
Chapter 2

Adverse Selection Has Increased Costs to the Detriment of the Hawaii Public Employees Health Fund, Unfunded Liabilities Have Increased Five-Fold, and Strategies for the Health Fund's Future Are Needed

In this chapter, we assess the current status of the Hawaii Public Employees Health Fund (health fund). We discuss the health fund's financial future, focusing on financial projections of the estimated costs of the program to employers (the State and counties) over the next 15 years and estimates of the unfunded liability for the post-retirement health benefits program. We review features of public employee health benefit programs in other states, such as governance and employer contributions. We present alternative prefunding strategies to finance the anticipated costs of providing retiree health benefits and make recommendations for the future of the Hawaii public employees health benefit program.

Summary of Findings

1. The presence of union plans competing with the health fund for enrollees has resulted in significantly higher employer contribution costs for active employees than would have been the case without such competition. This trend toward higher employer contributions will continue for the foreseeable future as long as the present program continues. The existence of union plans has also increased the premium costs for participants enrolled in health fund plans. The health fund's annual experience report understates certain cost increases in the public employee health benefit program because of limited information on the union plans.
2. The accrued post-retirement benefit liabilities have grown five-fold over the past decade. Prefunding these liabilities merits consideration.
3. Certain rate increases and rate stabilization reserve practices need attention.
4. Two states use an employer-union trust governance structure to provide a single health benefit program for public employees. Other effective governance models exist, all apparently using one statewide benefit program. These alternatives merit consideration.

Competition from Union Plans Will Continue to Drive Employer Costs Higher

The Hawaii Public Employees Health Fund is experiencing higher employer costs due to several factors resulting from the union plans competing with the health fund for enrollees. The health fund's current reporting which does not include financial information on the union plans fails to identify the overall cost of the health benefits program and drastically understates the rate of cost increases. The large growth in union plan enrollment and adverse selection have increased the overall cost of the program to employers more than these costs would have increased without such growth. The State and counties can expect such higher employer costs to continue until actions are taken to reduce adverse selection.

Employee organizations (unions) began to offer primary health benefit plans to public employees in Hawaii during FY1984-85. Enrollment in these plans grew slowly at first, but increased rapidly in the mid-1990s to 23,182 in FY1996-97. When enrollment in the union plans began increasing rapidly, enrollment of active employees in health fund plans began decreasing, from 42,292 in FY1993-94 to the FY1996-97 level of 25,167. Exhibit 2.1 and Exhibit 2.2 show these trends.

Competition with union health benefit plans places the health fund at a disadvantage because of a phenomenon called "adverse selection." Three factors—family size, the average age of union plan enrollees, and the availability of "no cost" union plans—significantly increase the cost to the State and county as employers. The State and counties need to address the impact of adverse selection on the health fund.

Families opting for union plans are smaller on average

Employer contribution costs for active employees are higher for the health fund because families enrolled in health fund health benefit plans are on average larger than those enrolled in union health benefit plans. Consequently, the State and counties are paying an estimated additional \$1.8 million per year.

As of June 30, 1998, active employees enrolled in the medical, dental, drug and vision plans offered by the unions had an average of 2.08 dependents in their household while active employees enrolled in the health fund's version of those plans averaged 2.33 dependents in their household. All of this difference was the result of a higher average number of children covered by the health fund plans for those employees selecting family coverage. The Hawaii Government Employees Association (HGEA), the union with the largest medical plan membership, had an even lower average household size of 1.98 dependents.

Exhibit 2.1

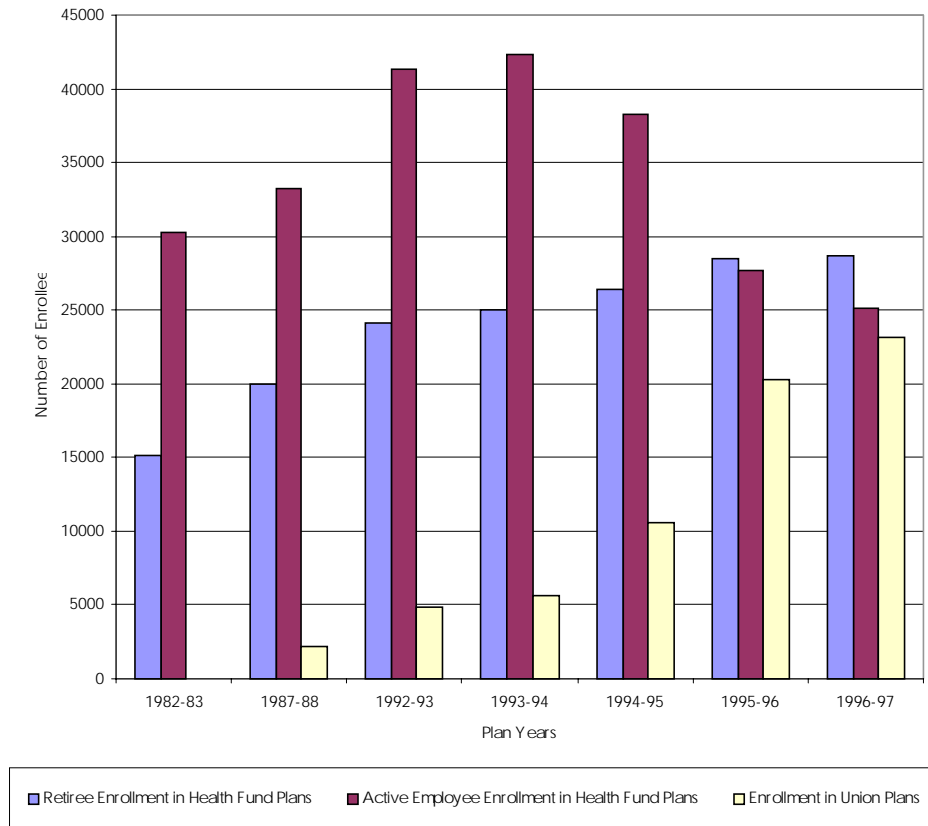
Enrollment in Health Fund Plans and Union Plans, Selected Years from FY1982-83 to FY1996-97

Fiscal Year	Total	Health Fund Plan Enrollment		Employee Organization Plan Enrollment
		Retirees	Actives	
1982-83	45,294	15,160	30,234	0
1984-85	N/A	N/A	N/A	1,645
1987-88	55,477	20,005	33,275	2,197
1992-93	70,359	24,176	41,325	4,858
1993-94	72,953	25,021	42,292	5,640
1994-95	75,205	26,375	38,256	10,574
1995-96	76,443	28,499	27,666	20,278
1996-97	77,010	28,661	25,167	23,182

Source: Hawaii Public Employees Health Fund.

Exhibit 2.2

Enrollment in Health Fund Plans and Union Plans, Selected Years from FY1982-83 to FY1996-97



Source: Hawaii Public Employees Health Fund.

Exhibit 2.3 shows the actual active employee enrollment as of June 1998. Union plan membership consists of more small households than the health fund plans (the opposite is the case for single employee coverage and the number of large households).

Exhibit 2.3
Distribution of Household Size Comparing the Health Fund and Union Health Plan Enrollment as of June 30, 1998

Medical Coverage Type	Active Employees Enrolled	
	Health Fund	Unions
Single Employee	13,765	7,424
Employee + Spouse	2,680	4,854
Employee + 1 Child	678	1,154
Employee + Spouse + 1 Child	2,505	3,697
Employee + 2 Children	419	367
Employee + Spouse + 2 Children	2,685	3,598
Employee + 3 or more Children	213	160
Employee + Spouse + 3 or more Children	1,620	1,490

Source: Hawaii Public Employees Health Fund.

Employer contributions for active employees are generally fixed at 60 percent of the rate for the plan with the highest enrollment in the health fund, which typically is the Hawaii Medical Service Association (HMSA) plan. The health fund's HMSA family premium rate as of June 30, 1998, was about \$413 per month. We estimate that the comparable average cost of family coverage for union family composition was about \$397 per month, or \$16 (4 percent) lower than the health fund's HMSA family rate.

A disproportionate number of two-person and three-person families choosing union HMSA coverage instead of the health fund's HMSA coverage increases the cost of the health fund's coverage. As a result, the employer contribution is determined based on premiums for families with larger households. That is, the HMSA premium is \$413, instead of the weighted average of the \$413 health fund premium and the \$397. Therefore, we estimate that as a result of the difference in average household size there has been approximately an extra \$1.8 million of annual employer contribution cost as a result of the availability of the union health coverage.

Employees in union plans are younger on average

Employer contribution costs for active employees are also higher because on average, the employee population with family coverage under the health fund plans is older than those with family coverage under the union plans. We estimate that the union plans have a lower average cost of about 4.5 percent than the expected cost of the health fund's family coverage.

In addition, the age distribution of those employees that selected single coverage in a union plan has an expected cost that is about 1.2 percent lower than the cost of single coverage for the population left in the health fund. This means that the union plans, assuming equal benefits, are expected to cost another \$13 (4.5 percent of \$413) per month less for family coverage; and \$2 (1.2 percent of \$134) per month less for single coverage. Based on the higher age of health fund enrollees, we estimate that the total annual employer contributions have been increased by about \$1.5 million per year, over what they would have been without the availability of the union plans.

One possible explanation for the fact that the union membership also tended to be younger on average is that younger families tend to have fewer dependents. Altogether, the effect of both smaller families and younger employees moving to the union plans has been to increase overall employer contributions for active employees by \$3.3 million per year.

The least costly strategy for enrollees is the most costly for employers

Benefit options with the smallest employee contributions will attract members. Price (or cost) to the employee is the most effective driver of enrollment in employee health benefit programs. Other incentives are greater benefits and more choices.

As shown above, active-employee enrollment in the union plans has been growing at the expense of enrollment in the health fund plans. One reason is that the union plans have the flexibility to provide different family rates or "tiers" for two-person, three-person, and four-person-and-larger households, unlike the health fund which is limited to one family rate tier.

Exhibit 2.4 compares the cost of one of HGEA's packages of medical benefits with the health fund's comparable package.

In this example, families of four or more members would pay over \$120 per month more for HGEA's medical coverage than the health fund's comparable family benefit package. However, a two-person family eligible for the HGEA coverage would save over \$120 per month on the HGEA plan.

Exhibit 2.4

Sample Comparison of an Employee's Monthly Cost of Coverage Under HGEA and the Health Fund's Plan

Coverage	<u>Monthly Employee Contributions</u>		Employee's Annual Savings or (Additional Costs) For HGEA Plans
	HGEA Plans	HF Plans	
Single	\$61.36	\$72.02	\$127.92
Two	\$90.40	\$210.98	\$1,446.96
Three	\$180.46	\$210.98	\$366.24
Family	\$331.32	\$210.98	(\$1,444.08)

Source: Hawaii Public Employees Health Fund.

If lower employee contributions attract employee enrollment, benefit plans available for *no* employee contribution should be even more effective in attracting membership. At least two of the unions (HGEA and UPW) offer a plan option called the Comprehensive Hospital and Medical Plan (CHAMP). These plans have a “zero” employee contribution for both single *and* family coverage. The CHAMP medical plan provides high-deductible health benefit coverage for the employee and any dependents. It is designed to be combined with spouse coverage from other than state or county employers. If families are covered under the spouse’s employer plan, the combined coverages will generally provide 100 percent reimbursement of all costs. These CHAMP plan options will attract any employee eligible for this union coverage, regardless of family size. This may explain why there are still so many large families that have chosen union plans. Therefore, we believe the cost differences due to family composition and age already discussed are possibly understated.

Since we have no data to show the numbers of employees (with their family composition) selecting a union CHAMP plan, or any other union plan, nor the actual premium rates for the CHAMP plans, we are not able to precisely estimate the impact that the CHAMP plan has had on costs. However, even if current data were available, this would only allow us to estimate the current year’s cost impact of the CHAMP and other union plans. The critical issue is not simply the current cost implications, but also the future cost implications. We believe that adverse selection will continue to cause larger employer contributions than necessary. We expect enrollment in union plans to continue to grow and the health fund enrollment to continue to decline unless changes are made to the overall health benefit program.

Given the current structure of the health benefit program, the most cost efficient strategy for married employees is to enroll in the spouse's health benefit coverage. These employees should then select the most favorable union CHAMP plan for which they qualify. Public employees who do not have spouse's coverage should select a union two-person or three-person rate plan for which they qualify. Lastly, those with more than three dependents and no spouse coverage should stay with the health fund programs. This strategy is the least costly for the employees who opt for these union benefit offerings but is the most costly for the state and county employers. In addition, this cost saving strategy for union plan enrollees leads to increased contribution rates for employees enrolled in health fund plans.

A better approach would be to either have the unions and the health fund offer the same benefits or to have only one health benefit program. In this way, one group of employees (those qualifying for certain union coverages) would not be in a position to inadvertently increase costs for the government employers and for those employees who are not able to qualify for one of the union plans. Our survey of 16 public employee health benefit programs in other states found that none currently have competing benefit programs, offering both government plans and union plans.

Employer contributions for CHAMP family coverage may exceed the premium costs

Employer contributions for the CHAMP family coverage may exceed the premium costs of providing that coverage.

We needed to estimate the anticipated costs (total premiums) for the CHAMP plan in comparison to the current employer contributions because we did not have access to the actual premium rates charged for CHAMP coverage. We used the HMSA health fund plan as the basis of the cost of "full health coverage" and used Ernst & Young's health care industry cost data to adjust the HMSA costs to a CHAMP-like plan.

We conservatively estimate that the total CHAMP monthly family premium cost is in the \$175-\$190 range, while the employer contribution ported to the union plans is \$248. Therefore, in each of these situations, the union administrator or trust fund receives from \$58-\$73 per month more for each such employee's coverage than may be needed for premium payments to the carrier (Royal State National Insurance Company). In fact, some bargaining units receive employer contributions of \$288, which increases the employer overpayment for this coverage by another \$40 per month for every employee with dependents selecting the CHAMP coverage.

While the above discussion illustrated that the potential overpayment by employers may be in the range of \$58 to \$113 per month for any particular employee, we have used an overpayment assumption of \$60 to illustrate the impact on employer costs. Therefore, assuming that the average employer's overpayment is \$60 per month the excess employer contributions would be about \$700,000 in one year for every 1,000 employees enrolling in a CHAMP plan.

Union CHAMP plan enrollment leads to much higher employer contribution costs

We believe that because of the availability of the CHAMP plan (with its "zero" employee contribution within the HGEA and UPW benefit packages), a large proportion of eligible public employees with coverage through their spouse's plan would likely select the CHAMP plan. The CHAMP plan would be preferred over the Kaiser and HMSA options, especially in the case of the large families, since these Kaiser and HMSA options could result in a larger employee contribution than would be the case in the health fund plans. Again, this might help explain why employees with three or more dependents have selected union coverage, rather than remain with the health fund plans.

As more public employees enroll in CHAMP plans, the cost of the employer contributions will increase. We estimate that every 1,000 CHAMP family contracts selected by employees would result in an increase in total annual employer contributions of at least \$3.8 million a year. This amount is in addition to the \$700,000 amount due to excess payments for the actual estimated cost of CHAMP coverage. Similarly, employee contributions for family coverage for those employees remaining in the health fund plans would also have been higher.

Competition from union plans has a cumulative effect in raising employer contribution costs

Competition from the union plans has a cumulative effect in raising employers' contribution costs. The impact of the CHAMP plans is independent of the additional employer costs due to family size and age. These amounts should be added to calculate the total impact of the adverse selection on employer costs. If we assume that there are 1,000 CHAMP enrollees, the estimated extra employer cost each year because of the availability of the union plans would be about \$7.8 million. If the CHAMP enrollment is about 2,000, then the extra cost is estimated to be \$12.3 million per year. Exhibit 2.5 summarizes the estimated annual increase of employer contributions. The total employer contribution for the active employees medical coverage during FY1996-97 was about \$107 million. Therefore, the \$7.8 million is about a 7.3 percent "overpayment" and the \$12.3 million would be about a 11.5 percent overpayment. Over time, it is likely that the amount and percentage of adverse selection will grow.

Exhibit 2.5

Summary of the Estimated Annual Increase of Employer Contributions Due to Competing Union Plans (in millions of dollars)

Employer Cost Impact	Assumption for CHAMP Enrollees	
	1,000	2,000
Effect from Family Size	\$1.8	\$1.8
Effect from Average Age Variance	\$1.5	\$1.5
Excess CHAMP Contributions	\$0.7	\$1.4
CHAMP Impact on Employer Costs	<u>\$3.8</u>	<u>\$7.6</u>
TOTAL (in millions of dollars)	\$7.8	\$12.3

The health fund annual experience report understates the cost increases of the health benefit program

The health fund's annual report does not provide a good financial picture of the cost and cost increases of the overall health benefit program. In fact, because the only information available to the health fund on the union plan costs is the amount of employer contributions ported to the unions, the report says nothing about the overall cost of the program and tends to drastically understate the rate of cost increase from one year to the next for active employees.

Exhibit 2.1 and Exhibit 2.2 show the gradual growth in the number of retirees and the dramatic drop in the enrollment of the health fund plan active employees along with the comparable increase of the union plans' enrollment.

The Hawaii Public Employees Health Fund Annual Experience Report for the 1996-97 Plan Year prepared by the Segal Company indicates that the "Health Fund Disbursements" for the plan year had only increased by 2.7 percent from \$275,169,418 in the prior year to \$282,513,260. Unfortunately, this understates the true financial cost of the program since the above amounts include *both* the employer and employee contributions for the health fund plans but only the employer contributions for the union plans.

Exhibit 2.1 shows that the health fund plan active employee count declined from 27,666 to 25,167 from 1995-96 to 1996-97. Part of the reason for the increase in health fund disbursements being only 2.7 percent is that there were about 2,500 fewer employee contributions in the 1996-97 plan year because these employees enrolled in union plans. It is likely that the majority of these employees have family coverage and therefore the current year disbursement amount of \$282.5 million would have been about \$5.3 million higher had these employees stayed with their health fund plans. Therefore, the increase in disbursements would have

been approximately 4.6 percent rather than the 2.7 percent stated in the annual experience report. This means that employer costs for the year probably increased by approximately \$12 to \$13 million, rather than the \$7.2 million shown in the experience report.

In addition, we believe that the results shown in the prior year's results would have been even more distorted. In FY1995-96, the number of active employees in the health fund had declined from 38,256 to 27,666, a drop of 10,590. This is partially offset by the fact that the retiree enrollment increased by 2,124, all in the health fund. The understatement in employer cost increase (or total program cost increase), was probably in the 6 to 7 percent range or three times as large as the understatement discusses above.

We believe that the more meaningful numbers to report would be the total cost of the health benefit program, which would include the employee contributions being received by the union plans. Alternatively, the report could show the amounts of the employer contributions only, which would generally be a reasonable approximation of the true rate of increase in total program costs.

If the health fund and the unions offered the same coverages, the impact of adverse selection would be lessened

If the health fund had the same flexibility to offer as many and comparable plan choices as the unions, as well as the ability to offer as many rate tiers, the degree of adverse selection currently present in the program would be somewhat reduced. While this would not solve all of the problems of the adverse selection, the problem would at least be somewhat lessened. Employer contribution costs would likely still be higher than they would be without the competition but at least the health fund would be in a position to keep more of the smaller families. The CHAMP-like plans would still be a problem in that both the union and health fund CHAMP plans would attract the low cost families. If the "CHAMP-like" plan in the health fund became the highest in enrollment, employer costs would drop dramatically.

The most effective solution to the adverse selection is a single health benefit program for all public employees

There have been discussions regarding a combined employer/union trust approach to providing the benefits to the public employees in Hawaii. Any approach where there is only one program seems to offer the greatest opportunity for eliminating or greatly reducing the potential for adverse selection. Combining all public employees into one health benefit program would increase the program's negotiating power with the insurance carriers and/or health plans. It would also consolidate the administrative functions and result in a more powerful administrative capability. In addition, most of the artificial hikes of employer contribution costs discussed above would be eliminated.

The Post-Retirement Benefit Liability Has Increased Five-Fold over the Past Decade

The Hawaii Public Employees Health Fund's cost to provide health benefits for active employees and retirees as well as the post-retirement health benefit liability have increased dramatically over the past decade. We estimate that as of July 1, 1998, the State and counties' accrued liability for providing future retiree health benefits, under the current plans, ranges from \$3.6 billion to \$7.4 billion. Our "most likely" (intermediate) estimate of this accrued liability is \$4.5 billion, which is almost a five-fold increase over the employers' liability in 1988. The employers' liability in 1988 was \$953.6 million, about 21 percent of the current estimated liability. As an additional comparison, the Employees' Retirement System of the State of Hawaii had an accrued unfunded liability of about \$1.4 billion as of June 1997, less than a third of the current estimated liability for the health benefit program, all of which is unfunded. By the year 2013, the State and counties' liability for providing post-retirement health benefits is estimated to grow to \$11.4 billion under our most likely estimate and a range of \$8.0 billion to \$24.8 billion.

Predictions of future costs are affected by many uncertainties but should be within some range of reasonable expectations. Exhibit 2.6 compares low, intermediate, and high trend scenario estimates of the liabilities by benefit type for 1998.

Our most likely estimate for the projected accrued liability for the year 2013 is \$11.4 billion. The same comparison is shown for the year 2013 in Exhibit 2.7.

Our intermediate estimates for the annual "pay-as-you-go" employer costs for retiree benefits increase from \$127.4 million in the current year to \$455.9 million in the year 2013. These projected annual employer costs for retirees are shown in Exhibit 2.8 for all three scenarios.

Similarly, the employer cost for providing these benefits to active employees is most likely to grow from \$138.7 million in 1998 to \$493.2 million by the year 2013. Exhibit 2.9 shows the pattern for these projected costs for all three scenarios.

The health fund added drug, dental, and vision benefits in 1990, two years after the health fund's last valuation study in 1988. These benefits represent about \$1.8 billion (or about 40 percent) of the total liability in 1998, with the drug portion being the largest piece at almost \$1.5 billion. The \$4.5 billion accrued liability is composed of a liability of \$2.3 billion for current retirees and \$2.2 billion for future retirees. Exhibit 2.10 shows the 1998 post-retirement health benefit liability by the type of benefit for the intermediate trend scenario.

Exhibit 2.6
Hawaii Public Employees Health Fund Employer Liabilities by Benefit Type Under Low, Intermediate, and High Trend Scenarios for 1998

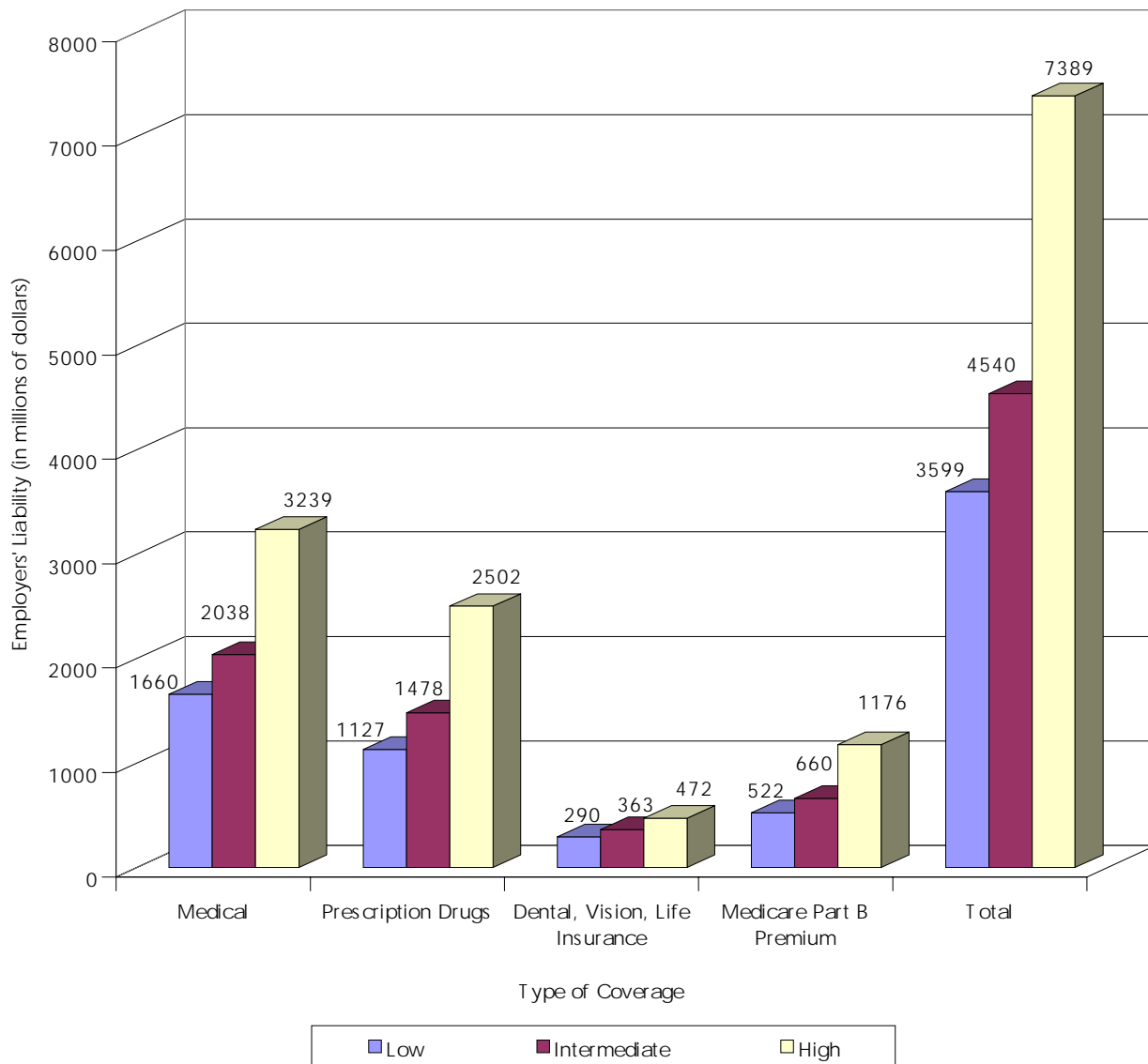


Exhibit 2.7
Hawaii Public Employees Health Fund Employer Liabilities by Benefit Type Under Low, Intermediate, and High Trend Scenarios for 2013

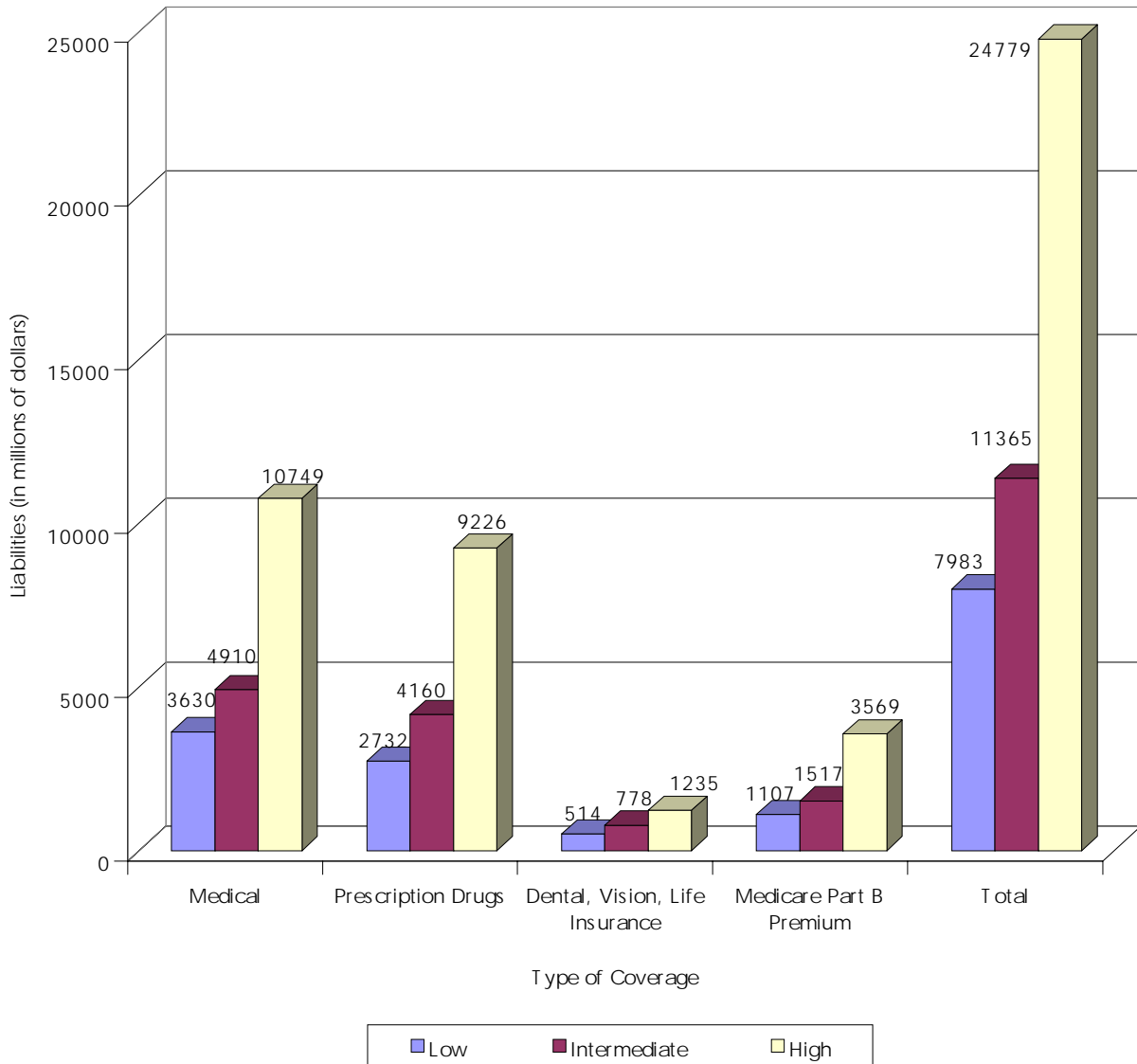


Exhibit 2.8

Employer Cost for Providing Health Fund Pay-As-You-Go Benefits for Retirees, FY1997-98 to FY2012-13

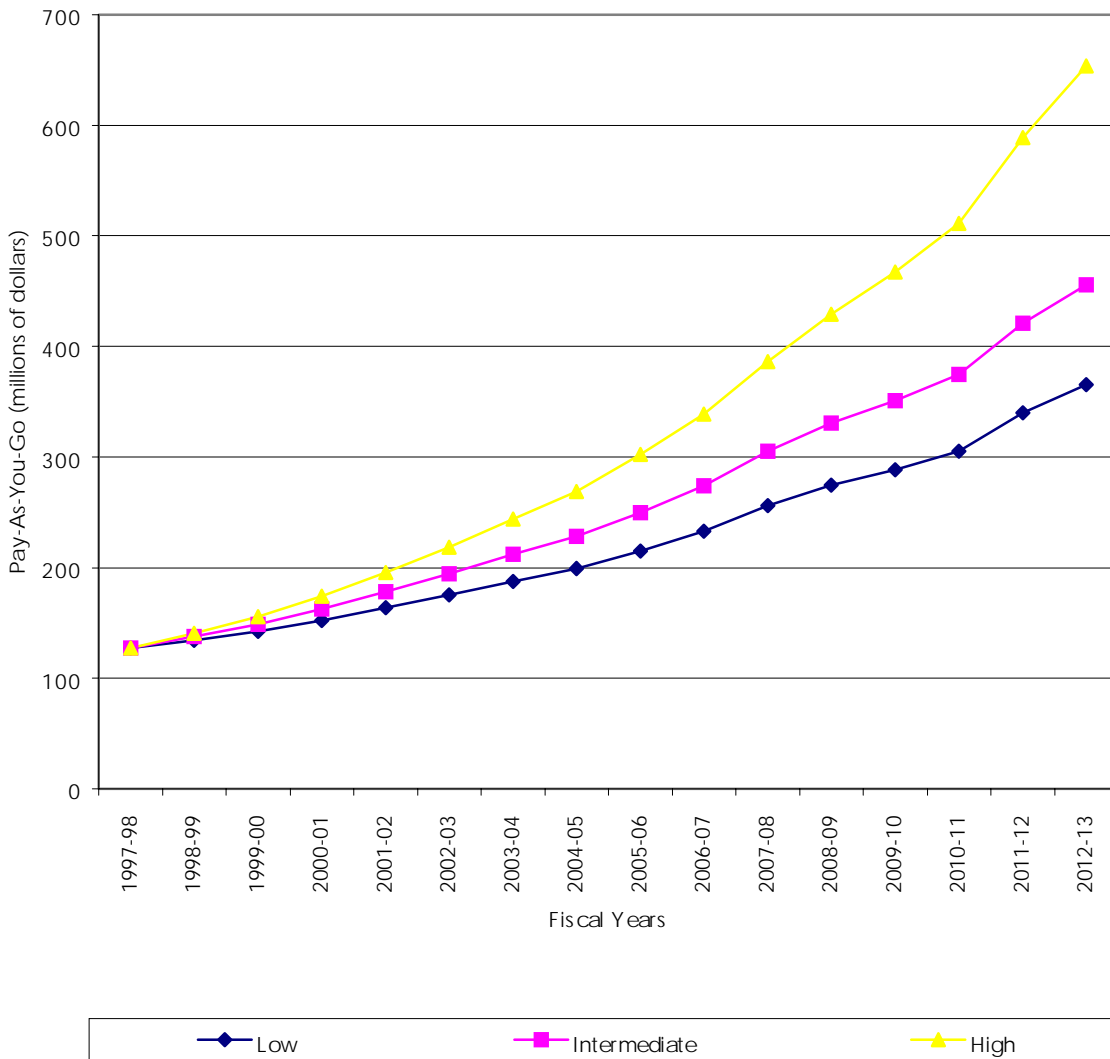


Exhibit 2.9

Employer Cost for Providing Health Fund Pay-As-You-Go Benefits for Active Employees, FY1997-98 to FY2012-13

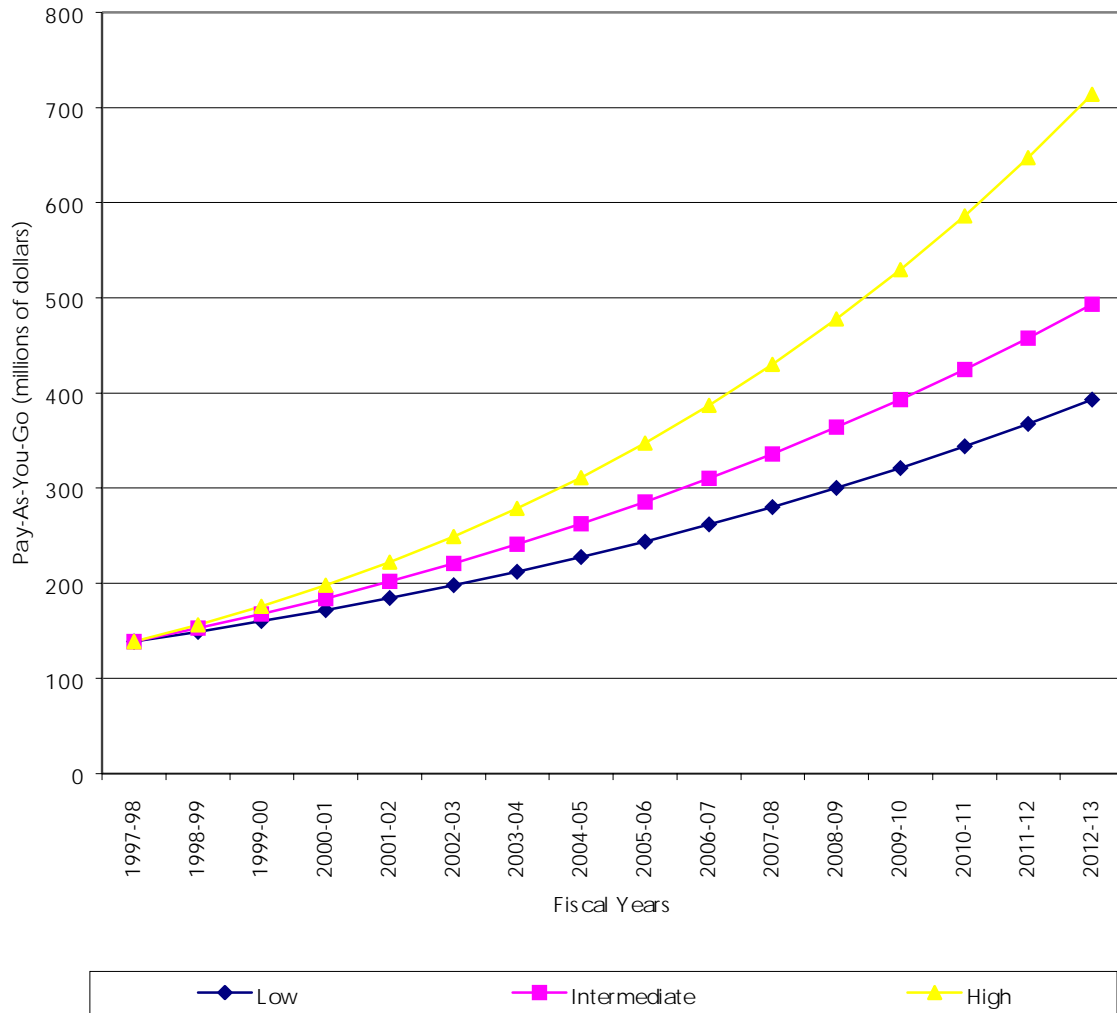


Exhibit 2.10
The 1998 Post-Retirement Health Benefit Liability by Type of Benefit (in millions of dollars)

Benefit	Intermediate Scenario Liability
Medical	\$2,039.4
Drug	1,478.4
Dental	299.5
Vision	34.8
Part B	660.4
Life	\$ 28.0
Total	\$4,540.5

The purpose of a valuation study is to determine the financial costs in the future for employers to provide the health benefit program to all employees and retirees, along with their dependents, and to calculate the liability for post-retirement benefits for these employer costs. Valuations require current claim payment levels and the likely direction of those payment levels under the various benefit plans in the future. This study incorporates different scenarios which vary the assumptions about future health care cost trends.

The valuation model of current liabilities takes into account many variables and has the ability to change variables such as inflation, health care costs, governmental reimbursement (Medicare) policy, and the discount rate of return.

The study provides an indication of the magnitude and range of the post-retirement benefit liability and the annual employers' costs of the overall program for the next 15 years.

The State may wish to consider alternatives to limit the growth of this liability

Two important considerations to keep in mind when reviewing this study and the retirement benefit program in particular are: (1) the program insures and provides 100 percent employer contribution for the retirees, who are the most costly, and only 60 percent employer contributions for the less costly active employees; and (2) the future trend of medical care costs is very uncertain, but there is general agreement that as a portion of the Gross National Product, medical care costs will continue to increase. Therefore, all indications point to a continually increasing post-retirement benefit liability over the foreseeable future.

This study reviews the financial impact of the current active and retiree health and welfare plans. The State may wish to consider other benefit/contribution design alternatives in meeting their financial and human resource objectives. Some of these alternatives are:

- Using defined contribution or defined cost plans for retiree health benefits. The current approach is to define the cost of the retiree program (e.g. 100 percent of the cost) as the retiree benefit. Consideration could be given to providing a fixed monthly contribution as the amount of the benefit following retirement;
- Providing reduced benefits for those employees who retire before age 65, since there are no offsetting Medicare benefits during those years; and
- Eliminating or reducing the employer subsidy of coverage for retirees' dependents.

Measuring the plan cost for retirees

One measure of plan cost for retirees is the accrued post-retirement benefit liability which represents the present value of the cost of future post-retirement benefits already earned (i.e., accrued) by employees, based on their prior years of service. Benefits are assumed to accrue or be earned over an employee's working lifetime from date of hire to the date of eligibility to receive a full retiree benefit. Retirees and active employees currently eligible to retire are assumed to have fully accrued their post-retirement benefits. Other active employees will have earned a pro-rata portion of the present value of the cost of future post-retirement benefits based on their service-to-date.

Employer costs for retiree benefits are expected to rise dramatically

Under all three scenarios, the employer costs for the retiree health benefits are already at a high level, \$127.4 million per year. By the year 2013, these annual employer costs are expected to be \$455.9 million for retirees under the intermediate trend scenario. Therefore, over the next 15 years and beyond, the employer costs for retirees are expected to increase significantly. These increases can be attributed to the increasing number of retirees, the aging of the retiree group, the effects of medical inflation, and increased utilization.

The projected annual employer costs for both the active and retired employees are presented in Exhibits 1, 2, and 3 of Appendix B. The costs and liabilities of both current and future retirees are as of July 1, 1997. Exhibit 4 of Appendix B shows the active and retiree enrollment associated with these projections.

We expect employer costs to continue to rise fairly dramatically in the future, if no changes are made to the overall benefit program.

Prefunding the Post-Retirement Benefit Liability: Merits Consideration

Prefunding the post-retirement health benefit liability of the Hawaii Public Employees Health Fund is an alternative which merits consideration by the State and counties. There are reasons for and against prefunding. Various actuarial cost methods for prefunding are available. There are also strategies for reducing the liability. For example, modifying the health fund's plan design is a strategy to share the burden of the health fund's costs between the employers and employees/retirees. However, future events may increase the post-retirement liability even more.

Currently, retiree health benefits under the Hawaii Public Employees Health Fund are funded on a pay-as-you-go basis. This means that the State and counties pay retiree health premiums as they are actually incurred. Prefunding methods offer a different approach which sets aside an additional amount of the employers' contribution to earn interest thereby covering a portion of future expenses as well as paying for health benefits as they are incurred. It is important to note that the liability associated with post-retirement health benefits is not altered by the funding method.

Pay-as-you-go funding produces the lowest initial annual cost and is easy to understand. However, using this method is similar to an individual covering his or her cost of living on an annual basis with no savings set aside for retirement or other needs. Costs under pay-as-you-go generally increase over time because new retirees enter the group at a rate faster than or equal to the rate that current retirees leave the group. Simultaneously, the cost of coverage is increasing due to medical inflation and other factors.

Reasons for and against prefunding

The health fund, like most other public employee health benefit funds, has not been prefunding the employers' portion of future retirees' health benefits. Reasons for prefunding retiree health benefits include:

1. Costs are more predictable and stable now and in the future.
2. Investment earnings on any accumulated employer funds can be used to help offset the cost of the retiree benefits.
3. Without prefunding, the unfunded liability continues to increase over time.

4. Employees tend to view retirement benefits, whether they are pension benefits or medical benefits, as “rights” that they have earned over their working lifetime. Having funds set aside during the working years to pay for the costs of those benefits at retirement is consistent with this view.
5. Accounting requirements already exist for private employers to recognize the post-retirement benefit liability and disclose the manner in which the liability is to be funded. Recognizing the post-retirement liability could become a requirement for government health benefit programs at some time in the future.
6. Benefits are more secure if funds have already been set aside to pay for them.

Reasons against prefunding retiree health benefits include:

1. Additional contributions are needed immediately for prefunding and these amounts are initially much larger than the pay-as-you-go costs.
2. Currently prefunding is not an accounting or statutory requirement for government programs.
3. Initially under prefunding, current taxpayers are required to pay for the cost of retiree benefits for both current and future retirees.
4. If funds are accumulated, it could change the legal nature of the State's and counties' post-retirement benefit commitment.
5. Administrative costs of the health fund would increase, if prefunding were to occur.

Various actuarial cost methods are available for prefunding

An actuarial cost method can be thought of as a vehicle used to (1) pay the pay-as-you-go costs each year and (2) put aside extra funds that can earn interest and offset future increases in payments (much like a savings account). Several widely accepted actuarial cost methods can be used by the State and counties to prefund the employers' portion of benefits. Each cost method seeks to accumulate enough assets for each employee to cover the value at retirement of his or her future expected health benefit costs. The difference between the methods is the pattern of the funding contributions (payments) made prior to retirement. For this study, we examined prefunding under three actuarial cost methods showing different patterns of payment.

All actuarial cost methods start with a calculation of the current value of each employee's expected future benefit payments during retirement. This amount is called the present value of benefits.

The first method is the Projected Unit Credit method. This method starts with lower annual costs than the following two actuarial methods. It recognizes the benefits already earned through the employees' years of service. The Projected Unit Credit method assigns the present value of benefits to employment service periods.

For example, let us assume that an employee's present value of benefits is \$10,000, with none yet funded. The individual has earned 5 years of service between the date of hire and the current date and has 15 years of service remaining until the date of retirement, for a total of 20 years of service. Under the Projected Unit Credit method, \$2,500 in assets (\$10,000 multiplied by 5 years of service earned divided by 20 years of total service) should already have been set aside for past service. The \$2,500 is known as the accrued liability. In addition, \$500 in assets (\$10,000 divided by 20 years of total service) should be set aside for service earned in the current year. The \$500 is known as the normal cost. Because we are just beginning to prefund this plan, the \$2,500 accrued liability is unfunded, and will be amortized over 30 years (with interest). The total annual cost for this employee would then be equal to \$688 (the \$500 normal cost plus the \$188 amortization of the \$2,500 unfunded accrued liability).

After the first year, any deviations in accrued liability—due for example to demographic changes, benefit plan amendments, or changes in assumptions—will be calculated each year and may be amortized over a period ranging from 5 years (gains and/or losses regarding actual benefit costs) to 30 years (assumption changes).

The second method we examined, the Entry Age Normal method, is designed to create a relatively level annual contribution. First, we calculate the present value of benefits at date of hire (unlike the Projected Unit Credit method, which uses the present value of benefits as of the current date). The present value at date of hire is smaller than the present value at any subsequent valuation date because the expected retirement benefits are the same, but they are discounted back to an earlier date.

Assume that the present value of benefits at date of hire is approximately \$7,000. This amount is then amortized over the expected working lifetime of the employee, adjusted for interest, assumed mortality and other terminations to obtain the normal cost. The expected working lifetime is equal to service from date of hire to date of retirement. For our example, assume an expected working lifetime of 13 years. The normal cost is \$538 (\$7,000 divided by 13 years). The accrued liability is the accumulated value (with interest) of all of the normal costs from date of hire to the current date (five years) and is equal to \$3,310. Similar to Projected Unit Credit method, the accrued liability at the initial prefunding date is unfunded and will be amortized over 30 years (with interest). The

total annual cost for this employee would be \$754 (the \$538 normal cost plus the \$216 amortization of the \$3,310 unfunded accrued liability).

As with the Projected Unit Credit method, any deviations in accrued liability due to demographic changes, benefit plan amendments, assumption changes, and so on, etc.—will be calculated each year and may be amortized over a period ranging from five years (gains and losses) to 30 years (assumption changes).

The third method we examined is called the Aggregate method. This method amortizes the unfunded liability faster than either the Projected Unit Credit or the Entry Age Normal methods. However, after 15 years the total annual cost is less than the annual costs for either of the two methods discussed earlier. Under this method, the cost for the employee in any given year is equal to the normal cost, with no amortization of the initial unfunded liability. The normal cost is defined as the excess of the present value of benefits at the current valuation date, over the asset value, amortized over the remaining working lifetime of each employee.

In our example, the present value of benefits at the current date is \$10,000 and there are no assets. The remaining working lifetime is equal to service from the current date to date of retirement.

If we assume a lifetime of ten years, the normal cost (adjusted for interest, mortality, and other terminations) is therefore \$1,000 (\$10,000 divided by ten years).

In the first year, FY1997-98, the cost under the Projected Unit Credit method, \$489 million, is the lowest of the three methods, but will increase as the population ages, to \$579 million in FY2012-13. Costs under the Entry Age Normal method are \$553 million in FY1997-98, should remain relatively level over time, and reach \$586 million in FY2012-13. Costs under the Aggregate method begin at \$692 million and should decrease over time, to \$455 million in FY2012-13.

The pay-as-you-go approach is expected to exceed the annual cost under the aggregate method in the year 2013. It is likely to exceed both the Projected Unit Credit and Entry Age Normal annual costs within about the following five years or so. The following Exhibit 2.11 and Exhibit 2.12 compare the total annual cost under each of the three actuarial prefunding methods of retiree health benefits, under the intermediate trend scenario.

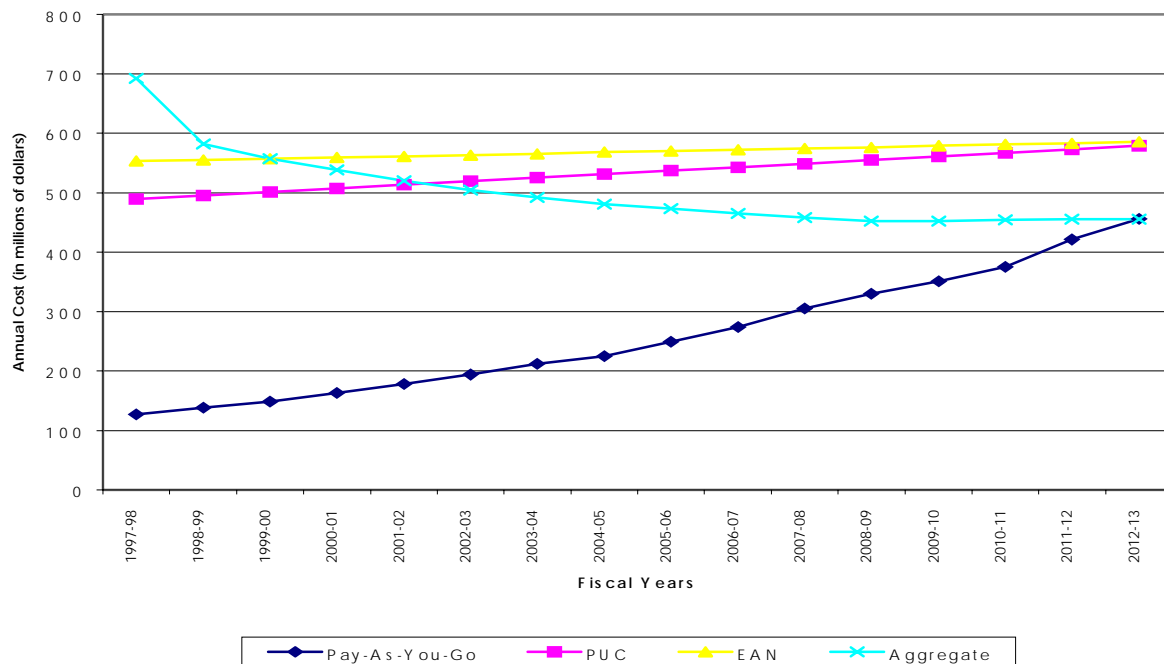
Exhibit 2.11

Year-by-Year Comparison of Projected Annual Costs for Pay-As-You-Go and Prefunding Methods (in millions of dollars)

Fiscal Year	Pay-As-You-Go	Prefunding Method		
		Projected Unit Credit (PUC)	Entry Age Normal (EAN)	Aggregate
1997-98	127	489	553	692
1998-99	138	495	555	582
1999-00	149	501	557	557
2000-01	163	507	559	538
2001-02	178	513	561	520
2002-03	194	519	563	504
2003-04	212	525	565	492
2004-05	225	531	568	481
2005-06	249	537	570	473
2006-07	274	543	572	465
2007-08	305	549	574	458
2008-09	330	555	576	452
2009-10	351	561	579	452
2010-11	375	567	581	454
2011-12	421	573	583	455
2012-13	456	579	586	455

Exhibit 2.12

Comparison of Prefunding Methods and Pay-As-You-Go Projected Annual Costs (FY1997-98 to FY2012-13)



Possible strategies to reduce the liability

There are a number of strategies that the health fund could consider to reduce future cost increases and prevent further escalation of the post-retirement benefit liability. These begin by reassessing the objectives and purposes of providing retiree health benefits, and how they fit with the objectives of the health fund, the government agencies participating in the program, and the unions.

A decision to modify the plans and manage the risk on a continuing basis ought to follow such an evaluation and a decision to continue the benefits in some form for each of the various categories of beneficiaries. A number of strategies to consider in managing the future liability include the employer contribution, plan design, communication, Medicare Risk and Medicare + Choice, early retirees, limiting employer contributions, limiting the contribution to the state level for mainland rate retirees, eliminating the subsidy for Medicare Part B premiums, and limiting contributions for retirees' dependents.

Employer contribution

Exhibit 2.13 shows estimates of employer contribution levels (expressed as a percent of total costs) for all 50 states. This information is based on the 1998 State Employee Benefits Survey performed by Workplace Economics, Inc. and the 1996 Survey of State Employee Health Benefit Plans performed by the Segal Company. In some cases, updated rates have been obtained during this study directly from state agencies. This information has not been audited.

Fifteen states do not provide any post-retirement health care benefits for early retirees (no information was available for Georgia and Ohio). This drops to 13 (or 14, no information available for Indiana) for retirees eligible for Medicare. About 19 or 20 states pay a lower percentage of the employer contribution for early retirees than for normal retirees, including those also eligible for Medicare. Also in most cases the employer contribution percentage is lower for family (or dependent) coverage than it is for employee or retiree coverage.

Hawaii's employer contribution percentage is very much on the high end of the range for retiree benefits but on the very low end for active employee benefits. Hawaii may wish to consider bringing its employer contributions more in line with the other state programs. This would mean raising the contributions for active employees and lowering the contribution for the retirees.

The median line entry at the bottom of Exhibit 2.13 shows the employer contribution levels that would place Hawaii at the midpoint for all states. For example, for retirees with Medicare, this would lower the employer contributions to 75 percent for single coverage and 50 percent for family

Exhibit 2.13

State/Public Employees Health Plans, Employer Contribution (As Percent of Total Cost)

State	<u>Retirees</u>					
	<u>Active</u>		<u>Without Medicare</u>		<u>With Medicare</u>	
	Single	Family	Single	Family	Single	Family
Alabama	100%	61%	48%	22%	100%	50%
Alaska	100%	100%	100%	100%	100%	100%
Arizona	98%	85%	59%	42%	100%	88%
Arkansas	74%	48%	0%	0%	0%	0%
California	64%	58%	64%	58%	96%	100%
Colorado	83%	61%	72%	29%	100%	50%
Connecticut	84%	77%	100%	100%	100%	100%
Delaware	87%	86%	100%	98%	100%	100%
Florida	84%	74%	28%	12%	71%	35%
Georgia	84%	75%	N/A	N/A	84%	75%
Hawaii	60%	60%	100%	100%	100%	100%*
Idaho	98%	87%	0%	0%	0%	0%
Illinois	94%	76%	100%	81%	100%	100%
Indiana	96%	84%	0%	0%	N/A	N/A
Iowa	100%	69%	0%	0%	0%	0%
Kansas	75%	75%	0%	0%	0%	0%
Kentucky	85%	48%	75%	43%	75%	38%
Louisiana	50%	50%	77%	77%	50%	50%
Maine	100%	80%	100%	49%	100%	50%
Maryland	80%	80%	80%	80%	80%	80%
Massachusetts	85%	85%	81%	81%	85%	85%
Michigan	95%	95%	95%	95%	100%	100%
Minnesota	100%	88%	0%	0%	0%	0%
Mississippi	100%	40%	0%	0%	0%	0%
Missouri	73%	32%	4%	2%	8%	4%
Montana	100%	81%	0%	0%	0%	0%
Nebraska	88%	82%	0%	0%	N/A	N/A
Nevada	100%	59%	62%	37%	100%	50%
New Hampshire	100%	100%	100%	100%	100%	100%
New Jersey	100%	100%	100%	100%	100%	100%
New Mexico	69%	68%	69%	25%	53%	26%
New York	90%	81%	90%	81%	90%	90%
North Carolina	100%	40%	100%	40%	100%	50%
North Dakota	100%	100%	0%	0%	0%	0%
Ohio	90%	90%	N/A	N/A	N/A	N/A
Oklahoma	100%	36%	32%	11%	63%	32%
Oregon	100%	100%	25%	22%	64%	32%
Pennsylvania	100%	100%	100%	100%	100%	100%
Rhode Island	90%	93%	50%	18%	50%	25%
South Carolina	90%	64%	90%	32%	100%	50%
South Dakota	100%	47%	0%	0%	0%	0%
Tennessee	79%	79%	60%	60%	16%	8%
Texas	100%	67%	100%	34%	100%	79%
Utah	100%	100%	100%	100%	0%	0%
Vermont	80%	80%	80%	80%	80%	80%
Virginia	95%	67%	23%	8%	40%	20%
Washington	100%	90%	0%	0%	18%	18%
West Virginia	95%	89%	0%	0%	0%	0%
Wisconsin	90%	90%	0%	0%	0%	0%
Wyoming	100%	44%	0%	0%	0%	0%
Median	95%	80%	61%	31%	75%	50%

*Hawaii's approach to the employer contribution for retiree health benefits has recently been modified somewhat, as explained in the text.

coverage from its current level with full qualification of 100 percent for both. This strategy would also significantly reduce the post-retirement benefit liability.

In the past in Hawaii, the entire cost of retiree health benefits was paid by the employer. Over time changes were made so that full employer contributions will be made only for those retirees with a minimum of ten years of government employment service. Currently, for employees hired after July 1, 1996, there is a graded schedule so that full employer contributions will result only for those employees with a minimum of 25 years of service. However, all hires before July 1, 1996 still require only ten years of service for the 100 percent employer contribution. Even with these changes the health fund's employer contributions for retirees is among the highest in the nation, as shown in Exhibit 2.13. One possible change to consider in this area is to implement the grading to 100 percent employer contribution for 25 years of service for all retirees immediately rather than to apply it only to employees hired after 1996. This would reduce the accrued liability estimate by approximately \$300 million from \$4.5 billion to \$4.2 billion.

Plan design

The plan can be redesigned, possibly both for current retirees and for future retirees. The plan could also be reviewed to determine if the types of health care services covered and the related plan limitations are appropriate and effective for the retirees. The plan provides essentially the same coverage for actives and retirees, yet their medical needs can be significantly different. One area for consideration is the pharmacy benefit for retirees. It is common among private employers to limit this benefit for retirees. Consideration can be given to using an annual limit, such as \$2,000, for the pharmacy benefits.

Communications

Good communications can improve awareness of and enhance the effective use of the medical plan and medical care in general. This is particularly important for retirees, who tend to use more medical care.

Medicare Risk and Medicare + Choice

Medicare Risk and Medicare + Choice plans are a health maintenance organization approach to providing medical care for eligible retirees. In general, participants have access to more services and benefits than are typically available through Medicare alone. Costs are controlled through the health plan providing needed services under a fixed rate agreement with Medicare. HMSA has recently introduced a Medicare + Choice product in the marketplace. Perhaps other health plans may decide to do the same. These types of programs should be considered as possible

options to help reduce retiree costs and liabilities. Currently, only Kaiser offers a Medicare Risk option to the health fund. Unfortunately, its cost is higher than the HMSA Medicare Supplement plan and therefore does not help to reduce retiree costs.

Early retirees

Most states have a lower employer contribution as a percent of total costs for employees who retire prior to age 65 than Hawaii's percentage, as shown in Exhibit 2.13. The annual premium cost for these early retirees is generally higher than the annual cost for those over age 65 because early retirees do not have the benefit of the Medicare subsidy. Therefore, Hawaii may wish to consider a lower employer contribution for early retirees in its program as well.

All retirees aged 65 or older must opt for full Medicare coverage

There are currently about 540 retirees and spouses of retirees above age 65 who have not taken Medicare Part B (i.e. the non-hospital portion of Medicare). In those cases, the health fund pays a much higher premium to carriers to additionally cover those costs that would normally be covered under Medicare. It should be a requirement that all retirees over age 64 must opt for Medicare Part A and Part B. The Board of Trustees is aware of the advantages of this requirement and has sponsored a bill in the 1999 legislative session to require Medicare enrollment. In any event, the employer contribution should be no greater than the amount that would be contributed if there was full Medicare coverage after a retiree attains the age of 65.

Subsidy for Medicare Part B premiums

Of the 16 state benefit programs included in our survey only Massachusetts currently provides a Medicare Part B premium subsidy. Based on the intermediate cost trend scenario, the Part B premium subsidy alone is estimated to be about 15 percent of the total accrued liability in 1998. Consideration could be given to eliminating this subsidy. It may be necessary to apply this approach only to future retirees. Even if this is limited to future retirees only, it would eliminate about \$300 million from the accrued liability estimate in 1998 and over \$700 million in 2013 based on the intermediate cost trend scenario.

Limit contributions

Employer contributions for active employees are limited to 60 percent of the health fund's HMSA premium. However, the definition of employer contributions for retirees is X percent of any plan the retiree chooses. For example, in the case of a retiree who qualifies for the 100 percent

employer contribution, it is 100 percent of the HMSA premium, 100 percent of the Kaiser premium or 100 percent of the Kapi'olani Health Plan premium. Consideration should be given to using an approach similar to the actives, where the percentage is applied to the largest in enrollment or, preferably, lowest cost retiree plan. Then that dollar amount defines the employer contribution for retirees.

Retirees on the mainland

Some Medicare Risk plans on the mainland have a much lower premium than might be the case in Hawaii. For example, the following Exhibit 2.14 shows the Kaiser premium under the California Public Employee Retirement System (CalPERS) program in California compared to the Kaiser premium in Hawaii for the health fund.

Exhibit 2.14
Comparison of Kaiser California and Kaiser Hawaii Premium Rates

	<u>Kaiser Hawaii</u>	<u>Kaiser CalPERS</u>
Single	\$82.56	\$46.71
Employee + 1	\$247.64	\$93.42
Employee + 2 or more	\$247.64	\$140.13

While the CalPERS benefits may be somewhat different, which may justify some of the cost difference, it is likely that the California Kaiser rate for the Hawaii government retirees residing in California would still be much lower than the Kaiser Hawaii rates. Therefore, for any retirees choosing Kaiser and residing on the mainland, the health fund should require that the mainland rate apply for those retirees.

Definition of dependents

The plan pays benefits to retired former employees and their dependents for life. An examination of the dependent definition may indicate some areas where tightening, at least for future dependents, is in order.

Future events may increase the liability even more

In managing the liability, it is necessary to consider risks that will affect the future cost of the benefits. Depending on the plan design, either the employer or the employee may be more vulnerable to specific risks. Among the possible risks, two major areas to closely monitor are future health care cost increases due to changes in the use of medical services and new technology, and the potential that the Medicare eligibility age will be increased.

Future health care cost increases, utilization changes and technology

These risks are divided between the employees and the employers on a prorated basis according to the applicable cost sharing percentage. The health fund shares this risk with Medicare for those individuals aged 65 and above. In these cases there would be no risk to the employees or retirees as long as the employer contribution is at 100 percent.

Increasing eligibility age for Medicare benefits

Increasing the eligibility age for Medicare benefits would produce a significant increase in the health fund program cost, depending on the age level for Medicare eligibility. Because of the lack of prefunding and the current financial difficulties within the Medicare system, this is a very real possibility for the future and continues to be discussed as a potential solution to Medicare's problems.

All of these risks can be addressed to a greater or lesser degree in plan design. None of the strategies can eliminate the risks, but they can help share the burden of the health fund's costs between the employer and employees/retirees. The key issue is to define the share of the risk which is to be borne by the State and counties through the health fund. It is also extremely important to communicate clearly in the Summary Plan Description each year and at the time of an employee's retirement that the benefit program is not guaranteed and is subject to change in the future.

HMSA Medical Plan Rate Increases and Rate Stabilization Reserve Practices Need Attention

Medical cost experience is subject to random statistical fluctuations from year to year. To address this issue, it is common for experience-rated programs like the health fund HMSA medical plans to establish a reserve fund whereby some of the surpluses in "good" years would be set aside in that fund to cover deficits in "bad" years, so that the fluctuations in the annual financial results can be excluded to some extent in setting the premium rates. The maximum amount accumulated in this reserve fund is usually subject to a limit, for example, 15 percent to 25 percent of the annual premium, deemed sufficient to cover potential annual fluctuations. Due to this stabilizing effect, these reserve funds are often called "rate stabilization reserves."

Effective July 1, 1993, the health fund HMSA plans did include provisions for the establishment of rate stabilization reserves. Under the active employees medical plan, annual contributions ranging from \$7 million to \$10 million were to be made available in the rate stabilization reserves to cover potential experience deficits. The retiree plan called for a maximum of \$8.5 million in rate stabilization reserves. However, Exhibit 2.15 shows that only \$5.2 million was allocated to the active plan rate stabilization reserves (not including accumulated interest), and a charge of \$2.1 million made against it to cover the FY1996-97 deficit. For the retiree plan, there was no rate stabilization reserve allocation. The State Legislature had decided to refund most of the past experience surpluses to the employers but not the employees portion of the excess reserves. It is possible that due to the almost routine large annual surpluses developed since FY1991-92, the rate stabilization reserve buildup was not considered necessary.

In order to assess the overall adequacy of the premium rating process, we have analyzed the financial experience of the health fund's HMSA medical plan over the last nine years. Exhibit 2.15 summarizes that experience in terms of the volume of annual premiums, the rate of premium increases and the adequacy of the premium rates in light of the underwriting results (surplus or deficit). The experience was analyzed separately for active employees and retirees, due to partial or full employer funding.

For the active employees health benefit plan, the annual rate increases tended to be relatively high up to FY1993-94. There were no rate increases for the following three years, followed by a high and a low increase for the last two years, respectively. For the retiree plan, the rate history followed a similar pattern, except that there was a substantial rate decrease for the last year. Exhibit 2.16 depicts the rate history for active employees. Exhibit 2.17 depicts the rate history for non-Medicare and Medicare retirees.

Given the size of the health fund, this pattern of historical rates appears somewhat unstable. More importantly, the historical premium levels have in most years produced substantial underwriting surpluses, suggesting that the rate increases tended to be higher than required. Although the excess employers' share of the premiums was returned to the health fund, there would still have been advantages to having more appropriate rate levels so that the rates that would be closer to the actual program costs. It is possible that HMSA's renewal rating approach considered the potential adverse selection to its health fund plan as a result of the competition from union plans and that part of the reason for the rating conservatism was an overestimation of the impact of this anticipated adverse selection.

Exhibit 2.15

HMSA Medical Plan Experience Summary (FY1989-90 to FY1998-99)

	Plan Year									
	FY1989-90	FY1990-91	FY1991-92	FY1992-93	FY1993-94	FY1994-95	FY1995-96	FY1996-97	FY1997-98	FY1998-99
Active Employees										
Premium Paid (\$000)	\$41,053	\$49,526	\$65,552	\$76,610	\$87,583	\$77,579	\$53,161	\$48,361	\$47,592	
% Rate Increase From Prior Year		10.0%	26.0%	10.5%	8.2%	0.0%	0.0%	0.0%	12.0%	1.9%
Experience Surplus (Deficit) (\$000)	(\$1,710)	\$383	\$5,323	\$11,891	\$13,761	\$5,944	\$1,736	(\$1,807)	\$3,410	
Annual Surplus (Deficit) % of Premium	-4.2%	0.8%	8.1%	15.5%	15.7%	7.7%	3.3%	-3.7%	7.2%	
Contribution (Charge) To Rate Stabilization Reserve (\$000)					\$5,196			(\$2,053)		
Retirees										
Premium Paid (\$000)	\$22,299	\$23,497	\$30,212	\$34,743	\$42,322	\$44,722	\$49,188	\$52,797	\$57,089	
% Rate Increase From Prior Year										
Non Medicare Retirees		8.7%	17.5%	11.4%	42.2%	0.0%	0.0%	10.0%	7.0%	-2.0%
Medicare Retirees		8.7%	15.1%	11.3%	-5.5%	0.0%	0.0%	10.0%	7.0%	-18.5%
Total		8.7%	16.0%	11.3%	12.2%	0.0%	0.0%	10.0%	7.0%	-10.8%
Experience Surplus (Deficit) (\$000)	\$2,068	(\$1,105)	\$2,552	\$4,504	\$5,850	\$4,814	\$5,807	\$4,220	\$9,190	
Annual Surplus (Deficit) % of Premium	9.3%	-4.7%	8.4%	13.0%	13.8%	10.8%	11.8%	8.0%	16.1%	

Exhibit 2.16

Rate History for HMSA Medical Plan, Active Employees, FY1989-90 to FY1998-99

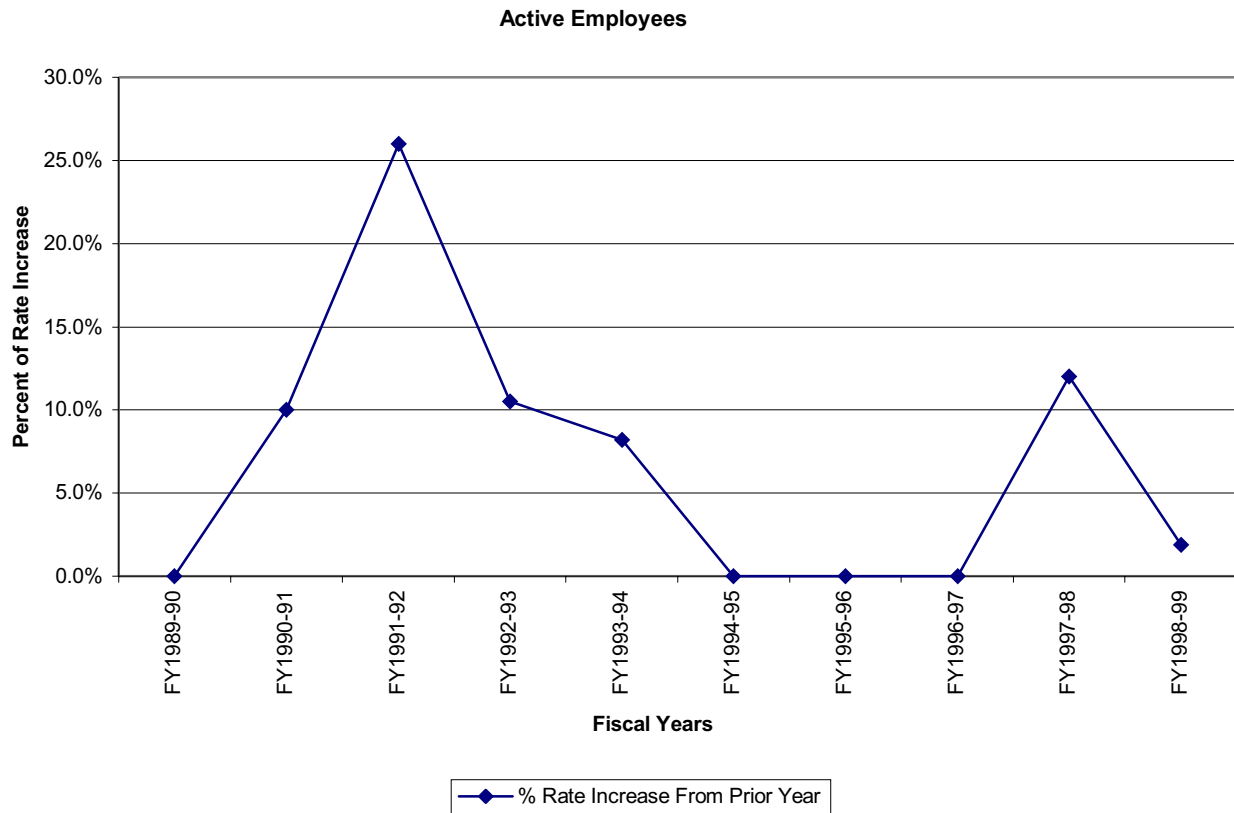
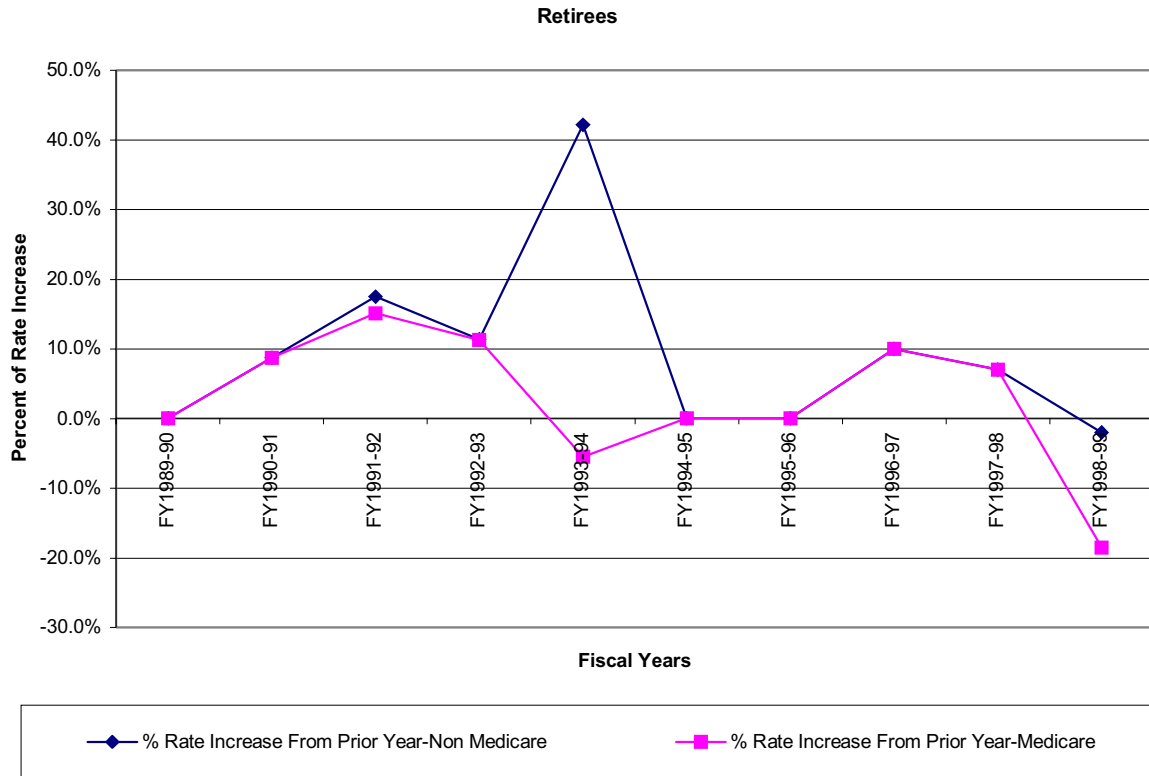


Exhibit 2.17
Rate History for HMSA Medical Plan, Medicare and Non-Medicare Retirees, FY1989-90 to FY1998-99



Based on our review of the health fund HMSA medical plans experience over the last nine years, we recommend analyzing the rate renewal process and the past experience in greater detail to develop a better projection of future program costs and setting the premium without undue conservatism. One way to accomplish this is to use a self-funded, experience rated approach for the health fund's largest plan where the health fund itself bears the risk of potential deficits in a plan year.

Recognizing that deviations from projected experience do occur, provisions should be made for reasonable surplus reserving and deficit recoupment over time. For instance, a typical agreement would provide that annual surpluses up to 3 percent of premiums be set aside in the rate stabilization reserves, until it reaches 15 percent of the current annual premium. Annual deficits would be charged against available funds in the rate stabilization reserves or carried forward if funds are insufficient, for up to three years after which any remaining deficit would be written off. This could be a reasonable approach for the health fund.

To enhance the financial stability and predictability of the health fund program the experience rating agreement should include *all* health fund program eligible participants by eliminating the separate union plans.

Features and Strategies Used by Other States Merit Consideration

Features and strategies used by other states merit consideration. Some states have a governance approach that is more flexible than the Hawaii Public Employees Health Fund. Two states have adopted an employer-union trust for their public employee health benefit programs. Funding, administration, and benefits in other states offer alternatives for the State and counties to consider.

The Board of Trustees of the Hawaii Public Employees Health Fund has the statutory responsibility to carry out the fund's functions. However, statutory limits affect the board's flexibility to provide coverage, benefits, and funding. We examined other states' health benefit programs and identified features such as employer-union governance approaches, financial management, administration, and benefit strategies which merit further consideration. Appendix C provides more detail on the state programs we surveyed.

Health care and health benefit programs have changed dramatically over the past 15 years. Managed care has replaced fee-for-service (indemnity) coverage as the dominant form of health benefit coverage in the nation, largely in response to sharp increases in health care costs. This shift to managed care has occurred not only for employer-sponsored health coverages but also for federal programs like Medicare and Medicaid. The shift has spawned new and diverse health care service organizations, all competing for growth in membership. This environment requires that purchasers of health care benefits be knowledgeable and have the flexibility to make necessary decisions and changes quickly in order to take advantage of cost saving opportunities and avoid situations that could increase costs unnecessarily.

Some states have a governance approach that is more flexible

State health benefit programs are governed in a variety of ways. This section includes other descriptive information pertaining to governance such as trustee qualifications and authority. Interest in an employer-union trust approach to governing the health fund led to identifying two states which have structured their governing boards so that there is equal representation of employer and employee representatives.

As in Hawaii, most of the state health benefit programs in our survey are governed by a board of trustees. Board size ranges from six members (in Texas) to 13 (in California and New Hampshire). Board members' terms appear to range from three to four years.

Boards typically have *ex-officio* members (they are appointed to the board by virtue of another state office that they hold). Most commonly appointed as *ex officio* board members are a state's comptroller, treasurer, director of human resources, insurance commissioner, and director of health. In a few states, the attorney general and the secretary of state are *ex officio* members. Some board members are appointed by the governor or the state legislature. Typically, board members are also selected from certain employee groups or unions covered under the health benefit program. These members include active employees, retirees, representatives of employee organizations (unions), or individuals employed by a government agency, such as school districts, police departments, and fire departments.

Of the Hawaii health fund's nine trustees, three must be representatives of employee organizations (unions) representing public employees, three must be from different private business organizations, and one member of the clergy, one teacher, and the state director of finance or a designated representative. Some of the health fund's trustees expressed that the learning curve to understanding the health fund and health benefits is challenging for a lay board. Health benefit programs are complex and require specific knowledge and expertise. We believe it would be beneficial to require some board members with previous expertise with health benefit programs or finance. For example, Arizona requires that one trustee have experience in economics or financial expertise such as a university professor of economics or health benefits.

Some states exert more control over the board by requiring that most or all of the members be appointed by the governor, state legislature, or be *ex officio* (Michigan, Missouri, Oregon). Other states appear to have membership-driven governance by having most of the members elected by the state employees/retirees (New Hampshire, New Mexico), and some attempt to strike a balance between the two (California, North Dakota, Texas).

The limited data available makes it difficult to reach general conclusions about the authority of boards. However, other states seem to have greater latitude with regard to the authority of the board and the state agency administering the program regarding benefit determination than in Hawaii. For instance, Pennsylvania's benefits are determined by its Board of Trustees, not by state law. In Oregon, state law provides for a health plan for state employees, however, its board decides the actual components and design of the various health benefits offered.

Most states give the board policy-making authority except in the areas of benefit determination and amount of employer contributions. Health benefit boards generally need approval from a state legislature before adding, deleting, or modifying significant benefit provisions, particularly in states where benefit provisions are determined by state statute.

The health and welfare benefit programs in Oregon and Pennsylvania are governed by a board with employer (state or local government) and union representation. Oregon and Pennsylvania require the unions and the public employers to be equally represented on the board.

Oregon recently established an employer-union trust

Oregon's employer-union trust program approach was established in May 1997, and became operational on January 1, 1998. The new program replaced two separate union-sponsored health benefit programs that were in effect before 1998, one that covered state employees represented by one large union and the other that covered employees represented by 12 other smaller unions, non-represented employees, and management. Oregon's program mainly covers active employees. Retired employees are covered under a separate program provided through the Oregon Public Employees Retirement System. Oregon's board of trustees has equal representation from unions and employers. This governance approach and the creation of a single large health benefit program was intended to achieve administrative efficiencies and enhance the program's negotiating leverage with the insurance carriers.

Pennsylvania has used an employer-union trust approach since 1988

The Commonwealth of Pennsylvania and a number of unions entered into an agreement and established the Pennsylvania Employee Benefit Trust Fund in 1988. Additional unions joined the trust in the following year. Effective July 1, 1997, the trust fund and the commonwealth agreed to include management positions in its program. Pennsylvania abandoned the use of multiple competing union health benefit plans and moved to a single statewide program to achieve administrative efficiency, greater negotiating leverage, and lower health program costs overall.

Funding

Like Hawaii, most other states fund their health benefits through a combination of employer and employee or retiree contributions. Public employer contributions are generally set by statute, or are a part of the budgeting process, and/or are subject to collective bargaining agreements. The employer contribution can be a fixed rate per month or a percentage of the total premium charged by the carriers or health plans.

However, unlike Hawaii, more than 25 percent of the states provide no employer contributions for retiree health benefits. For retirees, states usually contribute lower amounts than for active employees. Also, the employer contribution levels for early retirees (those retiring before age 65) are generally lower than for retirees eligible for Medicare. Exhibit 2.13 shows the portion of benefit costs paid by the employer for

each state. Note that at 100 percent, Hawaii's employer contributions for retirees (along with several other states) are among the most generous in the nation.

In some states, like Hawaii, health benefit coverage is fully insured; other states are self-insured. Health maintenance organizations (HMOs) provide pre-paid health coverage and tend to be fully insured. Where preferred provider organization (PPO) or indemnity benefits are offered, these tend to be either self-funded or fully insured with premium rates based upon prior costs (experience rating) of an employer group. Alaska is the only state we encountered with some prefunding of the post-retirement health benefit liability.

Only Colorado had readily available data on excess contributions and rate stabilization reserves. In Colorado, the state treasurer exercises control over expenditures, reserves, and investing excess funds. Because trust funds are not considered a part of the state's general fund, trust funds are outside the control of the state legislature. In general, when employee benefit trust funds are established, the trust agreements typically specify the purpose(s) for which contributed funds are to be used. Therefore, excess funds accumulated would generally be available only to provide benefit coverage for employees, retirees, and their dependents and could not be withdrawn for other purposes.

Administration

As in Hawaii, most of the programs were established by state law, have existed for many years, are administered by state agencies and were established as trust funds. Unlike Hawaii, in some states the same agency administers both the retiree pension program and the health benefits program (although the two functions are performed by two different divisions of the agency).

In health benefit programs, day-to-day administration is the responsibility of the department of human resources or another state agency. This agency usually sets up a division for employee/retiree benefits, with subdivisions handling specific administrative functions such as premium collection, benefit eligibility determination, financial reporting, and information technology. At least one state, South Dakota, outsources these administrative tasks to a third-party administrator. Typically, a state agency collects contributions, pays premiums to carriers, and determines eligibility. Some agencies also provide customer service assistance to public employer groups. Claims administration is usually performed by the individual carriers. The carriers provide customer service to members, with the state agencies also available to provide assistance to employees and retirees.

Based on the usefulness of their web sites and the availability of information related to their information technology practices, California,

Connecticut, Missouri, Oregon, South Dakota, and Texas appear to have the highest degree of computerization, especially California, Oregon, and Texas. These states probably produce their own reporting, while others specifically stated that they rely on their insurance carriers for the reporting used to make financial and benefit related decisions.

It is difficult to make any generalizations regarding management controls. Connecticut monitors its health care providers and utilization of services by members. Missouri monitors providers, tracks statistical information related to utilization by members, and tracks health care trends. New York monitors providers, tracks health care trends, and provides input on the impact of state legislation related to health benefits. West Virginia regulates the level of payments made to health care providers such as hospitals. California has extensive information on its management control structure. On renewal, carriers go through a rigorous rate renewal negotiation process. Some states have created committees that address financial oversight, investments, information technology, benefits, program administration, and strategic planning.

Benefits

In most of the states we surveyed, all full-time active employees working more than 20 hours per week are eligible for health benefits. Most cover employees in permanent, not temporary positions. Some have a 30-day waiting period before health coverage is provided. In general, dependents and employees on disability are also eligible.

Eligibility for retiree health benefits is usually based on eligibility for state pension benefits.

While benefits are usually determined by state statute, a few states determine benefits through collective bargaining. Rate and benefit negotiations with carriers are usually performed by a state agency or the board of trustees.

Unlike Hawaii, none of the states in our survey have union plans competing with other plans offered directly by the program. Therefore, benefits offered by other state health benefit programs are the same for all eligible members.

Indemnity, PPO, and HMO medical plans are usually available in the western states while midwestern and eastern states offer indemnity/PPO plans only. Pharmacy coverage is offered as an integral part of the medical plans or as a separate option. Some states offer dental plans, while relatively few appear to offer vision benefits.

Medicare Supplement and Medicare HMO medical plans are usually available in the western states, while midwest and eastern states offer Medicare Supplement only. Relatively few appear to offer dental benefits to retirees.

The examples and features discussed above may be useful in considering alternative approaches and future strategies for the Hawaii Public Employees Health Fund. These need to be examined further for their long-term financial viability and applicability to the State's and counties' current and future goals and environment for public employee and retiree health benefit program. We also believe that the employer-union trust models in Oregon and Pennsylvania should be given special consideration in exploring the future of the Hawaii Public Employees Health Fund.

Conclusions

1. The current health fund approach with competing union plans results in higher employer contributions than would be the case if there was only one statewide program. Union plans tend to attract a lower cost active employee group, while higher cost employees tend to remain in the health fund.
2. Because of the lack of financial information about the union plans, it is impossible to get a clear financial picture of the overall benefit program for public employees. The overall cost increase shown in the health fund's annual report is not correct and has been significantly understated in recent years.
3. The post-retirement benefit liability for the health fund has increased five-fold over the past ten years and is likely to increase by more than 250 percent over the next 15 years.
4. Pay-as-you-go costs will continue to escalate in the future for both active employees and retirees. Employer contribution costs are about \$266 million for 1998. These costs are projected to increase to \$949 million over the next 15 years.
5. Prefunding the post-retirement benefit liability will at least stop or greatly curtail the year-to-year cost increases of both the unfunded liability and annual costs for the retirees' health benefits.

Recommendations

1. The health fund program and all of the union programs should be combined into one overall program. This will reduce and possibly even eliminate the potential adverse selection in the current approach. In addition, it should increase the overall program's negotiating

leverage with health plans and create economies of scale. An employer/union trust fund approach is a reasonable way to accomplish this end.

2. As long as there are competing public employee health benefit plans, annual financial reports need to clearly show the underlying cost increases in the program, including the effect the union plans have on overall costs. This would require a much better understanding of the costs of the union plans than is now available to the health fund.
3. The health fund should be given more authority and flexibility to deal with the dynamics of the health care marketplace. Requiring legislative approval for simple changes to the program, such as moving to a multi-tiered contribution approach from a two-tier approach, results in a program that is not able to react to the marketplace. We believe a common view held for other state programs is that the state supplies funds, by defining the level of employer contributions and the boards, along with their administrative agency, determine the most cost effective means to utilize those funds.
4. Consideration should be given to restructuring a board to oversee a single program approach for the Hawaii Public Employees Health Benefit program. The size of the board is not necessarily of great importance, as is shown by the great variety in other state programs ranging in size from four to 13 trustees. However, there should be relatively equal representation between unions and government employers, if it is to be a joint union/employer trust or similar program. Some knowledge of employee health benefit programs and their financing should be required for at least some of the members of the board.
5. More carriers should be encouraged to participate in the program. The requirement of statewide service capabilities should be removed to allow qualified regional plans to participate in their service regions. This will create greater competition among health plans and should result in more competitive rates.
6. Medicare Risk and Medicare + Choice plans should be considered for retiree options as more of these kinds of programs become available. At times these can be more cost effective than Medicare Supplement coverage. Therefore, it is important to monitor these programs as changes occur both within the Medicare system and in the state.
7. Employer contributions for retiree coverage under the program are among the highest in the country. Because of the magnitude of the accrued post-retirement benefit liability, consideration should be given to reducing employer contributions for retirees in certain areas, which would reduce this liability. Some possibilities for future consideration

for such reductions include the Medicare Part B premium subsidy; contributions for spouses of retired employees and/or early retirees; limiting contributions to a percent of the cost of the lowest cost plan; contributions determined under the assumption that each retiree has both Medicare Part A and Part B coverage for those at age 65 and above; and contributions for retirees who reside on the mainland.

8. The amount of the accrued liability can also be reduced by changing the benefits for retirees and their dependents. Some possibilities for consideration include using an annual maximum for the prescription drug benefits, limiting other benefits, and improving utilization management or review practices.