to retire under an early retirement incentive program.

KNEA, the Kansas-National Education Association, offers an "Early Retiree Health Care Program" underwritten by Blue Cross-Blue Shield of Kansas. To be eligible for coverage under the KNEA program, the retiree must be between 55 and 65 years of age, a member of KNEA, and have been a member of Blue Cross-Blue Shield for at least three years at the time of retirement. An eligible KNEA member must transfer to the KNEA Early Retiree group within 30 days after retirement. For 1987 the monthly premiums for single coverage were approximately $105 for retirees between ages 55 and 59, and $111 for retirees ages 60 through 64.

Individual Policies

There are currently about 2,700 KPERS retirants who are under age 65. As a rough estimate, perhaps 1,700 of these retirants have continued coverage under an employer-sponsored plan. Among the estimated 1,000 under-65 KPERS retirants without employer-sponsored coverage, some have purchased individual policies or converted group coverage into an individual policy. For these retirants the cost of individual coverage is substantial. Moreover, some of the under-65 KPERS retirants without employer-sponsored

coverage may find it impossible to purchase an individual policy after the expiration of the conversion period, even if they are willing to pay the very high premiums that are generally charged for an individual health policy for a retiree who is under age 65.

For KPERS retirants 65 and over who are not covered under an employer-sponsored plan, various Medigap policies are available to supplement Medicare benefits. Examples of such policies include those offered by the American Association of Retired Persons and the National Education Association. Blue Cross and Blue Shield of Kansas also offers a plan that supplements Medicare benefits called "Plan 65"; the 1987 monthly premium for Plan 65 is $38.73 per person. As a result of the substantial increase in the State Plan premium for 1988, some retired State employees who are 65 and over may discontinue participation in the State Plan and enroll in Plan 65 or one of several other Medigap plans available to KPERS retirants.

III. LIABILITIES FOR KPERS RETIRANTS HEALTH BENEFITS

Health care benefits for retirees are generally provided by an employer-sponsored plan that covers both active and retired employees and their dependents. In the private sector, a substantial majority of large employers and an estimated 40% of smaller firms offer retiree health benefits. Recent surveys indicate that about half of the private employers that provide coverage pay the full premium for retirees. By contrast, public sector retirees usually pay part or the full cost of their health care premiums.

Employers that pay the full premiums for retirees, or for retirees and their spouses, have experienced substantial increases in costs. The rapid escalation in retiree health benefit costs and liabilities has resulted from a combination of factors, including the extraordinarily high rate of inflation in medical care costs, the shifting of costs to employer-sponsored plans, the growth in the number of retirees (especially retirees under age 65), and the fact that retirees are living longer. Moreover, because post-retirement health benefits are characteristically financed on a pay-as-you-go basis (with few exceptions), reserves have not been accumulated to help meet future increases in costs for current retirants or for active employees who expect to become eligible for benefits when they retire.

The State of Kansas is <u>not</u> in the same position as many other large employers. Kansas is <u>not</u> presently faced with a large and rapidly growing liability for post-retirement health benefits.

KPERS retirants who participate in the Kansas Health Benefits Plan pay a substantial portion of their total benefit costs. Covered retirees who are 65 and over and eligible for Medicare benefits pay for essentially the full cost of coverage. For 1988 the Blue Cross-Blue Shield premium rate for a Medicare-eligible retiree is approximately $60 a month.

KPERS retirants who are under age 65 and not eligible for Medicare benefits can also continue coverage under the State Plan. They have the same benefits and pay the same premium rates as the average total rates paid for active employees. For 1988 the Blue Cross-Blue Shield premium rate for single coverage is approximately $112 a month.

Separate data is not available on the claims experience of KPERS retirants who are under age 65 and continue coverage under the Kansas Health Benefits Plan. Based on the experience of other groups of under-65 retirees, it is estimated that the average claims of under-65 retirees covered by the State Plan are at least double (and possibly as high as triple) the average claims of the 36,000 covered active employees. If it is assumed that the average cost for under-65 retirees is double the average cost for all covered employees, the current State Plan "subsidy" for those under-65 retirees who continue coverage is estimated to be roughly $1-1/2 million a year.

The Kansas Legislature could enact legislation providing that the State will pay the full cost of single coverage for all 32,000 KPERS retirants. If such legislation were passed, the State would be faced with a gigantic unfunded liability for KPERS retirants health benefits.

Basis for Actuarial Calculations

Actuarial calculations were made to determine the estimated actuarial liability for post-retirement health benefits for the more than 32,000 KPERS retirants.

Because all KPERS retirants are not presently covered under a health benefits program, it is necessary to make assumptions regarding the approximate total premium rates for the 2,700 KPERS retirants under age 65 and the 29,500 KPERS retirants 65 and over. For purposes of our actuarial cost calculations, it was assumed that the average premium costs for 1988 are as follows: $212 a month for KPERS retirants under 65, and $60 a month for KPERS retirants 65 and over.

The estimated monthly cost of $60 for a retiree 65 or over is approximately the same as the State Plan premium for 1988. The assumed monthly cost of $212 for KPERS retirants under 65 is a rough estimate, based on the assumption that the average cost for these retirants is almost double - or approximately $100 a month higher than - the average cost of single coverage for active employees.

In addition to assuming that the monthly premium costs for 1988 will average $212 for retirants under 65 and $60 for retirants 65 and over, the actuarial calculations were based on an assumed long-term investment yield rate of 8% per year and the assumed mortality rates used in our actuarial valuations of KPERS, KP&F, and the Judges retirement systems as of January 1, 1987.

The actuarial liability for retirants health benefits is very sensitive to the assumed rate of inflation in medical care costs. Because of the uncertainty regarding the average rate of increase in medical costs in the future, we determined the actuarial liabilaties for current KPERS retirants based on three assumed rates of medical cost inflation: 6% per year, 8% per year, and 10% per year.

Our actuarial calculations included all of the 32,166 KPERS retirants receiving benefits as of December 31, 1986.

Results of Actuarial Calculations

Table 2 shows the actuarial liabilities for post-retirement health benefits for current KPERS retirants, by retirement system.

Based on an assumed medical cost inflation rate of 8% per year, the total actuarial liability for post-retirement health benefits for all current KPERS retirants is approximately $337.8 million. The total actuarial liability is $286.6 million based on a 6% medical cost inflation rate, and $404.6 million if it is assumed that medical costs will increase at an average rate of 10% per year.

Table 2

Actuarial Liabilities For Post-Retirement Health Benefits For Current KPERS Retirants

	Assumed Rate of Inflation in Medical Care Costs		
	6%	8%	10%
KPERS	$264,519,900	$311,242,600	$371,869,700
KP&F	21,783,100	26,205,800	32,343,700
Judges	276,500	315,100	362,800
Total	$286,579,500	$337,763,500	$404,576,200
Annual payment required to amortize total actuarial liability over 15 years	$ 32,312,700	$ 38,083,800	$ 45,617,200

Assumptions: Monthly premium costs of $212 until age 65 and $60 at 65 and over; 8% interest; and same mortality tables as used in actuarial valuations of KPERS, KP&F, and Judges retirement systems as of January 1, 1987.

The results of our actuarial calculations provide the Kansas Legislature with estimates of the total actuarial liability that would be incurred if legislation were enacted to provide that the State will pay the full cost of single coverage for the lifetimes of all KPERS retirants. If legislation provided that the State would pay half the cost of coverage at the assumed monthly rates (i.e., $106 until age 65 and $30 at 65 and over), the State's total actuarial liability would be half of the amounts shown in Table 2 (i.e., $168.9 million based on an assumed medical cost inflation rate of 8% per year). Similarly, the State's total liability would be one-third of the amounts shown in Table 2 if the State paid for one-third of the total estimated premium costs for current KPERS retirants.

The total actuarial liability for post-retirement health benefits for current KPERS retirants could be amortized over a period of 15 years (the same as the KPERS amortization period). As shown in Table 2, the annual payment required to amortize the total liability over 15 years ranges from $32.3 million to $45.6 million depending on the assumed rate of inflation in medical care costs.

<u>Liability Per Retirant</u>

The actuarial laibility for lifetime health benefits varies substantially depending on the retirant's age and sex. Based on the assumed monthly premium costs of $212 until age 65 and $60 at 65 and over, an 8% interest assumption, and an assumed medical cost inflation rate of 8% per year, the approximate liability per KPERS retirant varies by age and sex as follows

	Approximate Actuarial Liability Per KPERS Retirant	
Age	Men	Women
55	$35,000	$45,000
60	23,000	28,000
65	12,000	15,500
70	9,000	12,500
75	7,500	10,000

For a retirant who is age 55, the actuarial liability for lifetime health benefits is roughly triple the liability for an age 65 retirant. Because the average age of KP&F retirants is much lower than the average age of KPERS retirants, the average liability per retirant is significantly higher for KP&F retirants than for KPERS retirants. Based on the age distributions of current KP&F and KPERS retirants, and an assumed medical cost inflation rate of 8%, the average liability is approximately $26,000 per KP&F retirant and $10,000 per KPERS retirant.

Cost for Active Employees and Current Retirants

If the State of Kansas paid the full cost of single coverage for current retirants, legislation would undoubtedly be proposed to provide that the State will also pay the full cost of single coverage for active employees who retire in the future.

Table 3 shows, for KPERS and KP&F, the projected actuarial liabilities and funding costs for post-retirement health benefits for both active employees and current retirants. Based on an 8% medical cost inflation rate, the total actuarial liability for active employees and current retirants is approximately $495.5 million for KPERS and $57.2 million for KP&F.

The total projected actuarial liabilities for active employees and current retirants could be funded on a level-cost actuarial reserve basis. The State - or the State and all other employers participating in KPERS and KP&F - could make total contributions consisting of (a) the "normal cost" for active employees calculated as a level percent of payroll, plus (b) the annual payment required to amortize the actuarial liability for current retirants over 15 years. Based on KPERS and KP&F membership data or of December 31, 1986, and on an assumed medical cost inflation rate of 8%, the total annual "funding costs" for active employees and current retirants are $56.4 million for KPERS and $5.7 million for KP&F.

Table 3

Actuarial Liabilities and Funding Costs For Post-Retirement Health Benefits For Active Employees and Current Retirants, KPERS and KP&F

	Assumed Rate of Inflation in Medicaal Care Costs		
Total Actuarial Liabilities:	6%	8%	10%
Projected liability for active employees			
KPERS	$149,792,800	$184,289,500	$231,121,000
KP&F	26,382,500	31,035,100	37,259,700
Liability for current retirants			
KPERS	$264,519,900	$311,242,600	$371,869,700
KP&F	21,783,100	26,205,800	32,343,700
Funding Costs:			
"Normal cost" for active employees			
KPERS	$17,322,100	$21,317,700	$26,744,200
KP&F	2,309,000	2,716,200	3,261,000
Annual payment to amortize liability for current retirants over 15 years			
KPERS	$29,825,400	$35,093,500	$41,929,400
KP&F	2,456,100	2,954,800	3,646,800
Funding Costs as Percent of Total Payroll:			
"Normal cost" rate			
KPERS	0.87%	1.08%	1.35%
KP&F	2.09	2.46	2.95
Amortization payment percentage			
KPERS	1.50%	1.77%	2.11%
KP&F	2.23	2.68	3.30
Total contribution rate as percent of payroll			
KPERS	2.37%	2.85%	3.46%
KP&F	4.32	5.14	6.25

Table 3 also shows the funding costs as percentages of the total payrolls of employees covered by KPERS and KP&F, which amounted to almost $2.0 billion and $110.4 million, respectively, as of December 31, 1986. Based on an assumed medical cost inflation rate of 8%, the total contribution rates required to meet the normal cost of post-retirement health benefits for active employees and amortize the liability for current retirants over 15 years are 2.85% of payroll for KPERS and 5.14% of payroll for KP&F. If the medical cost inflation rate is assumed to average 10% per year, the total funding costs are 3.46% of payroll for KPERS and 6.25% of payroll for KP&F.

IV. OPTIONS FOR KANSAS LEGISLATURE

The Kansas Legislature could consider numerous possible actions relating to health benefits for KPERS retirants. One of the options would be to adopt legislation establishing a health benefits plan for some or all KPERS retirants. Another approach would be to adopt legislation expanding access to coverage for those KPERS retirants who are not presently allowed to continue coverage under the group health benefits plan after the expiration of the required COBRA continuation period.

Legislative action relating to health benefits for KPERS retirants would have far-reaching implications. Of course, the cost and other implications will vary significantly depending on the specific provisions of any legislation passed by the Kansas Legislature. For example, the short-term and long-term implications of establishing a health benefits plan for some or all KPERS reitrants would be fundamentally different than the implications of legislation expanding access to continuing group coverage.

Access to Coverage

Retired State employees who are KPERS benefit recipients and pay the required premiums can continue coverage under the Kansas Health Benefits Plan. About 7,000 retirants, or over 70% of the 9,600 retired State employees who are receiving KPERS benefits, are currently covered by the State Plan.

Unlike the State, a substantial majority of the local employers participating in KPERS do not allow retired employees to continue coverage under the group health benefits plan after the expiration of the 18-month COBRA continuation period. To expand access to continuing group coverage, the Kansas Legislature could pass legislation that encourages or requires local employers to offer continuing coverage for a longer period to retired employees who are receiving KPERS benefits.

State legislation could require local employers that participate in KPERS to provide an "eligible retirant" with access to continuing group coverage for a specified minimum continuation period. An eligible retirant could be defined as any KPERS retirant (or any KPERS retirant who is not eligible for Medicare benefits) who is a former employee of any local employer that participates in KPERS and maintains a health benefits plan for employees. The minimum continuation period for an eligible retirant could be extended by Kansas Statutes for the retirant's lifetime, or until the retirant becomes eligible for Medicare benefits.

State legislation extending the minimum continuation period to at least age 65 could also include a maximum limit on the premium that any local employer can charge an eligible retirant who continues coverage. One possibility would be to limit the maximum premium during the extended, State-mandated continuation period to the same 102% that can be charged under COBRA. Although local employers could then charge an additional 2% for the retirant's full continuation period (i.e., from date of retirement to age 65), it is likely that many local employers would charge eligible retirants 100% of the total composite premium for covered active employees.

For local employers, the cost effects of State legislation extending the minimum continuation period to age 65 will vary significantly. There will be no additional costs for local employers that currently allow retirants to continue coverage under the group plan to at least age 65. The additional costs for other local employers that participate in KPERS and maintain a health benefits plan will depend on such factors as:

- the number of eligible retirants who continue coverage after the expiration of the COBRA continuation period;
- the claims experience of such retirants during the State-mandated continuation period;
- the relationship between the claims experience of such retirants and the overall claims experience of covered employees and retirants; and

- the relationship between the premium rates paid by a particular local employer and the recent claims experience of individuals covered by that employer's health benefits plan.

To reduce the additional costs that would be incurred by some local employers, the Kansas "continuation legislation" could provide that the State will pay certain local employers an amount related to the months of continuing coverage resulting from the State-mandated continuation period. As an example, the State payment to any local employer that participates in KPERS and maintains a health benefits plan might be a specified dollar amount for each month of State-mandated continuation (i.e., for each month that an eligible KPERS retirant continues coverage, beginning with the month following the expiration of the COBRA continuation period and ending with the month the retirant attains age 65). Local employers could use the State payment to reduce their health plan costs or to reduce the premiums charged to eligible retirants who continue coverage under the plan.

KPERS Retirants Health Plan

A health benefits plan could be established for some or all KPERS retirants.

The Special Committee on Ways and Means will want to consider many interrelated policy and technical issues before proposing a "KPERS Retirants Health Plan Bill" for consideration by the Kansas Legislature. Section VI of this report presents general comments on retiree plan design and public sector issues. Three key policy questions that need to be addressed are:

- Who will be eligible for coverage under the KPERS Retirants Health Benefits Plan?
- How will the Plan be financed?
- Who will be responsible for managing and administering the Plan?

Eligible Retirants

The KPERS Retirants Health Benefits Plan could be made available to all KPERS retirants (and their spouses and dependents). If the Plan covers retirants under age 65 as well as those 65 and over who are eligible for Medicare benefits, different benefit programs might be offered to the two groups of retirants. Legislation establishing the Plan could provide that any KPERS retirant who is under age 65 will first become eligible to enroll in the Plan after the expiration of the 18-month COBRA continuation period. Another possibility would be to give under-65 retirants the option of either choosing COBRA continuation coverage (which might be offered for only 18 months) or enrolling in the separate KPERS Plan at the time of retirement.

Design and implementation of a KPERS Retirants Health Benefits Plan would be simplified by limiting coverage to retirants 65 and over. The types and levels of benefits provided for all retirants who enroll in the Plan could then be coordinated with Medicare benefits. Legislation establishing a KPERS Plan for retirants 65 and over could also include provisions extending the minimum continuation period to at least age 65.

Financing

The KPERS Retirants Health Benefits Plan could be financed by retiree contributions, employer contributions, or both. Employer contributions could be based on one of several possible statutory formulas: a percentage of the premium cost for single coverage, a flat dollar amount per month for each enrolled retirant, a dollar amount or percentage of the premium cost related to the retirant's years of credited service under KPERS, a percentage of the total payrolls of employees covered by KPERS, or a specified lump sum appropriation from the State.

Decisions made regarding Plan financing will determine the sharing of costs between retirees and employers, and also affect the Plan's benefit design and claims experience. If the Plan is financed solely by retiree

contributions, the KPERS retirants who enroll in the Plan are likely to be in relatively poor health and have higher-than-average per-capita claims costs. The extent of adverse selection will be reduced if employers make some contributions to the Plan, and minimized if employers paid the full cost of single coverage and almost all eligible KPERS retirants enrolled in the Plan. The amount of employer contributions (if any) will be one of the key factors that determines the number and proportion of eligible KPERS retirants who enroll in the Plan.

Administration

Who will be responsible for the management and administration of the KPERS Retirants Health Benefits Plan? The Plan Administrator could be a board or commission, an agency or department, or an individual. Options available include: Kansas Health Care Commission, KPERS Board of Trustees, a newly-created board or commission, Department of Administration, Secretary of Administration, or Executive Secretary of KPERS.

The legislation establishing the Plan could give the Plan Administrator broad authority and responsibility for determining the types and levels of benefits that will be offered to eligible KPERS retirants. If the Administrator is authorized to make decisions regarding specific Plan provisions, he should be provided with sufficient resources to effectively implement the Plan and the flexibility needed to effectively negotiate with insurance carriers, HMOs and PPOs, hospitals, doctors, and other providers of health care services.

KPERS Retirants Plan and State Plan

If a separate health benefits plan is established for KPERS retirants 65 and over, should the Kansas Health Benefits Plan (the State Plan) continue to offer coverage to retired State employees who are eligible to enroll in the KPERS Retirants Health Benefits Plan (the KPERS Plan)? Legislation establishing the KPERS Plan could give retired State employees who are eligible to participate in both plans the option of continuing coverage under the State Plan or enrolling in the KPERS Plan.

The relationship between the KPERS Plan and the State Plan may depend on the method of financing the KPERS Plan. If the KPERS Plan is financed in part by employer contibutions, it may be preferable to discontinue offering coverage under the State Plan to KPERS retirants who are eligible to enroll in the KPERS Plan.

If a separate KPERS Plan is not established, legislation could be considered to allow all KPERS retirants - or any KPERS retirant who is 65 or over - to enroll in the State Plan. The Special Committee on Ways and Means may want to discuss and evaluate the cost and other implications of making non-State KPERS retirants eligible for coverage under the State Plan, including the questions of equity that would be raised by such legislation.

Post-Retirement Benefit Increase

The Kansas Legislature could provide another post-retirement benefit increase for KPERS retirants. Although this option does not directly involve the provision of health benefits for KPERS retirants, another ad hoc increase in KPERS retirement benefits could be used by KPERS retirants to pay higher premiums and out-of-pocket medical care costs for 1988.

Post-retirement benefit increases have been provided for KPERS retirants almost annually. During the past six years, the percentage increases in retirement benefits for eligible KPERS retirants have been as follows: 1982 - 10%, 1984 - 10%, 1985 - 5%, 1986 - 3%, and 1987 - 2%. These post-retirement benefit increases have maintained the purchasing power of KPERS retirement benefits, and also helped KPERS retirants meet the rising costs of medical care.

V. RETIREE MEDICAL COSTS AND MEDICARE

Medical care protection is essential for the economic security of retirees. Because the probability of needing medical care increases with age, the per-capita cost of medical care is much higher for older Americans than for the total population.

For retirees 65 and over, Medicare is the primary source of medical care protection. Medicare, however, requires substantial cost sharing and currently pays less than half the total medical care costs for retirees 65 and over.

For retirees under age 65, employer-sponsored health benefit plans are the principal source of medical care protection. Significant gaps in protection exist for retirees under 65 without employer-sponsored coverage. Some early retirees are unable to purchase satisfactory coverage on an individual basis, regardless of the price they are willing to pay. For those retirees under 65 who purchase individual coverage, or convert employer-sponsored coverage into an individual policy, the cost of coverage is generally very high relative to total income.

Retiree Medical Expenditures

Medical care for the retired population is expensive. The U.S. Health Care Financing Administration reports that personal health care expenditures for individuals 65 and over increased from $43 billion in 1977 to $120 billion in 1984. As a percentage of Gross National Product, health care expenditures for this age group increased from 2.3% in 1977 to 3.3% in 1984.

For persons 65 and over, per-capita medical expenditures are triple the per-capita expenditures for the total U.S. population ($4,202 vs. $1,394 in 1984). Per-capita medical expenditures for the 65-and-over population increased from $1,785 in 1977 to $4,202 in 1984, a 13% average annual growth rate. Today, the per-capita cost of medical care for individuals 65 and over probably exceeds $5,500 a year.

In 1986 Medicare paid about 45% of the total medical care costs for the 65-and-over population. Medicaid and other government programs paid 20%; private insurance and other private programs paid 10%; with individuals paying the remaining 25% out-of-pocket. Recent studies indicate that out-of-pocket medical expenses tend to increase with age, and that they are especally high for persons 85 and over because many of them are institutionalized in nursing homes.

Medicare Overview

Medicare covers about 30 million people 65 and over, and three million disabled individuals. Although Medicare currently pays 45% of the total health care costs for persons 65 and over, the Medicare reimbursement percentage varies substantially depending on the type of service. In 1984, Medicare reimbursed the elderly for 75% of the cost of hospital services, 58% of the cost of physician services, but only 2% of the cost of nursing home care.

Medicare consists of two parts: Part A Hospital Insurance and Part B Supplementary Medical Insurance. An individual 65 or over who is eligible for monthly Social Security benefits is also eligible for Part A hospital insurance benefits. Part B medical insurance benefits are available to all persons 65 or over who elect coverage and pay the required monthly premium. Disabled persons who are under age 65 and entitled to Social Security disability benefits become eligible for coverage under Parts A and B of Medicare after two years of disability.

Part A hospital insurance is financed principally by payroll taxes. The current tax rate for employees and employers each is 1.45% of Social Security taxable wages. The separate hospital insurance tax is paid at the same time as the regular social security tax, and the same amount of wages is subject to the combined total tax rate.

In 1988 both the total tax rate and the maximum taxable wage base will increase, as shown below:

	Tax Rates			
	Social Security	Hospital Insurance	Total	Maximum taxable wages
1987	5.70%	1.45%	7.15%	$43,800
1988	6.06	1.45	7.51	45,000

In 1988 the maximum tax for an employee who earns $45,000 or more will be $3,379.50. The maximum tax for 1988 is $247.80 or 8% higher than this year's maximum tax of $3,131.70. For an employee who earns $20,000 in both 1987 and 1988, the tax will rise by $72 or 5% - from $1,430 in 1987 to $1,502 in 1988. Employer tax payments will also increase, because employers will continue to pay the same amount that is paid by each employee.

Medicare coverage is now mandatory for all state and local government employees hired after March 31, 1986. The same 1.45% hospital insurance tax rate applies to newly-hired state and local government employees who are not covered under the Social Security old-age, survivors and disability insurance programs. For such an employee who earns $20,000 and is covered under Medicare only, the employee and employer will each pay $290 in hospital insurance taxes in 1988.

Part A covers inpatient hospital costs for up to 90 days in any benefit period, subject to a deductible and a co-insurance charge for the 61st through 90th days of hospitalization. If an individual entitled to Part A benefits is hospitalized for more than 90 days, there is a non-renewable lifetime reserve of 60 days of hospital care for which the patient pays a per-day co-insurance charge. Post-hospital care in a qualified "skilled nursing facility" is also covered if a person has spent at least three consecutive days in a hospital. Nursing home care for an eligible beneficiary is covered for up to 100 days, with the patient required to pay a co-insurance charge for each day of such care over 20. In addition, Part A covers the costs of an unlimited number of home health visits made under an approved plan of treatment.

The Part A deductible and co-insurance amounts are increased annually. Effective January 1, 1988, the first day in-hospital deductible will increase from $520 to $540 and the co-insurance charge for the 61st through 90th day in the hospital will increase from $130 to $135 per day.

Table 4 shows the increases in the Part A deductible and co-insurance charges since 1970. From 1970 to 1979 the deductible and co-insurance amounts approximately tripled, with the first-day deductible increasing from $52 to $160. During the eight-year period from 1980 to 1988, these amounts tripled again and the first-day deductible jumped from $180 to $540.

Although the increases in the Part A deductible and co-insurance charges have been substantial, the hospital insurance trust fund is still in serious financial condition. The Board of Trustees of the hospital insurance program, in its 1987 report, projects that the hospital insurance trust fund will be exhausted shortly after the turn of the century (and possibly as early as 1996 if the pessimistic assumptions are realized). The Board recommends that Congress enact early remedial measures to bring the hospital insurance program's projected future costs and financing into balance. According to the Board, "early corrective action is essential in order to avoid the need for later, potentially precipitous changes."

Part B, the medical insurance portion of Medicare, helps pay for doctors' services, outpatient services, and certain other medical and health services. Part B usually pays 80% of "reasonable charges" for covered services, after the patient pays a $75 annual deductible. In addition to paying the annual deductible and 20% of the "reasonable charge" for a covered service, the patient frequently must also pay the difference between the doctor's full charge and the amount determined as "reasonable" by Medicare.

Table 4

Medicare Deductibles, Co-Insurance Amounts, and Part B Premiums, 1970-1988

	Part A				Part B		
	Deductible	Co-Insurance Amount Per Day					
	First 60 days	61st thru 90th day	60-day lifetime reserve	21st-100th extended care day		Monthly Premium	Annual Deductible
1/1/70	$ 52	$ 13	$ 26	$ 6.50	7/1/70	$ 5.30	$50
1/1/71	60	15	30	7.50	7/1/71	5.60	50
1/1/72	68	17	34	8.50	7/1/72	5.80	50
1/1/73	72	18	36	9.00	1/1/73	5.80	60
1/1/74	84	21	42	10.50	7/1/73	6.30	60
1/1/75	92	23	46	11.50	7/1/74	6.70	60
1/1/76	104	26	52	13.00	7/1/76	7.20	60
1/1/77	124	31	62	15.50	7/1/77	7.70	60
1/1/78	144	36	72	18.00	7/1/78	8.20	60
1/1/79	160	40	80	20.00	7/1/79	8.70	60
1/1/80	180	45	90	22.50	7/1/80	9.60	60
1/1/81	204	51	102	25.50	7/1/81	11.00	60
1/1/82	260	65	130	32.50	1/1/82	11.00	75
1/1/83	304	76	152	38.00	7/1/82	12.20	75
1/1/84	356	89	178	44.50	1/1/84	14.60	75
1/1/85	400	100	200	50.00	1/1/85	15.50	75
1/1/86	492	123	246	62.50	1/1/86	15.50	75
1/1/87	520	130	260	65.00	1/1/87	17.90	75
1/1/88	540	135	270	67.50	1/1/88	24.80	75

Medicare has special limits on certain covered services and excludes some services altogether. Expenses that are not covered under either Part A or B include those for: outpatient prescription drugs, most dental services, routine physical examinations, private duty nursing, first three pints of blood, eyeglasses, hearing aids, examinations for eyeglasses or hearing aids, most services by chiropractors and podiatrists, and surgical services for which a second opinion is required but not obtained.

Table 4 also shows the increases in the Part B standard monthly premium and annual deductible since 1970. The annual deductible was increased from $50 to $60 in 1973, and from $60 to $75 in 1982; it has remained at $75 since 1982. The Part B monthly premium, on the other hand, has been increased almost annually since 1970.

In 1988 the Part B premium will be $24.80 a month, for an annual premium of $297.60. The monthly premium will increase by $6.90 - from $17.90 in 1987 to $24.80 in 1988. Although the premium will increase 38.5% in 1988, the total premiums paid by beneficiaries will still cover only about one-fourth of the total anticipated costs of Part B. The remaining three-fourths of total Part B costs are financed by general government revenues.

Part B premiums are usually deducted from the retiree's Social Security benefit check. In 1988 Social Security benefits will increase 4.2% and the monthly Part B premium will rise by $6.90. For a retiree who is currently receiving the average Social Security benefit of about $500 a month, the net benefit increase for 1988 will be 2.8% or $14.10 a month ($21 benefit increase reduced by $6.90 increase in Part B premium).

Social Security benefits are automatically increased by the percentage rise in the Consumer Price Index. Although the 1988 benefit increase for most retirees will be reduced by the increase in the Part B premium, the 4.2% benefit increase for 1988 is the largest in 5-1/2 years.

From 1978 to 1988 the percentage increases in Social Security benefits have varied as follows:

Percentage Increases in Social Security Benefits

July 1978	-	6.5%	Jan. 1984	-	3.5%
July 1979	-	9.9	Jan. 1985	-	3.5
July 1980	-	14.3	Jan. 1986	-	3.1
July 1981	-	11.2	Jan. 1987	-	1.3
July 1982	-	7.4	Jan. 1988	-	4.2

Recent Medicare Changes

In recent years Congress has enacted major changes in the Medicare program, and most of these changes have had an impact on employer-sponsored health benefit plans. As one example, legislation making Medicare the secondary payor for active employees and their spouses age 65 and over had the effect of shifting medical costs that were previously paid by Medicare to employer-sponsored plans. The freeze on Medicare's reimbursements for physician services, which was in effect from July 1, 1984 to December 31, 1986, increased the cost of many retiree health benefit plans.

DRGs. One of the most significant changes in Medicare is the introduction of a new prospective payment system beginning in 1983. Most hospitals are no longer reimbursed on a reasonable-cost basis, but are paid a prospectively-determined amount per hospital admission. Upon admission to the hospital, a Medicare beneficiary is assigned to one of approximately 470 diagnostic-related groups (DRGs). The hospital receives a predetermined payment based on the assigned DRG, regardless of the patient's length of stay. Recent studies indicate that the introduction of DRGs has been largely responsible for reducing the average length of stay for Medicare beneficiaries.

HMOs and CMPs. Medicare benefits can now be provided through direct reimbursement, or through an approved health maintenance organization (HMO) or competitive medical plan (CMP). An HMO or CMP must meet specific federal requirements in order to become a provider under Medicare. A beneficiary who enrolls in an approved HMO or CMP receives health services through the organization and pays any deductible or co-payments required by the organization.

An approved HMO or CMP must offer benefits at least the same as Medicare benefits, but more comprehensive benefits may be offered. Some of the HMOs and CMPs participating in Medicare offer additional coverage if the beneficiary pays a supplemental premium. The types and levels of benefits provided by approved HMOs and CMPs may affect the design and cost of employer-sponsored retiree health plans. If a sizeable number of the retirees covered by an employer-sponsored plan are enrolled in approved HMOs or CMPs, the cost of the plan may be considerably less than the cost of a plan that supplements Medicare benefits provided on a reimbursement basis.

VI. RETIREE PLAN DESIGN AND PUBLIC SECTOR ISSUES

The design of a health benefits plan for a particular group of retirees - like all KPERS retirees or KPERS retirees 65 and over - will depend on the decisions made regarding numerous and sometimes conflicting issues. Broad issues that need to be considered include:

- Who will be eligible for coverage under the plan? Will coverage be extended to retirees under age 65, as well as to those 65 and over? Will the plan also cover spouses and dependents of retired employees?
- Will the retiree plan be a separate plan or combined with the health benefits plan for active employees?
- What types and levels of benefits will be provided by the retiree plan?
- Will retirees who participate in the plan be permitted to elect coverage under HMOs or PPOs, or possibly have the option of electing different levels of benefits?
- If the retiree plan is a reimbursement plan, will it be a comprehensive plan with deductibles and maximum out-of-pocket limits? Will the deductibles and out-of-pocket limits be indexed?
- How will the plan be coordinated with Medicare?
- Will the plan's reimbursement objectives be directed toward supplementing Medicare benefits, or helping to pay for a portion of very large, catastrophic hospital and medical bills?
- What cost management features will be included in the retiree plan?
- Will plan design be influenced by a specific financial limitation, such as a maximum annual cost per retiree?
- Will the plan be financed by retiree contributions, employer contributions, or both? If the plan is financed by both retiree and employer contributions, how will costs be shared and to what extent will the cost-sharing formula affect the plan's benefit design?

- What limitations on plan design will be imposed by the health care marketplace, particularly by existing insurance carriers, HMOs or PPOs?

If legislation is enacted to establish a health benefits plan for KPERS retirants, the agency responsible for administering the plan would need to evaluate all of the above issues before decisions could be made regarding plan design and specific plan provisions.

Cost Management Features

Retiree plans are generally characterized by high utilization of health care benefits by covered retirees. Consequently, the inclusion of cost management features can have a significant impact on plan costs. Cost management provisions can also influence the choices made by covered retirees regarding alternative types of care and providers.

Cost management provisions that could be considered for a KPERS retirants health benefits plan include: hospital preadmission review, precertification, length of stay assignments, mandatory second surgical opinions, incentives for outpatient surgery and diagnostic tests, extended care and home health benefits, hospice care, wellness benefits and incentives for healthier lifestyles, catastrophic claims management, mail order prescription drug program, and the use of alternative delivery systems such as existing or newly-created HMOs or PPOs.

Pre-65 Retirees

In the public sector, many employees retire before age 65. During the past three fiscal years, for example, approximately half of the employees who retired under KPERS were under age 65 at retirement. Under KP&F, the average retirement age is 55 or a full ten years before Medicare eligibility.

If the retiree health plan covers all retirants, the design of the plan may depend on the number and proportion of covered retirees who are under age 65. This is because the benefit package offered to pre-65

retirees is frequently the same as (or very similar to) the benefit package offered to active employees. When a large proportion of covered retirees are under 65, the design of the active employee plan and the needs of pre-65 retirees may become dominant forces in shaping the design of the retiree plan.

An important policy question is: Should pre-65 retirees be provided with the same health benefit coverage as active employees? If the answer is yes, the plan sponsor then needs to evaluate the implications of who pays for so-called gap coverage between retirement and age 65 when Medicare becomes available.

If the employer pays for the full cost of gap coverage, does that encourage employees to retire earlier and thereby result in higher future retirement system costs? Employer-financed health benefits for pre-65 retirees may prove to be "doubly expensive", because health care costs are much greater for pre- than for post-65 retirees and also because the plan's cost-sharing formula will be one of the many factors that influences the ages at which public employees choose to retire.

In recent years a number of public employers, including several Kansas school districts, have offered early retirement incentives to certain groups of employees. The experience of early retirement incentive plans in the public sector indicates that the percentage of eligible employees who elect to retire during the specified open window period depends on many factors, including the amount of the early retirement incentive, the form in which it is provided, and the extent to which the employer pays for the continuation of health insurance coverage for employees who elect to retire early.

An issue related to gap coverage is the substantial differential in the cost of lifetime health care benefits for employees who retire before and after age 65. If the lifetime benefit cost for an employee who retires at 55 is roughly triple the lifetime benefit cost for an employee who retires at 65, should the employer pay the same share of

the cost for all retirees? Does it represent good plan design to provide that the employer's share of the total cost (if any) will be the same for all retirees, regardless of the age at which they retire?

Some public employees retire early and pursue a second career. For example, a police officer or firefighter may retire under KP&F at age 55 and begin a second career with another employer. Which health benefit plan is primary? Should the retiree plan include a coordination of benefits provision which specifies that the "second career plan" is primary? Do special steps need to be taken in the retiree plan to ensure that this type of a COB provision is effectively administered?

Medicare Eligibility

What about those retired public employees who are 65 or over but are not eligible for Medicare? Although almost all KPERS retirees 65 and over are eligible for Medicare (including KP&F retirees who were not covered by Social Security as public employees), how should the retiree health benefit plan treat the relatively few over-65 retirees who are not eligible for Medicare benefits? Should these retirees be required to voluntarily enroll in Medicare Part A, or should the benefits payable under the retiree plan assume that all covered retirees are entitled to Medicare benefits?

The issue of Medicare eligibility will diminish in importance, because Medicare coverage is now mandatory for all state and local government employees hired after March 31, 1986. As a result, the relatively small number of retired public employees who are 65 or over and not eligible for Medicare will decrease in the future.

Structure of Coverage

A significant public sector issue is the structure or scope of coverage under health benefit plans and public employee retirement systems. In general, coverage under public employee retirement systems is much more centralized or significantly broader than coverage under health benefit plans.

KPERS covers a total of more than 97,000 employees, and more than 1,000 employers participate in KPERS. Like Kansas, most states have large statewide public employee retirement systems that cover a substantial majority of all public employees in the state. Retirement benefits are generally provided by large multiemployer state retirement systems (like KPERS), whereas health benefits are usually provided separately by each of the employers that participates in the state retirement system. Most of the more than 1,000 local employers that participate in KPERS maintain separate health benefits plans.

The difference in the scope of coverage under KPERS and employer-sponsored health benefit plans may influence the design, financing and administration of a health benefits plan for KPERS retirants. If a plan is established for all KPERS retirants, the Kansas Legislature and the plan administrator - rather than each local employer - will need to make decisions regarding the plan's design and financing.

Another implication of establishing a health benefits plan for all KPERS retirants is that it would provide an opportunity to relate cost sharing to years of credited service under KPERS. The ability to design cost-sharing formulas that take account of years of service would be enhanced if the scope of retiree health plan coverage is broadened to encompass all KPERS retirants.

Other Issues

Retiree health benefit plans require special communications and different approaches. It is no longer possible to have an employee meeting in the workplace to explain the health benefit plan to retirees. Another difference is that the geographic dispersion of covered retirees may affect the possibilities for HMOs, PPOs, and other alternative delivery arrangements that might be offered to active employees. If a retiree plan contains complex provisions, they may prove to be counter-productive if specific provisions are not fully understood by covered retirees.

Regarding possible changes in the design of retiree plans, we expect to see more cost sharing, more indexing, and more options. To a much greater extent in the future, retiree health benefit plans will be designed to influence choices about care and providers. There will also be a greater recognition of the importance of communications as a vehicle to encourage covered retirees to become more cost-conscious consumers of health care.