ORSC

Final Report

November 19, 1991

Ohio Retirement Study Commission

The Costs and Funding of Health Care Benefits Provided by the Ohio Retirement Systems

Findings and Recommendations

Ohio Retirement Study Commission
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INTRODUCTION

Beginning in 1920, the Ohio Retirement Systems (ORS) were created for the purpose of providing retirement income security for teachers, school employees, police, firefighters, state troopers and state and local government employees who render public service in Ohio. ORS' primary duty is to provide pension benefits earned during the working careers of public employees. These pension benefits are mandated by statute, and become vested upon retirement. It is also required that ORS accumulate and maintain the necessary reserves to pay for these promised benefits when they become due.

In 1974, ORS was given discretionary authority to make health care benefits available to retirees and their dependents. This authority recognizes that health care benefits are secondary to pension benefits by allowing the individual retirement boards to change the level of coverage and the costs paid by benefit recipients at any time.

Since 1974, the ORS health care plans have provided comprehensive health care coverage with relatively minimal cost sharing from benefit recipients. This coverage has been described as "very generous" by the Wyatt Company in its 1990 study of the ORS health care plans, and as "being at the generous end of the range of the types of programs commonly in place today" by Milliman & Robertson, Inc. in its recent evaluation of the level of benefits provided by the ORS plans. This coverage has also become prohibitively expensive to maintain, especially in an era of escalating health care costs.

One of the major concerns is the ever increasing imbalance between rising health care costs and available resources to finance these costs. By law, any costs borne by the systems are required to be financed out of the employer contribution rate. The ORSC health care report documents that higher rates of contributions are required to finance health care costs under the current ORS plans, and that the systems have little or no flexibility to increase the employer contribution rates because they are either fixed by statute or at or near the statutory maximum. **This situation means that as more and more of the employer contribution rate becomes necessary to finance health care costs, there becomes a gradual disfunding of pension benefits resulting in**

insufficient reserves to fund the level of pension benefits promised by the legislature.

Because the primary duty of the systems is to provide pension benefits, it is necessary to ensure that health care costs are not paid from assets reserved for pension benefits. This requires that the current ORS health care plans be altered due to the fact that rising health care costs exceed available sources of funding and jeopardize the actuarial funding of vested pension benefits.

The recommendations included herein are designed to protect the systems' pension assets from rising health care costs and to provide approaches to contain the systems' health care costs. They are also consistent with suggested recommendations made by the Wyatt Company and Milliman & Robertson, Inc. in their independent evaluations of the ORS health care plans.

FINDINGS AND RECOMMENDATIONS

FINDINGS

1. The enabling legislation authorizing the Ohio Retirement Systems'(ORS) health care plans gives the retirement boards broad discretionary authority in offering, structuring and financing retiree health care benefits, including the right to modify the plans for both current and future retirees.

2. The benefits currently offered by the ORS health care plans are generous compared to the benefits offered by many other employers, both public and private.

3. There is a significant imbalance between health care revenue sources and benefit costs which will increase in the coming years if there are no additional sources of income or changes to the ORS health care plans with the consequence of jeopardizing the actuarial funding of basic pension benefits.

RECOMMENDATIONS

Plan Design Changes

1. That the ORS health care plans increase the out-of-pocket limits and deductibles.

Rationale - The out-of-pocket limits of $500 per individual and $750 per family have remained the same since the creation of the ORS health care plans in 1974, and are very generous compared to other plans.

In addition to direct cost containment, deductibles involve the covered individual directly in decisions regarding the use of health care services. Deductibles which remain unchanged over time or are set at relatively low levels lose their effectiveness in reducing unnecessary usage.

2. That the ORS health care plans index the out-of-pocket limits and deductibles to changes in the medical component of the Consumer Price Index (CPI).

Rationale - Flat dollar out-of-pocket limits and deductibles lose their intended effects over time due to the high annual growth rates of medical care costs, and become ineffective in helping to contain rising health care costs. For example, had the $500 limit been indexed to the general inflation rate, it would have increased to $1,300 in 1990; had it been indexed to the medical inflation rate, it would have equaled $2,700.

The indexing feature helps the ORS health care plans keep pace with inflation without having to continually reduce benefit coverage.

Premium Cost Sharing

3. That the systems require retirees to share in the premium cost in accordance with the following guidelines:

a. Short-service retirees should bear a greater proportion of premium costs than long-service retirees.

b. Retirees who are not eligible for Medicare should bear a greater proportion of premium costs than retirees eligible for Medicare.

c. Spouse and dependents should bear a greater proportion of premium costs than benefit recipients.

Rationale - There is an increasing recognition that retirees need to share in the premium cost. Requiring contributions from retirees achieves the following objectives:

- Provides an additional source of revenue to help cover projected shortfalls under the present funding method while avoiding abrupt and severe long-term changes to the ORS health care plans.

- Spreads the cost sharing over a greater population than simply those who utilize health care services.

- Promotes intergenerational equity between current and future retirees.

- Encourages retirees to act as reasonable and informed consumers of health care services.

- Provides a potential incentive for covered individuals who are employed to enroll in their employer's health care plan.

The guidelines are designed to provide equitable cost sharing among the various individuals covered by the ORS health care plans based on the following considerations:

- Varying the premium cost by years of service recognizes that like pension benefits, the value of health care benefits should relate directly to the years of service rendered to the public employer. In 1989 SERS adopted this approach towards premium cost sharing.

- Varying the premium cost according to Medicare eligibility recognizes that the cost of coverage for non-Medicare eligible persons is three to four times higher than for Medicare eligible persons. Under the ORS health care plans, 31 percent of those individuals not covered by Medicare account for 64 percent of the total health care costs.

• Varying the premium cost between dependents and retirees recognizes that the primary obligation of the systems is to the individual retiree.

4. That the reimbursement of Medicare Part B premiums be capped in PERS, PFDPF and HPRS.

Rationale - The Medicare Part B premium is scheduled to increase from the current monthly rate of $29.90 to $31.80 in 1992, $36.60 in 1993, $41.10 in 1994 and $46.10 in 1995, an increase of 54 percent over four years. PERS, PFDPF and HPRS have no control over such increases. Capping the reimbursement of Medicare Part B premiums reduces the impact of future increases on the PERS, PFDPF and HPRS' health care plans.

H.B. 290 capped SERS' reimbursement level at $24.80 in 1988, and S.B. 329 froze STRS' level at $29.90 in 1991.

Segregation of Assets

5. That the systems segregate assets reserved for pension benefits from assets available for health care benefits and report in a timely and appropriate manner on their pension costs and health care costs.

Rationale - Segregating assets reserved for pension benefits from assets available for health care benefits achieves two important objectives:

• Provides a separate accounting of the systems' available resources and costs with respect to the provision of retiree health care benefits.

• Avoids the possibility of gradually disfunding pension benefits by annually transferring pension reserve funds in order to pay for rising health care costs.

Managed Care

6. That the systems negotiate on a collective basis with health care providers or provider network managers to establish effective managed care programs, and encourage benefit recipients to utilize such programs through medical benefit penalties.

Rationale - The ORS health care plans cover over 300,000 individuals - 80 to 90 percent of whom reside in Ohio. This enables them to use their large population of insureds as leverage in bargaining with providers to establish managed care programs that incorporate negotiated payment levels and utilization controls - the two key components of claim costs. This also enables them to reduce the impact of continued cost shifting from providers to plans that have not negotiated payment levels.

Establishing managed care programs requires that the ORS health care plans change roles from simply a payor of health care claims to a purchaser of health care services.

It is essential that the ORS health care plans negotiate on a collective basis with providers in order to maximize their buying power. It is equally important that the ORS plans encourage individuals to utilize managed care programs in order to maximize their cost savings. Because the ORS plans are already generous, the most cost effective approach is to impose additional cost sharing on individuals who elect not to utilize these programs rather than providing additional benefits as incentives for using such programs.

In 1974 the five state retirement systems created and formed the ORS Trust through which master agreements were negotiated with Aetna for the provision of medical, hospital and other health care benefits. These original agreements were subsequently modified to change from an insurance to a split-funding arrangement with Aetna, thereby making the systems essentially self-insured, in order to effect cost savings.

In 1981 the five systems collectively negotiated with Medco to establish the mail order maintenance drug program which not only has reduced the systems' prescription drug costs through negotiated discounts, but also has provided the systems with full information on the utilization and cost of the drugs prescribed to their retirees. Retirees retain the option of obtaining maintenance drugs from the local pharmacy, but at a higher cost.

In 1990 SERS established a preferred retail pharmacy network which is open to any pharmacy that agrees to abide by the terms of the contract. Retirees who go outside the network are subject to additional cost sharing. The preliminary results indicate that over 70 percent of the pharmacies in Ohio are participating in the network and that SERS has realized significant savings through reduced claims processing charges and prescription drug discounts.

CONCLUSION

In an era of escalating health care costs, the ORS health care plans are not alone in dealing with the challenge of providing access to quality health care coverage at a reasonable cost and within the constraints of available resources. The issues of accessibility, coverage and cost have left no employer-sponsored health care plans unaffected, and have prompted much legislative activity at both the national and state levels seeking to address the health care crisis. Any permanent solution to rising health care costs lies with the enactment of those proposals which impact the entire health care industry. However, it is important to recognize that the ORS health care plans are faced with immediate and probably continuing problems with rising health care costs until such legislative proposals are adopted.

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November 15, 1991

Mr. Aristotle L. Hutras
Director
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Dear Aris:

Thank you for sending a preliminary copy of the summary "Findings and Recommendations" regarding the ORS health care plans.

We agree with your recommendations and believe that they will enhance the financial soundness of these plans and hence help to preserve these important benefits for retirees.

Please let me know if I can provide any further information regarding these plans.

Sincerely,

William A. Reimert

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The Ohio Retirement Study Commission

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COOPER SNYDER
Chairman

ARISTOTLE L. HUTRAS
Director

November 19, 1991

TO : ORSC Members

FROM: Aristotle Hutras

RE : Final Report on The Costs and Funding of Health Care Benefits Provided by the Ohio Retirement Systems

At its meeting of November 19, 1991, the Ohio Retirement Study Commission voted to approve the findings and recommendations included in the final report on The Costs and Funding of Health Care Benefits Provided by the Ohio Retirement Systems.