



Position Paper – Long Term Retiree Benefits Changes

Agenda

1. Commendations
2. Pensioner Principles
3. Review key Position Paper findings
4. Recommendations
5. Further areas/items of study

The DRSPA Executive Board commends:

- Governor Carney for initiating a study of the retiree health care liability, using an investigation method that was reasonably transparent and provided an opportunity for input from this and other interested parties.

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- Retiree Benefits Study Committee members for their attention, hard work and perseverance, particularly through the Covid pandemic.

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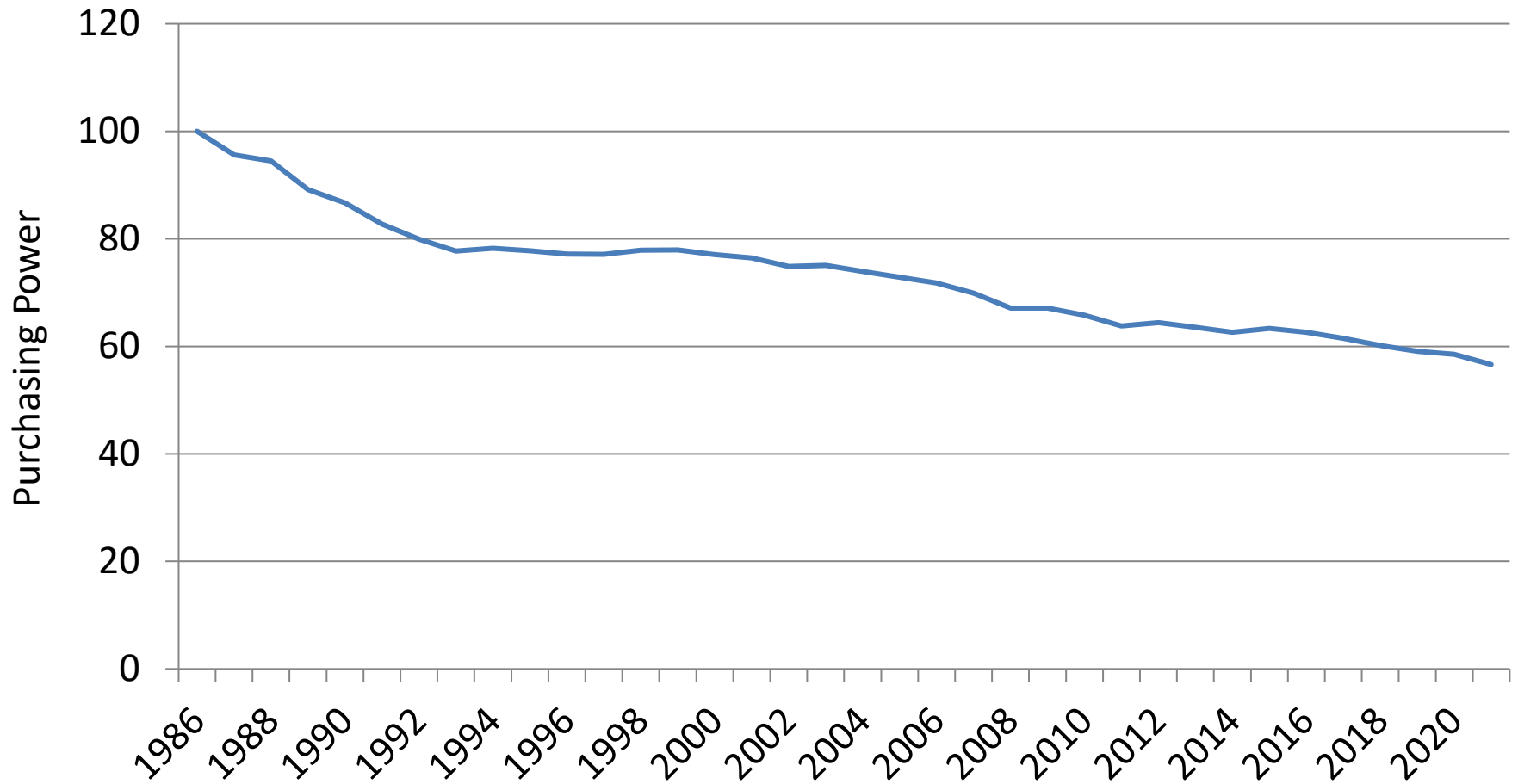
- Governor Carney for initiating a study of the retiree health care liability, using an investigation method that was reasonably transparent and provided an opportunity for input from this and other interested parties.
- Retiree Benefits Study Committee members for their attention, hard work and perseverance, particularly through the Covid pandemic.
- Rick Geisenberger, Secretary of Finance and RBSC Committee Chair, for his strong leadership in guiding the committee through its task, for his outreach to DRSPA officials, and his presentation to the DRSPA Executive Board.

Pensioner Principles

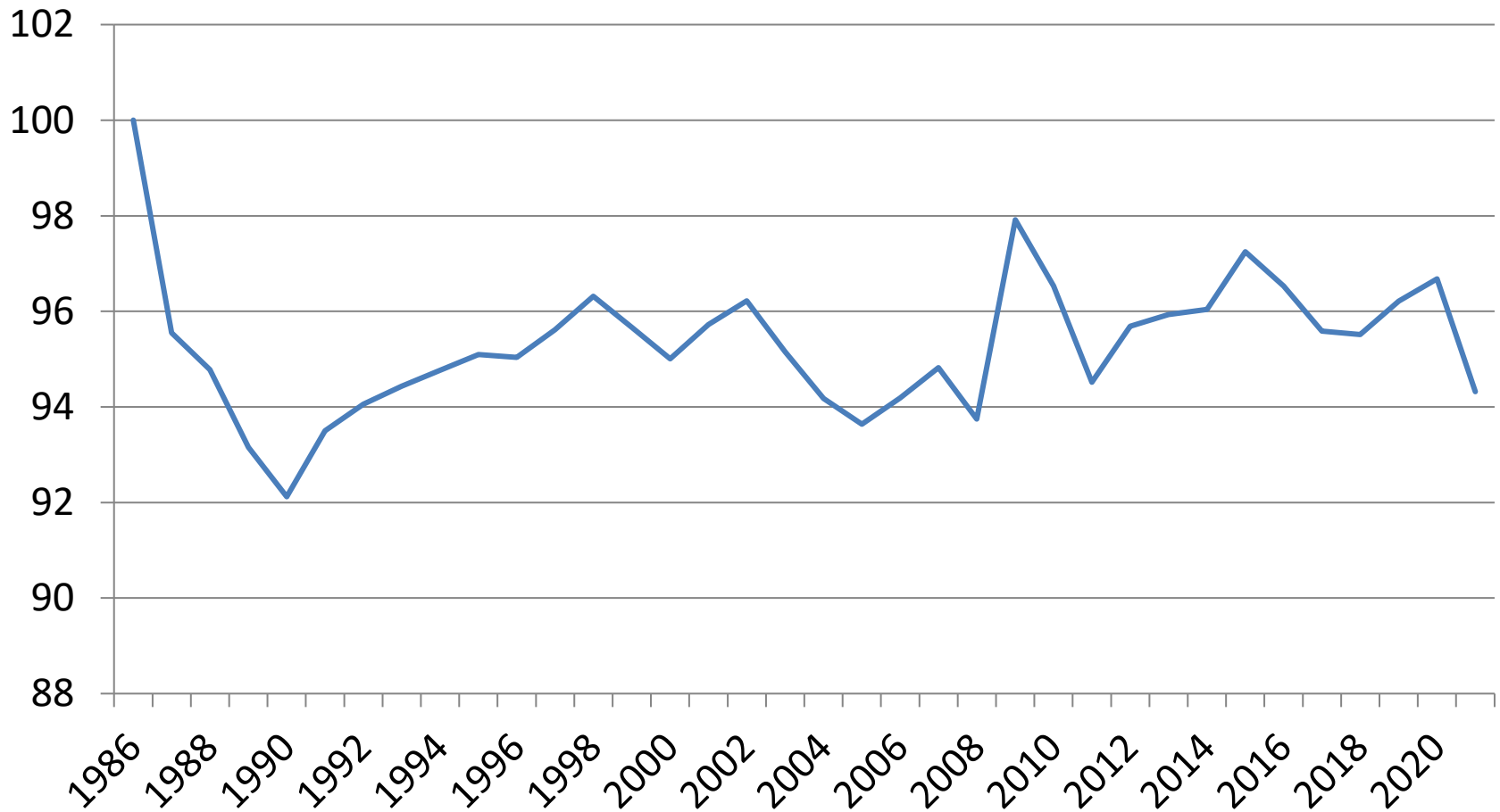
1. The purchasing power of pensions decreases over time.

Purchasing Power 1986 to 2021

(Pension Increases minus Inflation)



Purchasing Power of Social Security Benefit 1986 to 2021

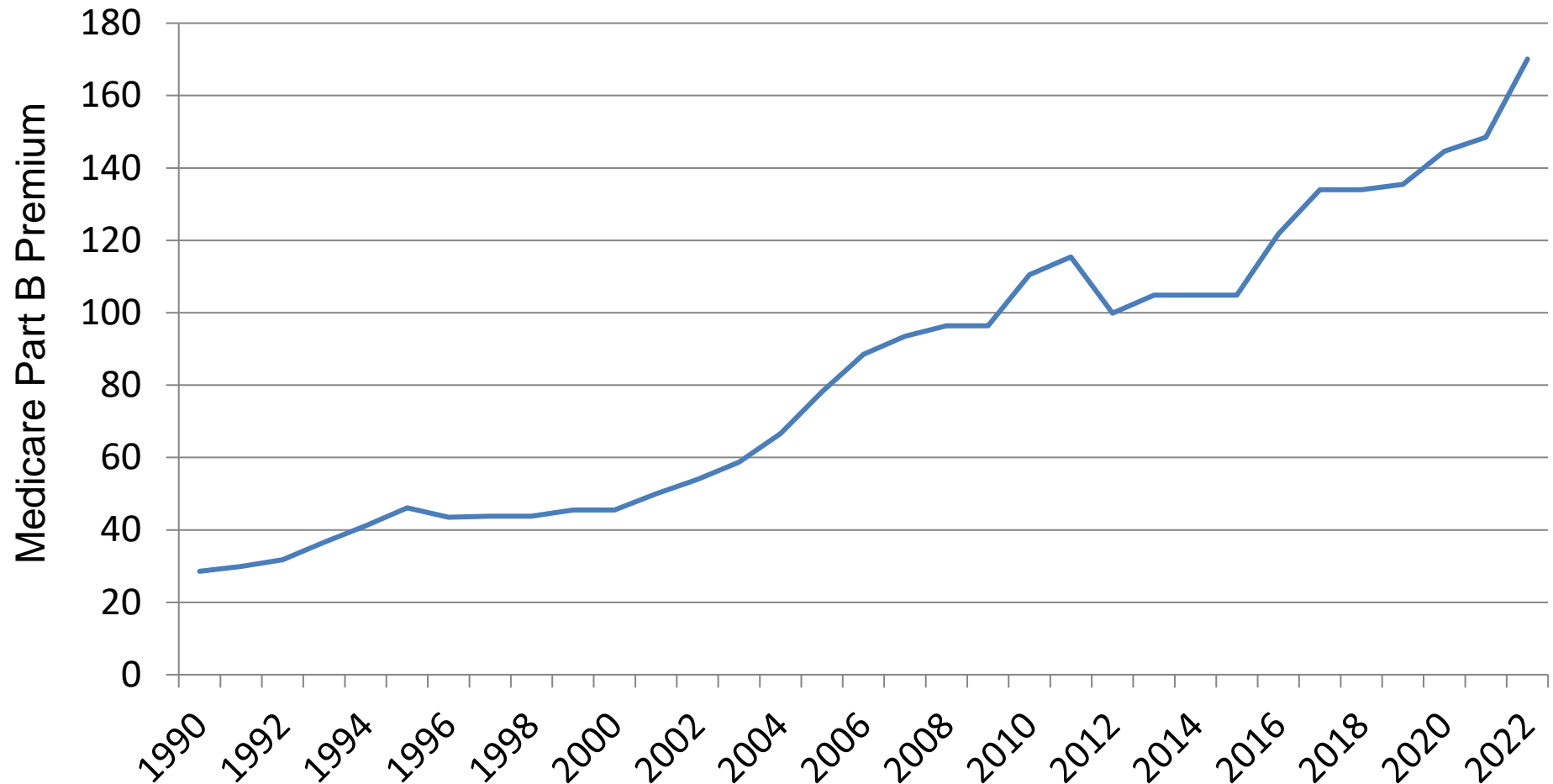


Pensioner Principles

1. The purchasing power of pensions decreases over time.
2. Health care costs increase over time.

Medicare Part B Premium 1990-2021

(Average 5.5% annual increase)



Health care costs increase over time.

- Medicare Part B premium increases
- Additional or increased drug co-pays

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- Medicare Part B premium increases
- Additional or increased drug co-pays
- Changes dictated by SEBC

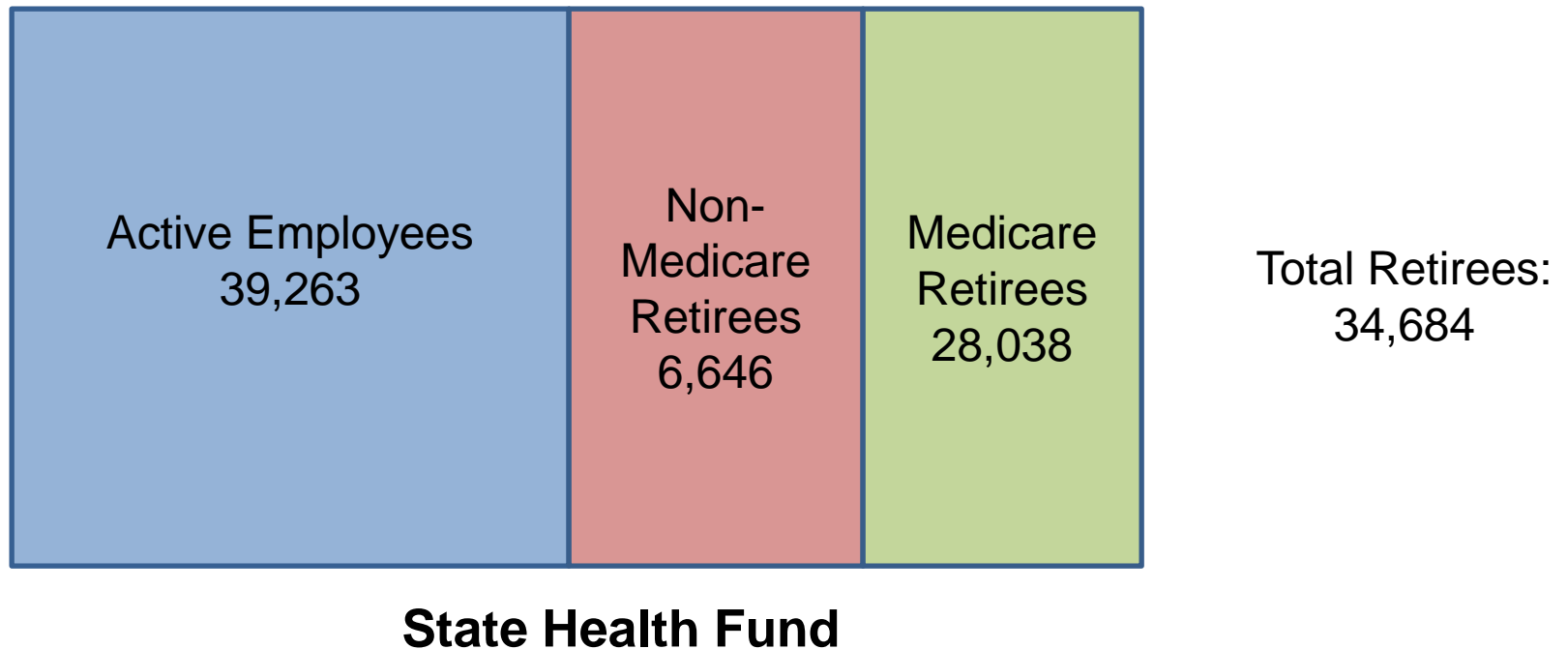
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- Medicare Part B premium increases
- Additional or increased drug co-pays
- Changes dictated by SEBC
- Changes that come about from RBSC

Pensioner Principles

1. The purchasing power of pensions decreases over time.
2. Health care costs increase over time.
3. Major economic decisions for retirees are made by others

Participants:



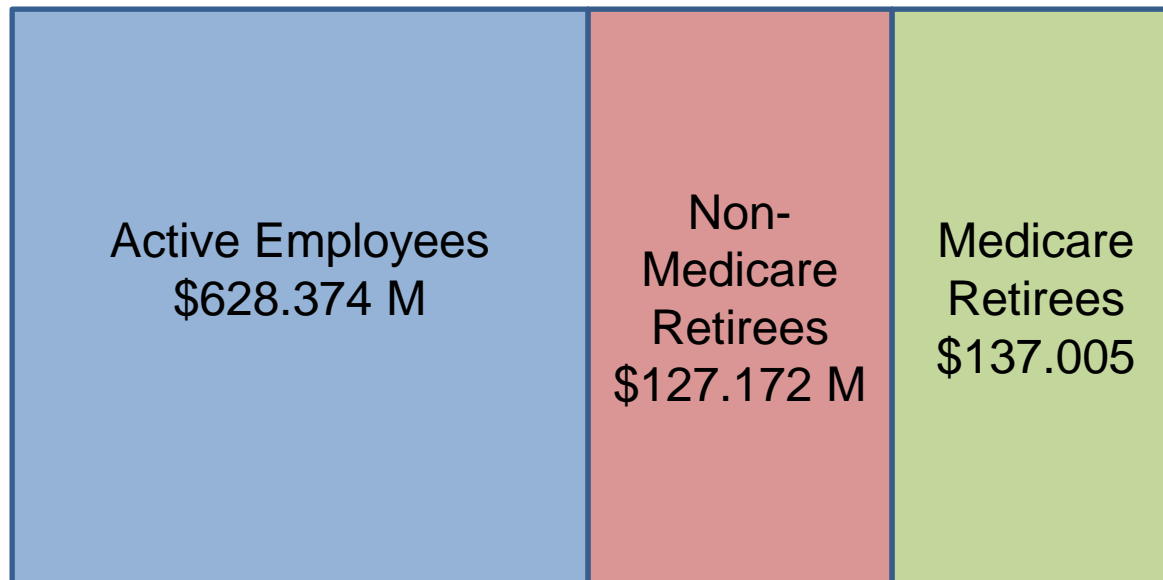
Available Plans:

Highmark Basic		Special Medicfill
Highmark PPO		
Aetna HMO		
Aetna CDH		Medicare
ExpressScripts/SilverScripts Prescription Plan		

State Health Fund

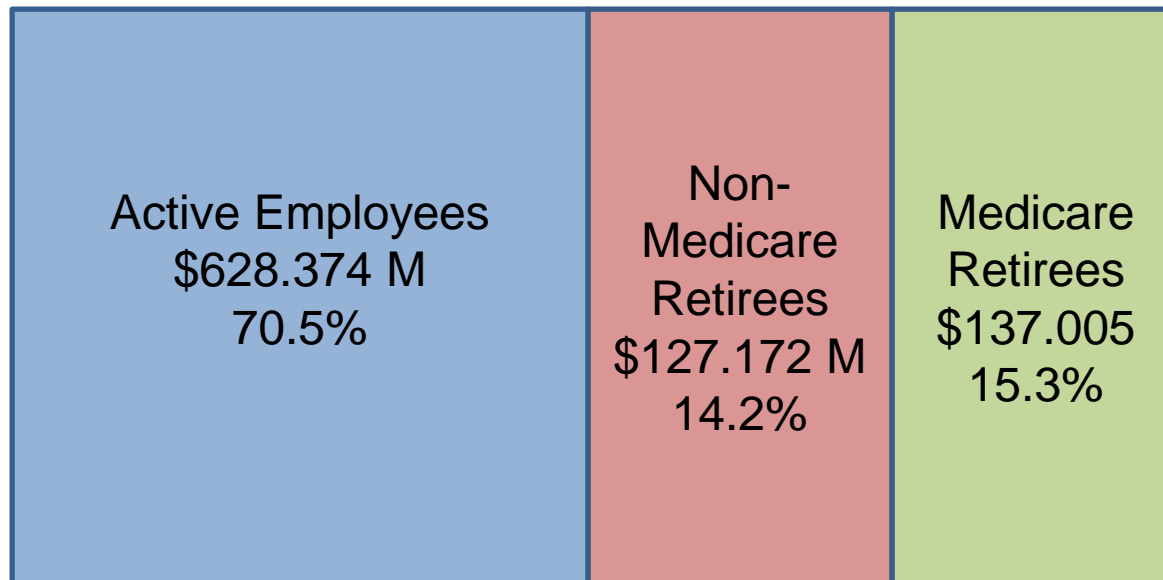
FY2021 Costs: Includes

- Claims
- Administrative Fees
- Operational Costs
- EGWP Savings
- Drug Rebates



State Health Fund

Percent FY2021 cost by Group



Total
Expense
FY2021
\$892.551 M

Retiree
Expense
\$264.177 M

State Health Fund

Per Participant Cost:

Active Employees \$628.374 M 70.5% \$16,003 pp	Non-Medicare Retirees \$127.172 M 14.2% \$18,545 pp	Medicare Retirees \$137.005 15.3% \$4,884 pp	Total Expense FY2021 \$892.551 M \$12,069 pp
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State Health Fund

State 95% share
Employee 5% Share
Employee Copays



Active Employees

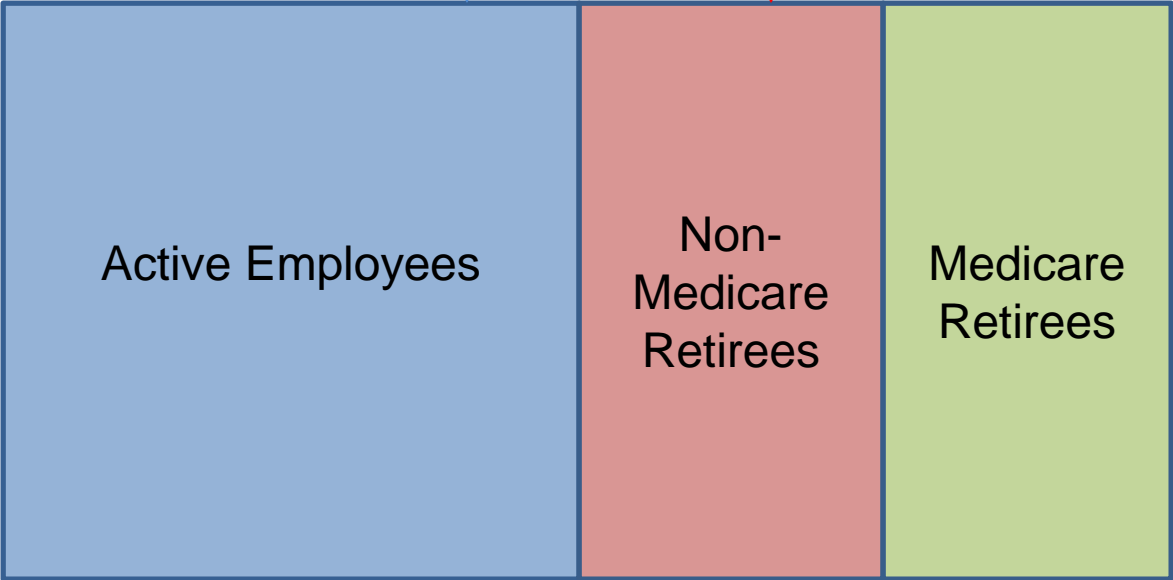
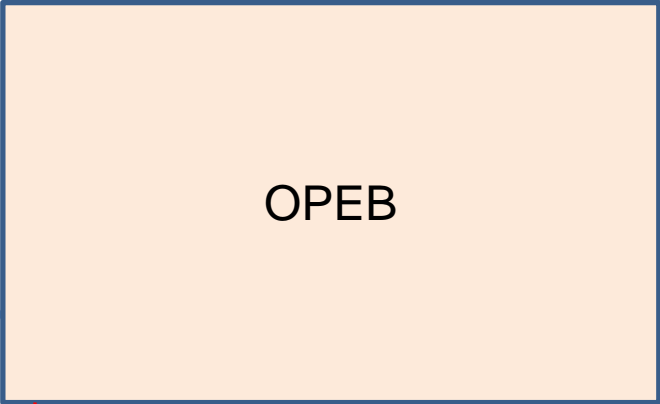
Non-
Medicare
Retirees

Medicare
Retirees

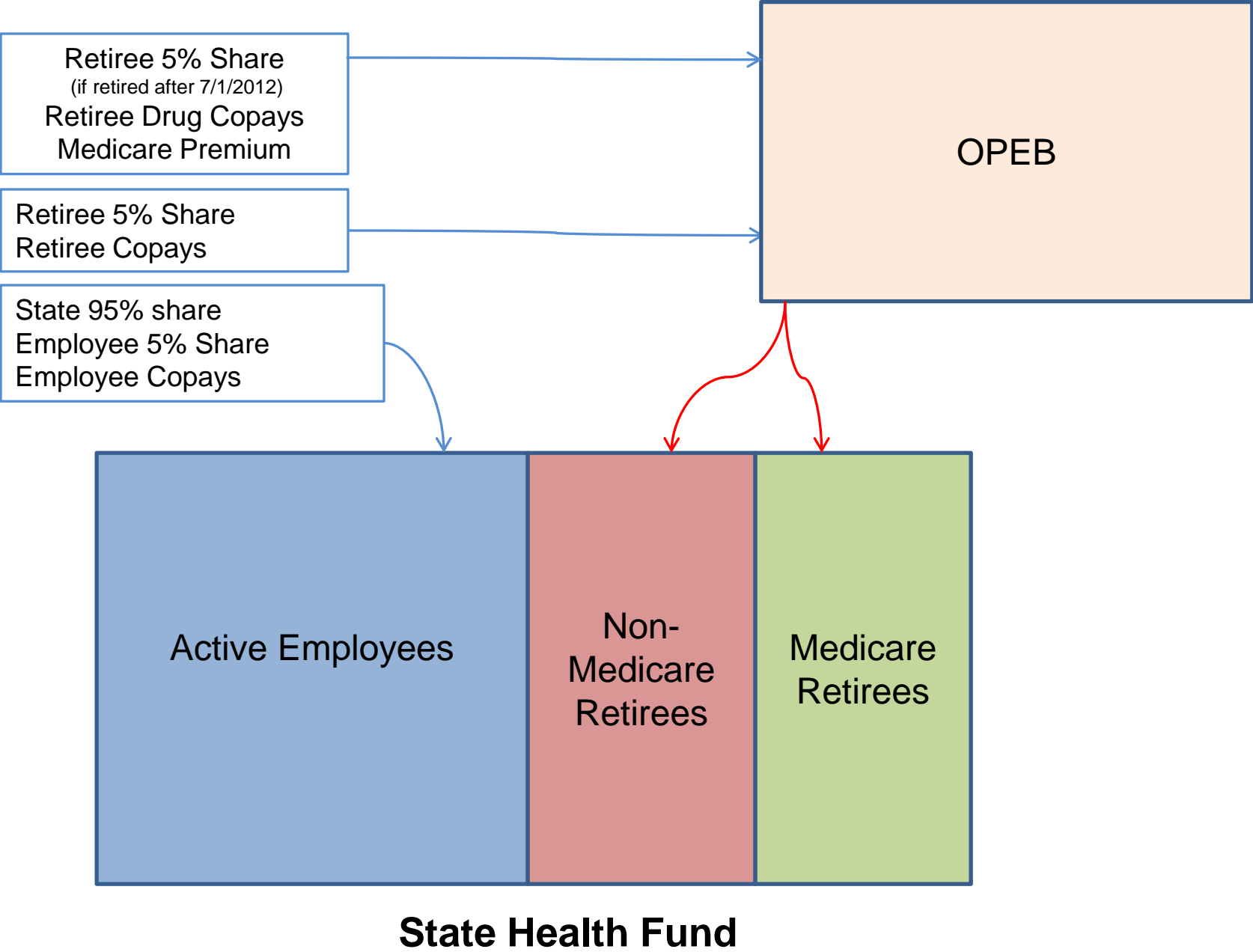
State Health Fund

Retiree 5% Share
Retiree Copays

State 95% share
Employee 5% Share
Employee Copays



State Health Fund

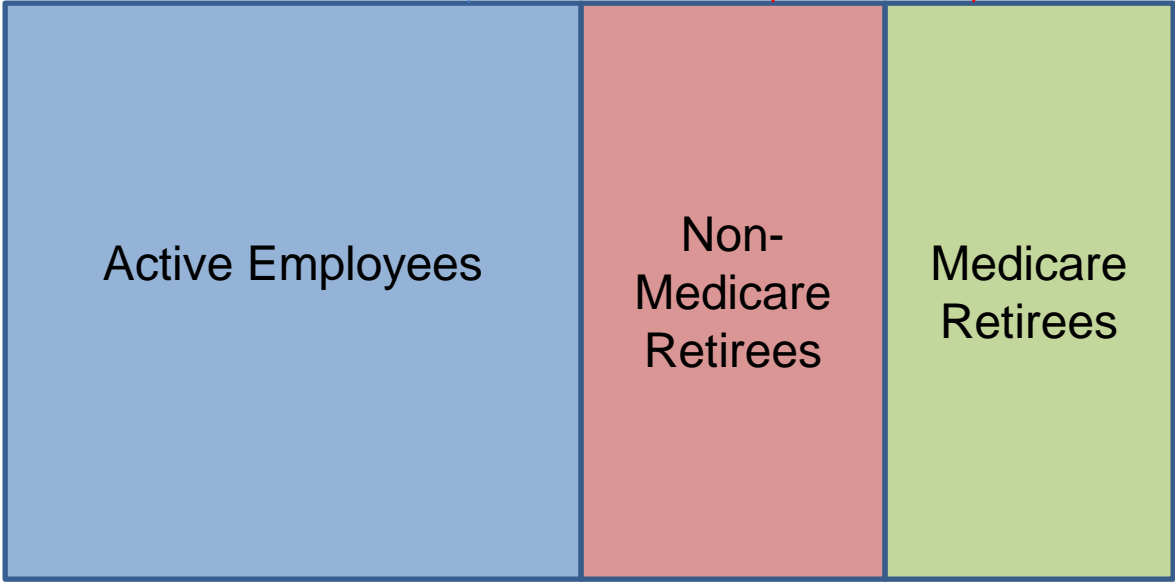
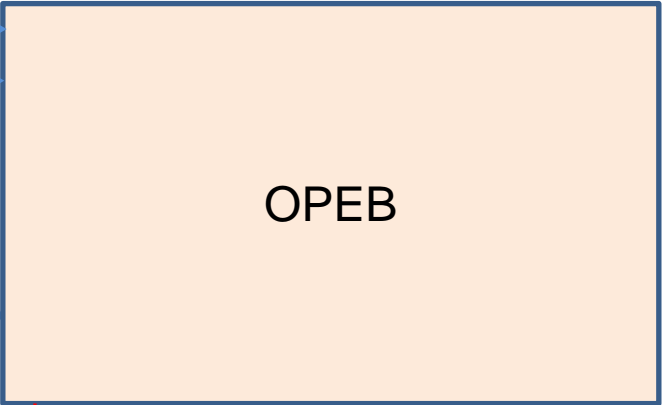


9.16% of State payroll

Retiree 5% Share
(if retired after 7/1/2012)
Retiree Drug Copays
Medicare Premium

Retiree 5% Share
Retiree Copays

State 95% share
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State Health Fund

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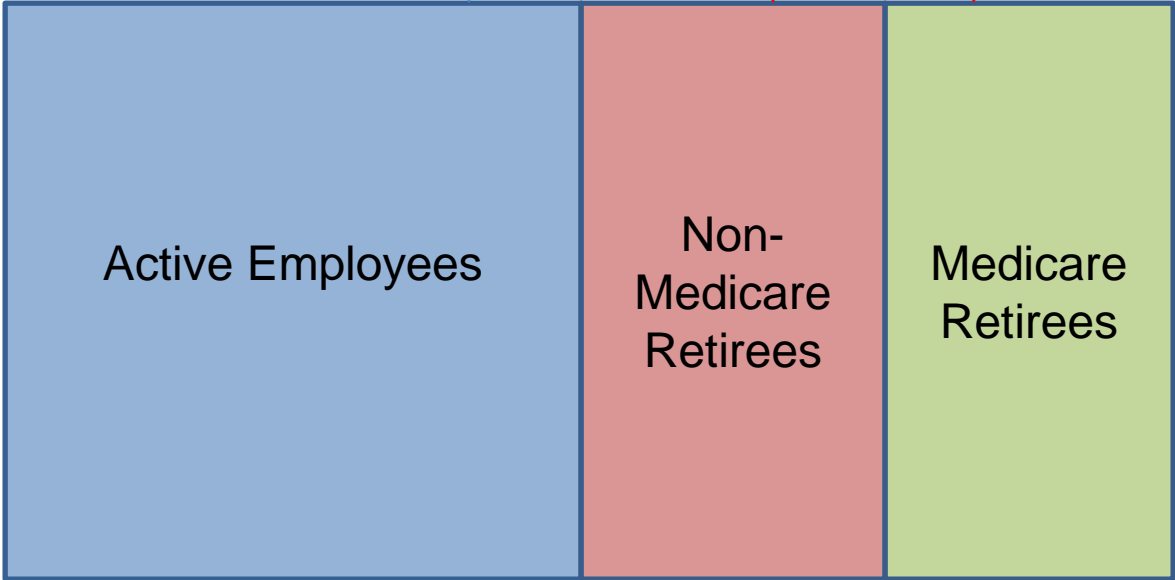
Retiree 5% Share
Retiree Copays

State 95% share
Employee 5% Share
Employee Copays

\$262.7 M

OPEB

\$254.9 M



State Health Fund

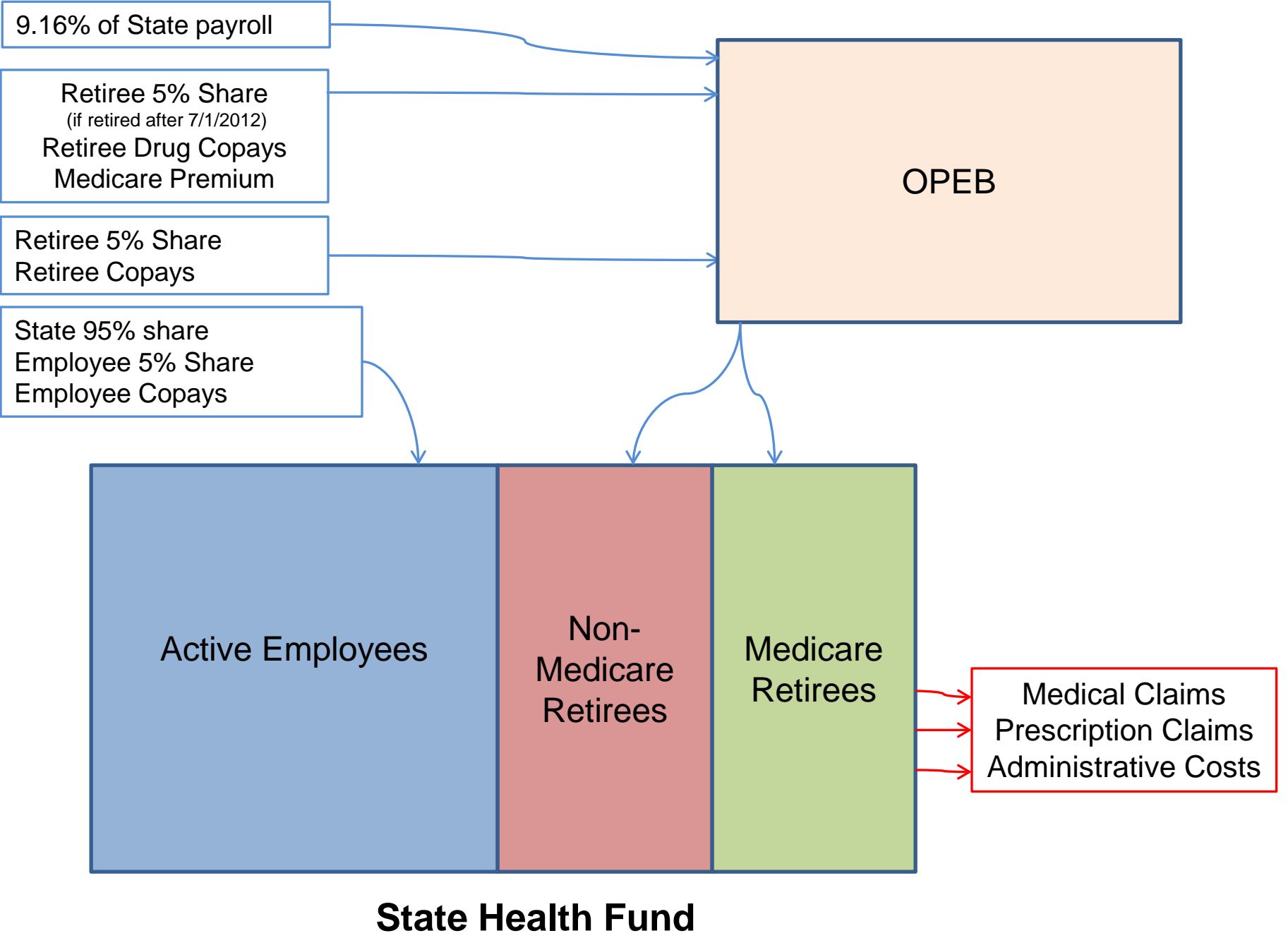
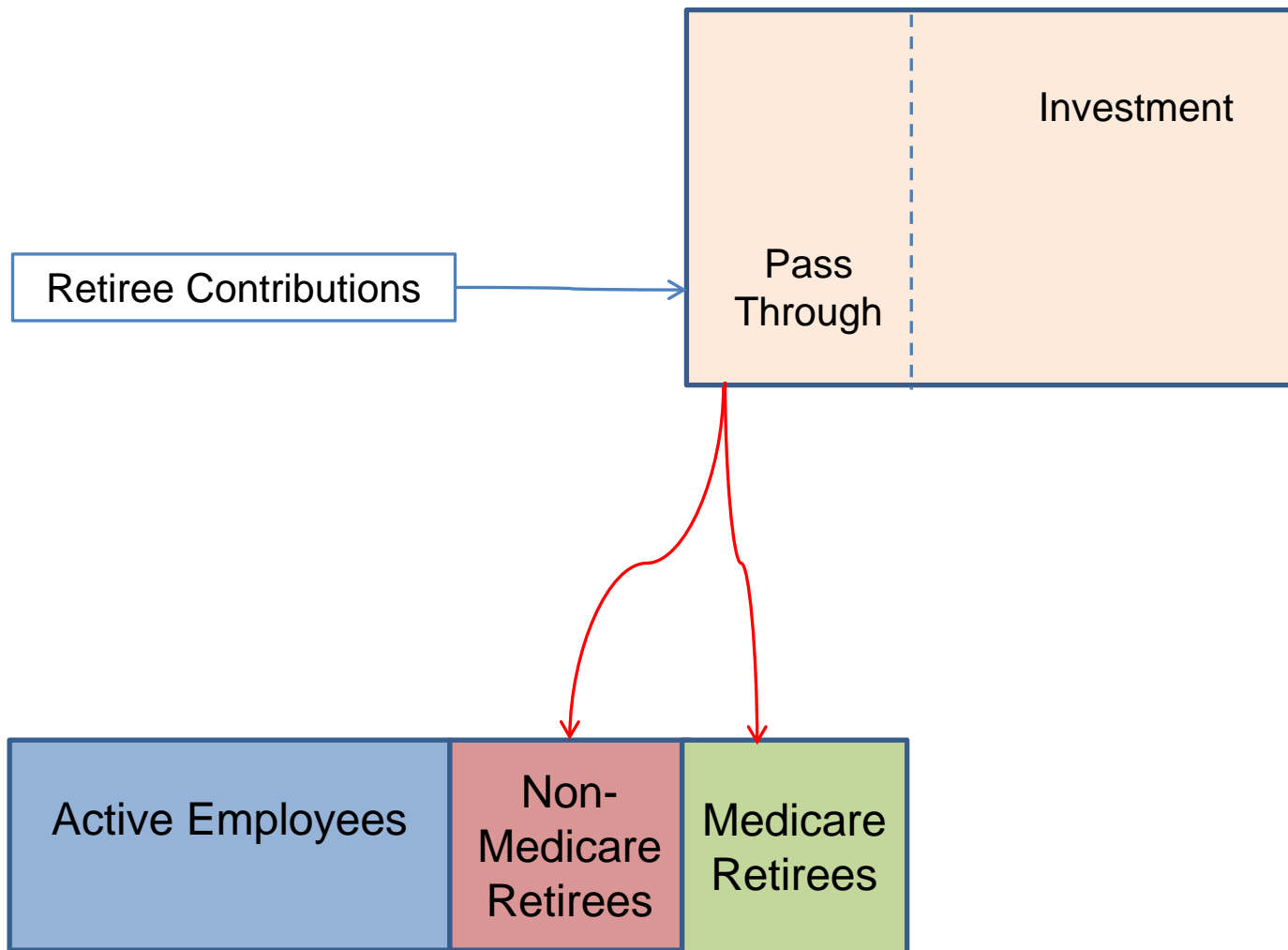
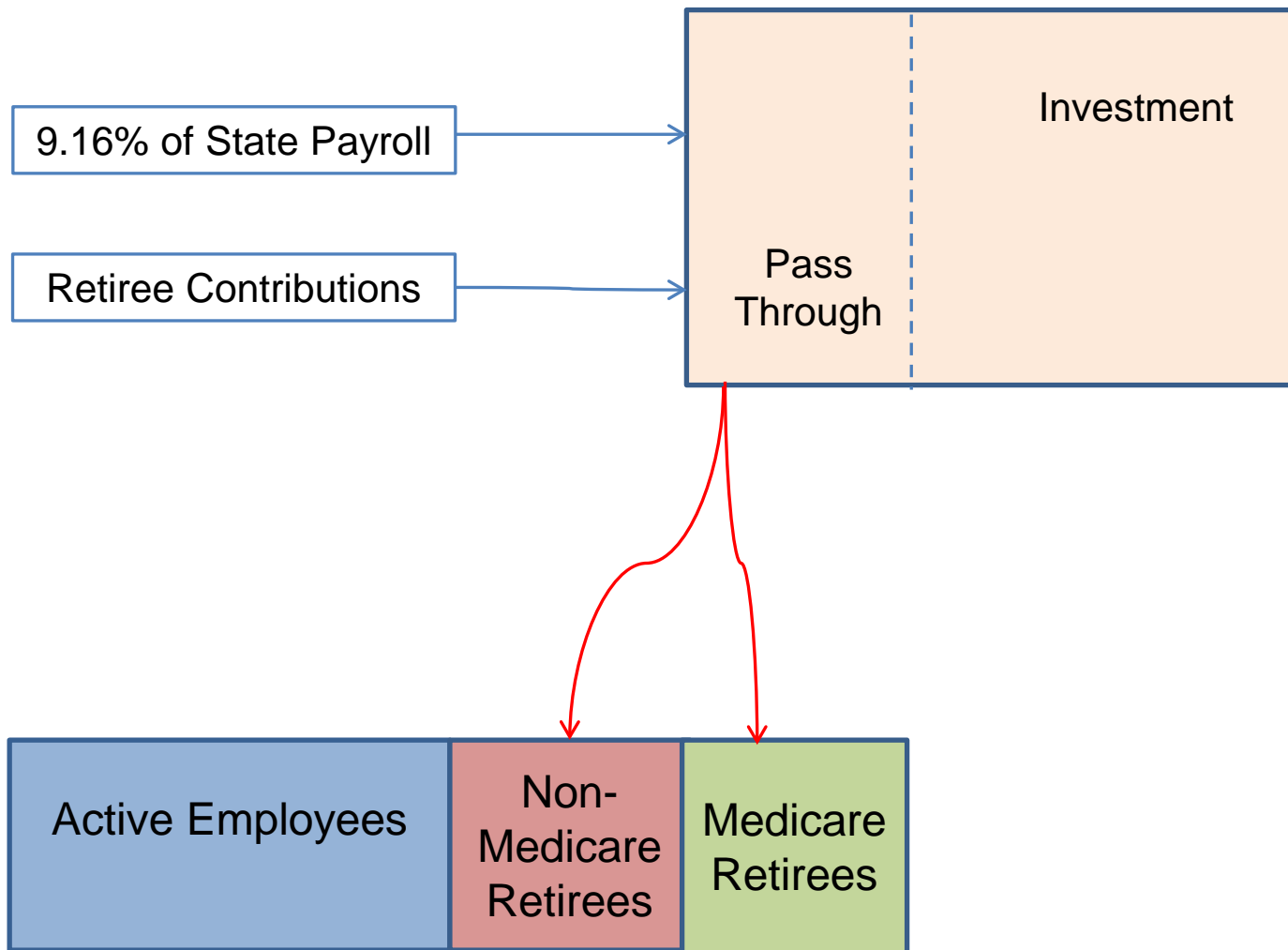


Table D
State of Delaware Health Fund
Summary of June 30 Balances, 2017 – 2021⁷

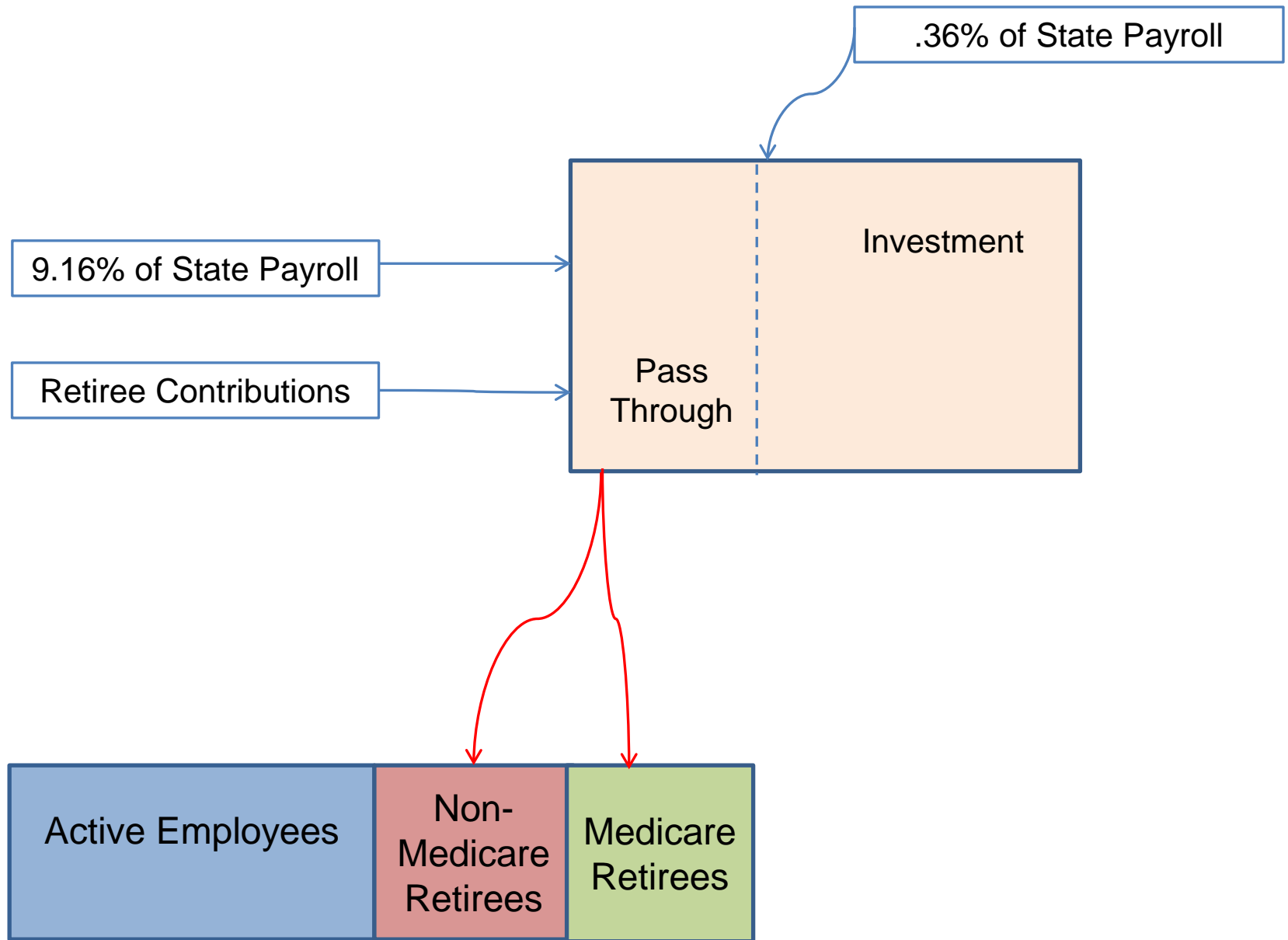
	<u>2017</u>	<u>2018</u>	<u>2019</u>	<u>2020</u>	<u>2021</u>
Fund Balance	\$102,722,763	\$151,837,806	\$163,757,321	\$189,763,755	\$152,332,231
Claim Liability	\$54,000,000	\$58,900,000	\$58,800,000	\$57,500,000	\$57,500,000
Minimum Reserve	\$24,000,000	\$24,000,000	\$24,300,000	\$24,300,000	\$24,300,000
Surplus	\$24,722,763	\$68,937,806	\$80,557,321	\$107,963,755	\$70,532,231



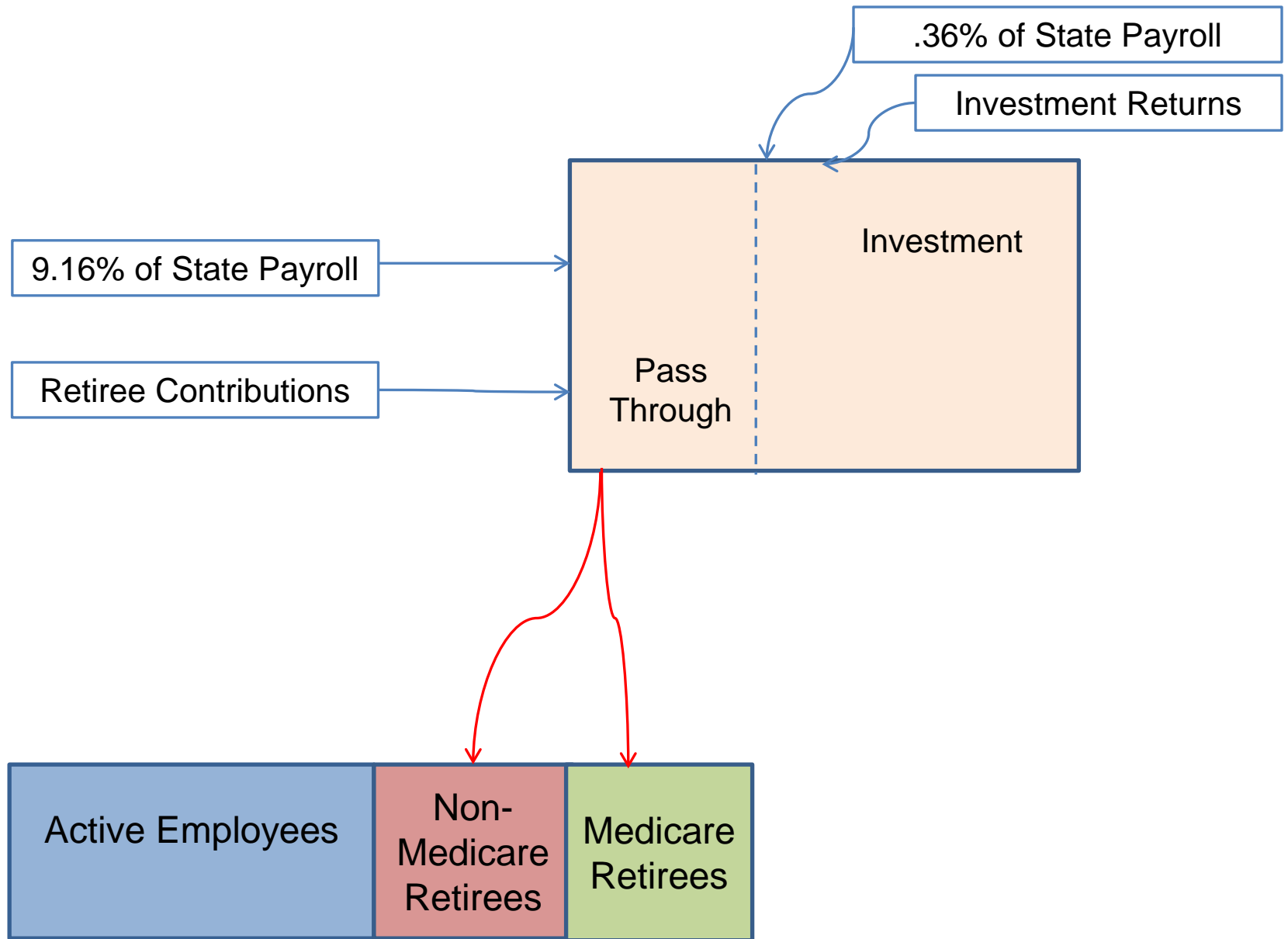
State Health Fund



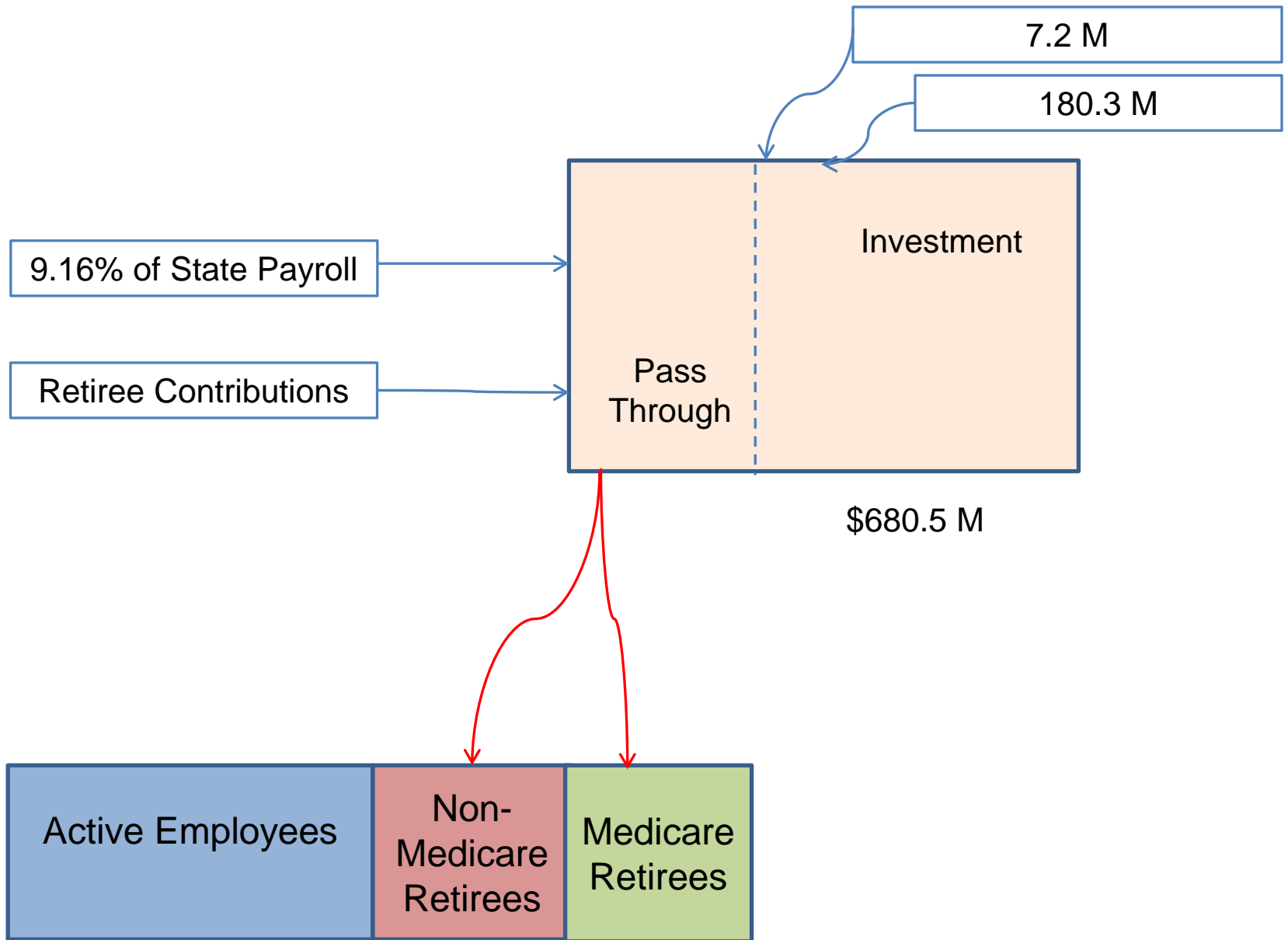
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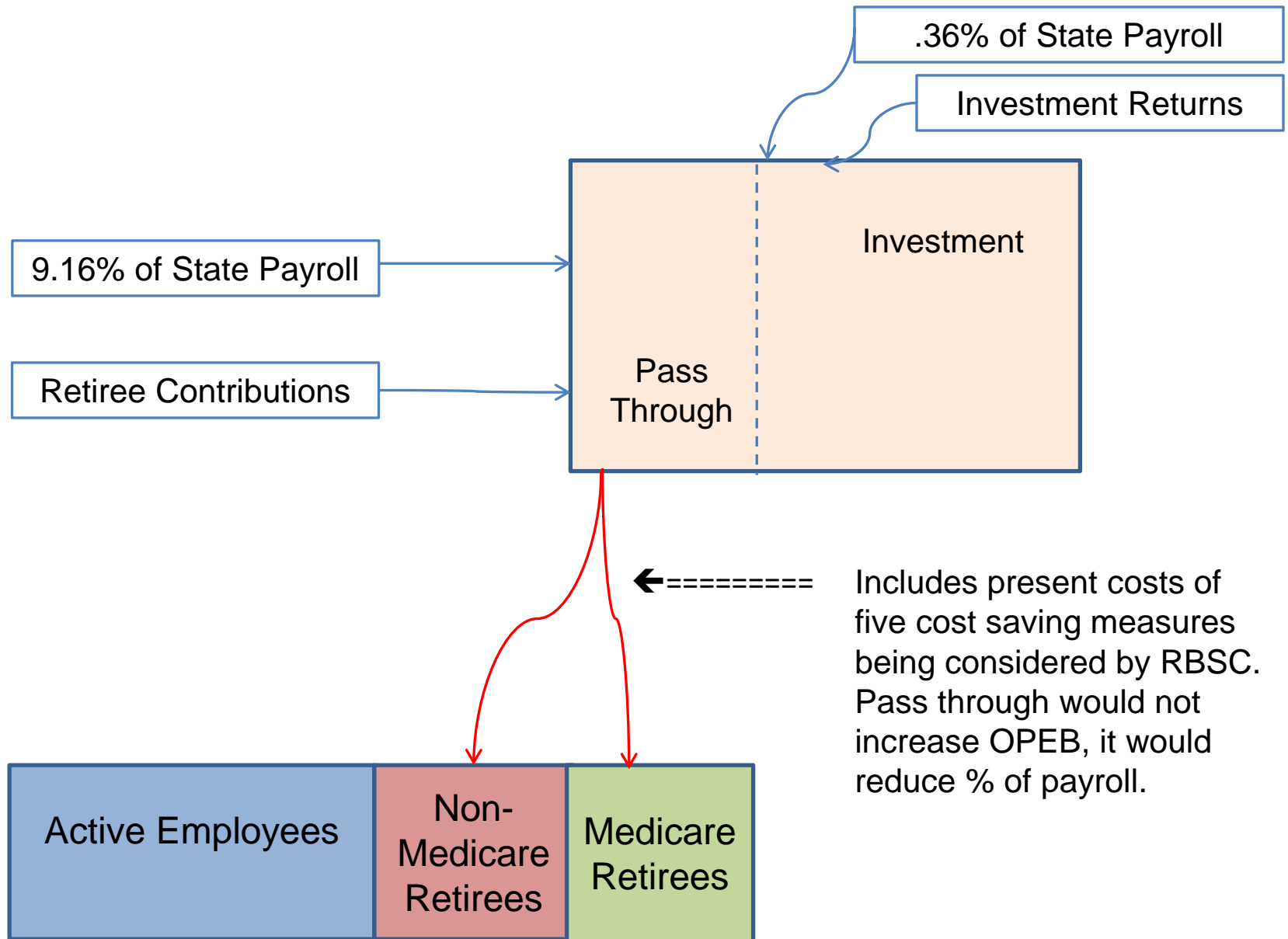
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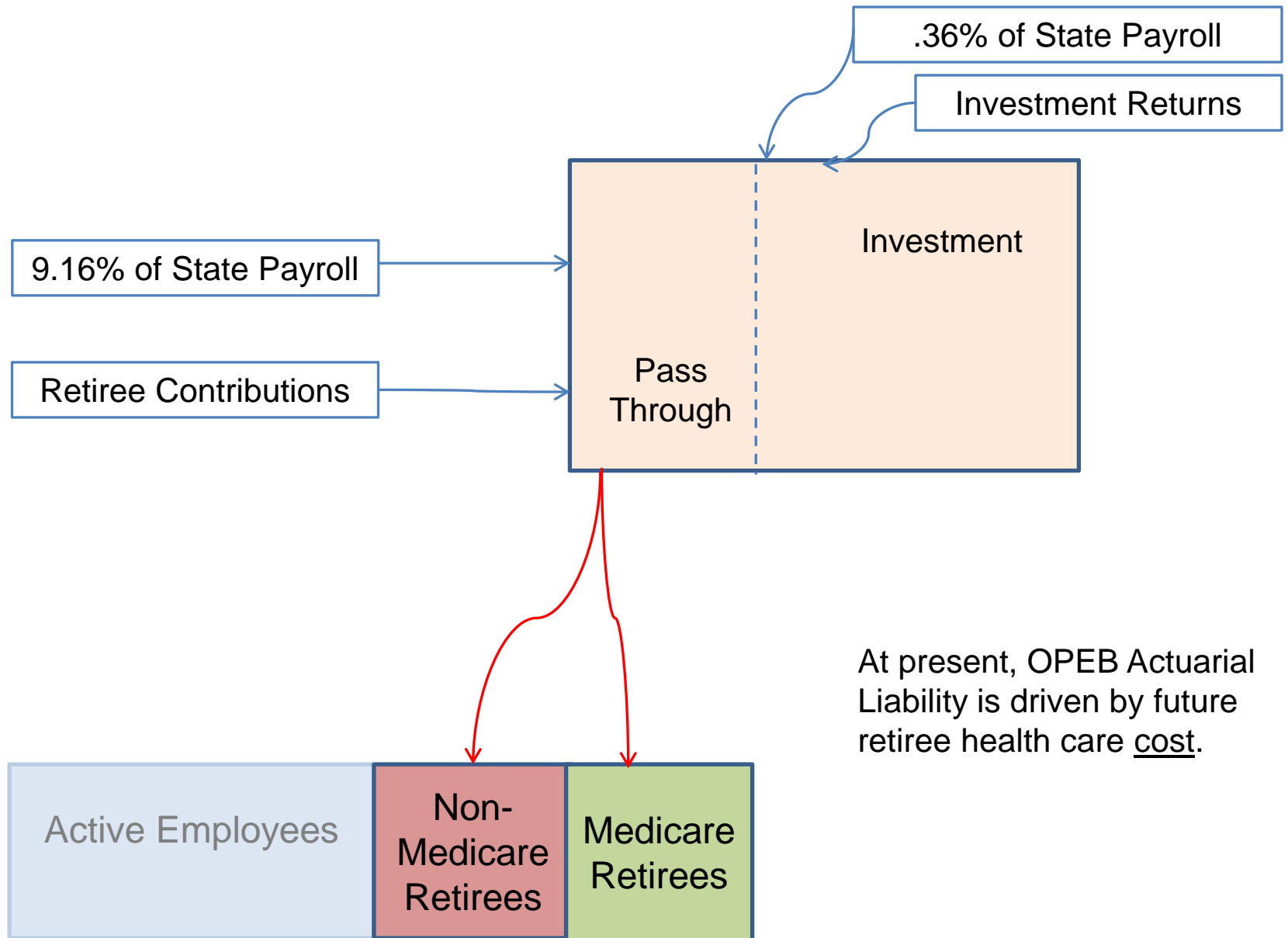
State Health Fund



State Health Fund



State Health Fund



At present, OPEB Actuarial Liability is driven by future retiree health care cost.

State Health Fund

Enact law that would limit
State's payroll contribution

1% Budget Carve out ??

Investment Returns

>9% of State Payroll

Retiree Contributions

Pass
Through

Investment

Active Employees

Non-
Medicare
Retirees

Medicare
Retirees

State Health Fund

- Could be enacted in for FY2023
- Allows harvesting of cost shifting actions
- Could be phased in if needed
- Limits future liability to State's contribution
- Necessary future cost shifting done by SEBC
- Could be changed in future
- Similar to present pension funding

DRSPA recommended modifications to RBSC

Possible cost shifting changes

Seven recommendations listed on page 1 and pages 8 – 10 continue

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Possible cost shifting changes

Seven recommendations listed on page 1 and pages 8 – 10 continue

Change the effective date from “on or after 1/1/2024” to “after 7/1/2024”

- Less Disruptive to schools.
- Richer job market in June-July compared to December-January
- Consistent with State’s fiscal year

DRSPA recommended modifications to RBSC

Possible cost shifting changes

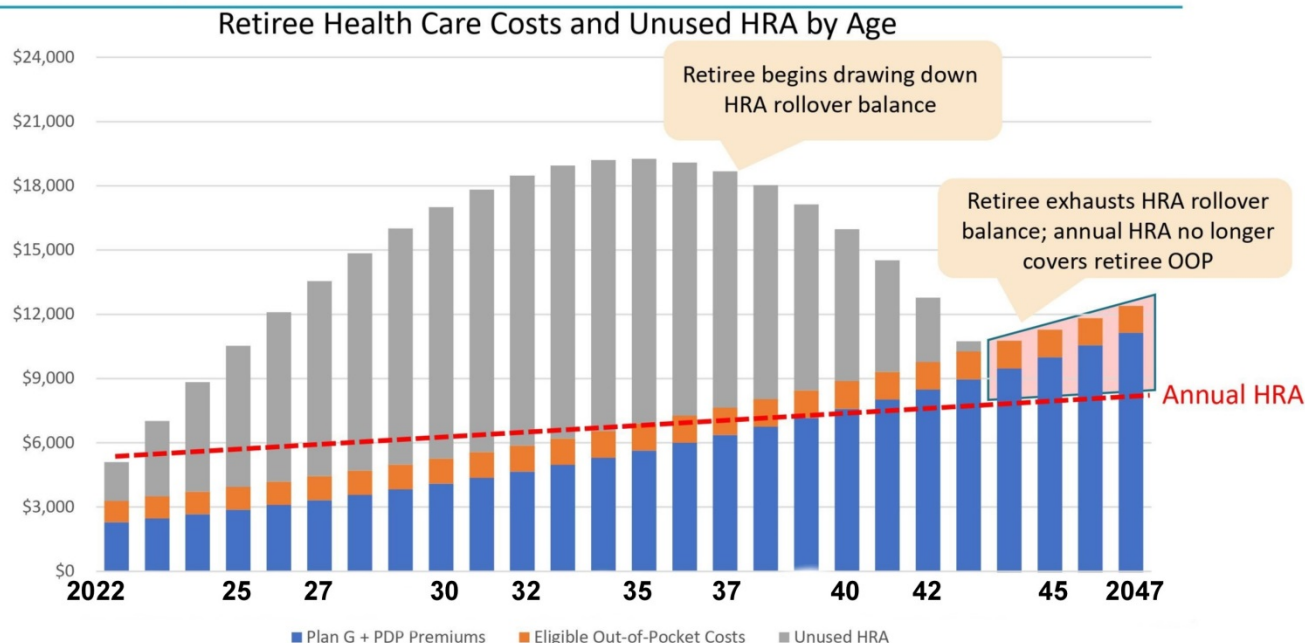
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Closer look at Health Reimbursement Arrangement (HRA)

Retiree impact analysis – Long term view (illustrative)

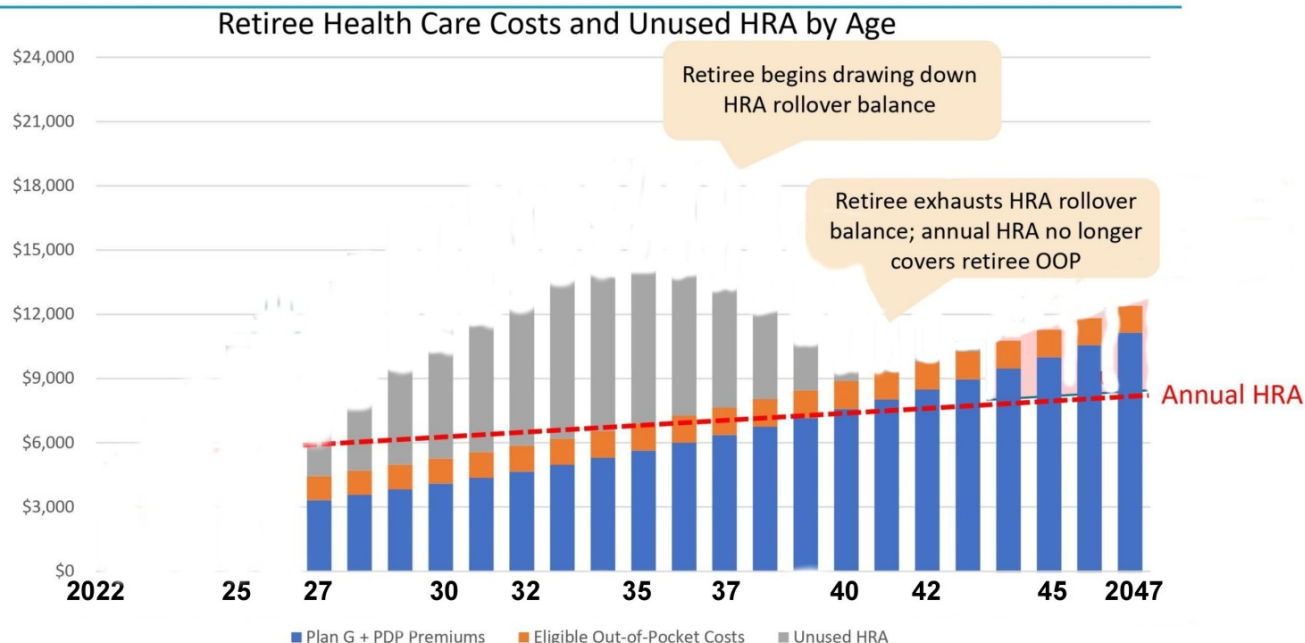


- Medigap/Medicare Advantage premiums and average out-of-pocket expenses generally increase with age and health care trend
- Retiree may not use full HRA allotment in certain years; unused HRA amount rolls over and accumulated HRA balance can be used to pay for qualified premiums and out-of-pocket expenses in future years
- HRA rollover amounts will vary based on retiree utilization and plan elections; the chart above reflects estimated premiums for Medigap Plan G, the **richest and highest** premium Medigap plan offered to new retirees. Younger retirees and/or lower utilizers will likely have access to cheaper plans in the Marketplace to maximize HRA savings

Note: long term illustration assumes retiree is age 65 in 2020 and reflects average Medigap Plan G with PDP premium across GHIP footprint; \$5,100 HRA per individual provided annually; \$1,000 in qualified out-of-pocket expenses at age 65; HRA indexed at 2% and premiums increase at health care trend assumptions per Cheiron OPEB Valuation as of October 2020; retiree would also continue to pay Medicare Part B premium, consistent with current Medicaid plan offering

HRA Retirement in 2022

Retiree impact analysis – Long term view (illustrative)

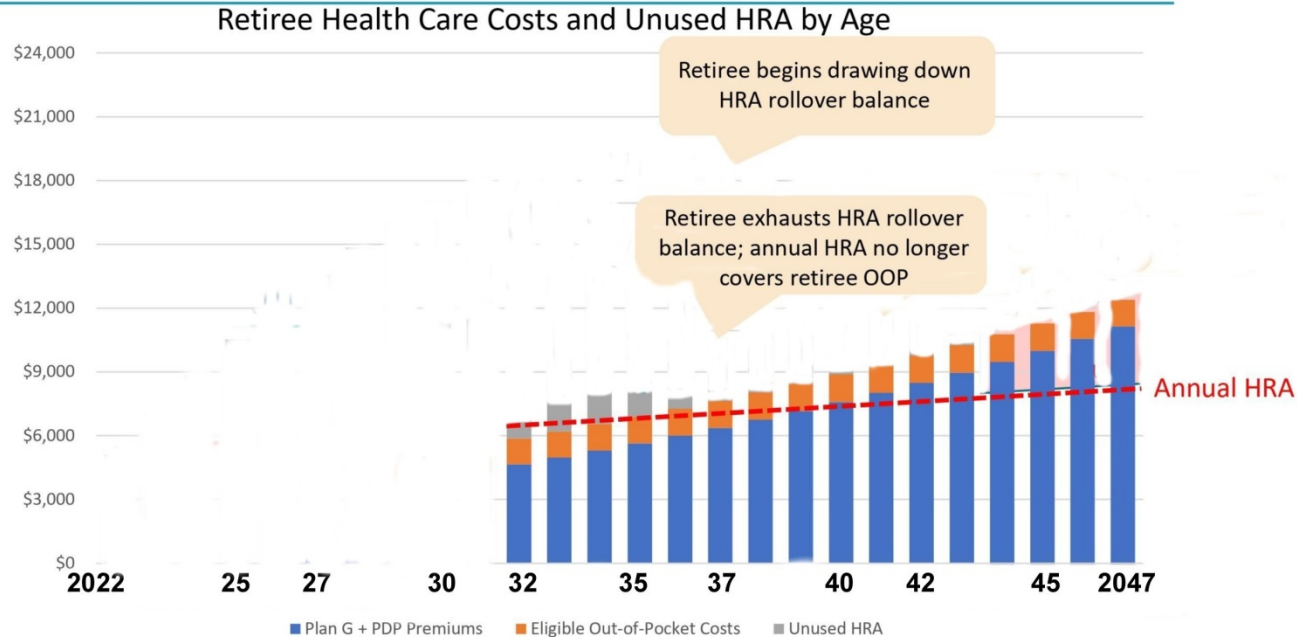


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HRA Retirement in 2027

Retiree impact analysis – Long term view (illustrative)



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HRA Retirement in 2032

DRSPA recommended modifications to RBSC possible cost shifting changes

5. Health Reimbursement Arrangement –

- Initial payment of \$5,510 annually with 3% annual increase to HRA amount provided in future years.

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- Pensioners who retired prior to July 1, 2024 would be grandfathered so that their health care cost would not increase during their or their covered spouse's lifetime.

DRSPA recommended modifications to RBSC possible cost shifting changes

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- Retirees would default to having the State act as the purchasing agent for their health insurance and prescription drug coverage.

DRSPA recommended modifications to RBSC possible cost shifting changes

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- Retirees would default to having the State act as the purchasing agent for their health insurance and prescription drug coverage.
- Upon the death of the retiree, the unused HRA funds would be added to the existing death benefit.

Further areas/items of study

1. Verify that retirees' health care costs to the state, over the past five years, are in fact, the same proportion as those identified in Tables B and C (i.e. Active Employees 70%, non-Medicare retirees 14% and Medicare retirees 15%).
2. More fully analyze the Health Reimbursement Account forecasts for those who retire at age 65 in 2024, 2029, 2034, 2039, etc.
3. Estimate the additional cost of purchasing bonds if the state's bond rating was lowered from AAA.
4. When it was created in 2001, the OPEB fund was designed to someday pay for retiree health care using the returns generate by the fund. Is this design still true today?
5. When would health care costs begin to be paid from the "Investment" OPEB fund? How large would the fund be at this point?

Further areas/items of study

6. The Health Reimbursement Account appears to be a cost-saving alternative for Medicare-aged retirees. In FY2021 nearly half of the retiree health care costs borne by the state were from 6,646 non-Medicare retirees. Will the RBSC be looking at changes for this group of retirees?
7. Active employee health care costs account for 70% of all costs. Would addressing future costs of this group provide a more persuasive demonstration to bond agencies of the State's effort to contain future health care costs?
8. Investigate the feasibility and ramifications of capping the State Pension Rate (presently 8.89%) by law at a maximum level.
9. Would a Third Party Administrator reduce the overall cost of retiree health care? What are the pro's and con's of third party administration?



Position Paper – Long Term Retiree Benefits Changes

Thank you

Questions ??

Comments ??