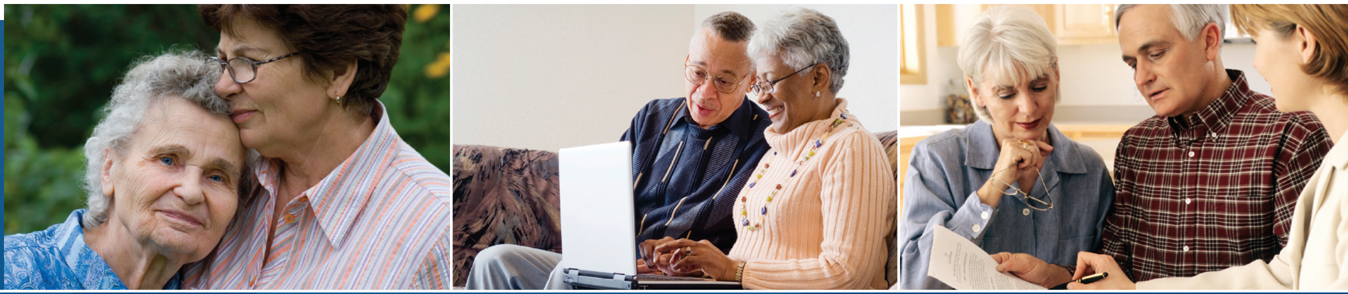
Center for State & Local Government Excellence

At a Crossroads: The Financing and Future of Health Benefits for State and Local Government Retirees



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When we look into the future for strategies on health care and to finance retiree benefits, a good starting point is with the country's most thoughtful and responsible employers, many of whom are state and local governments.

Governments have assumed leadership in finding ways to contain costs and to promote healthier lifestyles. Disease management programs have helped avoid costly health care for those with chronic illnesses.

Wellness programs are growing, too, especially in state governments. Although it may seem obvious that keeping people healthy can reduce health care costs, wellness programs are still relatively modest, especially in local governments.

Nearly all states have created a health care pool, providing uniform benefit levels for their active workforce and for their retirees. Some states have opened these pools to city and county governments as well, allowing them to reap the financial benefits of a large purchasing pool to negotiate lower prices.

Making health care accessible for routine and preventive medicine is another strategy gaining traction. On-site health clinics are expected to save $575,000 a year for Maricopa County, Arizona's 12,500 employees and dependents.

Although these programs are encouraging, state and local governments face significant challenges to addressing escalating retiree health care costs. The unfunded liabilities vary widely, as do the strategies to address them.

This comprehensive report by the North Carolina State University research team of Richard C. Kearney, Robert L. Clark, Jerrell D. Coggburn, Dennis M. Daley, and Christina Robinson, includes survey findings for all 50 states and for 2,136 local governments. It documents cost containment and cost reduction strategies as well as approaches governments are taking to fund retiree health care liabilities.

The Center for State and Local Government Excellence gratefully acknowledges the financial support from the ICMA Retirement Corporation to undertake this research project.

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Richard C. Kearney, Robert L. Clark, Jerrell D. Coggburn, Dennis M. Daley, Christina Robinson*

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Executive Summary

Overview

This report is arranged into five chapters:

Chapter 1 summarizes and analyzes existing state provisions for retiree health care, including eligibility requirements, premiums, co-payments, deductibles, dependent coverage, and relationship of the plans to Medicare.

Chapter 2 is based on careful reviews of actuarial reports and previous research by government entities, scholars, and consulting firms. It features data and comparisons of the current financial status of state retiree health care plans, including unfunded liabilities, annual required contributions, and present means of financing the plans.

Chapter 3 reports the results of a 50-state survey conducted by North Carolina State faculty. The chapter discusses findings on the availability of retiree health care coverage, plan financing, and, perhaps most important, changes in health care plans during the previous five years and changes anticipated during the next five years. The chapter also presents information on factors related to the states' future cost sharing and cost shedding plans.

Chapter 4 reports the results of a local government survey conducted for this project by ICMA, the International City/County Management Association. Throughout the chapter, comparisons are made between state and local governments.

Chapter 5 provides a summary of our findings and outlines policy alternatives for the states.

This analysis draws upon a number of information sources, including extant and original data. Extant data were acquired from various sources, including state human resources and budget web sites and compilations on health care benefits by research centers and consulting firms. Original data were obtained from a mail survey of the 50 states. Baseline data on the states' current OPEB plan features and on the states' recent and expected changes to OPEB plans are reported in Chapter 3. These data collection efforts were complemented by an extensive review of relevant scholarly and applied literature.

Summary of Key Findings

Eligibility and Coverage

- Virtually all states provide some type of retiree health benefit plan. However, these plans differ substantially across the states in their generosity and extent of coverage, and hence in their costs to the employer.

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- Eligibility for plan participation generally is a function of years of service and age.
- State and local governments (SLGs) can and do change eligibility requirements to moderate increases in costs of providing retiree health care (RHC) benefits.
- Most SLGs require employees to enroll in Medicare when they become eligible at age 65.
- A few states terminate retiree participation in the RHC plan at age 65, ending all subsidies.
- Premiums for retiree health care (RHC) plans vary substantially across the U.S., from requiring retirees to pay full cost to not requiring any premium payment.

Financing and Liabilities

- Unfunded actuarial accrued liabilities (UAAL) for many governments are large in absolute value and relative to total state expenditures, debt, and per capita income of the state.
- UAALs are now a major policy issue for many SLGs.
- All states are legally restricted from substantially altering the funding and generosity of pension benefits for retirees. But in general, executives and legislatures have greater flexibility to modify RHC benefits.
- Until recently, virtually all SLGs financed their RHC plans on a pay-as-you-go basis from general revenues. Most still do, despite rising expenditures for health care as a percentage of total employee compensation and escalating medical inflation.
- Virtually all actuarial reports for state RHC plans assume medical inflation will decline from the current level of 10 to 14 percent to a rate of 4 to 5 percent.
- Actuarial statements reveal substantial differences in total unfunded RHC liabilities. This is a function of work force size, plan generosity, and the portion of RHC costs paid by the employer.

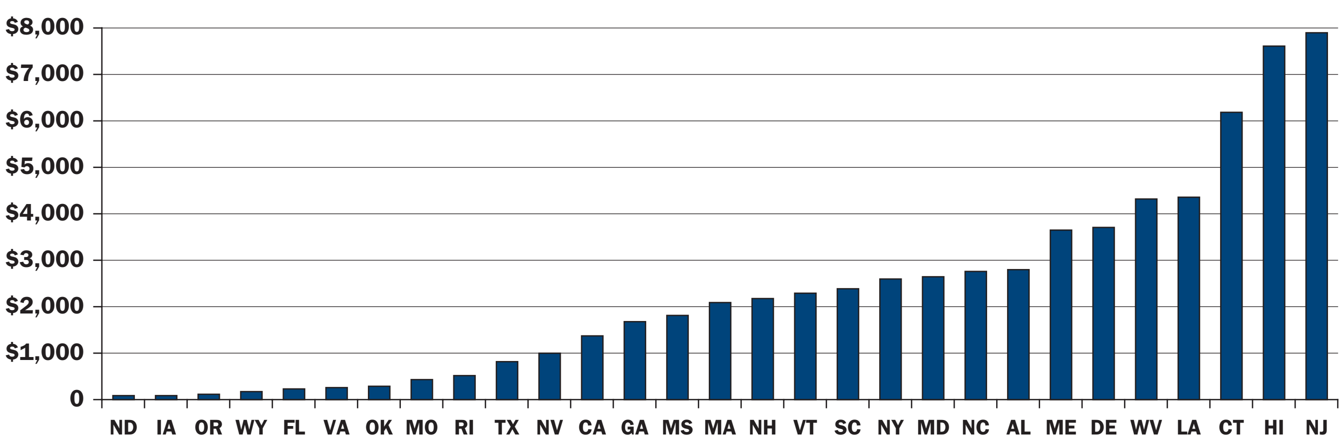
The Funding Gap

- This report, which includes liabilities associated with state promises of RHC for teachers, estimates total state unfunded liabilities at $558 billion.
- As annual costs rise, the ability to finance RHC may cause other priorities to go unmet.
- The overhang of billions of dollars jeopardizes bond ratings.
- To address the financial burden of RHC, SLGs can increase revenues, reduce benefits associated with these programs, or both. There are many options available and under active consideration.

Strategies and Choices

- Surveys indicate that SLG administrators are aware of OPEB liabilities, but that little has been achieved in adopting comprehensive strategies for dealing with them.
- SLGs have not yet been willing to make difficult and unpopular choices. Few have adopted advance funding of liabilities, and even fewer report a willingness to raise taxes or shift funds from other programmatic areas to pay down unfunded liabilities.

Retiree Health Plans: Who Owes What



Estimates of Per Capita Unfunded Liability for State Retiree Health plans.
Source: The Crisis in State and Local Retiree Health Benefit Plans: Myths and Realities

Chart A. *States and Localities Differ in How They Address Liabilities*

Strategy	States	Localities
Partially or Fully Fund Retiree Health Care	32%	16%
Cost Containment Strategies Implemented	64% (avg)	27% (avg)
Health Care Auditing	53% (avg)	18% (avg)
Recent Increases in Cost Sharing Charges	52% (avg)	27% (avg)
Currently Provide Wellness Programs	42% (avg)	16% (avg)

- Local governments have been much less active in addressing RHC liabilities than the states. See Chart A above.
- Most SLGs, however, have adopted various cost containment, cost shedding, and cost sharing policies, including retiree premium contributions, higher deductibles, and higher co-payments.
- Some have curtailed RHC benefits for future retirees.

Cost Cutting and Recruitment

- Other mechanisms under consideration are medical subaccounts, governmental trusts, voluntary employee benefit associations, and OPEB bonds. Selling assets to pay down unfunded liabilities may be considered in the future in some jurisdictions.
- Preventive medicine and wellness programs are catching on in the states, but most to date are limited in scope.
- SLGs report they are more willing to consider changes in age and/or years of service requirements for RHC.
- SLGs generally recognize the human capital implications of various RHC strategies, including those for recruitment and retention.

Decision-making

- Issues raised by GASB 45 touch many different actors and offices in SLG, each with different responsibilities and interests; decision-making authority is fragmented.
- Large unfunded liabilities must be addressed through long-term, intergenerational thinking, but elected officials tend to think in terms of election cycles and outcomes.
- Long-term strategies and choices present exceedingly complex legal, accounting, and tax issues, and choices can set in motion new forces that are unpredictable.
- The current fiscal crisis in SLGs promises to divert the attention of SLG officials from OPEB to more immediate concerns.
- Adding even greater uncertainty is the growing possibility of significant federal government action on national health care policy that could help ease RHC liabilities, make them even larger, or have no impact.
- In charting their courses for managing unfunded RHC liabilities, SLGs should consider a precautionary path along with the impacts of change on employees and retirees.

Introduction: Retiree Health Care In the Shadow of GASB 45

Public sector benefits are widely regarded as being more generous than those available from private sector employers. In a 2007 national survey, for example, almost 60 percent of respondents reported this belief (Center for State and Local Government Excellence, 2007). The same survey found that health care and retirement plans were among the most important job factors for respondents. The Pew Center on the States (PCS) recently reported on empirical studies showing not only that state government benefits are more generous than the private sector's, but also that the gap between the two may be widening (PCS, 2007). Not surprisingly, governments have successfully used their relatively lucrative benefits—in lieu of large salaries, bonuses, or stock grants—for competitive advantage in the market for human capital (Brady, 2007; Fleet, 2007).

Public employers have opted to enhance pensions and OPEB over large salary increases for a variety of reasons. Primary among these is the fact that benefit enhancements are less immediate and visible, hence less politically controversial, than salary increases.

Such emphasis has led to benefits constituting a higher proportion of total compensation (i.e., pay plus benefits) in the public sector than in the private sector (Zorn, 1994; Petersen, 2004). A major component of government's total compensation is retiree benefits, including pensions and retiree health care, which is the primary form of other (non-pension) post-employment benefits, or OPEB, offered by governments. OPEB represents "payments made directly to former employees or their beneficiaries, or to third parties on their behalf, as compensation for services rendered while they were still active employees" (Gauthier, 2005, 3).

Public employers have opted to enhance pensions and OPEB over large salary increases for a variety of reasons. Primary among these is the fact that benefit enhancements are less immediate and visible, hence less politically controversial, than salary increases (Kearney, 2003; Moore, 2001; Reilly, Schoener, & Bolin, 2007).

In contrast to pensions—which are now largely prefunded, though not necessarily *fully* funded—governments historically have funded OPEB on a pay-as-you-go (PAYGO) basis, that is, as an annual operating expense. As a result, little attention has been paid to the long-term cost implications of retiree health care commitments. For some time, this approach seemed reasonable: "A few decades ago, when the country was younger and governments were growing, paying a little extra each year to relatively few retirees for health care was no big deal" (Petersen, 2007, 70). In recent years, however, this picture has changed dramatically. Specifically, factors like the expected wave of baby boomer retirements, longer life expectancies, increased demands for earlier retirement, and rapid growth in medical care and prescription drug costs suggest that OPEB costs can be expected to increase substantially (PCS, 2007; Marlowe, 2007). Despite these concerns, governments' OPEB liabilities have generally gone unreported and unnoticed until fairly recently.

The Government Accounting Standards Board's (GASB) issuance of two new accounting and financial reporting standards, GASB 43 and 45 (see box), has effectively removed the cloak from OPEB liabilities. These standards, announced in 2004, require state and local governments to report annually on their OPEB liabilities. The goal of these requirements is to improve the transparency of government financial reporting, disclose governments' true total compensation costs, and better align government practices with the private sector (Mason, Doppelt, Laskey, & Litvack, 2005).

GASB Statements 43 and 45

The Governmental Accounting Standards Board (GASB) is an independent standards setter. Its accounting and financial reporting standards represent the highest source of generally accepted accounting practices (GAAP) for state and local governments.

GASB issued Statements 43, *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans* (April 2004), and 45, *Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions* (June 2004), in an attempt to establish more complete and accurate reporting on governments' OPEB costs and financial obligations. GASB 43 establishes uniform reporting standards for state and local governments' OPEB *plans*; GASB 45 focuses on all state and local government employers that provide retiree health care.

For more, see "Statements 43/45 Resource Center" (http://www.gasb.org/gasb43_45/index.html), located on GASB's web site (www.gasb.org).

Because they perceived retiree health care benefits as events happening far in the future and because they opted for PAYGO funding, many governments are only now discovering that their retiree health care plans are substantially underfunded. Indeed, early estimates of OPEB liabilities have produced some "huge and scary" numbers for government officials (Petersen, 2007). For example, the U.S. General Accountability Office (GAO, 2008) cites estimates of the combined present value of state and local government OPEB liabilities that range from as low as $600 billion to as much as $1.6 trillion. Accompanying these figures is a sense of urgency on the part of government officials to explore ways to reduce OPEB liabilities (Aon Consulting, 2005). Though there may be urgency, the states have yet to develop long-term strategies for dealing with escalating retiree health care costs (GAO, 2007). Meanwhile, of course, the cost of health insurance, particularly for medical care and prescription drugs, is escalating rapidly, with no apparent relief in sight. Public pressure on state and local elected officials to restrain expenses is escalating, fiscal crises are looming, and little or no immediate help from the national government is anticipated.

Because they perceived retiree health care benefits as events happening far in the future and because they opted for PAYGO funding, many governments are only now discovering that their retiree health care plans are substantially underfunded.

It is important to point out that these OPEB liabilities are not new, but rather newly reported. In other words, reporting under GASB 45 merely illuminates an existing situation (Brady, 2007). That said, GASB 45 is a significant change in governmental financing and accounting that can be expected to substantially influence financial decision making in the years to come (Keating & Berman, 2007). As this suggests, the future direction of retiree health care is a salient issue for governments. Key questions facing policy makers include how to control OPEB costs, what the appropriate level of benefits is, and who should pay the costs, i.e., current or future generations (GAO, 2007).

North Carolina State University Project on State and Local Government Retiree Health Care

Despite the recognized significance of OPEB and the potentially daunting challenges governments face in their provision, there is little in the way of systematic inquiry on the subject to date. The research reported here addresses this shortcoming by reporting baseline findings on the state of retiree health care in the American states. It should be noted that the focus of this study is limited to one aspect—the major aspect—of OPEB, retiree health care.

The Center for State and Local Government Excellence partnered with faculty from the School of Public and International Affairs and the College of Management at North Carolina State University to explore and report on the state and local retiree health care situation. This final report represents the culmination of phase one of the project, focusing on the 50 states and a representative sample of local governments across the country.

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Chapter 1: Description of State Retiree Health Plans

Virtually all states provide some type of retiree health benefit to their employees. However, these plans differ substantially in their generosity and coverage and hence their cost to each state. This report examines each state's retiree health plan and organizes the plans by their key characteristics. These characteristics include age and service requirements for coverage and the cost to the retiree and the state per retiree. We begin by providing an overview of the primary characteristics of the plans and then present a brief summary of each state's plan.

Characteristics of State Retiree Health Benefit Plans

Eligibility for participation in state retiree health plans generally is a function of a determined number of years of service with the state government. There may be other qualifications, such as receiving a state retirement pension benefit or reaching a specific age. Some states allow all retired state employees to participate in their health insurance systems, while other states require a minimum number of years of service (e.g., 20 years of service). Still other states allow for a type of graded vesting so that retirees with more years of service receive a larger subsidy than those with fewer years of service. A few states cease coverage when the retiree reaches age 65 and becomes eligible for Medicare. Table 1.1 (p. 10) provides information on the eligibility requirements of each state. In general, states can and do change these eligibility requirements in an effort to moderate increases in the cost of providing retiree health benefits.

The per retiree cost of state health plans differs depending on the retiree's age; specifically, whether the retiree has reached the age of 65. Most states require those retirees eligible for Medicare (aged 65 and older) to enroll in Medicare. This makes Medicare the primary payer of health care bills and the state insurance plan the secondary payer. Thus, the cost to the state of providing health insurance is much lower for older retirees due to this coordination with Medicare. A few states terminate retiree participation in their state health plan when a retiree reaches age 65, ending all subsidies to the retiree.

The premiums retirees must pay to participate in the retiree health plan offered by their state vary substantially. Some states provide the same health insurance for retirees as they do for active workers and charge them the same premiums. In some states, there is no premium for either active workers or retirees. In contrast, other states require retirees to pay the full cost of their health insurance. However, even this type of coverage is a benefit to retirees and involves a cost to the state. The cost of health insurance typically rises with age. Thus, a retiree paying the average cost per beneficiary in a state plan that includes active workers and retirees pays a lower rate than if the plan covered only retirees. This is an implicit subsidy from the state to its retirees and GASB 45 requires that states determine and report the cost of this subsidy. The U.S. Government Accountability Office (2008) reports that 14 states did not contribute to the premium for retired workers so the retiree paid the entire cost of the premium. In contrast, 14 states paid the entire premium so that retirees in these states were included in the state health plan without having to pay any premium. The remainder fell somewhere in between with the state and retirees each paying a part of the premium for health coverage. The premiums required by each state for participation, as currently listed on the state websites, are shown in Table 1.2 (p. 18). Table 1.2 also shows that in most states, the premium charged to the retiree is reduced when he or she becomes eligible for Medicare.

Summary of State Retiree Health Benefit Plans

This section presents a short summary of each state's retiree health benefit plans. These summaries are based on the information provided on the website of each state's plan as of March 2008. Listed at the end of each summary is a URL so the interested reader can easily access additional details.

Alabama

Alabama allows retirees to maintain their enrollment in the state employee health insurance plan (SEHIP); a PPO plan is provided if they have accumulated at least 10 years of creditable service and receive a monthly benefit from the Employees' Retirement System, the Teachers' Retirement System of Alabama, or the Judicial Retirement System. Additionally, the plan grants all dependents who were eligible for coverage when the employee was an active worker access to coverage through the retiree health insurance plan. Upon turning 65 years of age, all retirees are required to enroll in Medicare Parts A and B, at which point Medicare

Table 1.1. *Eligibility Requirements for State Retiree Health Benefit Plans*

State	Eligibility Requirements
Alabama	Retirees must have at least 10 years of creditable service and receive a retirement benefit from a state-sponsored retirement system. Retirees who are ineligible for Medicare may enroll in a PPO plan. The state pays 100% of the premium for retirees with 25+ years of creditable service. This contribution is reduced by 2% for each year of creditable service below 25 years; for example, a retiree with 20 years of service receives a 90% contribution.
Alaska	Retirees are eligible for retiree health insurance free of cost if they receive a benefit from the Public Employees Retirement System (PERS), Teachers Retirement System (TRS), Elected Public Officials Retirement System, Judicial Retirement System, or Marine Engineers Beneficial Association. Members of the PERS and the TRS who retire before age 60 and public employees who are over age 60 but have fewer than 10 years of service are eligible for coverage but must pay a premium. Retirees who are not eligible for Medicare may enroll in a PPO plan. • PERS benefit recipients who were hired after July 1, 1986, who are under age 60. • TRS benefit recipients who were hired after July 1, 1990, who are under age 60. • PERS benefit recipients who were hired after July 1, 1996, who are at least 60 years of age, but who do not have 10 years of creditable service.
Arizona	Retirees are eligible to receive retiree health insurance benefits if they are a member of the Arizona State Retirement System or any other state-sponsored retirement system. Retirees who are not eligible for Medicare may enroll in an HMO, a PPO, or an Indemnity Plan. For members of the Arizona State Retirement System who do not have Medicare, the state contributes \$75.00 to those with five years of creditable service and an additional \$15 per creditable service year, up to 5 additional years. The highest possible contribution is \$150.00. For retirees with Medicare, the state's contribution is \$50.00 for those with five years of service and an additional \$10 per year up to a maximum of \$100.00. For members of the Elected Officials' Retirement Plan who are not Medicare eligible, the state contributes \$90.00 for those with five or more years of service, an additional \$22.50 per year for the next two years of service, and \$15 for the eighth year of service. The maximum possible contribution is \$150.00. For those who are Medicare eligible, the contribution is \$60.00 for the first five years with an additional \$15.00 per extra year, up to a maximum of \$100.00. Members of the Corrections Officer Retirement System and the Public Safety Personnel Retirement System who are not eligible for Medicare receive a contribution of \$150.00, while those who have Medicare receive a contribution of \$100.00.
Arkansas	All former state and public school employees are eligible for retiree health insurance. For retired teachers who are not eligible for Medicare, the state contributes \$157.50; those eligible for Medicare receive \$111.64. For a retired state employee who is not eligible for Medicare, the state contributes \$419.17; those who are eligible for Medicare receive \$212.04.
California	Retirees are eligible for retiree health insurance provided their retirement date is within 120 days of separation from a state employer; they were eligible to enroll in a state run plan as an active employee; and they are eligible to receive a retirement allowance from a state-sponsored retirement system. Retirees who are not eligible for Medicare may choose among PPO, HMO, and EPO plans. The state's contribution to the premium varies by date of hire: • For those hired before January 1, 1985, the state pays 100%. • For those hired between January 1, 1985, and January 1, 1989, the state's contribution is 10% per year of creditable service.For those hired after January 1, 1989, the state pays 50% of the premium

Table 1.1. *Eligibility Requirements for State Retiree Health Benefit Plans (continued)*

State	Eligibility Requirements
California *(continued)*	for retirees with at least 10 years of creditable service; for those with 10–19 years of creditable service the state pays an additional 5% per service year; and pays 100% of the premium for those with 20+ years of service.
Colorado	Any retiree receiving benefits from the Public Employee Retirement Association is eligible for retiree health insurance. Retirees who are not eligible for Medicare may choose among three HMO's and one supplemental plan.
Connecticut	Retirees may choose among HMO, POE, and POS plans.
Delaware	Retirees must be eligible to collect a pension from a state-sponsored retirement system. Retirees who are not eligible for Medicare may choose between a PPO and an HMO. The state determines a base amount of the premium that it will pay, referred to as the "state share." • A retiree who worked for the state for less than 10 years must pay the entire premium. • A retiree who worked for the state 10–15 years is entitled to 50% of the state share. • A retiree with 15–20 years of service receives 75% of the state share. • Retirees with 20 or more years of service receive 100% of the state share.
Florida	Retirees must have retired under a State of Florida retirement system or a state optional annuity or retirement system; have been covered by a state-run health insurance plan at the time of retirement; receive retirement benefits immediately at the time of retirement; and have enrolled in the plan at the time they retire. Retirees who are not eligible for Medicare may enroll in an HMO or PPO plan. The state does not make a contribution to the premium.
Georgia	Retirees must have retired under a State of Florida retirement system or a state optional annuity or retirement system; have Retirees are eligible for coverage if they are entitled to receive an immediate annuity for a state-sponsored retirement system and were enrolled in the plan at the time of retirement. Retirees who are not eligible for Medicare may choose among HDHP, HMO, PPO, and CCO plans. On average, the state pays 75% of the premium for individual coverage.
Hawaii	Retirees who are not eligible for Medicare may choose between an HMO and a PPO. The state's contribution to the health insurance premium depends on the years of creditable service accumulated by the retiree and date of hire. • For retirees hired prior to July 1, 1996: with less than 10 years of service, the state contributes 50% of the premium; for those with 10 or more years of creditable service, the state makes a 100% contribution. • For retirees hired after July 1, 1996: with 10–15 years of service the state pays 50%; with 15–25 years the state contributes 75%; and for those with at least 25 years the state pays 100% of the premium. The state contribution applies only to individual coverage.
Idaho	Retirees must receive a retirement benefit from a state sponsored retirement system, the amount of which exceeds the premium for individual coverage, or receive a retirement benefit and have at least 10 years of creditable service. Retirees who are not eligible for Medicare may choose to enroll in a PPO plan.
Illinois	Retirees who are not eligible for Medicare may enroll in an HMO, OAP, or Quality Health Care Plan. Retirees receive a service credit based on the number of years they worked for the state. A retiree receives a 5% state contribution for each year of creditable service; a retiree with 20 or more years of service receives a state contribution equal 100% of the plan premium.

Table 1.1. *Eligibility Requirements for State Retiree Health Benefit Plans (continued)*

State	Eligibility Requirements
Indiana	Retirees who are not eligible for Medicare may enroll in an HMO or a Traditional Plan.
Iowa	Retirees must be receiving retirement benefits. Retirees who are not eligible for Medicare may enroll in an Indemnity, PPO, or MCO plan. Retirees who are not eligible for Medicare may be eligible for participation in the Sick Leave Insurance Program (SLIP), which allows retirees to convert their unused sick time into an account that the state will draw down to apply to the retiree's health insurance premium. The state makes a 100% premium contribution only if the retiree has a positive balance in his/her sick leave account.
Kansas	Retirees are eligible for retiree health insurance benefits provided they are a former state official, retired officer, or retired employee receiving retirement benefits from the state. Retirees who are not eligible for Medicare may enroll in Plan A, which combines the features of an HMO and PPO plan, or Plan B, a traditional plan.
Kentucky	Retirees may enroll in the plan provided they are not eligible for Medicare and receive a monthly retirement check from a state-sponsored retirement system. Retirees who are not eligible for Medicare may choose between the Commonwealth Enhanced and Commonwealth Premier plans, which are both PPOs. The state's premium contribution varies by the region in which a retiree lives and works. The contribution ranges from $394.80 to $496.28 for the Commonwealth Enhanced Plan and from $412.47 to $512.16 for the Commonwealth Premier Plan.
Louisiana	Retirees who are not eligible for Medicare may enroll in an EPO, PPO, or HMO plan. The state's contribution toward the premium for retiree coverage is based on years of Office of Group Benefits (OGB) enrollment. A retiree with 10 or fewer years will receive a 19% contribution; a retiree with 10–15 years of participation will receive a contribution equal to 38% of the premium; a retiree with 15–20 years will receive a 56% contribution; while a retiree with 20 or more years will receive a contribution of 75%.
Maine	Retirees must have participated in the state's health insurance program for at least one year immediately prior to retiring and be receiving a retirement check from the Maine State Retirement System. Retirees who are not eligible for Medicare may enroll in an EPO, PPO, or HMO plan. The state's share of the premium is based on the number of years the retiree participated in the group health insurance plan as an active employee. Those with less than five years of enrollment do not receive a contribution; those with at least five years of creditable service receive a 50% contribution; beyond that the state's contribution increases 10% for each additional year of participation. The state pays 100% of the premium for retirees hired before July 1, 1991.
Maryland	Retirees must receive a retirement allowance from the state and meet one of the following criteria: • have at least 16 years of creditable service; • have retired directly from the state with at least five years of creditable service; • have left state employment with at least 10 years of creditable service within five years of normal retirement age; • retired directly from state service with a disability retirement allowance; • or left state employment prior to July 1, 1984. Retirees who are not eligible for Medicare may enroll in a PPO, a POS, or an HMO plan. • Retirees who have 16 or more years of creditable service, received a disability retirement, or left state employment prior to July 1, 1984, receive a full subsidy from the state.

Table 1.1. *Eligibility Requirements for State Retiree Health Benefit Plans (continued)*

State	Eligibility Requirements
Massachusetts	Retirees who are not eligible for Medicare may enroll in a PPO or an HMO plan.
Michigan	Retirees may receive retiree health insurance benefits if they retired under the Defined Contribution plan, receive an immediate benefit under the State Employees Retirement Act or the State Police Retirement Act, or were enrolled in the state-sponsored HMO and receive an immediate pension benefit. Retirees who are not eligible for Medicare may enroll in a PPO or an HMO plan. The state's premium contribution is $607.45 for retirees who are not Medicare eligible and up to $334.83 for retirees who are Medicare eligible.
Minnesota	Retirees must have at least five years of allowable pension service or be 50 years of age with at least 15 years of creditable service. Retirees who are not eligible for Medicare may enroll in a PPO plan. The state does not make a contribution to the premium.
Mississippi	Retirees must participate in the state's retirement system or have participated in the state's health insurance plan for at least four years. Retirees must • have at least 25 years of creditable service; • be age 60 with four or more years of creditable service; • be age 45 with 20 or more years of creditable service (if retiring from the Mississippi Highway Safety Patrol); • be approved for disability; • or be an elected state or district official who does not run for reelection or who is defeated. The state does not make a contribution to the premium.
Missouri	Retirees must be eligible to receive a retirement benefit from an employer-sponsored retirement plan, or meet the retirement qualifications of the public entity. Additionally, retirees must meet one of three criteria: had coverage through a state-sponsored health plan since the last Open Enrollment period; had health insurance for the six months immediately prior to termination of employment; or had coverage since first eligible. Retirees who are not eligible for Medicare may enroll in a managed care or indemnity plan.
Montana	Retirees must be eligible to receive a monthly retirement benefit check from their retirement system. Retirees who are not eligible for Medicare may enroll in an HMO or Copay plan.
Nebraska	Retirees are eligible for coverage provided they pay into a state-sponsored retirement system. Retirees who are not eligible for Medicare may enroll in an HMO or a PPO plan. For retirees age 60–65, the state makes a premium contribution of: • 50% for those with 10–15 years of service • 70% for those with 16–27 years of service • 90% for those with 28–34 years • 100% for those with 35+ years For retirees age 65+, the state contributes: • 50% for retirees with 10–15 years of service • 70% for those with 16–19 years • 90% for those with 20–27 years of service • 100% for those with at least 28 years The state makes a 100% contribution for anyone (regardless of age) with at least 35 years of service.

Table 1.1. *Eligibility Requirements for State Retiree Health Benefit Plans (continued)*

State	Eligibility Requirements
Nevada	Retirees must receive benefits from a state-sponsored retirement system and enroll within 60 days of their retirement date. Retirees who are not eligible for Medicare may enroll in a PPO or HMO plan. For retirees who retired prior to January 1, 1994, the base subsidy is $365.64. For retirees with 15 years of creditable service who retired after January 1, 1994: the subsidy for individual coverage for non-Medicare eligible retirees is: • $339.74 for High Deductible PPO • $360.14 for Low Deductible PPO • $324.96 for Anthem HMO • $212.18 for Health Plan of Nevada. The subsidy for individual coverage for Medicare eligible retirees is: • $339.74 for High Deductible PPO • $360.14 for Low Deductible PPO • $324.96 for Anthem HMO • $212.18 for Health Plan of Nevada • $53.65 for Senior Dimensions (for retirees with Medicare Parts A and B). Retirees who retired after January 1, 1994, who have: • 5 years of service — subtract $274.23 • 6 years — subtract $246.81 • 7 years — subtract $219.38 • 8 years — subtract $191.96 • 9 years — subtract $164.54 • 10 years — subtract $137.12 • 11 years — subtract $109.69 • 12 years — subtract $82.27 • 13 years — subtract $54.85 • 14 years — subtract $27.42 • 15 years — do not subtract from the subsidy. Retirees with: • 16 years of service — add $27.42 to the state contribution • 17 years — add $54.85 • 18 years — add $82.27 • 19 years — add $109.69 • 20 years — add $137.12.
New Hampshire	Retirees must be eligible to receive a monthly retirement benefit check from their retirement system. Retirees who are not eligible for Medicare may enroll in a POS plan.
New Jersey	Retirees must have been full-time employees at the time of retirement and have at least 25 years of creditable service. Non-Medicare eligible retirees who belong to unions that have agreements with the state of NJ to cost share receive a subsidy of $463.16. Retirees who are not eligible for Medicare may enroll in a PPO or HMO plan.

Table 1.1. *Eligibility Requirements for State Retiree Health Benefit Plans (continued)*

State	Eligibility Requirements
New Jersey *(continued)*	Medicare eligible retirees who belong to unions that have agreements with the state of NJ to cost share receive a subsidy of $287.89.
New Mexico	Retirees are eligible for coverage provided they receive a retirement benefit from a state-sponsored retirement system, and meet any of the following: • retired with a pension before the employer's effective date with the New Mexico Health Care Authority (NMHCA); • made a contribution to the NMHCA from the employer's effective date until retirement; • made a contribution for at least five years prior to retirement. Retirees who are not eligible for Medicare may enroll in a PPO plan. The state makes a contribution of 6.25% for the first five years of service and 6.25% for each additional year.
New York	Retirees must have the minimum years of creditable service (five for those hired before April 1, 1975, and 10 for those hired after); be qualified for retirement as a member of a state-sponsored retirement system; and have been enrolled as an active employee or dependent in a state-run health insurance plan at the time of retirement. Retirees who are not eligible for Medicare may enroll in an HMO or the Empire Plan. The state typically makes a premium contribution of 90%.
North Carolina	Retirees must have contributed to the state sponsored retirement system for at least five years. Retirees who are not eligible for Medicare may enroll in a PPO or indemnity plan. For retirees enrolled in the PPO plan the state's contribution is $346.38.
North Dakota	Retirees must receive a benefit from a state-sponsored retirement system and enroll within 31 days of retirement. Retirees who are not eligible for Medicare may enroll in a PPO or an EPO plan. The state provides a service credit of $4.50 for each year of creditable service.
Ohio	Retirees must participate in a state-sponsored retirement system. Retirees who are not eligible for Medicare may enroll in an HMO or PPO plan. Retirees with at least 10 years of service accumulated prior to or on January 1, 2007 receive a 100% premium subsidy. Retirees hired prior to January 1, 2003, who have at least 10 years of service accumulated after January 1, 2007: • with 1–15 years of service receive a 50% premium subsidy; • with 15–30 years receive a prorated subsidy; • with 30 years of service receive 100%. Retirees hired after January 1, 2003, who have at least 10 years of service accumulated after January 1, 2007: • with 10–15 years of service receive a 25% premium subsidy; • with 15–30 years of service receive a subsidy of between 25% and 100% of the premium.
Oklahoma	Retirees must have at least eight years of creditable service. Retirees who are not eligible for Medicare may enroll in an HMO, PPO, or indemnity plan. The state contribution is $105.00.

Table 1.1. *Eligibility Requirements for State Retiree Health Benefit Plans (continued)*

State	Eligibility Requirements
Oregon	Retirees must belong to and receive a benefit from the Public Employees Retirement System. Retirees who are not eligible for Medicare may enroll in an HMO, PPO, or POS plan and receive a contribution from the state based on their years of service: • 8–9 years of service — $126.27 • 10–14 years — $151.52 • 15–19 years — $176.78 • 20–24 years — $202.03 • 25–39 years — $227.28 • 30 years or more — $252.54 Retirees who are eligible for Medicare receive a $60 subsidy.
Pennsylvania	Retirees are eligible for retiree health insurance benefits if they retire at normal retirement age (50 or 60 depending on class of employment) with 15 or more years of credited service, retire with 25 or more years of service regardless of age, or retire with a disability retirement benefit. Retirees who are not eligible for Medicare who retired before July 1, 2004, may enroll in an HMO or a PPO plan. Retirees who are not eligible for Medicare who retired after July 1, 2004, may enroll in an HMO, PPO, or consumer driven plan. Retirees who are eligible for Medicare may enroll in an HMO or PPO Medicare Advantage plan or a Medicare Private Fee Service plan. The state offers a subsidy to state employees based on their years of creditable service. If a retiree retired • before July 1, 2005, the state subsidy is 100% of the premium. • after July 1, 2005, but before July 1, 2007, the State Employee Retirement System will deduct the member share of 1% of the member's final base annual salary in equal monthly payments from the member's annuity payments. • after July 1, 2007, but before June 30, 2008, the State Employee Retirement System will deduct the member share of 1% of the member's final gross base annual salary in equal monthly payments from the member's annuity payments. • after July 1, 2008, but before June 30, 2009, the State Employee Retirement System will deduct the member share of 1.5% of the member's final gross base annual salary in equal monthly payments from the member's annuity payments. • after July 1, 2009, but before September 30, 2010, the State Employee Retirement System will deduct the member share of 2% of the member's final gross base annual salary in equal monthly payments from the member's annuity payments. • after October 1, 2010, but before June 30, 2011, the State Employee Retirement System will deduct the member share of 2% of the member's final base annual salary in equal monthly payments from the member's annuity payments.
Rhode Island	Retirees must belong to the Employees' Retirement System of Rhode Island (ERSRI). Retirees may enroll in a PPO plan. The state offers a subsidy to state employees based on their years of creditable service and their current age. If a retiree is between 60 and 65 years of age and has worked • 10–15 years — the state subsidy is 50% of the premium. • 16–22 years — the subsidy is 70%. • 23–27 years — the subsidy is 80%. • more than 28 years of service — the subsidy is 100%.

Table 1.1. *Eligibility Requirements for State Retiree Health Benefit Plans (continued)*

State	Eligibility Requirements
Rhode Island *(continued)*	If a retiree is at least 65 years of age and has worked • 10–15 years — the state subsidy is 50%. • 16–19 years — the subsidy is 70%. • 20–27 years — the subsidy is 90%. • at least 28 years — the subsidy is 100%. Additionally, a retiree with at least 28 years of service receives a 90% state subsidy regardless of age. Similarly, a retiree with at least 35 years of service receives a 100% state subsidy regardless of age.
South Carolina	Retirees must have participated in the state's health insurance program as an active employee and have at least five years of continuous and consecutive full-time employment. Retirees who are not eligible for Medicare may enroll in an HMO or POS plan. Retirees receive a contribution of $260.90.
South Dakota	Retirees who are not eligible for Medicare may enroll in a self-insured indemnity plan. Retirees who are eligible for Medicare may no longer be enrolled in the plan, but may enroll in the state-sponsored Medicare Supplement Plan.
Tennessee	Retirees must have at least 10 years of creditable service with at least three years of insurance coverage immediately preceding retirement, or 20+ years of creditable service with one year of insurance coverage immediately preceding retirement. Retirees who are not eligible for Medicare may enroll in an HMO, PPO, or POS plan.
Texas	Retirees must have at least 10 years of service and be at least 65 years of age, or they must have at least 10 years of service and their age and service must add up to 80. Retirees who are not eligible for Medicare may enroll in an HMO plan. For those working full-time at retirement the state pays the entire premium. For those working part-time the state's contribution to the premium is $180.28.
Utah	Retirees who are not eligible for Medicare may enroll in an HDHP plan.
Vermont	Retirees must have been enrolled in a state sponsored health insurance plan at the time of retirement and enroll for retiree health benefits at the time they retire. Retirees who are not eligible for Medicare may enroll in an HMO, POS, or Safety Net plan. The state contribution is 80% of the premium for individual coverage.
Virginia	Retirees must be eligible for and currently receiving a monthly annuity from the Virginia Retirement System or a benefit from an Optional Retirement Plan; have worked for the state immediately prior to retirement; be eligible to enroll in a state-sponsored health insurance program as an active employee; and enroll for retiree health benefits within 31 days of retirement. Retirees who are not eligible for Medicare may enroll in an HMO or HDHP plan. Retirees who have 15 years of creditable service, retire on disability, or receive a long-term disability benefit receive a credit of $4.00 per creditable service year.
Washington	Retirees must receive an immediate retirement allowance from a state-run retirement system and enroll in the retiree health insurance plan within 60 days of retirement. Retirees who are not eligible for Medicare may enroll in a managed care plan or a PPO plan. Medicare retirees receive a state contribution of $164.08.
West Virginia	Retiree must be eligible for service retirement and have been employed by the state immediately prior to retirement. Retirees who are not eligible for Medicare may enroll in an HMO.

Table 1.1. *Eligibility Requirements for State Retiree Health Benefit Plans (continued)*

State	Eligibility Requirements
Wisconsin	Retirees must receive an immediate retirement annuity from the state's retirement system or have at least 20 years of creditable service. Retirees who are not eligible for Medicare may enroll in a fee-for-service plan. The state does not make a contribution to the premium.
Wyoming	Retirees must have received state-sponsored health insurance for at least one year prior to retirement and apply for coverage within 31 days of their retirement date. Retirees who are not eligible for Medicare may enroll in a PPO plan. The premium contribution is $487.31.

Table 1.2. *Premiums, Dependent Coverage, and Medicare Enrollment*

State	Premium		Dependent Coverage	Must Enroll in Medicare
	Non-Medicare	Medicare		
Alabama	$167.00	$0.00	Yes	Yes
Alaska	$590.00	N/A	Yes	Yes
Arizona	$454.00 for HMO $420.00 for PPO[2]	$342.00 for senior supplement $210.00 for Medicare Complete[3]	Yes	Yes
Arkansas	$587.70 for teachers $589.13 for public	$136.74 for teachers $298.02 for public	Yes	Yes
California	$351.75–$742.41	$273.36–$404.60	Yes	Yes
Colorado	$299.00–$654.00	$140.00–$298.00	Yes	Part B only
Connecticut	N/A	N/A	Yes	N/A
Delaware	$437.14–$485.74	$158.56–$332.10	Yes	Yes
Florida	$351.20–$427.86	$172.76–$247.28	Yes	Yes
Georgia	$49.50–$290.40 $176.38–$388.52 for retirees over age 65, without Medicare Parts A and B	$107.96–$211.02	Yes	No
Hawaii	$391.02–$460.80	$215.76–$289.08	Yes	Yes
Idaho	$393.00–$480.00	$190.00–$269.00	Yes	No
Illinois	$505.92–$789.84	$308.50–$394.62	Yes	Yes
Indiana	N/A	N/A	Yes	N/A
Iowa	$386.36–$632.25	$210.40–$446.62	Yes	Yes
Kansas	$406.33–$459.53	$79.50–$452.04	Yes	Yes
Kentucky	$469.00–$501.20	N/A	Yes	Yes
Louisiana	$934.08–$1011.88	$138 to $329	Yes	Yes
Maine	$620.44	$306.56	Yes	Yes
Maryland	$306.30–$413.42	$156.59–$206.74	Yes	Yes
Massachusetts	Retired before July 1,1994: $308.30–$904.10 Retired after July 1, 1994: $324.40–$828.87	$151.87–$403.30	Yes	Yes
Michigan	$638.59–$857.92	$243.87–$417.08	Yes	Yes

Table 1.2. *Premiums, Dependent Coverage, and Medicare Enrollment (continued)*

	Premium			
State	**Non-Medicare**	**Medicare**	**Dependent Coverage**	**Must Enroll in Medicare**
Minnesota	$432.16	$237.50–$248.44	Yes	Parts A, B, and D
Mississippi	$388.00–$409.00	$160.00	Yes	Yes
Missouri	$1668.00–$1692.00	$1282.00–$1306.00	Yes	Yes
Montana	$444.00–$557.00	$160.00–$194.00	Yes	N/A
Nebraska	$374.46–$503.30	N/A	Through COBRA Only	Yes
Nevada	$316.68–$537.52	$80.07–$537.52	Yes	Yes
New Hampshire	N/A	N/A	Yes	Yes
New Jersey	$508.00–$617.54	$352.93–$385.02	Yes	Yes
New Mexico	Varies by years of service and plan—rates differ by each year between 5 and 20	N/A	Yes	Yes
New York	N/A	N/A	Yes	Yes
North Carolina	N/A	N/A	Yes	Yes
North Dakota	COBRA eligible: $324.58–$361.77 Non-COBRA eligible: $475.34	Retire prior to 7/1/07: $210.46 Retire after 7/1/07: $217.14	Yes	Yes
Ohio	N/A	N/A	Yes	Yes
Oklahoma	$302.44–$606.56	N/A	Yes	Yes
Oregon	$590.50–$829.11	$140.39–$203.39	Yes	Yes
Pennsylvania	N/A	N/A	Yes	Yes
Rhode Island	$452.28	$107.00 or $179.77	Yes	Yes
South Carolina	Funded: $9.28–$194.82 Non-Funded: $270.18–$455.72	Funded: $75.46–$194.82 Non-Funded: $336.36–$455.72	Yes	Yes
South Dakota	$220.78–$314.18	$95.75–$200.08	Yes	Yes
Tennessee	Less than 20 years of service: $191.21–$203.06 20–29 years of service: $143.94–$152.29 More than 30 years of service: $95.61–$101.53	N/A	Yes	Yes
Texas	$284.53–$388.97	N/A	Yes	Yes
Utah	N/A	N/A	Yes	Yes
Vermont	$360.78–$615.29	$241.52–$355.61	Yes	Yes
Virginia	$350.00–$469.00	$126.00–$277.00	Yes	Yes
Washington	$400.19–$484.32	$241.64–$396.70	Yes	Yes
West Virginia	$208.00–$744.00	$46.00–$339.00	Yes	Yes
Wisconsin	$476.20–$895.70	$301.10–$448.90	Yes	Yes
Wyoming	$528.32–$610.78	$151.43–$384.13	Yes	Yes

1 Unless otherwise specified, includes Medicare Parts A and B.

2 With the exception of residents in Maricopa, Pima, and Pinal counties, whose PPO premium is $600.00.

3 Not available in Mohave, Gila, Navajo, and Apache counties. In Maricopa, Pima, and Pinal counties, the premium is $145.00.

becomes the primary insurance provider, and the SEHIP provides complementary coverage only. If a retiree fails to enroll in Medicare Parts A and B, the SEHIP will calculate his/her benefit entitlement as if s/he had enrolled.

The premium paid by the retiree depends on his/her Medicare status and the Medicare status of dependents. A retiree who is not Medicare eligible faces a premium of $167, while a Medicare eligible retiree does not pay the state a premium for his/her own coverage. For retirees who are not eligible for Medicare, the state pays a portion of their premium, the amount of which is calculated using a sliding scale. For a retiree with at least 25 years of service, the state will pay 100% of the premium. For each year less than 25, the state's contribution is reduced by 2%.

http://www.alseib.org/healthinsurance/sehip/pdf/sehip_2008_rates.pdf

http://www.alseib.org/healthinsurance/sehip/pdf/state_booklet_2008.pdf

Alaska

Alaska permits retirees to obtain health insurance through AlaskaCare, a state sponsored PPO plan for retirees. The AlaskaCare plan grants all dependents who were eligible for coverage when the employee was an active worker access to coverage through the retiree health insurance plan. Members of the Public Employees' Retirement System, the Teachers' Retirement System, the Elected Public Officers Retirement System, the Judicial Retirement System, as well as recipients of the Marine Engineers Beneficial Association, who retired after July 1, 1986, are automatically enrolled in the plan and do not pay a premium. Members of the Public Employee Retirement system and the Teachers' Retirement System who retire before the age of 60 are eligible for enrollment in the plan but must pay a premium to obtain coverage. Additionally, a public employee who is over 60 years of age but has less than 10 years of credited service must pay a premium to obtain coverage.

Upon turning 65 years of age, all retirees are required to elect Medicare Parts A and B, at which point the health insurance plan available from the state becomes supplemental. If a retiree does not elect into Medicare, the amount of Medicare benefits available to him/her will be subtracted from all medical claims. For those who choose to retire before turning 60, the premium for individual coverage is $590.

http://www.state.ak.us/drb/ghlb/retiree/2003-retiree-handbook.pdf

Arizona

Arizona offers its retirees health insurance coverage through Pacificare. Additionally, the plan grants all dependents who were eligible for coverage when the employee was an active worker access to coverage through the retiree health insurance plan. Retirees who are not yet Medicare eligible may choose from among an HMO, a PPO, and an Indemnity plan.

Upon turning 65 years of age, all retirees are required to enroll in Medicare Parts A and B, at which point Medicare becomes the primary insurance provider, and the state-offered health insurance plan provides complementary coverage only. Medicare eligible retirees may choose between two state-sponsored plans, which provide coverage that is designed to complement Medicare benefits. Medicare eligible retirees who do not notify the Arizona Retirement System of their Medicare eligibility remain enrolled in their current health insurance plan, but receive a reduced premium benefit.

The premium for a non-Medicare eligible individual is $454.00 for the HMO or $420.00 for the PPO. The premium for a Medicare eligible individual is $342.00 for the Senior Supplement plan or $210.00 the Medicare Complete plan.

- The state makes a premium contribution for all retirees, the amount of which depends on their Medicare status, the retirement system/plan they belong to, and their years of creditable service.
- Members of the Arizona State Retirement System (AZASRS) who are not Medicare eligible and have accumulated at least five years of service credit receive a subsidy of $75.00, plus $15.00 for each additional year, up to a maximum of $150.00. Members of the AZASRS who are eligible for Medicare and have five years of service credit receive a subsidy of $50.00, plus $10 for each additional year up to a maximum of $100.00.
- Members of the Elected Officials' Retirement Plan, who are not Medicare eligible, receive a contribution of $90.00 after five years of service, an additional $22.50 per year for the next two years of service, and $15.00 for the eighth year of service. The maximum possible contribution is $150.00. For members of the Elected Officials' Retirement Plan who are eligible for Medicare the state contributes $60.00 after five years and then contributes $15.00 for each additional year, up to a maximum of $100.00.

- Retirees who belong to the Corrections Officer Retirement System and the Public Safety Personnel Retirement System who are not eligible for Medicare receive a $150 contribution from the state, while those who are Medicare eligible receive a contribution of $100.00.

http://www.azasrs.gov/web/pdf/forms/2007_Enrollment_Guide.pdf

http://www.azasrs.gov/web/pdf/2008_OE_Brochure.pdf

Arkansas

Arkansas provides health insurance to all state and public school retirees, regardless of their Medicare eligibility status, through ARHealth. The plan provides basic dental cleanings, vision screening, and, for retirees who are not Medicare eligible, prescription drug benefits. All those who qualified as an eligible dependent when an employee was considered an active employee, remain an eligible dependent when the employee's status changes from active to retired. Upon turning 65 years of age, all retirees are required to enroll in Medicare Parts A and B, at which point Medicare becomes the primary insurance provider and the state-offered health insurance plan provides complementary coverage only. If an eligible retiree fails to enroll in Medicare Part B, his/her benefits will be calculated as if s/he had enrolled.

The premium paid by retirees depends on their Medicare status, the Medicare status of their dependents, and whether they worked for the state or for a public school. A retiree of the public school system who is not Medicare eligible pays an individual premium of $587.70; the premium for a Medicare eligible retiree is $136.74. For a retiree of the state, the premium for a non-Medicare eligible individual is $589.13, while the premium for a Medicare eligible individual is $298.02.

The state has different premium and contribution rates for those who worked for the public schools and for those who worked for other state agencies. For a retired public school employee with no dependents, who is not Medicare eligible, the state's contribution is $157.50. For an identical individual who is Medicare eligible, the contribution is $111.64. For a retired state employee with no dependents who is not Medicare eligible, the state's contribution is $419.17. For an identical individual who is Medicare eligible, the contribution is $212.04.

http://www.arbenefits.org/ebd_pages/forms/egRetiree2007.pdf

California

California offers retiree health insurance benefits to all retirees provided their retirement date is within 120 days of separation from their state employer, they were eligible for enrollment as an active employee, and they will receive a monthly retirement allowance. Retirees under the age of 65 may choose from the same health insurance plans as active employees. All those who qualified as an eligible dependent when an employee was considered active remain an eligible dependent when the employee's status changes from active to retired.

Upon turning 65 years of age, all retirees are required to enroll in Medicare Parts A and B, at which point Medicare becomes the primary insurance provider and the state-sponsored plan provides complementary coverage only. If a retiree fails to enroll in Medicare Parts A and B, his/her benefits will be calculated as if s/he had enrolled. The state offers Medicare eligible retirees several supplemental options: three PPO plans that any eligible retiree may enroll in, an additional PPO plan for members of the California Association of Highway Patrolmen, and another plan for Peace Officers Research Association of California Police and Fire Health Plan members. There are two HMO plans available to all eligible retirees as well as a plan for members of the California Correctional Peace Officers Association. Additionally, there is an Exclusive Provider Organization (EPO) available only to retirees in Colusa, Mendocino, and Sierra counties. The premium for individual coverage for a non-Medicare eligible retiree ranges from $351.75 to $724.41, while the premium for a Medicare eligible retiree ranges from $273.26 to $404.60.

California has different vesting schedules for employees, which depend on the date of hire.

- For retirees hired before January 1, 1985, the state pays 100% of the health insurance premium upon retirement.
- For individuals hired between January 1, 1985, and January 1, 1989, the state pays 10% of the health insurance premium for each year of service.
- For all retirees who were hired after January 1, 1989, the state pays 100% of the premium for retirees with 20 or more years of service, 50% plus 5% for each year for retirees with 10-19 years of service, 50% for those with 10 years of service, and 0% for those with less than 10 years of service.

https://www.calpers.ca.gov/mss-publication/pdf/xShEa96a9zNF5_health-program-guide1.pdf

Colorado

Colorado offers retiree health insurance benefits to all retirees through PERACare. All those who qualified as eligible dependents when an employee was considered an active employee remain eligible dependents when the employee's status changes from active to retired. PERACare has distinct plan offerings for retirees who are eligible for Medicare and for those who are not. Those who are not Medicare eligible may enroll only in plans providing pre-Medicare coverage, while those who are Medicare eligible may enroll only in plans offering Medicare coverage. PERACare plans also include prescription drug coverage and provide insurance benefits to all eligible dependents. Retirees enrolling in pre-Medicare plans may choose among HMO, PPO, HDHP and HSA plans. Retirees who are Medicare eligible are required to enroll in Medicare Part B, but are not required to enroll in Medicare Part A. Medicare eligible retirees may continue enrollment in PERACare plans: PERACare offers plans that are designed to supplement, coordinate with, or replace Medicare Part A. Medicare eligible retirees can choose to enroll in an HMO plan or in a Medicare supplement plan. The state subsidy varies depending on Medicare status and years of service. For a Medicare eligible individual, the premium ranges from $140.00 to $298.00 and the state's subsidy is $5.75 for each year of service. For a retiree who is not Medicare eligible, the premium ranges from $299.00 to $654.00 and the state's subsidy is $11.50 for each year of service.

https://www.copera.org/pdf/2/2-106-08.pdf

https://www.copera.org/pdf/2/2-104-08.pdf

Connecticut

Connecticut offers its retirees a choice among POE, HMO, and POS plans. All those who qualified as eligible dependents when an employee was considered an active employee remain eligible dependents when the employee's status changes from active to retired. The premium paid by the retiree depends on the plan selected, date of retirement, Medicare status of the primary carrier, and the retiree's Medicare status. For those who retired before July 1, 1999, the premium for Medicare eligible individuals ranges from $0.00 to $1.34, and the premium for non-Medicare eligible individuals ranges from $11.28 to $21.02. For those who retired after July 1, 1999, the premium for Medicare eligible individuals ranges from $0.00 to $1.34, and the premium for non-Medicare eligible individuals ranges from $11.28 to $29.61.

http://www.osc.state.ct.us/empret/healthin/2007hcplan/Retiree97andafter.pdf

Delaware

Delaware allows retirees who are eligible to collect a pension to enroll in retiree health plans. All those who qualified as eligible dependents when an employee was considered an active employee remain eligible dependents when the employee's status changes from active to retired. Those enrolled in the state's retiree health care plans can choose between a PPO and an HMO. Enrolling in a health care plan automatically enrolls a retiree in the prescription drug plan managed by Medco Health Solutions, Inc. The only exception is the option of the Special Medicfill plan without prescription coverage, in which the coordination of benefits policy also applies to prescription coverage.

Upon turning 65 years of age, all retirees are required to enroll in Medicare Parts A and B, at which point Medicare becomes the primary insurance provider and the state-offered health insurance plan provides complementary coverage only. If a retiree fails to enroll in Medicare Parts A and B, his/her coverage will be terminated. After enrolling in Medicare, retirees become eligible for the Medicare Supplement plan, Medicfill, which is offered by BCBS of Delaware.

The premium is shared between the state and the retiree. The total premium depends on an individual's Medicare status and on the plan chosen. The premium for a non-Medicare eligible individual ranges from $437.14 to $485.74; the premium for a Medicare eligible individual ranges from $158.56 to $332.10. The state determines a base amount of the premium it will pay, referred to as the "state share." Each retiree is entitled to receive a percentage of the state share based on years of creditable service:

- Less than 10 years — 0%
- 10–15 years — 50%
- 15–20 years — 75%
- 20 or more years — 100%

http://ben.omb.delaware.gov/documents/oe/2007/open_enrollment_booklet_rev.PDF

Florida

Florida offers retiree health insurance to all retirees, provided they enroll in the program within 31 days of the date of retirement. If a worker terminates his/her employment with the state and does not convert coverage at that time, s/he cannot enroll for retiree coverage at any point in the future. All those who qualified as eligible dependents when an employee was considered an active employee remain eligible dependents when the employee's status changes from active to retired.

Those enrolled in the state's retiree health care plans can choose from among a PPO, Health Investor PPO, HMO, and Health Investor HMO. The health investor plans allow the retiree to open a Health Savings Account. Medicare eligible retires may choose between the HMO or the PPO plan. To enroll in the HMO plan, a retiree must enroll in Medicare Parts A and Part B and may not enroll in either of the Health Investor plans. The premium for individual coverage for a non-Medicare retiree ranges from $351.20 to $427.86, and for a Medicare eligible retiree from $172.76 to $247.28. The state does not make a premium contribution.

http://dms.myflorida.com/human_resource_support/state_group_insurance/publications

Georgia

Georgia offers retiree health insurance benefits to retirees and their eligible dependents. Retirees may choose among a High Deductible Health Plan with a Health Savings Account (HDHP), PPO, CCO or HMO plan. The state has previously offered an indemnity plan, which it is currently phasing out—the plan is available only to those who are already enrolled. Additionally, those enrolled in Medicare Parts A and B may choose to enroll in the Medicare Advantage plan, which has optional prescription drug coverage—enrollees may choose to have prescription coverage through Medicare Part D or through the private plan. Georgia does not require its retirees to enroll in Medicare, but calculates premiums and claim payments based on Medicare enrollment for Medicare eligible retirees. The state will pay primary benefits for members who are not eligible or not enrolled in Medicare; however, the premium will be higher than the premium for Medicare recipients. Plan premium varies by plan chosen and Medicare status; however, the state, on average, pays 75% of the total plan cost.

http://dch.georgia.gov/vgn/images/portal/cit_1210/3/23/91782017Retiree_Decision_Guide-2008.pdf

http://dch.georgia.gov/vgn/images/portal/cit_1210/12/28/911145892008_Retiree_Rates.pdf

Hawaii

Hawaii offers health insurance benefits to its retirees and their eligible dependents. Retirees may choose between an HMO or PPO plan. All those who qualified as an eligible dependent when an employee was considered an active employee remain an eligible dependent when the employee's status changes from active to retired. Retirees who become eligible for Medicare Parts A and B are required to enroll in both parts, and will receive premium reimbursement from the state. If a retiree fails to enroll in Medicare Part B, s/he forfeits his/her eligibility for retiree health insurance benefits. Once enrolled in Medicare, retirees must enroll in a plan designed to complement benefits received from Medicare.

The premium for individual coverage for a non-Medicare retiree ranges from $391.02 to $460.80, and for a Medicare eligible retiree from $215.76 to $289.08. The state's contribution to the health insurance premium depends on the years of creditable service accumulated by the retiree and his/her date of hire.

- For a retiree hired prior to July 1, 1996, with less than 10 years of service, the state contributes 50% of the premium; for those with 10 or more years of creditable service, the state makes a 100% contribution.
- For retirees hired after July 1, 1996, with 10-15 years of service, the state pays 50%; with 15-25 years, the state contributes 75%; and for those with at least 25 years of service, the state pays 100% of the premium.

The state contribution applies only to individual coverage.

http://www.eutf.hawaii.gov/FAQs/retiree%20health%20benefit%20information%20080131.pdf

Idaho

Idaho provides retiree health insurance benefits to its retirees provided they receive monthly retirement benefits from a state retirement system. Additionally, their unreduced regular retirement allowance must equal or exceed the single retiree premium rate in effect on the date coverage begins OR the retiree must have 10+ years (considered 20,800+ hours) of credited state service. Retirees and their eligible dependents are covered by either the Blue Cross Traditional or PPO plan, but do not receive vision or dental coverage. Retirees who are eligible for Medicare have the option of enrolling in Medicare and a supplemental plan offered by the state. There are currently 18 supplemental plans offered through Blue Cross of Idaho, Regence BlueShield of Idaho, and AARP. The premium for individual coverage for a non-Medicare retiree ranges from $567 to $579, and for a Medicare eligible retiree is $274.

http://adm.idaho.gov/insurance/retired.htm

Illinois

Illinois offers all retirees access to retiree health insurance. Retirees choose among the HMO, OAP, or Quality Health Care Plan available to active employees and have the option to purchase dependent coverage. All those who qualified as an eligible dependent when an employee was considered an active employee remain an eligible dependent when the employee's status changes from active to retired. Additionally, all retirees who are Medicare eligible must enroll in Medicare Parts A and B; if a plan participant does not enroll in Part B, his/her benefits will still be calculated as if s/he had enrolled and Medicare was the primary payer.

The premium paid for retiree health insurance depends on the plan chosen, the retiree's years of creditable service, and his/her Medicare status. The premium for the policyholder ranges from $505.92 to $789.84 per month for those not eligible for Medicare and from $308.50 to $394.62 for those who are eligible. Retirees receive a service credit based on the number of years they worked for the state. A retiree receives a 5% state contribution for each year of creditable service; a retiree with 20 or more years of service receives a state contribution equal to 100% of the plan premium.

http://www.state.il.us/cms/download/pdfs_benefits/StateBCOBookletFY08.pdf

http://www.state.il.us/srs/SERS/ins_bcotables.htm#anchor%201

Indiana

Indiana provides health insurance to its retirees. The coverage available to retirees depends on their Medicare eligibility status. Retirees who are not eligible for Medicare may continue their enrollment in all plans available to active employees, with the exception of the High Deductible Health Plan, which has an optional Health Savings Account. All those who qualified as an eligible dependent when an employee was considered an active employee remain an eligible dependent when the employee's status changes from active to retired. Medicare eligible retirees may enroll in the states Medicare complementary health insurance plans. Medicare complementary plans are offered with and without prescription drug benefits.

http://www.in.gov/jobs/benefits/2007/Medicare_Comp_COC_wRx.pdf

Iowa

Iowa offers health insurance benefits to all retirees who apply for and receive pension benefits. All retirees who participate in the health plan can continue to receive coverage for the rest of their lives. Retirees receive the same plan provisions as active employees. As such, all those who qualified as an eligible dependent when an employee was considered an active employee remain an eligible dependent when the employee's status changes from active to retired. Upon turning 65 years of age, all retirees are required to enroll in Medicare Parts A and B; at that point, Medicare becomes the primary insurance provider and the state-offered health insurance plan becomes the secondary payer.

To pay for retiree health insurance benefits, those not eligible for Medicare may be eligible for participation in the Sick Leave Insurance Program (SLIP). SLIP allows retirees to convert their unused sick time into an account that the state will draw down to apply to the retiree's health insurance premium. For retirees participating in SLIP, the state continues to pay their portion of the premium until their account is exhausted, or they become Medicare eligible, return to work, or leave the plan for any reason. The premium paid for retiree health insurance depends on the plan chosen, years of creditable service, Medicare status, number of dependents to be covered, and the Medicare status of dependents. The premium for Medicare eligible individuals ranges from $210.40 to $446.62. The premium for non-Medicare eligible retirees ranges from $386.36 to $632.25. The state makes a premium contribution of 100% for individuals with positive balances in their SLIP account.

http://das.hre.iowa.gov/benefits/benefit_pages/bene_retirees_continuing_benefits.html#availabeplans

Kansas

Kansas offers health insurance coverage to retirees who are former elected state officials, retired officers, or employees receiving retirement benefits from the state. However, if coverage is dropped, the retiree is not eligible for re-enrollment. All those who qualified as an eligible dependent when an employee was considered an active employee remain an eligible dependent when the employee's status changes from active to retired. For non-Medicare eligible retirees, the state offers a choice between Plan A, which combines the features of an HMO and PPO plan, or Plan B, which is a traditional PPO plan. Upon turning 65 years of age, all retirees are required to enroll in Medicare Parts A and B, at which point, they may enroll in one of four health care plans designed to supplement Medicare benefits. Medicare eligible retirees may opt to enroll in the plans designed for non-Medicare eligible retirees. The premium rates for non-Medicare individual coverage range from $406.33 to $459.53, while the premium rates for Medicare eligible individual coverage range from $79.50 to $452.04.

http://www.khpa.ks.gov/SEHBP/2008/DOCS/DB/OEBook.pdf

http://www.khpa.ks.gov/SEHBP/2008/DOCS/DB/DBPremRates.pdf

Kentucky

Kentucky allows retirees to maintain their enrollment in their current health insurance plan, provided they are not Medicare eligible and they draw a monthly retirement check from the Kentucky Community and Technical College System, Kentucky Judicial Retirement Plan, Kentucky Legislators Retirement Plan, Kentucky Retirement System, or Kentucky Teachers Retirement System. Upon turning 65 years of age, all retirees are required to enroll in Medicare Parts A and B, at which point Medicare becomes the primary insurance provider and the state offered health insurance plan becomes the secondary payer.

Non-Medicare eligible retirees may choose between the Commonwealth Premier and Commonwealth Enhanced PPO plans available to active employees and incur the same costs as active employees. The premium for individual coverage for non-Medicare eligible retirees ranges from $469.00 to $501.20. The state's contribution amount for retirees is determined differently from the state's contribution for active employees. The state's contribution for retirees depends on the date of retirement and the total number and type (hazardous or non-hazardous) of service credits.

http://personnel.ky.gov/NR/rdonlyres/CE7838A0-9193-490A-99A0-91018CBAACD0/0/2008Handbook.pdf

Louisiana

Louisiana offers its retirees health insurance coverage through the Office of Group Benefits (OGB). All those who qualified as an eligible dependent when an employee was considered an active employee remain an eligible dependent when the employee's status changes from active to retired. Retirees can choose among the EPO, PPO, and HMO plans available to active employees, with premiums paid directly from their retirement checks. Upon turning age 65, members are required to apply for Medicare. If a retiree is enrolled in Medicare Parts A and B, his/her group insurance is considered a secondary insurer. The premium rate is decreased for Medicare enrolled retirees. The prescription drug coverage will remain the primary Rx insurance.

Louisiana also offers Retiree 100, which is optional coverage available to retirees with Medicare A and B as their primary insurer. Retiree 100 may provider higher reimbursements for eligible medical expenses by considering the total charges billed by an eligible provider, not just the balance due after Medicare has paid.

The premium for individual coverage of a non-Medicare eligible retiree ranges from $934.08 to $1011.88. The premium for individual coverage of a Medicare eligible retiree who continues enrollment in one of the plans available to active employees ranges from $303.72 to $329.00. The premium for retirees opting into a Medicare supplemental plan ranges from $138.00 to $176.00. Retiree 100 is $39.00 per month in addition to the group benefit premium already paid. The state's contribution toward the premium for retiree coverage is based on years of OGB enrollment:

- 10 years or less — 19% contribution
- 10–15 years — 38% contribution
- 15–20 years — 56% contribution
- 20 years or more — 75% contribution.

https://www.groupbenefits.org/ogb-images/docs/ogb_retirees_booklet_2005.pdf

https://www.groupbenefits.org/servlet/page?_pageid=1789&_dad=portal30&_schema=PORTAL30

https://www.groupbenefits.org/ogb-images/docs/2007_08premiums.pdf

Maine

Maine offers its retirees health insurance provided they have participated in the state's health insurance program for at least one year immediately prior to retiring and are receiving a retirement check from the Maine State Retirement System. All those who qualified as eligible dependents when an employee was considered an active employee remain an eligible dependent when the employee's status changes from active to retired. Eligible retirees must apply for Medicare coverage as soon as they turn 65, at which point they are required to enroll in Medicare Parts A and B. If a retiree does not apply for Medicare Part B, s/he will not be eligible to continue enrollment in the state sponsored plans. Upon Medicare enrollment, retirees may enroll in a plan designed to complement coverage obtained through Medicare. If a retiree opts into such a plan, Medicare serves as the primary payer and the state becomes the secondary payer.

The premium for individual coverage for a non-Medicare retiree is $620.44, while the premium for a Medicare eligible retiree is $306.56. The state's share of the premium is based on the number of years the retiree participated in the group health insurance plan as an active employee. Those with less than five years of enrollment do not receive a contribution; those with at least five years of creditable service receive a 50% contribution; and beyond that the state's contribution increases 10% for each additional year of participation. Retirees hired before July 1, 1991, enjoy a state contribution of 100% of the premium.

http://www.maine.gov/beh/HealthBenefits/Healthbeneindex.htm

http://www.maine.gov/beh/HealthBenefits/documents/GuidetoRetireeHealthIns032007.pdf

Maryland

Maryland allows retirees to continue their enrollment in a state-sponsored health insurance plan provided they currently receive a monthly state retirement allowance and meet any of the following: accumulated at least 16 years of creditable service; retired directly from the state with at least five years of creditable service; left the state with at least 10 years of creditable service within five years of normal retirement age; retired directly from state service with a disability retirement allowance; or left state employment prior to July 1, 1984.

Eligible retirees may continue their enrollment in the health insurance plans available to active state employees. Additionally, all those who qualified as an eligible dependent when an employee was considered an active employee remain an eligible dependent when the employee's status changes from active to retired.

Upon turning 65 years of age, all retirees are required to enroll in Medicare Parts A and B, at which point Medicare becomes the primary insurance provider and the state plan provides complementary coverage only. If a retiree fails to enroll in Medicare Parts A and B, the state plan will calculate his/her benefit entitlement as if s/he had enrolled. The premium for an individual who is not eligible for Medicare ranges from $306.30 to $413.42, while the premium for individual coverage for a retiree who is eligible for Medicare ranges from $156.59 to $206.74. Retirees who have 16 or more years of creditable service, received a disability retirement, or left the state prior to July 1, 1984, receive a full subsidy from the state.

http://dbm.maryland.gov/dbm_publishing/public_content/dbm_search/employee_services/health_benefits/2008_health/205730deptbudget.pdf

http://dbm.maryland.gov/dbm_publishing/public_content/dbm_search/employee_services/health_benefits/2006_july_health/fy_2007_rates_all_charts_for_review_website.pdf

Massachusetts

Massachusetts offers health insurance benefits to its retirees. Retirees who are not Medicare eligible can enroll in the same HMO and PPO plans that are available to active employees, at a reduced premium. Upon turning 65 years of age, all retirees are required to enroll in Medicare Parts A and B, at which point Medicare becomes the primary insurance provider and the state plan provides complementary coverage only. Retirees who are Medicare eligible must enroll in Medicare to maintain their enrollment in the state's health insurance plan. Medicare eligible retirees may enroll only in plans designed to complement Medicare and cannot enroll in plans designed for those who are active workers or who are not yet 65. For retirees who do not have Medicare, all those who qualified as eligible dependents when an employee was considered an active employee remain eligible dependents when the employee's status changes from active to retired. Medicare eligible retirees may enroll dependents only if they are also eligible for Medicare Parts A and B.

The premium for individual coverage for a retiree who retired on or before July 1, 1994, and is not Medicare eligible ranges from $308.30 to $904.10, while the premium for an identical individual who retired after July 1, 1994, ranges from $324.40 to $828.87. The premium for individual coverage for a Medicare eligible retiree who retired on or before July 1, 1994, ranges from $151.90 to $403.30, while the premium for an identical individual who retired after July 1, 1994, ranges from $151.87 to $403.20.

http://www.mass.gov/gic/annualenroll2007/BAGMedicare.pdf

http://www.mass.gov/gic/bdg/bdgpdfs/bdgretnonmedicareoptions.pdf

http://www.mass.gov/gic/annualenroll2007/ratesheet07.pdf

Michigan

Michigan provides separate retiree health insurance benefits to retirees who are not Medicare eligible and those who are. Retirees who are not Medicare eligible can receive health insurance benefits if they retired under the state's Defined Contribution Pension Plan; receive an immediate pension under the State Employees' Retirement Act or the State Police Retirement Act; or were previously enrolled in a state-sponsored HMO and receive an immediate pension benefit. Eligible dependents include a spouse and unmarried children who are considered legally dependent.

Upon turning 65 years of age, all retirees are required to enroll in Medicare Parts A and B, at which point Medicare becomes the primary insurance provider and the state-sponsored plan provides complementary coverage only. If a retiree fails to enroll in Medicare Parts A and B, the state plan will calculate the retiree's benefit entitlement as if s/he had enrolled. The premium for individual coverage for a retiree who is not eligible for Medicare ranges from $638.59 to $857.92 annually, and the premium for individual coverage for a Medicare eligible retiree ranges from $243.87 to $417.08. The state also makes a premium contribution in the amount of $607.45 for retirees who are not Medicare eligible and up to $334.83 for retirees who are eligible.

http://www.michigan.gov/documents/retire_book_58659_7.pdf

http://www.michigan.gov/documents/SOMRetireeBenefits-Aetna_Transfers_137991_7.pdf

http://www.michigan.gov/documents/mdcs/Retiree_Rates_07-08_203585_7.pdf

Minnesota

Minnesota offers health insurance benefits to its retirees provided they are immediately eligible for retirement programs and had five years of allowable pension service, or are 50 years of age and have at least 15 years of creditable service. Additionally, all those who qualified as an eligible dependent when an employee was considered an active employee remain an eligible dependent when the employee's status changes from active to retired.

Upon turning 65 years of age, all retirees are required to enroll in Medicare Parts A, B, and D to remain eligible for participation in the state health insurance plan. Once a retiree enrolls in Medicare, Medicare becomes the primary insurance provider and the state plan provides complementary coverage only. Retirees who are Medicare eligible must enroll in Medicare to maintain their enrollment in the state's health insurance plan. Additionally, Medicare eligible retirees may enroll only in plans designed to complement Medicare.

The premium for individual coverage for a retiree who is not eligible for Medicare is $432.16. The premium for individual coverage for a retiree who is eligible for Medicare ranges from $237.50 to $282.44. Retirees are responsible for the full premium; the state does not make any contribution.

http://www.doer.state.mn.us/ei-segip/pdf/advantage%20retirees%20and%20fewd/RetireeHealthSummary.pdf

Mississippi

Mississippi offers health insurance benefits to its retirees provided they participate in a retirement plan approved by the Mississippi Public Employees' Retirement System (PERS) or participate in the State and School Employees' Health Insurance plan for four years or more. Additionally, to be eligible for health insurance coverage retirees must have at least 25 years of creditable service, be age 60 with four or more years of creditable service, be age 45 with 20 or more years of creditable service (if retiring from the Mississippi Highway Safety Patrol), be approved for disability, or be an elected state or district official who does not run for reelection or who is defeated. All those who qualified as an eligible dependent when an employee was considered an active employee remain an eligible dependent when the employee's status changes from active to retired.

Non-Medicare eligible retirees may remain enrolled in the plans available to active employees and have a choice between a low and high (base plan and select plan respectively) coverage option. Additionally, non-Medicare eligible retirees are eligible to enroll in prescription drug coverage through the state's insurance plan. Medicare eligible retirees are required to enroll in Medicare Parts A and B, at which time Medicare becomes the primary payer and the state becomes secondary. Medicare eligible retirees may receive their secondary insurance from the Select plan only and may not enroll in the Base plan. Medicare eligible retirees may not enroll in the prescription drug coverage offered by the state.

The retiree is responsible for the full premium cost: the state does not offer a subsidy or make a contribution to the cost. The premium for non-Medicare individuals is $388 for the base plan and $409 for the Select plan. The premium for Medicare eligible individuals is $160 for the Select plan.

http://knowyourbenefits.dfa.state.ms.us/Ins%20PDFs/PlanDocument2007.pdf

Missouri

Missouri offers health insurance to its retirees provided they are eligible to receive a retirement benefit from an employer-sponsored retirement plan or meet the retirement qualifications of the public entity. Retirees must also meet one of three other criteria: had coverage through a state sponsored health plan since the last Open Enrollment period; had health insurance for the six months immediately prior to termination of employment; or had coverage since first eligible. All those who qualified as an eligible dependent when an employee was considered an active employee remain an eligible dependent when the employee's status changes from active to retired. Retirees may choose between an HMO plan and a Copay plan. Both plans have an incentive rate and a base rate—retirees are eligible for the incentive rate only if they complete a personal health assessment. All Medicare eligible retirees must enroll in Medicare Parts A and B. Upon reaching age 65, Medicare becomes the primary payer.

The premium for a Medicare eligible retiree who receives individual coverage through a co-pay plan is $834 for the incentive plan or $846 for the basic plan. The premium for a Medicare eligible retiree who receives individual coverage from the HMO plan is $641 for the incentive plan or $653 for the basic plan. The premium for a non-Medicare eligible retiree who receives individual coverage from a co-pay plan is $1668 for the incentive plan or $1692 for the basic plan. The premium for a non-Medicare eligible retiree who receives individual coverage from the HMO plan is $1282 for the incentive plan or $1306 for the basic plan. Retirees are eligible to receive a subsidy toward the insurance premium (they are responsible for the same premium as active employees). The amount of the subsidy varies by date of retirement, years of service, and county of residence.

http://www.mchcp.org/se_member/se_OEPubs08/08RetireeEnrollmentGuide.pdf

Montana

Montana offers health insurance to its retirees if they are eligible to receive a monthly retirement benefit check from their retirement system. If a retiree does not elect coverage, or lets coverage lapse in any way, they are not eligible for re-enrollment in the plan. All those who qualified as an eligible dependent when an employee was considered an active employee, remain an eligible dependent when the employees status changes from active to retired.

The coverage guidelines depend on Medicare eligibility; a retiree who enrolls in the state plan and is not eligible for Medicare benefits must enroll in medical, dental, and life insurance. Retirees who are Medicare eligible may continue their enrollment in the state plan, and must continue to receive medical coverage. Medicare eligible retirees may enroll in the dental plan but are not eligible for life insurance. Medicare eligible retirees who enroll in Medicare but do not inform the state health insurance plan, will continue to have the state as their primary payer and will pay the same premium as retirees who are not Medicare eligible. The premium for individual coverage for a non-Medicare eligible retiree ranges from $444 to $557, while the same coverage for a Medicare eligible retiree ranges from $160 to $194.

http://benefits.mt.gov/docs/Retiree%20forms/2008_Retiree_Booklet.pdf

Nebraska

Nebraska offers health insurance to those who meet the state's retirement criteria, are not yet Medicare eligible, and who paid into the state's retirement system for at least one year immediately prior to retirement. Retirees are eligible to continue coverage in a state-sponsored plan and may choose between an HMO and PPO plan. Medicare eligible retirees cannot obtain health insurance from the state.

The premium for individual coverage ranges from $374.46 to $503.30. The state's premium contribution is based on accumulated years of service.

For retirees not eligible for Medicare:

- 10–15 years of service — the state pays 50%
- 16–27 years — the state pays 70%
- 28–34 years — the state pays 90%
- 35 years or more — the state pays 100%.

For retirees eligible for Medicare:

- 10–15 years of service — the state pays 50%
- 16–19 years — the state pays 70%
- 20–27 years — the state pays 90%
- 28 years or more — the state pays 100%.

http://www.das.state.ne.us/personnel/benefits/2008/cobra_retiree/enrollment_guide_cr.pdf

Nevada

Nevada offers health insurance to retirees who receive benefits from the Public Employees' Retirement System, the Legislators' Retirement System, the Judges' Retirement System, or the Retirement Plan Alternative. To obtain coverage, retirees must enroll in a health insurance plan within 60 days of retirement; if they fail to do so, they will not be eligible for re-enrollment. All those who qualified as an eligible dependent when an employee was considered an active employee remain an eligible dependent when the employee's status changes from active to retired. Both Medicare eligible and non-Medicare eligible retirees have a choice between a PPO and an HMO.

All retirees who are eligible for Medicare must enroll in Parts A and B to maintain enrollment in the state-sponsored plan. Upon enrollment in Medicare, Medicare becomes the primary payer and the state becomes secondary. If a retiree enrolls in Medicare Part B, the retiree will be considered the primary payer and will be responsible for all charges that would normally be paid by Medicare, and the state acts as the secondary payer. Those who are enrolled in Medicare Parts A and B may enroll in any plan offered to an active employee, and may also opt into a Medicare replacement plan.

The premium for individual coverage for a non-Medicare eligible retiree ranges from $316.68 to $537.52. The premium for individual coverage for a Medicare eligible retiree ranges from $80.07 (for the Medicare replacement plan) to $537.52. The state's contribution to the premium depends on the date of retirement, number of years of creditable service the retiree has accumulated, and for those who retired after January 1, 1994, the plan chosen.

- The base contribution for individuals who retired prior to January 1, 1994, is $365.64.
- The base contribution for individuals who retired after January 1, 1994, is $339.74 for the High Deductible PPO; $360.14 for the Low Deductible PPO; $324.96 for the Anthem HMO; $212.18 for the Health Plan of Nevada; and $53.65 for Senior Dimensions (available only to Medicare eligible retirees).

Regardless of retirement date, those with:

- 5 years of service — subtract $274.23 from the base contribution
- 6 years — subtract $246.81
- 7 years — subtract $219.38
- 8 years — subtract $191.96
- 9 years — subtract $164.54
- 10 years — subtract $137.12
- 11 years — subtract $109.69
- 12 years — subtract $82.27
- 13 years — subtract $54.85
- 14 years — subtract $27.42
- 15 years — do not adjust the base contribution
- 16 years — add $27.42 to the base contribution
- 17 years — add $54.85
- 18 years — add $82.27
- 19 years — add $109.69
- 20 years or more — add $137.12.

http://www.pebp.state.nv.us/help/PY08retireeguide_2.pdf

New Hampshire

New Hampshire offers health insurance benefits to retirees provided they are in a Class of Eligible Employees. A retiree is considered to be in a Class of Eligible Employees if their employer reports them as such to the insurance company. All those who qualified as eligible dependents when an employee was considered an active employee remain eligible dependents when the employee's status changes from active to retired. Non-Medicare eligible retirees may enroll in a POS plan.

Upon turning 65 years of age, all retirees are required to enroll in Medicare Parts A and B to remain eligible for participation in the state health insurance plan. Once a retiree enrolls in Medicare, Medicare becomes the primary insurance provider and the state plan provides complementary coverage only.

http://www.nh.gov/hr/documents/benefits_booklet_under_65.pdf

http://www.nh.gov/hr/documents/benefits_booklet_over_65.pdf

New Jersey

New Jersey offers health insurance to retirees who were classified as full-time employees and were eligible for employer-paid health insurance up until their retirement date. Additionally, members of the Teachers' Pension and Annuity Fund, the Public Employees' Retirement System, and the Alternate Benefit Program must have at least 25 years of service credit to participate in the plan. Retirees may also obtain health insurance for all those who qualified as an eligible dependent when they were considered active employees. In order to receive health benefits through the state, retirees must enroll in a plan within 60 days of retiring; if they fail to do so, they are not eligible to enroll at a later date.

Upon turning 65 years of age, all retirees are required to enroll in Medicare Parts A and B to remain eligible for participation in the state health insurance plan. Once a retiree enrolls in Medicare, Medicare becomes the primary insurance provider and the state plan provides complementary coverage only. The plan premiums are based on type of plan chosen, Medicare enrollment status, and union membership. Certain unions have arrangements with the state to share the cost of retiree health insurance, while others do not. For those who do not have cost sharing, the premium for individual coverage for non-Medicare eligible retirees ranges from $508 to $617.54. Non-Medicare eligible retirees who belong to unions that have agreements with the state to cost share receive a subsidy of $463.16 For a Medicare eligible retiree who does not have cost sharing, the premium ranges from $352.93 to $385.02. Medicare eligible retirees who belong to unions that have agreements with the state to cost share receive a subsidy of $287.89.

http://www.state.nj.us/treasury/pensions/fact11.htm

http://www.state.nj.us/treasury/pensions/hb_open_enrollment_apr2008/retired_state_full.htm

http://www.state.nj.us/treasury/pensions/hb_open_enrollment_apr2008/state_retired_share.htm

New Mexico

New Mexico offers health insurance to its retirees and their eligible dependents. Retirees who are not Medicare eligible may choose among three PPO plans that offer varying coverage levels. Retirees who are eligible for Medicare must apply for Medicare Parts A and B, and are eligible for enrollment in only one of the two Medicare supplement plans offered by the state. The state makes a premium contribution of 6.25% for the first five years of service and 6.25% for each additional year.

http://www.nmrhca.state.nm.us/Switch/2008Switch/2008BenefitsBooklet.pdf

New York

New York offers its retirees health insurance benefits provided they: meet the minimum years of creditable service requirement (five years for those hired before April 1, 1975, and 10 years for those hired after); are qualified for retirement as a member of a state-sponsored retirement system; and were enrolled (as an active employee or dependent) in a state-run health insurance plan at the time of retirement. All those who qualified as an eligible dependent when an employee was considered an active employee remain an eligible dependent when the employee's status changes from active to retired. All retirees may choose to enroll in either the Empire Plan or an HMO plan. In general, the state pays 90% of the premium for individual coverage under the Empire Plan and 90% of the hospital, medical, and mental health/substance abuse components of the premium for coverage under the HMO plan

Upon turning 65 years of age, all retirees are required to enroll in Medicare Parts A and B, at which point Medicare becomes the primary insurance provider, and the state plan provides complementary coverage only. If a retiree fails to enroll in Medicare Parts A and B, the SEHIP will calculate the retiree's benefit entitlement as if s/he had enrolled.

http://www.cs.state.ny.us/ebd/ebdonlinecenter/newgib/rethmo/10medica.cfm?group=RETHMO&section=hi

North Carolina

North Carolina provides health insurance benefits to all state retirees and their dependents, provided they contributed to the Teachers' and State Employees' Retirement System for at least five years while employed. Retirees who are not Medicare eligible may enroll in the same PPO and Indemnity plans available to active employees, at the same premium as active employees. Medicare eligible retirees are required to enroll in Medicare Parts A and B to maintain the same level of coverage as an active employee. Upon enrolling in Medicare, Medicare becomes the primary insurance provider, and the SEHIP provides complementary coverage only. If a retiree fails to enroll in Medicare Parts A and B, the SEHIP will calculate the retiree's benefit entitlement as if s/he had enrolled. The state makes a premium contribution of $346.38 for retirees in the PPO plan.

http://www.nctreasurer.com/NR/rdonlyres/95395749-1D35-419E-8202-A8C67D328217/0/NCYRBTeaStateFINAL031607.pdf

North Dakota

North Dakota offers health insurance to its retirees provided they receive retirement benefits from the North Dakota Public Employees Retirement System, North Dakota Highway Patrol Retirement System, Job Service Retirement Plan, Teacher's Fund for Retirement, or

TIAA-CREF. Retirees must enroll in the plan within 31 days of retirement or they will not be eligible to enroll at any time in the future. Non-Medicare eligible retirees continue their enrollment in the Dakota Plan, which is the plan offered to active employees. Medicare eligible retirees who have Medicare Parts A and B are eligible for the Dakota Retiree Plan. The Dakota Retiree Plan is a "Carve-Out" plan that pays secondary to Medicare; it is not a supplemental plan. As secondary payer, there will be an adjustment to the premium if transitioning from the Dakota Plan. The premium for coverage in the Dakota plan is the same for retirees as it is for active employees. The premium for individual coverage for a retiree who is not eligible for Medicare but is eligible for COBRA ranges from $324.58 to $361.77, while the premium for an individual who is not eligible for Medicare or COBRA is $475.34. The premium for an individual who is eligible for Medicare and who retired before July 1, 2007, is $210.46; while the premium for an individual who retired after July 1, 2007, is $217.44. The state provides a service credit of $4.50 for each year that can be applied toward the purchase of health insurance.

http://www.nd.gov/ndpers/employers/docs/kits/sfn-53723-retirement-kit.pdf#page=41

Ohio

Ohio provides health insurance coverage to retirees who participate in one of the five state-sponsored retirement systems. All those who qualified as eligible dependents when an employee was considered an active employee remain eligible dependents when the employee's status changes from active to retired. Non-Medicare eligible retirees will receive coverage from a state-sponsored PPO plan. Upon turning 65 years of age, all retirees are required to enroll in Medicare Parts A and B, at which point Medicare becomes the primary insurance provider and the state-offered health insurance plan provides complementary coverage only. If an eligible retiree fails to enroll in Medicare Part B, his/her benefits will be calculated as if s/he had enrolled.

The state retirement system provides all retirees an allowance, based on their years of service and the date they were first eligible to retire; this allowance will be used toward the health insurance premium.

- Retirees with at least 10 years of service accumulated prior to or on January 1, 2007, receive a 100% premium subsidy.
- Retirees with at least 10 years of service accumulated after January 1, 2007, and hired prior to January 1, 2003, with up to 15 years of service, receive a 50% premium subsidy; with 15–30 years receive a prorated subsidy; and with 30 years of service receive 100%.
- Retirees with at least 10 years of service accumulated after January 1, 2007, and hired after January 1, 2003, with up to 15 years of service, receive a 25% premium subsidy; and with 15–30 years of service receive a subsidy of 25–100% of the premium.

https://www.opers.org/pubs-archive/healthcare/coverage-guide/2007CoverageBook.pdf#zoom=100

https://www.opers.org/pdf/healthcare/allocation-charts.pdf#zoom=100

Oklahoma

Oklahoma permits its retirees to maintain health insurance coverage under their current insurance plan provided they have completed at least eight years of creditable service. All those who qualified as an eligible dependent when an employee was considered an active employee remain an eligible dependent when the employee's status changes from active to retired. After retiring, members cannot add new benefits to their insurance; however, they can reduce their coverage level. Once a retiree becomes Medicare eligible, s/he is required to enroll in Parts A and B, at which point s/he may opt into a Medicare supplemental plan offered by the state. The premium for individual coverage for a non-Medicare eligible retiree ranges from $302.44 to $606.56; the state will contribute $105 toward the health insurance of an eligible retiree.

http://www.ok.gov/TRS/Frequently_Asked_Questions/Health_Coverage_(Retired)/Post_Retirement_Health_Insurance_Benefits.html

Oregon

Oregon offers its retirees health insurance benefits through two avenues. First, those retirees who are not Medicare eligible may opt to continue their enrollment in their current health insurance plan until they reach age 65. Additionally, all retirees, regardless of Medicare eligibility, may enroll in health insurance plans provided through the Public Employees Retirement System (PERS), provided they are members of PERS and are receiving a retirement benefit. All those who qualified as an eligible dependent when an employee was considered an active employee remain an eligible dependent when the employee's status changes from active to retired. Retirees may choose a fee-for-service plan or one of three managed care options; all plans have Medicare and a non-Medicare coverage level.

Upon turning 65 years of age, all retirees are required to enroll in Medicare Parts A and B. If an eligible retiree fails to enroll in Medicare Part B, s/he will not be eligible for coverage from PERS until s/he enrolls in Part B. Once enrolled in Medicare Parts A and B, retirees may opt into a Medicare Supplemental Plan offered by PERS.

The premium for individual coverage for a retiree who is not Medicare eligible ranges from $590.50 to $829.11.The premium for individual coverage for a retiree who is Medicare eligible ranges from $140.39 to $203.39. The state of Oregon offers health insurance subsidies to some retirees.

Non-Medicare eligible retirees with:

- 8–9 years of service receive a contribution from the state of $126.27.
- 10–14 years of service receive a contribution of $151.52.
- 15–19 years of service receive a contribution of $176.78.
- 20–24 years of service receive a contribution of $202.03.
- 25–39 years of service receive a contribution of $227.28.
- 30 years or more of service receive a contribution of $252.54.

Retirees who are eligible for Medicare receive a $60.00 premium contribution regardless of years of service accumulated.

http://www.oregon.gov/PERS/RET/docs/health_insurance_program/general_information.pdf

http://www.pershealth.com/

Pennsylvania

Pennsylvania provides retiree health insurance to retirees who retire at normal retirement age (50 or 60, depending on class of employment) with 15 or more years of credited service; who retire with 25 or more years of service regardless of age; or who retire with a disability retirement benefit. Retirees who are not eligible for Medicare who retired before July 1, 2004, may enroll in an HMO or a PPO plan. Retirees who are not eligible for Medicare who retired after July 1, 2004, may enroll in an HMO, PPO, or consumer driven plan. Retirees who are eligible for Medicare may enroll in an HMO or PPO Medicare Advantage plan.

The state's premium contribution depends on date of retirement and is based on the retiree's final base annual salary. For those who retire:

- before July 1, 2005, the state subsidy is 100% of the premium.
- after July 1, 2005, but before July 1, 2007, the State Employee Retirement System will deduct the member share of 1% of the member's final base annual salary in equal monthly payments from the member's annuity payments.
- after July 1, 2007, but before June 30, 2008, the State Employee Retirement System will deduct the member share of 1% of the member's final gross base annual salary in equal monthly payments from the member's annuity payments.
- after July 1, 2008, but before June 30, 2009, the State Employee Retirement System will deduct the member share of 1.5% of the member's final gross base annual salary in equal monthly payments from the member's annuity payments.
- after July 1, 2009, but before September 30, 2010, the State Employee Retirement System will deduct the member share of 2% of the member's final gross base annual salary in equal monthly payments from the member's annuity payments.

http://www.sers.state.pa.us/sers/cwp/view.asp?a=237&Q=227664&sersNav=|2711|

http://www.sers.state.pa.us/sers/cwp/view.asp?A=237&Q=227678

Rhode Island

Rhode Island offers retiree health insurance to all retirees who are either an Employees Retirement System of Rhode Island retiree or pension recipient. All those who qualified as eligible dependents when an employee was considered an active employee remain eligible dependents when the employee's status changes from active to retired. The state offers one plan for non-Medicare eligible retirees and two for those who are Medicare eligible and have enrolled in Medicare Parts A and B. Upon turning 65 years of age, all retirees are required to enroll in Medicare Parts A and B. If an eligible retiree fails to enroll in Medicare Part B, s/he will not be eligible for coverage under a state sponsored plan.

The premium for individual coverage for non-Medicare eligible retirees is $452.28 per month, while the premium for individual coverage for Medicare eligible retirees is $107.00 or $179.77, depending on the plan chosen. The state offers a subsidy to state employees, based on their years of creditable service and their current age.

- If a retiree is between 60 and 65 years of age and has worked 10–15 years, the state subsidy is 50% of the premium; with 16–22 years of service, the state's contribution is 70%; with 23–27 years of service, the contribution is 80%; and with more than 28 years of service, the state pays 100%.
- A retiree who is at least 65 years of age and has 10-15 years of service receives a 50% contribution; with 16–19 years receives a 70% contribution; with 20–27 years receives a contribution of 90%; and with 28 years or more receives a 100% state subsidy.

Additionally, a retiree with at least 28 years of service receives a 90% state subsidy, regardless of age. Similarly, a retiree with at least 35 years of service receives a 100% state subsidy, regardless of age.

http://www.ersri.org/public/howto/health

South Carolina

South Carolina offers retiree health insurance to those who participated in the state insurance program as active employees and have at least five years of continuous and consecutive employment in a full time position with an employer that participates in the state's insurance program. All those who qualified as eligible dependents when an employee was considered an active employee remain eligible dependents when the employee's status changes from active to retired. Upon turning 65 years of age, all retirees are required to enroll in Medicare Parts A and B, at which point Medicare becomes the primary insurance provider and the state-offered health insurance plan provides complementary coverage only. If an eligible retiree fails to enroll in Medicare Part B, his/her benefits will be calculated as if s/he had enrolled.

The premium for individual coverage for a Medicare eligible retiree ranges from $336.36 to $455.72. The premium for individual coverage for a non-Medicare eligible retiree ranges from $270.18 to $455.72. Some retirees are eligible for an employer contribution of $260.90 toward their health insurance premium. Retirees receive such a contribution if they are eligible to retire and have 10 or more years of service credits from the South Carolina Retirement System, or are not eligible for retirement but have at least 20 years of service credit.

http://www.eip.sc.gov/category/index.aspx?cat=3&p=10

http://www.eip.sc.gov/publications/2008RRWITHOUTFUNDRETIREE.pdf

South Dakota

South Dakota offers health insurance to all retirees and their dependents. Eligible retirees may continue group health coverage up to the first day of the month in which they reach age 65. Upon turning 65 years of age, all retirees are required to enroll in Medicare. Medicare eligible retirees may not continue their enrollment in any plan offered to active employees, but may be converted to the state-sponsored Medicare Supplement Plan. Medicare will serve as the primary health insurance; the state-sponsored supplement serves as the secondary payer. The Medicare complement plan offers two levels of benefits, one in which the retiree pays a Part B deductible and another where s/he does not.

The premium for individual coverage for a non-Medicare eligible retiree ranges from $220.78 to $314.18. The premium for individual coverage in the Medicare supplement plan ranges from $95.75 to $200.08, depending on coverage chosen and the retiree's age. The premium increases with age; for example, individual coverage for a retiree age 65 who chooses the plan with the Part B deductible is $95.75, while enrollment in the same plan for a retiree age 80 (and up) is $167.67.

https://www.bopweb.com/uploadedFiles/HealthPlanSPD01-30-07.pdf

Tennessee

Tennessee offers health insurance benefits to its retirees provided they have at least 10 years of creditable service with the state and at least three years of insurance coverage in the plan immediately preceding retirement, or at least 20 years of creditable service with the state and at least one year of insurance coverage immediately preceding retirement. Retirees who are not yet eligible for Medicare benefits and wish to receive retiree health insurance through the state must continue enrollment in the plan they were enrolled in at the time they retired. An exception can be made for a retiree who lives outside the service area of such a plan. Dependents who are not eligible for Medicare Part A who were enrolled in the plan may remain enrolled; however, new dependents may not be added after retirement. Retirees and dependents who are eligible for Medicare may not continue their enrollment in a health insurance plan that is offered to active employees. However, retirees who are eligible for Medicare may apply for Medicare supplemental coverage.

The premium for retiree health insurance depends on the years of creditable service:

- less than 20 years of service, the premium for individual coverage ranges from $191.21 to $203.06.
- 20–29 years of service, the premium for individual coverage ranges from $143.41 to $152.29.
- 30 years or more of service, the premium for individual coverage ranges from $95.61 to $101.53.

http://tennessee.gov/finance/ins/st_ret.pdf

Texas

Texas offers health insurance to its retirees provided they have at least 10 years of service and are at least 65 years of age, or their age and service add up to 80 and they have at least 10 years of service. All those who qualified as an eligible dependent when an employee was considered an active employee remain an eligible dependent when the employee's status changes from active to retired. Retirees who are not eligible for Medicare can continue their enrollment in the state-offered plans and will receive the same benefits as the active employees. Upon turning 65 years of age, all retirees are required to enroll in Medicare Parts A and B, at which point Medicare becomes the primary insurance and the state sponsored plan becomes secondary. Retirees who do not enroll in Medicare B will still have their state insurance benefits calculated as if they had enrolled.

The premium for individual coverage for a retiree who was working full-time at the time of retirement ranges from $284.53 to $388.97. The state contribution for a retiree who was working full-time at retirement is 100% of the premium; the state contribution for a retiree who was working part-time at retirement is 50%.

http://www.ers.state.tx.us/retirement/pyr/documents/insurance_coverage.pdf

http://www.ers.state.tx.us/insurance/rates/documents/2008_premium_rates_fte_ret.pdf

Utah

Utah offers health insurance to its retirees and their eligible dependents. Retirees who are not yet 65 years old may maintain enrollment in plans offered to active employees. After turning 65 years of age, a retiree must either be entitled to Medicare Part A or enrolled in Medicare Part B to be a member of a state-sponsored plan. Retirees who are eligible for Medicare may enroll in a Medicare supplement provided they have earned service credit with the state, participate in the Utah Retirement System, and enroll within specified time limits; or they were enrolled in the state's health insurance program as an active employee and enroll as a retiree within 60 days of retiring.

http://www.pehp.org/general/pdf/mastpoli/preferred_master.pdf

http://www.pehp.org/general/pdf/benefitsummaries/Medicare_Supplement.pdf

Vermont

Vermont offers health insurance to its retirees provided they were enrolled in the state's health insurance plan immediately prior to retiring and elect coverage at the time they retire. A retiree who does not continue coverage when s/he leaves active employment may not enroll in the plan at a later time. All those who qualified as an eligible dependent when an employee was considered an active employee remain an eligible dependent when the employee's status changes from active to retired. Retirees who are not Medicare eligible may choose among a POS, PPO, indemnity, and safety net plan. Upon turning 65 years of age, all retirees are required to enroll in Medicare Parts A and B, at which point Medicare becomes the primary insurance and the state-sponsored plan becomes secondary. Retirees who do not enroll in Medicare B will still have their state insurance benefits calculated as if they had enrolled. Retirees who are eligible for Medicare may choose either an indemnity or a PPO plan.

The premium for individual coverage for a retiree who is not eligible for Medicare ranges from $360.78 to $615.29. The premium for individual coverage for a retiree who is eligible for Medicare is either $241.52 or $255.61, depending on the plan chosen. The state of Vermont makes a contribution of 80% of the premium for all retirees.

http://www.vermontpersonnel.org/employee/pdf/medical%20plan%20document.pdf

http://www.vermontpersonnel.org/employee/pdf/retrates08.pdf

http://www.vermonttreasurer.gov/retirement/state/planC.html#elig

Virginia

Virginia offers its retirees health insurance provided they are eligible for and currently receiving a monthly annuity from the Virginia Retirement System or a benefit from an Optional Retirement Plan, worked for the state immediately prior to retirement, were eligible to enroll in a state-sponsored health insurance program as an active employee, and enroll for retiree health benefits within 31 days of retirement. If a retiree declines coverage at any point after retiring, s/he is not eligible for re-enrollment. All those who qualified as eligible dependents when an employee was considered an active employee remain eligible dependents when the employee's status changes from active to retired. Upon turning 65 years of age, all retirees are required to enroll in Medicare Parts A and B, at which point Medicare becomes the primary insurance and the state-sponsored plan becomes secondary. Retirees who do not enroll in Medicare B will still have their state insurance benefits calculated as if they had enrolled. Retirees who are eligible for Medicare are eligible for enrollment in a Medicare-coordinating plan only.

The premium for individual coverage for a retiree who is not Medicare eligible ranges from $350 to $469. The premium for individual coverage for a retiree who is Medicare eligible ranges from $126 to $277. For retirees who have 15 years of creditable service, retire on disability, or receive a long-term disability benefit, the state will provide a health insurance credit—state employees and teachers receive a credit of $4.00 per creditable service year.

http://www.dhrm.state.va.us/hbenefits/retirees/factsheets/sheet2.pdf

http://www.dhrm.state.va.us/hbenefits/retirees/rates/rates2008.html

http://www.dhrm.state.va.us/hbenefits/openenroll07/premiums2007.html

Washington

Washington offers health insurance benefits to its retirees provided they receive an immediate retirement allowance from a state-run retirement system and enroll in the retiree health insurance plans within 60 days of retirement. All those who qualified as eligible dependents when an employee was considered an active employee remain eligible dependents when the employee's status changes from active to retired. Retirees who become eligible for Medicare Parts A and B are required to enroll in both parts. If a retiree fails to enroll in Medicare Part B, s/he forfeits his/her eligibility for retiree health insurance benefits. Once enrolled in Medicare, retirees may choose any plan available to active employees or a Medicare Supplement Plan.

The premium for individual coverage for a retiree who is not eligible for Medicare ranges from $400.19 to $484.32. The premium for a Medicare eligible retiree ranges from $241.64 to $396.70. The state's contribution to the premium depends on Medicare eligibility and the plan chosen. Retirees who are eligible for Medicare receive a subsidy of $164.08 from the state.

http://www.pebb.hca.wa.gov/publications/doc/51-205-2008.pdf

West Virginia

West Virginia offers health insurance to retired public employees, provided they meet the requirements of the applicable state retirement system and were employed by the state immediately prior to retirement. Additionally, all those who qualified as eligible dependents when an employee was considered an active employee remain eligible dependents when the employee's status changes from active to retired. Retirees who are not eligible for Medicare may maintain enrollment in any plan offered to an active employee. Upon turning 65 years of age, all retirees are required to enroll in Medicare Parts A and B, at which point Medicare becomes the primary insurance and the state sponsored plan becomes secondary. Those enrolled in Medicare Parts A and B will have their health insurance coverage switched to a Medicare supplement. Retirees who do not enroll in Medicare Part B forfeit their eligibility for enrollment in the state sponsored plan.

The premium for individual coverage for a non-Medicare eligible retiree ranges from $208 to $744, depending on the retiree's years of creditable service, the plan chosen, and whether the retiree smokes. The premium for individual coverage for a Medicare eligible retiree ranges from $46 to $339, depending on the retiree's years of creditable service and whether s/he smokes.

http://www.westvirginia.com/peia/content/PY%202008%20Summary%5FPlan%5FDescription%2Epdf

Wisconsin

Wisconsin offers health insurance to its retirees provided they are entitled to receive an immediate retirement annuity through the Wisconsin Retirement system or are at least 55 years of age and have at least 20 years of creditable service. Any employee with at least 20 years of service, regardless of age, may receive retiree health insurance; however, those who are not yet 55 will have to pay the full premium. All those who qualified as an eligible dependent when an employee was considered an active employee remain an eligible dependent when the employee's status changes from active to retired. Upon turning 65 years of age, all retirees are required to enroll in Medicare Parts A and B, at which point Medicare becomes the primary insurance and the state-sponsored plan becomes secondary. Retirees who do not enroll in Medicare B will still have their state insurance benefits calculated as if they had enrolled. Further, those enrolled in Medicare, will have their health insurance coverage switched to a Medicare supplement.

The premium for individual coverage for retirees who are not eligible for Medicare ranges from $476.20 to $895.70. The premium for individual coverage for a Medicare eligible retiree ranges from $301.10 to $448.90. Wisconsin does not make any contribution to the premium for retirees.

http://etf.wi.gov/publications/et4112.htm

http://etf.wi.gov/publications/dc_content/dc_2008/Annuitant_ET2108/complete_book.pdf

http://etf.wi.gov/publications/dc_content/dc_2008/premium_rates_ann.pdf

Wyoming

Wyoming offers health insurance to its retirees provided they had health insurance coverage for at least one year prior to retirement and apply for coverage within 31 days of their retirement date. If a retiree does not enroll at the time s/he retires, s/he is not eligible to enroll in the plan at a later date. All those who qualified as eligible dependents when an employee was considered an active employee remain eligible dependents when the employee's status changes from active to retired. Upon turning 65 years of age, all retirees are assumed to have enrolled in Medicare Parts A and B. The state-sponsored plan will calculate all benefits as if Medicare were acting as the primary payer, regardless of a retiree's actual Medicare enrollment status. Retirees who are not eligible for Medicare may choose among three PPO plans, with varying deductibles. Medicare eligible retirees may choose any plan available to a non-Medicare retiree, or a plan designed to complement coverage offered by Medicare.

The premium for individual coverage for a retiree who is not eligible for Medicare ranges from $528.32 to $610.78, depending on the plan's deductible. The premium for individual coverage for a retiree who is eligible for Medicare ranges from $151.43 to $384.13, depending on the plan chosen. Retirees not eligible for Medicare receive a state contribution of $487.31.

http://personnel.state.wy.us/EGI/2007%20Retiree%20Health%20Booklet.pdf

http://personnel.state.wy.us/EGI/2007RetireeRates_April.pdf

Chapter 2: Financing Retiree Health Benefits and Other Post Employment Benefits[1]

Virtually all states provide retiree health benefit programs along with other benefits such as vision, prescription drug, and dental insurance for their retired employees.[2] These state-managed programs vary widely in their provisions, degree of government subsidy, cost to the state government, and method of funding retiree health plans.

Some states require retirees to pay the full cost of participating in the plan while others offer health insurance that does not require any premium payment by the retiree.

Chapter 1 provides a detailed description of the retiree health insurance plans for each state, including eligibility conditions for coverage, premiums, co-payments, and deductibles.[3] Some states require retirees to pay the full cost of participating in the plan[4] while others offer health insurance that does not require any premium payment by the retiree. As a result of these differences, the pay-as-you-go benefit costs vary substantially from state to state. For example, the Federal Reserve Bank of Boston (2007) examined the Comprehensive Annual Financial Reports (CAFR) of the various New England states and found that annual benefit payments per eligible retiree in 2006 ranged from $3,300 in Maine to $11,000 for Connecticut.

This chapter focuses on the current financial status of the state retiree health plans and reports unfunded actuarial accrued liabilities (UAAL), annual required contributions (ARC), and the current method of financing these plans. The UAAL is the difference between all actuarial accrued liabilities (AAL) and any assets that the employer has set aside in an irrevocable trust. Obviously, if the plan is completely pay-as-you-go, the UAAL is equal to the AAL because there are no assets. The UAALs for many states are large in absolute value and relative to total state expenditures, debt, and per capita income of the citizens of each state. The ARC is the amount of annual contributions by the employer that are required to pay this year's cost of the OPEBs plus the amount needed to amortize the existing unfunded liability over a 30-year period. In general, the ARC will exceed the annual pay-as-you-go cost by the amortization of the unfunded liability over 30 years. ARCs and UAALs have been growing over time in most states and are now a major public policy issue for many states.

In general, GASB 45 requires states to report the present discounted value of the future liability of health care promises to current workers as these benefits are accrued, along with the present value of these promises to current retirees.[5]

Although GASB 45 does not require that states actually establish trust funds for these programs, several states have enacted trust fund legislation for their retiree medical plans as well as those of local entities in the state. Opinions vary on the number of states that have actually established such funds. Standard & Poor's (2007b) reports that Alabama, Georgia, Kentucky, Maryland, Massachusetts, Ohio, South Carolina, Utah, Vermont, and West Virginia had established trust funds for their retiree health programs. Other studies have presented different lists for states that have engaged in some prefunding. For example, Wisniewski and Wisniewski concluded in a report prepared for AARP (2004) that 11 states were using some type of prefunding in 2003. Their list included eight states that are not included in the S&P list shown in the text.

The Pew (2007) report finds a different set of states with some type of funding, including several states that are moving toward fully funding these obligations. In addition, California indicates that it is moving toward funding some part of their OPEB liabilities (CalPERS, 2007). Ohio appears to have the largest trust fund assets of about $12 billion (Standard & Poor's, 2007b). Of course, enacting legislation to establish authorization for a trust fund does not imply a commitment to actually prefund retiree health obligations.

This report reviews and examines each of the available 42 state OPEB actuarial reports. Table 2.1 (p. 38) provides a brief summary of these reports, showing the UAAL and the ARC for each state along with the key assumptions used to calculate future liabilities, the date of the report, and the firm that prepared the actuarial statement.

The present value of benefits based on current programs is determined by projecting the future age and service structure of the state labor force and retired state employees and the cost of the health care promises made to these workers and retirees, and then discounting all these costs back to the date of the report. The actuarial accrued liabilities represent the total cost associated with providing health insurance to current retirees and the expected cost of retiree health insurance earned to date by current employees. The

AAL indicates the amount of money needed to pay all these future liabilities. Alternatively, this means that if the state had a dedicated fund with assets equaling the AAL, then all currently accrued liabilities could be paid from the fund without any further contributions from the state. This is similar to having a fully funded pension plan or stating that the pension has a funding ratio of 100 percent.[6]

. . . most states have been amending their health plans for active workers and retirees in response to rising health care costs. Changes include higher premiums, higher deductibles, higher co-payments, and more years of service to qualify for coverage.

In addition to the demographic projections, key assumptions used by the actuarial consulting firm or the in-house actuaries to calculate the UAAL and the ARC are the rate of medical inflation and the discount rate used to determine the present value of future retiree health benefits. GASB requires that the actuarial statements assume that the current provisions of the retiree health plan will remain in effect. However, most states have been amending their health plans for active workers and retirees in response to rising health care costs. Changes include higher premiums, higher deductibles, higher co-payments, and more years of service to qualify for coverage.[7] The ability to modify retiree health plans provides states with some options to moderate their projected costs and thus reduce the UAAL and ARC presented in these actuarial statements.

Table 2.1. *Summary Information From State Actuarial Reports*

State	Unfunded Liability	ARC	Discount Rate	Inflation Rate*	Fund	Date of Report
Alabama[3,19]	$15.635 billion	$1.173 billion	5.0%	12.0% decreasing to 5.0% in 2013	No	2006
Alaska[2]	$1.526 billion		8.25%	9.0% decreasing to 5.0% in 2006	Yes	2006
Arizona[2]	$0.438 billion	$0.104 billion		8.0%	Yes	2007
Arkansas[16]						
California[5]	$47.88 billion	$3.59 billion	4.5%	10.0% decreasing to 4.5% in 2017	No	2007
Colorado[3]	$1.03 billion	$0.707 billion	8.5%	4.5%	Yes	2006
Connecticut[11]	$21.681 billion	$1.597 billion	4.5%	9.0% decreasing to 5.0% by 2010	No	2006
Delaware[7]	$3.1 billion	$0.286 billion	8.0%	Not Specified	No	2005
Florida[11]	$3.1 billion	$0.208 billion	4.0%	9.6% decreasing to 5.0% by 2010	No	2008
Georgia[3]	$15.035 billion	$1.262 billion	6.0%	10.0% decreasing to 5.5% in 2012	No	2007
Hawaii[1]	$9.678 billion	$0.705 billion	5.0%	11.0% decreasing to 5.0% in 2113	No	2006
Idaho[11]	$0.362 billion	$0.034 billion	5.0%	Not Specified	No	2006
Illinois[8]	$24.210 billion	$1.743 billion	4.5%	9.0% decreasing to 5.0% by 2016	No	2007
Indiana[17]						
Iowa[4]	$0.219 billion	$0.0002 billion	4.5%	Managed care: 8.88% decreasing to 5.0% by 2026 Non-Managed Care: 9.38% decreasing to 5.0% by 2026	No	2006

Table 2.1. *Summary Information From State Actuarial Reports (continued)*

State	Unfunded Liability	ARC	Discount Rate	Inflation Rate*	Fund	Date of Report
Kansas[17]						
Kentucky[3]	$4.83 billion	$0.4 billion	4.5% for nonhazardous employees 7.75% for hazardous employees	12.0% decreasing to 5.0% in 2015	Yes	2007
Louisiana[12]	$19.6 billion	$2.07 billion	4.0%	Under 65: 9.5% decreasing to 5.0% by 2022 Over 65: 10.5% decreasing to 5.0% by 2022	No	2007
Maine[6]	$4.756 billion	$0.356 billion	4.5%	3.75%, overall inflation rate	No	2007
Maryland[2]	$14.543 billion	$1.114 billion	4.25%	11.0% decreasing to 5.0% in 2017	No	2007
Massachusetts[1]	$13.287 billion	$1.062 billion	4.5%	10.5% decreasing to 5.0% in 2018	No	2006
Michigan[20]	$13.50 billion		4.0%	10.0% decreasing to 3.2% in 2020	No	2007
Minnesota[7, 19]	$0.659 billion	$0.066 billion	4.75%	9.13% decreasing to 5.0% in 2019	No	2006
Mississippi[3]	$5.14 billion	$0.436 billion	4.5%	Not Specified	No	2007
Missouri[13]	$2.185 billion	$0.159 billion	4.5%	12.0% decreasing to 5.0% in 2013	No	2006
Montana[17]						
Nebraska[18]						
Nevada[1]	$2.294 billion	$0.273 billion	4.0%	Not specified	No	2007
New Hampshire[8]	$2.858 billion	$0.234 billion	4.5%	9.0% decreasing to 5.0% in 2012	No	2007
New Jersey[1]	$68.833 billion	$5.840 billion	4.5%	10.5% decreasing to 5.0%	No	2007
New Mexico[8]	$4.11 billion	$0.383 billion	5.0%	Under 65: 11.0% decreasing to 5.0% by 2014 Over 65: 8.6% decreasing to 5.0% by 2014	Yes	2007
New York[2]	$49.66 billion	$3.810 billion	4.2%	10.0% decreasing to 5.0% in 2012	No	2006
North Carolina[1]	$23.785 billion	$2.389 billion	4.25%	11.0% decreasing to 5.0% in 2012	No	2005
North Dakota[7]	$0.031 billion	$0.004 billion	5.0%	11.0% decreasing to 6.0%	No	2007
Ohio[5]	$18.7 billion	$2.1 billion	6.5%	9.0% decreasing to 4.0%	Yes	2007
Oklahoma[1]	$0.815 billion	$0.087 billion	3.5%	9.0% decreasing to 5.0%	No	2007
Oregon[1]	$0.309 billion	$0.034 billion	4.5%	Not Specified	No	2007
Pennsylvania[15]	$8.659 billion	$0.720 billion	8.5%	8.0% decreasing to 5.0% in 2010	No	2008
Rhode Island[5]	$0.480 billion	$0.041 billion	8.25%	12.0% decreasing to 4.5% in 2016	No	2005

Table 2.1. *Summary Information From State Actuarial Reports (continued)*

State	Unfunded Liability	ARC	Discount Rate	Inflation Rate*	Fund	Date of Report
South Carolina[5]	$10.05 billion	$0.777 billion	4.5%	9.75% decreasing to 5.0%	No	2006
South Dakota[14]	$0.076 billion	$0.009 billion	3.0%	8.33% decreasing to 5.0% by 2012	No	2008
Tennessee[2]	$1.806 billion	$0.187 billion	4.5%	11.0% decreasing to 5.0% by 2020	No	2007
Texas[10]	$17.67 billion	$1.5 billion	6.0%	Not Specified	No	2007
Utah[5]	$0.569 billion	$0.054 billion	8.0%	10.0% decreasing to 4.5% by 2018	No	2007
Vermont[2]	$1.419 billion	$0.113 billion	3.75%	9.0% decreasing to 5.0%	No	2006
Virginia[7]	$1.616 billion	$0.122 billion				
Washington[7]	$7.495 billion	$0.634 billion	4.5%	11.0% dereasing to 5.0% in 2015	No	2007
West Virginia[9]	$7.761 billion	$0.824 billion	4.5%	9.0% decreasing to 6.0% in 2020	No	2007
Wisconsin[17]						
Wyoming[2]	$0.072 billion	$0.006 billion	4.0%	11.5% decreasing to 6.0% in 2012	No	2005

*Inflation rate given is medical inflation, unless otherwise specified
1 Report by Aon Consulting
2 Report by Buck Consulting
3 Report by Cavanaugh Macdonald Consulting
4 Deloitte Consulting LLP
5 Report by Gabriel Roeder Smith & Co
6 Report by Bartel Associates LLC and Glicksman Consulting LLC
7 Report done in-house
8 Report by Segal Company
9 Report by CCRC Actuaries, LLC
10 Report by Rudd and Wisdom, Inc
11 Report by Milliman Inc
12 Report by Mercer
13 Report by Price Waterhouse Coopers
14 Watson Wyatt
15 Hay Group
16 Report not yet completed
17 Report was to be prepared later in 2008 and was not available for this publication.
18 State officials believe that their UAAL is minimal and will not prepare an actuarial report.
19 Information collected from reports completed for state employees (excluding teachers), and teachers alone.
20 Information collected from 2007 CAFR

GAO (2008) reports that all states have legal protections for their retirement plans that limit the ability of a legislature to substantially alter the generosity of the pension. The majority of states have constitutional provisions that describe how their retirement plans are to be "funded, protected, managed, or governed." However, retiree health plans are not accorded similar status. Reductions in or elimination of retiree health benefits may be constrained by collective bargaining contracts, but in general, legislatures have flexibility to reduce and modify retiree health benefit plans for public sector employees.

GASB 45 requires plans to use a discount rate consistent with the return on the "investments that are expected to be used to finance the payment of benefits." For states that do not prefund their OPEBs, the appropriate discount rate should approximate the yield on the portfolio of the state's general assets from which funds are drawn to pay for the health benefits for retirees. However, if the state establishes an irrevocable trust to partially or wholly finance the retiree health benefit program, a rate consistent with the return on these investments can be used. For many cases, this may be the same discount rate used to determine the financial status of the state's pension plan.[8] In recent years, the rate of return on pension funds is often assumed to be in the range of 7 to 9 percent while the rates of return on more liquid financial accounts of the state are closer to 4 percent. Thus, states that establish fully funded plans can use the higher discount rates to determine their accrued liabilities and the ARCs. Using the illustrative rates above, partially funded plans can adopt a blended rate between 4 and 7 to 9 percent to calculate their accrued liabilities.[9]

Many of the OPEB statements that have been prepared by consulting and actuarial firms show the impact of alternative scenarios. Typically, the statements report the UAAL using a discount rate of approximately four percent, which is consistent with the current pay-as-you-go status of these plans. The

Table 2.2. *UAAL by Discount Rate (in billions of dollars)*

State	Discount Rate	UAAL
California	4.500%	$47.88
	6.125%	$38.24
	7.750%	$31.28
Connecticut	4.500%	$21.68
	4.700%	$20.88
	6.080%	$16.36
	8.500%	$11.37
Florida	4.000%	$3.08
	7.750%	$1.92
Georgia	4.500%	$19.56
	6.000%	$15.04
Hawaii	5.000%	$9.68
	8.000%	$6.27
Maine	4.500%	$4.76
	7.500%	$3.23
Maryland	4.250%	$14.54
	7.750%	$9.00
Massachusetts	4.500%	$12.29
	8.250%	$7.56
New Hampshire	4.500%	$2.86
	8.500%	$1.55
New Jersey	4.000%	$68.83
	8.250%	$37.37
North Dakota	5.000%	$0.031
	8.000%	$0.024
Oklahoma	3.500%	$0.815
	7.500%	$0.586
Oregon	4.500%	$0.309
	7.500%	$0.238
Rhode Island	5.000%	$0.696
	7.000%	$0.550
	8.250%	$0.480
South Carolina	4.500%	$10.049
	6.000%	$7.599
	7.250%	$6.446
Utah	6.0%	$0.670
	8.0%	$0.569
Vermont	3.750%	$1.419
	8.000%	$0.691
Wyoming	4.000%	$0.072
	8.500%	$0.041

consultants often illustrate the impact of a movement toward full funding by incorporating a discount rate of approximately 8 percent into the calculations.

Table 2.1 (p. 38) shows that most of the actuarial reports assume a discount rate between 4 and 5 percent. One outlier is Delaware, which used an eight percent discount rate even though the OPEB plans "are largely unfunded" (Delaware report, 2005). However, in 2000 Delaware established a trust fund and began to make contributions into this account. Another state using a rather high discount rate is Rhode Island, which reports its UAAL and ARC using a discount rate of 8.25 percent even though it had not established a fund for its OPEBs.[10]

[I]f a state does not establish a trust fund for its retiree health plan and continues to use pay-as-you-go funding, the annual cost of such plans will most likely increase…

Obviously, the higher the discount rate used in the calculation, the smaller the projected liability associated with retiree health plans. For example, the California OPEB statement presents estimates of its UAAL using three discount rates. A 4.5 percent discount rate that is consistent with a pay-as-you-go system produces an unfunded liability of $47.9 billion; using a discount rate of 6.125 for a partially funded plan results in a UAAL of $38.2 billion; and adopting a 7.75 percent discount rate as if the state were to move to full funding yields an unfunded liability of only $31.3 billion. The actuarial report for Connecticut provides estimates for various levels of funding and the impact of a proposal by the governor to establish a small trust fund. The magnitude of the estimated UAAL varies from $21.7 billion with a 4.5 percent discount rate to only $11.4 billion if an 8.5 percent discount rate is adopted.

Of course a lower UAAL also implies a lower ARC. Deputy Comptroller Thomas Sanzillo (2007) testified before the New York State Assembly that the OPEB liability of the state (including the State University of New York) was approximately $47 billion and that the annual required contribution was $3.7 billion if the state continued with no pre-funding. However, he then reported that if the state committed to fully fund its OPEB obligations, the ARC would be only $2.4 billion based on using a discount rate of 8.0 percent. This latter value represented $1.1 billion to support current benefits payable and $1.3 billion in contributions to a fund to support future benefits.

Until recently, virtually all states with retiree health plans financed these plans from general state revenues and so most of the reports are based on the lower discount rates associated with money market accounts and short-term paper. The aging of the population will be associated with an increase in the ratio of retirees to workers. Thus, if a state does not establish a trust fund for its retiree health plan and continues to use pay-as-you-go funding, the annual cost of such plans will most

Table 2.3. *Sensitivity of UAAL to Inflation Rate (in billions of dollars)*

State	Health Care Inflation Trend		
	–1%	Baseline	+1%
Florida	$2.66	$3.08	$3.08
Hawaii	$8.19	$9.68	$11.60
Idaho	$0.362	$0.362	$0.432
Maryland	$13.13	$14.54	$16.23
Massachusetts	$11.28	$13.29	$15.88
North Dakota	$0.028	$0.031	$0.033
Oklahoma	$0.745	$0.815	$0.895

Table 2.4. *Sensitivity of ARC to Inflation Rate (in billions of dollars)*

State	Health Care Inflation Trend		
	–1%	Baseline	+1%
Florida	$0.17	$0.21	$0.25
Hawaii	$0.58	$0.71	$0.88
Idaho	$0.28	$0.34	$0.42
Maryland	$0.47	$1.11	$1.27
Massachusetts	$0.87	$1.06	$1.32
North Dakota	$0.004	$0.004	$0.004
Oklahoma	$0.078	$0.087	$0.068

Table 2.5. *UAAL and ARC as Percentage of Payroll*

State	UAAL as % of Payroll	ARC as % of Payroll
Alabama	229.9	17.21
Arizona	4.8	1.12
Colorado	15.6	1.9
Georgia	129.466	10.870
Hawaii	359.595	26.189
Kentucky	251.1	21
Maine	273.333	20.460
Maryland	351.137	26.939
Minnesota	23.22	2.340
Missouri	140.300	9.800
New Mexico	101.0	9.41
North Carolina	192.443	19.333
Ohio	154.0	17.3
Oklahoma	29.965	3.200
Pennsylvania	223.566	18.601
Rhode Island	292.548	24.858
Texas	200.034	16.772
South Carolina	151.503	11.720
Virginia	15.283	1.160
Washington	67.890	5.749

likely increase as a percentage of all state expenditures for health care and as a percentage of total compensation for public sector employees.

The rate of medical inflation will determine the future cost of liabilities associated with retiree health benefits and thus the future liability of current programs if they are maintained. For the past two decades, medical inflation has typically been twice the annual increase in the consumer price index (CPI).[11] As a result, the cost of providing health insurance to workers and retirees alike has risen dramatically. The Kaiser Family Foundation/Hewitt Associates 2005 Retiree Health Benefits Survey reports that that the total cost to employers and employees of providing retiree health benefits increased by 16.0 percent in 2002, 13.7 percent in 2003, 12.7 percent in 2004, and 10.3 percent in 2005. While health care inflation continues to outstrip the increase in the CPI, most projections of health care costs used in the actuarial reports project a decline in the rate of medical inflation.

Virtually all of the actuarial reports for state retiree health insurance plans assume that medical inflation will decline from its current level of 10 to 14 percent per year to a rate of around 5 percent. Of course, lower assumed rates of inflation result in lower liabilities and annual required contributions, thus making the state's financial position look rosier. The statement for Hawaii illustrates the importance of the inflation assumptions. Baseline assumptions indicated an UAAL of $9.7 billion. A one percentage point increase in the health care inflation rate raises the UAAL to $11.6 billion or an increase of almost 20 percent. The assumptions on health care in the various state reports vary, in part, due to the date of the report and the rate of inflation at that time. If the rate of inflation for health care were to continue at its current rate, all projections of state UAALs and ARCs would be much higher.[12] Tables 2.3 and 2.4 illustrate the substantial change in the UAAL and ARC for state plans associated with a one percent change in the inflation assumptions as reported in the actuarial reports of six states. The sensitivity of these estimates to only a one percent faster rate of inflation in health care should alert policy analysts to the potential of considerably higher liabilities for these plans.

Table 2.1 (p. 40) illustrates the substantial differences in the total liabilities of state retiree health plans reported in the actuarial statements. Among the states whose actuarial reports this project examined, North Dakota ($31 million),Wyoming ($72 million), Iowa

Table 2.6. *Estimates of Per Capita Unfunded Liability and ARC as Percentage of Budget*

State	Unfunded Liability Per Capita	UAAL as Percentage of Budget	ARC as Percentage of Budget
Alabama	$3,444.13	74.34	5.58
Alaska	$2,279.62	18.95	
Arizona	$73.58	1.83	0.43
California	$1,330.91	22.82	1.71
Colorado	$220.38	5.49	3.77
Connecticut	$6,224.02	107.41	7.87
Delaware	$3,688.03	52.48	4.84
Florida	$174.79	4.40	0.30
Georgia	$1,646.95	44.37	3.73
Hawaii	$7,652.37	115.39	8.39
Idaho	$253.88	5.90	0.55
Iowa	$74.44	1.56	0.00
Kentucky	$1050.10	21.80	1.99
Louisiana	$4,359.75	91.60	9.67
Maine	$3,657.92	64.16	4.76
Maryland	$2,608.93	54.28	4.16
Massachusetts	$2,068.71	34.98	2.79
Michigan	$1335.58	26.25	
Minnesota	$128.87	2.18	0.22
Mississippi	$1,772.14	34.94	2.96
Missouri	$378.38	9.47	0.69
Nevada	$954.77	25.12	2.98
New Hampshire	$2,148.70	48.39	4.04
New Jersey	$7,946.92	139.66	11.85
New Mexico	$2,144.72	36.30	2.79
New York	$2578.06	36.30	2.79
North Carolina	$2,742.22	60.26	6.05
North Dakota	$48.75	0.89	0.11
Oklahoma	$230.49	5.19	0.55
Oregon	$85.12	1.61	0.18
Pennsylvania	$700.13	13.77	1.15
Rhode Island	$449.98	7.11	0.61
South Carolina	$2,361.93	44.25	3.42
South Dakota	$97.32	2.33	0.28
Texas	$773.51	21.73	1.85
Vermont	$2,259.03	31.54	2.55
Virginia	$211.71	4.88	0.37
Washington	$1,196.01	22.69	1.92
West Virginia	$4,319.83	79.38	0.83
Wyoming	$142.14	1.80	0.15

($0.2 billion), Oregon ($0.3 billion), Rhode Island ($0.5 billion), and Oklahoma ($0.8 billion) have the lowest reported unfunded liabilities. In comparison, New Jersey ($68.8 billion), New York ($49.7 billion), California ($47.9 billion), North Carolina ($23.8 billion) Connecticut ($21.7 billion), Louisiana ($19.6 billion), and Texas ($17.7 billion) have the highest UAALs. The substantial variation in unfunded liabilities is a function of the state work force, the generosity of the retiree health plan, and the portion of the total cost of the program paid for by the state.

To better illustrate the magnitude of these liabilities and their importance to the various states, this project examines the magnitude of the UAAL and ARC relative to various important financial variables. Several of the actuarial statements indicate the UAAL and the ARC as a percent of payroll. Those ratios are reported in Table 2.5.

The highest reported values for UAAL as a percent of payroll are Hawaii (359.6 percent), Maryland (351.1 percent), and Rhode Island (292.5 percent). The highest values for the ARC as a percent of payroll are Maryland (26.9 percent), Hawaii (26.2 percent), and Rhode Island (24.9 percent). These latter numbers are particularly impressive as they imply the proportion of state payroll needed to pay for current expenditures on retiree health care and the cost of amortizing the unfunded liability.

This report derives three additional measures of the relative size of the cost of retiree health benefit plans. First, the implied per capita debt for each of the states is determined, shown in Table 2.1 (p. 38) by dividing the UAAL by the state population. These values are reported in column one of Table 2.6; columns two and

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Sources (Table 2.6):
Column 1: Unfunded liability per capita is calculated by dividing the UAAL shown in Table 2.1, by the state's estimated population in 2005. Population estimates are from the U.S. Census population estimator, http://www.census.gov/popest/states/tables/NST-EST2007-01.xls.

Column 2: Unfunded liability as a percentage of the state's budget is calculated by dividing the UAAL shown in Table 2.1, by the state's share of the state and local expenditures in 2005. Estimates of state and local expenditures are from, http://sourcebook.governing.com/subtopicresults.jsp?ind = 695 . The estimate of the state's share of state and local expenditures is from http://sourcebook.governing.com/subtopicresults.jsp?ind = 696.

Column 3: Annual Required Contribution as a percentage of the state's budget is calculated by dividing the ARC shown in Table 2.1, by the state's share of the state and local expenditures in 2005. Estimates of state and local expenditures are from http://sourcebook.governing.com/subtopicresults.jsp?ind = 695 . The estimate of the state's share of state and local expenditures is from http://sourcebook.governing.com/subtopicresults.jsp?ind = 696.

three report the UAAL and the ARC as a percent of the state budget. New Jersey has the highest per capita RHI debt with a value of $7,947, closely followed by Hawaii with an RHI debt of $7,652 per person, and Connecticut with $6,224 per capita. States with the lowest per capita debt are North Dakota ($49), Iowa ($74), Oregon ($85), Wyoming ($142), Florida ($175), Virginia ($212), and Oklahoma ($230).

States with the highest values of UAAL as a percent of the state budget include New Jersey (140 percent), Hawaii (115 percent), and Connecticut (107 percent). States with the lowest UAAL as a percent of their budget include North Dakota (0.9 percent), Oregon (1.6 percent), and Wyoming (1.8 percent). A similar ranking is observed for the ARC as a percentage of the state budget.

Unfunded Actuarial Accrued Liabilities of State Retiree Health Plans

One objective of this project is to provide a comprehensive assessment of the financial status of all state retiree health plans and how these data were determined and reported in the actuarial reports. Table 2.1 (p. 38) is a first attempt to provide these data. Other studies have also reported some of this information. Table 2.7 reports estimates of the UAAL from a series of studies: Credit Suisse (Zion and Varshney, 2007), Goldman Sachs (2007), Standard and Poor's (2007b), and Pew (2007), and compares their estimates to the values this project has found in the actuarial statements.[13]

The estimated unfunded liabilities reported by these sources are in general agreement; however, there are some noticeable differences across the studies. Differences in the estimates arise because some sources report data only for state employees even if there is only one plan that includes other public employees within the state, such as teachers and municipal employees.[14] Other differences in the estimates are due to the fact that some of the states had not completed their actuarial reports and the authors attempted to estimate the state's unfunded liabilities. Still other reasons for the alternative estimates are due to the date of the actuarial report included in the study and whether the study used actual data for an actuarial report or the authors made their own estimates of the UAAL.

The reports by Standard and Poor's, Pew, and Credit Suisse provide the most comprehensive assessments of the current status of state-provided retiree health plans. The following provides a brief summary of the analysis presented in these reports.

Table 2.8 (p. 46) provides a complete picture of the UAALs of the various states reported by Standard and Poor's and whether the state had completed an actuarial report. The Standard & Poor's study states that 40 states had completed an actuarial report of their OPEB liabilities and that total liabilities were approximately $400 billion. The state liabilities reported in the S&P report ranged from $52 million for North Dakota to $58.1 billion for New Jersey. The study reports that

Table 2.7. *Estimates of Unfunded Liabilities of State OPEB: in billions*

State	Actuarial Report	Credit Suisse	Goldman Sachs	Standard & Poor's	Pew Center
Alabama	15.6	20.0		17.8	5.290
Alaska	1.53			Reported w/pension, Total 7.0	1.206
Arizona	0.44			1.1–1.2	0.094
Arkansas				3.0	2.130
California	47.9	70	31.3–47.9	47.9	47.878
Colorado	1.0	0.313		Reported w/pension, Total 1.0	1.033
Connecticut	21.7	21.1		12.7–23.9	21.681
Delaware	3.1		3.2–4.4	4.0	4.410
Florida	3.1			2.1–3.6	3.628
Georgia	15.0	20		19.2	4.905
Hawaii	9.7			7.2–12.5	6.791
Idaho	0.4			0.29–0.41	0.486
Illinois	24.2			48.000	
Indiana					
Iowa	0.2			0.22	0.220

Table 2.7. *Estimates of Unfunded Liabilities of State OPEB: in billions (continued)*

State	Actuarial Report	Credit Suisse	Goldman Sachs	Standard and Poor's	Pew Center
Kansas					
Kentucky	4.8			12.3	8.090
Louisiana	19.6				7.344
Maine	4.8			3.2–4.8	2.297
Maryland	14.5	22.9	22.9	9.0–14.5	14.543
Massachusetts	13.3		7.6–13.3	7.6–13.3	13.287
Michigan	13.5	22.7	30.0	7.36	7.968
Minnesota	0.7			0.659	
Mississippi	5.14	0 (no program)			
Missouri	2.19			1.3–2.2	2.186
Montana		0.525		0.31	0.525
Nebraska		0 (no program)			
Nevada	2.3		1.8–4.4	1.6–4.1	4.100
New Hampshire	2.9			1.5–2.9	2.906
New Jersey	68.8	60.0	20.0	58.1	21.587
New Mexico	4.1			4.1	4.990
New York	49.7	54.0	47.0	47.0	49.663
North Carolina	23.8	23.8	23.8	23.9	11.400
North Dakota	0.03	0.049		0.052	0.049
Ohio			20.2	21.7	6.500
Oklahoma	0.8			Reported w/pension	0.814
Oregon	0.3	0.432		0.42	0.645
Pennsylvania	8.7		13.8	9.4	13.501
Rhode Island	0.5	0.630		0.48–0.70	0.696
South Carolina	10.1		9.3	10.0	4.252
South Dakota	0.8			0.087	0.127
Tennessee	1.8			3.2	2.305
Texas	17.7	26.8			26.817
Utah	0.6	0.749		0.49	0.749
Vermont	1.4			0.69–1.4	0.552
Virginia	1.6	2.3		2.3	2.320
Washington	7.5			7.5	3.800
West Virginia	7.8		5.0–8.0	7.8	7.761
Wisconsin		0 (no program)			0.017
Wyoming	0.1	0.072			0.072

Sources:
Column 1, Actuarial Reports for various states, 2005–2007.

Column 2, Credit Suisse, "You Dropped a Bomb on Me, GASB," March 22, 2007, Americas/United States, Equity Research.

Column 3, Goldman Sachs, Global Markets Institute, "The Trillion Dollar Question: What is your GASB 45 number?" Summer 2007.

Column 4, Standard and Poor's, "U.S. States Are Quantifying OPEB Liabilities and Developing Funding Strategies as the GASB Deadline Nears," November 12, 2007.

Column 5, Pew Center On The States, *Promises with a Price: Public Sector Retirement Benefits,* December 2007.

Footnote: The range in UAAL presented by some studies indicates estimates using alternative discount rates and should be used for states with no trust fund.

Table 2.8. *UAAL Estimates from Standard & Poor's Study*

State	Report Completed	Unfunded Liability (Table 1 estimates)	Unfunded Liability (Table 2 estimates)
Alabama	Yes	Teachers $12.5 billion State $5.3 billion	$17.8 billion
Alaska	No, Alaska does not have a separate OPEB liability		Reported with pension
Arizona	Yes	$420 million (a preliminary report indicates health benefit liability is between $323 and $400 million)	$1.1–1.2 billion
Arkansas	No, expected to be done by the end of 2007	Initial estimates are $3.0 billion	$3.0 billion
California	Yes	$47.88 billion for health care programs	$47.9 billion
Colorado	Yes	$1.03 billion	Reported with pension
Connecticut	Yes	State (excluding teachers) $11.4–$21.7 billion	$12.7–23.9 billion
Delaware	Yes	$4 billion	$4.0 billion
Florida	Yes	$4.5 billion	$2.1–3.6 billion
Georgia	Yes	$19.18 billion (13.17 billion, teachers)	$19.18 billion
Hawaii	Yes	$11.1 billion	$7.2–12.5 billion
Idaho	Yes	$0.29–0.41 billion	$0.29–0.41 billion
Illinois	No		N/A
Indiana	No, OPEB study will be included in 2008 CAFR		N/A
Iowa	Yes	$0.22 million	.22 billion
Kansas	No		N/A
Kentucky	Yes	$4.2 billion for teachers $8.1 billion for state employees	$12.3 billion
Louisiana	No		N/A
Maine	Yes	$4.7 billion	$3.2–4.8 billion
Maryland	Yes	$9.0–$14.5 billion	$9.0–14.5 billion
Massachusetts	Yes	$13.287 billion	$7.6–13.3 billion
Michigan	Yes	$6.9 billion for state employees $0.467 billion for state police	$7.4 billion
Minnesota	Yes	$0.659 billion	$0.659 billion
Mississippi	No		N/A
Missouri	Yes	$1.267 billion (81.3% of payroll)	$1.3–2.2 billion
Montana		$0.31 billion	$0.31 billion
Nebraska	No		N/A
Nevada	Yes	$1.62–$4.10 billion	$1.6–4.1 billion
New Hampshire	Yes	$1.59–$2.9 billion	$1.5–2.9 billion
New Jersey	Yes	$58.1 billion	$58.1 billion
New Mexico	Yes	$4.1 billion	$4.1 billion
New York	Yes	$47 billion	$47.0 billion
North Carolina	Yes	$23.9 billion	$23.9 billion

Table 2.8. *UAAL Estimates from Standard & Poor's Study (continued)*

State	Report Completed	Unfunded Liability (Table 1 estimates)	Unfunded Liability (Table 2 estimates)
North Dakota	Yes	$0.52 billion	$0.52 billion
Ohio	Yes	$18.7 billion	$21.7 billion
Oklahoma		OPEB is supported by the pension fund. Their liability combined is greater than $9 billion	Reported with pension
Oregon	Yes	$0.42 billion	$0.42 billion
Pennsylvania	Yes	$9.388 billion	$9.4 billion
Rhode Island	Yes	$0.48 billion	$0.48–0.696 billion
South Carolina	Yes	$10 billion	$10.0 billion
South Dakota	Yes	$0.87 billion	$0.87 billion
Tennessee	Yes	$3.2 billion	$3.2 billion
Texas	No		N/A
Utah	Yes	$0.49 billion	$0.49 billion
Vermont	Yes	$1.4 billion	$0.69 - $1.4 billion
Virginia	Yes	$2.3 billion	$2.3 billion
Washington	Yes	$7.495 billion	$7.5 billion
West Virginia	Yes	$7.8 billion	$7.8 billion
Wisconsin	No, does not fund retiree health care		N/A
Wyoming	No		N/A

Source: Standard and Poor's, "U.S. States Are Quantifying OPEB Liabilities and Developing Funding Strategies as the GASB Deadline Nears," November 12, 2007, Tables 1 and 2.

Alabama, Delaware, Georgia, Kentucky, Maryland, Massachusetts, Ohio, South Carolina, Utah, Vermont, and West Virginia have established trust funds for their retiree health programs. Thus, future reports by these states will likely use higher discount rates and report lower UAALs. In addition, Alaska includes its OPEB programs in a single fund in conjunction with its pension plan, thus to some extent the retiree medical plans are also partially funded.

The Pew report concludes that the total actuarial accrued liability for state employees' retiree health care and OPEB is approximately $381 billion, and that 97 percent of these liabilities were unfunded.[15] This estimate does not include the liabilities associated with promises of retiree medical care to teachers and employees of local governments. It is unclear why the authors would want to separate these liabilities when, say, teachers and general state employees are in a single fund for which the state bears the ultimate funding responsibility.[16] For example, North Carolina has a single fund for teachers and state employees and the actuarial statement prepared by Aon Consultants reports an UAAL of $23.9 billion. The Pew study places the liability of North Carolina for its state employees at $11.4 billion while ignoring the liability for the teachers.

The Pew study finds that Arizona, Ohio, Oregon, North Dakota, Utah, and Wisconsin are moving toward full funding of their retiree medical programs and "at least 13 states have set up irrevocable trusts" to help finance future retiree medical plans. Based on its analysis, the Pew report concludes that "half the states account for almost 94 percent of the total unfunded OPEB liabilities." Finally, the Pew report concludes that the mean per capita cost of accrued liabilities for state employees (UAAL/population) was $1,283, which represented 3.4 percent of total state personal income. The three highest values are Connecticut ($6,186), Hawaii ($5,283), and Delaware ($5,167).

Credit Suisse also compiled a listing of the unfunded liabilities associated with the states' OPEBs. This study relied most heavily on information contained in each state's Comprehensive Annual Financial Report (CAFR). After searching other sources, Credit Suisse estimated the financial status of plans in 31 states. Finally, they used a simple transformation formula to derive an estimated value for all other states. This report estimated that the unfunded liabilities of the states were $558 billion. In contrast to the Pew report, this study included the liabilities associated with the promise of health care to retired teachers. In addition, the Credit Suisse report estimated the liabilities of municipal and other public sector workers in the various states and estimated an unfunded liability of almost $1 trillion. Thus, Credit Suisse concluded that the total unfunded liability for state employees, local employees, and teachers exceeded $1.5 trillion.

Concluding Observations

Analysis of the actuarial statements for retiree health insurance and other post-retirement employee benefits of the various states indicates that most of the states face substantial future liabilities associated with these programs, that relatively few states have established trust fund legislation to help finance these future costs, and that even fewer are making use of laws that allow funding. These substantial liabilities pose a serious financial problem for most states and will confront policy makers with difficult choices in the future. In 2006, the annual cost to state and local governments for retiree health plans averaged about two percent of employee salaries. If public sector employers continue to pay for these benefits on a pay-as-you-go basis, the cost of retiree health plans is projected to rise to five percent of payroll in 2050 (GAO, 2008).

Governments can either increase revenues or reduce benefits associated with these programs. However, there are many options that public employers can adopt to accomplish either of these.

As annual costs rise, the ability to finance these programs may cause other priorities to be unmet and the overhang of billion-dollar RHI liabilities may influence future bond ratings.[17] There are a number of options that states can adopt to address the impending financial burden. The choices are clear: governments can either increase revenues or reduce benefits associated with these programs. However, there are many options that public employers can adopt to accomplish either of these.

Increased revenues can be achieved by raising any of a variety of taxes or through the sale of public assets. The use of general or earmarked bonding for retiree health care can generate additional sources of money to be prudently invested. If such financing is used in conjunction with an irrevocable trust, new funds deposited into such a trust can yield returns on investments that can reduce the need for future tax increases.[18] New revenues to support retiree health programs can also be generated by reducing other government expenditures and transferring these unused funds into the trust for OPEBs.

Alternatively, states and other public employers can attempt to reduce expenditures on retiree health plans by reducing their generosity or shifting the cost from the employer to workers and retirees through higher premiums, co-payments, and deductibles. Employers can also increase the years of service required for eligibility in these programs, thus reducing the number of eligible participants, or further increasing the cost to retirees. States and local governments might also consider the total elimination of retiree health plans[19] or the shift from defined benefit type plans to retirement saving account plans, although some entities may face constitutional and statutory restrictions on eliminating these plans. Finally, states may adopt various methods to address the actual cost of health benefits. Such techniques include more effective delivery of health care to retirees, proper and efficient coordination with Medicare, and the use of health improvement programs (such as wellness programs) to reduce the use of medical care by their retirees.

In response to GASB 45 and financial pressures, states are considering many of these options. Other sections of this report will address the specific changes that public employers have adopted, in an effort to illustrate their effects and document potential changes that other states might pursue.

Notes

1 Helpful comments and suggestions were provided by Jerrell Coggburn, Dennis Daley, Rick Kearney, Kitty McCollum, Olivia Mitchell, Philip Peterson, and Andrew Stratton. Christina Robinson provided research assistance and created the tables while Amber Mattox helped obtain some of the actuarial statements.

2 There has been some disagreement about plan coverage of several states in previous studies. Credit Suisse (Zion and Varshney, 2007) reports that all states except Mississippi, Nebraska, and Wisconsin provide some type of retiree health insurance. Wisniewski and Wisniewski (2004) state that all 50 states offer health benefits to their retirees under the age of 65 and all but Indiana and Nebraska offered health insurance to retirees age 65 and older. In this project's survey of state finance and health care administrative leaders reported in Chapter 3, four states responded

that they did not have a retiree health benefit program. Such disagreements arise due to the diversity in plans.

3 Chapter 1 also provides websites for each of the state health plans so the interested reader can examine the health plans in more detail.

4 Typically, the "full cost" of a retiree health plan paid by retirees would be the average cost of all participants in the state's health plan for active workers and retirees. Due to age related differences in the cost of health insurance, allowing retirees to pay the same premium for participating in the plan involves an implicit subsidy. The new GASB standards require measurement and reporting of this subsidy to retirees.

5 The aging of the U.S. population is typically reflected in the aging of the populations of the various states. As a result, the costs of retiree health plans are expected to increase in the future due to an increasing number retirees. Mortality improvements result in more years in retirement and thus increase the cost of providing retiree health insurance.

6 Initially, this could mean that the state fully funds the annual required contribution. The ARC is equal to current annual expenses for retiree medical plus the amount needed to amortize the unfunded liabilities of the state RHI programs over 30 years. This would imply that the state is on track to shift from pay-as-you-go funding toward having assets in a fund equal to all accrued liabilities.

7 For example, North Carolina has extended the years of service required to be fully vested in its RHI plan from 5 years to 20 years.

8 GASB 27 issued in 1994 established standards for measuring and reporting pension expenditures and liabilities associated with public sector pension plans.

9 GAO (2008) reports that 70 percent of state and local government pension plans assumed a return of 8.0 to 8.5 percent per year in calculating their liabilities in 2006. Thirty percent of the plans used a somewhat lower rate with the minimum rate being 7.0 percent.

10 The Rhode Island actuarial statement also presents projected liabilities using a 7.0 percent and a 5.0 percent discount rate; however, the executive summary of the report only mentions the values based on the 8.25 percent discount rate.

11 Comparisons of the trends in the annual rate of increase in the CPI and the rate of medical care inflation can be seen on the website of the Bureau of Labor Statistics, www.bls.gov.

12 A similar problem confronts the Trustees of Medicare when they prepare their annual report estimating the unfunded liabilities and actuarial status of this program. In general, the Trustees have assumed that the rate of medical inflation will decline from current rates to the rate of growth of GDP plus one percent.

13 Also see a set of tables compiled by the National Association of State Comptrollers that summarizes various aspects of OPEBs and a paper by Keating and Berman (2007).

14 This raises an interesting question concerning the true liabilities facing the various states based on the degree of their residual responsibility for the debt generated by municipalities, counties, and school districts.

15 To determine the financial status of non-pension benefits, Pew reviewed state "CAFRs and the preliminary actuarial assessments completed for most states of their non-pension liabilities over the next 30 years. Several states have not completed their actuarial evaluations. The research was augmented with interviews with actuaries, economists, state controllers, auditors, legislative analysts and other experts in the field."

16 The authors of the Pew study write, "In an effort to ensure consistency among the states, PCS has limited its analysis to state employees, with OPEB obligations for teachers and local employees removed whenever possible." The Pew website includes more detailed information for the states. Philip Peterson of Aon Consulting commented there are several reasons that the authors may have decided to focus only on state employees. First, there are differences in statutory protections under state laws between employees and teachers. For instance, in Kentucky general employees have statutory rights that are stronger than for teachers. That is, teacher benefits can be changed without constitutional amendment, whereas employees are protected by the constitution. Second, teachers are often included in separate school system plans. So, including teachers in some states but not including local teacher programs in other states could produce misleading observations and conclusions concerning the general status of states.

17 Moody's Investors Service (2005) stated that "Moody's does not anticipate that the liability disclosures will cause immediate rating adjustments of a broad scale" and that "Moody's therefore will exclude OPEB liabilities from calculations of state or local debt burdens, but include them as a factor in the overall credit assessment of an issuer. This practice is consistent with Moody's approach to municipal pension liabilities."

18 Standard & Poor's (2007a) discusses the possibilities of a different prefunding strategy, the use of OPEB obligation bonds.

19 After the Financial Accounting Standards Board required private employers to report retiree health insurance liabilities in the same manner as GASB 45, there has been a sharp decline in the proportion of employers offering retiree health plans. The Kaiser Family Foundation (2006) reports that in 1988, before the adoption of the FASB standards, 66 percent of employers with 20 or more employees offered retiree health plans. After the standards were issued, the proportion of private employers offering such plans dropped to 46 percent in 1991 and further to 36 percent in 1993, a rate that continues today.

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Chapter 3: Survey of the States

This chapter examines how state administrators perceive the importance of retiree health care benefits to central human resources (HR) goals—namely, recruitment, retention, and retirement; how the states structure retiree health care programs; and which cost sharing and cost shedding measures have been adopted and/or are being considered.

Our findings suggest widespread recognition among state administrators of the importance of retiree health care to HR goals. These officials are also aware of OPEB liabilities, but they report that little has been achieved in the way of comprehensive strategies to deal with them. Relatively few states have adopted advance funding for OPEB liabilities and virtually none report a likelihood of taking unpopular action (e.g., raising taxes, shifting funds from programmatic areas to fund OPEB costs) to address their OPEB liabilities. Most states have adopted various cost containment strategies and cost sharing programs, and many have now begun to introduce preventive medicine and wellness efforts. A few states have even begun to contemplate major cost shedding options. The information presented in this chapter provides context for understanding how states arrived at their current situation regarding OPEB and how they intend to address it going forward.

Survey Methods

The survey reported here includes three sections addressing, in order, the current structure of state retiree health care benefits, recent changes, and future directions. The format of individual survey items varied, depending on the nature of the information sought and included: dichotomous choice (Yes/No) response items, where respondents were asked to indicate whether a certain practice or feature was present in their state; Likert-type response items, where respondents were asked to indicate their level of agreement or disagreement with a series of statements related to retiree health care; and open-ended questions, where respondents were asked to provide factual information (e.g., the number of years of work required for employee vesting in retiree health care plans) and their opinions on other retiree health care matters (e.g., what other states they look to as innovators in retiree health care).[1]

Because administrative responsibility for retiree health care varies from state to state and opinions related to retiree health care issues vary depending upon one's role in state government, the survey targeted a number of top officials potentially knowledgeable about retiree health care in their respective states. In particular, five top state officials in each state were targeted, including the state: 1) human resources (HR) director, as identified by the National Association of State Personnel Executives (NASPE); 2) budget officer, as identified by the National Association of State Budget Officers (NASBO); 3) retirement system administrator, as identified by the National Association of State Retirement Administrators (NASRA); 4) treasurer, as identified by the National Association of State Treasurers (NAST); and 5) auditor or comptroller, as identified by the National Association of State Auditors, Comptrollers, and Treasurers (NASACT).

There is a widely shared view that governments must continue to offer an attractive array of benefits, especially health care, in order to attract and retain employees.

The mail survey followed a tailored design method and was administered between December 2007 and March 2008 (Dillman, 2000). The approach included: 1) a brief prenotice letter sent to respondents several days prior to the survey mailing; 2) a survey mailing, including a cover letter explaining the general purpose of the survey, how respondents were selected, and the voluntary nature of the survey; 3) a follow-up postcard sent approximately one week after the survey to thank those who had already responded and to remind those who had not responded to do so; 4) a second mailing to nonrespondents containing a replacement survey, sent about four weeks after the initial survey mailing; 5) a final follow-up postcard reminder, about two weeks following the second survey mailing; and 6) personal telephone calls to key persons in nonresponding states. As suggested by Dillman (2000), all mailings were via first class mail, all correspondence was personalized (e.g., addressed to respondents by name, hand signed by the principal investigators, etc.), and respondents were provided postage-paid return envelopes.

Completed surveys were received from 121 officials from a total of 50 states (an additional 29 officials indicated their inability or unwillingness to complete the survey, bringing the total number of respondents to 150). For reporting purposes, the data are presented by state. In cases where multiple officials from a state responded, an overall "state response" was calculated by first averaging the responses to each survey item, then rounding up or down to the nearest whole number (i.e., up for scores of .5 or higher and down for .49 and lower).

Results

Importance of Retiree Health Care

There is a widely shared view that governments must continue to offer an attractive array of benefits, especially health care, in order to attract and retain employees (Keating and Berman, 2007). Previous research has shown almost universal agreement among state HR directors on the importance of health care benefits to meeting such staffing goals (Reddick and Coggburn, 2007). As reported in Table 3.1, the same general view emerges from the current survey focusing on retiree health care: state administrators see the provision of retiree health care as a valuable tool for recruiting and retaining employees, and for workforce planning. On the latter, the availability of retiree health care can facilitate early retirement, bridging the gap prior to Medicare eligibility. In the implementation of organizational strategic transformations, retiree health care (along with pensions) can be used as leverage to help avoid potential opposition to planned change. Generally, retiree health care is recognized as being important to key organizational HR goals. This general recognition foreshadows inevitable tension as governments attempt to balance their need to pursue strategic HR goals while simultaneously addressing unfunded OPEB costs.

Availability of Retiree Health Care in the States

The Agency for Healthcare Research and Quality (AHRQ) notes that there has been a steady drop in the number of private sector organizations offering retiree health care benefits, from 22 percent in 1997 to 13 percent in 2002. Coverage for early retirees is more likely than for those who are Medicare-eligible. However, larger organizations (more than 1,000 employees) are more likely to provide retiree health coverage. Yet, a decline is noted here as well. Early retiree coverage has declined from 88 percent in 1991 to 68 percent in 2003, while Medicare-eligible coverage went from 80 percent in 1991 to 56 percent in 2003 (Fronstin, 2005). Similarly, from 1997 to 2002, local government retiree health care coverage declined from 62 percent to 55 percent for early retirees and from 47 percent to 35 percent for Medicare-eligible retirees (Fronstin, 2005).

This trend is not yet reflected among state governments. To the contrary, state government coverage actually rose between 1997 and 2002, from 76 percent to 92 percent for early retirees and from 69 percent to 86 percent for Medicare-eligible retirees (Fronstin, 2005). The most recent Kaiser Family Foundation survey of health benefits indicates that 98 percent of state and local governments surveyed offer retiree health care benefits to early retirees, and 81 percent offer these benefits to Medicare-eligible retirees—both figures are the highest among the government and industry groups identified (Kaiser/HRET, 2007).

The Kaiser Family Foundation survey figures from earlier data are reflected in the current survey results (see Table 3.2). Specifically, 46 of the 50 responding states indicate that their state currently offers

Table 3.1. *Perceived Benefits of Retiree Health Care Benefits*

How helpful is the availability of retiree health care with respect to the state's ability to:	Very Helpful	Helpful	Somewhat Helpful	Not Helpful
Recruit employees	18% (9)	44% (22)	24% (12)	8% (4)
Retain employees	28% (14)	46% (23)	18% (9)	2% (1)
Influence the timing of retirement (i.e., early retirement) and help the state plan for employment transitions	18% (9)	44% (22)	26% (13)	6% (3)

Note: Figures are percentage (number) of states responding in each category. Remaining percentages (states) are missing values: rows may not sum to 100 percent.

Table 3.2. *Retiree Health Care*

In regard to retiree health care:	States Answering Affirmatively
Does your state offer retiree health care coverage?	92% (46)
Are newly hired employees eligible for future retiree health care benefits through the state?	90% (45)
Are Medicare-eligible retirees required to enroll in Medicare in order to continue to receive state retiree health care?	76% (38)

Note: Figures are percentage (number) of states responding affirmatively. Missing values included with "No" responses.

Table 3.3. *Current Financing of Retiree Health Care*

How does your state currently finance retiree health care? (select one)	States Indicating Approach
Pay as you go (all health care costs are paid out annually from the operating budget)	60% (30)
Partial funding (funds are set aside to offset the costs of retirees' future health care)	30% (15)
Full funding (funds are set aside to prepay the full costs of retirees' future health care)	2% (1)

Note: Figures are percentage (number) of states responding affirmatively. Missing values included with "No" responses.

retiree health care coverage (Iowa, Kansas, Missouri, and Nebraska indicated no such coverage), and 45 states offer it to new employees (with the important caveat that cost-sharing and vesting periods may have changed). These programs are, more than ever, coordinated with Medicare. These results show that, despite growing concerns over retiree health care costs and in contrast to the private sector, retiree health care continues to be offered almost universally by state governments.

Financing Retiree Health Care

The promise of retiree health care benefits and the costs of paying for them pose a serious obstacle for governments in the early 21st century. Escalating health care costs, in conjunction with a burgeoning number of projected retirements from the baby boom generation, add substantially to the seriousness and complexity of the issue. To address this, governments have a number of options, including doing nothing; raising taxes, cutting other spending or using surplus funds to begin prefunding existing liabilities; issuing bonds to prefund existing liabilities; or scaling back benefits (Boyd, 2006).

States traditionally have handled retiree health care expenses on a PAYGO basis, typically funding these expenses as an annual operating expense. There are exceptions to the general approach, as some states have instituted a separate fund or have begun setting aside additional monies to cover the growing, anticipated liabilities. As shown in Table 3.3, three-fifths of the states surveyed reported using the PAYGO approach, though one state reports fully funding this liability and another 15 states (30 percent) report partial prefunding. While GASB 45 only requires state and local governments to report their OPEB liabilities, it is likely that the reporting of substantial unfunded OPEB liabilities will serve as a catalyst for serious consideration of other, non-PAYGO funding.

Governments can choose to fulfill retiree health care promises by raising revenues. However, state responses quite clearly show that revenue-raising options are not presently under serious consideration (see Table 3.4). Currently, 80-90 percent of the states indicate they are either "Unlikely" or "Very Unlikely" to adopt any extra means for paying these costs.

These results are striking since states' actuarial valuations for OPEB liabilities often show unfunded liabilities reaching into the billions—and in some cases, tens of billions—of dollars. Viewed generously, one might surmise that, with recently completed actuarial valuations in hand, states are only now coming to understand the potentially daunting fiscal challenges they face. If true, then it might be understandable why

Table 3.4. *Future Financing Options for Retiree Health Care*

In the next five years, how likely do you think your state is to adopt the following strategies to finance its unfunded liabilities for non-pension/ other post employment benefits (OPEB) like retiree health care?	Already Adopted	Very Likely to Adopt	Likely to Adopt	Unlikely to Adopt	Very Unlikely to Adopt
Issuing OPEB bonds	0% (0)	0% (0)	6% (3)	48% (23)	38% (19)
Issuing general obligation bonds	0% (0)	0% (0)	0% (0)	46% (23)	46% (23)
Cutting other state programs and using the savings to pay for the unfunded liability	0% (0)	0% (0)	4% (2)	48% (24)	40% (20)
Borrowing funds from the state's pension fund	0% (0)	0% (0)	4% (2)	28% (14)	60% (30)
Raising revenue through higher taxes and fees	0% (0)	6% (3)	6% (3)	40% (20)	40% (20)

Note: Figures are percentage (number) of states responding in each category. Remaining percentages (states) are missing values: rows may not sum to 100 percent.

Table 3.5. *Funding Mechanisms*

States have several options for funding retiree health care obligations. In your opinion, how likely is your state to adopt the following options in the next five years?	Already Adopted	Very Likely to Adopt	Likely to Adopt	Unlikely to Adopt	Very Unlikely to Adopt
A medical subaccount from a qualified pension plan (Section 401(h) account)	4% (2)	2% (1)	6% (3)	48% (24)	32% (16)
A governmental (i.e., "grantor") trust (Section 115 Plan)	10% (5)	2% (1)	28% (14)	32% (16)	20% (10)
Voluntary Employee Benefit Association (VEBA)	6% (3)	0% (0)	2% (1)	48% (24)	36% (18)

Note: Figures are percentage (number) of states responding in each category. Remaining percentages (states) are missing values: rows may not sum to 100 percent.

. . . one could argue that the states are unwilling, at present, to accept the reality of having to make difficult and politically unpopular choices

states do not yet have a clear sense of how they are likely to try to finance their unfunded OPEB liabilities. Viewed less generously, one could argue that the states are unwilling, at present, to accept the reality of having to make difficult and politically unpopular choices. Marlowe (2007, 105–106) suggests that since most governments have not prefunded OPEB, such unwillingness should be short lived: governments will "be forced to meet new annual obligations by generating new revenues, diverting resources from programs and projects, or borrowing money in the public capital markets."

Other than an annual PAYGO approach, retiree health care funding can also be addressed through a number of mechanisms such as medical subaccounts [Section 401(h) account], governmental trusts (Section 115 plan), and voluntary employee benefit associations [VEBA, or 501(c)(9)]. Each of these approaches seeks to advance fund OPEB liabilities by creating a dedicated fund in which a portion of the actuarially determined costs of future benefits (known as the annual required contribution, or ARC) can be deposited and appreciate. GASB 45 does not *require* prefunding of OPEB, but "considerations of intergenerational equity, financial flexibility, and cost reduction favor advance funding" (Gauthier, 2005, xiii).

As Table 3.5 shows, only a handful of states report having already adopted any of these advance funding vehicles: Ohio and Vermont for 401(h) plans; Alabama, Alaska, Colorado, Maine, and Massachisetts for Section 115 trusts; and Montana, Ohio, and Washington for VEBAs.[2] These findings differ from research reported by Standard & Poor's (2007) showing that 11 states (Alabama, Delaware, Georgia, Kentucky, Maryland, Massachusetts, Ohio, South Carolina, Utah, Vermont, and West Virginia) have set up trust funds. This is intriguing in that the officials targeted for this survey should be among the most knowledgeable in the states about theses issues: either they are unaware of the funds' existence or previous reports are in error. As for likely adoptions, with the possible exception of creating a governmental grantor trust (which 29 percent, or 14 states, indicate they are likely to adopt), the states report little current interest in adopting these OPEB prefunding mechanisms. As was the case with identifying revenue sources for funding retiree health care, the reported unlikelihood of states adopting these funding mechanisms suggests that either the states are only now contemplating what is feasible and preferable in light of their OPEB obligations, or they are failing to come to terms with the potentially daunting fiscal challenges facing them. As mentioned in Chapter 1, governments that maintain PAYGO funding could see their retiree health care costs increase dramatically by mid-century, from about 2 percent of payroll to 5 percent—a 150 percent increase—by 2050 (GAO, 2007).

Structure and Generosity of Retiree Health Care Benefits

In addition to the various funding strategies, governments may also focus efforts to rein in costs by altering the structure and generosity of their respective retiree health care benefits. In other words, governments might consider reducing or even terminating promised benefits. Legally, this may be possible, since retiree health care benefits often do not possess the status afforded pension programs as a recognized form of deferred compensation. Indeed, the lack of a contractual obligation to provide retiree health care has been the main argument advanced in Texas, where state officials argue that GASB 45 does not apply since such

Table 3.6. *Limitations on Future Retiree Health Care Benefits*

In the past five years has your state introduced a: (check all that apply)	**States Indicating Approach**
Plan that limits the state subsidy for *future* retirees	10% (5)
Plan that terminates health care for *future* retirees	2% (1)
Plan that terminates all state subsidies for *current* retirees	0% (0)

Note: Figures are percentage (number) of states responding affirmatively. Missing values included with "No" responses.

Table 3.7. *Future Plans for Retiree Health Care Benefits*

In the next five years does your state intend to:	**Very Likely**	**Somewhat Likely**	**Somewhat Unlikely**	**Very Unlikely**
Introduce a plan that will limit subsidy for future retirees	4% (2)	30% (15)	34% (17)	26% (13)
Introduce a plan that will terminate health care for *future* retirees	0% (0)	2% (1)	18% (9)	72% (36)
Terminate all subsidies for *current* retirees	0% (0)	6% (3)	8% (4)	76% (38)

Note: Figures are percentage (number) of states responding in each category. Remaining percentages (states) are missing values: rows may not sum to 100 percent.

benefits could be scaled back at any time (Petersen, 2007; Marlowe, 2008). Recent case law also supports the states' ability to curtail health care benefits for future hires and even for current employees (*AARP, et al., v. EEOC*, 2007; *Duncan v. Retired Public Employees of Alaska*, 2003; *Studer v. Michigan Public School Employees Retirement Board*, 2006; Norfus, 2008). This notwithstanding, it is important to note that many states do face constraints in the form of statutory or constitutional provisions requiring retiree health care or, in some states, collective bargaining agreements that limit unilateral alterations to benefit plans (GAO, 2007).

According to the survey results (Table 3.6), within the past five years, five states have curtailed retiree health care benefits for *future* retirees and one has introduced a plan to terminate these benefits for future retirees. Not surprisingly, no state reported terminating benefits for *current* retirees.

When focus shifts from what the states have recently done to what they might do in the near future, the situation is to be expected to change. Facing newly reported and substantial unfunded liabilities, most states still see themselves as unlikely to undertake drastic action to curtail or eliminate retiree health care benefits (see Table 3.7). Still, it is important to note that 34 percent intend to introduce plans to limit retiree health care subsidies. Three states are also "Somewhat Likely" to terminate the health care benefits of current retirees altogether. These findings suggest the strong possibility of states gradually shifting the burdens of retiree health care benefits to plan beneficiaries: it appears unlikely that many states will terminate the benefits entirely, but the states' contributions are likely to diminish.

Other Cost Control Strategies

Governments could also introduce procedures designed to control costs (without sacrificing the quality of care), by monitoring health care treatments and expenses, sponsoring preventive and wellness programs that lead to healthier lifestyles (hence reduced costs), and introducing retiree health care savings accounts. Cost containment monitors the appropriateness of medical procedures and the efficiency with which they are provided. Cost containment is also obtained through gate-keeping efforts that require precertification or utilization reviews prior to an individual receiving treatment. These are designed to provide a second medical opinion on the appropriateness of procedures and tests. Since there may be a tendency for doctors to provide drugs that pharmaceutical companies heavily market and request various tests primarily as legal safeguards, an alternative, if not impartial, screening is appropriate. As shown in Table 3.8 (p. 56), about 80 percent of the states have instituted cost containment on the more costly medical areas (e.g., hospitalization and long-term disease management programs); about 50 to 60 percent report monitoring secondary expenses.

Related to these types of a priori reviews are post hoc audits that can help control costs through recovery of unnecessary expenses. These audits are designed to

Table 3.8. *Cost Containment Programs*

Which of the following programs does your state have? (check all that apply)	**States Indicating Approach**
Hospital inpatient precertification	80% (40)
Outpatient precertification	50% (25)
Prescription drug prior authorization	62% (31)
Prescription drug clinical intervention	58% (29)
Utilization of health care and hospital centers of excellence	50% (25)
Disease Management Program	84% (42)

Note: Figures are percentage (number) of states responding affirmatively. Missing values included with "No" responses.

Table 3.9. *Health Care Auditing*

Does the state engage in:	**States Indicating Approach**
Claims payer audits	74% (37)
Hospital bill audits	48% (24)
Utilization review vendor audit	58% (29)
Employee self audits	30% (15)

Note: Figures are percentage (number) of states responding affirmatively. Missing values included with "No" responses.

Table 3.10. *Tax-Exempt Savings Accounts*

Does the state offer:	**States Indicating Approach**
Employer-funded Retiree Medical Account (RMA), Health Reimbursement Account (HRA), Health Savings Account (HSA), or Medical Savings Account (MSA)	12% (6)
Employee/retiree-funded Health Savings Account (HSA) or Medical Savings Account (MSA)	34% (17)

Note: Figures are percentage (number) of states responding affirmatively. Missing values included with "No" responses.

verify the cost and appropriateness of care received by patients. As reported in Table 3.9, a majority of states have established claims payer, hospital bill, and vendor auditing programs.

To pay for uncovered aspects of health plans, the tax code allows states to establish individual health care accounts. Employee-funded options that derive their money entirely from contributions set aside by the employee have been adopted in a third of the states. A smaller group has created accounts in which they provide some kind of matching incentive. Employees can establish medical (as well as dependent care, elder care, and legal) accounts. The employees, according to a salary reduction agreement, deposit pre-tax dollars from their salary into these accounts. These personal "trust funds" are then used to pay the medical, dependent, or legal expenses incurred. Unexpended funds revert to the federal government at the end of the year. However, it is quite easy to budget for anticipated, on-going expenses or to plan some less serious medical procedures,. A small number of states have set up employer-funded accounts and about a third offer employee-only funded accounts.

Cost Sharing

Cost sharing programs establish a process that balances governmental subsidies with employee payments. From a governmental perspective, setting the balance of these various payments between employee/retiree and the governmental entity is a major cost containment factor. However, the more of the burden placed on retirees, the more likely it is that they will be priced out of obtaining services other than those involving catastrophic events.

Though the funding liability for retiree health care has begun to loom as a serious issue, states have not been inattentive or inactive with regard to other health care issues. Efforts at cost sharing have been ongoing (see Table 3.11). Most states have increased the premiums/contributions that retirees pay towards their health care coverage. Deductible amounts and co-payment fees that must be paid entirely by the retiree prior to any state subsidy have been raised in over two-thirds of the states. Total out-of-pocket expenses for retirees have also been increased in a large number of states. In addition, nearly a third have increased the coinsurance proportion of each bill that retirees pay.

Table 3.11. *Cost-Sharing Changes Recently Introduced*

In the past five years has your state increased the: (check all that apply)	**States Indicating Approach**
Retiree contribution premiums	66% (33)
Dependent contribution premiums	68% (34)
Retiree deductible amounts	46% (23)
Family deductible amount	50% (25)
Coinsurance rates	26% (13)
Co-payment amounts	56% (28)
Co-payments for prescription drugs	66% (36)
Cap on employee out-of-pocket expenses	34% (17)

Note: Figures are percentage (number) of states responding affirmatively. Missing values included with "No" responses.

Table 3.12. *Major Changes Recently Introduced*

In the past five years has your state introduced a: (check all that apply)	**States Indicating Approach**
Catastrophic plan plus a retiree medical savings account	8% (4)
Plan that eliminates prescription drug coverage	4% (2)
Plan to increase the age at which retirement health care is available	6% (3)
Plan to increase the years of service required for vesting	14% (7)

Note: Figures are percentage (number) of states responding affirmatively. Missing values included with "No" responses.

Cost Shedding

More drastic efforts can be seen in proposals for cost shedding. One may also note that four states report having instituted Medical Savings Accounts coupled with catastrophic plans (see Table 3.12). Now that there is a federal program that subsidizes the cost of prescription drugs, some states have eliminated the prescription drug benefit they used to offer. A few states have increased the age at which retiree health care is available, an appropriate strategy given that longer life spans are rendering traditional government retirement plans—which often allow retirement at relatively early ages—unsustainable (Miller, 2008). Finally, increasing the years required for vesting has gained some traction. For example, in 2006 North Carolina changed retirement (pension and health care) vesting for new hires from 100 percent after five years of employment to a tiered approach in which benefits are paid at the rate of 50 percent after 10 years of state service and 100 percent after 20.

Wellness and Preventive Approaches

Wellness programs focus on preventive health care. They attempt to encourage behaviors that lead to good health, ease stress, and discourage behaviors that are inimical to good health. Such programs encourage individuals to exercise, eat healthily, and give up poor habits. Many of these activities are geared to behaviors that are associated with the risk of cancer and heart disease—two of the costliest insured illnesses (Erfurt, Foote, and Heirich, 1992). Wellness programs entail startup and maintenance costs but accrue substantial savings to the extent that they help reduce the more costly expenses associated with severe health problems. Governments may also address cost issues through incentive programs and by disseminating information on healthy life styles (see Carlson, 2005).

The results reported in Table 3.13 (p. 58) show that certain aspects of preventive medicine and wellness programs have caught on in the states. A majority of states, for example, disseminate information on preventive medicine/wellness, encourage routine doctor visits by covering the full cost of physical exams and exempting those exams from annual deductibles, and offer smoking cessation and weight management programs. The results also show some planned adoption of incentive programs to promote healthy life styles.

Future Action on Benefit Structure and Generosity

To this point, research on OPEB suggests that states have not yet developed comprehensive strategies for addressing unfunded liabilities. Given that states are now aware of their unfunded liabilities, it is reasonable to assume that they are beginning to turn their attention to consideration of various alternatives.

Table 3.13. *Preventive Medicine and Wellness Programs*

Which of the following preventive medicine and wellness programs does the state currently provide or plan to provide to retirees?	Currently Provided	Plan to Provide
Preventive Medicine-Wellness Newsletter/Website	66% (33)	8% (4)
Full coverage of gym/spa membership	12% (6)	6% (3)
Subsidized/partial coverage of gym/spa membership	16% (8)	12% (6)
Full coverage of retiree's annual physical exam	72% (36)	6% (3)
Physical exams are exempt from deductible charges	54% (27)	2% (1)
On-site clinic	14% (7)	4% (2)
Weight management program	54% (27)	4% (2)
Smoking cessation program	70% (35)	4% (2)
Incentive programs for healthy living (e.g., monetary or other material incentives for participating in health/wellness programs)	24% (12)	20% (10)

Note: Figures are percentage (number) of states responding in each category. Remaining percentages (states) are missing values.

As reported in Tables 3.14 and 3.15, states appear poised to act incrementally to reduce future retiree health care costs by decreasing benefits through such measures as boosting retiree-paid contribution/premiums, deductible amounts, co-payments, and coinsurance rates. The reported likelihood of adopting such tactics is not surprising given that they have been used previously (see Table 3.11, p. 57). Though these approaches may be categorized as incremental, such cost-shifting measures can generate substantial savings for the states.

Turning to Table 3.15, it appears that more substantial cost shedding options may also be in the offing in coming years. A willingness to consider changes in age and/or years of service requirements is now becoming evident. When considered along with a willingness to reduce or eliminate retiree health care benefits for future and current retirees, there is, for the first time, the introduction of proposals for major change. If adopted, these changes would truly transform the retiree heath care system for state employees. The effect of such changes, if implemented, on state governments' ability to attract and retain employees is unknown.

Conclusion and Discussion

This chapter reports findings from a survey of retiree health care benefits in the American states. In addition to showing that state officials readily acknowledge the importance of retiree health care to HR recruitment and retention goals, findings suggest that comprehensive strategies for dealing with OPEB liabilities remain elusive. A few states have adopted advance funding for OPEB, and a number of others are contemplating doing so in the coming years. In general, state officials

Table 3.14. *Future Cost Sharing Changes*

In the next five years does your state intend to increase:	Very Likely	Somewhat Likely	Somewhat Unlikely	Very Unlikely
Retiree contribution premiums	34% (17)	42% (21)	8% (4)	8% (4)
Dependent contribution premiums	26% (13)	46% (23)	12% (6)	8% (4)
Retiree deductible amounts	16% (8)	48% (24)	22% (11)	6% (3)
Family deductible amounts	18% (9)	44% (22)	22% (11)	8% (4)
Coinsurance rates	6% (3)	44% (22)	34% (17)	8% (4)
Co-payment amounts	18% (9)	50% (25)	16% (8)	6% (3)
Co-payments for prescription drugs	18% (9)	52% (26)	14% (7)	6% (3)
Cap on employee out-of-pocket expenses	8% (4)	30% (15)	42% (21)	12% (6)

Note: Figures are percentage (number) of states responding in each category. Remaining percentages (states) are missing values: rows may not sum to 100 percent.

Table 3.15. *Future Cost Shedding Changes*

In the next five years does your state intend to:	Very Likely	Somewhat Likely	Somewhat Unlikely	Very Unlikely
Offer catastrophic plan plus a retiree medical savings account	0% (0)	14% (7)	60% (30)	22% (11)
Eliminate prescription drug coverage	0% (0)	0% (0)	24% (12)	64% (32)
Decrease the total benefit cap amount that the state will pay	0% (0)	10% (5)	34% (17)	44% (22)
Increase the age at which retirement health care is available	4% (2)	16% (8)	38% (19)	34% (17)
Increase the years of service required for vesting in retiree health care	10% (5)	22% (11)	30% (15)	30% (15)

Note: Figures are percentage (number) of states responding in each category. Remaining percentages (states) are missing values: rows may not sum to 100 percent.

report little likelihood of adopting politically unpopular action like raising taxes or cutting existing government programs to fund OPEB.

How are states and state employees likely to respond? In the near term, survey findings indicate that most states will likely opt for incremental, piecemeal approaches, hoping to chip away at their current costs by cost containment and cost sharing strategies and, by extension, reducing their longer-term obligations.

More broadly, it is important to consider the potential HR implications of the various strategies states are likely to employ in addressing OPEB liability. Relatively generous benefits packages have afforded governments a measure of competitive advantage in the market for human capital. The potential exists for cuts to OPEB generosity to have a negative impact on governments' recruitment and retention efforts. When considered alongside other recent changes affecting public service—such as shifting pension risks to employees through defined contribution plans, scaling back or eliminating employee grievance rights, and eliminating job security—cutting government OPEB could exacerbate existing HR difficulties. Such prospects only underscore the importance of understanding the implications of proposed actions so that difficult, yet informed, choices can be made.

Notes

1 This survey was developed following a review of employee benefits literature and with input from officials in the North Carolina Treasurer's Office and members of the Center for State and Local Government Excellence's practitioner advisory board. These individuals reviewed early drafts of the survey, making suggested improvements in both clarity and coverage.

2 It should be noted that at least one respondent from several other states indicated the adoption of OPEB funding mechanisms: Arizona, Missouri, and New Hampshire for 401(h); and California, Delaware, Hawaii, Minnesota, Virginia, and West Virginia for Section 115 trusts. Given this project's weighting of responses, these states are not reported as adopters in Table 3.5.

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Chapter 4: Local Government Retiree Health Care Benefits

While the magnitude of any individual unfunded liability among local governments pales in comparison to some states' tabs, the cumulative effect from the thousands of city and county governments may be staggering. Within the vagaries of counting government employees (e.g., military, contractors, teachers, special authorities, etc.), it is reasonable to assert that local governments employ between two and three times the number of people as state governments. With most cities offering retiree health care benefits, the call by GASB 45 to document unfunded liability is timely and prudent.

The survey of local governments mirrors that of state governments previously reported. This intentional paralleling of surveys enables us to compare and contrast the response from these different levels of government. While dealing with large organizations in both cases (561 of the 1,305 local governments offering retiree health care have populations over 25,000), this provides insight into the operation of intergovernmental relations and respective approaches to problem solving.

Methods

The survey includes three sections addressing the current structure of local governments' retiree health care benefits, recent changes, and future directions. The format of individual survey items varied depending upon the nature of the information sought and included dichotomous choice (asking respondents for yes/no answers on whether specific practices were followed) and ordinal Likert-type response items (respondents asked to indicate their level of agreement or disagreement with retiree health care options).

The mail survey was administered by ICMA between January and February 2008 following Dillman's (2000) tailored design method, as described in Chapter 3. Completed surveys were received from 2,136 of 8,044 local governments (27 percent). These can be further subdivided into 1,872 of 7,193 cities (26 percent) and 264 of 851 counties (31 percent).

Results

Importance of Retiree Health Care

As reported in Table 4.1, local government administrators see the provision of retiree health care as a valuable tool for recruiting and retaining employees and for workforce planning. On the latter, the availability of retiree health care can facilitate early retirement, bridging the gap prior to Medicare eligibility. In the implementation of organizational strategic transformations, retiree health care (along with pensions) can help avoid potential opposition to planned change. Generally, retiree health care is recognized as being important to key organizational HR goals, especially in its use as a retention factor.

While city and county leaders overall see the strategic benefit of offering a retiree health care option, the state governments' response (see Table 3.1, p. 52) is substantially stronger. Both levels of government see a larger role to be played in the retention of employees. In state governments, however, there is essentially a 10-point shift into the "very helpful" and "helpful" categories (and away from the "not helpful" response). Even so, local governments do have a strong understanding of the important role this benefit can play with an organization's human capital.

Availability of Retiree Health Care in Local Governments

While the Agency for Healthcare Research and Quality (AHRQ) notes a general decline in the number of private sector organizations offering retiree health care benefits, larger organizations (more than 1,000 employees) are more likely to provide retiree health coverage. Governments remain more likely to provide retiree health care benefits, though similar, if less drastic, declines have occurred (Fronstin, 2005). The state

Table 4.1. *Perceived Benefits of Retiree Health Care Benefits*

How helpful is the availability of retiree health care with respect to the city/county's ability to:	Very Helpful	Helpful	Somewhat Helpful	Not Helpful
a. Recruit employees	17%	23%	24%	24%
b. Retain employees	32%	29%	19%	11%
c. Influence the timing of retirement (i.e., early retirement) and help the local governments plan for employment transitions	23%	31%	21%	13%

Table 4.2. *Current Financing of Retiree Health Care*

How does your local government currently finance retiree health care? (select one)	Local Governments Indicating Approach
Pay-as-you-go (all health care costs are paid out annually from the operating budget)	61%
Partial funding (funds are set aside to offset the costs of retirees' future health care)	10%
Full funding (funds are set aside to prepay the full costs of retirees' future health care)	6%

survey presented in Table 3.2 (p. 52) shows that 46 of the 50 states responding indicate that their state currently offers retiree health care coverage. While state governments have continued to provide retiree health care coverage, the local government survey reported here finds only 1,305 of the 2,136 local governments (61 percent) doing so. The differences are perhaps attributable to organizational size. State governments are large organizations. Local governments (with populations over 25,000) are more likely to offer retiree health benefits; those cities and counties fewer than 5,000 mostly do not. The shift point occurs in governments with populations between 5,000 and 9,999 (with an approximate 50/50 chance on retiree health benefits). In essence, the greater likelihood of receiving retiree health care benefits from government employers may be because they are "large" organizations.

Who currently offers retiree health care?
92 percent of states
61 percent of localities

Financing Retiree Health Care

The promise of retiree health care benefits and the costs of paying for them pose a serious challenge for governments. Escalating health care costs and the projected retirements from the baby boom generation are driving this issue.

Local governments, like state governments, traditionally have handled retiree health care expenses on a pay-as-you-go basis; they have simply been included in the annual operating expense. There are exceptions to this general approach, as some local governments have instituted a separate fund or have begun setting aside additional monies to cover the growing, anticipated liabilities. As shown in Table 4.2, three-fifths of the local governments surveyed reported using a pay-as-you-go approach, though a small proportion has begun to fully (6 percent) or partially (10 percent) prefund this liability. Currently, GASB 45 requires state and local governments to report only their OPEB liabilities. However, it is likely that the reporting of substantial unfunded OPEB liabilities will serve to foster interest in examining other approaches.

While missing values somewhat distort local government percentages, we can see that similar proportions of state and local governments opt for a pay-as-you-go approach. However, more states are willing to assert that they have begun to partially or fully fund their retiree health care benefit. This, perhaps, indicates that the state governments are more aware and engaged in addressing this problem.

Governments can choose to fulfill their retiree health care promises by raising revenues. However, local government responses quite clearly indicate a reluctance to use revenue-raising options (see Table 4.3). Currently, 50 to 75 percent of the local governments indicate they are either "Unlikely" or "Very Unlikely" to adopt any extra means for paying these costs. If forced to address these problems, local govern-

Table 4.3. *Future Financing Options for Retiree Health Care*

In the next five years, how likely do you think your local government is to adopt the following strategies to finance its unfunded liabilities for non-pension/ other post employment benefits (OPEB) like retiree health care?	Already Adopted	Very Likely to Adopt	Likely to Adopt	Unlikely to Adopt	Very Unlikely to Adopt
Issuing OPEB bonds	0%	1%	3%	27%	43%
Issuing general obligation bonds	0%	0%	2%	26%	45%
Cutting other local government programs and using the savings to pay for the unfunded liability	1%	3%	16%	25%	30%
Borrowing funds from the local government's pension fund	0%	0%	1%	21%	50%
Raising revenue through higher taxes and fees	1%	4%	19%	20%	30%

Table 4.4. *Funding Mechanisms*

Local governments have several options for funding retiree health care obligations. In your opinion, how likely is your local government to adopt the following options in the next five years?	Already Adopted	Very Likely to Adopt	Likely to Adopt	Unlikely to Adopt	Very Unlikely to Adopt
A medical subaccount from a qualified pension plan [Section 401(h) account]	2%	1%	5%	29%	30%
A governmental (i.e., "grantor") trust (Section 115 Plan)	4%	5%	10%	27%	25%
Voluntary Employee Benefit Association (VEBA)	4%	2%	7%	28%	27%

ments are not likely to adopt tax increases and program cuts.

Neither state nor local governments are enthusiastic about financing the unfunded liabilities. Whereas only two or three states (see Table 3.4, p. 53) indicate that they are likely to consider any of these options, a fifth of cities and counties admit that they may be forced to cut programs or raise taxes.

Other than an annual pay-as-you-go approach, retiree health care funding can also be addressed through a number of mechanisms, such as medical subaccounts [Section 401(h) account], governmental trusts (Section 115 plan), and voluntary employee benefit associations [VEBA, or 501(c) (9)]. Each of these approaches seeks to advance-fund OPEB liabilities by creating a dedicated fund in which a portion of the actuarially determined costs of future benefits (known as the annual required contribution, or ARC) can be deposited and appreciate.

As Table 4.4 shows, only a handful of local governments report having already adopted any of these advance-funding vehicles. As for likely adoptions, with the possible exception of creating a governmental grantor trust (which 15 percent indicate they are likely to adopt), the local governments report little current interest in adopting these OPEB prefunding mechanisms. As was the case with identifying revenue sources for funding retiree health care, the reported unlikelihood of local governments adopting these funding mechanisms suggests that either the local governments are only now contemplating what is feasible and preferable in light of their OPEB obligations or they have yet to come to terms with the potentially daunting fiscal challenges facing them.

State government responses (see Table 3.5, p. 54) are surprisingly in line with local governments on adopting these mechanisms. While both state and local governments are unlikely or very unlikely to adopt them, states show somewhat more willingness to consider using section 115 trusts. With regard to medical subaccounts, neither state nor local governments show much interest.

Structure of Retiree Health Care Benefits

In addition to the various funding strategies, governments may also rein in costs by altering the structure and generosity of their respective retiree health care benefits. In other words, governments might consider reducing or even terminating promised benefits. Legally, this may be possible since retiree health care benefits typically do not possess the status afforded pension programs as a recognized form of deferred compensation. Recent case law (*American Association of Retired Persons, et al., v. Equal Employment Opportunity Commission*, U.S. 07-662; *Duncan v. Retired Public Employees of Alaska*, 71 P.3d 882 (Alaska 2003); *Studer v. Michigan Public School Employees Retirement Board*, 472 Mich. 642 (2006); Norfus, N. E. 2008) also supports the local governments' ability to curtail health care benefits for future hires and even for current employees. Statutory or constitutional provisions requiring retiree health care or, in some local governments, collective bargaining agreements, may limit unilateral alterations to benefit plans (GAO, 2007).

According to the survey results (Table 4.5, p. 64), few local governments have curtailed retiree health care benefits for future retirees, and even fewer have introduced a plan to terminate these benefits for future retirees. Also, and not surprisingly, almost no local governments reported terminating benefits for current retirees. Low as these percentages are, they are slightly higher than those exhibited among state governments (see Table 3.6, p. 55). Neither level of government appears to find these options palatable.

When the focus shifts from what the local governments have recently done to what they might do in the near future, the situation could be expected to change. Facing newly reported and substantial unfunded liabilities, most local governments still see themselves as unlikely to undertake drastic action to curtail or

Table 4.5. *Future Plans for Retiree Health Care Benefits*

In the next five years does your local government intend to:	Already Adopted	Very Likely to Adopt	Likely to Adopt	Unlikely to Adopt	Very Unlikely to Adopt
Introduce a plan that will limit subsidy for future retirees	7%	8%	16%	22%	27%
Introduce a plan that will terminate health care for future retirees	5%	4%	9%	25%	39%
Terminate all subsidies for current retirees	3%	1%	3%	23%	49%

eliminate retiree health care benefits (see Table 4.5). Still, it is important to note that, in addition to the 7 percent who have already done so, nearly 25 percent intend to introduce plans to limit retiree health care subsidies. Over 10 percent of local governments are also "Very" or somewhat likely to terminate the health care benefits of future retirees altogether (in addition to the 5 percent who have already done so). These findings suggest the strong possibility of local governments gradually shifting the burdens of retiree health care benefits to plan beneficiaries; i.e., employees and their families. Though it appears unlikely that many local governments will terminate the benefits entirely, local governments' contributions are likely to diminish.

Noting differences in question format here, states are far more emphatic in opposing any drastic termination of benefits. On the other hand, states may appear slightly more willing to introduce future limitations (Table 3.7, p. 55). In neither case are these options on anyone's "long list," let alone their "short list."

Cost Control Strategies

Governments can alternatively introduce procedures designed to control costs (without sacrificing the quality of care) by monitoring health care treatments and expenses, sponsoring preventive and wellness programs that lead to healthier lifestyles (and subsequently reduced costs), and introducing retiree health care savings accounts. Cost containment monitors the appropriateness of medical procedures and the efficiency with which they are provided. Cost containment is also obtained through gate-keeping efforts that require precertification or utilization reviews prior to an individual receiving treatment. These are designed to provide a second medical opinion on the appropriateness of procedures and tests. Since there may be a tendency for doctors to provide drugs that pharmaceutical companies heavily market and request various tests primarily as legal safeguards (or to pay off equipment purchased by their clinics), an alternative, if not impartial, screening is appropriate. As shown in Table 4.6, some local governments have instituted cost-control procedures on the more costly medical areas (e.g., hospitalization and long-term disease management programs); fewer report monitoring secondary expenses. Clearly, there is room for improvement here that can perhaps contribute to substantial cost savings.

City and county government cost containment efforts seriously lag behind those found among state governments.

City and county government cost containment efforts seriously lag behind those found among state governments (see Table 3.8, p. 56). In most cases, a majority of states (sometimes a super majority) has adopted these programs. Clearly, local governments missed the wave in the late1980s and early 1990s when

Table 4.6. *Cost Containment Programs*

Which of the following programs does your city/county have? (check all that apply)	Local Governments Indicating Approach
Hospital inpatient precertification	53%
Outpatient precertification	27%
Prescription drug prior authorization	23%
Prescription drug clinical intervention	11%
Utilization of health care and hospital centers of excellence	17%
Disease management program	32%

Table 4.7. *Health Care Auditing*

Does the city/county engage in:	Local Governments Indicating Approach
Claims payer audits	20%
Hospital bill audits	15%
Utilization review vendor audit	22%
Employee self audits	14%

Table 4.8. *Tax-Exempt Savings Accounts*

Does the city/county offer:	Local Governments Indicating Approach
Employer funded Retiree Medical Account (RMA), Health Reimbursement Account (HRA), Health Savings Account (HSA), or Medical Savings Account (MSA)	17%
Employee/retiree funded Health Savings Account (HSA) or Medical Savings Account (MSA)	14%

these were in vogue and have not caught it since then. Doubling the overall use of these programs among local governments is indeed quite feasible and would produce some financial relief for those that do not already employ them. While a majority of local governments use inpatient precertification and a third deploy disease management programs, states demonstrate more substantial adoption of inpatient precertification and disease management programs. In fact, the least-used state cost containment option nearly matches the most adopted program among local governments.

Related to these types of *a priori* reviews are *post hoc* audits that can help control costs through recovery of unnecessary expenses. These audits are designed to verify the cost and appropriateness of care received by patients. As reported in Table 4.7, a small minority of local governments have established claims payer, hospital bill, and vendor auditing programs. Again, potential cost savings are evident here.

Local governments trail the state governments in their employment of health care audits. While states have room for improvement here, they are twice to three times as likely as local governments to audit their expenditures. (See Table 3.9, p. 56).

To pay for uncovered aspects of health plans, the tax code allows local governments to establish individual health care accounts. Employee-funded options that derive their money entirely from contributions set aside by the employee have been adopted in a third of state governments. A smaller group has created accounts in which they provide some kind of matching incentive. Employees can establish medical, as well as dependent care, elder care, and legal accounts. The employees, according to a salary reduction agreement, deposit pre-tax dollars from their salary into these accounts. These personal "trust funds" are used to pay the medical, dependent, or legal expenses incurred. While unexpended funds revert to the federal government at the end of the year, it is quite easy to budget for anticipated, on-going expenses or to plan some less serious medical procedures. Survey results reported in Table 4.8 indicate that close to 15 percent of local governments have set up employer-funded accounts and employee-only funded accounts.

In contrast to state governments (see Table 3.10, p. 56), local governments are slightly more likely to offer employer-funded accounts, whereas states are more likely to prefer the non-government funded (i.e., employee funded) options. In neither case are these tax-exempt accounts fully used as a means of addressing the costs of health care by either level of government.

Cost Sharing

Cost sharing programs establish a process that balances governmental subsidies with employee payments. From a governmental perspective, setting the balance of these various payments between employee/retiree and the governmental entity is a major cost containment factor. However, the more of the burden placed on retirees, the more likely it is that they may be priced out of obtaining services other than those involving catastrophic events.

Though the funding liability for retiree health care has begun to loom as a serious issue, the local governments have not been inattentive or inactive with regard

Table 4.9. *Cost-Sharing Changes Recently Introduced*

In the past five years has your city/county increased the: (check all that apply)	**Local Governments Indicating Approach**
Retirees' contribution premiums	44%
Retirees' dependent contribution premiums	37%
Retirees' deductible amounts	27%
Retirees' dependent deductible amount	22%
Retirees' coinsurance rates	17%
Retirees' co-payment amounts for medical service/treatment	27%
Retirees' co-payments for prescription drugs	37%
Cap on retirees' out-of-pocket expenses for health care	6%

to other health care issues. Efforts at cost sharing have been ongoing (see Table 4.9). Over a third of local governments have increased the premiums/contributions that retirees pay toward their health care coverage. Deductible amounts and co-payment fees that are paid entirely by the retiree prior to any local government subsidy have been raised in over a quarter of the governments. While total out-of-pocket expenses for retirees have not been increased in a large number of local governments, over 15 percent have increased the coinsurance proportion of each bill that retirees pay.

Cost sharing changes in premiums, deductibles, and co-payments have been far more popular among state governments than among their local counterparts

Cost sharing changes in premiums, deductibles, and co-payments have been far more popular among state governments than among their local counterparts (see Table 3.11, p. 57). In most instances, state adoption levels are 50 percent higher than those found among city and county governments. States have preferred to increase premium contributions and co-payments while local governments, at a much reduced rate, have adjusted premium contributions. In meeting rising health care costs, states have already resorted to greater burden-sharing with their employee/retirees while local governments have been more likely to shield them from these costs.

Wellness and Preventive Approaches

Wellness programs focus on preventive health care. They attempt to encourage behaviors that lead to good health, ease stress, and discourage behaviors that are inimical to good health. Such programs encourage individuals to exercise, eat healthily, and give up poor habits. Many of these activities are geared to behaviors that are associated with the risk of cancer and heart disease—two of the costliest insured illnesses. Wellness programs entail start-up and maintenance costs but accrue substantial savings to the extent that they help avert more costly expenses associated with severe health problems. Governments may also address cost issues by disseminating information on healthy life styles and incentive programs.

The results reported in Table 4.10 show that preventive medicine and wellness programs have not caught on among local governments. Only a third of local governments, for example, disseminate preventive medicine/wellness information or encourage routine doctor visits by covering the full cost of physical exams or exempting those exams from annual deductibles. Smoking cessation and weight management programs (focused on behaviors that can contribute significantly to health) are not widespread. The results also show only some adoption and planned adoption of incentive programs to promote healthy lifestyles.

State governments (see Table 3.13, p. 58) are clearly a leader here in preventive medicine and wellness programs. They have already established wellness newsletters and websites, along with paying the full charge for physical exams. Weight management and smoking cessation programs that target two of the major contributors to future health problems and costs are being addressed at the state government level. City and county governments, on the other hand, have adopted these programs at half the rate of the states. Both government levels have somewhat similar plans for future adoptions. However, given the wider adoption rate among state governments, local governments will continue to lag.

Who has adopted wellness and preventive programs?		
Program	**% states that have adopted**	**% localities that have adopted**
Wellness newsletter/ website	66%	36%
Full coverage of annual physicals	72%	29%
Smoking cessation	70%	21%

Future Action on Retiree Health Care Benefits

According to the GAO (2007) and our survey results, local governments have not yet developed comprehensive strategies for addressing unfunded OPEB liabilities. Given that local governments are now becoming aware of their unfunded liabilities, it is reasonable to assume that they are beginning to turn attention toward consideration of various alternatives.

As reported in Tables 4.11 and 4.12 (p. 68), local governments appear poised to act to reduce future retiree health care costs by decreasing benefits through such measures as boosting retiree-paid contribution/ premiums, deductible amounts, co-payments, and coinsurance rates. Increasing the proportion individuals pay toward their health insurance premium clearly draws the most government interest. Yet, increased deductibles and co-payments are also appealing choices. The reported likelihood of adopting such tactics is not surprising given the measures already taken (see Table 4.9). Though these approaches can be categorized as incremental, such cost-sharing measures can generate substantial savings for the local governments.

State government cost sharing plans are found in Table 3.14 (p. 58). Overall, local governments are more cautious about whether they would consider various options. Interestingly, the "very likely" and "somewhat

Table 4.10. *Preventive Medicine and Wellness Programs*

Which of the following preventive medicine and wellness programs does the city/county currently provide or plan to provide to retirees?	**Currently Provided**	**Plan to Provide**
Preventive Medicine-Wellness Newsletter/Website	36%	6%
Full coverage of gym/spa membership	3%	2%
Subsidized/partial coverage of gym/spa membership	9%	2%
Full coverage of retiree's annual physical exam	29%	1%
Exempt annual physical exams from deductible charges	16%	1%
On-site (that is, city/county facility) medical clinic for city/ county retirees	3%	3%
Weight management program	15%	5%
Smoking cessation program	21%	5%
Incentive programs for healthy living (e.g., monetary or other material incentives for participating in health/wellness programs)	10%	7%

Table 4.11. *Cost Sharing Future Changes*

In the next five years, how likely do you think your city/ county is to increase the following?	**Very Likely**	**Somewhat Likely**	**Somewhat Unlikely**	**Very Unlikely**
Retirees' contribution premiums	34%	22%	12%	18%
Retirees' dependent contribution premiums	31%	19%	10%	20%
Retirees' deductible amounts	16%	31%	19%	15%
Retirees' dependent deductible amounts	15%	28%	19%	17%
Retirees' coinsurance rates	13%	26%	20%	17%
Retirees' co-payment amounts for medical services/ treatment	15%	32%	17%	15%
Retirees' co-payments for prescription drugs	18%	31%	16%	15%
Cap on retirees' out-of-pocket expenses for health care	5%	14%	25%	31%

Table 4.12. *Future Cost Shedding Changes*

In the next five years does your city/county intend to:	Already Adopted	Very Likely	Somewhat Likely	Somewhat Unlikely	Very Unlikely
Offer catastrophic plan plus a retiree medical savings account	2%	3%	15%	25%	33%
Eliminate prescription drug coverage	2%	2%	5%	33%	46%
Decrease the total benefit cap amount that the city/county will pay	2%	4%	13%	24%	33%
Increase the age at which retirement health care is available	3%	4%	9%	26%	37%
Increase the years of service required for vesting in retiree health care	8%	7%	10%	25%	36%

unlikely" categories reflect similar response percentages for state and local governments. However, state governments are far more likely to indicate that they are "somewhat likely" to consider an option, while cities and counties indicate that they are "very unlikely" to do so. In general, three-fourths of the states are likely to increase premiums, as opposed to only half the cities and counties. Two-thirds of states are likely to increase deductibles, compared with only around half the local governments. Nearly three-fourths of state governments may increase co-payments, while slightly less than half the cities and counties have this on the table.

Measures that are more drastic can be seen in proposals for cost shedding. One may also note that few local governments report having instituted Medical Savings Accounts coupled with catastrophic plans (see Table 4.12). Nor are local governments planning to eliminate prescription drug coverage (for those on Medicare, local government health coverage has primarily served this purpose). However, there is some slight interest in raising the years of service required for vesting in these plans.

While not very widely adopted, some state governments (see Table 3.12, p. 57) have already introduced changes that shed their costs onto the employee/retiree. This is especially true with regard to increasing the vesting period for new employees. Percentage adoptions among local governments are basically half the rate found in the states.

Evidence reported in Table 4.12 appears to indicate that additional cost shedding options may not be likely in coming years. A willingness to consider changes in age and years of service requirements is not becoming evident. Along with an unwillingness to reduce or eliminate retiree health care benefits for future and current retirees, one is seeing an evident reluctance for major change.

Neither state nor local governments view cost shedding approaches favorably. With regard to major cost shedding changes, state governments appear to indicate a somewhat greater reluctance to engage in such practices (see Table 3.15, p. 59). However, these differences most likely reflect the fact that double the proportion of states, compared to cities and counties, have already "pulled the trigger" (see Table 3.12, p. 57) on some of these options.

Conclusion

This chapter reports results of a survey on retiree health care benefits in the American local governments. With GASB 45 requiring reporting of their unfunded liabilities for other (non-pension) post employment benefits, local governments face the dilemma of finding funds or reducing benefits. While local governments see retiree health care benefits as a vehicle for attracting and retaining employees and for navigating succession issues at retirement, they remain uncertain as how to pay for them.

GASB 45's documentation of unfunded liabilities exposes a potential problem for many municipalities and counties in which the traditional pay-as-you-go approach cannot meet future obligations. Operating expenses cannot absorb both escalating costs and beneficiaries. However, alternative financing options elicit little enthusiasm among officials. Faced with a series of tough and unpopular choices, the options of cutting programs and raising taxes are likely to face strong political opposition. Alternatively, limiting subsidies or terminating the retiree health care benefit entirely hardly offers a better option.

Incremental approaches focused on cost containment, cost sharing, and cost shedding draw the most, if reluctant, interest. Surprisingly, many governments have not yet fully implemented promising cost containment strategies. While these programs provide limited relief, their marginal effects can ease the overall burden. Similarly, preventive medicine and wellness programs are a relatively untapped area. Investments in these programs can pay off in substantial future cost savings.

Cost sharing measures in which retirees (and current employees) are required to pick up more of their health care expenses are a preferred option. While retirees are required to pay more toward their health care, they still receive significant assistance. On the other hand, cost-shedding measures transfer virtually the entire cost of various benefits from the public to the individual retiree.

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Chapter 5: Policy Alternatives and Strategies

Earlier chapters have introduced the state retiree health care problem in the context of GASB 45, reported findings from an analysis of GASB 45 actuarial statements and other financial reports, discussed the financing issues and implications of GASB 45, and summarized the retiree health care policy approach of each of the 50 states and a sample of local governments. Special attention was given to unfunded actuarial liabilities and annual required contributions. Comparative measures helped to place state GASB 45 obligations in perspective in terms of payroll, population, and other variables. We briefly explored varying assumptions about discount rates, medical inflation rates, and cost projections.

Survey results indicate that the majority continue to manage retiree health care obligations on a pay-as-you-go basis with little or no attention to the potential impacts of mounting unfunded obligations, despite these benefits consuming increasing proportions of annual payroll costs. Most states have adopted cost containment policies such as hospital pre-certification, prior prescription authorization, and disease management programs. A slight majority of states have raised cost-sharing responsibilities for insured retirees, including hikes in co-payments, deductibles, and premium contributions. Other states have increased the years required to vest for coverage. Some progress is reported in state wellness promotion, although most such wellness and preventive medicine activities are modest in scope. Only a few states reported that they are likely to adopt strategies for financing future retiree health care liabilities through OPEB bonds, VEBAs, or trust funds.

Most states report substantial levels of unfunded retiree health care liabilities. Baby boomer demographics, including an aging public sector labor force, increased longevity, and the inevitable health afflictions of age, portend greater demand for health care services at higher costs. Persistently high rates of inflation for health services and prescription drugs appear to be driving up costs perennially. Pressures from a variety of sources are increasing on those states confronting significant retiree health care liabilities to take appropriate actions to reduce, contain, or even eliminate these costs in the future. The alternative appears to be a growing overhang of billions of dollars in retiree health care liabilities that could endanger future bond ratings and lead to other spending priorities being underfunded.

As a whole, the local patterns of OPEB underfunding and policy responses generally parallel those found in the states. However, local governments appear to be less inclined to offer retiree health care or to see strategic benefits in offering it. But like the states, local jurisdictions that do provide retiree health care benefits are overwhelmingly likely to fund it on a pay-as-you-go basis. Local governments are much less likely than states to have adopted policies for paying down unfunded OPEB liabilities. Apparently, retiree health care liabilities and OPEB reporting requirements have a lower profile and, as a consequence, receive less attention from local government officials than they do in the states. Nonetheless, a minority of local jurisdictions have decided to take aggressive action to tackle their OPEB-related problems.

Based on this project's state and local surveys and print and Internet-accessed data, this chapter first examines the wide range of policy alternatives for addressing retiree health care liabilities under GASB 45. It next categorizes these alternatives and provides brief descriptions of their advantages and disadvantages. Third, we provide an overview of the uncertain policy environment as the states and localities confront GASB 45 within a desultory economic environment caused by the financial crisis of 2008–2009. A precautionary, multifaceted approach to ameliorating the unfunded liability problem is suggested.

Policy Alternatives

There is no one best way—no silver bullet—to alleviate future retiree health care liabilities. Each jurisdiction exists within a complex and distinctive economic, political, and policy environment. By virtue of legislation, court decisions, executive orders, or attorney general opinion in some 42 states, employee and retiree health care benefits may be subject to determination by collective bargaining (Kearney, 2009) and therefore may be embodied in a legally enforceable contract. (Even here there is diversity, however; in some states and localities, health care benefits are excluded from the scope of bargaining). Alterations in health care provisions are possible through contract negotiations, but it is substantially more difficult to do so in a bargaining state than in a non-bargaining state where unions are not a factor and only legislative or executive action is required. When present, unions are nearly certain to resist any reductions in health care benefits for present and future retirees. As a recent case showed in Rhode Island, the power of the governor to impose new health care insurance costs on union-represented workers is highly constrained (Peoples, 2008).

For the small number of state and local governments that bear no significant retiree health care liabilities because such benefits are not provided or are not meaningfully subsidized, no future policy actions appear to be necessary. Those jurisdictions that do report significant GASB 45 liabilities vary in what actions, if any, they are taking or considering to address them. In some, governors, mayors, managers, key legislators and legislative staff, treasurers, controllers, human resource directors, finance directors, or other official actors are engaged in debate and policy proposals. In others, a head-in-the-sand posture is notable.

There is certainly no shortage of possible policy paths for those jurisdictions setting out preemptively to manage retiree health care costs. The real challenge is for each to select an option or a package of options appropriate for its unique circumstances, and continually assess results in the context of new policy developments at the federal level to inform any necessary adjustments. As a severe global economic recession ravaged the country in early 2009, exacting a devastating toll on state and local budgets, the possibility of getting ahead of the OPEB funding issues seemed increasingly untenable for most states.

A different cost-containment approach that appears to be gaining traction is for states to partner with local jurisdictions to expand the retiree health care retirement pool and create additional purchasing power.

For organizational purposes, this chapter classifies retirement health care policy alternatives into the following categories: (1) cost containment, (2) cost sharing, (3) future cost shedding and shifting, (4) prefunding mechanisms, (5) wellness and preventive illness programs (6) cost savvy strategies, and (7) other potential options.

1. Cost Containment. The cost containment strategies that have been written into health care plan designs are commonsensical. Typical are *a priori* reviews and permissions. For years now many states under Medicaid have utilized hospital inpatient pre-certification before admission, prescription drug prior authorization, and disease management programs that are designed to reduce costs for the chronically or terminally ill. For inpatient pre-certification and prior drug authorization, a second opinion of physicians may be required to ensure that, for example, a specific medical procedure or prescription drug is needed. The same procedure is required in at least 15 states for certain outpatient treatments. Another cost containment approach is to require retirees to use health care and hospital "centers of excellence." Such centers are recognized for their established reputations in such areas as cancer, heart, or kidney treatment and their use of evidence-based medicine. CalPERS's Partnership for Change provides retirees with tools for comparing hospital quality, cost, and effectiveness. Finally, plan design can specify or subsidize the use of formulary drugs and/or generics to hold down prescription pharmaceutical costs. None of the options mentioned above imposes significant additional costs on retirees.

The poor state of health care record keeping has often been commented upon. According to one study, administrative costs account for some 11 percent of total health care premiums (IPPSR, 2008: Matrix 4, p. 2). Efficiency improvements in electronic data bases for information access and storage could result in faster, more accurate and less expensive record keeping. South Carolina has been an innovator in medical records improvements with its Health Information Exchange for Medicaid patient histories, an approach that could be adapted to retiree health care.

There are also *post hoc* design policies intended to contain costs. These usually take the form of audits of claims filed by clinics, hospital and physician bills, and bills for various procedures ordered by physicians such as MRI or CT scans. A majority of states indicated in this project's survey that they engage in such audits. Only about one in four local jurisdictions did so.

A different cost-containment approach that appears to be gaining traction is for states to partner with local jurisdictions to expand the retiree health care retirement pool and create additional purchasing power for negotiating lower prices with providers of the full range of health care services and products (Marlowe, 2008: 222). Nearly all states have created a statewide health care pool, providing uniform benefit levels for the active workforce and all retirees residing in state. Eleven states combine state and municipal retiree health care into a single pool (Moran and O'Neil, 2008). Many also include teachers and some have a local option to participate for municipalities, counties, and special purpose governments, such as water and sewer districts and airport authorities. There is some debate about what constitutes an optimal size purchasing pool. According to one source (NASPE, 2006: 7), maximum economy of scale is attained at 20,000 participants.

Finally, health plan coordination with Medicare or another available option to serve as first payer for health care and prescription drug costs is commonplace. At age 65 to 66, retirees are helped by their former employers to declare Medicare as their primary provider in many of the states. In others, retirees are dropped completely from state-assisted health care upon turning 65. Michigan estimates cost savings of transition into Medicare at $12,000 annually per retiree (IPPSR, 2008: 13). States can also offer financial inducements for retirees to opt into Medicare or a spouse's health insurance plan, or to transfer to a plan from a former employer as primary payer. For instance, Illinois pays individuals $150 to drop state health care coverage for alternative coverage (IPPSR, 2008).

2. Cost Sharing. These arrangements establish a process for sharing health care costs between the insured and the government provider. Like cost containment, health care cost sharing is widely practiced in state and local governments and by private employers. Practices such as higher premiums, co-payments, and deductibles help discourage needless or casual physician visits and medical procedures while reducing overall government health care expenses. On the negative side, they result in a net reduction in the retirees' retirement and benefits package and may price retirees out of obtaining services, procedures, or prescription drugs that could help prevent debilitating and costly ailments. In essence, cost-sharing provisions reduce the value of retiree health care coverage by increasing out-of-pocket costs. As such, they will usually be opposed by public employee unions. Some plans assess the cost-share in percentage terms, and others in absolute dollar amounts. In the latter case, if the pronounced growth in health care inflation continues, as seems likely, this may necessitate hiking the dollar contributions by retirees.

As reported in Chapters 3 and 4, cost-sharing strategies have been widely adopted during the past five years. A large majority of states and a smaller proportion of local governments anticipate expanding them in the near future. The most popular cost-sharing choices are imposition of, or increase in, retiree and dependent contribution premiums and co-payments on health care services and prescription drugs. Alabama, Ohio, and Utah are among the states that have recently hiked premiums, and a number of others were considering premium increases in early 2009. But policies vary widely: 13 states do not pay retiree health care premiums at all (except through an implicit subsidy from group rates in all of these states, with the exclusion of Nebraska), whereas another 13 states continue to pay the full cost of retiree health care premiums. To limit costs for recipients with large medical and pharmaceutical bills, some jurisdictions cap retirees' out-of-pocket expenses in a calendar year or some other temporal basis.

3. Future Cost Shedding and Shifting. This general cost-reduction strategy incorporates a variety of possible options, including terminating retiree health care or prescription drug coverage entirely for present or future retirees and raising the minimum retirement age and/or years in service (vesting) period to qualify for, or begin to receive, health care coverage. For those government employers providing coverage for dependent care, this entire category of recipients may be eliminated. The goal is to cut costs by eliminating classes or categories of individuals from coverage either entirely or for an extended period of time.

A relatively straightforward strategy that has been used in a handful of states and has potential for other jurisdictions in the future is to extend the years of service that must be completed before vesting in the retiree health care plan. California, Colorado, Kentucky, Michigan, New Jersey, Ohio, and North Carolina are counted among the states that have opted for longer vesting periods. In effect, this option creates a new, less privileged, tier of future retirees based on employment start date. Oregon has gone much further by completely discontinuing retiree health care benefits for employees hired since 2003 (U.S. GAO, 2007: 38). Such strategies effectively shift future retiree health care costs to new employees, but do little to reduce current expenses.

At least two states, Oklahoma and Pennsylvania, have found a means to shift costs by establishing a federally qualified Medicare Prescription Drug Plan to obtain offsetting federal funding for prescription drugs (National Conference of State Legislatures, 2008:6). As noted above, in other states, Medicare becomes the primary insurer and the state secondary. This option is limited or nonexistent for employees who have not participated sufficiently in the Social Security system to become eligible for Medicare because their employers did not participate. In 2007, West Virginia shifted retiree prescription drug coverage to Medicare; retirees must pay more for coverage, but the state's UAL was cut from $8 billion to $5 billion (NCSL, 2008: 8).

4. Prefunding Mechanisms. Several methods are available for setting aside monies for funding future health care liabilities. Among the most commonly mentioned are the Health Care Benefits Sub Account, Voluntary Employee Beneficiary Association (VEBA), Health Care Trust Fund, Health Reimbursement Arrangement (HRA), Health Savings Account (HSA) and High Deductible Health Plan (HDHP), OPEB Bonds, and asset sales. Some of these mechanisms are rather exotic, making expert—and objective—financial, tax, and legal advice very important.

Health Care Benefits Sub Account. This arrangement, allowable under Internal Revenue Service section 401(h), is defined by the Government Accountability Office as a defined benefit pension trust sub account that allows the employer to dedicate up to 25 percent of the total pension fund contribution for allocation to retiree health care benefits (U.S. GAO, 2007: 37). This is a separate sub account within a pension trust that is dedicated exclusively to paying retiree health care benefits. Investment income of the sub account accumulates tax free and benefits paid to retirees and their eligible dependents are not taxed. The plan is said to be compatible with funding through assets residing in a qualified pension plan ("Funding for Retiree Health Care," 2006). There are limitations on the amounts that can be placed in the 401(h) account. It has been suggested that states blessed with a strong pension fund balance that exceeds estimated future liabilities might consider using excess assets to "seed" a pre-funded OPEB trust fund (Miller, 2007c). More than one consulting firm is currently promoting this approach. Because complicated IRS regulations apply, state governments are urged to undertake due diligence.

Voluntary Employee Beneficiary Association (VEBA). This is also a tax-exempt, non-taxable distribution account (usually a trust) that can be voluntarily established for and accessed by retirees under IRS Section 125 501(c)(9) and administered by a union, employee association, or other organization (U.S. GAO, 2007:37). The set-up can be implemented through individual accounts or a pooled participant account. Employer and pre-tax employee contributions fund the VEBA and are reserved for paying health care costs. If the VEBA is terminated, its assets can be distributed to employees and retirees or transferred to another funding vehicle. Essentially, the VEBA represents a defined contribution approach to retiree health care funding.

VEBAs received public attention in late 2007 when the United Auto Workers and General Motors, Ford, and Chrysler created them to seal collective bargaining contract deals that had been stymied by the issue of retiree health care benefits. Under a VEBA, the employer makes annual contributions to a retiree health care benefit fund, "much like a 401(k)" (Miller, 2007a: 1). In the GM case, the contributions are made to a union-administered plan. We could find only two examples of existing VEBA-type arrangements in the states—Alaska, which in 2005 began automatically enrolling all new employees in a defined contribution retiree health plan, and Montana, which established a VEBA in 2005 for current employees, retirees, and dependents—but the concept bears research and consideration. It does not differ significantly from the deferred compensation plans already offered by many states under Section 457 of the federal tax code (Miller, 2007a: 2). Advantages of this approach include the plan's portability if a retiree relocates to another state; the provision that employees can make additional after-tax contributions to the account; and institutionalization of the principle that future health care expenditure risk is shared by the employer and the retiree. Risk is shifted from the employer to the employees and retirees. Disadvantages include the risk of the VEBA failing, thereby imposing a significant financial burden on retirees if suitable alternative arrangements are not made, and the risk of a reduction in federal funds normally transferred to the state for Medicaid and the Children's Health Insurance Program (CHIP).

Health Care Trust Fund (or Governmental Trust). This irrevocable trust arrangement permits unlimited contributions for tax-free pre-funding of future retiree health care benefits. Employer contributions, investment income, and payouts to retirees are not taxed if the plan is approved as such by the IRS under Section 115. California established the California Employers' Retiree Benefit Trust Fund in March 2007 for pre-funding of CalPERS OPEB liabilities (U.S. GAO, 2007: 37). In 2006, West Virginia enacted a bill to create the Retiree Health Benefit Trust Fund and adopted a schedule for transferring reserves into the fund (CCRC, 2007). Alaska reports committing surplus revenues to a Governmental Trust. South Carolina is also funding a trust on an *ad hoc* basis. As in the case of the pre-funding vehicles described above, setting up the Health Care Trust Fund is complex. It does, however, transfer risk from the employer to employees and provides a highly flexible means for paying down future OPEB obligations, as well as great latitude in determining employee eligibility and the amount and type of benefits offered.

Health Reimbursement Arrangement (HRA). Set out in several IRS rulings and notices, the HRA establishes an individual employee account whose balance can be carried over into retirement without a "use it or lose it" penalty. The HRA can be pre-funded during the employee's work years. Benefits paid are not taxable. The employee cannot personally contribute to the HRA and usage is only for qualified expenses ("Funding for Retiree Health Care," 2006: 16).

A similar pair of programs is the *Health Savings Account (HSA)* and the *High Deductible Health Plan (HDHP)*, which may benefit those who have retired but not yet reached Medicare eligibility. Such plans, which function similar to a 401k retirement plan, are in use in at least 10 states for various categories of state and local workers. They have minimum deductibles (at least $1,000 for individuals and $2,000 for families) and maximum out-of-pocket expenses for participants. Both individual and employer contributions are permitted. There are modest annual contribution limits, set in 2006 at $2,850 for single coverage ("Funding for Retiree Health Care," 2006: 19). The accounts are "owned" by the employee/retiree and savings can be rolled over to subsequent years. By shifting the burden of health care expenditures to the employee/retiree, the plans encourage informed consumer choices on health-related expenditures. The IRS rules, as expected, are numerous and complex. Expert assistance is recommended to set up and administer such a program. Individual recipients would require professional help as well in interpreting and utilizing the HSA and HDHP. According to one report, the HSA and HDHP are more appropriate for relatively affluent individuals than for those with lower incomes (Lemov, 2007).

According to this project's survey results, several states and a handful of local governments have recently taken actions to pre-fund retiree health care using one of the mechanisms described above. Alabama created a defined contribution scheme for future retirees that was effective July 1, 2006; Hawaii is planning to do the same. Connecticut reports that it is establishing an irrevocable trust fund for OPEB liabilities. We do not have sufficient information at the present time to determine what specific approach or vehicle these states have adopted.

OPEB Bonds. This option involves the state borrowing money to pay all or part of its unfunded liabilities for retiree health care. The concept is very similar to that underlying the Pension Obligation Bonds issued in the late 1990s and early 2000s by various local governments. It is embodied in the strategy adopted by several states including Oregon and, most recently, Alaska, to help alleviate future pension liabilities by investing POB proceeds in equities. OPEB bonds, then, represent a form of risk arbitrage. The assumption is that return on equities will exceed debt service on the bonds. As with any arbitrage practice, risks are involved. Specifically, if investment returns do not meet expectations over time, the financing could go "underwater," lose money, and actually add to the UAL. Several states experienced this problem with POBs in 1998 (Miller, 2007b), most notably New Jersey, which lost an estimated $10.3 billion (Guillory, 2006).

However, OPEB bonds do present attractive advantages, particularly in the low-interest rate environment that prevailed in late 2008 and early 2009 (Miller, 2009). True costs of OPEB liabilities would be recognized and paid, impacts on the operating budget would be reduced, and a trust fund composed of bond and equity proceeds would reduce the future discount rate.

As Gerald Miller, GFOA, and several investment firms have pointed out, results of such bonds depend in large part on fortuitous market timing and prudent investment decisions (Miller, 2007b, 2008). One must sell bonds when interest rates are low, purchase equities at reasonable prices, and hope that they appreciate over the life of the bonds. GFOA's (2005) *Evaluating the Use of Pension Obligation Bonds* provides cautionary advice and recommended practices. An important consideration with OPEB bonds is recognition that the retiree health care liability is inherently volatile because of medical inflation and the unstable health policy environment. Certainly, a state or locality interested in the OPEB bond option should retain knowledgeable consultants to help develop and implement the option, and ensure that the bonding strategy is authorized under state law and regulatory policy. Among the states that currently authorize POBs, and plausibly OPEB bonds as well, are California, Florida, Indiana, Massachusetts, New Jersey, New York, Ohio, Oregon, Pennsylvania, and Wisconsin. According to a recent report (Miller, 2008b), Minnesota and Virginia have provided state and local officials with authorization to establish an OPEB trust fund and to issue bonds to fund it.

5. Wellness and Preventive Illness Programs. It is said that 10 percent of the sickest patients consume 70 percent of total health care costs. Much discussed, but seldom adopted in a substantive way, are programs aimed at discouraging unhealthy habits and behaviors; instilling more healthy activities, behaviors, and lifestyles; and identifying and treating potentially costly health problems in early stages. Such programs can range from the basic (newsletters and websites on wellness), to the physically-oriented (coverage or subsidization of gym or health club memberships, encouragement of individual and team athletic activities), to disease management (containing health care costs while also improving patient care for chronic conditions such as asthma, diabetes, hypertension, or HIV/AIDS), to behavior modification (smoking cessation, weight management, health coaching), to early detection programs (on-site medical clinics or medical personnel, full coverage or subsidization of annual physical examinations, prostate screening).

Disease management programs help avoid costly side effects of illness, as shown by Medicaid programs in Florida and Wyoming.

6. Cost savvy strategies. Disease management programs help avoid costly side effects of illness, as shown by Medicaid programs in Florida and Wyoming (Goodman, 2008). On-site health clinics encourage workers to get timely medical interventions at a reasonable cost. Maricopa County, Arizona, opened a health clinic and pharmacy for its 12,500 employees and dependents, expecting savings of some $575,000 a year (Wingett, 2009). Free employee-only clinics have also opened in Charleston, West Virginia, and Port St. Lucie, Florida, among other local jurisdictions (see “Creating a Culture of Health, 2008). Additional innovative wellness employers are Asheville, North Carolina; Ames, Iowa; and Tacoma, Washington.

Efficiencies can be harvested from decentralizing health care services. For example, routine health care cases can be handled by physicians’ assistants or nurse practitioners, with complicated cases directed to higher-cost specialists, clinics, and hospitals. Such a system established by Kaiser Permanente in Utah, called Intermountain Healthcare, estimates significant savings from its fixed-fee, integrated system (Intermountainhealthcare.org).

Though these programs are primarily, if not entirely, for in-service employees, it is hoped that healthy behavior changes will carry over into retirement, thereby reducing demand for health care services and products. States might be well served to consider making wellness and preventive illness services available to retirees in the future. Such services can be offered to both in-state and out-of-state retirees through technology. For example, disease management programs for chronically or seriously ill retirees may be offered by Internet or telephone. South Carolina reports that disease management programs and preventive health screenings are available today for non-Medicaid retirees. Utah extends its wellness and preventive programs to all non-Medicare retirees as well.

As observed in Chapter 3, a substantial proportion of states make information available in newsletters and websites. Most offer smoking cessation assistance and cover the cost of physical exams, and nearly half provide a weight management program. States are experimenting with both positive and negative incentives for smoking cessation. Idaho offers a co-payment on “quit aids” and North Carolina provides free nicotine patches if retirees go to counseling. But Alabama, Georgia, Kentucky, and West Virginia impose smoker surcharges on health insurance premiums. Alabama goes an extra step by also charging obese state workers an extra $25 a month for health insurance. Other states and localities could adopt a similar strategy by charging more for covering obese workers or even denying them coverage until they meet weight reduction goals.

The success of wellness and preventive illness programs ultimately depends upon their ability to motivate individuals to make changes in their lifestyle in order to improve their health. Research is needed on what incentives—and disincentives—are effective in stimulating healthy changes.

7. Other potential options. A “one fell swoop” approach to eliminating OPEB liabilities is to dispose of state assets through sale or privatization. This option has many ramifications that should be studied more thoroughly. Targets might include the state lottery, toll roads and bridges, or capital goods and equipment. Proceeds could then be applied to reduce or eliminate OPEB liabilities or placed in a trust fund to pay future retiree health care obligations. Obviously, this is an approach that demands a great deal of preparation, caution, and due diligence.

GASB 45 and the Politics of Uncertainty

Many unknowns lurk in the GASB 45 decision-making environment. It is quite challenging to state and local governments to develop informed responses to the questions that have arisen and that demand informed decisions. First, and most fundamentally, the issues raised by GASB 45 touch many different offices and officers in state and local governments, with great variance as to who the salient actors and offices are. Primary decision making responsibility for unfunded state retiree heath care liabilities rests with the state legislature. This presents the inherent problem of short time horizons, particularly in the lower houses in which elections are held every two years. Addressing large unfunded liabilities requires long-term, intergenerational thinking by elected representatives. Reelection cycles put more pressure on elected officials to give more attention to short-term issues. Spending operating funds today to ameliorate future obligations may not be politically popular if existing programs are cut, taxes are raised, or the state's assets are sold. Under such conditions the legislative propensity to act incrementally is reinforced.

Extinguishing today's financial fires will take precedence over longer term OPEB problems.

Similarly, governors and mayors also function on relatively short election cycles—four years in all but two states. Many pressing, high-visibility issues confront governors, including a profound economic recession and associated revenue and spending implications, public education, economic development, corrections, and Medicaid, just to name a few. All of these issues place demands on the budget. There is pressure on elected officials to put off longer-term problems, like addressing the implications of GASB 45, to another day and, unfortunately, to another generation of taxpayers.

In some states, treasurers have primary executive authority for retiree health care liabilities. In others, state auditors/controllers, state budget officers, state personnel executives, or retirement system administrators exercise decision-making authority. In some jurisdictions, responsibility for GASB 45 actions is fragmented among two or more individuals or offices; always, the legislative body is a player. Retiree health care decision-makers in local government may also include mayors, managers, department heads, and state actors. The important point is that various political and executive actors have primary or secondary responsibility for retiree health care. Fragmented authority and a predilection for incremental decision-making do not make a good recipe for fast and decisive action.

Second, as this chapter has shown, there is a myriad of strategies, choices, and options that may be chosen in regard to GASB 45 liabilities. Many of these alternatives present exceedingly complex legal, accounting, and tax questions in which primary decision-makers are not schooled. Each action, once implemented, sets into motion new forces that are not entirely predictable. Significant changes in retiree health care can push some current employees into retirement, encourage others to take jobs elsewhere, or motivate some to stay on the job well past their productive years. Such implications argue for caution, diligence, and study before any substantive action is taken. Decision makers must also fend off consultants and consulting firms eager to lead the state into their favored (and lucrative) program designs. All of this argues for caution, diligence, and study before taking substantive action, despite the immediate financial and political pressures.

Third, a majority of states have collective bargaining contracts with one or more employee groups. Unilateral management action to change the terms and conditions of the current contract or to impose new rules and restrictions in a subsequent contract is ill-advised, if not illegal. As protectors of the welfare of employees in the bargaining unit and, in many cases, of retirees as well, unions demand to be equal partners in making such decisions. Change—if agreed to by the union at all—is seldom far-reaching.

Fourth, the alarming financial situation of state and local governments today, replete with substantial declines in tax revenues and growing spending demands for virtually all services, will drive the political agenda. Extinguishing today's financial fires will take precedence over longer term OPEB problems. In filing for bankruptcy, Vallejo, California, is an example of what can occur in worst-case municipal scenarios. Yet the financial crisis also presents an opportunity for public officials to gain traction in efforts to reduce present and future OPEB liabilities though adoption of some of the strategies described above.

Finally, there is a creature under the bed and the states and localities do not know when it will crawl out, what it will look like, or the dangers (or opportunities) it will bring. That creature would be the federal government's actions on health care reform. There are active discussions and debates in the Congress, within the Obama administration, and in the media about the nature and scope of national health care reform. Most agree that the present health care system is ineffective, leaving too many working Americans without any health insurance at all and costs for doctor and hospital visits, procedures, and prescription drugs rising rapidly with no relief in sight. Alternative approaches being discussed include everything from a universal national single-payer system like Canada's, to mandatory employer coverage of workers, to modest market-based adjustments. Early in February 2009, one incremental change had already been made: an extension of the State Children's Health Insurance Program to tens of thousands of additional children. No one can say with any certainty how health care reform will be resolved, if indeed it can be resolved. Meanwhile, Hawaii, Massachusetts, Oregon, Tennessee, and other states have enacted comprehensive state-wide health care policies for their residents that approach universal coverage.

. . . one cannot blame officials for treading water or swimming slowly when the policy environment is so roiled with uncertainty.

Implications for state and local governments and their retirees could be major (e.g., national health care) or minor (changes that affect only the private sector). Outcomes could range from the federal government assuming all future state health care liabilities (unlikely), cost-saving policies that could reduce the future liabilities, greater federal funding of Medicaid, expansion of health care to uninsured adults, to no effect whatsoever. But one cannot blame officials for treading water or swimming slowly when the policy environment is so roiled with uncertainty. Indeed, a precautionary path has much to recommend it as federal health care policy evolves.

What might a precautionary path look like? For one thing, state and local government employers are well advised not to rush into comprehensive action on retiree health care. There is no one best way to solve the problem. Even in those jurisdictions with the highest relative levels of unfunded liabilities, relatively modest changes now can have substantial effects years hence. An attractive policy entry point might be to make slight course changes through cost containment, cost sharing, and wellness programs, while seriously investigating a pre-funding option that is not irrevocable with regard to assets stashed away to pay GASB liabilities. While the economy remains weak and interest rates low, OPEB bonds are attractive but, again, careful and prudent research and advice is important. As a general principle, a multi-pronged approach to managing OPEB liabilities is the safest course of action.

Any given jurisdiction should not act in isolation. As has become quite common, state and local decision makers should look to innovators for promising approaches and policy advice. Our survey asked states to identify those they consider to be innovators and initiators of best practices in managing retiree health care liabilities. No single state received more than two specific mentions. Several states report looking first to their regional peers. Others reported that they examine what AAA-rated states are doing. Several states mentioned actuarial firms or associations (e.g., GFOA, National Association of State Auditors, Comptrollers and Treasurers, NASBO). The most frequently identified organization for best practices was the Kaiser Family Foundation, receiving four mentions (http://www.kff.org/about/index2.cfm). Kaiser is a non-profit foundation with its own research and policy analysis staff that serves as a clearinghouse and information provider on health care issues. Two states identified the Commonwealth Fund (http://www.commonwealthfund.org/aboutus/), a private foundation that promotes improved health care systems by supporting independent research through grants.

The challenge of financing state employee retiree health care has been made more pressing by GASB 45's requirement that government employers release the amount of their unfunded liabilities. Contributing to the financing problem are the costs of medical care and prescription drugs that are rising persistently and precipitously, presenting direct threats to adequate funding for education, prisons, highways, and other public purposes and indirect threats to state and local bond ratings. In the struggle to gain control of future retiree health care costs, jurisdictions must be careful not to enact such Draconian benefit reductions that their ability to attract and retain desirable workers suffers. And they should understand that retraction or significant reduction of current retiree benefits will provoke strong negative reactions and claims that the government employer is acting immorally and possibly illegally, by breaking a contract. Future retirees, of course, are owed less fealty and can make necessary financial adjustments to contend with their reduced benefits.

In charting their course for managing the unfunded liabilities of retiree health care, states and localities should be attentive to the need to educate, and in some cases assist, employee and retiree recipients in making the transition to new arrangements. The transition should be as seamless and transparent as possible to mitigate the concern and confusion that many retirees and their families might experience. It bears repeating that incremental change at a measured pace sometimes has significant advantages over comprehensive, disruptive change.

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