Retiree Health Savings Plans For Public Sector Employers

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Introduction

The delivery and funding of health care to active and retired individuals in the United States involve public policy questions with enormous long and short term implications for this country. National and state government public policy makers examining the issue are faced with a Gordian Knot of challenges that will not be easily unraveled.

For the public sector, the sheer size of retiree health obligations for public employees is causing state and local governments to take a step back and reassess some of the fundamentals of how health care is designed and delivered.

It is relatively clear that any solution will need to address the three major areas: 1) how healthcare is delivered, 2) how healthcare cost risks should be shared (e.g., private vs. public insurance mechanisms), and 3) how healthcare should be paid for.

It is the purpose of this paper to examine the role defined contribution retiree health savings vehicles may play as a means for addressing the funding of retiree health care for state and local government employees. Through a discussion of these plans the authors hope to identify best practices for defined contribution retiree health savings plans and identify related issues and actions that state and local governments may wish to consider in the larger public policy discussion on this issue.

The Public Sector Retiree Health Environment

A National Perspective

The driving forces behind the national discussion of the design, delivery and funding of retiree health benefits are complex and do not lend themselves to easy solutions.

Rising Healthcare Costs
Health care spending in the United States is expected to grow twice as fast as the economy as a whole and is taking an ever-increasing share of total GDP: 12 percent in 1990, 15 percent in 2003 and is projected to consume 20% of GDP by 2016.

Aging of the Population
The average age of the U.S. population is increasing; the Baby Boomers are getting older and beginning to retire and make greater demands on both private and public health care systems.

Medicare and Social Security Funding
The Social Security Administration Board of Trustees 2007 report indicates that the Medicare Trust Fund is estimated to run out of money in 2019 and the Social Security Trust Fund will run out of cash in 2041.

Federal Finances Are Stressed
The Government Accounting Office has issued a 2006 report entitled: *21st Century Challenges - Retirement Insecurity* that the federal finance picture is highly stressed and unsustainable over the long-term absent fundamental change. The report states that balancing the budget in 2040 could require actions as large as cutting total federal spending by 60 percent or raising federal taxes to 2 times today's level.

The State and Local Government Perspective

Retiree Health Benefits Are More Common in the Public Sector
Public sector entities commonly provide some level of access to health insurance programs to their retirees. This access is also commonly accompanied by significant premium cost subsidies. According to the 2003 Segal State Health Benefits Survey of 39 states that responded in whole or in part, state employers subsidize over 50 percent of the total retiree monthly premium rates for single retirees under and over age 65. About 20 percent of the respondents said that they pay 100 percent of the premium rates for single retirees under 65. Almost 30 percent paid 100 percent of the cost for retirees age 65 and over.

Public Sector Retiree Health Costs Are Increasing Too
Health care costs for most states now consume about 15 percent of total compensation but are expected to increase to 20 percent of wages by 2008.

New GASB Accounting Rules Are Shining A Light on Retiree Health Liabilities

Under new GASB rules for other post-employment benefits (OPEB) that go into effect in fiscal 2006, state and local governments will have to begin reporting and disclosing (but not expensing) their level of retiree health liabilities. GASB Standard Nos. 43 and 45 will also require disclosure of how much funding will be required on a going forward basis to pay for unfunded liabilities over a period not to exceed thirty years.

These new reporting and disclosure accounting requirements may hurt the credit ratings of governmental entities that do not take remedial action. They will certainly put pressure on state and local governments to seek alternatives for funding, refinancing, and reducing current retiree health liabilities.

A recent Pew Center on the States report titled *Promises With A Price, Public Sector Retirement Benefits* estimates that states have about $370 billion in unfunded benefit promises for retiree health care and other non-pension benefits. This represents the liability only for state employees. Retiree health promises made by local governments for public employees are in addition. In 2006, Mercer Human Resources estimated that total state and local government liabilities for retiree health care benefits may exceed $1.4 trillion. The Pew report states that many states owe so much that they may find it cost-prohibitive to fully fund their non-pension liabilities—the median annual contribution required is almost three times what they currently are paying.

A variety of alternatives are potentially part of any overall solution considered by public policy makers:

- Reducing or eliminating eligibility for retiree health benefits
- Increasing age and/or service requirements
- Cutting coverage for certain classes of employees
- Reducing insurance costs
- Reducing benefits (e.g., increasing deductibles and co-payments)
- Mandating Medicare Part B coverage
- Providing catastrophic coverage only
- Reducing employer premium sharing levels
- Providing access only with no employer subsidy
- Increasing retiree contributions
- Issuing so-called “retiree health obligation bonds”

An additional possible alternative some public sector entities will consider is to change the nature of the retiree health benefit promise from one that is a promise of continued insurance coverage to one that only provides access to insurance coverage with a fixed DB- or DC-based health care cost subsidy that is no longer tied to underlying medical cost inflation.

Cost and Risk Shifting to Employees

Absent some fundamental change in this environment, it is expected that many of the actions taken by public sector employers will result in employees and retirees having to take on more of the cost and more of the risk of financing their healthcare costs during retirement. This financial burden is not small.

A recent study estimates that, assuming medical inflation at 7 percent per year, a 65-year-old retiree who lives to age 90 will need to have $214,000 or more in savings to pay

for Medicare part B premiums, Medicare supplement insurance and other out-of-pocket health expenses. Other studies have developed similar results.

Defined Contribution Retiree Health Savings Plans

Public sector employers are also exploring new options under federal law to restructure their retiree health benefit promises including the use of Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs).

In addition to or in conjunction with some of the above-referenced federal plans, state and local governments, as tax-exempt entities, are largely free to establish a variety of vehicles for receiving and accumulating assets to pay for retiree health care costs. The most common vehicles include so-called IRC 115 integral governmental trusts, IRC 401(h) medical accounts held within tax-qualified pension plans, and 501(c)(9) VEBA trusts. Assets in these “trust” vehicles could be available to offset any GASB OPEB liabilities.

The remainder of this paper will be given over to examining the legal requirements of these defined contribution retiree health savings, best practices for plan design, some case studies and, finally, suggestions for changes in laws or regulations that could make these plans more effective in the future.

Defined Contribution Retiree Health Savings Plans For Public Employees

Designing defined contribution retire health savings plans requires consideration of many of the issues that exist for the design of defined contribution retirement plans. Provisions relating to eligibility and participation, contributions, vesting, investments, distributions, and an appropriate funding arrangement must all be addressed.

Plan Design Considerations

There is no ideal plan design because each plan sponsors face varying circumstances that may dictate a different approach. However, there are some considerations that can help with plan sponsors pick plan designs that are a better fit.

Retiree Health Needs Are Different Than Pension Needs

A 2006 study by EBRI[1] estimates that an individual who retires currently at age 65 in that year and lives to age 90 will need $143,000 in savings to pay for Medicare Part B premiums and employment-based health insurance to supplement Medicare. If he or she also wants to cover about $1,800 in out-of-pocket expenses each year, the savings required increases to $214,000. These amounts do not include any additional cost for long-term health care. Medical inflation will likely increase this amount over time. The amount needed will be double if for couples.

The level of funding needed to meet these needs is higher than what many employers and employees can afford, particularly when taking the impact of medical inflation into account over the longer term. Solving this issue is beyond the scope of this paper, but one implication is that the financial resources necessary to pay for retiree health costs are the same for each individual and do not vary by compensation.

Contributions

Retiree health savings plans are generally funded with employer contributions. The IRC tax rules do not currently allow elective pre-tax employee contributions for this purpose.

The contribution structure for retiree health savings plans should be based on the benefit objective established by the plan sponsors. As noted above, participants are faced with the same retiree health care financing needs regardless of pay levels. This has important implications for designing the contribution formula for a DC retiree health plan. Flat percentage of pay contribution levels (e.g., 1% of pay) may generate savings levels that work for higher paid individuals, but fall short for lower paid employees. This means that flat dollar based contribution formulas that are the same for everyone regardless of pay may be more appropriate (e.g., $100/month).

Investments

Plan sponsors have a great deal of discretion in designing the investment structure for DC retiree health plans. The individual account assets can be invested by the plan sponsor, invested by plan participants, or a combination of both. Regardless, the investment risk lies with the participants. Plan sponsors may wish to consider

[1] *Savings Needed to Fund Health Insurance and Health Care Expenses in Retirement, July 2006,* EBRI Issue Brief #295

investment designs that include many of the investment risk management features that are used by DC retirement plans including the use of lifestyle or target date lifecycle funds as well as investment education and advice services that take into account retiree health needs of participants.

Distributions

Plan sponsors also have wide discretion with regard to eligibility for and distribution of benefits from DC retiree health plans. Decisions will need to be made regarding when benefits can begin. Benefits could be made at termination of employment, but some plan sponsors may want to set minimum age and service requirements (e.g., age 65, age 55 and 10 years of service).

Plan sponsors may also want to consider distribution provisions that protect against a participant from outliving their retiree health asset. Some options to be considered here include 1) requiring or encouraging that at least some of the account balance to be used to buy insurance coverage, and 2) mandatory partial annuitization of the DC retiree health account or annual distribution limits. These and similar restrictions could prevent catastrophic big ticket expenses from wiping out the retiree health account.

Distributions from these must be limited to the payment of eligible health benefits as defined by IRC Section 213(d). The plan will need appropriate claims adjudication services to determine whether claimed expenses have been properly documented by the participant and are eligible for payment.

Types of Funding Arrangements:

The funding arrangement selected is another consideration when addressing the design of a DC retiree health plan. Plan sponsors can use one or more of these accounts in conjunction with each other trusts to fund retiree health benefits.

The following is a summary of funding arrangements that may be used to fund retiree healthcare.

Employer General Account Assets

Public sector employers can pay retiree health care, as well as other post-employment benefits from their general purpose revenues. In the past, this has often been handled on a pay-as-you-go basis, which means that general assets have been used to pay current year retiree health care obligations without considering future liabilities.

While this approach may be simple and flexible for funding and plan design, there are certain short-comings as well. For instance, the employee cannot make contributions towards their retiree health care and there are no guarantees that assets will be available in the future to pay these benefits. Additionally, an employer's general account assets may be attachable in bankruptcy proceedings.

Voluntary Employees' Beneficiary Association (VEBA)

A VEBA is a tax exempt trust under Section 501(c)(9) of the IRC that is established to pre-fund retiree health benefits (or other employee benefits). The VEBA assets and earnings are specifically set aside in a trust for the sole purpose of providing specified benefits (e.g., health, life, accident or other). Governmental employers that establish a VEBA are exempt from some of the requirements that apply to private sector employers,

including certain tax reporting and UBTI (unrelated business taxable income) taxes on earnings.

The assets in a VEBA trust are typically invested with earnings accumulating on a tax free basis. Payments made out of the trust are also not taxed if they are used for tax qualified benefits – e.g., medical and dental insurance, prescription drugs.

There is a good deal of case law and guidance on VEBAs since their inception in 1928.

IRC Section 115 Governmental Integral Part Trusts/State-Law Grantor Trusts This is a grantor trust established by the governmental unit to set aside funds for paying future employee benefits. This approach allows the entity to prefund health benefits and hold in a secure, exclusive benefit trust to pay current and future retiree health benefits.

A governmental trust is a trust that qualifies for exemption from Federal income tax under IRC Section 115. It must be established only for an essential government function and the income earned on the trust's investments must accrue to the benefit of the state or local government entity. Although there is no explicit legal authority that addresses the use of the fund for the retiree health care obligation, Treasury Regulation 301.7701-1(a)(3) and several
IRS Private Letter Rulings are favorable to using an IRC Section 115 trust as a retiree health benefit funding vehicle.

Medical Account for Retirees of a Pension or Annuity Plan A pension or annuity plan may provide for payment of benefits for sickness, accident, hospitalization and medical expenses of its retirees, their spouses and dependents. The plan must comply with Section 401(h) of the IRC, which requires that medical benefits be subordinate to the pension benefits and that the plan create a sub-account within the plan for the purpose of contributing assets to fund retiree medical benefits. This can only be part of a qualified defined benefit or money purchase plan and contributing to the 401(h) trust can only occur after the pension plan is fully funded.

Section 401(h) provides a method that permits qualified pension plans to provide retiree medical benefits and establishes how these benefits are taxed. The 401(h) account may be funded by employer contributions and/or employee contributions. Pre-tax employee contributions are permitted through a mandatory "pick-up" arrangement that requires all eligible employees to participate. The employer must separately account for and fund the pension and the subordinate medical benefits.

In general, assets in the section 401(h) sub-account must be used to provide retiree health benefits to employees eligible for retirement benefits under the pension or annuity plan. Like other assets in the plan, earnings on assets in the section 401(h) account are not currently taxable. In addition, heath care benefits provided through the section 401(h) account are not taxable to the retirees. Any amounts that exceed the retiree health benefit liabilities must revert to the employer.

A drawback of 401(h) arrangements as a means to fund retiree health care is the limitations on contributions. The total contribution to a 401(h) must not exceed 25% of the aggregate total contributions to the qualified retirement plan (not considering contributions to fund past service credits for DB plans). Thus, employers with well-

funded pension plans may have a very limited ability (if any) to contribute to the section 401(h) account.

Another drawback to a 401(h) account is that it is a qualification requirement for the retirement plan. If the 401(h) account does not meet the form and operational requirements 401(h), the defined benefit plan as well as the 401(h) account could be disqualified.

HSAs vs. HRAs

Health Savings Account (HSA): An HSA is a tax favored savings account that may be established for employees covered by a "high deductible health plan" (HDHP). An HSA may funded by both employer and employee contributions, within IRS established limits, to finance health care costs. This was enacted as part of the Medicare Prescription Drug Improvement and Modernization Act of 2003 and the rules are found in Section 223 of the IRC. Contribution limits are relatively high ($2,900 for individuals in 2008), but can be used at any time. There is no certainty that the HSA account will be available to pay for retirement health costs.

A trust is established to accumulate funds on a tax-deferred basis, similar to 401(k) retirement accounts. An HSA may be offered through a cafeteria plan (Section 125 plan).

Under the current contribution requirements, it is difficult for employees to accumulate sufficient account balances to fund retiree health care as the amount in the account is typically needed to pay current year health care costs.

Health Reimbursement Accounts (HRA) HRAs are health care savings accounts that may be, but are not required to be tied to a high deductible health plan (which is required in an HSA). These employer-provided health reimbursement arrangements are established to reimburse medical care expenses incurred by employees, their spouses, and dependents up to a maximum dollar amount for that particular period, with unused amounts carried forward to the next period. The reimbursements are excludable from gross income of the employee.

An HRA may be used in conjunction with active employee health benefits and/or established for retiree health care. Employees and retirees are not permitted to make contributions to this account.

Other Considerations

The Problem of Pre-tax Employee Contributions
Employer contributions to fund retiree health benefits are generally not taxable to employees. Voluntary employee contributions are permitted, but only on an after-tax basis. There is some question as to whether employee contributions can be made on a pre-tax basis if they are mandatory (i.e., required as a condition of employment). Pre-tax employee contributions may be made to an IRC Section 401(h) medical account if implemented through a non-elective IRC Section 414(h)(2) employer pickup arrangement. Regardless, employees cannot be given a choice between receiving cash compensation and making contributions to a retiree health savings plan. Plan sponsors should seek the advice of legal counsel on these issues.

Unused Leave Payments to Retiree Health Plans

Retiree health plans are often funded through unused sick or other leave accumulations that would have otherwise been paid out in cash when the employee retirees. Under this funding scenario, contributions of leave balances or portions thereof must be automatically made to the plan for all eligible employees, with no choice for receiving cash payments.

Unused Balances Must Be Forfeited

Current IRC rules do not allow unused balances in retiree health savings plans to be paid out in cash to surviving beneficiaries or an estate after the death of a participant. Such amounts are forfeited back to the plan and can be used to offset future employer contributions or pay for plan expenses.

Public Sector Defined Contribution Retiree Health Plan Case Studies

Governmental employers are seeking to control their liabilities for retiree healthcare and also provide a funding vehicle to employees. Governance issues play a role when policymakers decide which vehicle to use. For example, only governmental entities can establish 115 trusts and there is some possibility that assets might be accessible for purposes other than retiree healthcare. The following section provides an in-depth review of four case studies highlighting what some state and local government employers have done regarding retiree healthcare and how defined contribution retiree health funding vehicles have played a role.

1. Minnesota State Retirement System has established a defined contribution plan for assets to fund retiree healthcare.
2. Oakland County, Michigan has established a VEBA and an intermediary trust to address retiree healthcare for employees hired prior to 2006. Employees hired after 2006 have a defined contribution plan to provide for retiree healthcare expenses.
3. The Municipal Employees' Retirement System of Michigan (MERS), a multi-employer system, established a 115 Medical Trust allowing different plan design choices for different employers.
4. The Ohio Public Employees' Retirement System (OPERS) created a HealthCare Preservation Plan, which established a VEBA to hold assets in Retiree Medical Accounts (RMAs). The RMA operates differently depending on which retirement plan a member has chosen.

We have tried to carefully describe these plans, since terminology is still inconsistent in the industry.

Minnesota State Retirement System
Health Care Savings Plan

Background

The Minnesota State Retirement System (MSRS) administers a defined benefit retirement plan for approximately 66,000 current and former state employees and provides monthly retirement benefits to over 23,000 retirees and other benefit recipients.

MSRS also administers Minnesota Deferred Compensation Plan (MNDCP) which is a supplemental, voluntary 457 retirement plan. Currently, assets of more than 78,000 participants exceed $3.7 billion.

MSRS is governed by a Board of 11 members both elected and governor appointees.

Retiree Health Situation

The majority of public employees in Minnesota do not receive retiree paid healthcare. MSRS, as the retirement administrator for State employee pension continuously heard from active employees on their concerns regarding rising healthcare costs and how it was affecting their retirement plans. State retirees are able to continue participation in the group insurance program; however the retiree is responsible for the full cost of the premium.

Initial research and legislation (during the year 2000) regarding healthcare funding options included a defined benefit style healthcare program where the employee and employer would each contribute a percentage of payrolls and as a retiree would be paid a monthly benefit based on a schedule for healthcare expenses. Due to budget constraints at the time, this structure was not acceptable and research into a defined contribution for retiree healthcare began.

Proposals in 2001 included the current structure initially only included state employees only; however it was expanded to allow any public employer to participate voluntarily. The legislation was very clear that there was not an obligation for the state or other municipalities to contribute to this program to increase liabilities. As with other states by the end of 2001, Minnesota was facing a significant budget deficit.

The Solution: The Health Care Savings Plan

The Health Care Savings Plan (HCSP) is the newest program administered by MSRS. The tax-free trust allows eligible public employers in Minnesota to set aside funds for post-employment healthcare expenses. Currently, the HCSP assets exceed $191 million for more than 30,000 participants.

The program has been in effect since July of 2001. The Laws of Minnesota, Special Session 2001 Chapter 10, Article 7, section 1 authorized MSRS to provide a health care savings reimbursement plan.

Participation by state and other public employees is determined during negotiations between the bargaining units, or group of employees if there are no bargaining units, and the employer with final language approval by MSRS.

Joining the Plan is not necessarily a permanent arrangement for the employers. The initial arrangement requests a two year commitment. After that point, the Plan can be amended based on the results of new negotiations (agreements must be in place for two years).

Legal Authority

Minnesota Statutes Chapter 352.98 authorizes MSRS to establish a plan or plans, known as the post employment health care savings plans, through which public employers and employees may save to cover post employment health care costs. The law mandates the MSRS to make available one or more trusts, authorized under the Internal Revenue Code to be eligible for tax-preferred or tax-free treatment.

Private Letter Ruling

The State, acting through the MSRS, established an Integral Part Trust (Section 115). MSRS received a private letter ruling from the IRS establishing the HCSP as exempt from income tax and FICA tax as an integral part of the State on July 29, 2002. The Internal Revenue Service (IRS) tax code authorizes government bodies to establish essential functions which are deemed to be an "integral part" of the organization. IRS rulings state that providing employee welfare benefits to retirees is an "essential function" of state or local government's activities. The IRS also deemed that providing retiree health benefits are an "essential function." Therefore, it is considered an integral part of the government's activities and, as a result, it enjoys the entity's tax exempt status.

Plan Design

Eligible Employers

All Minnesota public employers are eligible to participate in the Plan. One of the criteria used is membership in one of the following pension plans:

- Public Employees Retirement Association (PERA)
- Teachers Retirement Association (TRA)
- Minnesota State Retirement System (MSRS)
- St. Paul Teachers' Retirement Fund Association
- Duluth Teachers' Retirement Fund Association
- Minnesota State Colleges and Universities (MNSCU) Individual Retirement Account Plan (IRAP)
- Or other smaller MN Public Pension Plans

Employer participation is voluntary. There is not an administrative fee to the employer to participate. There may be some initial costs associated with beginning deductions such as programming changes; however the employer does achieve FICA savings on contributions that should offset these nominal costs.

Bargaining agreements or a personnel policy determine which groups of employees will be part of the Plan. Employee accounts are activated once funds are contributed to their account. Employees pay an annual administrative fee of 0.65 percent of their account balance. The fee is prorated monthly and capped at $140 per year.

Contributions
There are a number of different funding options that may be implemented by employers based on the agreement reached with the bargaining units or employees. Contributions may be derived from a number of sources as determined by the agreement. The following are examples:

- Employer elects to apply a specific dollar amount into employee accounts.
- It may be mandatory for an employee to contribute a percentage of salary increases directly into the fund.
- The employer can make contributions in addition to the salary and other benefits provided to the employees.
- The employer can elect to pay unused vacation and/or sick leave as severance pay at the time an employee terminates employment.

Contributions are made by public employers to the HCSP trust and amounts credited to an employee's account can be used to reimburse qualified health care expenses after the employee terminates employment or in other limited circumstances.

Assets in the program accumulate tax-free and are paid out on a tax-free basis for medical expenses (in accordance with IRS Publication 502 and Internal Revenue Code 213(d)). This is not simply a post retirement program. Any employee who leaves employment, becomes disabled, is on medical leave for six months or longer, or on a leave of absence for more than one year may access their account. The money is available to pay for health care and dental premiums, long-term care insurance and additional out of pocket medical costs incurred. The IRS has a list of approved items that may be reimbursed. Approving requests will require some discretion by plan representatives. The list cannot encompass all possibilities.

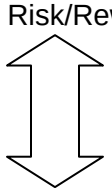
Investments
Participants may choose their own investment allocation. There are seven different investment options ranging in risk and reward. These investments are commingled funds (Supplemental Investment Funds) administered by the State Board of Investment (SBI). If a participant does not make an investment selection the default investment is the Money Market Account.

No one within the HCSP reviews the investment returns of the participant. Each person is responsible for reviewing their investment strategies. Investment allocations can be changed more than once a month but only the final change is implemented for the coming month. Any changes can be made by the participant by completing the Investment Allocation Form, by phone with any HCSP representative or via PIN access to their personal on-line account.

The range of investment choices has varying degrees of risk and earnings. The percentage invested must equal 100%. The seven investment options are:

1. Money Market
2. Fixed Interest Account
3. Bond Market Account
4. Income Share Account
5. Common Stock Index

(Less Risk/Reward)



6. Growth Share Account
7. International Account (More Risk/Reward)

The State of Minnesota neither guarantees investment performance nor assumes any liability for loss in any account.

A summary of funds is included in the Welcome Packet. A prospectus is available to participants and employers upon request. The prospectus provides greater detail about each account and should be read before deciding how to invest assets. The prospectus is also available from the State Board of Investment's web site at www.sbi.state.mn.us

Once the funds are invested, in accordance with the Trust Document, they are held in trust for the sole purposes of reimbursing qualified health care related expenses of participants and their eligible dependents.

Reimbursements
Reimbursement for eligible healthcare expenses for the employee, their spouse and dependents may begin following separation of service by the employee.

Reimbursements from the plan will never be taxed for the participant and may only be used to offset health care costs. Once the money is deposited into a participant's HCSP account it is for the benefit of the participant, spouse and legal dependants. After a participant's death, their spouse and legal dependents may continue to use the Plan to offset health care costs. If there is no spouse or dependents, the designated beneficiary on their account will receive a lump sum life insurance benefit. The account balance is absorbed into the Trust.

Participants collect receipts totaling $75 or more then submit their claims to the HCSP. All claims are reviewed and if approved, are generally paid on a weekly basis. Reimbursements for premiums can be set up for payment in an on-going status. These are paid the last Friday of each month and may be made by check or by direct deposit into the participant's account.

Outcome
The HCSP has been relatively successful. It has received a positive response from both public employers and public employees throughout the state. There has been significant growth of participation and plan assets over the short life of the plan as shown in the following chart.

	Assets (in Millions)	**Participants**
FY02	$ 2.7	1,608
FY03	$25.6	5,622
FY04	$54.5	13,777
FY05	$83.4	20,100
FY06	$122.2	24,191

FY07	$174.1	30,904

At the end of November 2007, plan assets exceed $191 million and the plan is expected at the first of the year to have more than 46,000 participants with active accounts and over 400 Minnesota public employers participating.

The majority of contribution arrangements have been established through the collective bargaining process. For example, through the bargaining process the bargaining unit agrees to a set reduction of pay for each represented employee. This amount plus any unused sick leave and vacation paid upon separation is then deposited to the HCSP for each employee. In addition, some employers will provide a nominal contribution that might be a portion of the FICA savings they incur because of the contributions.

More recently, local public employers who in the past have provided retiree healthcare coverage are moving away from that design and contributing to plans like HCSP for the future healthcare costs of their employees. They may negotiate an annual lump sum contribution in combination with an employee contribution.

Future Considerations

The HCSP was created prior to IRS regulations or ruling governing these types of plans. As a result, there have been some challenges to the "death benefit" outlined in the original plan design.

Original Death Benefit

Minnesota Statute 352.98, subdivision 4 requires that remaining account balances in the HCSP be paid to the beneficiary(ies) or estate upon the death of a participant if they do not have a spouse or legal dependent(s). The initial plan design specified that upon the death of participant, the spouse or legal dependent(s) as defined by the Internal Revenue Code could continue to request reimbursement from the HCSP account for eligible healthcare expenses. The reimbursements would be tax-free. If the participant did not have a spouse or legal dependent at the time of the participant's death, the designated beneficiary(ies) would continue to request reimbursement for healthcare expenses until the depletion of the account. The reimbursements would be taxable to the beneficiary(ies).

At the time of the plan implementation; the design was acceptable to the IRS. There were several plans throughout the country with similar designs; many plans had this design in place for more than twenty years. Subsequent Internal Revenue rulings related to Health Reimbursement Arrangements (HRAs) were not clear regarding the death benefit design; however, the most recent ruling 2006-36 addressed this specific plan feature and indicated that it was not acceptable.

Current Plan Design

The IRS offered a transition period for plans that had this provision in place prior to August 14, 2006 to be modified by July 1, 2009. In response to the revenue ruling, after consultation with Mercer Human Resources, MSRS established a life insurance benefit for HCSP plan assets beginning in September 2006.

The life insurance policy is a group term policy that insures the total assets of the HCSP; premiums are paid by MSRS and the life insurance is treated like a bundled benefit. Upon the death of a participant, if there is a surviving spouse or legal dependent(s) the HCSP account could continue to be used for reimbursement of eligible healthcare expenses. The life insurance benefit is contingent upon the participant not having a surviving spouse or legal dependent(s) at the time of their death. If the participant does not have a surviving spouse or legal dependent(s), the account balance reverts to the trust and a life insurance benefit is payable to the beneficiary(ies).

MSRS continues to work with other plan administrators throughout the country and the Minnesota Congressional Delegation to modify current federal law to ensure that Minnesota Statutes 352.98, subdivision 4 and federal laws and regulations are not in conflict.

Oakland County, Michigan

Background
Oakland County, MI is a governmental employer of 4,000 employees and 2,000 retirees. The County pre-funded retiree healthcare for 23 years by setting money aside in a non-exclusive general account of the County. This set-aside money was invested by the defined benefit pension retirement board invest it in the same manner as other retirement contributions. The money was separately accounted for, but not protected from the possibility of being used for purposes other than retiree healthcare.

Retiree Health Situation
Although the County had been attempting to pre-fund retiree healthcare, actuarial projections showed it was weakly funded – approximately 30% funded in 2006. To manage costs, the County had been tweaking the requirements to qualify for retiree healthcare and offered lump sum buyouts to deferred retirees willing to opt out of the program on three occasions. The County was showing a $550 million unfunded liability for retiree healthcare on its books as required by GASB 45.

The Solution: The Health Care VEBA
The County observed the State legislature reallocate assets intended to fund retiree healthcare for State employees. The governing body and staff wanted to protect the assets that had been set aside for Oakland County retiree healthcare. The County made a proposal to the IRS to approve a VEBA. It took over a year to draw up the VEBA plan and get a letter of approval from the IRS. The explicit costs of the VEBA approval process were a $10,000 filing fee plus internal attorney fees.

In 2000, the County set up the VEBA to hold the money which had been accumulated in the separate fund managed by the retirement system for retiree healthcare. The VEBA structure protects the assets from being used for purposes other than retiree healthcare. These assets are used to pay for retiree healthcare for employees hired prior to 2006.

The County sold retiree health obligation bonds to raise the $550 million in unfunded retiree healthcare liabilities. The proceeds were placed into an intermediary trust to pay what is needed into the VEBA or to repay the bonds. The trust provides a contingency plan in the case of national health insurance; assets would be first used to repay the bonds and any remaining assets used for contributions to the defined contribution health plan established for newer employees.

To take care of future liabilities for retiree healthcare, the County stopped all future retiree healthcare benefits for employees hired in 2006 or later (with the exception of 2 uniformed bargaining units, which are still bargaining). Employees hired in 2006 and later receive $50 per pay period into a defined contribution health plan. ICMA-RC is the service provider for this new plan for new hires. The funds can be used for healthcare once an employee retires to pay for eligible health expenses. It takes 15 years to be 60% vested and 25 years to be 100% vested in the defined contribution health plan.

Outcome
The retiree health obligation bond issue and creation of the intermediary trust removed the explicit unfunded retiree health liability from the County's books. The County does, however, retain the debt service obligations for the bond issue. Future retiree health

liabilities other than the related bond debt have ceased since the County has no retiree healthcare for employees hired after 2006.

For everyone retiring with a hire date prior to 2006, the County pays healthcare bills out of the VEBA. With only two years of experience under this new benefit structure, it is unknown what this will do to the ability of Oakland County to attract and retain appropriate employees. It is also unknown how much retiree healthcare the current level of funding ($50 per pay period) to the defined contribution health plan will purchase in the long-term.

Future Considerations

It is anticipated the County will need to require retirees eligible for retiree healthcare to pay some amount for healthcare. How to structure the payment will be a legal question. County officials believe national healthcare will eventually come into being.

Municipal Employees' Retirement System of Michigan (MERS) Case Study

Background

Municipal Employees' Retirement System of Michigan (MERS) was created by the Michigan State Legislature in 1945 and became an independent public corporation in 1996. MERS is a multiple employer, voluntary municipal pension plan. The voluntary nature of MERS participation within the state and the evolving fiscal and employee benefit needs of current and future member municipalities provides continual pressure for MERS to improve its benefit options.

MERS provides retirement benefits to more than 65,000 members in more than 600 municipalities maintaining more than 1,850 separate benefit divisions.

Retiree Health Situation

Employers throughout the State are faced with significant health care obligations to their employees/dependents and retirees/dependents. The cost of providing these benefits is growing at an exponential rate and there is limited opportunity to control the rising costs of both active and retiree health care. Adding further to the problem is the new accounting requirements requiring accrual and potential funding of the GASB OPEB liability for member employers. The impact of these pressures will likely have an adverse impact on retiree health care sponsorship, plan designs as well as premium contribution sharing strategies.

Further to the cost, design and funding issues is the probable adverse impact that this new financial accounting liability will have on the various members bond ratings dependent upon their unfunded liability.

MERS recognized that that some retiree health funding issues could be addressed by taking advantage of holding assets in medical trusts for the future health care expenses of retirees. MERS analyzed the feasibility of the following trust vehicles:

- §401(h) Accounts
    - Defined Contribution accounts that are associated with defined benefit plans. There is a contribution funding requirement that no more than 25% of contributions to the entire plan be placed for benefit in the medical trust, therefore potentially limiting funding into the retirement pension benefit of the defined benefit plan. Governance is from the defined benefit plan board.
- Voluntary Employees' Beneficiary Associations (VEBA)
    - A VEBA medical trust can be used for the purposes identified as solutions to the stated problems. Governance of a VEBA trust is as identified by the trust document and the trustees selected for trust oversite.
- §115 Governmental Trusts
    - These trusts are for governmental employer use only and the benefits provided are authorized by §115 as an essential government function.

The Retiree Health Solution

MERS sought and received IRS approval in January of 2004 for a new Health Care Savings Program. The HCSP is a defined contribution retiree health savings plan funded through an IRC §115 Integral Part Medical Trust. MERS chose the §115 trust over a §401(h) plan and VEBA for a number of reasons. The §115 plan is not subject to the subordination limits of the defined benefit plan as is true for the 401(h) plan, and

voluntary employee contributions may be made after-tax, however this does not preclude mandatory salary reductions. The disadvantage to the §115 model is that State statutory authority may be required, including IRS approval. In order to qualify as an "integral part" of the governmental entity, the member entities must have "substantial control" and "substantial financial involvement" in the plan. MERS sought and received IRS approval in January of 2004 for a §115 Medical Trust. From this ruling MERS developed two savings vehicles:

- Health Care Savings Program for individual employee accounts
- Retiree Health Care Funding Vehicle for employer accounts

The HCSP

The Health Care Savings Program is a defined contribution retiree health employer-sponsored program, designed to provide employees with individual tax-favored savings accounts to cover post employment medical expenses for themselves and their dependents. The employer and employee groups work together to establish and fund the program. The employer remits tax-free contributions into individual employee savings accounts. Contributions are commingled for investment purposes and grow tax-free. Accounts are available for tax-free reimbursement of medical expenses upon leaving employment.

The employer and employee groups have a flexible design of contribution structure and by use any one, or all, of the following designs:

- Tax-Free
  - Basic Employer
  - Mandatory Salary Reductions
  - Mandatory Leave Conversions
- Post-Tax
  - Voluntary Employee Contributions
- While collecting a disability benefit from any public pension plan
- While on medical leave for 6 months or longer
- Upon separation from employment

As with the other funding vehicles, the IRS has determined that upon the death of a member, funding in this vehicle will be available to the spouse and to eligible dependents. Any funds in the member's account absent a spouse or eligible dependent is forfeited.

The Retiree Health Care Funding Vehicle

The Retiree Health Care Funding Vehicle is an employer investment account designed to help municipalities save and grow assets to offset future retiree health care liabilities**.** The Retiree Health Care funding vehicle adds value in complying with the GASB OPEB standards as follows:

- Assistance with the reporting requirements
- Automatic actuarial valuations at reduced fees
- Allows for an assumed rate of return of 8% on valuations based on the actuarial calculations of the MERS retirement portfolio
- Enables employers to report assets within the approved medical trust on their financial statements to offset liabilities

Outcome
While still a relatively new program, the Health Care Savings Program has 34 employers enrolled covering over 1,000 members with almost $5 million in assets. The Retiree Health Funding Vehicle had 27 employers enrolled with almost $17 million in assets.

Future Considerations
Education is needed to develop effective communication plans. A collaborative process may need to be established between employers and employee groups. The keys to participation are clearly 1) plan design flexibility, 2) liability foresight, and 3) cost effective plan administration.

Ohio Public Employees Retirement System (OPERS)

Background
OPERS first offered fully insured health care coverage to its retirees in 1962. The plan was not subsidized by the System; the retiree paid the entire premium. In 1974, OPERS began self-funding healthcare and only charged premiums for dependents. OPERS has had a long history of providing a dependable array of retirement benefits including a sound retiree health care coverage plan. But like other payors of health care from the federal government to private industry, OPERS has experienced significant inflationary pressures resulting in increased annual expenditures.

Organization Description
With December 31, 2007 assets of $82.9 billion, OPERS is the largest State pension fund in Ohio, the 10th largest public retirement system and the 14th largest retirement system in the U.S. The system serves more than 908,000 members and provides retirement, disability and survivor benefit programs for public employees throughout the State who are not covered by another State or local retirement system.

OPERS is governed by an unpaid governing board of 11 members responsible for the administration and management of the system. Board members are elected by the employee groups they represent or are appointed by elected officials.

Retiree Health Situation
The OPERS Board of Trustees recognized that providing health care coverage is an important element in planning for any retiree's future. However, factors beyond the control of any retirement system, such as skyrocketing health care costs, increased longevity and the retirement of baby-boomers, place significant strains on health care funds. Similar to managing pensions, OPERS' plan to manage the health care fund so that coverage can be preserved into the future involves a multi-faceted approach aimed at controlling expenditures through active management, evaluating plan design to preserve intergenerational equity, implementing a wellness program, and maximizing revenue through investment returns and System funding.

Retiree Health Solution – The Health Care Preservation Plan
In 2004, the OPERS Board and staff had the foresight to create the Health Care Preservation Plan. The HCPP is a multi-disciplinary and strategic set of changes to the OPERS health care plan designed to extend solvency, reduce unfunded liability and improve funding.

HCPP 2.0 utilizes a balanced approach with responsibilities distributed among OPERS, retirees, the legislature, employer groups, the greater health care community and business partners. It is not simply a "cost shift" to the retiree or a reliance on increased contributions and remains consistent with the original HCPP guiding principles to:

1. Preserve access to quality health care coverage for all eligible members and their dependents.
2. Commit to a long-term solvency period.
3. Balance health care changes between current and future retirees.
4. Consider career service, membership status and affordability in determining health care premiums.
5. Balance OPERS responsibilities with the personal accountability and consumerism of our members to preserve benefits for the long-term.

6. Manage the program using sound business practices consistent with industry norms and marketplace developments.
7. Review annual program adjustments to keep pace with increasing health care and pharmacy cost trends, which allow for a phased-in approach to benefit changes.
8. Support health and disease management activities that assist benefit recipients and hold vendors accountable for results.
9. Pursue health care public policy changes and related advocacy activities.
10. Maintain affordability of health care for members through multiple plan designs while maximizing group purchasing power.
11. Educate and communicate with all interested parties as early as possible and on an ongoing basis about all aspects of the OPERS health care program.

OPERS uses a 401(h) structure for its retiree health care program and a VEBA for the Member-Directed RMA. In 2007, OPERS implemented changes to the structure of its program in order to improve the financial solvency of its health care fund in the face of constantly rising health care costs. The changes are different depending on the pension plan the member participates in.

OPERS offers three pension plans: The *Traditional Pension Plan* (a traditional defined benefit plan), the *Combined Plan* (a combination of a defined benefit and a defined contribution plan) and the *Member-Directed Plan* (a defined contribution plan). The changes for the Member-Directed Plan are different than for the other two plans.

Traditional Pension and Combined Plan Solution

In 2007, instead of providing health care coverage, OPERS began giving members in these two plans a set allowance each month to spend on health care. The amount the member receives is based on length of service, the year in which the member is eligible to retire (before or after Jan. 1, 2007) and the member's date of hire (before or after Jan. 1, 2003). If the cost of the medical/pharmacy plan and dental and vision options the member selects amounts to less than the monthly allowance, the excess goes into a Retiree Medical Account (RMA), which the member uses to obtain reimbursement for qualified health care expenses.

Member-Directed Plan Solution

The Member-Directed Plan and associated RMA was established Jan. 1, 2003. Unlike the Traditional and Combined Plans in which the RMA is created after retirement, under the Member-Directed Plan, an RMA is part of the member's defined contribution benefit. A portion of the annual employer contribution to the Member-Directed Plan is credited to the RMA. Members vest in their RMA based on their attained years of participation in the Plan as follows:

Attained Years of Participation*	Percentage Vested
1-2 years	0%
3 years	30%
4 years	40%
5 years	50%
6 years	60%
7 years	70%

8 years	80%
9 years	90%
10 years	100%

Unlike the member's individual retirement account which is self-directed, OPERS manages and directs the investment of the member's RMA. The current annual contribution rate for State employers is 14 percent and 14 percent for local employers. Of these employer contributions, 4.50% are used to fund the RMA account. Contribution rates and interest rates are subject to change based on the Retirement Board's recommendation. Amounts contributed to the RMA may be used once the member separates from service.

RMA Features

Since the money may only be used to pay qualified health care expenses, RMA distributions are not subject to federal income taxes. RMA assets may be used to pay health care expenses for qualified dependents as defined by OPERS and, if the member dies while contributing or while receiving a payment, the beneficiary may use the remaining vested portion of the RMA account for the payment of qualified health care expenses if the beneficiary is a qualified dependent under OPERS guidelines. All qualified dependents may access the RMA account after the member's death and if the beneficiary is eligible for health care coverage, he or she may continue to accrue and use the RMA.

OPERS manages and directs the investment of the member's RMA. Interest at a rate of 4% is credited annually to the member's RMA. After the member begins receiving reimbursements from the RMA, the member will receive quarterly statements and an Explanation of Payment in any month a disbursement occurs.

Outcome

Historically, OPERS has taken a proactive approach to funding health care benefits. These efforts have yielded tangible results as reported in the New York Times, "Ohio is one of a few states to set aside significant amounts. Its public employee retirement system has been building a health care trust fund for years, so it has money today to cover at least part of its promises." Since 1974, when OPERS first offered health care coverage, the System has conscientiously worked to pre-fund coverage. OPERS is one of only a few systems that set aside funds to pay for this intended purpose. In 2005, OPERS' Health Care fund assets were segregated from the pension portfolio for investment purposes. These assets are invested in a separate mix of investments designed to facilitate steady growth and minimize volatility. The OPERS health care fund now stands at $12.8 billion.

Future Considerations

OPERS is planning to offer the option for members and retirees to make deposits to a Voluntary RMA (Post Tax) beginning July 1, 2009. OPERS will continue to explore Voluntary Pre-Tax options, but the current Federal tax law climate is not favorable for such options.

Future Considerations

The public sector currently enjoys a great deal more latitude than the private sector in designing and funding retiree health benefits. However, the size and nature of the challenge are such that certain changes in federal law could be helpful to developing new opportunities that would help governmental employers and employees to adequately plan for and manage retiree healthcare costs.

Current Tax Advantages
Currently, employer contributions to a trust to provide medical benefits to retirees are tax free. The earnings on those contributions accrued on a pre-tax basis. When amounts are distributed from the trust to pay for medical benefits described in Code §213(d) on behalf of the retiree, spouse and/or dependents are tax free. This tax treatment is available whether the vehicle used is an IRC Section 115 Integral Part Trust, a Voluntary Employee Benefit Association (VEBA) or an IRC Section 401(h) account under a qualified IRC Section 401(a) retirement plan. The basis for this treatment is set out in Revenue Ruling 2002-45, and a number of private letter rulings.

Roadblocks to Employer Funding of Retiree Healthcare
The main obstacles with the current Health Reimbursement Arrangement (HRA) guidelines are that voluntary pre-tax employee contributions are not allowed and any amounts accrued on behalf of a participant must be used for medical benefits for the participant, spouse and dependents, and if there is an amount remaining in the account, it must be forfeited back to the plan or employer and cannot be paid as a taxable death benefit to a beneficiary.

Congressional Proposals
The following changes in federal regulation may be helpful to encourage more employers to fund their future retiree health care liability:

1. Allow taxable death benefits to be paid from retiree health savings plans. All assets in an HRA plan are subject to a risk of forfeiture since such amounts must revert back to the plan or employer if there is no qualifying spouse or dependent to use such funds for medical expenses. So long as taxable death benefits cannot be paid, irrevocable employee contributions elected in the prior year should be allowed. This follows §125 plan guidance.

2. Allow pre-tax employee contributions to HRAs. Perhaps amounts similar that allowed for HSAs could be considered.

3. Allow mandatory employee contributions (as a condition of employment) to be made on a pre-tax basis. This provision would be similar to the current §414(h)(2) provisions that allow mandatory employee contributions in public sector §401(a) plans to be "picked up" by the employer and treated as pre-tax employer contributions.

Service Provider Products

Service providers are attempting to assist governmental employers by offering savings programs designed to accumulate assets to fund employer's current and future retiree healthcare liability. In this effort, the following products are available to fund the employers' retiree healthcare liability, the employees' retirement healthcare liability or both: 1) Section 115 Integral Part Trusts, 2) Voluntary Employee Benefit Associations, and 3) §401(h) accounts with qualified §401(a) plans.

Unfortunately, as long as these plans are subject to the roadblocks discussed above, they do not adequately reflect the labor environment and plan design needs of public sector employers struggling to design and implement retiree healthcare funding solutions.