HEALTH CARE BENEFIT COSTS FOR RETIRED PUBLIC EMPLOYEES: ISSUES AND FUNDING OPTIONS

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FOREWORD

This report was prepared in response to Senate Resolution No. 138, S.D. 1, which was adopted during the Regular Session of 1987. The report examines the problem of the increasing cost to the state and county governments of providing free health insurance to their retirees and the funding options that could be considered by the Legislature to continue such benefit.

The data presented and the findings and conclusions reached in this report could not have been achieved without the cooperation and assistance of the parties named in the Senate Resolution in the furnishing of data and in consenting to be interviewed by the Bureau staff. The Bureau extends special thanks to Cenric Ho, Health Fund Administrator; Stanley Siu, Executive Secretary of the Employees' Retirement System; and Russell Okata, Executive Director of the Hawaii Government Employees' Association for their assistance in reviewing the draft of this report.

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INTRODUCTION

Medical care cost-containment continues to be a major concern at both the national and state levels as medical costs keep escalating and access to care becomes prohibitive for the poor and the elderly with fixed incomes. To obtain needed medical care, the poor rely on Medicaid, the federally supported health care program for the poor which is administered by the states while the elderly, those aged 65 and over, rely on the Medicare program, the federally administered health care program for the elderly. Continuing efforts by the federal government to reduce the federal deficit have, in part, resulted in increased restrictions which make Medicaid eligibility more difficult to achieve, and reduced reimbursement levels and increases in the premium levels and deductibles which make Medicare less affordable. For those who are not poor or elderly, relief from the high cost of health care comes primarily from employer sponsored health care plans. Often, employers also provide health insurance benefits to retirees which may include the payment of the premiums for the Part B (medical services) portion of Medicare, a supplemental plan, or both. The long-term cost of such health plans, however, has eroded many employer bankrolls and, increasingly, employers are becoming more cautious and less generous in doling out health benefits.

Most other states, like Hawaii, offer health care benefits to their retired government employees. Since many public sector retirement plans permit employees to retire before age 65, this means that retirees in the pre-Medicare group are able to obtain medical coverage through a group plan prior to eligibility for Medicare at age 65. Typically, once the retiree qualifies for Medicare, the public employer, if it has contributed to the retirement health plan premium before the retiree was eligible for Medicare, will contribute toward the Medicare premium.

Of growing concern in those states that contribute to retiree health benefits is the uncertainty as to future cost implications. Due to breakthroughs in medical research, advanced medical technology, and a health conscious lifestyle, Americans are living longer. The U.S. Census Bureau estimates that the 65 and over population will increase by 22 per cent (from 28.6 million to 34.9 million) in the year 2000 but the 85 and over population is expected to increase by 81 per cent (from 2.7 million to 4.9 million).[1] With the average life expectancy for men in Hawaii at 75 years and 81.5 years for women,[2] it is conceivable that a public employee in Hawaii who retires at age 55 after 30 years of service could live another 25 years. Consequently, a retiree's health care cost to Hawaii's public employers could become a protracted financial commitment.

Current statistics reveal that the number of public sector retirees in Hawaii has been increasing steadily by five to six per cent while the number of active public sector employees has experienced only slight increases of about one per cent each year.[3] The Hawaii Public Employees Health Fund (hereinafter Health Fund) enrollments for the past five years have averaged increases of about two per cent annually for active employees and nearly

seven per cent for retirees.[4] The cost for health benefits for Hawaii's state and county retirees have exceeded the amounts expended for active employees not only because the public employers contribute only 60 per cent of the premium cost for the active employees while they contribute 100 per cent for the retirees, but also because of the steady increase in the number of retirees added to the Health Fund enrollment each year, and the longevity of these retirees.

In recent years, the private sector has been distressed over the problem of growing unfunded liabilities of retiree medical plans and saddled with suits by retirees whenever benefits have been reduced or withdrawn. An expert in the employee benefits field noted that the ballooning liabilities of retiree medical plans and the financial stability of employers will soon become apparent and retiree medical plan liabilities might then become a factor in establishing credit ratings for public and private employers just as pension liabilities are used today.[5]

Senate Resolution No. 138, S.D. 1, was adopted by the Senate during the 1987 Legislative Session stating that "...the future of developing new or improved Health Fund plans for all employees and retirees is contingent upon sufficient public employer funding of health benefit plan premiums...." (See Appendix A for the text of the Resolution.) The Board of Trustees of the Health Fund (hereinafter Board) has been exploring the feasibility of offering adult dental, prescription drugs, and vision coverages; however, due to the statutory requirement that retirees must receive the same benefits as the active employees, the cost of providing expanded benefits coupled with the increasing cost of retiree premiums, is a major inhibiting factor.

Senate Resolution No. 138 requested the Legislative Reference Bureau (hereinafter Bureau) to "...conduct a study of Health Fund benefit costs for retired State and County employees, identify alternative funding sources and make recommendations on proposed legislation to continue a reasonable level of public employer funding of Health Fund benefit costs for all retired State and County employees...." In the conduct of the study, the Bureau was directed to consult with members representing the State of Hawaii, City and County of Honolulu, Hawaii County, Maui County, Kauai County, Hawaii Government Employees' Association, United Public Workers, University of Hawaii Professional Assembly, Hawaii State Teachers' Association, the State of Hawaii Organization of Police Officers, the Hawaii Fire Fighters' Association, the Hawaii Public Employees Health Fund, the Employees' Retirement System, and the Coalition of State and County Retirees. All of the aforementioned organizations, except the Hawaii State Teachers Association which was involved in contract negotiations, offered their insights to this study.

A similar resolution, House Resolution No. 436, H.D. 1, was adopted by the House of Representatives. The House Resolution differed in that it requested that the study be conducted by the Hawaii Public Employees Health Fund and that the Public Employees Management Association of Hawaii (PEMAH) be consulted in addition to the other public employee organizations. The Administrator of the Health Fund informed us that the Health Fund did not have staff to conduct such a study; consequently, the Bureau proceeded with the study as directed by Senate Resolution No. 138, H.D. 1, with the exception that input from PEMAH was included.

The Bureau's focus in this study was to obtain and compile pertinent information regarding the cost of retiree health benefits in order to provide direction for the Legislature in determining policy. The chapter on alternative funding options merely provides a review of such options. The Bureau is not equipped with expertise to determine whether or not the present health fund system can be more efficiently operated and which alternative funding options are most suitable for Hawaii from an actuarial perspective.

Chapter 2

THE HAWAII PUBLIC EMPLOYEES HEALTH FUND

Legislative History of the Health Fund Law

The Hawaii Public Employees Health Fund was created in 1961 by Act 146, Session Laws of Hawaii 1961. Act 146 established a government-administered group medical and hospital care program for officers, employees, retirees, and pensioners of the State and counties and their dependents. The administration of the program was vested in a Board of Trustees of the newly established trust fund which was authorized to negotiate for medical and hospital care plans with coverage as determined by the Board.

The original version of the bill[1] included a provision requiring retirees to pay their own premiums in full. That provision, however, was subsequently deleted as the Legislature was "...of the opinion that retired employees should be accorded full benefits of the program including the government's contribution to the medical and hospital plan".[2] Retirees were required to coshare in the premium payment in the same manner required of the active employees.

In 1965, the law was amended by Act 235 to provide free medical benefits to retired employee-beneficiaries and their dependents "...since these are the people who have great need for medical and dental services but who are bound by rather inflexible retirement or pension payments. Provision of fully paid benefits to those groups will aid in offsetting the continued rise in the cost of living against the relatively static retirement or pension payments".[3] Act 235 also required that the monthly contribution to the health plan of a retired member, or the retiree's beneficiary upon the retiree's death, be paid from funds accumulated from rate credits, reimbursements, interests, or from the state general fund as necessary.[4]

In the 1961 Act, the employer's contribution rate was set at $3 for single persons and $10 for employees with families representing approximately 50 per cent of the plan cost. Hawaii's health care benefits for retirees preceded the federal Medicare program which began in 1966, but the law provided for state contribution to any federal medical care program for the aged if the benefits under such health plan are not equivalent to, or better than, benefits of health benefits plans under the Act. The law further provided that benefits under any respective health benefits plan shall be equally available to all members and their dependents selecting such plan regardless of age to prevent possible discrimination regarding availability of benefits against older persons.[5]

In the establishment of the Health Fund, the Legislature made it clear that the fund would be "...developed mainly from contributions by the state and public officers, employees, retirees and pensioners...[and] used for the sole purpose of providing such persons and their dependents with health services...[and] that the board of trustees should have wide discretion to determine the type of health benefits plan and the eligibility requirements of participants."[6]

The 1961 law permitted the Board to contract for the following health benefits:[7]

> (a) a statewide indemnity benefit plan under which a carrier agrees to pay certain sums of money not in excess of the actual expenses incurred for health services;
>
> (b) a statewide service benefit plan under which payment is made by a carrier under contracts with physicians, hospitals or other providers of health services, or, under certain conditions, payment is made by a carrier to the employee;
>
> (c) comprehensive group-practice prepayment plans which offer health benefits, in whole or in substantial part on a prepaid and community rated bases, with professional services provided by physicians practicing as a group in a common center or centers. Such a group shall include physicians representing at least three major medical specialties who receive all or a substantial part of their professional income from the prepaid funds.

In 1965, the law was amended to permit the Board to negotiate for a plan to offer dental benefits to those children of employee-beneficiaries who have not attained the age of 19 through either an indemnity, statewide service benefit plan, or a comprehensive group-practice prepayment plan.[8] The dental benefit plan for dependents under 19 years of age began in January, 1966, with Hawaii Dental Service as the carrier. In 1980, amendments to the health fund law prescribed the details for the determination of dental plan benefits and Act 95 changed the references to comprehensive group practices to health maintenance organizations.[9] In 1985, the law was expanded to allow benefits for prescription drugs and vision care through either a statewide indemnity plan, a statewide service benefit plan, health maintenance organization plans, or a combination thereof.[10]

Administration of the Health Fund

Board of Trustees - The Health Fund is a trust fund consisting of contributions, interest, income, dividends, refunds, rate credits, and other returns, under the control of a board of trustees.[11] The Board is composed of nine members, three of whom are representatives from different organizations representing public employees, three from different private business organizations, a member of the clergy, a teacher, and the director of finance.[12] The trustees are appointed by the governor and, except for the director of finance, the trustees serve for a term of four years.[13] The trustees serve without compensation but are reimbursed from the fund for necessary expenses.[14] The Board's primary responsibility is to determine the health benefits plan and to contract for the component health benefits offered with appropriate health care carriers. The Board is also responsible for establishing eligibility requirements for employees and operational policies for the Health Fund and for the financial transactions of the trust fund.[15]

To contract for the indemnity health care plan, the Board prepares specifications of a health benefits plan, calls for sealed bids by interested

carriers, and evaluates the bids. Prime consideration is given to the carrier offering the lowest net cost and high quality of services.[16] The other plans submit cost data without sealed bids.[17] Following the selection of the carriers, the premium rates are communicated to the public employers and the public employee unions for collective bargaining purposes. The HMSA health plans are experience rated; consequently, the premium rates for retirees are higher than that for active employees. The HMO plans, however, are community rated, so the premiums for the retirees and active employees are the same.[18]

Staff - The Health Fund staff consists of thirteen permanent positions, two of which were approved by the Legislature during the 1987 session. The staff, headed by the Health Fund Administrator, consists of a secretary, an accountant who heads the accounting section, two account clerks, a health fund assistant who heads the enrollment section, and seven clerks. The two new clerk positions which are still in the process of being established will be used to service retiree accounts.[19] The duties of the Health Fund staff include:[20]

(1) Training state and county personnel and fiscal officers to enroll their respective employees and retirees in fringe benefit plans and publicizing benefit plan information.

(2) Administering fringe benefit plans; reviewing eligibility determinations; processing enrollment applications; recording cancellations and terminations; updating files; and responding to inquiries about benefit plan coverage.

(3) Collecting and reconciling employee payroll deductions and employer contributions in accordance with statutes and collective bargaining agreements; remitting premiums to insurance carriers.

(4) Authorizing the disbursement of Health Fund life insurance plan proceeds to beneficiaries and Medicare Part B health insurance premiums to eligible retirees and their spouses.

(5) Maintaining liaison with insurance carriers, legislative committees, the Social Security Administration, unions, state and county directors of finance and personnel, and the State Office of Collective Bargaining.

(6) Administering enrollment and premium payment records for qualified beneficiaries eligible under the federal Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, which mandates a temporary extension of health insurance benefits for certain persons.

(7) Processing enrollment changes for state and county retirees updating their records.

The Health Fund retains a benefits plan consultant on a contractual basis, usually for three-year periods, and the Attorney General serves as the legal advisor to the Board. The consultant advises the Board and staff on program administration, provides comprehensive data on benefit trends,

reviews the performance of benefit plans, prepares the Health Fund annual experience report, and conducts special studies on benefit improvements as directed by the Board.[21] Special studies conducted in recent years by the consultant include one on cafeteria benefit plans and one on the comparison of group benefit plans in Hawaii. The consultant is currently working on an age trending report to assist the Board in making future projections on retiree health fund costs.[22]

The departments or subdivisions of the public employers are designated the "employing agencies" while the Employees' Retirement System of the State of Hawaii is designated as the "employing agency" for the state and county retiree members. Employing agencies are required to assist the Health Fund by furnishing and transmitting information to the Health Fund on prescribed forms and by distributing information to each employee-beneficiary on approved Health Fund benefit plans, enrollment opportunities, status of employee monthly contributions, and other related Health Fund matters.[23] Most of the basic enrollment questions by Health Fund members are fielded by the employing agencies while the Health Fund staff is involved primarily in program administration, post auditing, and premium payment functions.

Administrative Costs - The administrative costs of the Health Fund are funded by state general fund appropriations. Twenty per cent of such cost is recovered from the counties. During the 1987-1989 fiscal biennium, $563,057 and $573,828 were appropriated for the respective fiscal years.[24]

Health Fund Plans

Carriers - Since the inception of the Health Fund, the Hawaii Medical Services Association (hereinafter HMSA) and Kaiser have been carriers for the medical plan. In 1981, Island Care, a federally qualified health maintenance organization (hereinafter HMO), became the third carrier.[25]

The HMSA provides a service benefit plan, a community health program plan (CHP) which is an HMO plan, and a BCS plan. Under the service benefit plan which is the most popular plan in the Health Fund, there is a wider choice of providers since HMSA has contracted with the majority of the physicians in the State. The plan will cover care provided by participating providers who have agreed to charge no more than what HMSA determines to be reasonable for a given service.[26] The BCS plan is available to retirees and their dependents residing on the mainland. Coverage under the BCS plan is similar to the service benefit plan. The CHP plan is an individual practice plan in which participants may enroll in any one of the 15 health centers throughout Oahu, Hawaii, Maui, and Kauai.

The Kaiser plan is a group practice HMO plan which provides comprehensive coverage. Employees obtain medical services from any of the nine outpatient facilities available (seven on Oahu; two on Maui). Finally, Island Care is an individual practice association plan with one facility on Oahu and one on Kauai.[27] The HMSA-CHP, Kaiser, and Island Care plans are the only three federally qualified HMO plans offered by the Health Fund.

Benefits - The Health Fund provides medical coverage for hospital and physicians services and dental coverage for children under 19 years of age. Under present law, coverage for retirees is the same as that for active employees, whether or not they pay a portion of the premium. The only major benefit changes for the 1987-1988 plan year were in the CHP plan where cardiac rehabilitation is covered and the maximum copayment will increase from $1,800 to $2,000 on January 1, 1988, and in the life insurance plan where supplemental benefits of up to $2,700 have been provided with surplus funds pursuant to the mandate under section 87-3, Hawaii Revised Statutes.[28] (See Appendix B for a summary of benefits offered by the different plans.)

Eligibility - State and county employees who are employed for at least three months and who are employed in at least a 50 per cent full-time equivalent position, retirees currently receiving a pension allowance from the State or the former county retirement system, the surviving spouse and dependent children under age 19 of an active employee who is killed in the performance of duty or a deceased retired employee, and elective officers of the state or county government are eligible for enrollment in the Health Fund.

In order to receive benefits, employees and retirees must file enrollment applications through their employing agency. Employees are required to pay their benefit plan contributions by payroll deductions.[29]

Premiums - The premium rates for the various health plans are set by contracts between the Board and the carriers every two years. Premium increases for fiscal year 1986-1987 ranged from zero per cent in the HMSA plan to 10 per cent in the Island Care plan with no improvements in benefits. Children's dental premiums for plan year 1986-1987 remained unchanged due to favorable group experience. Reimbursement of Medicare insurance premiums increased by 15 per cent per eligible retiree on January 1, 1987.[30] From plan year 1986-87 to 1987-88 the HMSA premium rates increased by 14 per cent, Kaiser by two per cent, and Island Care by 10 per cent. The current premium rates are displayed in Table 1.

Employer-Employee Contributions - Under the public sector collective bargaining law,[31] negotiations relating to the Health Fund are limited to the amount to be contributed by the employers. The State, through the Department of Budget and Finance, and the counties pay to the Health Fund a monthly contribution as specified under chapter 89C, Hawaii Revised Statutes, or in the applicable collective bargaining agreement.[32] Currently, the employer pays a flat contribution of $31.16 for the self only plans and $95.80 for the family plan. The active employees pay the balance which amounts to about 57 per cent for the Kaiser plan and 60 per cent for the HMSA plan. For those retirees who retired after June 30, 1984 with less than 10 years of service, the employer contributions are $25.96 for the employee only plan and $79.84 for the family plan.[33]

With the enactment of a 1973 law, the counties were required to pay all monthly contributions to the Health Fund for their own retired employee-beneficiaries and to reimburse the fund for any contributions for voluntary medical insurance coverage under federal Medicare for retired county

Table 1

MEDICAL PLAN MONTHLY PREMIUM RATES FOR FY 1987-88

Carrier	Total Premium (Self Only Family)	Employer Contribution	Employee/ Retiree Contribution	1986-87 Premiums	% Difference 1986-87 to 1987-88
Kaiser					
Active Employees	$ 55.96	$ 31.16	$ 24.80	$ 55.00	2.00%
(Includes TEFRA)	167.88	95.80	72.08	165.00	2.00
Retirees					
Regular	55.96	55.96	0.00	55.00	2.00
	167.88	167.88	0.00	155.00	2.00
Medicare	40.72	40.72	0.00	36.36	12.00
	158.84	158.84	0.00	141.80	12.00
Act 252 - Regular	55.96	25.96	30.00	55.00	2.00
	167.88	79.84	88.04	165.00	2.00
Act 252 - Medicare	40.72	25.96	14.76	36.36	12.00
	158.84	79.84	79.00	141.80	12.00
HMSA					
Active Employees	$ 51.92	$ 31.16	$ 20.76	$ 45.56	14.00%
	159.68	95.80	63.88	140.08	14.00
Retirees					
Regular	61.16	61.16	0.00	53.64	14.00
	187.20	187.20	0.00	164.20	14.00
Medicare	57.92	57.92	0.00	53.64	8.00
	177.32	177.32	0.00	164.20	8.00
Act 252 - Regular	61.16	25.96	35.20	53.64	14.00
	187.20	79.84	107.36	164.20	14.00
Act 252 - Medicare	57.92	25.96	31.96	53.64	8.00
	177.32	79.84	97.48	164.20	8.00
HMSA BCS - Retirees					
Regular	$ 61.16	$ 61.16	$ 0.00	$ 53.64	14.00%
	187.20	187.20	0.00	164.20	14.00
Medicare	57.92	57.92	0.00	53.64	8.00
	177.32	177.32	0.00	164.20	8.00
Act 252 - Regular	61.16	25.96	35.20	53.64	14.00

Carrier	Total Premium (Self Only Family)	Employer Contribution	Employee/ Retiree Contribution	1986-87 Premiums	% Difference 1986-87 to 1987-88
	187.20	79.84	107.36	164.20	14.00
Act 252 - Medicare	57.92	25.96	31.96	53.64	8.00
	177.32	79.84	97.48	164.20	8.00
HMSA-CHP					
Active Employees	$ 65.00	$ 31.16	$ 33.84	$ 63.36	3.00%
	178.72	95.80	82.92	174.20	3.00
Retirees					
Regular	65.00	65.00	0.00	63.36	3.00
	178.72	178.72	0.00	174.20	3.00
Medicare	47.40	47.40	0.00	47.86	-1.00
	143.52	143.52	0.00	143.20	- .02
Act 252 - Regular	65.00	25.96	39.04	63.36	3.00
	178.72	79.84	98.88	174.20	3.00
Act 252 - Medicare	47.40	25.96	21.44	47.86	-1.00
	143.52	79.84	63.68	143.20	- .02
Island Care					
Active Employees	$ 57.80	$ 31.16	$ 26.64	$ 52.66	10.00%
	177.40	95.80	81.60	161.68	10.00
Retirees					
Regular	57.80	57.80	0.00	52.66	10.00
	177.40	177.40	0.00	161.68	10.00
Medicare	44.04	44.04	0.00	42.94	3.00
	123.72	123.72	0.00	120.64	3.00
Act 252 - Regular	57.80	25.96	31.84	52.66	10.00
	177.40	79.84	97.56	161.68	10.00
Act 252 - Medicare	44.04	25.96	18.08	42.94	3.00
	123.72	79.84	43.88	120.64	3.00

Source: Compiled from information provided by the Hawaii Public Employees Health Fund.

employee-beneficiaries.[34] Prior to this law, the State paid the monthly medical contributions for all retired employee-beneficiaries. In 1972, an opinion by the Attorney General ruled that counties were responsible not only for contribution costs for active employees, but for retirees also.[35]

The counties also pay monthly contributions for children's dental benefits and group life insurance benefits. The counties annually reimburse the State, no later than December 30th of each fiscal year, for their pro rata share of cost of administering the fund for the fiscal year.

Where an employee-beneficiary participates in the health benefits plan of an employee organization, the Health Fund pays a monthly contribution toward such plan equivalent to the amount it contributes for its members.[36] The Health Fund also reimburses retiree members and eligible spouses for the premiums they pay for Medicare Part B (physician and other medical services) coverage.[37] Under Medicare, Part A (hospital) coverage is free to all eligible persons 65 years of age. To obtain Part B coverage Medicare enrollees must pay a monthly premium of $17.90.[38] Reimbursement to retiree members of this premium amount is in addition to the health plan the Health Fund provides to Medicare eligibles.

The Health Fund collects both state and county employer and employee contributions and, after processing and reconciling enrollments, remits these moneys to insurance carriers and employee organization life insurance plans. In the contracts with the carriers, the carrier and the Board agree on a specified amount for the contract year and if the actual cost of the premiums is less than the agreed upon amount, the carrier must return the surplus to the Health Fund. If the actual premiums are more than the contract amount, the carriers must absorb the loss.

Section 87-3, Hawaii Revised Statutes, requires that any rate credit or reimbursement from any carrier or any earning or interest derived therefrom be used in addition to the provision of a health benefits plan, to finance the children's dental plan and the employee's portion of the monthly contribution for retired employees. The Attorney General has ruled that rate credits and other returns can only be used for purposes set forth in section 87-3, Hawaii Revised Statutes,[39] and that funds may not be used for services consisting principally of retirement planning and assistance.[40]

The rate credits for the current plan year have amounted to about $5 million. The credits derived from the medical plans have been applied to keep the rates constant for the ensuing plan years, while the credits in the life insurance account have been used to provide additional life insurance benefits.[41]

Chapter 3

FACTORS IMPACTING THE HEALTH FUND

There were 17,086 pensioners in the Employees' Retirement System (ERS) as of March 31, 1986.[1] As of June 30, 1987, the enrollment total for the Health Fund medical plan was 53,844, of which 19,544 enrollments were attributable to retirees. The employer's Health Fund contribution requirements for retirees in the Health Fund for the 1986-87 fiscal year was $27,335,491.64 while the requirements for active employees totalled $23,551,146.38. The amount contributed for the 19,544 retirees enrolled in the Health Fund constituted 54 per cent of the total employer contributions made to the Health Fund while the retirees comprised only about 36 per cent of the total medical plans enrollment (see Table 2).

The Growing Retiree Population

The free Health Fund benefits for retirees apply to any retiree, with at least 10 years of service, who is a "...retired member of the employees retirement system, the county pension system, or the police, firefighters, or bandsmen pension system of the State or county...."[2] Under the contributory plan, a member is eligible for service retirement if the member has: (1) five years of service and attained the age of 55 years; (2) 25 years of service; or (3) 10 years of service including service as a judge, elected official, or the chief clerk or sergeant-at-arms of the legislature.[3]

An employee who leaves government service before age 55 with at least five years of credited service and leaves the contributions in the retirement system has vested benefit status. This means that upon reaching 55 years of age, the employee would be eligible for a service retirement benefit.

In 1984, the Legislature enacted a law[4] creating a noncontributory plan for class C members[5] within the retirement system wherein 10 years rather than five years of service would be required to become a vested member. Police officers, firefighters, judges, elected officials, and persons employed in positions not covered by social security are excluded from the noncontributory plan and remain in the contributory plan.[6] To obtain full retirement benefits, an employee must be 62 instead of 55 years old with at least 25 years of service or the employee must have at least 30 years of service and be at least 55 years old. Employees may retire early with reduced benefits at age 55 if the employee has 20 or more years of service. Former employees who terminated service with vested benefit status would be eligible for a pension upon reaching the age of 65. Class C employees who were members of the contributory system had a choice of remaining in the contributory system or switching to the noncontributory system; however, all class C employees entering service after June 30, 1984 would automatically become members of the noncontributory system.

In an effort to contain the rising cost of Health Fund benefits for retirees, the Legislature amended the Health Fund law to require that an employee have 10 years or more of service to become eligible for the free

Table 2

HAWAII PUBLIC EMPLOYEES HEALTH FUND
EMPLOYER/EMPLOYEE CONTRIBUTIONS AND ENROLLMENT DATA
AS OF JUNE 30, 1987

	State of Hawaii Active	State of Hawaii Retired	City & County of Honolulu Active	City & County of Honolulu Retired	City & County Bd. of Water Supply Active	City & County Bd. of Water Supply Retired	Hawaii County Active	Hawaii County Retired	Maui County Active	Maui County Retired	Kauai County Active	Kauai County Retired	Total
1. EMPLOYER CONTRIBUTIONS													
Medical Plans	16,749,370.67	16,457,368.20	4,344,927.32	4,898,797.94	341,102.38	625,223.08	921,858.31	1,033,003.35	704,108.22	782,402.15	489,779.48	584,122.42	47,932,063.52
Medicare		2,112,990.40		484,313.00		68,718.80		124,359.80		80,743.80		83,448.70	2,954,574.50
Subtotal Medical	16,749,370.67	18,570,358.60	4,344,927.32	5,383,110.94	341,102.38	693,941.88	921,858.31	1,157,363.15	704,108.22	863,145.95	489,779.48	667,571.12	50,886,638.02
Children's Dental Plan	1,818,314.08	61,495.44	524,149.92	42,084.00	34,919.60	2,943.40	118,728.60	5,714.72	94,363.40	4,052.76	58,559.12	3,279.08	2,768,604.12
Life Insurance Plan	966,350.25	333,373.50	206,010.00	82,233.00	16,958.25	9,765.00	40,884.75	15,133.50	31,585.50	11,493.00	21,519.00	9,492.75	1,744,798.50
TOTAL EMPLOYER CONTRIBUTIONS	19,534,035.00	18,965,227.54	5,075,087.24	5,507,427.94	392,980.23	706,650.28	1,081,471.66	1,178,211.37	830,057.12	878,691.71	569,857.60	680,342.95	55,400,040.64
TOTAL AGENCY		38,499,262.54		10,582,515.18		1,099,630.51		2,259,683.03		1,708,748.83		1,250,200.55	55,400,040.64
2. EMPLOYEE CONTRIBUTIONS		11,385,542.13		3,203,601.12		239,450.91		593,442.74		516,318.93		376,741.12	16,315,096.95

3. CONTRIBUTION SUMMARY--
ALL BENEFIT PLANS

Active	27,483,488.85
Retired	27,916,551.79
Total Employer	55,400,040.64
Total Employee	16,315,096.95
Grand Total (Unaudited)	71,715,137.59

4. ENROLLMENTS - 6/30/87

													Active	Retired
Medical Plans	24,914	13,704	6,098	3,587	498	456	1,215	763	920	566	655	468	34,300	19,544
Totals	38,618		9,685		954		1,978		1,486		1,123		53,844	
Medicare Reimbursements	---	8,458	---	1,942	---	260	---	480	---	323	---	325	---	11,788
Children's Dental Plan	25,694	838	7,431	574	488	42	1,716	78	1,321	57	835	45	37,505	1,634
Totals	26,532		8,005		530		1,794		1,378		900		39,139	
Life Insurance Plan	35,699	12,857	7,655	3,137	631	388	1,528	584	1,169	439	805	369	47,487	17,774
Totals	48,556		10,792		1,019		2,112		1,608		1,174		65,261	

retiree health benefit.[7] Employees with less than 10 years of service who retired after June 30, 1984, must pay a monthly contribution as established by statute.[8] Current contributions by such retirees amount to about 43 per cent for retirees under the HMSA plan and 45 per cent for retirees under Medicare (see Table 1 in Chapter 2 for the various contribution amounts). As of February 28, 1987, there were only 200 retirees with less than 10 years of service of which only 80 were enrolled in the Health Fund plan (see Table 3).

During the past two fiscal years, the number of new retirees by age groups showed an increasing number of employees retiring at an earlier age (see Table 4). However, this trend of early retirement may not continue for long since the retirement age under the noncontributory plan is higher and, for social security purposes, will become higher beginning in the year 2000.[9] As of March 31, 1986, four per cent of the total employees in active service were 55 years or older with less than 10 years of service. The percentage is increased to 10 per cent if employees with less than 25 years of service are included in the count (see Table 5). The Health Fund's projected enrollment and monthly medical premium costs for fiscal years 1986-1987, 1987-1988, and 1988-1989 are reflected in Table 6.

Retiree Pensions

Of the 14,725 service pensions (this number excludes disability retirements) in force as of March 31, 1986, only 7,934 or 54 per cent were for retirees with 25 or more years of service and 10 per cent for retirees with less than 10 years of service (see Table 7). The average monthly pension for the entire group of retirees was $541; however, the average monthly pension for those retiring with 25 or more years of service is a lot higher, ranging from $654 to $831. Typically, the lower average monthly pensions occur in the groups with less years of service and in the ordinary and accidental disability retirement groups. In the service retirement category, the average monthly pension is $566.78, the lowest average is in the general employees-women group and the highest is in the police, fire, and corrections group (see Table 8). A chart of the pensioners by monthly pension amounts is provided in Table 9 to illustrate the large number of lower pensions. Similar data for 1986 were not available so the 1985 data have been used in this instance. Of the 16,162 pensions in force on March 31, 1985, 58.37 per cent were below $500 while the average monthly pension in 1985 was $521. The pensions of the most recent retirees, of course, reveal a higher average of $882 (see Table 10).

With the implementation of the noncontributory system, the average pension in the future when those in the noncontributory plan retire will be lower than they would have been under the contributory system since these pensioners will be receiving amounts based on one and one-fourth rather than two per cent of the average final compensation.[10] Moreover, under the noncontributory plan, an employee under 55 years of age is not eligible for service retirement and to be eligible for an early retirement allowance, the employee must have at least 20 years of service and be at least 55 years old.[11] As of March 31, 1986, 45 per cent of the total employees in active service were receiving salaries below $20,000 annually, so it is likely that

Table 3

ENROLLMENT OF RETIREES WITH LESS THAN 10 YEARS OF SERVICE AS OF FEBRUARY 28, 1987

	Self	Family	Medical Plans Dependents	Dental Plans Dependents	Life Insurance Plans
State	34	14	14	12	167
City & County of Honolulu	5	5	7	6	24
Hawaii County	-	-	-	-	3
Maui County	1	-	-	-	3
Kauai County	-	1	1	-	1
Board of Water Supply	-	-	-	2	2
	40	20	22	20	200

Source: Information compiled by the Hawaii Public Employees Health Fund.

Table 4

RETIREES BY AGE GROUPS

	Under age 55	Age 55 to 59	Age 60 to 64	Age 65 and over	All ages
General Employees	14	312	336	149	811
Teachers	10	177	78	30	295
Police, Fire and Corrections	44	22	3	2	71
Total service retirees (1985-86)	68	511	417	181	1,177
Percentage of new service retirees, by age groups:					
1981-82	1.4%	16.7%	73.8%	8.1%	100%
1982-83	1.8	20.4	69.8	8.0	100
1983-84	2.5	20.1	69.6	7.8	100
1984-85	5.2	43.3	36.9	14.6	100
1985-86	5.8	43.4	35.4	15.4	100

Source: Employees' Retirement System of the State of Hawaii, Report of the Actuary on the Sixty-first Annual Actuarial Evaluation as of June 30, 1986, submitted by Martin E. Segal & Company, Inc., January 1987, p. 7.

Table 5

EMPLOYEES IN ACTIVE SERVICE AS OF MARCH 31, 1986 BY AGE AND BY YEARS OF SERVICE

ALL EMPLOYEES

Age	Years of Service									
	Total	0 - 4	5 - 9	10 - 14	15 - 19	20 - 24	25 - 29	30 - 34	35 and over	Unknown
Total	46,106	11,870	8,416	6,989	8,904	4,502	3,089	1,070	286	980
Under 20	25	13	-	-	-	-	-	-	-	12
20 - 24	875	843	31	-	-	-	-	-	-	1
25 - 29	3,607	2,725	839	43	-	-	-	-	-	-
30 - 34	6,263	2,712	2,399	1,099	53	-	-	-	-	-
35 - 39	8,107	2,048	1,733	2,392	1,898	33	-	-	-	3
40 - 44	7,842	1,412	1,123	1,173	2,941	1,163	27	-	-	3
45 - 49	6,121	760	790	732	1,370	1,543	917	9	-	-
50 - 54	5,667	542	631	638	1,039	915	1,354	542	6	-
55 - 59	4,038	434	476	521	901	529	583	434	159	1
60 - 64	1,918	288	302	259	444	259	191	76	99	-
65 and over	391	70	79	73	82	40	17	8	22	-
Unknown	1,252	23	13	59	176	20	-	1	-	960

Source: Employees' Retirement System of the State of Hawaii, Report of the Actuary on the Sixty-first Annual Actuarial Valuation as of June 30, 1986, submitted by Martin E. Segal & Company, Inc., January 1987, p. 11.

Table 6

PROJECTED ENROLLMENT AND MEDICAL PREMIUM PAYMENTS FOR RETIREES

1986-87 through 1988-89 Plan Years

Plan Year	Estimated Average Number	% Change from Previous Year	% Change from 1985-86	Estimated Monthly Premium Payments
1986-87	18,766	5.50%	5.50%	$2,024,826
1987-88	19,743	5.21%	10.99%	$2,376,669
1988-89	20,719	4.94%	16.48%	$2,951,907

Source: Hawaii Public Employees Health Fund Annual Experience Report 1985-86 Plan Year, prepared by Benefit Plan Consultants (Hawaii), Inc., December 1986, p. 16.

Table 7

SERVICE PENSIONS IN FORCE ON MARCH 31, 1986
BY YEARS OF SERVICE, EMPLOYEE GROUP, AND AVERAGE MONTHLY AMOUNT

Years of Service	Total		General Employees		Teachers		Police, Fire & Corrections	
	Number	Average pension	Number	Average pension	Number	Average pension	Number	Average pension
Total	14,725	$541	10,215	$479	3,613	$610	897	$ 977
Less than 10 ...	1,523	120	1,230	117	287	133	6	95
10 - 14	1,830	205	1,484	191	335	261	11	327
15 - 19	1,625	328	1,279	306	337	409	9	283
20 - 24	1,813	450	1,390	418	383	560	40	529
25 - 29	2,790	654	1,772	546	588	757	430	956
30 - 34	2,884	831	1,778	765	764	875	342	1,074
35 and over	2,260	818	1,282	909	919	667	59	1,191

Source: Employees' Retirement System of the State of Hawaii, Report of the Actuary on the Sixty-first Annual Actuarial Valuation as of June 30, 1986, submitted by Martin E. Segal & Company, Inc., January 1987, p. 16.

Table 8

PENSIONS IN FORCE ON MARCH 31, 1986 BY EMPLOYEE GROUP, TYPE, AND AVERAGE MONTHLY AMOUNT

Employee Group	Number	Average pension
All Employees	17,026	$ 551.61
	SERVICE	
Total	15,938	$ 566.78
General Employees - men	6,567	524.84
General Employees - women	4,533	462.88
Teachers - men	1,137	785.31
Teachers - women	2,733	590.34
Police, Fire and Corrections	968	1,014.63
	ORDINARY DISABILITY	
Total	588	$ 300.34
General Employees - men	262	312.59
General Employees - women	180	250.00
Teachers - men	22	506.32
Teachers - women	91	303.39
Police, Fire and Corrections	33	332.02
	ACCIDENTAL DISABILITY	
Total	445	$ 367.96
General Employees - men	223	339.14
General Employees - women	84	297.81
Teachers - men	1	1,162.70
Teachers - women	2	616.68
Police, Fire and Corrections	135	449.65
	OTHER	
Total	55	$ 328.69
General Employees - men	42	279.68
General Employees - women	4	291.57
Teachers - men	4	697.96
Teachers - women	2	520.42
Police, Fire and Corrections	3	444.21

Source: Employees' Retirement System of the State of Hawaii, Report of the Actuary on the Sixty-first Annual Actuarial Valuation as of June 30, 1986, submitted by Martin E. Segal & Company, Inc., January 1987, p. 15.

Table 9

PENSIONS IN FORCE ON MARCH 31, 1985 BY MONTHLY AMOUNT

Monthly Pension	General Employees	Teachers	Police Officers Fire Fighters	Total	Per Cent of Total
Less than $100	1,317	367	10	1,694	10.49
$ 100-$ 199	2,005	381	45	2,431	15.05
200- 299	1,628	357	72	2,057	12.73
300- 399	1,267	422	57	1,746	10.81
400- 499	1,030	418	52	1,500	9.29
500- 599	831	315	66	1,212	7.50
600- 699	688	243	58	989	6.12
700- 799	571	223	94	888	5.50
800- 899	508	163	100	771	4.77
900- 999	403	168	102	673	4.17
1,000- 1,099	298	169	97	564	3.49
1,100- 1,199	230	167	69	466	2.89
1,200- 1,299	157	107	59	323	2.00
1,300- 1,399	89	100	41	230	1.43
1,400- 1,499	77	59	37	173	1.07
1,500- 1,599	53	50	25	128	.80
1,600- 1,699	42	26	12	80	.50
1,700- 1,799	30	9	15	54	.34
1,800- 1,899	25	18	10	53	.33
1,900- 1,999	19	9	10	38	.24
2,000- 2,099	15	6	7	28	.18
2,100- 2,199	10	3	2	15	.10
2,200- 2,299	8	3	2	13	.08
2,300- 2,399	6	2	0	8	.05
2,400- 2,499	23	1	4	28	.18
	11,330	3,786	1,046	16,162	100.11

Source: Information compiled from Tables 19-A, 19-B, 19-C, 19-D, and 19-E, Employees' Retirement System of the State of Hawaii, Report of the Actuary on the Sixtieth Annual Actuarial Valuation as of June 30, 1985, submitted by Martin E. Segal & Company, Inc., May 1986.

Table 10

PENSIONS AWARDED DURING YEAR ENDED MARCH 31, 1986 AND STILL IN FORCE AT END OF YEAR BY EMPLOYEE GROUP, TYPE, AND AVERAGE MONTHLY AMOUNT

Employee Group	Number	Average pension
All Employees	1,208	$ 882.46
	SERVICE	
Total	1,177	$ 892.05
General Employees - men	440	772.27
General Employees - women	371	691.99
Teachers - men	111	1,214.73
Teachers - women	184	1,153.19
Police, Fire and Corrections	71	1,498.50
	ORDINARY DISABILITY	
Total	22	$ 339.37
General Employees - men	8	225.63
General Employees - women	6	219.67
Teachers - men	1	805.00
Teachers - women	5	515.62
Police, Fire and Corrections	2	360.00
	ACCIDENTAL DISABILITY	
Total	9	$ 955.19
General Employees - men	3	1,015.89
General Employees - women	5	853.60
Police, Fire and Corrections	1	1,281.00

Source: Employees' Retirement System of the State of Hawaii, Report of the Actuary on the Sixty-first Annual Actuarial Valuation as of June 30, 1986, submitted by Martin E. Segal & Company, Inc., January 1987, p. 14.

there will still be a large number of pensioners in the future at the lower end of the pension scale (see Table 11). Although employees in the noncontributory plan have been encouraged to enroll in the State's deferred compensation plan or to establish other individual retirement plans, it is impossible to predict the adequacy of the incomes of future retirees. It can be assumed, however, that the free medical benefit will still be important to the noncontributory members.

The Rising Cost of Medical Insurance

From 1950 to 1985, the cost of health care in the United States has increased at an average annual rate of 10.4 per cent. In every year during that period, except 1972, 1978, and 1984, the inflation rate in national spending for health care outpaced that of the rest of the economy. From 1950 to 1985 the share of the gross national product devoted to health care more than doubled and such shifting implies that other goods and services, i.e., housing, food, national defense, were consuming a decreasing portion of the gross national product.[12]

Health insurers reported that claim costs for 1987 were much higher than anticipated and that the recent increases are reminiscent of the early 1980s when annual rate jumps of 30 per cent to 40 per cent were common. In explaining the reasons for this unsettling escalation, experts in the field have noted that: (1) cost containment efforts have proven less effective than expected; (2) retiree health benefit costs are growing; (3) there has been an increase in acquired immune deficiency syndrome cases and substance-abuse claims; and (4) the growth of alternatives to indemnity plans, e.g., health maintenance organizations (HMOs) and preferred provider organizations, are causing more rate increases in the indemnity plans since hospitals and physicians are shifting costs to the fee-for-service patients to offset discounts given to HMOs and other group plans and because the HMOs attract younger, healthier participants, a higher percentage of older, higher risk participants are left in indemnity plans.[13]

Longevity of Retirees

The life expectancy rate as projected by the Group Annuity Mortality Tables has been increasing steadily. In 1983 a 55-year-old male could have expected to live to age 79 and a 55-year-old female to age 84 whereas in 1950 the expectancies were to ages 71 and 80, respectively.[14] It can be assumed that the life expectancies for 55-year-olds in 1987 is higher than that projected for 1983 and that life expectancies in ensuing years will increase. Based on actual retirement patterns during the 1980-84 period, the ERS has assumed that the retirement ages for the contributory plan members is 60 for general employees and teachers and 54 (or completion of 25 years of service, if later) for police, fire, and corrections officers while the assumed retirement age for noncontributory plan members is 64.[15] According to the Health Fund's life insurance age report prepared as of April 30, 1987, there were 1,467 retirees who were 80 years of age or older. These statistics mean that Hawaii's public employers could expect to be liable for the payment of retiree health insurance premiums for about 20 to 25 years for the average retiree.

Table 11

EMPLOYEES IN ACTIVE SERVICE AS OF MARCH 31, 1986 BY ANNUAL SALARY AND BY PLAN

ALL EMPLOYEES

Salary	Total	Contributory Plan	Noncontributory Plan
Total	46,106	25,742	20,364
Less than $10,000.....	1,728	908	820
$10,000 - 14,999	7,111	3,568	3,543
15,000 - 19,999	11,922	5,626	6,296
20,000 - 24,999	8,779	4,889	3,890
25,000 - 29,999	7,641	4,590	3,051
30,000 - 34,999	5,422	4,034	1,388
35,000 - 39,999	1,600	1,004	596
40,000 - 44,999	827	527	300
45,000 - 49,999	500	277	223
50,000 - 54,999	260	161	99
55,000 - 59,999	129	64	65
60,000 - 64,999	81	41	40
65,000 - 69,999	26	13	13
70,000 and over	80	40	40

Source: Employees' Retirement System of the State of Hawaii, Report of the Actuary on the Sixty-first Annual Actuarial Valuation as of June 30, 1986, submitted by Martin E. Segal & Company, January 1987, p.10.

Federal Health Care Progams

In the United States Congress, the most recent version of the Medicare Catastrophic Loss Prevention Bill, S. 1127 as of this writing, which passed the Senate in October, 1987, would provide benefits for acute catastrophic illness costs beyond $1,850 and cover outpatient prescription drug expenses beyond a $600 deductible. The expanded Medicare benefits would be financed by a $4.00 increase in 1988 in the monthly Part B premium and a supplemental income-related premium to be collected on the tax returns of the approximately 36 per cent of senior citizens with incomes high enough to require them to pay taxes. In 1988, the supplemental premium amount would be $12.20 per enrollee for each $150 of taxes paid, up to $800 per enrollee. The cap on the supplemental premium rises to $1,000 in 1992.[16] Any added costs to Medicare Part B would mean increased costs to the state and county governments since the Health Fund reimburses retirees for the Medicare Part B premiums paid.

Litigation in Retiree Benefits

In the private sector where the escalating costs of retiree health benefits have caused many employers to reduce or terminate such benefits, there has been a flurry of suits on behalf of retirees claiming that their benefits should be viewed as earned compensation for their years of service or that benefits cannot be altered without their consent. The extent to which an employer may modify or terminate welfare benefits for retirees is a matter still unsettled in the courts where the key issue lies in determining the nature of the retiree's right to health benefits. A recent analysis of major court decisions noted that there is a clear trend in finding that retirees are vested in their welfare benefits as fully as in their pension benefits.[17]

In the public sector, where health benefits for retirees are usually statutorily rather than contractually established and where no state has had to take drastic action by modifying or reducing the benefits of existing retirees, there is much uncertainty as to how the private sector court decisions will impact on the public sector. A board of education case in New York, however, suggests that the private sector trend may not apply to the public sector. Although New York requires state retirees who retired after January 1, 1983 to contribute 10 per cent of the premium cost while maintaining the free coverage for those retirees who retired prior to January 1, 1983,[18] for employees of other employers, such as counties or boards of education, participation in the health plan is different. The law requires that participating employers pay not less than 50 per cent of the premiums for its employees and retirees and not less than 35 per cent for their dependents and allows them to pay a higher or lower rate than that paid by the state for its employees and retirees.

Effective July 1983, the Board of Education of Sewanhaka Central school District reduced the district's contribution from 100 per cent to 50 per cent for retirees and from 50 per cent to 35 per cent for their dependents. In a suit brought by an employed teacher eligible for retirement and two retired teachers challenging the Board's action, the Supreme Court, Special Term, Albany County, granted relief to the teachers; but on appeal, the Supreme

Court Appellate Division held that the contributions by the Board of Education were not constitutionally protected pension benefits as the employer's portion was paid directly to the insurer by the school board and no part of that amount was from the retirement system. The Appellate Division found, among other things, that since the reduction of the contributions were within the minimum levels expressly provided for by statute, there was no breach of any contractual obligation by the school district.[19] Subsequently, the Appeals Court affirmed the holding of the Appellate Division noting that the employer's contribution to the health insurance premium is a benefit resulting from being employed by the State or participating employer and not from being a member of the retirement system.[20]

Chapter 4

OTHER HEALTH FUND PROGRAMS

State Health Funds

The Bureau conducted a survey of the 50 states regarding their health fund operations, but only 30 states responded and not all responses were complete. Accordingly, the Bureau relied heavily on the state survey data compiled by Martin E. Segal, Inc., to provide this overview of state health funds (see Appendix C, Tables 1 to 4). The only shortcoming of the Segal survey is that it did not include information as to the coverage of retirees below age 65. From the information received in the Bureau survey responses and information compiled by the American Federation of State, County and Municipal Employees, AFL-CIO,[1] it appears that most of the states that offer retiree health benefits to 65-year-olds, provide benefits to younger retirees since the retirement age for many government retirement systems is younger than 65.

Only one state, Nebraska, does not provide for some type of retiree health benefit program. The Segal survey reported that Indiana does not provide for retiree coverage for retirees 65 and older who are eligible for Medicare; however, Indiana, which began its retiree health plan in 1983, does provide coverage for retirees who are ineligible for Medicare and who have at least 20 years of credited service.[2] According to the Segal survey, as of January, 1987, there were a total of 32 states that paid 100 per cent of the premiums for the active employees self-only coverage (see Appendix C, Table 2). Of the 32 states, only 12 states also pay 100 per cent for the family coverage of active employees (see Appendix C, Table 3).

A total of 14 states, including Hawaii, pay 100 per cent of the premiums for retirees who are 65 years of age or older and who have Medicare coverage (see Table 12). Of this number, only four states (Hawaii, Colorado, Michigan, and Ohio) do not contribute 100 per cent to the premiums of their active employees. Ten of the 14 states (Alabama, Alaska, California, Illinois, Maine, New Hampshire, North Carolina, Pennsylvania, South Carolina, and Texas) pay 100 per cent of the premium cost for employee-only coverage for active employees and only four of these states (Alaska, California, New Hampshire, and Pennsylvania) pay 100 per cent for active employees family plan coverage.

New Jersey's response to the Bureau's survey indicated that retirees with 25 or more years of service or who are on disability retirement receive paid hospitalization coverage, although the state does not contribute to the premiums for other medical coverage. In January, 1988, Delaware will begin paying 100 per cent for its retirees.[3] New York pays the total cost for employees retired before 1983, but pays 90 per cent of the premiums for those who retire in 1983 and later. To make the retiree contribution less burdensome, New York permits the payment of premiums through a retiree's accumulated sick leave credits.[4]

Table 12

STATES CONTRIBUTING 100 PER CENT TO RETIREE HEALTH PLAN

	Employer Contributions Active Employee Coverage		
	Employee Only	Family	Conditions for 100% Retiree Contribution
1. Alabama	100%	58.1%	Retirees must be receiving monthly pension.
2. Alaska	100	100	Retiree must be receiving monthly benefit from the retirement system. Persons younger than 60 years of age must pay full group premium for retiree major medical coverage; persons 60 years old but under 65 years old pay half of the premium; and the disabled and those 65 years of age and older do not pay.
3. California	100	100	If retirement is more than 30 days but less than 120 days after separation, coverage not automatic; if separation more than 120 days, retiree ineligible for coverage.
4. Colorado	84.6	31.7	Retirees must have 20 years of service; contribution requirements for other retirees prorated based on years of service with retirees with less than six years of service paying full premium.
5. Hawaii	60	60	Retirees retiring after 6/30/84 with less than 10 years of service must contribute to premiums as provided by law (about 43%); all other retirees receive free benefits including family coverage.
6. Illinois	100	55.3	Retirees, like active employees, pay difference between employee-only and family plans; retirees must have at least 8 years of credited service.
7. Maine	100	71.2	Must retire directly from state employment, be eligible for pension, and have been enrolled in health plan during previous 12 months; retiree pays for dependent coverage.
8. Michigan	90	90	For retirees ineligible for Medicare, State pays 90% of premium; 100% for Medicare eligible retiree and spouse.
9. New Hampshire	100	100	State pays full coverage for retiree and spouse of retirees retiring directly from state service.
10. North Carolina	100	41.7	Retirees need not be in active service immediately prior to retirement to receive full coverage.
11. Ohio	73	73	Effective 7/1/86, retirees must have 10 years of service to qualify for full coverage.
12. Pennsylvania	100	100	Retirees must have 25 years of service or 10 years of service at age 60; vested terminated employees with at least 25 years of service who subsequently retire at age 60 also receive fully paid coverage. All others receive $5/month toward premiums. State has composite premium rate for both employee-only and family plans.
13. South Carolina	100	50.5	Retirees, like active employees, pay difference between employee-only and family plans.
14. Texas	100	49.6	Retirees, like active employees, pay difference between employees and family plan.

Source: 1987 Update of Martin E. Segal Company's Survey of State Employee Health Benefit Plans, Legislative Reference Bureau survey and state statutes.

Although not reflected in the Segal survey, Florida recently enacted a law which requires the state to contribute $1 to a retiree's health care plan for each year of service the retiree served as an active employee, e.g., an employee with 25 years of services upon retirement would receive a $25 contribution toward the health fund premium.[5]

Alabama contributed only 39.4 per cent of the retiree's premium for the self-only plan in 1986; but in 1987 the state contributed 100 per cent. Connecticut, Georgia, and Missouri increased the employer's contribution in 1987 while Idaho ceased the small contribution made in 1986 (see Appendix C, Table 4). Alabama, Missouri, and Nevada require that the retiree must have been actively enrolled in the health plan as an active employee to qualify for retiree health benefits.

In another survey involving 336 public sector employers (primarily counties, school boards, and cities) that was conducted by William M. Mercer-Meidinger, Inc., in cooperation with the Public Risk and Insurance Management Association, it was found that 73 per cent of the respondents provided medical benefits for retired employees. Of that number, 46 per cent provided supplements to Medicare and 45 per cent provided benefits identical to active employees. Only 24 per cent of the respondents paid the entire cost of the medical benefits for retirees. Sixty-eight per cent provided coverage for the retiree's dependents, but only 14 per cent absorbed the entire cost of dependent coverage. Finally, 78 per cent of the respondents indicated that they were planning to pass on future cost increases to the retirees.[6]

Cost-containment Efforts

Responding to the rising costs of health care, most states initiated cost-containment strategies in their health benefits plans. A popular strategy was the switching of the health benefits plan from a fully insured to a self-insured or self-funded plan. The states that went this route found that the savings realized were substantial and that more money for the health fund could be generated through interest earnings on the amounts remaining in the fund. Other common cost-containment strategies included the requirement of, or fiscal incentives to encourage, second opinions for certain surgical procedures; precertification of admissions to hospitals; and preadmission testing.[7] Many states also reported an increasing number of health fund enrollees opting for health maintenance organization (HMO) plans which are generally cheaper. In January, 1987, 74 per cent of the health fund participants in Wisconsin were enrolled in HMOs while Indiana has 64 per cent and California has 61 per cent. Hawaii's HMO enrollments, which have increased over recent years, are about 28 per cent (see Appendix C, Table 1).

The Martin E. Segal Company surveys of state health plans for 1986 and 1987 found that the increase in state health plan costs was 5.3 per cent from January 1986 to January 1987 and 3.5 per cent from January 1985 to January 1986 while the increases in the medical component of the Consumer Price Index for the same 12-month periods were 7.5 per cent and 6.9 per cent, respectively. (As was noted in chapter 2, Hawaii's HMSA indemnity plan

rates increased 10 per cent from FY 1985-1986 to 1986-1987.) The continuing commitment of the states to health care cost management initiatives was cited as the key factor for holding down state health fund costs.[8]

Federal Government

The Health Fund's consultant made a comparison of the Health Fund's HMSA plans with those of the federal government, a service industry Taft-Hartley multi-employer and two construction industry Taft-Hartley multi-employers.[9] The consultant's report revealed that the federal government's basic medical plan was similar to the Health Fund's in many respects; however, federal employees and retirees also receive vision and drug coverage, an adult dental plan, and coverage for one health appraisal every two years. Federal retirees pay the same premiums as the active federal employees, $18.77 for the individual plan and $69.68 for the family plan, which are approximately 25 per cent and 35 per cent of the total premium rates of $75.10 and $199.01, respectively.

Private Sector Health Funds

The three private sector labor union health plans reviewed by the Health Fund's consultant were Taft-Hartley multi-employer plans established with a board of trustees representing management and labor. Benefits in those plans are provided through a trust fund to the extent income and assets are available. The trust fund derives its income through employer contributions determined by collective bargaining agreement and through interest earnings. The consultant found that the benefits were generally liberal and while one organization offered free benefits to both active employees and retirees, the other two organizations required a flat $50 monthly contribution from retirees while the active employees received free benefits.[10]

The Hawaii Employers Council conducted a survey in 1982 of employee benefit plans of companies in Hawaii.[11] All of the 143 companies in the sample provided health care plans for their employees. Almost all the companies covered employees and their dependents; 60 per cent paid 100 per cent for employee-only coverage (eight per cent paid between 80 to 100 per cent); 37.5 per cent paid 100 per cent for employee and family coverage. Retirees under age 65 were covered by 38.3 per cent of the companies while 49.6 per cent did not provide any coverage and 9.2 per cent allowed retirees to continue in the health plan if they paid the premium. For retirees 65 years of age or older, 35.4 per cent of the companies permitted continued coverage under the health plan, of which five per cent required the retiree to pay for such coverage, and 55.8 per cent of the companies terminated coverage. A 1987 update of this survey was conducted by the Hawaii Employers Council, but at the time of this writing, the results were not yet published.

Chapter 5

IDENTIFICATION OF ALTERNATIVE FUNDING OPTIONS

The Resolution calling for this study directed that the Bureau identify alternative funding sources for Health Fund retiree benefit costs, but the Resolution failed to elaborate on the definition of "funding source". In the Bureau's opinion, there are only two "sources" of funding...the employers and the employees/retirees. If the phrase identification of alternative funding sources is interpreted literally, the only alternatives would be methods requiring contributions from the active employees and/or retirees. Cost-shifting to the employees and retirees through such methods as the requirement of deductibles and/or co-sharing of premium costs, is viewed by employers as unavoidable since employer resources are not unlimited. Employers have argued that employees must share in the cost of health benefits if they are to be more responsible in their use of health care services. New York's Executive Deputy Director of the Governor's Office of Employee Relations has said that "...unless employees have some investment in the program, they don't pay attention to what it costs."[1] On the other hand, it has been argued that "It is a myth that workers don't care about the cost of their health benefits because they don't have to pay for them. Workers know they have to pay for benefits by giving up wages."[2]

The Bureau's research revealed that it is also possible to offset the increasing costs of retiree health benefits by making administrative changes to the funding mechanism rather than changing the contribution ratios. With the intent of presenting a more meaningful report, the phrase "alternative funding options", rather than "alternative funding sources", has been applied in this study to permit exploration of funding mechanisms involving different variations of employer financing as well as administrative changes such as self-insurance and prefunding.

Options Involving Employer Contributions

1. The most widely discussed alternate funding option among the public employee unions in Hawaii has been the tapping of investment profits from the Employees' Retirement System (ERS). In the past ten years, the ERS has been highly successful in its investments with earnings above the investment yield rate totalling about $506.8 million.[3] The ERS is required by law to return any profit from investments in excess of the investment yield rate to the public employers as credits against the amounts the public employers must pay to the retirement system.[4] See Tables 13 and 14 for a display of the excess interest credited to the employers over the past five years. Because the employers contribution to the retirement system is a regular and continuous budget item, any money earmarked for such payment, but later not required, can be applied to other programs which might have been cut previously because of insufficient funds.

Advocates for the use of some of this money to pay for the health plan costs for retirees feel it is appropriate since the health plan is viewed as a benefit of retirement although it is not a part of the retiree's pension benefit.

Table 13

EMPLOYEES' RETIREMENT SYSTEM INVESTMENT EARNINGS AND EMPLOYER CREDITS FY 1981-82 TO FY 1985-86

Investment Earnings		Excess Investment Earnings Credited to Employer	
Fiscal Year	Amount	Appropriation	Amount
1981-82	$135,603,006	1984-85	$ 31,084,400
1982-83	$178,791,155	1985-86	$ 59,319,300
1983-84	$206,102,489	1986-87	$ 67,750,000
1984-85	$224,145,762	1987-88	$ 51,498,100
1985-86	$325,913,974	1988-89	$138,371,000

Source: Information compiled by the Employees' Retirement System, July 14, 1987.

Table 14

EMPLOYEES' RETIREMENT SYSTEM
REQUIRED EMPLOYER APPROPRIATIONS
FISCAL YEARS ENDED JUNE 30, 1985 - 1989

FYE 6/30		State General fund	State F/S Funds	Total State	C & C Honolulu	Board of Water Supply	County of Hawaii	County of Maui	County of Kauai	Total
1986	P/A Appropriation	80,247,764	20,061,941	100,309,705	25,171,180	1,764,850	4,610,675	3,507,640	2,382,515	137,746,600
	Excess Earnings Credit	(80,611,524)	(20,152,881)	(100,764,405)	(25,285,280)	(1,772,850)	(4,631,575)	(3,523,540)	(2,393,350)	(138,371,000)
	Net P/A Appropriation	(363,760)	(90,940)	(454,700)	(114,100)	(8,000)	(20,900)	(15,900)	(10,800)	(624,400)
	P/R Appropriation	16,820,400	4,659,800	21,480,200	5,702,500	376,400	1,038,800	783,300	535,500	29,916,700
	Total Appropriation Required FY 1988-89	16,456,640	4,568,860	21,025,500	5,588,400	368,400	1,017,900	767,400	524,700	29,292,300
1985	P/A Appropriation	84,507,693	21,126,923	105,634,616	26,508,303	1,858,876	4,864,086	3,689,702	2,513,317	145,068,900
	Excess Earnings Credit	(30,000,733)	(7,500,183)	(37,500,916)	(9,408,703)	(659,176)	(1,725,186)	(1,313,202)	(890,917)	(51,498,100)
	Net P/A Appropriation	54,506,960	13,626,740	68,133,700	17,099,600	1,199,700	3,138,900	2,376,500	1,622,400	93,570,800
	P/R Appropriation	17,917,280	4,479,320	22,396,600	5,945,800	392,500	1,083,100	816,700	558,300	31,193,000
	Total Appropriation Required FY 1987-88	72,424,240	18,106,060	90,530,300	23,045,400	1,592,200	4,222,000	3,193,200	2,180,700	124,763,800
1984	P/A Appropriation	101,076,653	28,508,800	129,585,453	31,437,146	2,371,692	5,521,973	4,247,134	2,908,902	176,072,300
	Excess Earnings Credit	(38,892,791)	(10,969,762)	(49,862,553)	(12,096,546)	(912,592)	(2,124,773)	(1,634,234)	(1,119,302)	(67,750,000)
	Net P/A Appropriation	62,183,862	17,539,038	79,722,900	19,340,600	1,459,100	3,397,200	2,612,900	1,789,600	108,322,300
	P/R Appropriation	20,104,500	5,670,500	25,775,000	7,111,000	467,100	1,223,200	936,900	640,200	36,153,400
	Total Appropriation Required FY 1986-87	82,288,362	23,209,538	105,497,900	26,451,600	1,926,200	4,620,400	3,549,800	2,429,800	144,475,700
1983	P/A Appropriation	107,984,873	30,457,272	138,442,145	33,434,094	2,496,844	5,883,894	4,483,475	3,111,848	187,852,300
	Excess Earnings Credit	(34,099,061)	(9,617,684)	(43,716,745)	(10,557,694)	(788,444)	(1,857,994)	(1,415,775)	(982,648)	(59,319,300)
	Net P/A Appropriation	73,885,812	20,839,588	94,725,400	22,876,400	1,708,400	4,025,900	3,067,700	2,129,200	128,533,000
	P/R Appropriation	20,390,136	5,751,064	26,141,200	7,241,300	466,600	1,252,300	950,500	658,800	36,710,700
	Total Appropriation Required FY 1985-86	94,275,948	26,590,652	120,866,600	30,117,700	2,175,000	5,278,200	4,018,200	2,788,000	165,243,700
1982	P/A Appropriation	95,887,121	28,641,607	124,528,728	28,648,013	2,258,536	5,132,355	3,803,133	2,690,635	167,061,400
	Excess Earnings Credit	(17,841,304)	(5,329,224)	(23,170,528)	(5,330,413)	(420,236)	(954,955)	(707,633)	(500,635)	(31,084,400)
	Net P/A Appropriation	78,045,817	23,312,383	101,358,200	23,317,600	1,838,300	4,177,400	3,095,500	2,190,000	135,977,000
	P/R Appropriation	18,073,825	5,398,675	23,472,500	6,224,900	421,800	1,096,600	804,800	568,000	32,588,600
	Total Appropriation Required FY 1984-85	96,119,642	28,711,058	124,830,700	29,542,500	2,260,100	5,274,000	3,900,300	2,758,000	168,565,600

P/A = Pension Accumulation Fund
P/R = Post Retirement Fund

Source: Table compiled by the Employees' Retirement System, October, 1987.

The employers contend that the credit should be maintained because the law also requires the employers to make up the difference if the ERS investment returns fall short of the required investment yield rate. Experts in the field are wary of the use of any retirement system funds for retirement health benefit costs in light of increasing litigation involving the yet unsettled issue of the employers' right to reduce or discontinue welfare benefits.[5] Should the health benefit, if paid through retirement system funds, be considered a vested retirement benefit, employers may not be able to discontinue such benefits in the future despite their financial situation.

An alternative and more indirect method of using the excess credit would be to delete the requirement in the law that excess amounts be credited to the employers and require that all investment amounts remain in the system and be applied to increased benefits to retirees, such as automatic cost-of-living increases for retirees or periodic bonuses aimed at certain groups of retirees. If pensioners receive periodic pension increases, presumably, they would be in a better position to contribute to their Health Fund medical plan premiums.

According to the ERS, no other state retirement system has a law like Hawaii's that requires excess investment earnings by the retirement trust fund to be returned to the employers.[6] In the next fiscal year, it is probable that the credit due to the employers will exceed the amounts owed to the retirement system pension accumulation fund, and the employers may not have to appropriate any money to the retirement system post retirement fund for the ensuing fiscal year. While the excess investment credit may be viewed by the employees as extra cash, the employers are now counting on the credit as a revenue source in their budgeting process. The counties have argued that they have been unsuccessful for years in getting increased grant-in-aid appropriations from the State and since they have limited revenue generating capability, they can ill afford to lose the excess investment earnings credit.

2. The manner in which the retiree health plan is administered could be altered as was done in Colorado which has a separate health plan for retirees. Colorado initiated a plan whereby the employer was assessed an amount equal to eight-tenths of one per cent of payroll which was deposited into a trust fund that was separate from the pension fund although the retirement system administered the health plan for retirees. Contributions made by retirees based on their years of service were also deposited into the trust fund. The moneys in the fund were invested and the proceeds from such investment were added to the fund. Premium costs for the retiree health care plans offered by the Public Employees' Retirement Association of Colorado were paid through this fund. The employer contribution rate being statutorily set and tied to payroll, was a predictable factor each year. The Bureau was unable to obtain the audit reports conducted on Colorado's retiree health plan, but according to the Public Employees' Retirement Association of Colorado, this method of handling the retiree health plan was more cost-effective than under the previous method where retirees were under the state's health plan. However, to ensure control over the subsidy cost, a 1987 amendment to the law deleted the eight-tenths of one per cent assessment and now requires that the Board of Trustees recommend a subsidy amount which will be subject to legislative approval.[7]

Cost-sharing by Retirees

1. Of the 49 states that provide health benefits to retirees, 10 states require the retirees to pay a portion of the premium while 25 states require the retiree to pay the full premium (see Appendix C, Table 4). A common practice among those states that provide for cost sharing of retiree health benefits is the proration of retiree contributions based on the retiree's years of service. Several variations are possible. The disadvantage of prorating the contributions of retirees based on years of service is that the record keeping and accounting could be more complicated since retirees would be paying different amounts. Most states prorate the contribution based on the number of years of service where the retiree with 25 or more years of service would not have to contribute and those with less than 25 years would contribute a certain percentage based on the years of service, e.g., a retiree with 20 years of service pays 20 per cent, a retiree with 15 years pays 25 per cent, and a retiree with 10 years pays 30 per cent. Florida, on the other hand, requires a flat dollar contribution for each year of service, e.g., if a retiree has 25 years of service, the employer will contribute $25 per month toward the cost of the retiree's insurance.

2. If the concern is with the age of the retiree, a system could be implemented whereby retirees below 65 years of age would have to contribute to their premiums and those 65 and over who qualify for Medicare would not. The rationale behind such a scheme is to target assistance to the older retirees who have been on fixed incomes for a longer period of time and whose pensions have not kept pace with inflation.

3. Another variation of employee cost-sharing would be to provide for 100 per cent coverage to retirees' self-only plans but require that the retiree contribute to the premium for family coverage. The Segal survey did not reveal how many states paid for family coverage for retirees; however, the Bureau's survey found that at least Illinois and North Carolina required retirees to cost share in the family plans.

Prefunding

According to Dr. John P. Mackin, Vice President of Martin Segal, Inc., there are two basic financing methods...pay-as-you-go or prefunding. Most retiree health plans are now financed on a pay-as-you-go basis, which means that the long-term survival of the plan depends on annual increases in contributions over a long period of time.[8] A prefunding approach, similar to that used for funding a retirement system, would require amounts contributed by either the employer or employee, or both, to the plan in order to ensure the continuation of benefits for the lifetime of current retirees and to ultimately establish a reserve sufficient to provide benefits for future retirees. Although there is a growing consensus that retiree benefit plans should be prefunded, private sector employers have not been willing to pursue prefunding if they would have to pay income taxes on such plan reserves as required under the Deficit Reduction Act of 1984. Public sector employers, however, do not have this concern since they do not pay income taxes.

Hawaii's Health Fund is currently financed on a pay-as-you-go basis and each year the premium rates have increased. Prefunding could be beneficial to Hawaii if funds were required to be invested like the funds of the ERS. The ERS has been successful in its investment practices in recent years and if it was not required to return excess profits to the employers, the ERS would have a substantial trust fund that could be used for expanded benefits or kept in reserve as protection from future financial instability.

The Colorado retiree health plan discussed earlier in this chapter is partially prefunded by the amount assessed from the employers which is placed in a trust fund. Prefunding could also involve assessments from the active employees to be placed in a trust fund.

Self-funding

The concept of self-funding requires the employer, rather than an insurance company, to assume the risk of potential losses. Under a totally self-funded health fund program, the employer directly pays all the costs of eligible medical claims and is responsible for all legal, actuarial, and administrative costs. If an employer is unwilling to assume all of the risks, a partially self-funded program can be established where the risks of only some coverages are assumed and the remaining coverages are insured. An employer may also purchase stop-loss coverage for protection against abnormally high losses. Stop-loss insurance can be in the form of specific stop-loss coverage, which will pay claims for an employee after the employee's claims have reached a specified limit such as $2,000, or aggregate stop-loss coverage, which will pay when the total amount of claims reaches a certain percentage above expected claims (usually 125 per cent). A self-funded employer may either handle the claims in-house or contract for such administrative services through an insurance company or a firm specializing in claims processing.[9]

In response to the growing number of firms interested in self-funding, many carriers now offer alternative packages for health insurance. Under administrative services only contracts, the carrier provides claims processing, individual stop-loss, and aggregate stop-loss while the employer pays directly for claims as they incur. Another arrangement called "minimum premium funding" requires the employer to pay the carrier retention fees but incurred claims are paid on a "pay-as-you-go" basis. With this arrangement, the employer can retain cash control for a longer period of time. The "reserveless minimum premium funding" alternative also requires the payment of retention fees, but there is no reserve fund deposited with the carrier. Thus, when claims exceed projections, the employer must fund the extra cash to pay the excess up to the total of its annual premium plus reserves. Liability for any deficit remains with the carrier.[10]

Of the 30 states that responded to the Bureau's survey, 13 states (Florida, Illinois, Indiana, Iowa, Louisiana, Minnesota, Missouri, Montana, Nevada, New Jersey, North Dakota, Rhode Island, and South Carolina) reported switching from a fully insured plan to a self-funded or minimum premium plan. Oregon reported that it is considering the possibility of converting to self-funding. The attraction of self-insurance lies mainly in the

savings realized by employers who have switched from a fully insured scheme. States have reported cost-savings ranging from four per cent to eight per cent after self-funding. The reasons for such savings are:

(1) By maintaining a reserve, interest can be accumulated on deposits held to pay claims.

(2) Savings are likely to occur through proper coordination of benefits.

(3) Savings occur by elimination of state premium or franchise taxes.

(4) Employers pay for claims, risk charges, and overhead only after they have been incurred.

(5) Employers are able to take advantage of the time lapse between when the claims checks are issued and when they clear the bank account.

(6) A self-funded, self-insured employer does not pay retention charges to the insurance company.[11]

Self-funding, however, is not for every employer. Before venturing into self-funding, an employer must be sure of its ability to assume the risks of the coverages it provides and the increased administrative responsibility. Disadvantages of self-funding include:

(1) The firm's actual claim experience determines the cost of the program so firms with worse-than-average claim experience could be paying more than under an insured arrangement.

(2) Self-funded employers must develop a budgeting program to anticipate monthly fluctuations in claims.

(3) Termination of the program can be difficult since a self-funded plan does not provide for claims that occur before, but are not reported until after, termination.

(4) A self-funded program can require more employer involvement, such as distributing claim checks, printing booklets, and maintaining a trust.

(5) Under a self-funded arrangement, the employer assumes greater fiduciary and legal responsibilities. In a court of law, the employer may become the employee's adversary. The employer must assume the role of an insurance company and, therefore, is not protected by a third party buffer.[12]

The State of Washington reported that a proposal to change the health fund to a self-funded system was rejected by the Legislature.

Cafeteria Benefit Plans

Although cafeteria benefit plans may not be applicable to retirees, the cost-savings that could result from implementing such plans could alleviate the need to eliminate or reduce the free retiree health benefit.

In 1985, the Health Fund's Board of Trustees was directed to study the feasibility of authorizing the State and counties to establish cafeteria benefit plans for their employees. The Board found that extensive research was required to plan and install a cafeteria benefit plan and recommended that the Legislature provide $150,000 to allow the Board to hire a consultant to conduct a benefit feasibility study. No subsequent legislative action was taken following the submission of the Board's report.[13]

The concept of cafeteria benefits has increased in popularity in recent years because of the tax advantages for both the employer and the employees. Private employers and employees who must pay income taxes do not have to include the amounts paid for cafeteria benefits. The primary advantage of a cafeteria benefits program, however, lies in its flexibility and ability to meet differing needs of the employee group. A typical cafeteria plan provides an employee with a basic core of benefits that provides a minimum security level, e.g., medical coverage, life insurance, plus the opportunity to purchase supplemental coverages, e.g., a higher level of medical coverage, additional group life coverages, dependent life coverage, or additional benefits such as coverage for dental, prescription drugs, or vision, or to take a cash allowance. The cash allowance is the essential element of the cafeteria plan. The cash allowance, to be used either in the purchase of supplemental coverages or additional benefits may be generated by (1) employer contributions, (2) conversion of existing benefits, or (3) an employee salary reduction plan. Where the allowance is derived from an employer contribution or a conversion of existing benefits the employee may take the allowance in lieu of any additional coverage.[14]

Oregon reported that it had begun implementation of a flexible benefits plan and Idaho reported that it is exploring flexible spending accounts and cafeteria benefits.

Cost-containment Strategies

Unlike most other states, Hawaii has employed few cost-containment strategies to lower the cost of medical insurance. Since April, 1987, a subcommittee of the Board began serious exploration of the impact of cost-containment measures by directing the HMSA to submit a proposal for a Managed Care Program that would feature certain cost-containment strategies. The proposal was reviewed, revised, and discussed at a series of subcommittee meetings. Preliminary findings of the subcommittee indicated that implementation of the program would not be cost-effective, but the subcommittee will continue further exploration in this area.

The Wall Street Journal reported that cost-containment strategies have proved less effective than expected in keeping medical costs down as hospitals and doctors learn to "game the system" by increasing other ancillary costs

while hospital stays are reduced[15] Despite this situation, however, many states reported worthwhile cost-savings resulting from cost-containment measures.[16]

Cost-containment measures which involve more out-of-pocket expenses by the enrollee, e.g., deductibles and copayments, have met with opposition from employee unions since they actually shift costs from the employer to the employees. An innovative cost-savings strategy which was favorable to the employee's position was implemented in the City of Buffalo, New York. Effective July 1, 1984, the City began paying employees $40 per month for dropping the city health plan and enrolling in their spouse's plan. The City classifies the bonus as taxable income to the employee and requires that each employee sign a waiver as well as present proof of alternative coverage. The City also surveyed its retirees in 1982 for general information and found that the City was unnecessarily paying for such items as family coverage for widows and widowers and other inconsistencies. Since then, the City has computerized information on its retirees which is regularly updated.[17]

Chapter 6

FINDINGS AND RECOMMENDATIONS

Senate Resolution No. 138, S.D. 1, requested that the Bureau "...identify alternative funding sources and make recommendations on proposed legislation to continue a reasonable level of public employer funding of Health Fund benefit costs for all retired State and County employees...." The Bureau's findings and recommendations are reported herein.

Findings

1. Medical costs and the retiree population have been increasing at a steady pace over the years and there is no hope for reversal of these trends in the near future. As employers, the State and counties have been providing health insurance coverage for their employees since 1961, with free insurance coverage to retirees since 1965, as an incidental expense to running the business of government. Public employers have little control over escalating medical costs; but, as employers who are required to provide health insurance coverage to their employees and retirees, they must be prepared to deal with future increases in health care costs.

2. The Resolution implies that the level of funding required by the public employers to pay for retiree health insurance is prohibitive and *unreasonable. The Bureau finds, however,* that the question of the employer's inability to pay is debatable. The mere fact that the cost of retiree health benefits is higher than what is being paid for active employees does not mean that the employer cannot afford to continue the benefit nor does it justify cost shifting to retirees.

The employers' concern with the 100 per cent funding of the retiree health benefit program lies primarily with the uncertainty as to whether they can continue to bear the continually rising cost of the program. The counties, which have limited revenue sources, are especially concerned when a program cost, over which they have limited control, keeps increasing and they have no alternative but to pay. The inadequacy of revenue sources at the county level, however, is a larger issue which cannot and should not be resolved by targeting cuts in one program such as the Health Fund.

Most active employees consider the retirement benefit package, which includes the free health insurance, as something they have earned through their years of faithful service to the state or county government. The active employees feel that since the benefits they receive for the premiums they pay are not as liberal as that offered by the federal government or some private sector companies, it is only fitting that their health benefit in retirement be more generous. Their unions argue that the employers' concern that the retiree benefit is too costly is without merit since the employers have been receiving windfalls from the excess investment earnings of the Employees' Retirement System (ERS). In 1986, the State and counties were credited $138,371,000 *in excess investment earnings, so instead of paying* $167,663,600 to the ERS for fiscal year 1988-89, the employers will only pay $29,292,300.

The total Health Fund payments made by the employers for retirees for fiscal year 1986-87 was $27,916,551.74. On balance, the unions contend that the employers are paying less in total employee benefits than they should be. It is difficult for the unions to sympathize with the employers' position that the retiree health benefit is too costly and that the retirees must now contribute their fair share.

The issue of how much of the cost burden the state and county governments, as public employers, should continue to bear is a policy issue that must first be addressed by the Legislature before it acts on any changes to the contribution ratio. In addressing this issue, the Legislature must consider its total role in assuring public accessibility to proper health care. Affordability of the retiree health benefit should be examined in a broader context, not in the narrow view of a line item increase, to ensure that any cost-savings effort will not adversely impact the State in other ways, e.g., the creation of a retiree gap group without adequate health insurance coverage or an increased reliance on the Medicaid program.

3. While there is widespread concern both in the private and public sectors as to the growing cost of retiree health benefits, there is also momentum building among elderly groups to lobby state governments to provide better health benefits for the elderly. With the federal government relying on the states to shoulder more of the health care burden, state governments cannot escape the high costs of elderly health care. Some states that have conducted studies to address the cost of retiree health benefits have done so because of pressures from retirees for the state to pay a greater share. There does not appear to be a trend to reduce the State's contribution among those states that pay 100 per cent for their retirees.

4. The per capita cost of the retiree health benefit when compared to that of the active employee is significant enough to warrant serious legislative consideration. It does not appear that immediate legislative action must be taken to drastically change the contribution ratio or funding method; however, the Legislature can and should initiate some changes to the Health Fund law to mitigate future liabilities.

5. For collective bargaining purposes, the employers have maintained a steadfast position that they only have a certain amount to spend and that the negotiations must be on how the exclusive representatives desire to apportion the total amount among the various benefits, including the health fund. With such a position, benefits such as the health plan which do not affect the entire membership are not high priority issues.

While the unions have been pushing for expanded health plan coverage, e.g., the inclusion of coverages for adult dental, prescription drugs, and vision, they are reluctant to sacrifice the retiree benefit in exchange for such coverage. With pay in the private sector usually higher, it is believed that a primary attraction to state and county service has been the retirement benefit which includes the free health insurance. Under the new noncontributory retirement system where the pensions are smaller, the free health insurance benefit will have greater impact on the overall retirement benefit package.

6. Whether or not public employers contribute to their retiree health plans, they regard the health plan as part of the cost package that is negotiated with the exclusive representatives. Considering the active employees' view that the free retiree health benefit is something they have earned partly by foregoing expanded benefits as active employees, any alteration in the funding structure which would require retirees to contribute, may well result in a concomitant demand for expanded benefits for the active employees.

7. Hawaii has traditionally been a state which protects the interests of the elderly. The free retiree health insurance benefit was implemented not only because the State was in a healthy financial state, but because lawmakers emphatically believed that pensioners on fixed income required assistance in obtaining medical care. If the State maintains this posture, it would be incongruous to shift health insurance premium costs to the retirees. Moreover, the shifting of the cost burden to retirees on fixed income may in turn impact on the State's Medicaid program where more people might be required to rely on Medicaid for medical assistance.

Recommendations

1. Before any change is made to the employer-retiree contribution ratio, a comprehensive evaluation of the entire Health Fund operation should be conducted by an employee benefits consultant to ascertain: (1) whether or not a major change in the funding mechanism, e.g. self-funding, prefunding, or cafeteria benefits, might improve the cost-efficiency of the Health Fund; (2) which administrative and programmatic cost containment measures might be effectively applied by the Health Fund; (3) if contributions will be required from retirees, the impact such contributions might have on retiree pensions assuming that increases to the health insurance premiums will continue; and (4) the number of retirees with dual coverage (coverage under a spouse's private sector or federal government plan as well as the Health Fund plan) and the feasibility of paying such retirees cash, as in the City of Buffalo, as an incentive to drop the free insurance coverage.

While cost-sharing decreases the employers immediate cost burden, it cannot guarantee the containment of future health insurance increases. If retirees are required to contribute to their premiums, it is only fair that the Legislature ensure that retirees are getting their money's worth. The implementation of cost-containment schemes is viewed by its proponents as an excellent means of educating and training health plan enrollees to be more prudent in their use of medical services. Hawaii's Health Fund has only recently begun serious examination of the feasibility of implementing cost-containment strategies.

Upon reaching similar crossroads in health insurance cost-containment, many states have ordered comprehensive studies conducted by consultants with expertise in the employee benefits field to review the state's health fund operation and to make recommendations as to required administrative and programmatic changes to improve the cost-efficiency of the health fund program. The Bureau is cognizant that the Legislature is often hesitant to appropriate funds for such contracts; however, unless all issues concerning

the present health fund operations are addressed, any recommendation for a major change for cost-cutting purposes would be arbitrary and without foundation.

2. Whether or not a comprehensive study is authorized by the Legislature and undertaken, the Bureau recommends that the law be amended to require that only the current coverages (basic medical plan, children's dental, and life insurance) be available to retirees at no cost to the retiree and that other additional coverages that may be offered in the future, e.g., adult dental, vision, or prescription drugs, be optionally available to retirees at the same cost the active employees would pay for such plans. If this is done, the active employees will not be penalized by not receiving expanded benefits just because it costs the employer too much to provide the same benefits to retirees. Of course, the Legislature would still have the flexibility of specifically designating by legislative act or authorizing the Health Fund to determine that a particular coverage being offered, such as prescription drugs, be included as part of the retiree health benefit package.

The medical needs for retirees differ greatly from that of active employees. Many retirees, for example, do not require much dental or vision care; however, if adult dental and vision coverages were included as part of the health plan benefit package, the employers would be paying the additional cost to cover retirees who may have little use for such coverage. On the other hand, retirees may desire some type of prescription drug or long-term care coverage which could conceivably be offered in the future on a group basis and would be willing to pay premiums for such coverage.

3. While the Bureau does not recommend any changes in the employer-employee contribution ratio unless an evaluation of the Health Fund operation is made, if the Legislature chooses to require retirees to contribute to the premium cost of the basic medical plan, the Bureau recommends that such a requirement apply only to those who retire after the effective date of the amendment to the law, not to current retirees, and that career employees who retire with 25 years or more or service be provided with the free health benefit.

FOOTNOTES

Chapter 1

1. The New York Times, "Crisis is Predicted in Care of Elderly", September 13, 1987, p. 1.

2. Eleanor C. Nordyke, Richard K. C. Lee, and Robert Gardner, A Profile of Hawaii's Elderly Population, Papers of the East-West Population Institute, No. 91 (Honolulu: 1984), p. 12.

3. Active Employees and Retirees - Years Ending March 31, 1981 to 1986:

Year	Active Employees	% Change	Retirees	% Change
1981	43,598	--	12,772	--
1982	44,243	+1%	13,573	+6%
1983	44,731	+1%	14,463	+6%
1984	45,191	+1%	15,264	+5%
1985	45,551	+1%	16,162	+6%
1986	46,106	+1%	17,026	+5%

Source: Information compiled by the Employees' Retirement System of the State of Hawaii, July 1987.

4. Health Fund Enrollments - Active Employees and Retirees:

Plan-Year	Active Employees Average #	% Change	Retirees Average #	% Change
1980-81	30,570	--	12,812	--
1981-82	30,130	-1.44	13,867	8.23
1982-83	30,504	1.24	14,890	7.38
1983-84	30,701	.65	15,834	6.34
1984-85	32,748	6.67	16,810	6.16
1985-86	34,007	3.84	17,788	5.82

Source: Hawaii, Hawaii Public Employees Health Fund Annual Experience Report, 1985-86 Plan Year, Table 4, p. 13.

5. William M. Mercer, "Public Sector Retiree Medical Benefits: A Challenge for Employers", The Public Sector Report, Meidinger-Hansen, Inc., Spring 1987. (Reprint with no page numbers.)

Chapter 2

1. Senate Bill No. 17, First Legislature, Regular Session of 1961, State of Hawaii.

2. Hawaii, Senate Standing Committee Report No. 39 on Senate Bill No. 17, Senate Committee on Ways and Means, Journal of the Senate of the First Legislature, Regular Session of 1961, p. 702.

3. Hawaii, House Standing Committee Report No. 890 on House Bill No. 1155, House Committee on Appropriations, Journal of the House of Representatives of the Third Legislature, Regular Session of 1965, pp. 770-771.

4. Hawaii, Senate Standing Committee Report No. 930 on House Bill No. 1155, Journal of the Senate of the Third Legislature, Regular Session of 1965, p. 1204.

5. Hawaii, House Standing Committee Report No. 978 on Senate Bill No. 17, House Committee on Finance, Journal of the House of Representatives of the First Legislature, Regular Session of 1961, p. 1048.

6. Hawaii, Senate Standing Committee Report No. 165 on Senate Bill No. 17, Journal of the House of Representatives of the First Legislature, Regular Session of 1961, p. 710.

7. 1961 Haw. Sess. Laws, Act 146.

8. 1965 Haw. Sess. Laws, Act 235.

9. 1980 Haw. Sess. Laws, Acts 61 and 95.

10. 1985 Haw. Sess. Laws, Act 304.

11. Hawaii Rev. Stat., sec. 87-2.

12. Hawaii Rev. Stat., sec. 87-11.

13. Hawaii Rev. Stat., sec. 87-13.

14. Hawaii Rev. Stat., sec. 87-15.

15. Hawaii, The Multi-Year Program and Financial Plan and Executive Budget for the Period 1987-1993 (Budget Period 1987-1989), Submitted to the Fourteenth State Legislature, Vol. III (Honolulu: 1986), p. 1655, hereinafter cited as Financial Plan and Executive Budget.

16. Hawaii Rev. Stat., sec. 87-24.

17. Cenric Ho, Health Fund Administrator, comments on review of draft of this report, December 14, 1987.

18. Interview, Cenric Ho, Health Fund Administrator, May 29, 1987.

19. Telephone interview, Cenric Ho, Health Fund Administrator, November 5, 1987.

20. Financial Plan and Executive Budget, p. 1655.

21. Ibid.

22. Telephone interview, Cenric Ho, Health Fund Administrator, November 5, 1987.

23. Hawaii Administrative Rules (Hawaii Public Employees Health Fund), section 6-33-1(d).

24. 1987 Haw. Sess. Laws, Act 216, Section 3, Item K 22 (BUF 142).

25. Hawaii, Hawaii Public Employees Health Fund Annual Experience Report, 1980-1981 Plan Year (Honolulu: 1981), p. i, hereinafter cited as Health Fund Annual Experience Report.

26. Hawaii, Health Fund Benefit Plans for State and County Employees and Retirees, Revised July 1987, pp. 7-35, hereinafter cited as Health Fund Benefit Plans.

27. Health Fund Annual Experience Report, p. 19.

28. Health Fund Benefit Plans, pp. 1 and 29.

29 Financial Plan and Executive Budget, p. 1655.

30. Ibid.

31. Hawaii Rev. Stat., sec. 89-9(d).

32. Hawaii Rev. Stat., sec. 87-4.

33. Hawaii Rev. Stat., sec. 87-4.5.

34. 1973 Haw. Sess. Laws, Act 24.

35. Att'y Gen. Ops. No. 72-20, August 4, 1972.

36. Hawaii Rev. Stat., sec. 87-22.3.

37. Hawaii Rev. Stat., sec. 87-27.

38. U.S., Department of Health and Human Services, Health Care Financing Administration, Guide to Health Insurance for People with Medicare - 1987, Pub. No. HCFA 02110, p. 15.

39. Att'y Gen. Op. No. 63-45, September 18, 1963.

40. Att'y Gen. Op. No. 64-42, August 31, 1964.

41. Telephone interview, Cenric Ho, Health Fund Administrator, November 5, 1987.

Chapter 3

1. Hawaii, Employees' Retirement System of the State of Hawaii, Report of the Actuary of the Sixty-first Annual Actuarial Valuation as of June 30, 1986, submitted by Martin E. Segal & Company, Inc., January, 1987, p. 8, hereinafter cited as ERS, Sixty-first Annual Actuarial Valuation.

2. Hawaii Rev. Stat., sec. 88-73.

3. Ibid.

4. 1984 Haw. Sess. Laws, Act 108.

5. "Class C members" is defined in section 88-47(3), Hawaii Revised Statutes, as follows:

> "(3) Except for members covered by section 88-74(3), and those members whose salaries are set forth in sections 26-52, and 26-53, class C members shall consist of all employees in positions covered by Title II of the Social Security Act who:
>
> (A) First enter service after June 30, 1984;
>
> (B) Reenter service after June 30, 1984, without vested benefit status as provided in section 88-96(b);
>
> (C) Make the election to become a class C member as provided in part VII; or
>
> (D) Are former class C retirants who return to service requiring the retirant's active membership.

6. Hawaii, Employees' Retirement System of the State of Hawaii, Report of the Actuary on the Sixtieth Annual Actuarial Valuation as of June 30, 1985, submitted by Martin E. Segal & Company, Inc., May 1986, p. 2.

7. 1985 Haw. Sess. Laws, Act 72.

8. The current employer contributions as set under section 87-4.5 are $25.96 (self) and $79.84 (family) for fiscal year 1987-1988 and $28.56 (self) and $87.82 (family) for fiscal year 1988-1989.

9. Beginning in the year 2000 the full benefit retirement age will be gradually increased until it reaches 67 in 2027. This will affect people born in 1938 and later. U.S., Department of Health and Human Services, Social Security Administration, Thinking About Retiring?, January 1987 Edition, SSA Publication No. 05-10055 (Washington, D.C.: 1987), p. 5.

10. Hawaii Rev. Stat., secs. 88-74 and 88-282.

11. Hawaii Rev. Stat., sec. 88-281.

12. Steven C. Renn, "The Structure and Financing of the Health Care Delivery System of the 1980s", Health Care and Its Costs, ed. Carl J. Schramm (New York: 1987), pp. 45-46.

13. The Wall Street Journal, May 15, 1987, p. 37.

14. ERS, Sixty-first Annual Actuarial Valuation, p. 21; and Hawaii, Employees' Retirement System of the State of Hawaii, Report of the Actuary on the Fifty-fourth Annual Actuarial Valuation as of June 30, 1979, submitted by Martin E. Segal & Company, February, 1980, p. 20.

15. ERS, Sixty-first Annual Actuarial Valuation, p. 19.

16. "Senate Turns to Catastrophic-Costs Bill", Congressional Quarterly Weekly Report, October 24, 1987, p. 2617; and "Senate Passes Catastrophic Health Bill", The Week in Congress, October 30, 1987, p. 1.

17. Institute of Industrial Relations Publication Center, University of California, Los Angeles, Retiree Nonpension Benefits, Management Guidelines, Current Issues Series: 2 (Los Angeles: 1987), p. 31.

18. N.Y. Civil Service Law §167(1).

19. Lippman v. Board of Education, 104 App Div 2d 123, 483 NYS 2d 446 (Sup. Ct. 1984).

20. Lippman v. Board of Education, 66 NY2d 313, 496 NYS 2d 814, 487 NE2d 897 (Ct. App. 1985).

Chapter 4

1. "State Retiree Health Plan coverage in Selected States", attachment to letter from

Janet M. Kail, Employee Benefit Specialist, Department of Research, AFSCME-AFL-CIO, to Kenneth Okuma, Executive Secretary, HGEA Retirees Unit, dated September 30, 1987.

2. Indiana's response to Legislative Reference Bureau questionnaire, July, 1987.

3. Delaware Health Fund's response to Legislative Reference Bureau questionnaire, July, 1987.

4. N.Y. Civil Service Law §167 (Consol.).

5. Florida Health Fund's response to Legislative Reference Bureau questionnaire, July, 1987.

6. William M. Mercer-Meidinger, Inc., Healthcare Cost Containment in the Public Sector - 1986, A Mercer-Meidinger Survey in Cooperation with the Public Risk Management Association, pp. 1 and 5.

7. The Bureau of National Affairs, Inc., Controlling Health Care Costs: Crisis in Employee Benefits, A BNA Special Report (Washington, D.C.: 1983), p. 93.

8 John P. Mackin, "States Grapple with Health Care Cost Crunch", Pension World, August 1987, p. 50; and John P. Mackin, "Survey Indicates States are Holding Down Health Plan Costs", Pension World, August 1986 (reprint with no page numbers).

9. The report entitled, "Group Benefit Plan Comparison Report", was submitted to the Board of Trustees on June 16, 1987 by Paul Tom, Consultant with Benefit Plan Consultants, Hawaii, Inc. The benefit information used was that in effect on January 1, 1987.

10. Letter from Paul A. Tom, Consultant, Benefit Plan Consultants, Hawaii, Inc., to the Board of Trustees, Hawaii Public Employees Health Fund, June 16, 1987.

11. Hawaii Employers Council, Survey of Employee Benefit Plans in Hawaii, Special Publication No. 151 (Honolulu: 1982).

Chapter 5

1. The Bureau of National Affairs, Inc., Controlling Health Care Costs: Crisis in Employee Benefits, A BNA Special Report (Washington, D.C.: 1983), p. 91, hereinafter cited as BNA Special Report.

2. Statement made by Karen Ignagni, Assistant Director of the AFL-CIO Department of Social Security, BNA Special Report, p. 31.

3. Testimony by Stanley Siu, Secretary, Employees' Retirement System, before the House Committee on Labor and Public Employment on House Bill No. 1596-87, February 26, 1987, p. 1.

4. Hawaii Rev. Stat., sec. 88-107.

5. Telephone conversation with John Mackin, August 20, 1987, and William M. Mercer-Meidinger-Hansen, Inc., "Public Sector Retiree Medical Benefits: A Challenge for Employers", The Public Sector Report, Spring 1987. (Reprint with no page numbers.)

6. Interview with Stanley Siu, Secretary, Employees' Retirement System, August 5, 1987.

7. Telephone conversation with Rick Larsen, Public Employees' Retirement Association of Colorado, September 24, 1987.

8. John P. Mackin, "Post Retirement Health and Welfare Programs", Public Employee Benefit Plans, ed. Catherine C. Hayne (Brookfield: 1984), p. 86.

9. International Foundation of Employee Benefit Plans, "Benefits Basics: Considerations in Self-Insurance". (Reprint with no page numbers.)

10. Ibid.

11. Ibid.

12. Ibid.

13. Hawaii, Hawaii Public Employees Health Fund, Report to the Thirteenth State Legislature, Regular Session of 1986 on Cafeteria Benefit Plans for State and County Public Employees (Honolulu: 1985).

14. Ibid., p. 6.

15. The Wall Street Journal, May 15, 1987, p. 37.

16. The Bureau received positive responses from Delaware, Idaho, Illinois, Indiana, Mississippi, South Carolina, Virginia, Washington, and Wisconsin indicating effectiveness of their cost-containment measures.

17. BNA Special Report, p. 93.

THE SENATE
FOURTEENTH LEGISLATURE, 1987
STATE OF HAWAII

S.R. NO. 138 S.D. 1

SENATE RESOLUTION

REQUESTING A STUDY OF HEALTH FUND BENEFIT COSTS FOR RETIRED STATE AND COUNTY EMPLOYEES, ALTERNATE FUNDING SOURCES AND RECOMMENDATIONS.

WHEREAS, the cost of State and County employer-sponsored retiree health care benefits has become prohibitive due to such factors as the increasing ratio of retirees to active employees, inflationary health care cost increases, longer life expectancies, financial, legal and regulatory uncertainties; and

WHEREAS, the increasing number of State and County retirees have consumed a greater share of public employer fringe benefits funds on a pro-rata basis than the amounts paid for active employees; and

WHEREAS, one of every three enrollees in the Hawaii Public Employees Health Fund's medical plan is a retiree; and

WHEREAS, Section 87-6, Hawaii Revised Statutes, requires State and County public employers to pay for the entire health benefits plan premium costs of retirees; and

WHEREAS, Section 87-27, Hawaii Revised Statutes, requires State and County public employers to reimburse eligible retirees and their spouses for their Medicare Part B medical insurance premiums that are withheld from their monthly Social Security checks; and

WHEREAS, the expected number of State and County employees retiring in the next few years is predicted to be at least 1,000 persons a year; and

WHEREAS, the related public employers' cost to fund the current level of Health Fund benefits for retired State and County employees continues to increase unabated; and

WHEREAS, the future of developing new or improved Health Fund benefit plans for all employees and retirees is contingent upon sufficient public employer funding of health benefit plan premiums; now, therefore,

BE IT RESOLVED by the Senate of the Fourteenth Legislature of the State of Hawaii, Regular Session of 1987, that the Legislative Reference Bureau conduct a study of Health Fund benefit costs for retired State and County employees, identify alternative funding sources and make recommendations on proposed legislation to continue a reasonable level of public employer funding of Health Fund benefit costs for all retired State and County employees in consultation with members representing the State of Hawaii, City and County of Honolulu, Hawaii County, Maui County, Kauai County, Hawaii Government Employees' Association, United Public Workers, University of Hawaii Professional Assembly, Hawaii State Teachers' Association, the State of Hawaii Organization of Police Officers, the Hawaii Fire Fighters' Association, the Hawaii Public Employees Health Fund, the Employees' Retirement System and the Coalition of State and County Retirees; and

BE IT FURTHER RESOLVED that the Legislative Reference Bureau submit its recommendations to the Legislature twenty days prior to the convening of the Regular Session of 1988; and

BE IT FURTHER RESOLVED that certified copies of this Resolution be transmitted to the Governor of the State of Hawaii, the Directors of Finance of the State of Hawaii, the County of Hawaii, the County of Maui, the County of Kauai and the City and County of Honolulu, the Executive Director of the Hawaii Government Employees' Association, Executive Director of the United Public Workers, Executive Director of the University of Hawaii Professional Assembly, Executive Director of the Hawaii State Teachers' Association, Executive Director of the State of Hawaii Organization of Police Officers, Executive Director of the Hawaii Fire Fighters' Association, the Administrator of the Hawaii Public Employees Health Fund, the Executive Secretary of the Employees' Retirement System, the Chairman of the Coalition of State and County Retirees and the Director of the Legislative Reference Bureau.

SUMMARY OF MEDICAL PLAN COVERAGES AND COSTS*

	HMSA SERVICE BENEFIT PLAN PAYS	KAISER HEALTH PLAN	HMSA'S COMMUNITY HEALTH PROGRAM (CHP)	ISLAND CARE
EMPLOYEE'S MONTHLY PREMIUM COST*	$20.76 Self Only $63.88 Family	$24.80 Self Only $72.08 Family	$33.84 Self Only $82.92 Family	$26.64 Self Only $81.60 Family
PHYSICIANS' VISITS	80% of Eligible Charges for office, home, and hospital emergency room visits by a physician 50% of Eligible Charges for immunizations Major Medical Benefits reimburses 80% of eligible Basic Benefit "copayments" after a $100 deductible — up to $250,000 lifetime maximum. Applies to most Basic Benefits shown here See this booklet for "copayment," $1500 limit on your share of "copayments," and exclusions	$1 per office visit. Includes physical exams, pediatric checkups, immunizations and eye exams for glasses No charge for home visits by nurse or health aide 50% of charges for prescribed occupational and speech therapy New immunizations and Hepatitis B vaccine	No charge for routine preventive care. Includes scheduled physical exams, standard childhood immunizations, prenatal and postpartum exams, well-baby care up to age 2 Member pays $5 for office visit. Includes diagnosis and treatment of illness or injuries Member pays $10 for home visit Additional Benefit Plan pays 100% of all eligible charges for physician and hospital services after a member has reached the maximum annual copayments of $1,800	No charge for hospital visits. $3 per office or home visits. Includes physical exams, pediatric checkups and immunizations
SURGERY	100% of Eligible Charges for surgery 80% of Eligible Charges for anesthesiologist	No charge	No charge	No charge
HOSPITAL ROOM & BOARD	100% of Eligible Charges for ward rate and intensive care or coronary care unit up to 150 days per calendar year Same hospital benefits for 60 days per calendar year in a Skilled Nursing Facility	No charge for 365 days per year for semiprivate or intensive care room or private room (if medically necessary) No charge for 100 days per year for care at Skilled Nursing Facility.	Plan pays 80% of Eligible Hospital Charges. Plan pays 80% of Eligible Hospital Charges for care at Skilled Nursing Facility, up to 100 days a calendar year (See Additional Benefit above) Plan pays 100% of all eligible hospital charges for qualified Health Plus members	No charge for semiprivate or intensive care room or if hospital has only private room. No charge for 100 days per year for care at Skilled Nursing Facility
INPATIENT HOSPITAL EXTRAS	100% of Eligible Charges for operating room, surgical supplies, anesthesia, drugs, dressings, oxygen, antibiotics, and transfusion service charges while an inpatient in a hospital or skilled nursing facility	No charge for operating room, surgical supplies, anesthesia, drugs, dressings, lab and X-ray, therapy (X-ray, physical and inhalation) and blood transfusion (if blood replaced) 50% of charges for prescribed occupational and speech therapy	Plan pays 80% of Eligible Hospital Charges for operating room, surgical supplies, anesthesia, drugs, dressings, oxygen, antibiotics, lab and x-ray, and physical and occupational therapy. (See Additional Benefit and Health Plus under Hospital Room & Care above)	No charge for operating room, surgical supplies, anesthesia, drugs, dressings, oxygen, lab and X-ray, therapy (physical and inhalation) and transfusion service
HOSPICE	100% Eligible Charges for up to 150 days of hospice services	Not covered	Plan pays 100% of Eligible Charges for up to 150 days of hospice services	No charge
LAB AND X-RAY	100% of Eligible Charges for X-rays for injuries and malignancies 50% of Eligible Charges for Lab and X-ray for illnesses and for allergy testing	No charge No charge for allergy testing.	Covered under physician and hospital benefits	No charge No charge for allergy testing and injections.

*Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in each insurance carrier's contract with the Health Fund. EMPLOYEES WITHOUT NEGOTIATED CONTRACTS – refer to page 40 for monthly premiums.

	HMSA SERVICE BENEFIT PLAN PAYS	KAISER HEALTH PLAN	HMSA'S COMMUNITY HEALTH PROGRAM (CHP)	ISLAND CARE
MATERNITY	All benefits listed here are available for pregnancy, childbirth, and related medical conditions Also, physician and hospital benefits for a newborn child for in-hospital routine nursery care, premature birth, illness, injury, or birth defect No waiting period	No charge. No waiting period	Covered under physician and hospital benefits. No waiting period	Covered under physician and hospital benefits. No waiting period
MENTAL HEALTH	Inpatient Benefits 75% of Eligible Charges for psychiatric services and psychological testing — 30 visits calendar year Hospital benefits — 30 days per calendar year Outpatient Benefits 75% of Eligible Charges for psychiatric services beginning with 2nd visit and psychological testing — up to $1000 per calendar year	Inpatient cost to member 25% of professional fees during covered hospitalization No charge for 30 days of hospitalization Outpatient $1 per visit. Maximum 20 visits. Includes psychological testing, individual and group sessions	Inpatient Plan pays 75% of eligible professional fees during covered hospitalization Plan pays 80% of Eligible Hospital Charges for 30 days of hospitalization Outpatient Member pays $10 a session for 20 individual sessions Member pays $5 a session for 20 group sessions Member pays $20 for psychological testing (1 series a calendar year)	Inpatient cost to member 25% of professional fees during covered hospitalization No charge for 30 days of hospitalization Outpatient (Maximum 20 visits per year) $20 per individual session $10 per group session $25 for psychological testing (1 per year)
SUBSTANCE ABUSE	All benefits listed here are available for alcoholism and drug abuse treatment. See this booklet for clarification.	No charge for semiprivate room for detoxification.	Covered under physician and hospital benefits for detoxification.	Member responsible for: 25% of hospital charges $3 per outpatient visit
EXCLUSIONS	Cosmetic surgery, eye refractions, eye glasses or contact lenses, refractive eye surgery to correct visual problems, services done by dentists and not physicians, rest cures, routine physical exams, screens, or checkups, work-related injuries or illnesses, care furnished by government agencies and available at no cost to you, expenses which you have no legal obligation to pay or for which no charge would be made if you had no health plan coverage, services from a member of your immediate family or household, services or expenses connected with confinement which is primarily for custodial or domiciliary care, acts of war, services not medically necessary and charges which exceed the Eligible Charge, services that do not follow or are not standard medical practice (e.g., experimental or investigative services), reversal of sterilization, fertilization by artificial means, services related to sex transformations or sexual dysfunction or inadequacies; biofeedback and other forms of self-care or self-help training and any related diagnostic testing If confined in a hospital or skilled nursing facility when coverage first becomes effective, benefits will be limited to $500 for the injury or illness that required confinement	Workers' compensation cases, custodial, domiciliary or convalescent care, cosmetic services, dental care, physical exams required for employment or government licensing, experimental procedures, podiatry and routine foot care, in-vitro fertilization, procedures not generally and customarily available, organ transplants except for kidney transplants and liver transplants for children with biliary atresia, eye examinations for contact lenses, services to reverse voluntary surgically induced infertility, durable medical equipment, corrective appliances and artificial aids, services related to sex transformations, outpatient drugs, services not arranged by Kaiser Plan	Services not arranged by your CHP Health Center, cosmetic surgery, dental care, surgical correction of malocclusion, experimental transplants, eye refractions for glasses and appliances, refractive eye surgery to correct visual problems, private duty nursing, injury or illness caused by a third party, no-fault motor vehicle insurance or workers' compensation cases, major disaster, epidemic, war, outpatient drugs, physical exams solely for non-medical reasons, services related to sex transformations and sexual dysfunctions or inadequacies, artificial insemination, in-vitro fertilization or reversal of surgical sterilization, custodial or domiciliary care	Experimental treatment, corrective appliance and artificial aids (except as specified in benefit schedule), physical exams for employment, licenses or insurance, durable equipment other than initial provision, dental services including hospitalization, eye refractions, eye glasses, contacts, custodial or domiciliary care, cosmetic surgery, outpatient drugs, sex transformations, reversal of voluntary sterilization, blood, plasma, major disaster, epidemic, war, workers' compensation cases, services not provided or arranged by Island Care physicians

Source: Hawaii, Health Fund Benefit Plans for State and County Employees and Retirees, Revised July 1987.

Appendix C

STATE EMPLOYEE HEALTH BENEFIT PLANS - 1987

1987 UPDATE OF MARTIN E. SEGAL COMPANY'S SURVEY OF STATE EMPLOYEE HEALTH BENEFIT PLANS

TABLE 1

PARTICIPANTS IN STATE EMPLOYEE HEALTH BENEFIT PLANS
AS OF JANUARY 1987

STATE	EMPLOYEES COVERED BY PLAN [a]	RETIREES COVERED BY PLAN [b]	HMO PARTICIPATION		
			NUMBER OF HMOs OFFERED	EMPLOYEES ENROLLED IN HMOs	
				NUMBER	PERCENT
ALABAMA	33,000	5,900	2	700	2%
ALASKA	13,000	7,600	0	0	0
ARIZONA	37,400	3,200	4	21,200	57
ARKANSAS	19,000	3,000	0	0	0
CALIFORNIA [c] ...	164,600	64,900	29	100,200	61
COLORADO	22,400	[d]	17	13,000	58
CONNECTICUT	45,000	7,000	6	6,000	13
DELAWARE	25,000	5,000	2	5,200	21
FLORIDA	103,500	10,300	61	38,000	37
GEORGIA	149,000	28,600	5	17,400	12
HAWAII	34,700	18,800	3	9,600	28
IDAHO	12,500	2,000	0	0	0
ILLINOIS	119,500	41,000	22	76,900	64
INDIANA	31,200	0 over 65	5	14,000	45
IOWA	26,300	2,100	6	2,000	8
KANSAS	35,700	6,200	8	11,700	33
KENTUCKY	109,000	4,500	14	40,500	37
LOUISIANA	64,000	25,500	7	18,000	28
MAINE	14,000	6,000	0	0	0
MARYLAND	51,000	15,000	14	16,000	31
MASSACHUSETTS	90,900	38,100	19	44,000	48
MICHIGAN	56,000	20,700	20	23,900	43
MINNESOTA	50,000	7,500	9	18,900	38
MISSISSIPPI	43,000	4,000	0	0	0
MISSOURI	30,000	5,100	7	4,400	15
MONTANA	10,000	1,600	0	0	0
NEBRASKA	12,000	0	4	2,000	17
NEVADA	13,500	1,800	2	4,300	32
NEW HAMPSHIRE	9,000	1,100	4	600	7
NEW JERSEY [c] ...	88,400	14,300	16	28,500	32
NEW MEXICO	18,000	2,200	3	4,000	22
NEW YORK [c]	239,000	76,000	25	59,000	25
NORTH CAROLINA ...	200,700	57,500	3	41,000	20
NORTH DAKOTA	12,000	2,000	3	500	4
OHIO	50,500	[d]	34	24,100	48
OKLAHOMA	37,500	6,500	3	10,000	27
OREGON	22,500	4,200	7	6,300	28
- BUBB PLAN	16,500	3,000	5	8,000	48
PENNSYLVANIA	85,000	44,000	20	10,400	12
RHODE ISLAND	17,000	7,500	3	7,400	44
SOUTH CAROLINA ...	125,200	26,100	4	29,800	24
SOUTH DAKOTA	11,100	400	0	0	0
TENNESSEE	57,100	2,200	2	4,300	8
TEXAS	109,000	20,000	14	31,000	28
UTAH	12,500	3,500	2	2,500	20
VERMONT	6,000	1,800	1	30	1
VIRGINIA	84,500	16,700	7	9,500	11
WASHINGTON	70,000	15,000	7	23,000	33
WEST VIRGINIA	84,000	16,000	2	1,000	1
WISCONSIN	53,000	13,000	30	39,200	74
WYOMING	10,300	1,800	0	0	0

[a] Approximate total number of covered employees, including employees enrolled in HMOs.
[b] Approximate total number of covered retirees.
[c] Participants shown are State employees and retirees only (i.e., figures exclude local employees and retirees).
[d] Retired State employees are covered by a separate health benefit plan for all retired members of the statewide public employees retirement system.

Table 2

MONTHLY CONTRIBUTIONS TO STATE EMPLOYEE HEALTH BENEFIT PLANS
JANUARY 1986 AND JANUARY 1987

EMPLOYEE ONLY COVERAGE

	COST TO EMPLOYEE		COST TO STATE		TOTAL COST		PERCENT OF TOTAL COST PAID BY STATE	
STATE	1986	1987	1986	1987	1986	1987	1986	1987
ALABAMA	0	0	105.00	125.00	105.00	125.00	100.0%	100.0%
ALASKA	0	0	222.60	222.60	222.60	222.60	100.0	100.0
	0	0	237.75	237.75	237.75	237.75	100.0	100.0
ARIZONA	1.00	1.00	79.46	86.78	80.46	87.78	98.8	98.9
ARKANSAS	8.36	9.26	62.50	70.00	70.86	79.26	88.2	88.3
	25.40	28.20	62.50	70.00	87.90	98.20	71.1	71.3
CALIFORNIA	0	0	71.61	77.22	71.61	77.22	100.0	100.0
	39.39	54.78	85.00	88.00	124.39	142.78	68.3	61.6
COLORADO	8.12	10.00	57.00	55.12	65.12	65.12	87.5	84.6
CONNECTICUT	0	0	89.30	100.80	89.30	100.80	100.0	100.0
DELAWARE	0	0	72.48	77.08	72.48	77.08	100.0	100.0
	19.06	20.30	72.48	77.08	91.54	97.38	79.2	79.2
FLORIDA	15.18	15.18	65.20	65.20	80.38	80.38	81.1	81.1
GEORGIA	13.60	13.60	62.65	68.55	76.25	82.15	82.2	83.4
	26.65	23.40	62.65	68.55	89.30	91.95	70.2	74.6
HAWAII	18.22	18.22	27.34	27.34	45.56	45.56	60.0	60.0
IDAHO	0	0	69.52	69.52	69.52	69.52	100.0	100.0
ILLINOIS	0	0	75.24	73.32	75.24	73.32	100.0	100.0
INDIANA	1.58	1.58	72.45	72.45	74.03	74.03	97.9	97.9
IOWA	0	0	68.24	75.06	68.24	75.06	100.0	100.0
KANSAS	0	0	78.53	92.55	78.53	92.55	100.0	100.0
KENTUCKY	0	0	60.22	69.79	60.22	69.79	100.0	100.0
LOUISIANA	39.52	39.52	39.52	39.52	79.04	79.04	50.0	50.0
MAINE	0	0	72.56	72.92	72.56	72.92	100.0	100.0
MARYLAND	10.22	11.51	57.92	65.25	68.14	76.76	85.0	85.0
	19.54	22.37	57.92	65.25	77.46	87.62	74.8	74.5
MASSACHUSETTS ...	10.22	11.65	91.95	104.84	102.17	116.49	90.0	90.0
MICHIGAN	11.12	11.12	100.14	100.14	111.26	111.26	90.0	90.0
MINNESOTA	0	0	73.00	69.70	73.00	69.70	100.0	100.0
MISSISSIPPI	0	0	72.00	72.00	72.00	72.00	100.0	100.0
MISSOURI	0	0	69.00	69.00	69.00	69.00	100.0	100.0
MONTANA	0	0	96.20	97.60	96.20	97.60	100.0	100.0

Table 2 (Cont'd.)

EMPLOYEE ONLY COVERAGE (CONT'D.)

STATE	COST TO EMPLOYEE		COST TO STATE		TOTAL COST		PERCENT OF TOTAL COST PAID BY STATE	
	1986	1987	1986	1987	1986	1987	1986	1987
NEBRASKA	0	0	41.25	41.25	41.25	41.25	100.0%	100.0%
	11.26	11.26	44.47	44.47	55.73	55.73	79.8	79.8
NEVADA	0	0	129.20	129.20	129.20	129.20	100.0	100.0
NEW HAMPSHIRE ...	0	0	67.96	78.01	67.96	78.01	100.0	100.0
NEW JERSEY	0	0	58.93	65.89	58.93	65.89	100.0	100.0
NEW MEXICO	15.30	16.55	45.88	49.63	61.18	66.18	75.0	75.0
	24.48	26.48	36.70	39.70	61.18	66.18	60.0	60.0
NEW YORK	7.51	8.64	67.66	77.86	75.17	86.51	90.0	90.0
	9.07	10.06	83.15	91.99	92.22	100.63	90.0	91.4
NORTH CAROLINA...	0.26	0	63.82	63.82	64.08	63.82	99.6	100.0
NORTH DAKOTA	0	0	60.00	60.00	60.00	60.00	100.0	100.0
OHIO	25.50	25.50	68.95	68.95	94.45	94.45	73.0	73.0
OKLAHOMA	0	0	115.31	115.31	115.31	115.31	100.0	100.0
OREGON	0	0	72.46	90.68	72.46	90.68	100.0	100.0
- BUBB PLAN	0	0	144.90	153.59	144.90	153.59	100.0	100.0
PENNSYLVANIA	0	0	57.81	56.15	57.81	56.15	100.0	100.0
	0	0	70.50	70.03	70.50	70.03	100.0	100.0
RHODE ISLAND	0	0	77.97	96.71	77.97	96.71	100.0	100.0
SOUTH CAROLINA...	0	0	62.29	67.27	62.29	67.27	100.0	100.0
	7.02	7.58	62.29	67.27	69.31	74.85	89.9	89.9
SOUTH DAKOTA	0	0	53.42	53.42	53.42	53.42	100.0	100.0
TENNESSEE	11.70	11.70	46.82	46.82	58.52	58.52	80.0	80.0
TEXAS	0	0	66.29	66.29	66.29	66.29	100.0	100.0
UTAH	8.25	8.25	74.25	74.25	82.50	82.50	90.0	90.0
VERMONT	8.65	10.85	34.58	43.40	43.23	54.25	80.0	80.0
VIRGINIA	0	0	71.16	78.36	71.16	78.36	100.0	100.0
WASHINGTON	0	0	64.52	64.52	64.52	64.52	100.0	100.0
WEST VIRGINIA ...	0	0	79.95	79.95	79.95	79.95	100.0	100.0
WISCONSIN [a]....	12.31	16.29	72.69	77.02	85.00	93.31	85.5	82.5
WYOMING	5.94	0	100.00	100.00	105.94	100.00	94.4	100.0

[a] Contributions vary by benefit plan and by county. State pays lesser of 90% of standard plan rate or 105% of lowest cost HMO in employee's county. Rates shown in table are for standard plan in Dane County (Madison).

Table 3

MONTHLY CONTRIBUTIONS TO STATE EMPLOYEE HEALTH BENEFIT PLANS
JANUARY 1986 AND JANUARY 1987

EMPLOYEE AND FAMILY COVERAGE

	COST TO EMPLOYEE		COST TO STATE		TOTAL COST		PERCENT OF TOTAL COST PAID BY STATE	
STATE	1986	1987	1986	1987	1986	1987	1986	1987
ALABAMA	82.50	90.00	105.00	125.00	187.50	215.00	56.0%	58.1%
ALASKA	0	0	222.60	222.60	222.60	222.60	100.0	100.0
	0	0	237.75	237.75	237.75	237.75	100.0	100.0
ARIZONA	59.78	65.30	150.98	164.64	210.76	229.94	71.6	71.6
ARKANSAS	50.58	33.20	62.50	70.00	113.08	103.20	55.3	67.8
	77.54	89.20	62.50	70.00	140.04	159.20	44.6	44.0
CALIFORNIA	0	0	193.57	198.26	193.57	198.26	100.0	100.0
	97.34	139.29	211.00	219.00	308.34	358.29	68.4	61.1
COLORADO	117.12	119.00	57.00	55.12	174.12	174.12	32.7	31.7
CONNECTICUT	44.56	50.46	193.34	217.96	237.90	268.42	81.3	81.2
DELAWARE	0	0	178.26	189.60	178.26	189.60	100.0	100.0
	45.90	48.78	178.26	189.60	224.16	238.38	79.5	79.5
FLORIDA	55.64	55.64	122.80	122.80	178.44	178.44	68.8	68.8
GEORGIA	39.80	39.80	109.50	122.05	149.30	161.85	73.3	75.4
	66.00	59.46	109.50	122.05	175.50	181.51	62.4	67.2
HAWAII	56.03	56.03	84.05	84.05	140.08	140.08	60.0	60.0
IDAHO	63.40	63.40	69.52	69.52	132.92	132.92	52.3	52.3
ILLINOIS	67.18	67.18	96.32	82.98	163.50	150.16	58.9	55.3
	123.02	123.02	96.12	86.62	219.14	209.64	43.9	41.3
INDIANA	36.66	36.66	178.01	178.01	214.67	214.67	82.9	82.9
IOWA	57.76	59.12	99.20	113.54	156.96	172.66	63.2	65.8
KANSAS	127.39	158.12	78.53	92.55	205.92	250.67	38.1	36.9
KENTUCKY	83.94	97.00	60.22	69.79	144.16	166.79	41.8	41.8
LOUISIANA	90.96	90.96	90.96	90.96	181.92	181.92	50.0	50.0
MAINE	52.46	52.82	129.46	130.30	181.92	183.12	71.2	71.2
MARYLAND	30.08	33.83	170.48	191.73	200.56	225.56	85.0	85.0
	53.78	61.27	170.48	191.73	224.26	253.00	76.0	75.8
MASSACHUSETTS ...	22.16	25.61	199.48	230.47	221.64	256.08	90.0	90.0
MICHIGAN	31.16	31.16	280.52	280.52	311.68	311.68	90.0	90.0
MINNESOTA	9.34	8.92	157.18	150.08	166.52	159.00	94.4	94.4
MISSISSIPPI	89.70	89.70	72.00	72.00	161.70	161.70	44.5	44.5
MISSOURI	151.75	151.75	69.00	69.00	220.75	220.75	31.3	31.3
MONTANA	61.20	57.60	105.00	115.00	166.20	172.60	63.2	66.6

Table 3 (Cont'd.)

EMPLOYEE AND FAMILY COVERAGE (CONT'D.)

STATE	COST TO EMPLOYEE		COST TO STATE		TOTAL COST		PERCENT OF TOTAL COST PAID BY STATE	
	1986	1987	1986	1987	1986	1987	1986	1987
NEBRASKA	0	0	147.68	147.68	147.68	147.68	100.0%	100.0%
	39.95	39.95	159.23	159.23	199.18	199.18	79.9	79.9
NEVADA	69.73	83.90	129.20	129.20	198.93	213.10	64.9	60.6
NEW HAMPSHIRE ...	0	0	183.50	210.62	183.50	210.62	100.0	100.0
NEW JERSEY	0	0	143.83	160.56	143.83	160.56	100.0	100.0
NEW MEXICO	39.57	42.40	118.69	127.19	158.26	169.59	75.0	75.0
	63.31	67.84	94.95	101.75	158.26	169.59	60.0	60.0
NEW YORK	29.19	33.70	132.77	153.12	161.96	186.86	82.0	82.0
	34.53	39.16	163.33	183.32	197.86	217.02	82.5	84.5
NORTH CAROLINA...	89.54	89.28	63.82	63.82	153.36	153.10	41.6	41.7
NORTH DAKOTA	0	0	168.00	168.00	168.00	168.00	100.0	100.0
OHIO	61.13	61.13	165.27	165.27	226.40	226.40	73.0	73.0
OKLAHOMA	108.00	108.00	115.31	115.31	223.31	223.31	51.6	51.6
OREGON	0	0	130.41	141.74	130.41	141.74	100.0	100.0
- BUBB PLAN	0	0	144.90	153.59	144.90	153.59	100.0	100.0
PENNSYLVANIA	0	0	139.33	140.81	139.33	140.81	100.0	100.0
	0	0	189.81	187.92	189.81	187.92	100.0	100.0
RHODE ISLAND	0	0	207.86	235.66	207.86	235.66	100.0	100.0
SOUTH CAROLINA...	61.12	66.02	62.29	67.27	123.41	133.29	50.5	50.5
	72.10	77.88	62.29	67.27	134.39	145.15	46.4	46.3
SOUTH DAKOTA	130.74	123.62	53.42	53.42	184.16	177.04	29.0	30.2
TENNESSEE	29.22	29.22	116.89	116.89	146.11	146.11	80.0	80.0
TEXAS	88.36	88.36	87.00	87.00	175.36	175.36	49.6	49.6
UTAH	21.82	21.82	196.39	196.39	218.21	218.21	90.0	90.0
VERMONT	23.99	30.11	95.98	120.45	119.97	150.56	80.0	80.0
VIRGINIA	52.52	57.00	128.60	139.54	181.12	196.54	71.0	71.0
WASHINGTON	0	0	183.56	183.56	183.56	183.56	100.0	100.0
WEST VIRGINIA ...	0	0	187.95	187.95	187.95	187.95	100.0	100.0
WISCONSIN [a] ...	26.00	28.74	181.89	199.35	207.89	228.09	87.5	87.4
WYOMING	111.42	115.00	100.00	100.00	211.42	215.00	47.3	46.5

[a] Contributions vary by benefit plan and by county. State pays lesser of 90% of standard plan rate or 105% of lowest cost HMO in employee's county. Rates shown in table are for standard plan in Dane County (Madison).

Table 4

MONTHLY CONTRIBUTIONS TO STATE EMPLOYEE HEALTH BENEFIT PLANS
JANUARY 1986 AND JANUARY 1987

RETIREE ONLY COVERAGE (Over 65 with Medicare)

	COST TO RETIREE		COST TO STATE		TOTAL COST		PERCENT OF TOTAL COST PAID BY STATE	
STATE	1986	1987	1986	1987	1986	1987	1986	1987
ALABAMA	34.35	0	22.35	60.00	56.70	60.00	39.4%	100.0%
ALASKA	0	0	175.00	165.00	175.00	165.00	100.0	100.0
ARIZONA	67.68	73.84	0	0	67.68	73.84	0	0
ARKANSAS	41.50	43.00	0	0	41.50	43.00	0	0
CALIFORNIA	0	0	51.70	54.05	51.70	54.05	100.0	100.0
	10.53	18.31	85.00	88.00	95.53	106.31	89.0	82.8
COLORADO [a]	0	0	35.52	35.52	35.52	35.52	100.0	100.0
	35.52	35.52	0	0	35.52	35.52	0	0
CONNECTICUT	25.59	22.93	20.94	34.38	46.53	57.31	45.0	60.0
DELAWARE	3.20	3.40	31.18	33.16	34.38	36.56	90.7	90.7
	21.36	22.72	31.18	33.16	52.54	55.88	59.3	59.3
FLORIDA	55.30	55.30	0	0	55.30	55.30	0	0
GEORGIA	13.60	13.60	62.65	68.55	76.25	82.15	82.2	83.4
	26.65	23.40	62.65	68.55	89.30	91.95	70.2	74.6
HAWAII	0	0	53.64	53.64	53.64	53.64	100.0	100.0
IDAHO	35.54	58.00	5.68	0	41.22	58.00	13.8	0
ILLINOIS	0	0	75.24	73.32	75.24	73.32	100.0	100.0
INDIANA	-	-	-	-	-	-	-	-
IOWA	31.90	35.10	0	0	31.90	35.10	0	0
KANSAS	36.59	43.16	0	0	36.59	43.16	0	0
KENTUCKY	51.75	54.15	0	0	51.75	54.15	0	0
LOUISIANA	20.62	20.62	20.62	20.62	41.24	41.24	50.0	50.0
MAINE	0	0	37.12	36.00	37.12	36.00	100.0	100.0
MARYLAND	7.90	9.35	44.76	52.99	52.66	62.34	85.0	85.0
	21.12	25.07	44.76	52.99	65.88	78.06	67.9	67.9
MASSACHUSETTS ...	6.65	6.20	59.86	55.84	66.51	62.04	90.0	90.0
MICHIGAN	0	0	75.57	75.57	75.57	75.57	100.0	100.0
MINNESOTA	51.28	51.28	0	0	51.28	51.28	0	0
MISSISSIPPI	34.50	34.50	0	0	34.50	34.50	0	0
MISSOURI	33.75	32.25	3.00	4.50	36.75	36.75	8.2	12.2
	60.00	58.50	3.00	4.50	63.00	63.00	4.8	7.1
MONTANA	61.00	61.00	0	0	61.00	61.00	0	0

[a] Portion of premium paid by Colorado Public Employees' Retirement Association varies from 0% for a retiree with less than six years service to 100% for a retiree with 20 or more years service.

Table 4 (Cont'd.)

RETIREE ONLY COVERAGE (CONT'D.)

STATE	COST TO RETIREE 1986	COST TO RETIREE 1987	COST TO STATE 1986	COST TO STATE 1987	TOTAL COST 1986	TOTAL COST 1987	PERCENT OF TOTAL COST PAID BY STATE 1986	PERCENT OF TOTAL COST PAID BY STATE 1987
NEBRASKA	-	-	-	-	-	-	-	-
NEVADA	56.89	56.89	34.81	34.81	91.70	91.70	38.0%	38.0%
NEW HAMPSHIRE ...	0	0	40.00	44.02	40.00	44.02	100.0	100.0
NEW JERSEY [b] ..	43.71	45.00	0	0	43.71	45.00	0	0
NEW MEXICO	46.50	52.69	0	0	46.50	52.69	0	0
NEW YORK [c][d] .	9.07	10.06	81.59	90.57	90.66	100.63	90.0	90.0
NORTH CAROLINA...	0	0	48.58	48.58	48.58	48.58	100.0	100.0
NORTH DAKOTA	50.00	50.00	0	0	50.00	50.00	0	0
OHIO	0	0	50.00	53.29	50.00	53.29	100.0	100.0
OKLAHOMA	45.90	45.90	0	0	45.90	45.90	0	0
OREGON	36.03	40.21	0	0	36.03	40.21	0	0
- BUBB PLAN	43.78	53.92	0	0	43.78	53.92	0	0
PENNSYLVANIA	0	0	57.78	49.09	57.78	49.09	100.0	100.0
	0	0	68.93	60.24	68.93	60.24	100.0	100.0
RHODE ISLAND	41.37	41.37	0	0	41.37	41.37	0	0
SOUTH CAROLINA...	0	0	54.04	67.27	54.04	67.27	100.0	100.0
	0	7.58	54.04	67.27	54.04	74.85	100.0	89.9
SOUTH DAKOTA	51.92	51.38	0	0	51.92	51.38	0	0
TENNESSEE	33.96	31.89	0	0	33.96	31.89	0	0
TEXAS	0	0	66.29	66.29	66.29	66.29	100.0	100.0
UTAH	54.50	60.00	0	0	54.50	60.00	0	0
VERMONT	3.54	4.45	14.17	17.78	17.71	22.23	80.0	80.0
VIRGINIA	37.16	39.96	0	0	37.16	39.96	0	0
WASHINGTON	38.86	38.86	0	0	38.86	38.86	0	0
WEST VIRGINIA ...	23.97	23.97	0	0	23.97	23.97	0	0
WISCONSIN [c][e].	57.15	65.32	0	0	57.15	65.32	0	0
WYOMING	44.12	54.12	0	0	44.12	54.12	0	0

[b] State pays total cost for employees who retire with 25 or more years of credited service or retire on a disability pension.
[c] Sick leave credits may be used by retirees to pay premiums.
[d] State pays total cost for employees who retired before 1983.
[e] Rates shown are for standard plan.

Source: Attachment to letter to Susan K. Claveria, Researcher, Legislative Reference Bureau, from John P. Mackin, Ph.D., Senior Vice-President, Martin E. Segal Company, dated August 11, 1987.

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