Actuarial Study and Operational Audit of the Hawaii Public Employees Health Fund

A Report to the Governor and the Legislature of the State of Hawaii

Report No. 99-20
May 1999

THE AUDITOR
STATE OF HAWAII

Office of the Auditor

The missions of the Office of the Auditor are assigned by the Hawaii State Constitution (Article VII, Section 10). The primary mission is to conduct post audits of the transactions, accounts, programs, and performance of public agencies. A supplemental mission is to conduct such other investigations and prepare such additional reports as may be directed by the Legislature.

Under its assigned missions, the office conducts the following types of examinations:

1. *Financial audits* attest to the fairness of the financial statements of agencies. They examine the adequacy of the financial records and accounting and internal controls, and they determine the legality and propriety of expenditures.

2. *Management audits*, which are also referred to as *performance audits*, examine the effectiveness of programs or the efficiency of agencies or both. These audits are also called *program audits*, when they focus on whether programs are attaining the objectives and results expected of them, and *operations audits*, when they examine how well agencies are organized and managed and how efficiently they acquire and utilize resources.

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OVERVIEW

Actuarial Study and Operational Audit of the Hawaii Public Employees Health Fund

Report No. 99-20, May 1999

Summary

The Legislature requested this study and audit in House Concurrent Resolution No. 88, House Draft 1, Senate Draft 1, Conference Draft 1 of the 1998 session. The project was conducted by the Office of the Auditor and Ernst & Young LLP, which provided actuarial and related services.

Health benefits are a significant component of the total compensation package for public employees and a significant cost to public employers. The Hawaii Public Employees Health Fund (health fund) provides health and life insurance benefits to eligible active state and county employees, retirees, their dependents, and reciprocal beneficiaries. Eligible employees and retirees can enroll in a health benefit plan sponsored by a public employee organization or union in lieu of a plan provided directly by the health fund.

Each month, the health fund receives contributions from employers and employees for health benefits. From FY1995-96 to FY1997-98, employer contributions rose from approximately $235.3 million to $262.6 million and employee contributions declined from about $39.2 million to $32.2 million because of the large migration of employees from the health fund plans to the union plans. As of July 31, 1997, a total of 77,478 active employees and retirees were enrolled in medical plans. Of these, about 66 percent were enrolled in the health fund medical plans and about 34 percent in union medical plans. Each month, the health fund "ports," or transfers, to the union health plans the employer contributions for the employees enrolled in the union plans.

We found that the presence of union plans competing with the health fund for enrollees will continue to drive state and county costs higher, perhaps by several million dollars a year, because of a phenomenon called "adverse selection." Active employees enrolled in union plans tend to be younger in age and have smaller families. The least costly strategy for enrollees is the most costly for employers. The existence of union plans has also increased the premium costs for participants enrolled in health fund plans. Furthermore, 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.

We also found that the 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. Our "most likely" (intermediate) estimate is that as of July 1, 1998, the State and counties' accrued liability for providing future retiree health benefits, under the current plans, is $4.5 billion. Our most likely estimate of the liability for the year 2013 is $11.4 billion. Prefunding the liability—an alternative to the current pay-as-you-go method of funding—and other alternative approaches merit consideration.

We also found that two states—Oregon and Pennsylvania—use an employer-union trust governance structure to provide a single health benefit program for public employees.

Moreover, we found that the Board of Trustees of the health fund needs to attend to pressing operational issues. The board has not ensured that the health fund's reserves have been properly managed. Erratic premium rates indicate ineffective rate stabilization efforts, and excess reserves have not been returned to employees.

Finally, we found that the board has never audited the union plans' use of the funds paid to the union plans, has taken too long to replace the health fund's inadequate computer system, has yet to implement a required long-term care plan, and can improve on customer service.

Recommendations and Response

We recommend combining the health fund program and all of the union programs into one overall health benefit program.

We also recommend giving the health fund more authority and flexibility to deal with the dynamics of the health care marketplace. Furthermore, consideration should be given to restructuring the Board of Trustees to oversee a single program approach. There should be relatively equal representation on the board between unions and government employers if there is to be a joint union/employer trust or similar program. At least some members of the board should be required to have some knowledge of employee health benefit programs and their financing.

Finally, we recommend specific actions by the Board of Trustees to address problems in the areas of rate stabilization, excess reserves, porting of premiums to the union plans, computerization, long-term care, and customer service.

Commenting on our draft report, the chairman of the health fund's Board of Trustees expressed some immediate concerns related to our discussion of computerization, long-term care, and auditing of the union plans. He indicated that over the next few months, the board will work with legislative committees to review our findings, explain the rationale for the board's decisions, and implement appropriate program changes. The Department of Budget and Finance expressed general agreement with the recommendations in our draft report.

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A Report to the Governor and the Legislature of the State of Hawaii

Conducted by

The Auditor
State of Hawaii
and
Ernst & Young LLP

Submitted by

THE AUDITOR
STATE OF HAWAII

Report No. 99-20
May 1999

Foreword

This actuarial study and operational audit of the Hawaii Public Employees Health Fund was initiated pursuant to House Concurrent Resolution No. 88, House Draft 1, Senate Draft 1, Conference Draft 1 of the 1998 legislative session.

The study was conducted by the Office of the Auditor and Ernst & Young LLP, which provided us with actuarial and related services.

We wish to express our appreciation for the cooperation extended to us by the Board of Trustees, administrator, and staff of the Hawaii Public Employees Health Fund, by the Department of Budget and Finance, and by others in Hawaii and across the nation who assisted us during the course of the project.

Marion M. Higa
State Auditor

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Chapter 1
Introduction

Health benefits have become a significant component of the total compensation package for public employees and a significant cost to public employers. The large number of baby boomers approaching retirement, increasing health care costs, and retirees' increased life expectancy have raised concern about the future financial stability of the current pay-as-you-go funding method of the Hawaii Public Employees Health Fund (health fund).

The health fund has provided health and life insurance benefits for public employees and retirees since its inception in 1961. The fund provides these benefits through its own plans or through plans offered by public employee organizations (unions). In the mid-1980s, relatively few employees and retirees participated in union plans compared to the health fund plans. However, since the mid-1990s, active employees enrolled in union medical plans have accounted for nearly half of those enrolled in medical plans.

The Hawaii State Legislature requested the State Auditor to conduct an actuarial study and a programmatic audit of the Hawaii Public Employees Health Fund's operations. This request was made in House Concurrent Resolution No. 88, House Draft 1, Senate Draft 1, Conference Draft 1, of the 1998 session.

The resolution requested an assessment of future costs and liabilities of public employer contributions, including unfunded liabilities and the impact of porting funds to union benefit plans. The resolution indicated that the study should include a comparison of Hawaii's health fund to state employee and retiree health care benefit programs nationwide. In addition, the resolution sought information on long-term strategies to finance the retiree health benefit program and control expenditures, and recommendations on the advisability of replacing the health fund with a system based on an employer-union trust structure.

Background on the Hawaii Public Employees Health Fund

The Hawaii Public Employees Health Fund provides health and group life insurance benefits to eligible active state and county employees, retirees, their dependents, and reciprocal beneficiaries. Benefits available under the fund include medical, hospital, surgical, prescription drug, vision, dental, and life insurance plans, and Medicare Part B premium reimbursement.

For employees hired before July 1, 1996, public employers pay the entire monthly health care premium for employees retiring with ten or more years of credited service, and 50 percent of the monthly premium for employees retiring with fewer than ten years of credited service.

For employees hired after June 30, 1996, and who retire with fewer than ten years of service, public employers make no contributions. For those retiring with at least ten years but fewer than 15 years of service, public employers pay 50 percent of the retired employees' monthly Medicare or non-Medicare premium. For employees hired after June 30, 1996, and who retire with at least 15 years but fewer than 25 years of service, public employers pay 75 percent of the retired employees' monthly Medicare or non-Medicare premium; for those retiring with over 25 years of service, employers pay the entire health care premium.

Retirees enrolled in both the federal Medicare plan and the health fund's Medicare Supplement plan or the Medicare Risk plan receive a monthly Medicare Part B reimbursement from the health fund. Spouses participate in these retiree benefits as well.

The health fund is also required to provide a long-term care benefits plan, available to employees, spouses, and beneficiaries who enroll between the ages of 20 and 85. However, this plan has not been initiated.

Established by Chapter 87, Hawaii Revised Statutes (HRS), the health fund is a trust fund attached to the Department of Budget and Finance for administrative purposes. The health fund is controlled by a nine-member Board of Trustees appointed by Hawaii's governor. The state director of finance is an *ex officio* member of the board and custodian of the fund. The board negotiates employee benefit plan contracts with insurance carriers and oversees enrollment and financial operations.

Three medical plans are offered: a fee-for-service medical plan through the Hawaii Medical Service Association (HMSA) and two health maintenance organization plans, Kaiser Permanente, and Kapi'olani HealthHawaii. Eligible employees and retirees can enroll in a union-sponsored health benefit plan in lieu of a plan provided directly by the health fund. Thirteen employee organizations or unions sponsor health benefit plans for their members, including the Hawaii Government Employees Association, the United Public Workers, the Hawaii State Teachers Association, the University of Hawaii Professional Assembly, the State of Hawaii Organization of Police Officers, and the Employees Association of the City & County of Honolulu.

Each month, the health fund receives contributions from employers and employees for health benefits. From FY1995-96 to FY1997-98, employer contributions rose from approximately $235.3 million to $262.6 million and employee contributions declined from about $39.2 million to $32.2

million because of the large migration of employees from the health fund plans to the union plans. As of July 31, 1997, a total of 77,478 active employees and retirees were enrolled in medical plans. Of those, 51,516 or about 66 percent of active employees and retirees were enrolled in the health fund medical plans and 25,962 or about 34 percent were enrolled in union medical plans. Among active employees, 22,973 or about 48 percent, were enrolled in the health fund's medical plan, while 25,403, nearly 53 percent, were enrolled in union medical plans. The health fund transfers (ports) the employer contributions to the union health plans each month. Employee contributions for union plan enrollees are paid directly to the union plans and do not pass through the health fund.

For the year ended June 30, 1998, the health fund paid approximately $203 million in premiums to insurance carriers.

In response to concerns about the health fund's governance structure, benefit levels, and costs, the Legislature passed Act 309, SLH 1996 to develop an employer-union trust concept for determining and administering health benefits. The employer-union trust is purported to be a mechanism for linking benefit levels and costs, with the flexibility to establish appropriate health benefits coverage.

Approach to Technical Terms

This report contains many technical terms familiar to specialists in health benefit programs, actuarial science, and related subjects. To assist the general reader, we have explained key technical terms in the text where they appear and in the Glossary following the text of the report.

Objectives of the Study

The objectives of this study were to:

1. Project future demands upon, and costs and liabilities of, the Hawaii Public Employees Health Fund.

2. Develop long-term strategies to finance public employee and retiree health care benefits under the health fund while controlling costs.

3. Examine possible alternatives to the health fund's governance structure.

4. Assess the efficiency, effectiveness, and accountability of selected health fund operations.

5. Make recommendations as appropriate.

Scope and Methodology

Our study examined the health and life insurance benefit plans of the Hawaii Public Employees Health Fund and the employee organizations (unions). In this report we use the phrase "health benefit program" when referring to all of the plans available, whether they are offered by the health fund or the unions. In addition, statements about the "health plan(s)" refer to all—medical, drug, dental, vision, and life insurance plans.

To assist us with Objectives 1, 2, 3, and 5, the State Auditor engaged the services of Ernst & Young LLP, which provided actuarial and related services. The firm assisted us by estimating the future unfunded liabilities and annual costs to finance the retiree health benefit program under the health fund's pay-as-you-go funding method compared with actuarial pre-funding methods, and assessing the impact of porting funds to union plans. The firm also assisted in identifying alternative strategies to finance health benefits and control expenditures, and in examining alternatives for restructuring the health fund's governance, such as the employer-union trust.

The firm gathered information on other states' employee and retiree health benefit programs including governance practices, management practices over reserves, the practice of porting funds to union benefit programs, information on computer systems and capabilities, customer service, and administrative services being provided.

The methodology used to project future costs and the unfunded liability of Hawaii's program first involved projections of estimated future employer contribution costs per employee and retiree for the various benefits provided under the health fund program and the employer contributions ported to the union benefit plans. In addition, the firm projected the number of employees, retirees, dependents, and reciprocal beneficiaries anticipated to be covered under the program in total, as well as by type of coverage. Based on these population projections and the anticipated employer contribution costs per enrollee, the firm developed a 15-year projection of the future cost of the program and the estimated unfunded post-retirement benefit liability.

The firm applied generally accepted actuarial procedures to determine the anticipated impact on the health fund plan costs from an employer's perspective due to the competition from the union benefit plans. The relative values of the union-provided medical benefit plans were compared to the health fund medical benefit plans using pricing data gathered by Ernst & Young from nationwide healthcare industry data. For the purpose of determining the impact on the health fund for this aspect of the study, the firm restricted its analysis to the impact as a result of the basic

health benefit plans, such as medical, surgical, hospital, since these benefits, along with prescription drugs, represent about 85 percent of the amounts paid out by the health fund to carriers or to union plans.

While the Hawaii Government Employees Association, the Hawaii State Teachers Association, and the United Public Workers did not provide the information that we requested such as experience reports, premiums/dues revenue, stabilization reserves, tiered rate and enrollment history, and experience refunds among their various health plans, the firm was able to estimate the expected impact that the union plans have had on employer contributions.

The firm performed a large scale Internet search for available information on other states' public employee benefit programs and supplemented this information with direct telephone and e-mail communications. In addition, the firm contacted the Government Finance Officers Association, National Association of State Retirement Administrators, National Conference on Public Employees Retirement Systems, and National Council on Teachers Retirement.

The Office of the Auditor relied upon the expertise of Ernst & Young and did not independently verify the actuarial computations and analyses performed by the firm. In addition, the auditor's office did not independently verify the data provided by the health fund or the Segal Company, the fund's consultant.

The Office of the Auditor obtained general background information and performed fieldwork for Objective 4. We reviewed the health fund's duties and responsibilities under Chapter 87, HRS. We reviewed the health fund's mission, functions, responsibilities, and management practices. We reviewed relevant documents and reports regarding the fund. We also reviewed the request for proposal and specifications for the health fund's new computer system.

We interviewed the health fund trustees, the administrator, selected staff, and the health fund's consultant. We interviewed public employer representatives from the State and counties. We interviewed officials from the public employee unions and representatives from the insurance carriers and a third-party administrator. We also interviewed administrators from the Executive Office on Aging, the Department of Human Resources Development, and the Department of Budget and Finance.

We contacted other states' health benefit programs. We also obtained information on other states' customer service activities.

We relied to some extent on the results of our recent financial audit of the health fund, Report No. 99-18.

We attended the December 1998, January 1999, and February 1999 meetings of the fund's Board of Trustees.

We surveyed a random sample of active employees and retirees about their experiences with their health coverage through the health fund or union plans, their experience with their insurance carriers, and their impressions of customer service.

Our work was performed from June 1998 through March 1999 in accordance with generally accepted government auditing standards.

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.

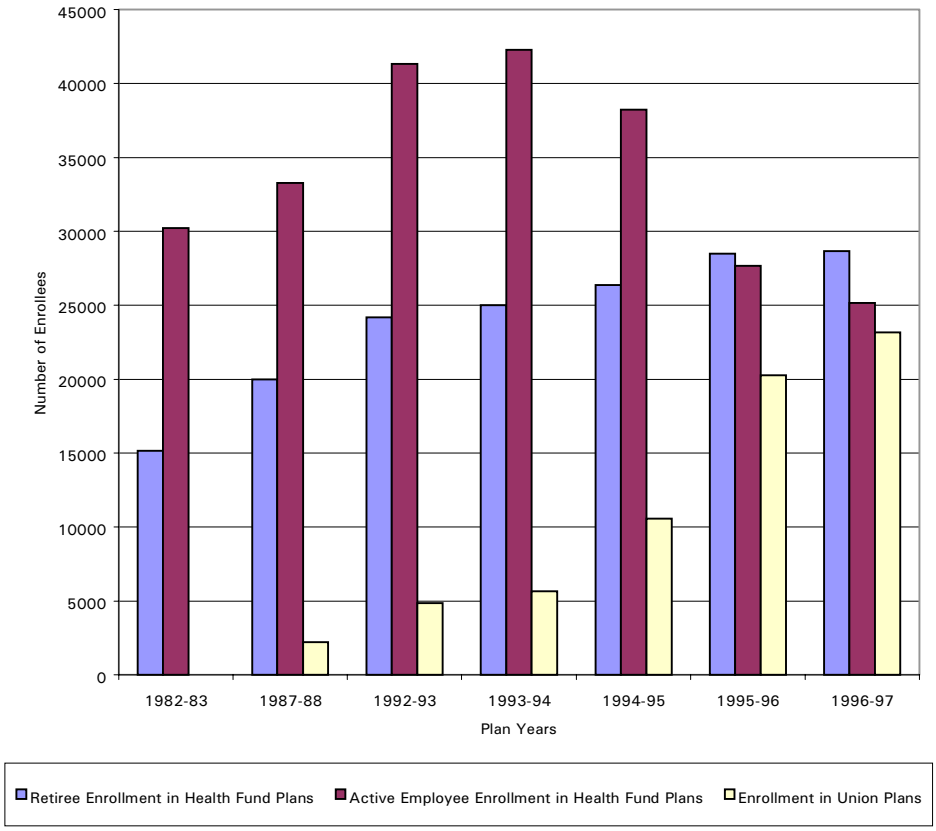
As of June 30, 1998, active employees enrolled in the medical, dental, drug and vision plans offered by the unions had an average of 2.08 dependents in their household while active employees enrolled in the health fund's version of those plans averaged 2.33 dependents in their household. All of this 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	Monthly Employee Contributions HGEA Plans	HF Plans	Employee's Annual Savings or (Additional Costs) For HGEA 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	$3.8	$7.6
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

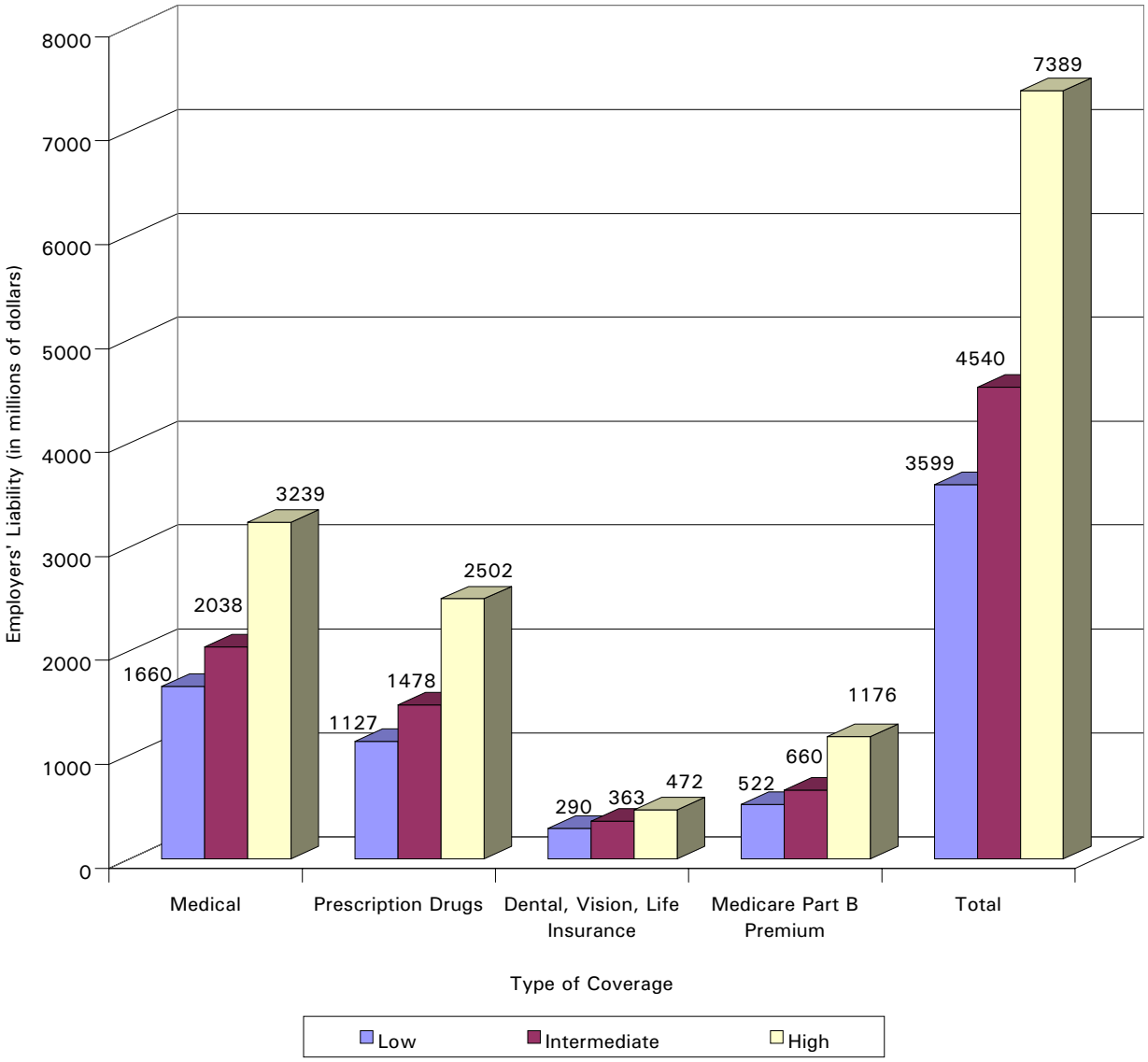


Exhibit 2.7
Hawaii Public Employees Health Fund Employer Liabilities by Benefit Type Under Low, Intermediate, and High Trend Scenarios for 2013

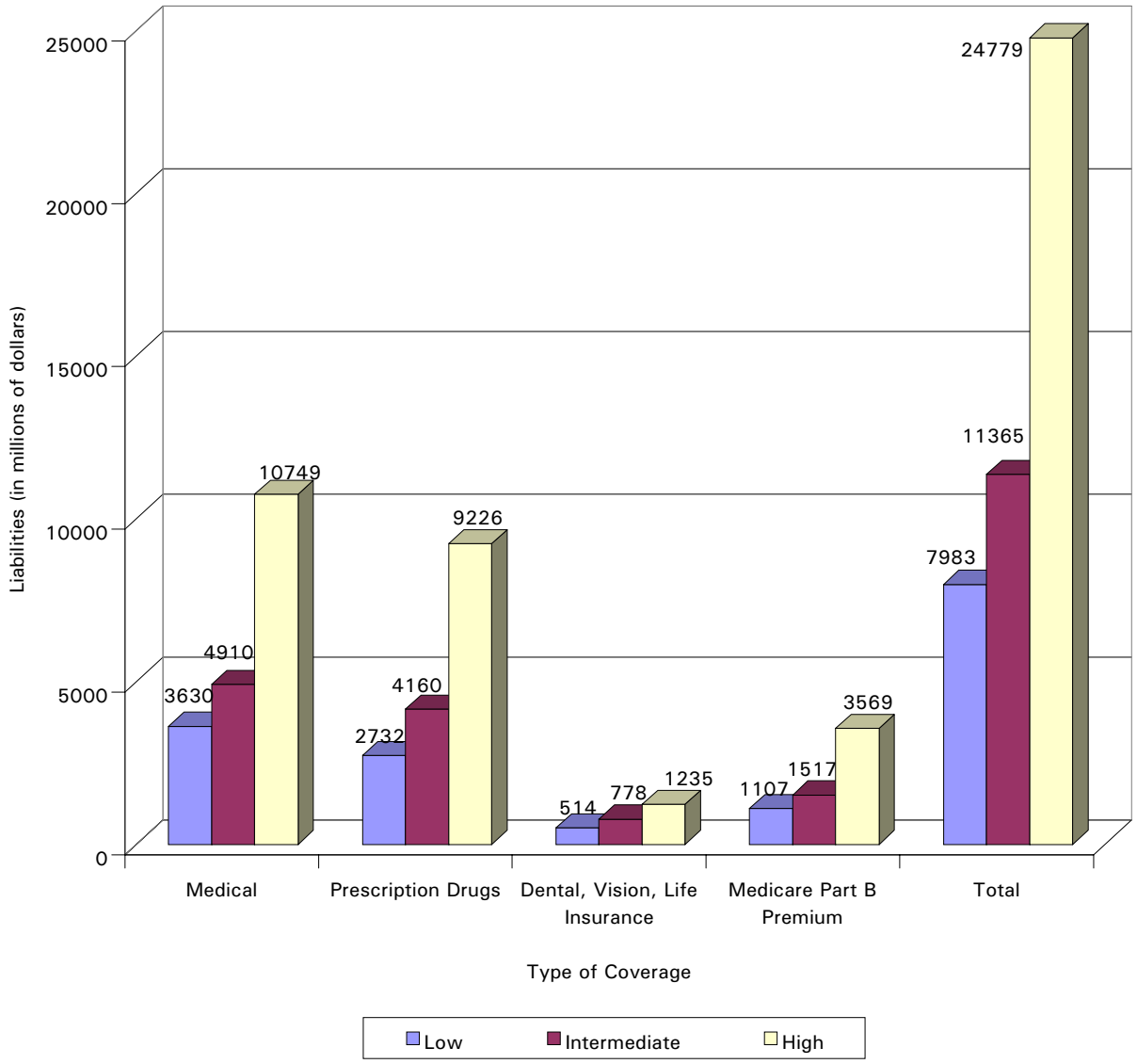


Exhibit 2.8
Employer Cost for Providing Health Fund Pay-As-You-Go Benefits for Retirees, FY1997-98 to FY2012-13

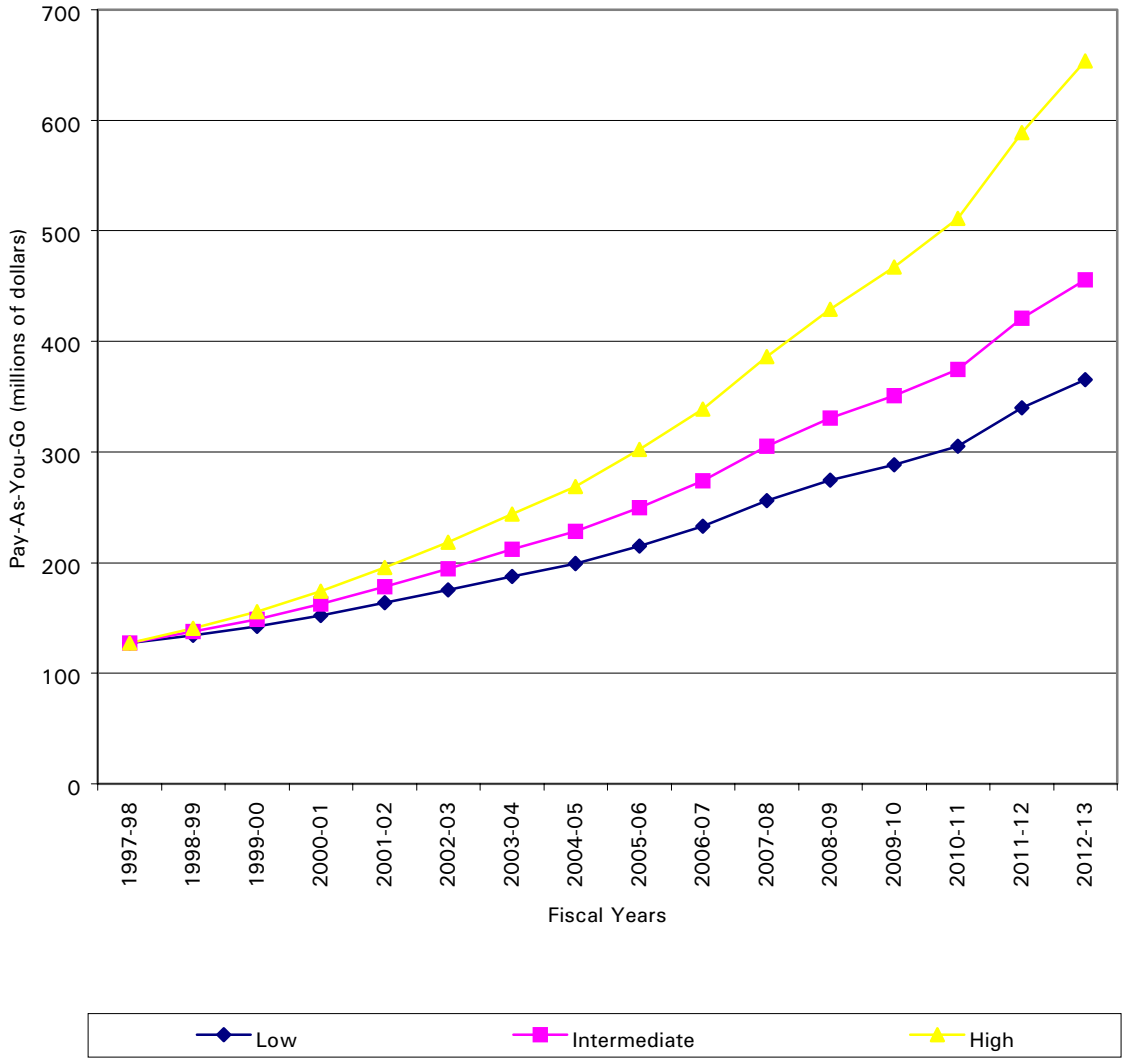


Exhibit 2.9
Employer Cost for Providing Health Fund Pay-As-You-Go Benefits for Active Employees, FY1997-98 to FY2012-13

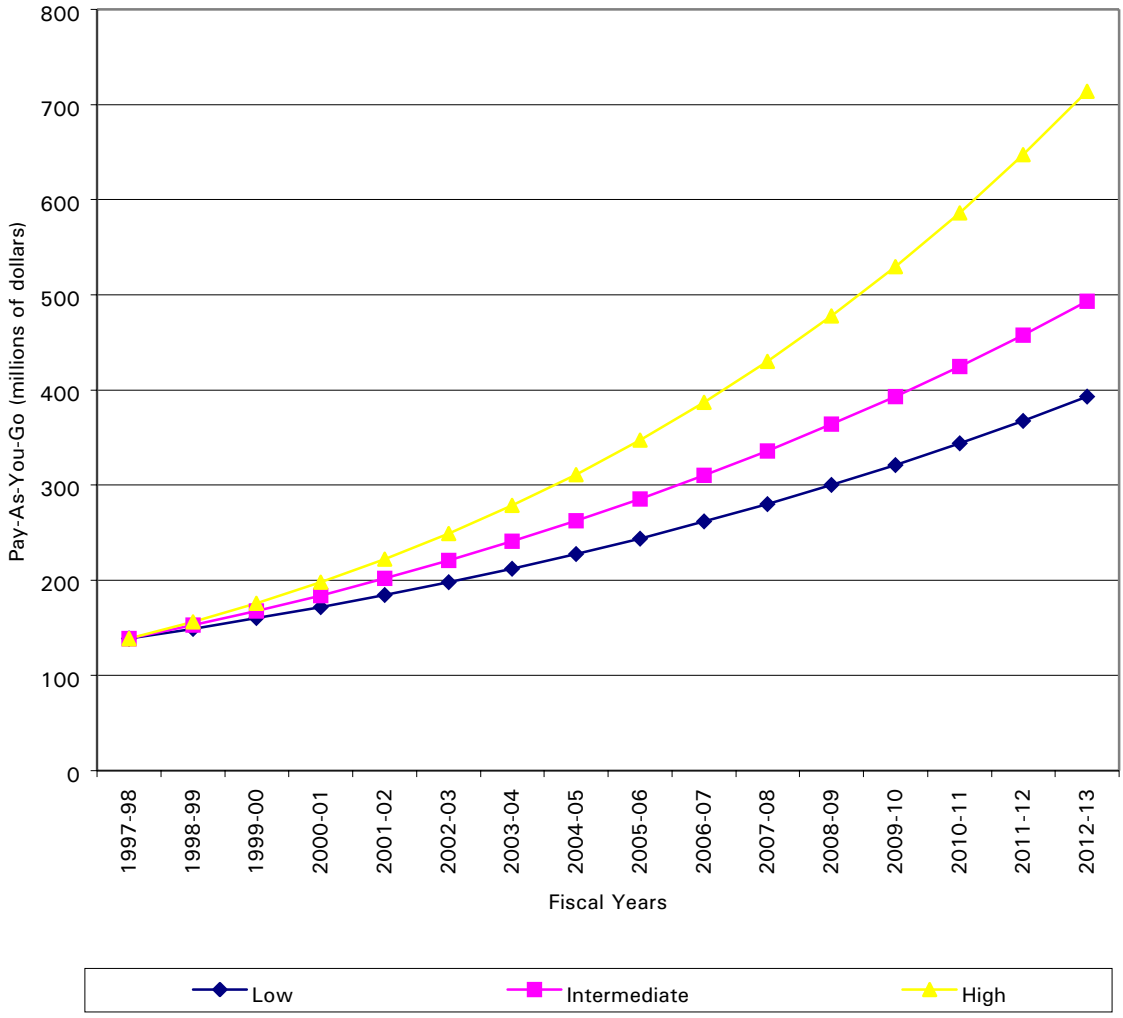


Exhibit 2.10
The 1998 Post-Retirement Health Benefit Liability by Type of Benefit (in millions of dollars)

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).

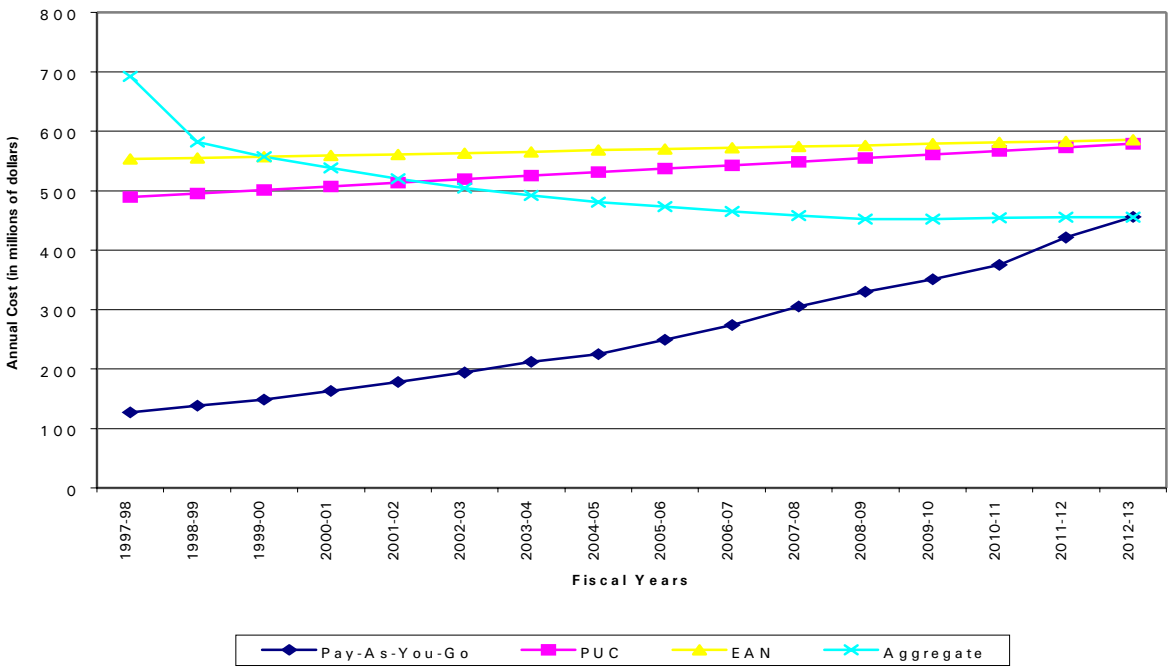
In the first year, FY1997-98, the cost under the Projected Unit Credit method, $489 million, is the lowest of the three methods, but will increase as the population ages, to $579 million in FY2012-13. Costs under the Entry Age Normal method are $553 million in FY1997-98, should remain relatively level 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)

		Prefunding Method		
Fiscal Year	Pay-As-You-Go	Projected Unit Credit (PUC)	Entry Age Normal (EAN)	Aggregrate
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)

			Retirees			
	Active		Without Medicare		With Medicare	
State	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

	Kaiser Hawaii	Kaiser CalPERS
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

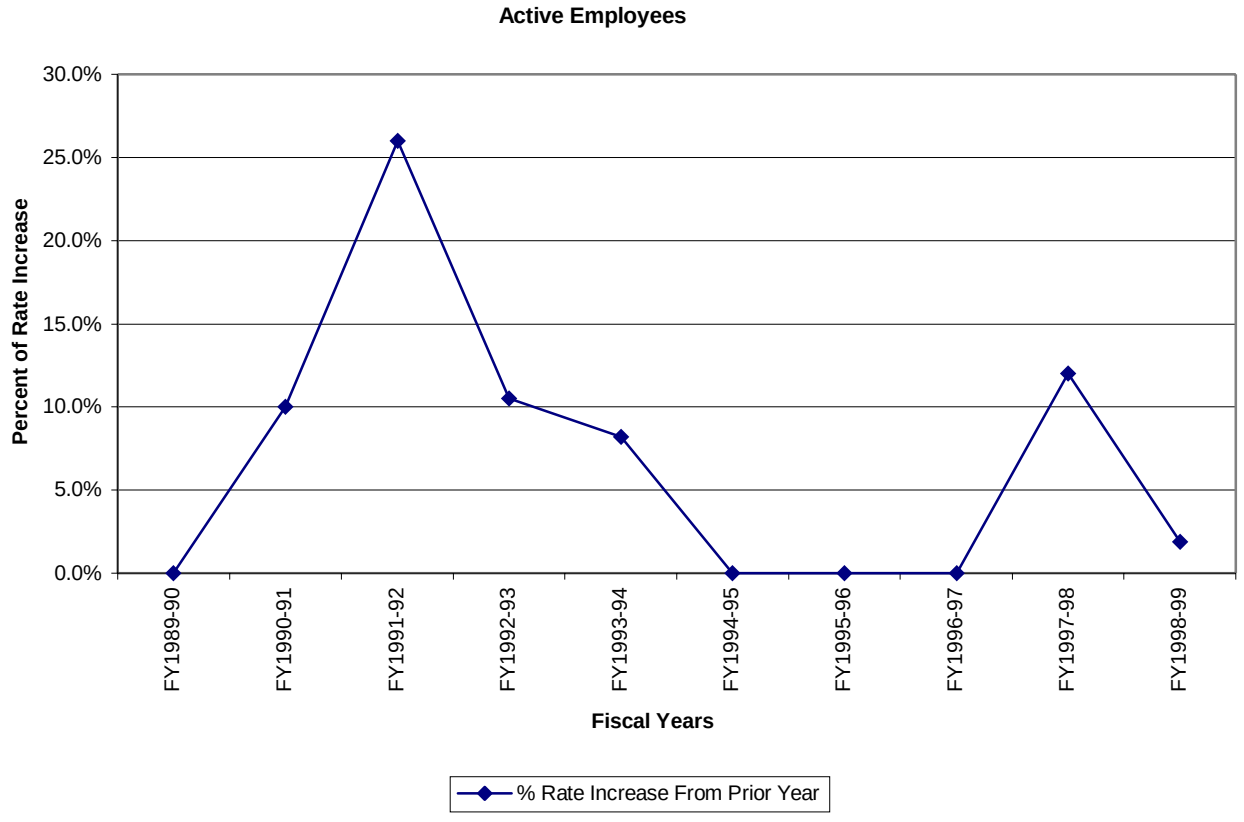
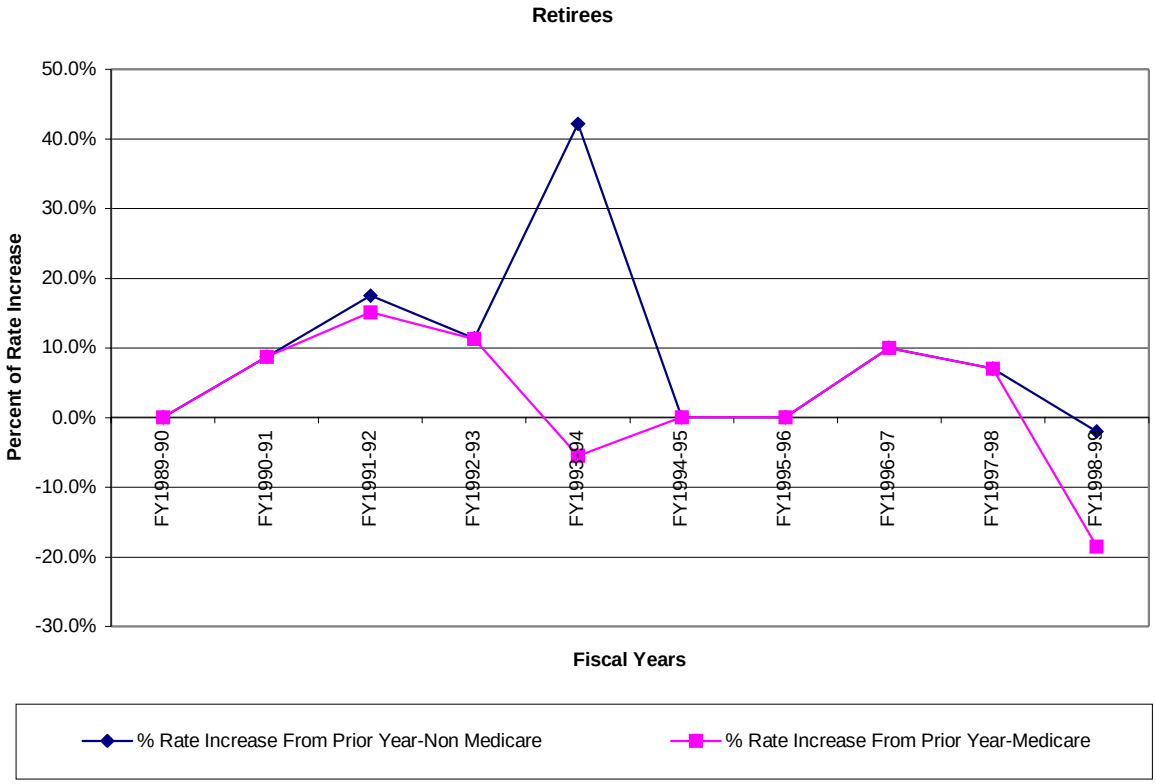


Exhibit 2.17
Rate History for HMSA Medical Plan, Medicare and Non-Medicare Retirees, FY1989-90 to FY1998-99



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.

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Chapter 3

The Board of Trustees Needs to Attend to Pressing Issues

This chapter presents the findings and recommendations of our review of selected operations of the Hawaii Public Employees Health Fund (health fund). We examined the health fund's use of reserves and the practice of porting funds to the union health benefit plans. We also reviewed the health fund's efforts to replace its computer system, the status of establishing a long-term care benefits plan, and customer service.

Summary of Findings

1. The Board of Trustees has not ensured that the Hawaii Public Employees Health Fund's reserves have been properly managed. Erratic premium rates indicate ineffective rate stabilization efforts. In addition, excess reserves have not been returned to employees.

2. The board has not ensured that premiums are being paid to purchase health benefits from union plans. The State's interest is significant as millions are ported to union health plans. However, the board has never audited the union benefit plans' use of the ported funds.

3. The board has taken far too long to replace the health fund's inadequate computer system. Numerous systemic problems have been known for years. The health fund's new computer system may not be compatible with other public employee computer systems. Work has begun even though complete funding for the computer system is not secured.

4. The board has yet to implement a long-term care plan. The health fund has had the statutory requirement to establish a plan since 1989. Delays in establishing the plan persist.

5. The health fund's customer service could be improved. Our survey of enrollees identified areas of concern regarding retirees. Respondents also reported problems with their insurance carriers.

The Board Has Not Ensured That the Health Fund's Reserves Have Been Properly Managed

The Board of Trustees has the fiduciary responsibility over the Hawaii Public Employees Health Fund. Several trustees indicated that the board controls health care costs through the use of rate stabilization funds and also by negotiating the best plan with the carriers. Over the past ten years, the health fund has set aside significant moneys to stabilize insurance premium rates. However, the health fund's medical indemnity insurance plan premium rates have fluctuated erratically, indicating ineffective rate stabilization efforts. In addition, excess reserves have not been returned to employees as required by law.

Erratic premium rates indicate ineffective stabilization efforts

Setting aside funds or *reserves* for stabilizing insurance premium rates is a common practice in the health insurance industry. Based on a plan's claims experience and other factors such as inflation, a rate stabilization amount is set aside to keep premium rates within a certain range, for instance plus or minus 10 percent of the previous year's annual costs.

Our recent financial audit of the health fund (Report No. 99-18) found that the health fund has no definition of reserves. In addition, our actuarial consultant found that the health fund's medical plan premium rates have been relatively volatile, ranging from minus 19 percent to plus 42 percent over the past ten years as shown in Exhibit 2.15, Exhibit 2.16, and Exhibit 2.17. Although substantial claims surpluses have accumulated in the past, they have not been used to moderate rate changes. Given such large fluctuations, the board should review and improve its rate stabilization strategy.

Excess reserves have not been returned to employees

Our financial audit also found that the board has not returned the excess contributions to employees and retirees. Several laws (Act 183, SLH 1995, Act 269, SLH 1996, and Act 276, SLH 1997) have been passed to return the employers' share of the excess contributions. However, the board has had difficulty determining how the employees' share of the reserves should be returned. One trustee observed that the health fund does not have a mechanism to return the reserves to employees. The board has a bill in the 1999 legislative session seeking to return the excess reserves to employee beneficiaries. This topic is discussed in more detail in our financial audit of the health fund, Report No. 99-18.

The Board Has Not Ensured That Premiums Are Being Paid to Purchase Health Benefits From Union Plans

The Board of Trustees has not ensured that premiums ported to the union plans are being used to purchase health benefits. The State's interest here is significant, as more employees have been enrolling in the union plans and the amount of premiums paid (ported) to union plans has grown to many millions. The board has never audited whether the union plans are using the ported funds to purchase health benefits

The State's interest is significant as millions are ported to union health plans

The State's interest is increasingly significant as the premiums paid have grown with more and more public employees enrolling in the union plans. In FY1993-94, 5,640 active employees, about 8 percent of all active employees under the health fund, were enrolled in union medical plans. By FY1996-97, this number had grown to 25,403, or about 53 percent of active employees. From FY1993-94 to FY1996-97, premiums paid by the employers for health benefit plans of the Hawaii Government Employees Association (HGEA) increased nearly 216 percent, from $9,815,046 to $31,001,911. For the same time period, premiums paid by the employers for the health benefit plans of the Hawaii State Teachers Association (HSTA) increased 381 percent, from $3,767,097 to $18,119,524. Employers' premiums paid for the plans of the United Public Workers (UPW) increased over 620 percent, from $1,458,931 in FY1993-94 to $10,516,871 in FY1996-97. Yet, in spite of the significant increases in premiums ported to union health plans, the current board has not requested the unions to provide information on their health benefit plans' operations until this study.

The board has never audited funds ported to union plans

The board has never audited the union health benefit plans. Consequently, the board falls short of fulfilling its fiduciary responsibility to carry out the purposes of the health fund. Section 87-21, HRS, gives the board the power to administer and carry out the purposes of the fund. The fund's administrative rules require the union plans to maintain records for the board's review.

State law identifies the nature of contributions toward purchasing union health benefits. Under Chapter 87, HRS, the board transfers or ports the employer's monthly contribution to the appropriate union plan. By statute, the amount ported is determined by collective bargaining agreements or the actual monthly cost of the coverage, whichever is less. However, without auditing the union health benefit plans, the board has no way of verifying the actual monthly cost of the coverage. Beyond the unions' assertion, the board has no assurance that the ported funds are used for purchasing health benefits for union plan enrollees. At least one union that was about to receive a premium refund from a health insurance

carrier has contacted the health fund inquiring about the disposition of the refund. None of the union plans has ever returned any difference between what it cost to provide coverage and what was ported to them.

The health fund's administrative rules, Title 6, Chapters 34.9(3), 35.5(3), and 36.7(3), require the union plans to state that they will comply with the board's requirements to maintain reasonable accounting records and furnish such records and reports as may be requested by the board, administrator, or state comptroller. In addition, the union plans agree to permit representatives of the board or state comptroller to audit and examine their records and accept adjustments for errors or other reasons that may be required under Chapter 87, HRS, or the administrative rules.

We asked the Board of Trustees to request on our behalf from the three largest public employee unions—HGEA, HSTA, and UPW—actuarial and other information regarding their health plans that was important for our study. However, to date, those unions have not provided any information on their plans, raising additional questions about the system of porting funds to union plans.

Lack of monitoring traced to a 1979 attorney general opinion

The lack of monitoring the union plans is traced to a 20-year-old opinion of the state attorney general. In 1979, the Board of Trustees requested an attorney general opinion on its responsibilities and liabilities for the union health benefit plans. Specifically, the board asked whether it is obligated to require employee organization plans to submit an accounting or annual report on health fund contributions paid to them on behalf of employees. The then attorney general stated that porting funds to the union plans discharges the health fund from being accountable for those funds and the board is not obligated to require the submission of accounting or annual reports on contributions paid on behalf of employees. Once the payment is made, the employee organization (union) becomes trustee of the funds received and must apply them for the purpose designated. In addition, some trustees also indicated that the health fund may be liable for the union plans if the board monitors the plans.

In FY1978-79, the health fund ported approximately $186,000 in employer contributions to union health benefit plans. In FY1996-97, the health fund ported $63,571,634 to the union plans, almost 342 times the money ported in FY1978-79.

We believe that the board should fulfill its fiduciary responsibilities by ensuring that the union plans are using the ported funds to provide health benefits, and are in compliance with the statutory requirements set forth in Section 87-22.3(2), HRS. The amount of the funds ported to the union

plans is significant. We also believe that the board should reexamine the scope and applicability of the 1979 attorney general opinion.

The Board Has Taken Far Too Long to Replace the Health Fund's Inadequate Computer System

The Board of Trustees has taken far too long to replace the health fund's inadequate computer system. Numerous systemic problems have been known for years and few dispute the health fund's need for a new computer system.

The health fund's computer system has been revised over the years to accommodate new data requirements and plan modifications. In December 1997, the health fund installed a local area network to share files and print records in anticipation of the new Health Fund Information Management System (HFIMS). But the health fund's existing computer system is still slow and the functional needs of the health fund are no longer being met.

The health fund is making progress toward installing a new computer system. However, some are concerned that it may not be compatible with other public employee related computer systems. Furthermore, the unanticipated added expense of the contract for the new HFIMS system has led the health fund and its contractor to begin work on Phase II and verbally agree that the health fund will seek funding for Phase III during the 1999 legislative session and 2000 session if needed.

Numerous systemic problems have been known for years

The health fund's existing computer system was developed in 1975. In 1993, the Department of Budget and Finance retained the Segal Company to prepare an in-depth study of the health fund's operations. Segal found that the health fund's computer application programs lacked many features that are standard in most health benefit programs. Segal recommended a complete replacement of the fund's computer system.

Information integrity has been lacking

In 1997, Watson Wyatt Worldwide's (Watson) Conceptual Design Study for the Health Fund Information Management System, which had been commissioned by the board, listed a number of problem areas. For example, there was no easy way for an employee to update personal changes, such as marriage, divorce, or birth information. The system did not provide a confirmation notice when an employee entered a plan, or changed coverage level. The 20-year-old computer system limited payroll entries to $999.99. This caused an incorrect amount to be passed through the health fund system if an employee's deductions were doubled up or adjustments exceeded $999.99. Another problem was that the health fund could handle only one enrollment application, update, or any other transaction which affected the premium per employee each month.

Watson also noted that there was no standard procedure to correct invalid data. Data was not validated before processing. The actual data editing occurred when it was processed through the system. Even then, the editing was incomplete and many data errors occurred. For example, the system did not identify duplicate spouse enrollment until after the transaction was posted. Because errors were identified at the end of the process, rather than at the beginning, many processing delays resulted in an attempt to determine the correct information that should be processed.

Service center concept was proposed

The Watson study provided the system requirements and design alternatives for a new computer system for the health fund. Watson recommended a service center concept where all employee, employer, union plan, and insurance carrier inquiries are handled at a central location. This approach was intended to completely redesign the health fund's current processes. The health fund would use an interactive voice response system backed up by on-line service representatives and off-line referral specialists to answer employee questions, process employee transactions, and respond to union plan and insurance carrier needs. While Internet access would not be added at this time, the recommended system was intended to reduce paperwork, automate access to information, and provide improved customer service.

Also recommended was improved access to better management information not readily available from the health fund's obsolete computer system. For example, the health fund would be able to access information on transactions and enrollment patterns; track the number and content of inquiries from employees and other users; identify situations that are generating the most problems; and track costs and customer satisfaction.

The design and implementation consultant has begun working even though complete funding is not secured

The Hunter Group was selected by the board to develop and implement the health fund's new computer system, working from Watson's recommendations with the health fund's input. The Hunter Group is a custom vendor which builds computer applications depending on the client's needs. The new system will use *PeopleSoft* software. The Watson study noted that this software's specialty is benefits administration and appears to satisfy almost all of the needs for a human resource information system.

Hunter Group staff began working at the health fund in February 1999. As of March 1999, the consultant is in the design phase working toward creating the customized prototype for the new computer system. However, work has begun even though complete funding for both the design phase and the implementation phase has not been secured.

The Hunter Group's proposed price for both phases exceeded earlier project estimates. The unanticipated added expense of the consultant's

proposal exceeded the $3.6 million trust fund appropriation authorized by the Legislature in FY1998-99. The board chair noted that the board frequently implements contracts before they are executed because it takes a long time to get the attorney general's approval. To move the project ahead, the health fund and its contractor verbally agreed to begin work under a contract covering the design phase before securing the funding for the entire project and executing a contract for the implementation phase. In the 1999 legislative session, the health fund is seeking an additional $2.5 million trust fund appropriation to cover the remaining cost of the project agreed to by the board and the Hunter Group.

We believe that verbal agreements to continue work place the State in a position of being potentially liable for the cost of the next phase (implementation) if the health fund cannot get approval for full funding. Our financial audit of the health fund, Report No. 99-18, identified other contract management concerns. The health fund should ensure that work on the implementation phase does not happen prior to a properly executed contract.

Compatibility with other public employee computer systems is unresolved

The health fund's existing computer system is not linked to other public employee related systems, such as personnel, payroll, and the Employees' Retirement System. There has been much discussion about designing the new computer system to be compatible and integrated, but no trustee or state personnel are sure that integration will be successfully implemented. Many trustees expressed concern that the health fund's new computer system may not integrate with other public employee computer systems. Even the administrator is not sure how well the health fund's computer system will interface with the Department of Human Resource Development's new computer system, which is using an earlier version of *PeopleSoft* than the health fund plans to use. Although that department's new computer system is expected to be running by 2000, the health fund administrator reports that there have been no discussions on linkage with the health fund's system.

The Board Has Yet to Implement a Long-Term Care Plan

The board has yet to implement a long-term care benefit plan for the Hawaii Public Employees Health Fund. Act 334, SLH 1989 required the health fund to establish a long-term care benefit plan for the health fund's beneficiaries. In 1991, the health fund's consultant, William M. Mercer, Inc., issued its report on the benefit design, pricing, administration, and communication strategies to establish a long-term care benefit plan. However, in the eight years since the Mercer study, the board has been unable to obtain approval to adopt such a plan or to follow up on the study. Our financial audit Report No. 99-18 discusses these issues in detail.

The board has attempted to obtain funding to establish the long-term care plan. However, the health fund's budget requests to implement a long-term care plan for fiscal biennium (FB) periods FB1991-93, FB 1993-95, and FB1995-97 were not funded. At one point, it was thought that the Executive Office on Aging's statewide long-term care initiative, the Hawaii Family Hope Project, would eliminate the need for the health fund to establish a long-term care plan for public employees. However, Hawaii Family Hope failed because the plan was to be funded through a new tax on all taxpayers.

Delays in establishing a long-term care plan persist

Delays in establishing the health fund's long-term care plan persist. In the 1999 legislative session, the health fund is seeking $103,000 to hire a consultant to review the 1991 Mercer reports and to develop a request for proposal for the long-term care benefit plan. The health fund is seeking an additional $3,000 for training and communication related to establishing the plan. We believe that the Board of Trustees should proceed to implement the law that calls for a long-term care plan for state and county employees, retirees, and beneficiaries.

Customer Service Could Be Improved

The health fund currently provides a basic level of assistance to participants. According to the administrator, the health fund is not structured to be a high-powered customer service organization. Neither the board nor the administrator has surveyed those it represents. We randomly sampled public employees and retirees about their health benefits, customer service, experiences with insurance carriers, and suggestions for improvement. Our survey of enrollees identified areas of satisfaction and concern. We found that satisfaction is generally lower among retirees. The health fund also needs to improve its communication with public employers and their staff to ensure that health benefit enrollments are handled efficiently and effectively.

Importance of communication

Benefit plans must be frequently restudied to determine whether a group benefit plan is continuing to meet its desired purpose and the needs of the workforce. It should clarify what the benefits mean and explain why changes are made. Effective communication can minimize dissatisfaction that arises from misunderstandings about the benefit program and can encourage prudent use of benefits.

The health fund's primary communication with employees and retirees each year is through its benefit plan booklets delivered prior to the open enrollment period. For the first year of the two-year benefit period, a booklet presents information on each of the health fund's plans offered,

and instructions for enrolling in those plans. In the following year, since the benefits do not change, the health fund prepares an abbreviated benefit newsletter for active employees and retirees.

Experts in employee benefits management suggest that effective communication about health benefits is more than just distributing a summary plan description. The basic purpose of benefits communication is to help achieve the goals of the benefit program and increase employee awareness, understanding, and appreciation of the benefits provided. Person-to-person contact is important to keep tabs on what employees, managers, and supervisors are thinking and to clear up any misunderstandings that may arise.

Customer service in other states

We contacted a number of states about their public employee health benefit programs. We found that many states have detailed health benefit information ranging from newsletters, brochures, publishing employee survey results, and establishing Internet web sites.

A number of states, including California, Connecticut, Georgia, Maine, Michigan, and Pennsylvania have Internet web sites. Maine and New Hampshire provide ombudsman assistance for enrollees if there are problems with their insurance carriers. Colorado surveys its membership on a regular basis. Oregon and Pennsylvania have conducted membership surveys about customer service. Oregon recently published its survey results in a booklet for its membership.

Pennsylvania has customer service representatives and an interactive voice response system. Pennsylvania's benefit plan representative noted that the interactive system did not result in a big reduction of calls to customer service representatives because most people want to talk to a real person, not a computer.

Arizona and Pennsylvania prepare newsletters for enrollees. Maine requires its insurance vendor to provide a quarterly newsletter for its membership.

There are many ways in which the Hawaii Public Employees Health Fund can improve customer service to enrollees. Improving customer service and communication with enrollees is an important tool to help people understand and appreciate health benefits and use those benefits in a cost effective manner.

Our survey of enrollees identifies areas of satisfaction and concern

The health fund is established to provide health, life, and long-term care benefits for public employees, retirees, and their beneficiaries. However, to date, neither the Board of Trustees nor the health fund has surveyed enrollees about customer service, benefits, or concerns about their insurance carriers. Also troubling is that the health fund does not track inquiries or complaints from participants.

We randomly sampled public employees and retirees using the health fund's master list. Our survey found that overall, respondents are satisfied with their health benefits. However, retirees are less satisfied than active employees. Some enrollees would like the health fund to provide clearer and more information. Respondents also want the health fund to ask for their suggestions.

Our random sample included participants in the health fund and union plans. Nearly 75 percent of health fund medical plan participants reported that they are not likely to transfer to a union medical plan. Similarly, 78 percent of the union plan participants are not likely to transfer to a health fund plan. For health fund participants, the leading reasons for choosing the health fund plans were cost, better coverage, and wanting to stay with the same health plan. Union plan participants reported that cost and better coverage were the reasons for choosing the union plan.

Differences indicate that retirees need more attention

We found that retirees are less satisfied than active employees with the length of time spent waiting for assistance, courtesy, quality of response to request for information, quality of response to a complaint, and speed in making a change or correction. For instance, when contacting the health fund for information, 93 percent of active employees were satisfied compared to 64 percent for retirees.

We also asked participants to rate their satisfaction regarding how long they waited for assistance. Over 83 percent of our respondents were satisfied with how long they waited for assistance. While the majority of active employees, 90 percent, were satisfied with their wait, fewer retirees, 67 percent, were satisfied.

The majority of respondents, about 87 percent, understand the information in the open enrollment benefit plan booklets. However, slightly fewer retirees, 85 percent, report that they understand the benefit booklets compared to 88 percent for active employees.

Evaluations of respondents' satisfaction with the courtesy of health fund staff showed a similar spread between retirees and active employees. Over 87 percent of respondents are satisfied with the courtesy of the

health fund's staff. However, 73 percent of the retirees reported satisfaction with staff courtesy compared to over 93 percent of active employees.

We asked respondents to rate the quality of the response by the health fund to their complaint. Seventy-three percent of respondents were satisfied with the quality of the health fund's response. Slightly over three-quarters, 77 percent, of active employees indicated that they were satisfied with the health fund's response to complaints, compared to about two-thirds, 67 percent, of retirees.

The health fund acknowledges that its computer system hinders speedy error correction. Accordingly, far fewer respondents, nearly 59 percent, reported that they are satisfied with the speed with which the health fund makes changes or corrections. Still, somewhat more active employees, over 61 percent compared to 50 percent of retirees, reported that they were satisfied with the speed in making changes or corrections.

The differences indicate areas in which the health fund can better serve employees' and retirees' needs. While active employees can contact their designated personnel officer at their work site about their health benefits, the health fund is the primary source of information for retirees when they have questions about their health benefits. These survey responses point to the need for the health fund to examine ways it can improve its communication and services for retirees.

Problems with insurance carriers

We asked participants about their experiences with their insurance carrier. The majority of respondents did not report any problems with their insurance carrier. However, about 13 percent of respondents did report problems. HMSA received 78 percent of the complaints from respondents. Kaiser, Kapi'olani HealthHawaii, and Hawaii Dental Service (HDS) received fewer complaints. Reported difficulties with carriers included long delays in claims reimbursement and poor billing services. Out-of-state beneficiaries also reported problems with insurance carriers. These problems provide an opportunity for the health fund to step in and assist enrollees. Other state health plans perform an ombudsman role to ensure prompt and appropriate action from insurance carriers, to identify and track performance, trends, and also to ensure that enrollees' health benefit needs are met.

One respondent reported a potentially serious problem. A mail-order prescription drug company twice sent medication mixed in with another prescription medicine. Neither HMSA nor the mail-order prescription company reportedly resolved this problem satisfactorily. We did not independently verify this reported problem.

The health fund plans to include performance standards in its HMSA contract. These measures include timely responses to inquiries and prompt problem resolution. The health fund should inform enrollees that all carriers' service to its membership is important. This feedback can be used to improve carriers' performance.

Better communication with employers is needed

We found that the health fund needs to improve its communication with county employers. The health fund relies upon the assistance of state and county staff during the open enrollment period. Much of the person-to-person benefit information and enrollment is handled by approximately 500 designated personnel officers at all levels of state and county government. According to the administrator, the health fund trains these staff once a year prior to the open enrollment period.

County representatives indicated that they would like to have more communication with the health fund to provide feedback on training, benefits, or insurance plans. Three counties identified specific problems needing attention. For example, one county noted the once a year training for open enrollment is intense and provides an overwhelming amount of information. They would like on-going training and more contact with the health fund to provide feedback. Other problems cited by the counties included late notification of shortages in an employee's contributions leading to cancellation notices, problems with insurance carriers, and administrative problems.

Issues for Further Study

The Hawaii State Ethics Commission issued an opinion about a potential conflict of interest. In addition, it noted other issues in the course of its investigation. The commission expressed concern about the board's minutes and the trustees' understanding of the criteria for selecting an insurance carrier. The commission acknowledged that while its other observations about the board were outside its jurisdiction, it nevertheless believed that it has an obligation to bring additional matters to the board's attention. We did not explore these issues in our study, but we believe they may warrant further study.

Potential conflict of interest with union life insurance plans

There were recent concerns about a potential conflict of interest and favoritism regarding health fund trustees who represent unions voting in December 1998 for a life insurance plan offered by an insurance company which handles health benefits for those unions. By statute, three of the nine trustee positions are designated for public employee union representatives. The HGEA and the UPW already offered health benefit plans through Royal State Insurance. Some felt that HGEA's and UPW's

representatives on the board should have recused themselves from voting on the life insurance carrier since the executive directors of their unions serve on the board of Royal State Insurance.

However, those trustees did vote and Royal State was awarded the health fund's life insurance 1999-2000 contract. In FY1996-97 the health fund paid nearly $3.2 million for life insurance benefits. The board's secretary-treasurer protested that Royal State's life insurance plan was more expensive and had less attractive benefits than another insurance carrier's plan. The controversy also led the governor to express his concerns about the matter to the board.[1]

The Hawaii State Ethics Commission examined whether there was a conflict of interest or favoritism. It found insufficient evidence to establish any violation of the State Ethics Code's conflicts of interest law or favoritism law. However, the commission went on to state that it believes that having state officials or board members taking official action directly affecting companies run by boards on which their "bosses" sit raises a matter of concern. As a result, the commission has decided to study whether Section 84-14(a), HRS, Conflicts of Interest, should be amended.

Adequacy of board minutes

The ethics commission reported that the Board of Trustees' meeting minutes did not indicate what companies were under consideration by the board, or the views expressed by board members when considering the award of the contract. The lack of minutes providing a description of the board's deliberation in awarding the contract resulted in no record for the commission's review in determining whether or not there was any violation of Section 84-13, HRS, Fair Treatment.

The commission explained that Chapter 92, HRS, Public Agency Meetings and Records, sets forth how minutes for both public and executive portions of board meetings must be prepared and maintained. Section 92-9, HRS, Minutes, states that neither a full transcript nor a recording of the meeting is required, but the written minutes shall give a true reflection of the matters discussed at the meeting and the views of the participants. The commission believed that the issue of whether or not the minutes are in compliance with Section 92-9, HRS, should be brought to the attention of the board's counsel. The board indicated that it intends to include more detail in its meeting minutes.

Concerns about procurement criteria

The commission also noted that there may have been confusion about what aspects of various proposals were significant or not. It observed that Section 87-24, HRS, Selection of a Carrier...for a Health Benefits, Group Life Insurance, or Long-Term Care Benefits Plan, appears to exclude the health fund's board from the State's procurement law. This

allows the board flexibility in determining the specifications for awarding contracts. The commission observed that the board's flexibility and discretion may have created confusion for board members as to what aspects of the life insurance proposals were significant or not. The commission stated that it was difficult to evaluate the allegations of possible wrongdoing because of the flexible process for awarding contracts. It suggested that the board consider taking steps to ensure that trustees clearly understand the weight accorded to various elements of different insurance proposals.

Conclusion

The Board of Trustees of the Hawaii Public Employees Health Fund must address several pressing issues. The board has not effectively handled its reserves to stabilize premium rates and has not returned excess reserves to employees. Another deficiency is the board's insufficient oversight of and pursuit of information about the union health benefit plans and their impact on the health fund.

The health fund's new computer system was long delayed, but now holds the promise of better management information, and streamlined, more efficient operations. The board should ensure that work on the implementation phase does not occur prior to a properly executed contract. Finally, the board needs to improve the health fund's customer service for its employee and retiree beneficiaries.

Recommendations

1. The Board of Trustees of the Hawaii Public Employees Health Fund should fulfill its fiduciary responsibilities by reviewing and improving its rate stabilization efforts.

2. The board should work closely with the Legislature, the Department of Budget and Finance, and the Department of the Attorney General to resolve the disposition of excess reserves created by employee contributions.

3. The board should immediately begin to audit the union health benefit plans on a periodic basis to ensure that premiums are being paid to purchase health benefits.

4. The board should exercise its fiduciary responsibility by analyzing the impact of the union plans on the health fund. It should reexamine the validity and applicability of the attorney general's July 1979 opinion concerning the board's responsibilities and liabilities for the union health benefit plans.

5. The board should continue with its plans to design and implement a new Health Fund Information Management System.

6. The board should ensure that work on the implementation phase of the health fund's new computer system does not begin prior to a properly executed contract.

7. The board should review and improve its contract management practices to protect the interests of the State, the health fund, and the consultant.

8. The board should continue its efforts to establish a long-term care plan for the Hawaii Public Employees Health Fund.

9. The board should improve customer service for retiree and employee beneficiaries by:

    a. requiring the administrator to establish a formalized feedback system with employees, retirees, and beneficiaries, and also with the state and county employers;

    b. examining ways of improving customer service for retirees;

    c. monitoring the carriers' customer service; and

    d. considering the creation of an ombudsman role for the health fund to trouble-shoot problems on behalf of its beneficiaries.

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Glossary

The following health benefit-related terms are defined based on their use in this report.

accrued liability
The actuarial present value of the post-retirement benefits earned to date by active employees and retired employees at a point in time. This includes the benefits to be received by dependents of the retirees as well. Benefits are the contributions employers pay for the employer portion of the medical, prescription drug, dental, vision, and life insurance benefits and the Medicare Part B premium subsidy for those retirees also covered by Medicare.

actuary
A professional trained in business, mathematics, and statistics, who studies and evaluates risks to determine the cost and potential liabilities to fund those risks, such as for benefit programs and their current and future costs.

adverse selection
In the context of employee benefit programs, adverse selection occurs when one group of employees is able to take advantage of their situation, thus reducing their own costs at the expense of inadvertently increasing the employers' costs and/or the costs of other employees.

aggregate method
An actuarial method to calculate the employers' total annual cost to prefund a post-retirement benefit liability as the sum of the annual amounts needed for each individual to fully fund that employee's retiree benefits by the time that employee retires.

amortization
A process of gradually reducing the unfunded portion of a liability by systematically accumulating funds to fully cover the employees' health benefit liability upon retirement.

annual experience report
The report that shows the amount of premiums, claims costs, administrative costs, and resulting surplus or deficit under the health benefit program. This is computed separately for each type of benefit coverage.

community rated
In health insurance or health maintenance organization (HMO) coverage, premium rates are community rated when they are calculated based on the expected average costs of the entire community, not on subsets of that community (e.g., an employer group). A community could be a city, a county, or some other specifically defined geographic division.

disbursements from health fund
The amounts paid by the health fund either to carriers or to union plans to pay health insurance premiums.

discount rate
The interest rate used to calculate the present value of an amount or a liability to determine its value today.

economic assumption
Any assumptions used in the calculation of an amount, such as the amount of post-retirement health benefits liability in this case, where any change in those assumptions will change the amount calculated.

employer contribution
The employer's share of the total monthly cost or premium paid to the health fund for the benefits being provided to the employees, retirees, and their dependents.

entry age normal
An actuarial method to calculate the total annual cost to prefund a post-retirement health benefit liability on the basis of a level or equal annual contribution from the first day of employment (entry age) to the assumed date of retirement.

excess contributions
The excess of the amount of contributions paid by the employers and employees over the actual total annual cost of an employee benefit program.

experience rated
In the case of employee benefit coverage, premium rates are experience rated when they are based on the specific historical cost experience of an employer group rather than the expected average costs of the entire community in which the employer is located.

health benefit program
This refers to the entire program of medical, dental, prescription drug, vision, and life insurance benefits and Medicare Part B reimbursement that is available to public employees in Hawaii, including both health fund and union plans.

Medicare Part B
The non-hospital portion of Medicare. The hospital portion is called Medicare Part A.

Medicare risk plan
Coverage provided through an HMO where the HMO takes on the full risk of providing Medicare-like coverage plus, usually, additional coverage not provided by Medicare. The total premium received by the HMO for Medicare risk coverage is an amount paid by the Health Care Financing Administration, the federal agency that administers Medicare, plus (in most cases) an additional amount paid by the individual covered and/or the employer.

Medicare Supplement
Insurance coverage for healthcare expenses that will not be reimbursed by Medicare.

mortality rate
The probability of death for a given population in one year.

normal cost
The portion of the post-retirement benefit that is earned in each year of employment service. For example, an employee 30 years from retirement who is expected to earn a benefit that has a current value of $30 might earn (i.e. have a normal cost of) $1 per year of service.

pay-as-you-go
A method to pay for retiree health benefit costs as they are incurred each year rather than setting aside or prefunding the cost of those benefits over the working lifetime of the employees before they retire.

porting
The term used to describe the function performed by the health fund to pass the employer contributions for union members over to the union plans.

prefunding method
A method of setting aside extra funds that can earn interest similar to a savings account to accumulate enough assets for each employee to cover the value of his or her health benefit costs at the time of retirement.

premium
The amount charged by a carrier to provide the employee benefit coverage.

present value

The calculated value today of an amount needed in the future taking into account the time value of money (i.e. interest discount) and the probability that the amount in the future will actually be needed.

projected benefits

In the context of this report, the projected benefits are the expected future employer contributions that will be required to pay for the health benefit costs for active employees and retirees.

projected liabilities

In the context of this report, the projected liabilities are the present value of the employer contributions that will be needed to pay for the post-retirement health benefits for retirees under an assumption that the rights to these benefits are earned over the working lifetime of those retirees.

projected unit credit method

An actuarial method to calculate the total annual cost to prefund a post-retirement benefit liability as the sum of the portion of the benefit earned in one year (i.e. the normal cost) plus the annual amount needed to amortize any unfunded liability existing at the time that the funding method was first adopted.

reserves

Reserves, or more precisely, rate stabilization reserves are amounts set aside for those unusual circumstances when the total amounts available from employer, employee, and retiree contributions are insufficient to cover all of the premium costs of the health benefit program.

tiered rating

Carriers can express their premium rates in different ways for various benefit coverages. For example, a two-tier rating structure would be one where the rates are expressed in terms of single (i.e. employee only) or family (i.e. employee plus all dependents). A three-tier rate would be single, two-person (i.e. employee plus one dependent) and family (i.e. employee plus two or more dependents), and so on.

trend assumptions

Projections which are made based on what might occur in the future. A range of trend rate assumptions, such as low, intermediate, and high, is used to show a likely range for future health program costs and a likely range for the post-retirement health benefit liability.

trend rates
The expected increase in health care costs from one year to the next. This increase is due to cost increases in the units of service, such as per office visit to physicians, per day of hospital stay, etc., as well as a greater utilization of services, such as more office visits, more hospital days, etc.

unfunded liability
The portion of the total liability that is not set aside or prefunded. At the present time the entire post-retirement benefit liability for the health fund is unfunded.

unfunded post-retirement benefit liability
See "unfunded liability."

valuation
An actuarial estimate of the post-retirement health benefit liability.

valuation date
The date at which the "present values" were calculated to determine the post-retirement health benefit liability.

valuation report
The report that discusses the actuarial estimate of a liability.

withdrawal rate
Assumed rate of termination of employment.

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Introduction to Appendixes

Appendix A presents the assumptions used to project the employer contribution costs and the post-retirement unfunded actuarial liabilities for the Hawaii public employees health benefit program. We use the phrase "health benefit program" to refer to all of the plans available to the employees whether they are offered by the health fund or the unions. The model computes age-specific medical claims costs for each year. The formula employed to compute the plan's anticipated claims cost varies by plan design and the availability of claims data. For example, paid claims data were available for the health fund plans, but not for the union plans. The health fund's claims experience was consistent with the premium information, so the premium information was used as the basis for benefit costs for all plans in this study.

The model used to project current and future retiree medical claims costs is similar to models used to project the corresponding current and future amounts needed for pension benefits (cash flows and present values). For each year in the future, the number of retirees at each age is estimated. The assumptions used for projecting the number of retirees were taken from the 1997 actuarial valuation by the Segal Company for the Employees' Retirement System of the State of Hawaii. These assumptions were adopted by the Board of Trustees of the retirement system, based on statutory requirements and on Segal's actuarial experience report on the retirement system covering the 1990-95 period.

New retirees are projected to enter from the active employee population based on assumed retirement and mortality rates applied to the retiree enrollment after their date of retirement. The resulting population at each age is multiplied by the assumed age-specific employer cost for each employee or retiree, including dependents. The results for each employee or retiree are summed to obtain the expected claims costs for each year. The cost for all years, are summed, taking interest into account (present values) to estimate the liability.

The significant difference in the models for pension plans and retiree medical plans comes in the mechanics of computing the age-specific claims costs. The cost of providing retiree medical benefits typically changes with each year of age and year in time, but pension benefits are usually fixed or adjusted only for inflation.

Another difference between models projecting the costs and liabilities of health benefit programs and pension plans, is that the population for which health benefits are paid must also take into account employees,

retirees, and *all* eligible dependents. However, pension plan cost and liability models only include the surviving spouse as the only dependent in the projections along with the employees and retired employees.

Appendix A, Exhibit 1 presents information on employer costs estimated on a per person monthly net cost to the employer for the year beginning July 1, 1998.

Appendix A, Exhibit 2 presents the economic assumptions used to project the future years' employer costs per employee, retiree, or family. The percentages represent the percent increase in costs for each year. Over time, the percentages generally decrease simply to try to be somewhat optimistic that health care costs in the future will not continue to increase at the high levels of today.

Appendix A, Exhibit 3 shows the demographic assumptions used to project the enrollment in future years of both active employees and retirees. Withdrawal rates refer to the probability of an active employee terminating his or her employment in a particular year. Higher rates were used for our withdrawal assumptions during the first three years of employment because there is a tendency for higher termination rates. After the third year of employment we applied lower termination rates, in which we assume that age was the only variable that affected the level of terminations.

Appendix B, Exhibits 1, 2, and 3 present the projected annual employer contribution costs and the post-retirement unfunded actuarial liabilities for the Hawaii public employees health benefit program. The assumptions used in the model to calculate these values are summarized in Appendix A. The results of the projections are shown for three scenarios based on low, intermediate, and high trend rates.

Appendix B, Exhibit 4 presents the projected number of retirees over the 15-year projection period. It shows the number of employees and retirees covered. Future retirees are the retirees from the current active employee population.

Appendix C presents information obtained from other states' public employee and retiree health benefit programs. We requested information on governance, program design, funding, administration, rate and benefit negotiation, management practices over excess contributions or reserves held by the state or carriers, and management controls. Twelve states that we contacted had readily available information about their program: Arizona, California, Colorado, Connecticut, Michigan, Missouri, New York, Oregon, Pennsylvania, South Dakota, Texas, and West Virginia.

Appendix A

Exhibit 1
Employer Costs

Net Cost

We estimate the per person monthly net costs to the employer for the year beginning July 1, 1998 to be:

Medical

	Health Fund			Union
	HMSA	Kaiser	Kapiolani/HMO	
Single Coverage				
Active				
Regular Employees Units	$80.58	$80.58	$80.58	$80.58
01, 10, 61, 70, 20, 90 & 33	$120.88	$120.88	$120.88	$120.88
Retiree				
Non-Medicare	$190.36	$209.56	$159.76	N/A
Medicare	$64.04	$82.56	$76.24	N/A
Family Coverage				
Active				
Regular Employees Units	$247.98	$247.98	$247.98	$247.98
01, 10, 61, 70, 20, 90 & 33	$288.28	$288.28	$288.28	$288.28
Retiree				
Non-Medicare	$531.00	$628.64	$479.28	N/A
Medicare	$210.24	$247.64	$228.72	N/A

Prescription Drugs

	Health Fund		Union
	HMSA	Kaiser	
Single Coverage			
Active Employees	$12.72	$11.24	$12.72
Retiree			
Non-Medicare	$34.28	$15.72	N/A
Medicare	$42.28	$21.72*	N/A
Family Coverage			
Active Employees	$39.16	$33.72	$39.16
Retiree			
Non-Medicare	$95.60	$47.16	N/A
Medicare	$138.96	$65.08*	N/A

*Based on expected future rates rather than current year rates.

Exhibit 1
Employer Costs (continued)

Vision Care

	Health Fund	Union
Single Coverage		
Active Employees	$3.10	$3.10
Retiree		
Non-Medicare	$3.92	N/A
Medicare	$3.92	N/A
Family Coverage		
Active Employees	$6.06	$6.06
Retiree		
Non-Medicare	$7.72	N/A
Medicare	$7.72	N/A

Adult Dental

	Health Fund		Union
	HDS	Denticare	
Single Coverage			
Active Employees	$11.58	$11.58	$11.58
Retiree			
Non-Medicare	$21.20	$19.32	N/A
Medicare	$21.20	$19.32	N/A
Family Coverage			
Active Employees	$23.18	$23.18	$23.18
Retiree			
Non-Medicare	$42.44	$37.16	N/A
Medicare	$42.44	$37.16	N/A

Childrens Dental

	Health Fund		Union
	HDS	Denticare	
Per child under age 19	$11.80	$11.08	$11.80

Life Insurance

	Health Fund	Union
Grand Pacific Life	$4.30	$4.30

Exhibit 1
Employer Costs (continued)

Part B Premiums

	Health Fund	Union
Medicare	$43.80	N/A

Employees hired before July 1, 1996 with ten or more years of service at retirement receive a benefit equal to 100 percent of the medical, prescription drug, vision, and adult dental premiums shown above. Employees hired before July 1, 1996 with less than ten years of service receive a benefit at retirement equal to 50 percent of the rates shown above. Employees hired on or after July 1, 1996 receive benefits at retirement subsidized by the employer according to the following schedule:

Years of Service at Retirement	Percentage of Cost Shown Above
25 or more	100%
15 or more, but less than 25	75%
10 or more, but less than 15	50%
Less than 10	0%

Trend rates applicable to these costs are shown in Exhibit 2 of this appendix.

Exhibit 2
Economic Assumptions

Valuation Date	July 1, 1998 through July 1, 2013
Discount Rate	7.00%
Trend Rates	We calculated projected benefits and liabilities based on three trend rate scenarios. The percentages below represent the percentage increase in the employers' cost under the low trend scenario.

Low Trend Scenario

Year	Medical	Drug	Dental	Vision
1998	6.0%	12.0%	5.0%	2.0%
1999	6.0	11.6	4.9	2.0
2000	6.0	11.2	4.8	2.0
2001	6.0	10.8	4.7	2.0
2002	6.0	10.4	4.6	2.0
2003	6.0	10.0	4.5	2.0
2004	6.0	9.6	4.5	2.0
2005	6.0	9.2	4.5	2.0
2006	6.0	8.8	4.5	2.0
2007	6.0	8.4	4.5	2.0
2008	6.0	8.0	4.5	2.0
2009	6.0	7.6	4.5	2.0
2010	6.0	7.2	4.5	2.0
2011	6.0	6.8	4.5	2.0
2012	6.0	6.4	4.5	2.0
2013 and Later	6.0	6.0	4.5	2.0

Trend Rates	We calculated projected benefits and liabilities based on three trend rate scenarios. The percentages below represent the percentage increase in the employers' cost under the intermediate trend scenario.

Intermediate Trend Scenario

Year	Medical	Drug	Dental	Vision
1998	9.0%	13.5%	7.0%	3.0%
1999	8.8	13.1	6.9	3.0
2000	8.6	12.7	6.8	3.0
2001	8.4	12.3	6.7	3.0
2002	8.2	11.9	6.6	3.0
2003	8.0	11.5	6.5	3.0
2004	7.8	11.1	6.4	3.0
2005	7.6	10.7	6.3	3.0
2006	7.4	10.3	6.2	3.0
2007	7.2	9.9	6.1	3.0
2008	7.0	9.5	6.0	3.0
2009	6.9	9.1	6.0	3.0
2010	6.8	8.7	6.0	3.0
2011	6.7	8.3	6.0	3.0
2012	6.6	7.9	6.0	3.0
2013 and Later	6.5	7.5	6.0	3.0

Exhibit 2
Economic Assumptions (continued)

Trend Rates — We calculated projected benefits and liabilities based on three trend rate scenarios. The percentages below represent the percentage increase in the employers' cost under the high trend scenario.

High Trend Scenario

Year	Medical	Drug	Dental	Vision
1998	12.0%	15.0%	9.0%	4.0%
1999	11.8	14.7	8.9	4.0
2000	11.6	14.4	8.8	4.0
2001	11.4	14.1	8.7	4.0
2002	11.2	13.8	8.6	4.0
2003	11.0	13.5	8.5	4.0
2004	10.8	13.2	8.4	4.0
2005	10.6	12.9	8.3	4.0
2006	10.4	12.6	8.2	4.0
2007	10.2	12.3	8.1	4.0
2008	10.0	12.0	8.0	4.0
2009	9.8	11.7	7.9	4.0
2010	9.6	11.4	7.8	4.0
2011	9.4	11.1	7.7	4.0
2012	9.2	10.8	7.6	4.0
2013 and Later	9.0	10.5	7.5	4.0

Medicare Part B premiums are trended at the same rate as medical benefits.

Exhibit 3
Demographic Assumptions

Retirement Rates The assumed retirement rates per 100 for employees eligible to retire at selected ages are as follows:

	General Employees		Teachers		Police, Fire and Correction Officers	
Age	Male	Female	Male	Female	Male	Female
45	N/A	N/A	N/A	N/A	35.0	35.0
50	N/A	N/A	N/A	N/A	20.0	20.0
55	7.0	7.0	8.0	10.0	35.0	35.0
60	7.0	10.0	5.0	10.0	90.0	90.0
65	60.0	40.0	20.0	30.0	100.0	100.0
70	100.0	100.0	100.0	100.0	100.0	100.0

Mortality Rates The life expectancies projected by the assumed mortality tables at selected ages are shown below:

	General Employees		Teachers		Police, Fire and Correction Officers	
Age	Male	Female	Male	Female	Male	Female
40	38.4	43.6	42.3	44.5	37.4	43.6
45	33.7	38.7	37.5	39.9	32.7	38.7
50	29.1	34.0	32.8	34.9	28.2	34.0
55	24.7	29.3	28.3	30.2	23.9	29.3
60	20.6	24.8	24.0	25.7	19.8	24.8
65	16.6	20.5	19.8	21.3	15.9	20.5
70	13.1	16.4	16.0	17.1	12.4	16.4
75	10.1	12.7	12.5	13.4	9.5	12.7
80	7.5	9.6	9.6	10.2	7.1	9.6

Withdrawal Rates The withdrawal rates are dependent on both the age of the employee and the number of years of service the employee has completed. For this purpose, we have used a 3-year select and ultimate withdrawal table, with higher rates used for the first three years for employment, followed by an ultimate rate. The assumed ultimate withdrawal rates per 100 for employees at selected ages are as follows:

	General Employees		Teachers		Police, Fire and Correction Officers	
Age	Male	Female	Male	Female	Male	Female
22	9.21	8.99	4.36	7.62	2.80	2.80
27	6.00	7.20	4.32	6.53	3.79	3.79
32	5.00	6.05	4.25	5.35	3.40	3.40
37	3.86	4.17	4.14	3.98	2.08	2.08
42	2.92	2.93	3.65	2.63	1.27	1.27
47	2.47	2.55	2.45	1.72	1.16	1.16
52	2.08	2.12	1.84	1.32	1.33	1.33

Exhibit 3
Demographic Assumptions (continued)

Disability Rates — The disability rates project the percentage of employees at each age who are assumed to become disabled before retirement. All disabilities are assumed to be ordinary disability rather than accidental disability. The assumed total disability rates at select ages are as follows:

	General Employees		Teachers		Police, Fire and Correction Officers	
Age	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
22	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%
27	0.02	0.02	0.01	0.01	0.02	0.02
32	0.02	0.02	0.01	0.01	0.02	0.02
37	0.02	0.02	0.01	0.01	0.03	0.03
42	0.04	0.04	0.02	0.02	0.05	0.05
47	0.08	0.08	0.04	0.04	0.10	0.10
52	0.18	0.18	0.09	0.09	0.22	0.22

Marriage — 55 percent for both male and female employees while active.
60 percent for both male and female active employees upon retirement.
Actual spouse information used for current retirees.

Spouse Age Difference — Males are assumed to be three years older than their spouses for active employees. Actual spouse information used for current retirees.

Spouse Coverage — Continues for lifetime of spouse.

Eligibility — Employees are assumed to be eligible for benefits at the same time that they are eligible for pension benefits. Service is credited beginning at date of hire.

Part B premiums are reimbursed for all retirees (and their spouses) who have ten or more years of service at retirement.

Participation — 85 percent for future retirees.

Coverage — Active and current retiree coverage is determined by current plan of benefits with the exception of life coverage (extended to all employees) and children's dental (based on average enrollment for 1997).

Future retirees are assumed to remain in current plan with exception of union employees who are assumed to have benefits in the HMSA medical and drug plans, the VSP vision plan, the HDS dental plan, and Grand Pacific Life Plan at retirement.

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Appendix B

Exhibit 1
Projection of Future Employer Contribution Costs(*) and Post-Retirement Unfunded Liability
15-Year Projection 1998 to 2013, Low Trend Scenario

	Active Employee Cost			Current Retiree Cost		
Year	Health Fund	Employee Organizations	Total	Non-Medicare	Medicare	Total
1998	76,223,505	62,500,064	138,723,568	52,684,518	70,554,997	123,239,515
1999	81,772,453	67,185,403	148,957,856	50,055,057	76,659,597	126,714,654
2000	87,717,105	72,214,471	159,931,576	47,247,284	82,888,969	130,136,253
2001	94,080,550	77,607,992	171,688,543	44,383,100	89,100,776	133,483,876
2002	100,886,424	83,387,221	184,273,646	41,827,247	95,009,363	136,836,610
2003	108,158,857	89,573,892	197,732,748	38,702,473	101,185,915	139,888,388
2004	115,922,418	96,190,174	212,112,592	35,534,561	107,201,407	142,735,968
2005	124,218,507	103,265,352	227,483,858	32,299,610	113,026,598	145,326,208
2006	133,075,170	110,823,479	243,898,649	29,236,419	118,446,240	147,682,659
2007	142,521,063	118,889,088	261,410,150	25,753,859	123,824,127	149,577,986
2008	152,585,476	127,487,199	280,072,675	23,130,638	128,181,218	151,311,856
2009	163,298,389	136,643,371	299,941,761	20,513,214	132,085,306	152,598,520
2010	174,690,560	146,383,777	321,074,337	17,667,867	135,647,256	153,315,123
2011	186,793,647	156,735,305	343,528,953	15,119,258	138,443,030	153,562,288
2012	199,640,382	167,725,716	367,366,097	13,151,935	140,174,097	153,326,032
2013	213,264,780	179,383,822	392,648,602	11,245,235	141,264,282	152,509,517
Liability						
1998				359,659,559	1,504,184,914	1,863,844,473
2013				53,419,398	1,456,112,479	1,509,531,877
Segal's 1988 Accrued Liability						408,048,100

(*)Estimated Using the Health Fund's 7-1-97 Census Data.

	Future Retiree Costs			
Year	Non-Medicare	Medicare	Total	Grand Total
1998	1,697,617	2,469,545	4,167,162	266,130,246
1999	3,212,241	4,519,885	7,732,126	283,404,637
2000	6,651,355	5,359,423	12,010,778	302,078,607
2001	9,532,025	9,131,390	18,663,415	323,835,834
2002	16,648,966	10,265,092	26,914,058	348,024,314
2003	18,875,010	16,381,566	35,256,576	372,877,712
2004	27,374,674	17,695,608	45,070,282	399,918,842
2005	26,375,384	27,410,939	53,786,323	426,596,389
2006	38,070,771	28,868,406	66,939,176	458,520,484
2007	39,057,576	44,065,989	83,123,565	494,111,701
2008	57,706,950	46,831,930	104,538,880	535,923,410
2009	70,905,758	50,693,147	121,598,905	574,139,186
2010	77,415,311	57,823,251	135,238,561	609,628,021
2011	40,375,329	111,463,320	151,838,649	648,929,890
2012	61,507,822	124,783,722	186,291,544	706,983,673
2013	79,839,881	132,082,546	211,922,427	757,080,545
Liability				
1998	309,053,521	1,426,711,086	1,735,764,607	3,599,609,080
2013	836,221,239	5,636,970,369	6,473,191,608	7,982,723,485
Segal's 1988 Accrued Liability			304,683,300	712,731,400

(*)Estimated Using the Health Fund's 7-1-97 Census Data.

Exhibit 2
Projection of Future Employer Contribution Costs(*) and Post-Retirement Unfunded Liability
15-Year Projection 1998 to 2013, Intermediate Trend Scenario

	Active Employee Cost			Current Retiree Cost		
Year	Health Fund	Employee Organizations	Total	Non-Medicare	Medicare	Total
1998	76,223,505	62,500,064	138,723,568	52,684,518	70,554,997	123,239,515
1999	83,760,114	68,876,885	152,636,998	51,333,715	78,401,249	129,734,964
2000	91,917,384	75,785,292	167,702,676	49,614,326	86,585,509	136,199,835
2001	100,726,655	83,252,182	183,978,837	47,648,294	94,945,915	142,594,209
2002	110,218,186	91,303,454	201,521,640	45,837,565	103,150,746	148,988,311
2003	120,420,732	99,963,630	220,384,362	43,229,660	111,795,772	155,025,432
2004	131,361,082	109,255,448	240,616,531	40,394,307	120,395,287	160,789,594
2005	143,063,585	119,199,428	262,263,013	37,309,991	128,879,211	166,189,202
2006	155,549,637	129,813,423	285,363,061	34,265,757	136,969,246	171,235,003
2007	168,837,172	141,112,160	309,949,332	30,579,939	145,056,236	175,636,175
2008	182,940,130	153,106,767	336,046,897	27,784,865	151,956,564	179,741,429
2009	197,867,941	165,804,312	363,672,254	24,892,645	158,296,153	183,188,798
2010	213,792,485	179,345,644	393,138,130	21,644,358	164,276,465	185,920,823
2011	230,751,496	193,760,725	424,512,221	18,686,570	169,360,125	188,046,695
2012	248,781,280	209,077,926	457,859,205	16,387,933	173,146,849	189,534,782
2013	267,916,510	225,323,820	493,240,331	14,118,378	176,122,156	190,240,534
Liability						
1998				397,268,021	1,808,784,286	2,206,052,307
2013				68,967,427	1,957,065,670	2,026,033,097
Segal's 1988 Accrued Liability						495,972,000

(*)Estimated Using the Health Fund's 7-1-97 Census Data.

	Future Retiree Costs			
Year	Non-Medicare	Medicare	Total	Grand Total
1998	1,697,617	2,469,545	4,167,162	266,130,246
1999	3,294,383	4,628,041	7,922,424	290,294,386
2000	6,984,577	5,606,428	12,591,005	316,493,516
2001	10,230,602	9,761,404	19,992,006	346,565,052
2002	18,238,601	11,173,666	29,412,267	379,922,218
2003	21,067,996	18,186,162	39,254,159	414,663,952
2004	31,101,830	19,940,609	51,042,439	452,448,564
2005	30,449,385	31,428,094	61,877,479	490,329,694
2006	44,602,023	33,505,695	78,107,718	534,705,782
2007	46,359,516	51,920,912	98,280,428	583,865,935
2008	69,307,136	56,011,800	125,318,936	641,107,262
2009	86,049,193	61,110,529	147,159,722	694,020,774
2010	94,870,010	70,209,374	165,079,384	744,138,337
2011	49,921,634	136,922,154	186,843,788	799,402,704
2012	76,704,487	154,717,809	231,422,296	878,816,283
2013	100,314,157	165,326,817	265,640,974	949,121,839
Liability				
1998	376,738,607	1,957,728,147	2,334,466,754	4,540,519,061
2013	1,115,865,353	8,223,125,161	9,338,990,514	11,365,023,611
Segal's 1988 Accrued Liability			457,393,500	953,365,500

(*)Estimated Using the Health Fund's 7-1-97 Census Data.

Exhibit 3
Projection of Future Employer Contribution Costs(*) and Post-Retirement Unfunded Liability
15-Year Projection 1998 to 2013, High Trend Scenario

	Active Employee Cost			Current Retiree Cost		
Year	Health Fund	Employee Organizations	Total	Non-Medicare	Medicare	Total
1998	76,223,505	62,500,064	138,723,568	52,684,518	70,554,997	123,239,515
1999	85,747,774	70,568,366	156,316,140	52,612,371	80,142,900	132,755,271
2000	96,354,917	79,565,946	175,920,863	52,122,397	90,490,878	142,613,275
2001	108,146,002	89,580,311	197,726,314	51,314,804	101,469,621	152,784,425
2002	121,228,293	100,704,348	221,932,640	50,611,003	112,749,375	163,360,378
2003	135,715,170	113,036,239	248,751,409	48,943,605	125,009,502	173,953,107
2004	151,725,986	126,679,328	278,405,314	46,900,598	137,753,686	184,654,284
2005	169,385,818	141,741,897	311,127,715	44,430,736	150,925,670	195,356,406
2006	188,825,141	158,336,859	347,162,000	41,859,107	164,212,027	206,071,134
2007	210,179,392	176,581,363	386,760,755	38,326,575	178,094,980	216,421,555
2008	233,588,423	196,596,303	430,184,726	35,733,239	191,114,223	226,847,462
2009	259,195,840	218,505,713	477,701,553	32,857,425	204,006,674	236,864,099
2010	287,148,223	242,436,060	529,584,283	29,305,953	216,897,514	246,203,467
2011	317,594,209	268,515,428	586,109,637	25,938,881	229,040,155	254,979,036
2012	350,683,459	296,872,572	647,556,032	23,306,100	239,812,566	263,118,666
2013	386,565,484	327,635,872	714,201,357	20,562,817	249,787,638	270,350,455
Liability						
1998				459,223,995	2,543,402,539	3,002,626,534
2013				110,768,120	3,445,550,533	3,556,318,653
Segal's 1988 Accrued Liability						786,013,000

(*)Estimated Using the Health Fund's 7-1-97 Census Data.

	Future Retiree Costs			
Year	Non-Medicare	Medicare	Total	Grand Total
1998	1,697,617	2,469,545	4,167,162	266,130,246
1999	3,376,524	4,736,195	8,112,719	297,184,130
2000	7,337,612	5,867,554	13,205,167	331,739,304
2001	11,014,778	10,466,147	21,480,925	371,991,664
2002	20,128,882	12,247,137	32,376,020	417,669,038
2003	23,830,863	20,445,128	44,275,991	466,980,507
2004	36,080,630	22,905,355	58,985,985	522,045,583
2005	36,223,234	37,057,391	73,280,625	579,764,746
2006	54,429,747	41,566,227	95,995,974	649,229,108
2007	58,027,887	64,506,553	122,534,440	725,716,750
2008	89,032,891	70,457,975	159,490,866	816,523,054
2009	113,465,100	78,960,632	192,425,732	906,991,383
2010	128,405,179	92,833,800	221,238,978	997,026,728
2011	69,242,778	186,977,294	256,220,072	1,097,308,746
2012	109,094,681	216,846,993	325,941,673	1,236,616,371
2013	146,024,770	237,058,725	383,083,495	1,367,635,307
Liability				
1998	528,087,943	3,858,231,778	4,386,319,721	7,388,946,255
2013	2,036,522,621	19,186,547,964	21,223,070,585	24,779,389,238
Segal's 1988 Accrued Liability			1,173,292,500	1,959,305,500

(*)Estimated Using the Health Fund's 7-1-97 Census Data.

Exhibit 4
Total Population, 15-Year Projection 1998 to 2013

	Number of Active Employees			Number of Current Retirees		
Year	Health Fund	Union	Total	Non-Medicare	Medicare	Total
1998	24,485	22,735	47,220	8,434	20,103	28,537
1999	24,730	22,962	47,692	7,332	20,314	27,646
2000	24,977	23,192	48,169	6,339	20,395	26,734
2001	25,227	23,424	48,651	5,409	20,391	25,800
2002	25,479	23,658	49,137	4,662	20,187	24,849
2003	25,734	23,895	49,629	3,884	19,997	23,881
2004	25,991	24,134	50,125	3,228	19,671	22,899
2005	26,251	24,375	50,626	2,644	19,262	21,906
2006	26,514	24,619	51,132	2,128	18,777	20,905
2007	26,779	24,865	51,644	1,642	18,256	19,898
2008	27,047	25,114	52,160	1,329	17,560	18,889
2009	27,317	25,365	52,682	1,041	16,841	17,882
2010	27,590	25,618	53,209	787	16,092	16,879
2011	27,866	25,875	53,741	592	15,291	15,883
2012	28,145	26,133	54,278	438	14,462	14,900
2013	28,426	26,395	54,821	330	13,601	13,931

	Number of Future Retirees*			
Year	Non-Medicare	Medicare	Total	Grand Total
1998	232	544	776	76,533
1999	407	888	1,295	76,634
2000	819	1,036	1,856	76,759
2001	1,103	1,566	2,669	77,120
2002	1,865	1,720	3,585	77,572
2003	1,961	2,453	4,414	77,924
2004	2,720	2,609	5,329	78,353
2005	2,422	3,616	6,038	78,570
2006	3,346	3,750	7,097	79,134
2007	3,209	5,160	8,368	79,910
2008	4,571	5,332	9,903	80,953
2009	5,311	5,307	10,618	81,182
2010	5,520	5,854	11,374	81,462
2011	2,586	10,414	13,000	82,624
2012	3,849	10,834	14,683	83,861
2013	4,716	10,804	15,519	84,271

*The number of future retirees is based upon the number of active employees expected to remain until retirement age.

Appendix C

Review of Other States' Public Employee and Retiree Health Benefit Plans

STATE	DESCRIPTION
Arizona	**BACKGROUND** **State Agency:** Arizona's employee health benefits program for active employees is administered by the Department of Administration (ADOA) through its Human Resources Division. The administration department is directly responsible to the governor and the legislature. Health benefit coverage for most of the retirees is available through a separate state agency, the Arizona State Retirement System (ASRS), which also administers the pension benefit program for the state and other government agencies in Arizona. **Established by Statute:** Yes. **GOVERNANCE PRACTICES** **Board Composition:** Only the ASRS is governed by a Board of Trustees. The board is composed of nine members. Five of the members must include an educator, an employee of one of the political subdivisions participating in the program, a retiree in the program, a state employee and an at-large member. The other four members must be individuals with at least ten years of experience with investments/securities and economic theory such as a certified financial analyst, a professor of economics or investments at a university, or an economist with at least five years of management experience. **Authority of Board:** The board has broad authority over the program. **FUNDING** **Contribution Formula:** The employer contribution for active employees and their dependents is determined as part of each year's budgeting process. The employer subsidy is a maximum of $95 per month for retirees not yet eligible for Medicare and $80 for dependent coverage. For those eligible for Medicare, the subsidy is $65 for the retirees and $50 for dependent coverage. Only those retirees with at least ten years of service are eligible for the maximum subsidies. Those with less than five years of service receive no subsidy. **Funding Method:** The health maintenance organization (HMO) and other prepaid coverages are fully insured with no experience rating. The Preferred Provider Organization (PPO) and indemnity coverages are also fully insured but involve prospective experience rating. **Practice of Porting to Union or Other Competing Plans:** No. There are no union or other competing public employee health benefit plans.

Arizona – cont.

Reserves: No. The rate renewal process uses prior year excess contributions in renewal rates negotiations with the indemnity or PPO carriers. The HMO plans are community rated each year and therefore have no "excess" contributions by definition.

ADMINISTRATION

Organizational Structure: The ADOA's Human Resources Division administers the active state (and other) government employee benefit program and reports directly to the governor's office and the state legislature.

The ASRS administers most of the state (and other) government retiree benefit programs and reports to the governor's office and the state legislature.

Contribution/Premium Collection: The contributions are directed to the agencies that administer the two health benefit programs. These agencies submit premiums to the insurance carriers or HMOs. The ASRS also administers the government employee/retiree pension program. It therefore is able to deduct the retiree contributions for health and dental coverage from the monthly pension benefits, adds the amount of government/employer subsidy and submits premiums to the carriers.

Eligibility Determination: The ADOA and ASRS determine eligibility. For retirees, the ASRS also administers the pension program, which can be very helpful in determining eligibility for the health and dental benefits as well.

Claims Administration: This is performed by the insurance carriers and HMOs.

Customer Service: This is performed by the insurance carriers and HMOs.

Financial Reporting: Not readily available for ADOA and active employees.

The ASRS gathers the financial information from carriers and with the help of outside actuarial consultants provides annual reports to its board, along with its recommendations for renewal rates and possible benefit changes.

Rate/Benefit Negotiation with Carriers: Performed by the respective agencies for renewals. For any new plans to be offered, the negotiations are with the State Procurement Office.

Benefits Eligibility: All full-time state employees, long term disability participants, and their eligible dependents. Retirees of Arizona's state agencies and universities and their eligible dependents.

Benefit Options: Indemnity, PPO and HMO medical plans are available for active employees. Indemnity, PPO and Medicare HMO medical plans are available for retirees.

Arizona – cont.

Benefit Determination: State statutes mandate that state government employee, retiree and dependent health benefits be made available, but do not define the coverage. Benefit changes are not subject to legislative approval but are part of the renewal negotiation process with the carriers and HMOs.

Benefits for retirees are determined by the ASRS and approved by its board.

California

BACKGROUND

The California Public Employees Retirement System (CalPERS) Health Benefits Program is a state agency. Its Board of Administration administers the state employee health benefit program. It has over one million members and is the second largest purchaser of health care in the nation, second only to the Federal Employees' Health Benefit Program.

Established by Statute: Yes.

GOVERNANCE

Board Composition: CalPERS is administered by a 13 member Board of Administration consisting of elected, appointed, and ex officio members. It consists of five for active employees, one for retirees, one from a public agency, one official of a life insurer, one jointly appointed by the house and senate, and four ex officio members (state treasurer, state controller, personnel director, and a state personnel board member).

Authority of Board: Constitutional and statutory authority over the system's administration and investment decisions. It has over 1,000 professional employees. The board has exclusive control of administration, investment of retirement fund assets, membership and benefit issues, and all powers reasonably necessary to carry out the health benefits program. Its authority includes setting employer contribution rates, determining asset allocations, and providing actuarial valuations.

FUNDING

Contribution Formula: Funded by a combination of employer and employee contributions. For active employees, the amount of employer contributions is subject to collective bargaining agreements. Retirees' contributions are based on a statutory requirement of the average of the three largest CalPERS health plans.

Funding Method: The PPO is self-funded and administered by Blue Cross of California. HMO coverage is fully insured and the coverage is provided through about 20 HMOs, which must negotiate with CalPERS for each year's renewal.

Practice of Porting Funds to Union Benefit Plans: No. There are no union or other competing health benefit plans for public employees.

Reserves: There are no "excess contributions" with HMO coverage, because of the very stringent rate renewal negotiations involved. The PPO plans are self-funded. If there are excess funds, these would belong to the CalPERS benefit program.

California – cont.

ADMINISTRATION

Organizational Structure: CalPERS' organizational structure consists of many divisions and offices including actuarial and employer services, benefits services, fiscal services, health program development, long-term care, information technology, investment, and audit services, and planning and research.

Contribution/Premium Collection: Handled by CalPERS' actuarial & employer services.

Eligibility Determination: Handled by CalPERS' health benefit services.

Claims Administration: CalPERS' health benefit services provides assistance with claims, however claims processing is done by the respective health plan and not by the CalPERS agency itself.

Customer Service: CalPERS' health benefit services provides assistance, however customer service for members is done by the respective health plans and not by CalPERS. CalPERS' actuarial & employer services handles the employer as the customer.

Financial Reporting: Handled by CalPERS.

Information Technology: CalPERS' Information Technology Services Division utilizes the following technologies in providing services to CalPERS:

Server Technologies - client/server technology strategy is based on the use of "open" systems (nonproprietary) using the UNIX operating system. CalPERS has an extensive investment in departmental servers running Novell Netware and Windows/NT. Database management and warehousing is based upon relational technology from Oracle.

Client Technologies - The standard client workstations are Intel-based Pentium computers running Windows 3.11, Windows 95, or Windows NT Workstation from Microsoft.

Network Technologies - Novell Netware is used as the standard local area network operating system and is being integrated with additional open systems networking protocols like TCP/IP to provide the inter-enterprise networking capability.

Applications Development Technologies - Enterprise-wide application development standards include programming tools from Forte. Non-enterprise-wide application standards include Powerbuilder from Powersoft Corporation and Visual Objects from Computer Associates. End-user analysis and data access tools include Impromptu and Powerplay.

Foundation application technologies - groupware, using Microsoft Exchange/Schedule+, provides e-mail, calendar & scheduling, public folders, and the infrastructure for their Internet/Intranet applications. Microsoft internet information server hosts the CalPERS On-line Home Page (http://www.calpers.ca.gov) while Netscape Navigator is their standard browser.

California – cont.

Applications Strategy phases out all legacy applications. Key operational components include baseline analysis and business process re-engineering, integrated corporate database, the CalPERS online member and employer transaction system, and Year 2000 compliance.

Benefit Determination: Benefits cannot be added, changed, or deleted without the concurrence of the State Legislature.

Rate/Benefit Negotiation with Carriers: Handled by CalPERS.

Management Controls: The Board of Administration has established several committees to review and report on specific programs, projects, and issues and make recommendations to the board. The full board and standing committees typically meet once each month. There are a number of committees including:

Finance
This committee provides financial oversight on all budget matters, evaluates funding alternatives, oversees preparation and recommends approval of the CalPERS budget, and oversees the CalPERS annual and periodic audits.

Benefits and Program Administration
This committee reviews all matters related to benefit program structure, actuarial studies and rate setting, retirement program policy, and administrative issues.

Strategic Planning
This committee oversees the strategic planning process, including selection of consultants, defining process direction and monitoring development of the CalPERS Strategic Plan.

BENEFITS

Eligibility: Active and disabled employees must be appointed to a state, public agency, or school district job that will last at least six months and one day, and is at least half-time or more. State limited-term employees (seasonal, temporary) are not eligible.

Retirees must have been enrolled in a CalPERS health plan at the time they separated from employment.

Benefit Options: Active/Disabled Employees can choose PPO or HMO benefit options. Benefits are standardized across all carriers.

Retirees can choose Medicare Supplement and Medicare HMO benefit options. Early retirees receive the same benefit options as the active employees.

Benefit negotiation process involves a very rigorous exercise where each HMO must justify its rates (including components of its total rates) by providing CalPERS with detailed utilization and unit cost information. This utilization data can be periodically audited by CalPERS.

Colorado

BACKGROUND
State Agency: Public Employees Retirement Association.

Established by Statute: Yes.

GOVERNANCE PRACTICES
Board Composition: Information on the board of trustees was not available.

FUNDING
Reserves: A group benefit plans reserve fund is established by state statutes. Expenditures are made from the group benefit plans reserve fund, upon certification by the director, for the payment to the carriers of premiums, claims costs and administrative fees and costs associated with the group benefit plans.

A premium stabilization fund is established within the group benefit plans reserve fund for the purpose of offsetting unexpected year-end deficits and extraordinary fluctuations in annual premiums. The director certifies in writing to the state treasurer which portion of the funds shall be invested that are in the director's judgment not needed for the payment of premiums and claims costs to the carriers. Investments are limited to securities authorized by the board of trustees of the public employees retirement association.

Contribution/Premium Collection: The director remits to the treasurer for deposit in the fund all payments received by the director for group benefit plans premium costs from employees and the state as employer. The director also remits to the treasurer for deposit any payments received for the carriers of group benefit plans.

Practice of Porting Funds to Union Benefit Plans: No. There are no union or other competing health benefit plans for public employees.

Connecticut

BACKGROUND
State Agency: State Employees Retirement System.

Established by Statute: Yes.

GOVERNANCE PRACTICES
Board Composition: The State Employees Retirement Commission. The State Comptroller is Secretary Ex Officio. Other board information was not readily available.

ADMINISTRATION
Organizational Structure: The plan is administered by the state comptroller's Retirement and Benefit Services Division. The division administers state employee health benefits, and manages the state deferred compensation plan. It directs plan design, benefit administration, and policy for all state insurance benefits including medical, surgical, hospital, and life insurance. It negotiates with insurance carriers, monitors providers, and reviews health care utilization and cost reports.

Contribution/Premium Collection: The comptroller's retirement and benefit services division.

Connecticut – cont.

Eligibility Determination: The comptroller's retirement and benefit services division.

Information Technology: The comptroller's information technology division provides network support; mainframe support including production and input/output control and disaster recovery; personal computer technical support; local area network administration, infrastructure and helpdesk support; personal computer application development and support; Internet/Intranet application development and support; data and system security, and inter-division project management.

Benefit Determination: The comptroller's retirement and benefit services division.

Rate/Benefit Negotiation with Carriers: The comptroller's retirement and benefit services division.

Management Controls: The comptroller's retirement and benefit services division monitors providers, and analyzes reports on health care utilization and costs.

Practice of Porting Funds to Union Benefit Plans: No. There are no union or other competing health benefit plans for public employees.

Michigan

BACKGROUND

State Agency: The Michigan State Employees Retirement System (SERS) enrolls retirees and beneficiaries for health, dental, and vision insurance, the Michigan Department of Management and Budget's Office of the State Employer administers the health insurance programs.

Established by Statute: Yes.

GOVERNANCE PRACTICES

Board Composition: The SERS is governed by a nine member board composed of two employee and two retiree members, all appointed by the governor, and five ex-officio members. The ex-officio members include the attorney general, state treasurer, acting insurance commissioner, state personnel director, and deputy auditor general.

ADMINISTRATION

Organizational Structure: SERS enrolls retirees and beneficiaries for health, dental, and vision insurance. The department's management and budget office administers the health insurance programs, and also administers employee benefits programs for classified and unclassified state employees and retirees, including administration of life, health, vision, and dental insurance plans; flexible spending accounts; and continuation of insurance coverage.

Missouri

BACKGROUND

State Agency: The Missouri Consolidated Health Care Plan (MCHCP), administers health benefits for state employees and retirees. It is a non-profit entity which has the responsibility of administering the law and bears a fiduciary obligation to the State of Missouri, the taxpayers and its members.

Missouri – cont.

Established by Statute: Yes.

GOVERNANCE PRACTICES

Board of Composition: The Board of Trustees has 11 members. The board is comprised of one member of the Senate, one member of the House, three citizens of the State of Missouri who are not members of the plan, but who are familiar with medical issues, three members of the board shall be members of the plan, and three *ex officio* members (health director, insurance director and the administration commissioner).

Authority of Board: The board has the authority to operate the benefit program.

ADMINISTRATION

Organizational Structure: The executive director, who is appointed by the board, is responsible for managing the plan. The director advises the board on all matters pertaining to the plan and, with the approval of the board, contracts for professional services and employs the staff needed to operate the plan.

The plan's organization structure consists of the following departments: fiscal affairs, membership services, customer support, research and compliance, data management systems, human resources, and marketing.

Management Controls: The assistant director is responsible for monitoring health care trends and determining how they may impact the plan, and ensuring that the plan is in compliance with new state and federal regulations. The assistant director also coordinates the development, evaluation, and award of requests for proposals, and assists in the negotiation and execution of contracts.

Research and compliance provides collection, analysis and reporting of various statistical health related data, including Group Health Association of America reports, and the Health Plan Employer Data and Information Set (HEDIS). The department evaluates and monitors HMO, PPO, purchase of service plans (POS), and indemnity plan vendors who are awarded contracts by the plan. It maintains data on network development, provider turnover and other factors affecting performance of the contractors. The department is also responsible for conducting audits, performing customer satisfaction surveys, and serving as a patient advocate when necessary.

Practice of Porting Funds to Union Benefit Plans: No. There are no union or other competing health benefit plans for public employees.

New York

BACKGROUND

State Agency: The Governor's Office of Employee Relations (GOER) is the management representative at collective bargaining negotiations with the eight unions representing 93 percent of the state executive branch employees.

Established by Statute: Yes. Employee health benefits are a mandatory subject of collective bargaining.

GOVERNANCE PRACTICES Information Not Readily Available

New York – cont.

ADMINISTRATION

Organizational Structure: The state's health insurance plan is regulated and administered by the civil service department.

Employer-Union Trust Approach: A joint committee on health benefits was established with the unions to cooperatively develop and oversee administration of health care programs for represented employees. The committee process has facilitated many effective program changes or modifications outside of regularly scheduled labor negotiations. These modifications and program improvements would not have occurred as readily without this joint labor-management forum.

Management Controls: In addition to having a benefit planning and oversight role for employees represented by unions, the office of employee relations is also responsible for benefit program development on behalf of management and legislative employees, and represents the State on various health benefit coalitions. In addition, the office analyzes the impact of proposed health care legislation, researches health care trends, and provides assistance on emerging developments in the health care field.

GOER staff are co-responsible with civil service and the state public employee unions to provide oversight to the various health plan contracts. GOER conducts an annual HMO review process, and trains agency health benefit administrators.

Benefit Eligibility: The plan is available to all state active and retired employees and employees of state and local governments that elect to participate and their dependents.

Practice of Porting Funds to Union Benefit Plans: No. There are no union or other competing health benefit plans for public employees.

Oregon

BACKGROUND

State Agency: In Oregon, there is a health benefit plan for active employees and a separate plan for retirees' health benefits. The Oregon Public Employees Benefit Board (PEBB) was established in May 1997, and became active on January 1, 1998. The single board replaces two union boards that covered state employees represented by Oregon's largest public employee union, and the other board which covered unrepresented, management and employees represented by 12 smaller labor unions. The PEBB board is under the state's Department of Administrative Services.

The Oregon Public Employees Retirement System (PERS) sponsors a group health insurance program for its retired and disabled employees. PERS contracts with different health care plans that offer comprehensive benefits. Almost 900 public employers participate, including all state agencies, public school districts, cities, and counties in Oregon. PERS is the retirement program for about 95 percent of state and local government employees in Oregon. This program offers coverage for both non-Medicare and Medicare PERS retirees and dependents. PERS offers three health plans through competitive bidding.

Established by Statute: Yes.

Oregon – cont.

GOVERNANCE PRACTICES

Board Composition: The PEBB Board consists of ten members: two ex-officio members from the legislature, four state employees, four union representatives and one representing classified, unrepresented state employees.

Trustees for PERS are appointed by the governor and ratified by the senate for three-year terms. Four trustees are selected from management and four trustees must be members of collective bargaining units. One of the eight trustees described above must be a retired member of the system.

Authority of Board: The PEBB Board functions as an employer-union trust governance system. It determines health policy, but does not to get involved in day-to-day health benefit issues. It negotiates and renews health plan contracts and rates annually. The board determines benefits and plans that are best designed to meet the needs and provide for the welfare of eligible employees and the state. Emphasis is placed on: (1) employee choice among high quality plans; (2) a competitive marketplace; (3) plan performance and information; (4) employer flexibility in plan design and contracting; (5) quality customer service; (6) creativity and innovation; (7) plan benefits as part of the total employee compensation; and (8) improvement of health of members.

FUNDING

Contribution Formula: The state pays 100 percent of the PEBB premiums for active employees.

Oregon's statutes authorize payments from PERS toward the monthly cost of health insurance sponsored by the system. Currently, the law provides up to $60 per month contribution toward premium cost for eligible PERS members. The payments are from the PERS Retirement Health Insurance Account (RHIA). PERS pays the lesser of the monthly premium cost or $60. Premium payments exceeding that amount can be deducted from your monthly benefit checks.

Funding Method: PEBB offers a variety of options to employees, including PPO, HMO and POS plans. These will tend be fully insured.

Practice of Porting Funds to Union Benefit Plans: No. Oregon's union health benefit plans combined to create a single health benefit program for Oregon's public employees in January 1998.

BENEFITS

Benefit Eligibility: Active employees are eligible for health care coverage under the PEBB program.

Retired members of PERS enrolled in Medicare receive a retirement allowance under the system. A legal spouse, dependent child(ren), and the surviving spouse of a PERS retiree are also eligible for PERS health benefits.

Non-Medicare retirees can enroll in the PERS plans, but are not eligible for the monthly premium contribution until enrolled in Medicare. Upon enrollment in Medicare, retirees can receive payments.

Oregon – cont.

Benefit Options: Active employees can select PPO, HMO or POS plans and can make use of a Section 125 cafeteria approach.

Retirees can select from three different health care plans, an indemnity, fee-for-service insurance plan, a non-Medicare plan and a Medicare Companion plan to Medicare and non–Medicare retirees, and a Kaiser HMO plan, through its group insurance program. Insurance is provided by five licensed insurance carriers, through contracts approved by the PERS Board.

Pennsylvania

BACKGROUND

State Agency: Pennsylvania's public employee health benefits are provided by the Pennsylvania Employees Benefit Trust Fund (PEBTF). The Commonwealth of Pennsylvania entered into an Agreement and Declaration of Trust (Agreement) with Council 13, American Federation of State, County and Municipal Employees, AFL-CIO (AFSCME) to form Pennsylvania Employees Benefit Trust Fund (the trust fund). The purpose of the trust fund is to provide hospital, medical/surgical and supplemental benefits under a jointly administered, multi-union health and welfare fund.

In accordance with the terms of the respective collective bargaining agreements between the commonwealth and AFSCME, the Pennsylvania Social Services Union and the Independent State Stores Union, the separate union health benefit trust funds were merged into the trust effective January 1, 1993. Additional collective bargaining units were merged into the trust effective April 1994. In July 1997, another trust agreement incorporated management employees into the health benefits program.

The trust fund is a qualified trust under the Internal Revenue Code and is exempt from federal income taxes under provisions of Section 501(c)(9).

Established by Statute: No.

GOVERNANCE PRACTICES

Board composition: The PEBTF board is established as an employer-union trust. The board has 14 members, in which seven are affiliated with the commonwealth and seven are affiliated with the unions.

Authority of Board: The Board of Trustees has the right to modify the benefits provided to active employees. The plan may be terminated only by the agreement of the Commonwealth, AFSCME, and the trustees subject to the provisions set forth in ERISA.

FUNDING

Contribution Formula: The commonwealth's collective bargaining agreements obligate it to provide certain contributions on behalf of all bargaining unit employees. The commonwealth submits contractually established contributions on behalf of active managerial employees and union employees, and also on behalf of retired employees. The trust receives approximately 94 percent of its contributions from the commonwealth.

Pennsylvania – cont.

Active Employees

Contributions are recorded when due based on rates established through agreements between the commonwealth, the trust fund and the unions. The rate effective for the fiscal years ended June 30, 1998 and 1997 was $4.94 annually per active full-time employee. This rate is not necessarily indicative of the contribution rate for future fiscal years.

Retirees

Contributions are recorded when due. At fiscal year end, if contributions exceed the annuitant's incurred expenses, the trust fund is obligated to refund to the commonwealth the excess of the year's contributions over the incurred expenses. If expenses exceed contributions for the fiscal year, the commonwealth is obligated to fund the deficit.

Practice of Porting Funds to Union Benefit Plans: No. Pennsylvania consolidated its separate union health plans into a single health benefit program for all public employees in 1988.

Reserves: No. Excess funds in the trust are refunded to the commonwealth at the end of each year. If there is a deficit, the commonwealth must fund that deficit each year.

ADMINISTRATION

Organizational Structure: Pennsylvania has a private industry third-party administrator (TPA) called the Pennsylvania Employees Benefit Trust Fund (PEBTF) for active employees which processes claims, provides customer service, and conducts internal audits. The PEBTF was established in 1988 and is *not* part of the state government. The TPA does its own contracting and bidding.

The trust fund and the commonwealth entered into an administrative agreement that defines the rights and obligations of the commonwealth and the trust fund as they relate solely to the administration of medical benefits for individuals enrolled in Pennsylvania retired employee annuitants health plan. Under this agreement, the trust serves as the administrator of benefits and provides administrative services for the annuitants plan. In addition, the trust fund is not an insurer, underwriter or guarantor of any benefits for the annuitants plan.

Under the retiree agreements, the commonwealth is responsible for the costs of claims paid, including retention costs and claims incurred but not reported, and direct and indirect administrative. Under the current administration agreement, the indirect costs incurred are allocated based on factors developed by the trust and agreed to by the commonwealth. The trust and the commonwealth review these factors every six months for reasonableness.

The TPA handles contributions and premium collection, claims administration, financial reporting, rate/benefit negotiations with insurance carriers, and management controls.

Customer Service: Customer service is handled by both the TPA and the insurance carriers.

Pennsylvania – cont.

BENEFITS

Benefit Options: Active or disabled employees can select from four geographically separate Blue Cross/Blue Shield plans, 13 HMO plans, five POS plans and one PPO plan. The health program covers hospital, medical/surgical, prescription drug, dental, vision and hearing aid benefits.

The retirees health program covers hospital, medical/surgical, prescription drug, dental, vision and hearing aid benefits.

Benefit Determination: Benefits are determined by the Board of Trustees.

South Dakota

BACKGROUND

State Agency: South Dakota's Bureau of Personnel administers its state employee health plan. The plan's intent is to prudently use available resources to fix true medical problems and to help employees and their covered dependents avoid the serious financial consequences that could result from catastrophic illnesses or injuries. It is not intended to provide first dollar coverage for every health care service or treatment.

The bureau is responsible for designing and administering the plan, and paying claims. The administrator can change the plan's design, modify coverages, and change premiums or funding mechanisms at any time with or without notice.

Established by Statute: Yes.

FUNDING

Contribution Formula: South Dakota's state employee health plan is funded through a combination of state dollars and employee contributions.

Funding Method: The state employee health plan became self insured in 1991.

Practice of Porting Funds to Union Benefit Plans: No. There are no union or other competing health benefit plans for public employees.

ADMINISTRATION

Organizational Structure: At present, the health plan uses three companies that are identified as "third party administrators. The first, Dakota Care, has the responsibility for re-pricing claims and managing health care utilization. The second, PAID Prescription Network, helps employees save dollars through prescription discounts. The third, Wellmark Blue Cross Blue Shield of South Dakota, processes and pays claims.

The plan administrator can hire companies with the expertise, manpower, and computer systems to do tasks that the bureau is unable to do.

BENEFITS

Benefit Eligibility: All full-time employees and dependents, and COBRA participants.

South Dakota – cont.

Funding: Employees pay the full cost of all dependent coverage under all four plans. The amount of the contribution is established by the bureau at its discretion. The State pays the full cost of coverage for active "nonsmoking" employees under the $500 deductible, $1,000 deductible and provider network plans. The cost for employee and spouse coverage increases by $25 a month per person if either smoke tobacco.

The plan administrator reserves the right to adjust contribution rates during the plan year.

Employees can choose to opt out of health coverage or to enroll in the $1,000 deductible plan, in those cases the state will provide the employee $300 per plan year in flex credits. Employees can use the flex dollar credits to reduce the cost of dependent health plan, dental, vision, major injury, hospital, or toward a medical expense reimbursement account.

Retirees: All retired employees, as determined by the State.

Benefit Options: Active and disabled employees have a PPO plan.

Retirees have a PPO plan and a Medicare supplement plan.

Texas

BACKGROUND

State Agency: The Texas Employees Retirement System (ERS). In 1975, the Legislature created the Texas Employees Uniform Group Insurance Program to provide high quality health insurance and other optional coverages for employees, retirees and their eligible dependents.

Established by Statute: Yes.

GOVERNANCE PRACTICES

Board Composition: The ERS Board of Trustees has six members. The governor, chief justice of the Texas supreme court and speaker of the House each appoint a member, and three members are state employees elected by the ERS members.

FUNDING

Contribution Formula: The state pays the cost of health and basic term life coverage, not to exceed the cost of the basic plan for full-time employees working 20 hours a week or more. Full-time employees also receive up to one half the cost of health coverage for eligible dependents, not to exceed one half the cost of dependent coverages provided by the carrier for the basic plan.

Part-time employees are eligible for one half the contributions that full-time employees receive for their health, life insurance, and dependent health coverages.

The state pays 100 percent of the cost of health coverage, not to exceed the cost of the basic plan for retirees. The state pays up to 50 percent of the cost of health coverage for eligible dependents, not to exceed 50 percent of the cost for dependent coverages provided by the carrier for the basic plan. The retiree is responsible for paying the remaining cost of health coverage for dependents and for other coverages selected.

Texas – cont.

BENEFITS

Eligibility: Full or part-time employee of the state of Texas.

Retired employees are eligible if they fulfill all of the certain requirements including ten years of service, age and service requirements for the retirement system.

Benefit Options: Active and disabled employees can select from HealthSelect, HealthSelect Plus, and a number of approved HMOs. Blue Cross and Blue Shield of Texas, Inc. administers the HealthSelect plan for the ERS.

Retirees have the same health options as active employees.

Practice of Porting Funds to Union Benefit Plans: No. There are no union or other competing health benefit plans for public employees.

West Virginia

BACKGROUND

State Agency: The Public Employees Insurance Agency (PEIA) administers the health benefit and the basic and supplemental life insurance plans for all state employees.

Established by Statute: Yes.

GOVERNANCE PRACTICES

Board Composition: The agency is governed by a five-member finance board that includes a state employees' representative, a teachers' representative, two business representatives and an executive director. All board members are appointed by the governor. The executive director is the leading member of the board and is also responsible for the agency's administrative duties.

Authority of Board: The finance board makes all decisions regarding benefits and contributions under the state employees life and health benefits plans.

FUNDING

Contribution Formula: The employer contribution is approximately 93 percent of premiums for active employees and their dependents, and approximately 70 percent of premiums for retirees and their dependents.

Funding Method: The basic health plans for active and retirees are self funded. The HMO and other prepaid coverages are fully insured with no experience rating.

Practice of Porting Funds to /Union Benefit Plans: No. There are no competing union health benefit plans.

Reserves: There generally are no reserves to deal with, since the self funded plans are funded on a pay-as-you-go basis. The fully insured plans by definition do not involve any reserves to be held by the agency or the carriers.

ADMINISTRATION

Organizational Structure: The executive director reports directly to the secretary of administration.

West Virginia – cont.

Contribution/Premium Collection: The PEIA invoices and collects the premiums from all public employers, retains the premiums under the self-funded plans and remits the applicable premiums to the appropriate carriers/HMOs.

Claims Administration: The third party administrator (TPA) is responsible for administering claims for the self-funded plans. The carriers/HMOs for the fully insured plans. The agency monitors the performance of the TPAs and audits the carriers/HMOs.

Customer Service: Customer service is performed by the TPAs/carriers/HMOs. Customer complaints can also be directed to the agency.

Financial Reporting: The PEIA provides quarterly reports to its board. It also makes recommendations for renewal rates and possible benefit changes. PEIA also collects and analyzes quality of care data.

Benefit Determination: Benefits are determined as part of the renewal process and negotiations with carriers/HMOs. The agency director recommends changes to the board.

Rate Setting/Benefit Negotiation with Carriers: This is performed by the agency with assistance from outside consultants.

BENEFITS

Benefit Options: Active employees and retirees not eligible for Medicare can select from self-funded indemnity plans and six HMO or POS medical plans are available.

Medicare Eligible Retirees: Only Medicare Supplement indemnity plans are available.

Practice of Porting to Union or Other Competing Plans: No. There are no union or other competing public employee health benefit plans.

Notes

Chapter 3

1. The governor stated:

> The decision by the Board of Trustees deeply disturbs me because it smacks of favoritism at the expense of taxpayers and Health Fund beneficiaries. There appears to be no defensible reason for the Board's choice of Royal State over the competing carrier. I would strongly urge the Board of Trustees to reconsider its decision.

Letter to the Chair of the Hawaii Public Employees Health Fund Board of Trustees from Benjamin Cayetano, Governor of the State of Hawaii, December 22, 1998.

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Responses of the Affected Agencies

Comments on Agency Responses

We transmitted drafts of this report to the Board of Trustees of the Hawaii Public Employees Health Fund, the administrator of the health fund, and the Department of Budget and Finance on April 27, 1999. A copy of the transmittal letter to the Board of Trustees is included as Attachment 1. Similar letters were sent to the administrator of the health fund and to the Department of Budget and Finance. The responses from the Board of Trustees and the Department of Budget and Finance are included as Attachment 2 and Attachment 3, respectively. The health fund administrator did not submit a separate response.

The chairman of the Board of Trustees commented that due to the limited time to respond, the board and staff were unable to fully respond to our recommendations or to the information and premises on which the recommendations were based.

However, the chairman did identify a few of his immediate concerns. First, he commented that our report did not acknowledge the board's efforts since 1992 to convince the Department of Budget and Finance and the Legislature that replacement of the existing computer was needed. Second, he made similar observations concerning long-term care insurance. Third, he commented that the health fund's staffing is not sufficient to meet workload demands and operational requirements. He observed that any additional requirements, such as monitoring, auditing, and oversight of the union plans, would require staff increases and funds for auditors. He also stated that over the next few months, the board will work with various legislative committees to review our findings, explain the rationale for the board's decisions, and implement appropriate program changes.

The Department of Budget and Finance expressed general agreement with the recommendations in our draft report. The department also provided specific comments in the areas of adverse selection, board composition, carrier participation, program design, excess reserves, auditing union health benefit plans, and long-term care.

We made some editorial changes to our draft report for purposes of accuracy, clarity, and style.

ATTACHMENT 1

STATE OF HAWAII
OFFICE OF THE AUDITOR
465 S. King Street, Room 500
Honolulu, Hawaii 96813-2917

MARION M. HIGA
State Auditor

(808) 587-0800
FAX: (808) 587-0830

April 27, 1999

COPY

Mr. George Butterfield, Chair
Board of Trustees
Hawaii Public Employees Health Fund
City Financial Tower
201 Merchant Street, Suite 1520
Honolulu, Hawaii 96813

Dear Mr. Butterfield:

Enclosed for your information are 9 copies, numbered 6 to 14 of our draft report, *Actuarial Study and Operational Audit of the Hawaii Public Employees Health Fund.* We ask that you telephone us by Thursday, April 29, 1999, on whether or not you intend to comment on our recommendations. Please distribute the copies to the members of the board. If you wish your comments to be included in the report, please submit them no later than Monday, May 3, 1999.

The Administrator of the Hawaii Public Employees Health Fund, Department of Budget and Finance, Governor, and presiding officers of the two houses of the Legislature have also been provided copies of this draft report.

Since this report is not in final form and changes may be made to it, access to the report should be restricted to those assisting you in preparing your response. Public release of the report will be made solely by our office and only after the report is published in its final form.

Sincerely,

Marion M. Higa
State Auditor

Enclosures

STATE OF HAWAII
DEPARTMENT OF BUDGET & FINANCE
HAWAII PUBLIC EMPLOYEES HEALTH FUND
P . O . BOX 2121
HONOLULU , HAWAII 96805

April 30, 1999

Ms. Marion M. Higa
State Auditor
Office of the Auditor
465 South King Street, Room 500
Honolulu, Hawaii 96813-2917

Dear Ms. Higa:

Due to the limited amount of time, four days, to respond to your Auditor's draft report, the Board of Trustees and staff is unable to fully respond to the recommendations put forth or to the information and premises upon which those recommendations were based.

Please refer to the attached page for a few of my immediate concerns on certain issues.

Over the next few months, our Board will work with various legislative committees to review your Auditor's findings, explain the rationale for our Board's decisions and implement appropriate program changes.

Sincerely,

BOARD OF TRUSTEES

George Butterfield

GEORGE BUTTERFIELD
Chairman

Attachment

CHAIRMAN'S COMMENTS

1. Your report does not acknowledge the Board's efforts since 1992 to convince the Department of Budget and Finance and the Legislature that the replacement of the existing computer was a necessity. It implies that the Board has been slow moving on the computer project.

   The Board was already working on this issue prior to the 1994 Segal Management Study. We had hoped the Study's conclusions would enhance our ability to complete the computer replacement project. We submitted budget requests in fiscal years 1993, 1994 and 1995 for this project, but those requests were repeatedly denied by the Department of Budget and Finance and the Legislature. It was not until the Board requested the use of Special Reserve Trust Funds that approval was received, but it has not come easily.

   The Health Fund staff and Board should be commended for their persistence in pursuing this project because that persistence is the only reason that this project is where it is today.

2. What was said above regarding the computer project, can also be said about the long-term care insurance project. The Board has sent numerous requests to the Department of Budget and Finance and the Legislature to implement the plan since 1990.

3. The Health Fund's current staffing is insufficient to meet the workload demands and requirements to operate the fund. The staff is smaller today than it was two years ago as a result of budget restrictions and cuts. Any increase in workload or additional operational requirements, such as the monitoring, auditing and oversight of the union plans, is not possible unless the staff is increased and funds for auditors are provided. This concern was raised during the exit conference with the members of your staff. They acknowledged the staff workload situation.

BENJAMIN J. CAYETANO
GOVERNOR

EARL I. ANZAI
DIRECTOR

WAYNE H. KIMURA
DEPUTY DIRECTOR

EMPLOYEES' RETIREMENT SYSTEM
HAWAII PUBLIC EMPLOYEES HEALTH FUND
OFFICE OF THE PUBLIC DEFENDER
PUBLIC UTILITIES COMMISSION

STATE OF HAWAII
DEPARTMENT OF BUDGET AND FINANCE
P.O. BOX 150
HONOLULU, HAWAII 96810-0150

ADMINISTRATIVE AND RESEARCH OFFICE
BUDGET, PROGRAM PLANNING AND
MANAGEMENT DIVISION

May 3, 1999

Ms. Marion M. Higa
State Auditor
Office of the Auditor
465 S. King Street, Room 500
Honolulu, Hawaii 96813-2917

Dear Ms. Higa:

The Department of Budget and Finance (DB&F) has reviewed the draft Actuarial Study and Operational Audit of the Public Employees Health Fund. We are in general agreement with the recommendations contained in the draft report. Specific comments are provided as follows:

1. Reduce Potential for Adverse Selection

The Legislature authorized the porting of employer contributions as a means of expanding employee/retiree choices in health care. However, porting reduces the pool of participants and possibly results in adverse selection. Cautious of the financial consequences, we have opposed measures that increase the potential for adverse selection. For example, we recently opposed House Bill No. 762 which authorizes payment of Medicare Part B reimbursements to employee-beneficiaries and their spouses who are enrolled in an employee organization supplemental Medicare plan. A major exodus of retirees could result in higher premium rates and higher total costs should Health Fund enrollee levels be reduced, low risk enrollees leave and high risk enrollees remain.

The Employer-Union Trust is an alternative means of providing employee health benefits. We have supported studying this concept to the extent: 1) potential cost savings are generated; 2) the Board of Trustees is comprised of the Director of Finance and equal representatives from the unions and the public sector; 3) a single trust is established to minimize administrative costs; and 4) inclusion of retirees is satisfactorily addressed.

No. 1 Capitol District Building, 250 S. Hotel Street, Honolulu, Hawaii 96813

2. Composition of the Board of Trustees

The Department believes that in addition to the Director of Finance, the Board of Trustees should be comprised of equal representatives from the unions and the public sector.

The report further finds that knowledge of employee health benefit programs and their financing should be required for at least some of the members of the Board. During the 1998 session, the Administration submitted legislation to address concerns on the composition of the Health Fund Board. Senate Bill No. 2816 proposed the replacement of the clergy member of the Board with a private citizen for the purpose of providing greater flexibility in response to the evolving dynamics and complexities of the health care industry. Senate Bill No. 2816 failed to pass.

3. Increase Carrier Participation

The Department agrees with the recommendation that more carriers should be encouraged to participate in the program. The recent enactment of House Bill No. 1042, House Draft 2 (Act 25/99), an Administration measure, addresses the Legislative Auditor's recommendation to encourage carrier program participation by removing the requirement for statewide service capability.

4. Restructure Program Design for Cost Containment

The Department is deeply concerned with the rising costs of health benefits. It would, however, be extremely difficult to achieve substantial cost savings under the current statutes. Several variables affect the cost of providing health benefits for State and County employees and retirees including: benefit levels, negotiated premium rates, the number of enrolled actives and retirees opting for self or family plan, and the contribution rates negotiated through the collective bargaining process. In order to achieve any real cost savings, changes to one or more of these variables are required.

In an attempt to control costs, the Administration submitted House Bill No. 1060 during the 1999 legislative session but it was held by the Senate Committee on Commerce and Consumer Protection. This Bill provides a viable option to reduce cost by eliminating employer health benefit contributions for dependents of employees hired after June 30, 1999. In addition, when these employees retire, it limits the employer contributions to a percentage based on the employee's years of service as applied to a self-only plan. Savings would initially be

limited, approximately $1.6 million over the fiscal biennium 2000-2001. Over the long run, however, this plan would result in substantial savings, especially when employees hired after June 30, 1999 begin to retire.

The Administration also submitted a measure (House Bill No. 1048/Senate Bill No. 1294) to mandate participation by eligible employee-beneficiaries and their spouses in the federal medicare plan for voluntary medical insurance coverage. This measure would reduce employer premium contribution costs. As of April 30, 1999, House Bill No. 1048 was in Conference Committee. Senate Bill No. 1294 was reported as Conference Draft 1 and contains language from the Administration's initial proposal.

5. Disposition of Excess Reserves Created by Employee Contributions

The Department agrees with the recommendation that the Board should work closely with the Legislature, the Department of Budget and Finance, and the Department of the Attorney General to resolve disposition of excess reserves created by employee contributions. Section 87-22.3, Hawaii Revised Statutes (HRS), permits carrier rate credits or reimbursement derived from employee-beneficiary contributions to be utilized only to improve health benefit plans or to reduce employee-beneficiary monthly contributions.

To resolve the issue of excess reserves, we submitted House Bill No. 1041/Senate Bill No. 1287 in the 1999 legislative session to permit return of the employee's share of insurance carrier refunds and rate credits to employee-beneficiaries based on their years of benefit plan participation. House Bill No. 1041 became a vehicle bill for the Employer Union Trust Fund pilot project and Senate Bill No. 1287 failed first lateral.

6. Audit Employee Organization Health Benefit Plans

The Department believes employee organizations which receive "ported" funds should be accountable and subject to the same provisions imposed on the Health Fund regarding return of carrier rate credits and reimbursements. The Administration submitted House Bill No. 1049/Senate Bill No. 1295 to: 1) clearly authorize the examination and audit of employee organization plan enrollment and financial transactions; and 2) require employee organizations providing health and life insurance programs to return to the Health Fund the employer's share of any rate credits or reimbursements from any carrier or self insurance plan and interests derived thereon. House Bill No. 1049 was held by the Senate Committee on Commerce and Consumer Protection and Senate Bill No. 1295 was never heard by the Senate.

7. Long-Term Care Plan

As noted in our comments provided on the Legislative Auditor's Financial Report of the Hawaii Public Employees Health Fund of the State of Hawaii, trust funds are included in the Fiscal Biennium 2000-2001 Budget request to implement the Long-Term Care program.

Thank you for the opportunity to comment on the report.

Aloha,

E. I. ANZAI
Director of Finance

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