



**Health Care Have and Have Nots:**  
*A Crisis for California's Retired Educators*

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Report of the Public Education Health Benefits Task Force  
to the California Teachers' Retirement Board  
May 2008



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# Executive Summary

The California State Teachers' Retirement System (CalSTRS), established in 1913, provides retirement benefits to California's public school teachers from pre-kindergarten through community college. Although CalSTRS' primary focus is the pensions of California educators, it knows that the availability of affordable health care can have a tremendous impact on the ability of members to maintain their standard of living in retirement. However, CalSTRS plays a very modest role in providing health benefits for retired members and plays no role in providing health benefits to active CalSTRS members. Instead, provision of health insurance is a collective bargaining issue addressed at the local district level.

Throughout the years, the Teachers' Retirement Board has evaluated a number of different approaches that it could take to improve the health security of CalSTRS members. CalSTRS has been cautious to ensure that it plays a role for which it is suited. In May 2003, the Board decided that it was not appropriate for CalSTRS to provide health insurance, but that it might finance health insurance in the future when funds become available.

In the summer 2006, the Board established the Public Education Health Benefits Task Force to discuss opportunities for CalSTRS and CalPERS to address various challenges that school employers face in providing health benefits to their active and retired employees. The Board asked the Task Force to focus on three issues: compliance with Governmental Accounting Standards Board (GASB) disclosure requirements, accessibility to health care, and affordability of health care.

## Compliance with GASB Requirements

The Task Force elected to monitor CalPERS' progress in pursuing legislation (AB 554—Hernandez) that gives it the authority to extend assistance to all

public employers, including school districts, to meet their GASB reporting requirements. Because CalPERS was successful, the Task Force felt that it is not necessary for CalSTRS to provide similar services.

### Accessibility to Health Care

The Task Force heard from experts on the state of health care in the nation, actions to deal with the health care crisis being taken by other states, and proposals being considered in California. It chose to defer any action at this time on recommendations concerning accessibility until it has further opportunity to review the health care school pool study conducted by CalPERS, in consultation with CalSTRS. The study examines the feasibility and cost-effectiveness of creating a single statewide health care pool that would cover all public school employees (active and retired) working in school districts, county offices of education, and community colleges.

### Affordability of Health Care

The Task Force concentrated on various approaches that CalSTRS could take to assist members in improving the affordability of health care. Because the biggest concern is that few retired members receive employer assistance for health benefits after age 65, the Task Force focused on four programs that would be helpful to this group: payment of monthly health allowances, payment of Medicare Part B premiums, medical purchasing power payments, and health care security accounts.

The Task Force recommends adoption of monthly health allowances. The benefit is a specific dollar amount or allowance per month that would be made available to retired members exclusively to pay allowable medical expenses. The Task Force recommends adoption of this program with an initial benefit of \$100 per month, representing the approximate amount required to pay the Medicare Part B premium, for members who retire after implementation of the program. The benefit would be \$300 per month for retired members who retired in or after 1999. This amount represents the approximate amount required to pay a Medicare supplement insurance premium. The benefit increases to \$400 per month for members who retired prior to 1999 recognizing the higher benefits being paid to members who retired after 1998 due to legislated benefit enhancements.

**The Task Force recommends adoption of monthly health allowances.**

The Task Force would like to increase the monthly health allowance for currently active members to \$300 per month, but recognizes that establishment of this benefit at this higher level would require a significant increase in employer contributions and redirection of state contributions, which is not be viable immediately. Therefore, it is acceptable to initially implement this program at a lesser amount with plans to increase the benefit in subsequent years.

On-going costs for this benefit would be supported by district, member or the State. The costs to develop this program would come from a redirection of employer Defined Benefits contributions and reimbursements to the funds.

This is the first report of the Public Education Health Benefits Task Force based on its work since August 2006.



## I

## Introduction

The California State Teachers' Retirement System (CalSTRS), established in 1913, is one of the oldest public pension funds in the United States. It provides retirement benefits to California's public school teachers from pre-kindergarten through community college and presently covers over 800,000 active and retired educators and their beneficiaries. Although concentrated in California, the 208,000 members and beneficiaries who receive monthly benefits live in every state and throughout the world.

The average CalSTRS retired member worked 29 years, retired at age 61, and is expected to live 27 years after retirement (i.e. to age 88). Approximately 64 percent of CalSTRS retired members are women and almost 60 percent are unmarried. For newly retired members, the pension benefit replaces 63 percent of the member's salary. Because California teachers do not pay the Social Security tax, members do not receive Social Security benefits for CalSTRS-covered service, and any Social Security benefit for which they might be eligible from other employment will probably be reduced due to the Social Security Windfall Elimination Provision and Government Pension Offset.

CalSTRS meets its mission of securing the financial future and sustaining the trust of California educators primarily by focusing on the pensions of California educators. However, CalSTRS found when completing the *CalSTRS Retirement Benefits Comparison and Adequacy Study* in November 2004 that the availability of affordable health care can have a tremendous impact on the ability of members to maintain their standard of living in retirement. Members without employer-paid postretirement health care can expect to see a loss of discretionary income due to ongoing increases in health care costs.

As a result, the Teachers' Retirement Board (Board) includes health care as part of its goals: "Explore alternative ways to assist active and retired

educators in obtaining affordable health care.” Yet, CalSTRS plays no role in the health benefits provided to active CalSTRS members because provision of health insurance is a collective bargaining issue addressed at the local district level. CalSTRS participates in the provision of health benefits for retired members in two modest ways. It administers the Medicare Premium Payment Program and deducts the premiums for health benefits from a member’s allowance at the request of the member and forwards that premium to the health benefit provider.

Throughout the years, the Board has evaluated a number of different approaches that it could take to improve the health security of CalSTRS members.

As stated in the May 2001 CalSTRS report *A Review of Potential Health Care Benefit Programs Provided by the California State Teachers’ Retirement System*, “By committing a portion of resources available to CalSTRS for the Medicare Premium Payment Program, the Teachers’ Retirement Board, the Legislature and the Governor have demonstrated a willingness to use resources available to CalSTRS to implement solutions to

**In May 2003, the Board decided that it was not appropriate for CalSTRS to provide health insurance, but that it might finance health insurance in the future when funds become available.**

ease the burden of rising health care costs for retired members. Yet it is not possible for CalSTRS alone to meet all the health benefit needs of its members. A truly universal, comprehensive health benefit for retired educators will require additional funding sources in the form of premiums or additional contributions from members, employers or the State.”

The Board has been cautious to ensure that it plays a role for which it is suited and does not subject itself to financial liabilities over which it has limited control or ability to evaluate. In May 2003, the Board decided that it was not appropriate for CalSTRS to provide health insurance, but that it might finance health insurance in the future when funds become available. In addition, it agreed that CalSTRS should educate its members about health care.

However, the health care environment is very fluid. Many Americans think that the health care system is in crisis or has major problems and are dissatisfied with the cost of health care in this country. Action may take place at the national level as 2008 presidential candidates from both parties have health care proposals. There are also numerous health care proposals being considered in California. One focus at the state level is on the Public Employee Post-Employment Benefits Commission (Commission), established in December 2006 by the Governor, to propose ways for addressing unfunded post-employment benefits.

The Commission issued its report, *Funding Pensions and Retiree Health Care for Public Employees*, on January 7, 2008, after a year's effort by the bi-partisan 12-member group. The portion of the report that received the most press was that the total liability for retiree health care (as self-reported by California state and local governments) is at least \$118 billion over the next 30 years. Unlike pensions, most public entities fund retiree health care on a pay-as-you-go basis.<sup>1</sup>

The Commission's report outlines an eight point plan, comprised of 34 recommendations, to address the unfunded pension and retiree health care liabilities for California's state and local governments. As expected, the bulk of the recommendations dealt with providing adequate funding for retiree health care benefits. Recommendation 1 is that all public agencies, including the state, adopt pre-funding as a policy if they provide Other Post-Employment Benefits (OPEB). Further, the commission said that prefunding OPEB is just as important as prefunding pensions and the ultimate goal of a prefunding policy should be to achieve full funding.<sup>2</sup>

Simultaneously, CalSTRS and other pension funds are working to meet their obligations after lower than expected investment returns during the three-year market downturn early in the decade. CalSTRS remains a strong, stable organization and the Board is moving forward now with strategies to ensure a healthy and secure fund for CalSTRS members.

In the summer 2006, the Board established the Public Education Health Benefits Task Force (Task Force) to discuss opportunities for CalSTRS and CalPERS to address various challenges that school employers face in providing health benefits to their active and retired employees. Representatives from organizations representing both certificated and classified school employees, school employers, health benefits administrators and CalPERS first met in August 2006. Board members have also participated in the Task Force. The list of Task Force members and participating staff is included in the Appendices.

The Board asked the Task Force to focus on three issues: compliance with Governmental Accounting Standards Board (GASB) disclosure requirements, accessibility to health care, and affordability of health care.

This is the first report of the Public Education Health Benefits Task Force based on its work since August 2006. The report begins with the state of health benefits in California schools and then considers what health care benefits other state teacher retirement systems provide their retired members. The report then moves to the issues on which the Task Force focused. Compliance with GASB standards is discussed in Section V. Accessibility including the

state of health benefits at the national level, other states' plans and California proposals is discussed in Section VI. The approaches that CalSTRS could take to assist members with the affordability of health care are discussed in Section VII followed by the Task Force's recommendation in Section VIII. We include copies of presentations as well as other pertinent information as appendices.

## II

## Health Environment for California Educators

The provision of health insurance is a collective bargaining issue addressed at the local district level. California public school employers, which spend nearly 15 percent of their annual budgets on health insurance,<sup>3</sup> secure health insurance through a variety of different vehicles. Approximately 115 school districts contract with the California Public Employees' Retirement System (CalPERS) health benefits program, known as Public Employees Medical and Hospital Care Act (PEMHCA), to obtain health care coverage for their employees. Most districts join together to form trusts (with their employees) or joint power agencies (JPA) to purchase health insurance as a large block. A trust is a joint effort of labor and management to pool resources to provide a variety of health and welfare benefits to school employees while a JPA is an entity formed and operated by one or more public agencies to spread risk among them for the purpose of establishing, operating and maintaining a joint program for employee benefits. The Southern California Voluntary Employees Benefit Association and the Central Valley Schools Health and Welfare Trust are two examples of trusts that provide health benefits. There also are districts that individually purchase their own health insurance.

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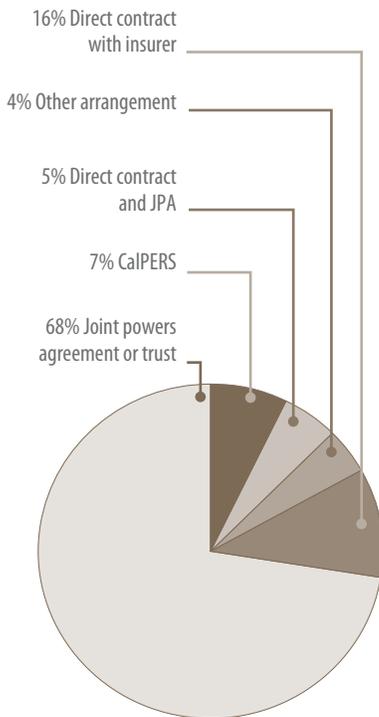
### CALSTRS HEALTH CARE SURVEY RESULTS 2003 AND 2006

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Triennially, CalSTRS conducts a survey of health benefit programs provided by California school employers. In the 2006 health survey, districts overwhelmingly reported that they participate in JPAs or contract directly with insurers. However, for the first time five districts reported that they pay no medical benefits and that their "health benefit" is part of employees' salary.

The following chart shows the sources of health insurance reported in the 2006 CalSTRS health benefits survey. This data is very similar to the data provided in the 2003 CalSTRS health benefits survey.

### Sources of Health Insurance



Another key finding of the 2006 survey was that there were lower increases in premiums during the last three years than employers expected when surveyed in 2003.

### Health Benefits for Retired Members

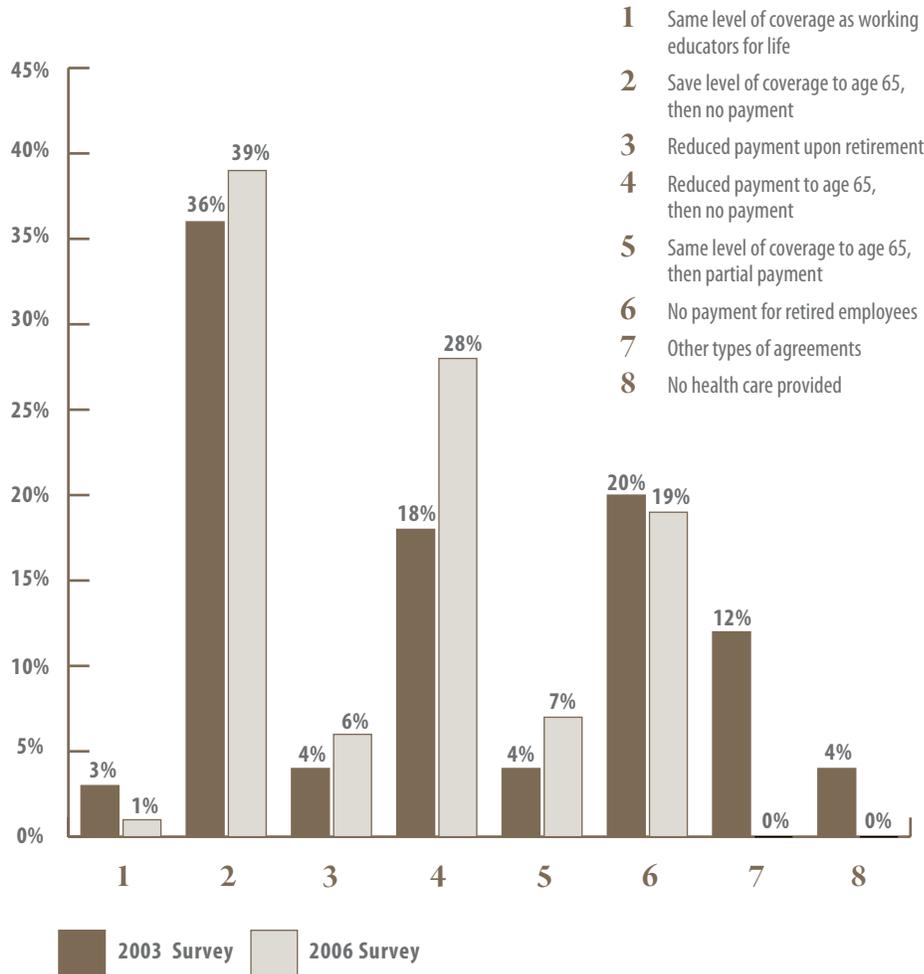
The availability and cost of health benefits to retired educators varies widely throughout the state. Districts are required to permit retired employees to purchase health insurance, at the employees' own cost. These are often called AB 528 benefits, a reference to the bill that was enacted in 1985 to require such benefits. In many districts, this is the only health benefit made available to retired employees. Most districts require that employees take this benefit immediately upon retirement, or else the employees lose eligibility. At the other extreme, some districts contribute toward the cost of health insurance throughout the remaining lifetime of the retired employees. In some cases, there is a vesting retirement, such as working 20 years for the district. Finally, many districts fund health benefit costs until the retired employee reaches age 65, when Medicare eligibility begins. Those districts that contract with CalPERS for health benefits are required by state law to contribute toward their retired employees' health benefit costs.

The 2006 CalSTRS health benefits survey showed that 78 percent of the employers surveyed (representing 60 percent of the employees) do not pay for employee health insurance after age 65. This is an increase from the 74 percent of employers (representing 57 percent of retired employees) in the same category in the 2003 survey. Nineteen percent of the employers surveyed offer no employer-paid health care for any retired employees, other than that which is paid entirely by the retired employee.

The following graph shows the distribution of districts offering health insurance to retired members as reported in the 2006 CalSTRS health benefits survey.

The following table compares the responses to these questions in 2003 to the 2006 survey. The percentage of districts that paid the entire cost for health benefits for life decreased from three percent in 2003 to one percent in 2006.

### Fewer Employers Pay for Retiree Health Care



### Post-Retirement Health Care Paid for by the Employers

	2003 Survey	2006 Survey
Full payment for health benefits for life	3%	1%
Full payment to age 65, then no payment	36	39
Partial payment for life	4	6
Partial payment to age 65, then no payment	18	28
Full payment to age 65, then partial payment	4	7
No payment for health benefits	20	19
Other types of agreements	12	0
No health benefits provided	4	0

### Change in Employer Health Care Coverage for Retired Employees

In the 2006 health benefits survey, 12 percent of the responding districts reported some change in coverage for retired employees over the last three years. The primary change reported is that some employers have gone from providing full employer-paid health insurance to age 65 to partial health insurance support to age 65. Other employers noted that some of the health coverage benefits are now limited to a specified amount, and the employer no longer pays for all of the employee's health insurance coverage. Other employers reported that the eligibility requirements have changed, including coverage for a spouse. There is an increase in the number of employers providing full or partial premium payment for Medicare Part B (doctor), but the proportion of employers offering this benefit is still very low.

### Health Care for Part-Time Retired Employees

The 2006 survey also investigated whether health benefits are provided to retired part-time employees. Forty percent of the employers reported that they did not have part-time certificated employees, while another 22 percent indicated that they did not offer post-retirement health care insurance benefits to their part-time employees. Of the 38 percent that indicated that they do offer post-retirement care insurance benefits to their retired part-time employees, most districts require that the member have a specified amount of service, typically 10 to 15 years, with the district. Some employers paid the health care coverage based on a percentage resulting from a variety of formulas including age, years of service and basis of employment.

### Disabled Employees Health Insurance Options

Districts provide a variety of health care alternatives for members who become disabled while working. Only two percent provide either a full or partial health care package, unless the member is eligible to retire or meets the other employer requirements for post-retirement health care. Twenty-six percent of the employers will pay for the disabled member's health care until the member is eligible to retire, and then the member is subject to the same post-retirement coverage as other retired members. Disabled employees from 30 percent of the districts have the option to be covered by district health insurance while on disability but must pay all the premiums. Another 28 percent of employers offer health care for the period of time required by federal law and then require employees to secure health insurance individually. In some instances, members can secure health care coverage while on disability through more

than one alternative. For instance, the employer may pay the member's health care until the member reaches retirement age. At this point, the member may opt for health care coverage under the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) or opt to be covered by the employer plan, but pay all of the premium costs. Fifteen percent of the responding employers had alternative coverage generally involving time and age requirements and health care caps. These findings are consistent with the 2003 CalSTRS health benefits survey.

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### CALSTRS CURRENT ROLE IN HEALTH BENEFITS

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CalSTRS plays no role in the health benefits provided to active CalSTRS members. CalSTRS does, however, participate in the provision of health benefits for retired members in two ways. First, CalSTRS administers the Medicare Premium Payment (MPP) Program. Under the MPP Program, which started in 2001, CalSTRS pays the Medicare Part A premium for eligible retired Defined Benefit Program members who do not otherwise qualify for Medicare Part A coverage without payment of a premium. Currently CalSTRS pays the Medicare Part A premium for approximately 6,300 members. Even though the eligibility for the MPP Program is now limited to members who retire prior to July 2012, the funds that have been "set aside" are well in excess of currently estimated cost of CalSTRS MPP Program if all otherwise eligible retired members would be covered. In addition, CalSTRS will deduct the premiums for health benefits, including Medicare Part B, from a member's allowance at the request of the member, and forwards that premium to the health benefit provider. In this latter activity, CalSTRS provides a service to the member, but does not have contracts with the carriers or negotiate coverage provisions or rates. For example, CalSTRS members who live in northern California may belong to what is called Kaiser Group 63. The requirements for enrollment are that the individual has the deduction for health insurance taken from his or her CalSTRS allowance check. CalSTRS then forwards the funds to Kaiser. CalSTRS is not the administrator of the group and does not negotiate the benefits or premium amounts.

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### HISTORY OF CALSTRS INVOLVEMENT IN HEALTH CARE

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Throughout the years, the Teachers' Retirement Board has evaluated a number of different approaches that it could take to improve the health security of CalSTRS members. An early study, *Health Care Benefit Program: An Overview Discussion of Issues and Concerns*, was prepared in December 1987 in response to health care benefit proposals. "The lack of affordable health care benefits or insurance coverage for retired California teachers is a very real problem that needs

to be addressed and solved. There are no easy solutions. Health care is a very expensive and extremely dynamic area that must be approached with caution to avoid creating a fiscal disaster of major proportions.”<sup>4</sup> For perspective purposes, the Medicare Part B premium in 1987 was \$17.90 per month. It has increased almost 540 percent. The cost of living went up a little more than 180 percent in that same time period. This study focused on issues that are very familiar.

- Should retired members be covered in a separate group?
- Should CalSTRS or CalPERS be the administrator of health care for all California teachers?
- Would the costs be considered mandated costs and therefore State supported?
- Would the program be funded on a pay-as-you-go basis or pre-funded?
- Would five or ten years be a reasonable vesting period or would a graduated vesting requirement be better?
- How do we manage plan design to recognize that some retired members are not eligible for Medicare benefits without paying premiums? [Reminder: this was 16 years before the CalSTRS Medicare Premium Payment Program was implemented.]
- How do we ensure that services are available to all retired members, no matter their location?

*ACR-62 Study Panel Issue Paper on Health Care Benefits*, prepared September, 1984, was attached to the 1987 report. The same concerns and issues were covered.<sup>5</sup>

The Board was required by Chapter 968, Statutes of 1998 (SB 1528—Schiff) to conduct a study of providing health insurance benefits for CalSTRS members and their families. The Board engaged the national consulting firm William M. Mercer, Inc. to assist in this effort, and conducted a comprehensive survey of medical, dental and vision benefits for all CalSTRS active and retired members. The survey was completed in the summer of 1999, with a report on the survey findings issued later that year.<sup>6</sup>

When CalSTRS initiated its review of health benefit needs of CalSTRS members in 1999, the Board established the Health Benefits Committee to assess the scope and breadth of CalSTRS members’ health care coverage needs. In addition, the CalSTRS Health Benefits Taskforce (different group than the

present Public Education Health Benefits Task Force), comprised of constituent group representatives, Board members (specifically the State Controller and the State Treasurer) and CalSTRS staff, was created to assist in evaluating the many aspects of a comprehensive and fiscally sound health benefit program. With the cooperation of the taskforce, CalSTRS worked for nearly three years evaluating the administrative and financial structures of various health care coverage and delivery designs.<sup>7</sup> The result of that work was the May 2001 report: *A Review of Potential Health Care Benefits Programs Provided by the California State Teachers' Retirement System*.

This report evaluated six different health care models:

1. Provide and fund a comprehensive or catastrophic prescription drug plan;
2. Fund participation by retired members in local district medical plans;
3. Provide and fund statewide health benefit program for all retired members;
4. Provide or fund local and statewide Medicare supplement plans;
5. Fund individual retired member health benefit premium payments; and
6. Administer retirement health care security accounts for active members

Several of the benefit program ideas discussed had broad support, but no one proposal emerged as the unanimous first priority. However, two options had the most support: (1) a catastrophic prescription drug plan, which was the initial choice of most constituent groups and (2) using CalSTRS resources to fund individual retired member health benefit premiums, particularly the Medicare Part B premium. CalSTRS' review of alternative health benefit programs indicated that crediting contributions into individual nominal health benefit accounts while members are employed is a potential long-term solution to making affordable health care available to members when they retire in the future.

At that time the Board recommended that the Legislature, subject to the availability of resources to CalSTRS, enact legislation that:

1. Establishes a prescription drug plan that covers prescription drug costs above a specified level to provide catastrophic coverage for retired members; and
2. Establishes individual nominal health benefit accounts for retired members, with CalSTRS contributions credited to the accounts to pay the cost of health care benefits in retirement, including Medicare Part B premiums.

The Board also directed CalSTRS staff to explore the legal and tax issues associated with establishing such accounts. In June 2002, staff presented information about Nominal Health Benefits Accounts, which are similar to the Health Security Accounts discussed in this report.

Since these efforts were last studied, the focus of the Board shifted to other issues, particularly developing a strategy to eliminate the unfunded obligations in the Defined Benefit Program after lower than expected investment returns during the three-year market downturn early in the decade. Nevertheless, in May 2003, the Teachers' Retirement Board agreed that CalSTRS should continue to play a role as a financier of health insurance to the extent that funds are available. The primary advantage of the financier role is that CalSTRS already has expertise in collecting, investing and paying funds. It also has the capability to deduct premiums from members' allowances if necessary. In addition, there is the possibility of providing increased benefits to members with a potentially more limited exposure to CalSTRS if health care costs should escalate at a greater rate than anticipated. As a financier, CalSTRS could completely or partially fund the cost of health insurance, but would not necessarily negotiate coverage or premiums with the carrier. This is the role that CalSTRS plays with the MPP Program.

The Board also concluded that CalSTRS should be an educator about health care programs by providing information to assist employers and members on issues that affect their health care programs. CalSTRS staff assists members in understanding the factors to consider when making that decision about their health care in retirement and refer members to the other resources such as Health Insurance Counseling and Advocacy Program (also known as HICAP).

Finally, the Board decided that CalSTRS should not be a provider of health insurance. The health care environment is volatile and the risks are high. As important, it would be wasteful to duplicate the efforts of CalPERS, which already provides health insurance to state employees, approximately 115 school districts, and numerous municipalities and local agencies. CalPERS is the third largest purchaser of health benefits in the United States, behind the federal government and General Motors. In the past, CalPERS' size has enabled it to exercise considerable leverage in the marketplace to control its costs. Lately, however, CalPERS has lost a lot of that leverage, and is now under a great deal of pressure due to the rising cost of health care.

The implementation of the federal Medicare Prescription Drug, Improvement and Modernization Act of 2003 made the suggested comprehensive prescription drug plan unnecessary. This bill made the most far-reaching change in

Medicare since its creation in 1965 and included the addition of outpatient prescription drug coverage, Medicare Part D. Because Medicare Part D provisions do not allow for the donut hole to be covered by a catastrophic prescription drug plan, such a plan is no longer viable.

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## CALIFORNIA EDUCATION COALITION FOR HEALTH CARE REFORM

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The California Education Coalition for Health Care Reform<sup>8</sup> is trying to improve health care for California educators. It is a joint coalition of education labor and management groups with goals to significantly reduce the rate of increase in health care costs in public education, protect and enhance the quality of education for California students, and maintain and increase the real income of public education employees. The Coalition, established in 2004, makes decisions by consensus. The chairs of the Coalition participated in the Task Force. The following groups are members:

- Association of California School Administrators;
- California Association of School Business Officials;
- California Federation of Teachers;
- California School Boards Association;
- California School Employees Association;
- California Teachers Association;
- School Employers Association of California; and
- Service Employees International Union.

The coalition developed a six-point program to achieve its goals: education, awareness, trainings, advice, consultation, and legislative action. In December 2005, it initiated its campaign to provide a consistent educational program to all schools and colleges and developed a comprehensive tool-box to provide clear and thorough information to healthcare purchasers. The tool box and training included best practices for district insurance committees, code of conduct, model contracts for brokers and consultants, advisories for cash-out plans and health savings accounts, interview guides for insurers including model contract, and data and information for local regions and areas. By February 2008, nearly 100 presentations to approximately 6,000 people had been completed with many groups requesting additional information and training.

The coalition believes that long term systemic changes are required and will advocate for reform through all state and federal bodies. Two of its members sponsored AB 256—De La Torre (now Chapter 708, Statutes of 2005) that requires CalPERS, in consultation with CalSTRS, to conduct a health care school pool study. Such a pool may bring short term relief. See more about this study on page 47.

The coalition also promotes value purchasing through the use of regional purchasing coalitions and the establishment of the California Health Care Coalition. The key premise of the California Health Care Coalition is that the bargaining dynamic must be shifted from who will pay for rising costs to joint action against industry price gouging and poor quality care. The greatest opportunity lies in combining strength as purchasers to challenge excessive industry prices, high per patient costs, and deficient quality.

The strategies to accomplish this are to organize purchasers, adopt common performance standards, negotiate collectively and directly with the industry to meet its standards or risk losing business, and educate plan participants and the general public about efforts to preserve affordable, quality health care.

The presentation “School Management and Labor Unions Together Are Attacking Escalating Healthcare Costs,” that the California Education Coalition for Health Care Reform provided to the Task Force on September 15, 2006, is included in the accompanying CD.

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## CALIFORNIA SCHOOL DISTRICT INITIATIVES

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New Government Accounting Standards Board (GASB) standards 43 and 45 have brought the costs of health care for retired employees into public view. Under these standards, beginning in 2007, public employers including school districts that have a financial liability associated with the provision of health care and other benefits to their retired employees will be required to disclose that liability on their financial statements. The GASB rules do not require a school district to initiate a program to fund those liabilities. To the extent that districts begin to fund those liabilities, it could be accomplished through a combination of pre-funding contributions, similar to employer contributions for pension plans, or issuance of bonds similar to pension obligation bonds, or a combination of the two approaches.

Illustrating these methods are the actions of two California school districts. Elk Grove Unified School District has established a trust and operates a Voluntary Employee Benefits Association to fund retired members’ health care. Peralta

Community College District took a different approach by selling limited obligation bonds to help fund its existing post-retirement health care obligations.

### **Elk Grove Unified School District – Employee Retirement Trust**

Established in 1995, the Elk Grove Benefit Employee Retirement Trust was the first health benefits trusts to pay for retiree health care established by a school district in California. It is run by a joint labor-management trust and consultants (an attorney, investment advisor, actuary, and auditor) who provide guidance. The trust provided benefits to the first group of retirees in July 2000.

A strong relationship between management and labor are key in this type of trust. Over the last seven years, actions have been taken to increase contributions, modify eligibility and benefits, and to maximize investments. However, escalating health costs have continued to dramatically increase the unfunded liability. The directors of the trusts are currently considering further action.

All employees with a 50 percent workload are eligible for benefits with 100 percent of the benefits paid by the employer. Coverage is provided to an eligible employee and one dependent. The vesting period for all employees is 10 years of district service if hired on or before June 30, 2005, or 15 years if hired on and after July 1, 2005. Employees who do not have sufficient years of service to vest may purchase their own health benefits through the district's plan, but must pay 100 percent of the cost.

The district's contribution rate has risen from \$500 per member per month from July 1996 through June 1999 to \$960 per member per month plus one percent of salary in July 2005. The Trust has an unfunded liability of approximately \$195 million, which is largely due to rapid growth in the retirement population. In 2005 the district contributed approximately one half of the annual required contribution of \$15 million. Even though the district's contribution was higher in 2006, it contributed about 36 percent of the annual required contribution of over \$22 million. Currently, Elk Grove is anticipating that approximately 300 of the total 5,500 employees will retire in 2007 or 2008.

The trust funds are invested in domestic (60 percent) and international (10 percent) equities and bond funds (30 percent). The average rate of return for investments for the first ten years of operation has been 9.07 percent.<sup>9</sup>

The Elk Grove Benefit Employee Retirement Trust presentation provided to the Task Force at the March 16, 2007, meeting is included in the accompanying CD.

### **Peralta Community College District – Limited Obligation Bonds.**

Peralta Community College District's previous agreements provide qualifying employees and their families with lifetime health care insurance. In the past, this obligation had been funded on a pay-as-you-go basis. The estimated net present value of the benefit ranged from \$132 to \$196 million depending on the inflation assumptions. The annual costs were projected to double in 10 years. Currently, retiree health benefits account for five percent of general fund revenues. If the pay-as-you-go system continued, these costs would rise to nearly 8.5 percent in less than 15 years.

The district considered various alternatives to address the problem. The increased risk of future financial pressure made ignoring the obligation unacceptable. Eliminating the benefit would create difficult labor issues and potential litigation. If the district established a trust to fund these benefits, the 2006-2007 annual required contribution to fund the amortized cost would have been over \$13 million, making this unacceptable. The district concluded that offering limited obligation bonds to refinance the benefit was its only alternative.

The district's financing through bonds received judicial validation from the Alameda Superior Court. No vote approval was required because the bonds are refinancing an existing obligation. Further, legal debt of the district is payable from all legally available sources. The security of limited obligation bonds mirrors commonly issued pension obligation bonds.

The projected limited obligation bond repayment is structured to remain at seven percent of general fund revenues, assuming a 2.5 percent in annual growth in general funds revenues. The bond funds will be professionally invested in a CalPERS /Alameda County Employees' Retirement Association based asset allocation model. The bonds were rated well and the initial offering was significantly oversubscribed.

One of the Task Force's concerns is that the implementation of the new GASB standards will cause those districts that presently provide employer paid health care to retired members to eliminate that coverage. This was the case at Peralta Community College District. The obligation to fund the existing health benefits for retired members was a key factor in securing labor agreements to discontinue health benefits during retirement for new hires.<sup>10</sup>

# III

## Health Care Offered to Retired Members by Other State Teachers' Retirement Systems

The Task Force reviewed information from other statewide teacher retirement systems that provide health benefits to their retired members. With the assistance of the National Association of State Retirement Administrators (NASRA), we identified only eight such systems. The eligibility requirements, portion of premiums paid, and plan design vary a great deal. Not all disabled members receive health care subsidies. Many systems have two tiered systems based on when members entered or retire from the system. Members do not participate in Social Security in six of these systems. However, most require that retired members enroll in Medicare Parts A and B if eligible. Features for the eight plans are outlined below.

### **Alaska Division of Retirement Benefits**

Alaska pays the full health insurance premium for retired members, but has a two tiered system. Tier I is for those who entered the system prior to July 1990 and Tier II is for those who entered in or after July 1990. Individuals in Tier II must have 25 years of service or be age 60 to be eligible for the system to pay for the health insurance after retirement. There are no service requirements to receive health benefits if one is disabled.

Alaska teachers do not participate in Social Security. All members must enroll in Medicare Part B at age 65. Members must also enroll in Medicare Part A if eligible without paying a premium.

### **Colorado Public Retirement System**

Members who retire with one or more years of service are eligible, but the subsidy toward the health insurance is based on years of service. The full subsidy of \$230 per month is paid for a member with 20 years of service with a five percent reduction for each year under 20. Members who are eligible for Medicare receive one-half of the subsidies based on their years of service.

Disabled members are also eligible for health insurance subsidy based on the years of service used to calculate their disability retirement.

Colorado teachers do not participate in Social Security. All members must enroll in Medicare Part B at age 65, but they are not required to enroll in Medicare Part A.

The Denver Public Schools are not part of the Colorado Public Retirement System.

### Illinois Teachers' Retirement System

Retired members must have at least eight years of service to be eligible for the system to pay their health insurance. There is no service requirement for a disabled member to have the system pay their health insurance. The subsidy depends on the availability of Health Maintenance Organizations (HMO) in the members' area. If there is a HMO available, members who enroll in the HMO will be subsidized for 75 percent of the premium. The same subsidy is available to members who enroll in major medical plan if no HMO is available. If members enroll in a major medical plan in an area in which an HMO is available, the subsidy drops to 50 percent of the major medical plan premium.

Illinois teachers do not participate in Social Security. Members do not have to enroll in Medicare, but lower premiums are available to those who enroll in Medicare Parts A and B.

The Chicago Public Schools are not part of the Illinois Teachers' Retirement System.

### Kentucky Teachers' Retirement System

The subsidy for members hired prior to July 1, 2002, is based on years of service as shown in the table.

For members hired on or after July 1, 2002, the members must have 27 years of service *or* be at least age 55 and have five years of service to be eligible for the premiums subsidy that is graduated from 10 to 100 percent based on years of service. Disabled members with five or more years of service are eligible for a health insurance subsidy.

Kentucky teachers do not participate in Social Security. All members must enroll in Medicare Part B at age 65. Members must also enroll in Medicare Part A if eligible without paying a premium.

#### Kentucky's Subsidy for Health Insurance – Members Hired Prior to 7/1/02

Years of Service	Percent of Premium Paid by System
20+	100%
15 – 19	75
10 – 14	50
5 – 9	25

### **Michigan Public School Employee Retirement System**

The health insurance premium is fully subsidized for members with 20 or more years of service and who retired directly from being an active member. For those members who are inactive for a period prior to their retirement, the premium subsidy is based on service credit, ranging between 17.5 and 100 percent of the premium.

Michigan teachers participate in Social Security. All members must enroll in Medicare Parts A and B at age 65.

### **New Jersey Division of Pension & Benefits**

The State of New Jersey pays insurance premiums for retired New Jersey educators. It was reported in early August 2007, that the state has a \$58 billion unfunded obligation for health care for all retired employees of the state. Currently, school districts do not pay a contribution toward retired members' health care.

If members do not have Medicare coverage, they must have 25 years of service to be eligible for subsidy for the full premium. The system will also pay the Medicare Part B premium. Those members enrolled in Medicare do not have to have 25 years of service to receive the subsidy. Members with disability retirements receive full health premiums subsidies.

New Jersey teachers participate in Social Security. All members must enroll in Medicare Parts A and B at age 65.

### **Ohio State Teachers' Retirement System**

If members have 15 or more years of service, premiums are subsidized at 2.5 percent of the premium for each year of service up to a maximum of 75 percent (paid at 30 + years of service). Disabled members may pay premiums. There is an assistance program including lower premiums and lower out-of-pocket expenses for eligible benefit recipients.

Ohio teachers do not participate in Social Security. The Ohio system reimburses a portion of the members' Medicare Part B premium. Members do not have to enroll in Medicare, but lower premiums are available to those who enroll in Medicare Parts A and B.

### **Texas State Teachers' Retirement System**

Members who retire after September 1, 2005, must have 30 years of service *or* 10 years of service and the sum of the member's age and years of service must equal 80 to be eligible for the system to subsidize health insurance premiums at \$150 per month. Members with a disability retirement will receive the subsidy, but the benefit will stop when the disability ends for those with less than 10 years of service.

Texas teachers do not participate in Social Security.

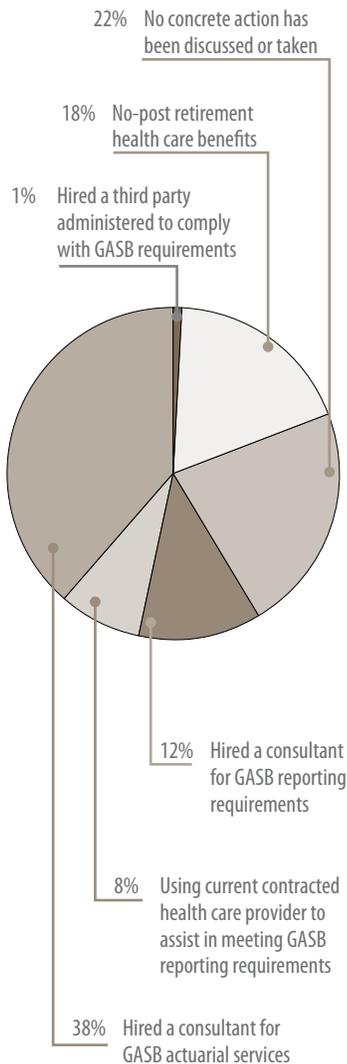
# IV

## Assisting in Meeting Financial Disclosure Requirements

The Teachers' Retirement Board established the Public Education Health Benefits Task Force to discuss opportunities for CalSTRS and CalPERS to address various challenges that school employers face in providing health benefits to their active and retired employees. The first issue that the Task Force considered was the new requirements under GASB standards 43 and 45. Under these standards, beginning in 2007, public employers including school districts that have a financial liability associated with the provision of health care and other benefits to their retired employees will be required to disclose that liability on their financial statements. Although the GASB rules do not require a school district to initiate a program to fund those liabilities, the disclosure of substantial liabilities could affect the public's perception of the fiscal health of that district. In addition, the Public Employees Post-Employment Benefits Commission recommends that all public agencies pre-fund any retiree health care they offer. To the extent that districts begin to fund those liabilities, that could be accomplished through a combination of pre-funding contributions, similar to employer contributions for pension plans, or issuance of bonds similar to pension obligation bonds, or a combination of the two approaches. Earlier, the report discussed examples of districts that used each of these methods. Elk Grove Unified School District established a trust and operates a Voluntary Employee Benefits Association (VEBA) to fund retired members' health care. Peralta Community College sold limited obligation bonds to help fund its post-retirement health care obligations.

The need for school districts to comply with GASB disclosure requirements creates two concerns. The first issue is that the implementation of the new GASB standards will cause those districts that presently provide employer paid health care to retired members to eliminate that coverage. That certainly occurred in the private sector when private employers eliminated retiree health benefits in response to Financial Accounting Standard (FAS) 106 promulgated

## Complying with GASB Requirements



in 1993 by the Financial Accounting Standards Board (FASB), which provides accounting rules and financial reporting standards for private companies. FAS 106 is similar to GASB 43 and 45 in that private firms are required to recognize retiree medical benefits as a form of deferred compensation and to report the present value of these future benefits. Previously, private firms had been able to report retiree health benefits on a pay-as-you-go basis. An important factor for private companies is that federal regulations do not allow tax-advantage funding for this form of deferred compensation. The percentage of medium and large firms offering retiree health plans to active employees fell from 71 to 41 percent between 1988 and 1993, the year in which FAS 106 became operative. Eighty-nine percent of firms cutting retiree health care benefits did so within one year of adoption of FAS 106, but increasing costs were also a factor.<sup>11</sup>

In its 2006 CalSTRS health benefit survey, CalSTRS found that 19 percent of the school districts that responded to the survey offer no employer-paid health care for any retired employees. This is within one percent of the results of the 2003 CalSTRS health benefit survey. There has been a small drop in the number of school districts that do not pay for employee health insurance after age 65. In the 2006 survey, 78 percent of the employers (representing 60 percent of the employees) fell in this category. This is an increase from the 74 percent of employers (representing 57 percent of retired employees) reported in the 2003 CalSTRS health benefits survey. As CalSTRS continues its triennial health benefits surveys, it may be possible to discern if implementation of the new GASB standards causes more districts to eliminate paid health care to retired members.

The second, but more immediate issue is determining the liabilities for health care and addressing those liabilities through a funding program

In the 2006 CalSTRS health survey, districts were asked about these issues. When asked whether they had taken any steps to ensure that the reporting requirements under GASB 43 and 45 will be met, 50 percent of the employers said they had hired a consultant to lead them through the GASB reporting requirements. An additional two percent indicated that they had consulted with CalPERS or CalSTRS on GASB provisions. Eighteen percent indicated that they do not provide post-retirement health care benefits and are thus not subject to GASB. The chart shows the responses from the survey.

Determining the liabilities for health care and addressing those liabilities through a funding program is very similar to what must be done as retirement systems administer their pension plans. CalPERS initiated a program that allows public agencies, including about 115 school districts that participate in

the Public Employees Medical and Hospital Care Act (PEMHCA), their state-wide health care program, to receive CalPERS assistance in undertaking the necessary actuarial valuations of their individual PEMHCA obligations. This occurs by enabling PEMHCA employers to utilize CalPERS contract actuarial firms to conduct the valuations. CalPERS also provides each employer with the data needed for the valuation. In addition, CalPERS will be able to manage assets that are accrued by PEMHCA employers in addressing their unfunded health care obligations, if the employer chooses.

In 2006, CalPERS sponsored legislation that would have authorized CalPERS to provide similar assistance to non-PEMHCA employers, which includes approximately 90 percent of school districts. Although the Legislature approved such an authorization last year in SB 1729 (Soto), that bill was vetoed due to concerns that it could create new health care benefit obligations in the future. CalPERS worked with the administration to address those concerns and in 2007 again pursued legislation (AB 554--Hernandez) to give it the authority to extend GASB assistance to all public employers, including school districts. This solution is for GASB purposes only and does not address issues regarding the availability or rapidly increasing costs of health care. The Task Force monitored CalPERS progress in their efforts. The bill passed, was signed by the Governor, and beginning January 2008 CalPERS has authorization to provide assistance to non-PEMHCA districts in determining their liabilities for health care and addressing those liabilities through a funding program. Therefore, the Task Force feels that it is not necessary for CalSTRS to provide similar services. As a result, it elected not to focus on this issue.

CalPERS established the California Employers' Retiree Benefit Trust Fund, a trust fund to pre-fund other post employment benefits. The funds are invested on a parallel basis with the pension funds. As of the early February 2008, twenty-five cities or public agencies, including the Sacramento County Office of Education, have contracted with CalPERS to participate in the fund.<sup>12</sup>





## Improving Accessibility to Health Care

The second major focus of the Task Force was accessibility to health care. Although the Task Force is looking at health care access for California educators, it considered different factors that affect health care access in general. It learned about the national environment from Dr. Henry Simmons, President, National Coalition on Health Care, and about other states' health care initiatives from Anthony Wright, Health Care Access, and CalSTRS staff. It also reviewed the health care proposals being made here in California. It also heard progress reports on the health care school pool study, being conducted by CalPERS, in consultation with CalSTRS.

In the discussion about these four topics, references to federal poverty levels, established programs and other terms may not be familiar. Therefore, a glossary is provided in the appendix.

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### GENERAL HEALTH CARE ENVIRONMENT

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The American public is very concerned about the health care system. A survey by the Harvard School of Public Health and the Robert Wood Johnson Foundation reported that that 75 percent of Americans think that the health care system is in crisis or has major problems. A second poll by ABC News, USA Today, and the Kaiser Family Foundation reported that 80 percent of Americans are dissatisfied with the cost of health care in this country, and 60 percent of insured Americans are worried about being able to afford health insurance costs over the next few years.<sup>13</sup>

The American health care system is large and complex. There is a consensus that three major and interrelated problems are affecting the system. The first is rapidly escalating costs. A January 2008 Center for Medicare and Medicaid Services (CMS) study reports that U.S. health care spending increased 6.7 percent to \$2.1 trillion or over \$7,000 per person in 2006. Health Care spending accounted for 16 percent of the gross domestic product. Even though this was

the slowest rate of growth since 1999, it outpaced overall economic growth and general inflation in 2006.<sup>14</sup>

A new CMS study projects that U.S. health-care spending will reach \$4.3 trillion in 2017, nearly double the 2007 amount. This would be approximately 19.5 percent of the gross domestic product.<sup>15</sup> In 2003, the most recent year for which cross-national comparative numbers are available, the United States spent more than two-and-a-half times the per-person average for advanced industrialized countries. Yet despite this much higher spending in the United States, 34 nations have higher life expectancies than the United States and 41 nations have lower infant mortality rates. In just the past six years, health insurance premiums have jumped 87 percent, more than four times the cumulative increase over that same period in overall inflation and in earnings. The average annual premium for family coverage in 2006 was nearly \$11,500.



These enormous increases are making it much more difficult for employers to continue providing health coverage or to sustain the same levels of health coverage and financial contribution for employees and retirees. Although most non-elderly Californians receive health coverage through employment, the employer-based coverage is slowly and steadily declining. It fell from almost 65 percent in 1987 to approximately 55 percent in 2005.<sup>16</sup> The increases are also making it much more difficult for individuals and families to pay their shares of the cost of employer-sponsored coverage or to buy health insurance themselves. The rapid rates of increase in these costs also erode the living standards of those who receive retirement income, including CalSTRS members.

This is exacerbated by longevity. People are living significantly longer than in the past. The average life expectancy is over 75 years for males and almost 81 years for females<sup>17</sup>. California educators, at age 61 (the average age at retirement), have even longer life expectancies of 85 years for males and 86 for women. There is a 50 percent chance that at least one member of a healthy 65-year-old couple will live to age 92.<sup>18</sup>

Among non-institutionalized beneficiaries, Medicare covers only 51 percent of expenses associated with health care services.<sup>19</sup> Therefore, people need funds to pay their portion of medical expenses. Fidelity Employer Services Company predicted in March 2008 that an average 65-year-old couple needs an estimated \$225,000 to cover health care costs in retirement. “Since the estimate was first calculated in 2002, it has risen 41 percent with an average annual increase of 5.8 percent.”<sup>20</sup> The Employee Benefits Research Institute reported that an even larger amount was required. “A couple, both age 65, today living an average life expectancy could need as much as \$295,000 to cover premiums

for health insurance coverage and out-of-pocket expenses during retirement. A couple who lives to age 95 could need as much as \$550,000.<sup>21</sup>

The second facet of our health care crisis is a huge and growing number of Americans without any health insurance. The number of uninsured Americans rose to 45 million in 2005, an increase of nearly seven million in just five years. In California, nearly 6.6 million people, 20 percent of residents,<sup>22</sup> had no health coverage last year. The California HealthCare Foundation reported that “more than 30 percent of the uninsured have family incomes of more than \$50,000 per year and nearly three-quarters of uninsured children are in families where the head of the household has a full-time job.”<sup>23</sup> Being uninsured exacts a grim toll on the health of these individuals. Without coverage, they receive less care, endure more pain and suffering, and are more likely to die prematurely. The costs of providing uncompensated care to uninsured patients, in emergency rooms and other settings, are built into the charges for care of those with health coverage. According to a study by Professor Kenneth Thorpe, health care economist at Emory University, these surcharges add \$1,160 per year to the average cost of employer-sponsored family coverage in California.

The third major problem in our health care system identified by experts is an epidemic of sub-standard care. There is a wide gulf between the care that patients should receive and the care that is actually delivered. Nationwide, an average adults receive recommended care less than half the time.<sup>24</sup> Hundreds of thousands of Americans die prematurely each year because of sub-standard care. Millions more are harmed. Unnecessary accidents, errors, and poor quality are now the nation’s third leading cause of death, just behind cancer and heart disease. Health care quality is also an enormous cost issue. Some experts have estimated that we may be wasting more than \$600 billion a year because of sub-standard care.

In June 2007, The Commonwealth Fund published the first State Scorecard on Health Systems Performance to provide comparative state (and the District of Columbia) health system performance. It indicates “American’s health system falls far short of achievable benchmarks, especially given the resources the nation invests.”<sup>25</sup> The analysis confirms that the three issues—escalating costs, large number of uninsured and lack of quality—are interrelated. For example, the report also stated that “better access is closely associated with better quality... [yet] higher quality is not associated with higher costs across the states.”<sup>26</sup> “Affordable access is a first step to ensure that patients obtain essential care and receive care that is well coordinated and patient-centered.”<sup>27</sup> To bring this closer to home, California’s overall rating is in the bottom quartile of the states<sup>28</sup> and

in quality it is rated 50<sup>th</sup>. This is in the same state that is ranked third for healthy lives.<sup>29</sup> “Quality” measures three related components: receipt of the ‘right care,’ coordinated care, and patient-centered care while “healthy lives” measures the degree of which a state’s residents enjoy long and healthy lives.<sup>30</sup>

As Dr. Simmons aptly said, “We have reached the point where America’s top domestic concerns, economic growth, jobs, retirement security, and health care, are now bundled together. Economic growth, jobs, and retirement security cannot be assured unless health care costs are controlled.”<sup>31</sup>

**“We have reached the point where America’s top domestic concerns, economic growth, jobs, retirement security, and health care, are now bundled together. Economic growth, jobs, and retirement security cannot be assured unless health care costs are controlled.”**

*Dr. Henry E. Simmons, M.D., M.P.H., F.A.C.P.  
President, National Coalition on Health Care*

This is reflected on the national level in that every presidential candidate from both parties has a health care proposal. There have been federal bills introduced by members of both parties calling for health care reform. A number of states have implemented or have proposed health care reform. The discussion often gets down to a basic debate: Do we expand government programs or use market forces including consumer driven components? Simultaneously, there are also numerous proposals being considered in California. Funding the plans continues to be one of the major hurdles. Some of the plans include the use of additional federal funds, but that has yet to be agreed upon. Legal uncertainties include whether the state can mandate coverage under federal ERISA provisions.<sup>32</sup>

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## ACCESSIBILITY – OTHER STATES

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A number of states are expanding health insurance coverage and others are considering programs. At this point, the Massachusetts’ program is the most far reaching and is being viewed as a model by other states. It is also helpful to look at the efforts of other states. Leaders of both major parties are involved in the reforms.

### Massachusetts

Massachusetts’ new program requires that adults age 18 or more, who can afford a health plan,<sup>33</sup> secure health insurance by July 1, 2007. The landmark legislation was passed in 2006 with the goal of covering 95 percent of its residents within three years. This new health care reform represents a culmination of more than a year of negotiations and compromise between lawmakers and the governor. It includes provisions to increase access to health insurance, contain health care costs, and improve quality. However, some key issues were not resolved in legislation, particularly what was meant by *available* healthcare, *affordable* health care and *covered* health care.

The Massachusetts model for health benefits spurred the debate in California on health benefits. Anthony Wright, Executive Director of Health Access California, gave a presentation entitled “Massachusetts Health Care Law: Model, Mirage or Momentum?”<sup>34</sup> at the January 19, 2007, Task Force meeting. Although Mr. Wright is not an advocate for the Massachusetts model, he feels that it has some good qualities and resolves some issues that could benefit California, even though the demographics of the two states are significantly different. For example, California has a higher number and a higher percentage of uninsured than Massachusetts. Another difference is that Massachusetts is largely dominated by a handful of nonprofit health insurers, while California has a mix of for-profit and nonprofit insurers. One of California’s for-profit insurers has already pledged a significant amount to lobby against health care reform.

The Massachusetts program includes both individual mandates and employer mandates. The individual mandate, which only applies to those who can afford a health plan,<sup>35</sup> requires adults 18 years or older to obtain health insurance by July 1, 2007. Starting in 2007 income tax forms will require disclosure of insurance status for the tax year. The penalties for not having insurance, in the 2007 tax year, will include loss of the personal exemption of approximately \$150. In subsequent tax years, the penalty will include a fine of 50 percent of the monthly cost of health insurance for each month without insurance, which is currently estimated at \$1,000. Individuals who cannot afford insurance, as determined by the Commonwealth Health Insurance Connector, established to assist individuals and small businesses find affordable health coverage, will not be penalized. The Connector set affordability standards for people earning below approximately 600 percent of the federal poverty level (FPL).<sup>36</sup>

The employer mandates apply to employers with 11 or more employees. Those employers that do not make a “fair and reasonable” contribution towards their employees’ health insurance coverage will be required to make a per-worker contribution, estimated to be approximately \$295 per full-time employee. Regulations identify “fair and reasonable” contributions as either an employer with 25 percent enrolled in a group health plan *or* an employer that offers to pay 33 percent of a full-time employee’s health premium. This is well below the national market average of 84 percent employer contribution for individual coverage and 72 percent for family coverage.<sup>37</sup> This has been viewed as an assessment rather than a tax. Employers with seasonal or part-time employees pay a pro-rated amount. By January 1, 2007, they must have adopted a Section 125 cafeteria plan as defined in federal law, which permits workers to purchase health care with pre-tax dollars and will reduce the cost of

premiums by up to 25 percent. Those employers that do not offer to contribute toward, or arrange for the purchase of health insurance may be assessed a “free rider” surcharge if their employees access free care a total of five times per year in the aggregate or one employee accesses free care more than three times. The surcharge will exempt the first \$50,000 of free care that the employees use. After that the employer will be charged between 10 and 100 percent of the cost to the state as determined by the Division of Health Care Finance and Policy. Part-time and seasonal workers are allowed to combine employer contributions. This also allows individuals to keep their policy if they switch employers.

Insurance market reforms were also included in the legislation. Unlike California, Massachusetts already has a form of community rating for some parts of the insurance market, which means that a patient cannot be turned down or charged more for non-group insurance because he or she has a pre-existing medical condition. Starting in July 2007, the non- and small-group markets will be merged. The merger is expected to reduce premiums by nearly a quarter of their current cost for people currently purchasing in the individual market. It will also allow Health Maintenance Organizations to offer coverage plans that are linked to health savings accounts. Young adults may remain on their parents’ policy for two years past the loss of their dependent status, or until they turn 25, whichever occurs first.



The state also subsidizes coverage for some individuals. The legislation established the Commonwealth Care Health Insurance Program, which will provide sliding scale subsidies to individuals with incomes below 300 percent of the FPL. No premiums will be imposed on those individuals with incomes below 100 percent FPL. Premiums for those between 150 and 300 percent of FPL are set according to an affordability scale for subsidized health plans. Premiums for those between 300 and 600 percent of the FPL, are set on the sliding scale is based on premiums for insurance.<sup>38</sup> The Connector set three levels of standardized coverage. Gold plans have the most comprehensive benefits, the highest premiums, no deductibles and limited cost sharing. Silver plans have medium benefits and premiums, no deductibles and some cost sharing. Bronze plans have the least comprehensive benefits. Deductibles under the bronze plans are up to \$2000 per individual and \$4000 per family and there is cost sharing.<sup>39</sup>

Even though over 216,000 people are newly insured since the program began,<sup>40</sup> it is still too early to know how successful the Massachusetts program

will be. However, the State now estimates an enrollment of 342,000; double that of the late 2006 estimate, at a cost of \$1.35 billion annually within three years. Two unforeseen problems contributed to the funding shortfall. The shift from no-cost to insurance subsidized care has been slower than expected and the State has not collected as many penalties as expected from employers that do not offer health insurance to their workers.<sup>41</sup> Another issue that has created problems is the shortage of primary-care physicians in the state. Many internists and physicians in general practice are not taking new patients. The governor acknowledged “healthcare coverage without access is meaningless.”<sup>42</sup>

### Arkansas

In March 2006, Arkansas received approval from the Centers for Medicare & Medicaid Services (CMS) for the Arkansas Safety Net Benefit Program, which is a Health Insurance Flexibility and Accounting (HIFA) Section 1115 waiver. The primary goal of a HIFA demonstration initiative is to encourage new comprehensive state approaches that will increase the number of individuals with health insurance coverage within current-level Medicaid and State Children’s Health Insurance resources.<sup>43</sup> Arkansas’ program will be available to firms that employ 2 to 500 employees and have not offered health insurance for one year. It requires employers to enroll all employees unless they can document prior coverage. Employees who earn less than 200 percent of the FPL will be subsidized by Medicaid. The program is funded by a combination of employer and employee premiums and state and federal funds. During Phase I, which will last 12 to 18 months, they hope to enroll up to 15,000 members. Based upon the evaluation and availability of federal and state funds, during Phase II they will be able to enroll up to 80,000 Arkansas residents.

### Indiana

In mid-December 2007, Indiana received approval of a Medicaid waiver from U.S. Health and Human Services that permits the state to enroll low-income residents in a state-subsidized, high-deductible health care plan.<sup>44</sup> Individuals with incomes from 22 to 200 percent of FPL or approximately 130,000 can be covered the Healthy Indiana Plan. They must have been uninsured for the past six months and have no access to insurance through another source. By the end of December, approximately 4,500 have applied for the benefit and most have been approved. The program is innovative because participants contribute a monthly fee not to exceed five percent of their income and includes provisions similar to health savings accounts.<sup>45</sup>

## Michigan

In January 2008 the Michigan Universal Health Care Access Network (MichUHCAN), a state-wide network that promotes comprehensive health care for all through education, strategy development and advocacy, plans to begin a petition drive to have voters approve statewide universal health care.<sup>46</sup> The network has support from labor and religious groups, advocacy groups and some key politicians. The proposal would amend the constitution to require the Legislature to enact “affordable and comprehensive health care coverage” in the same way the constitution mandates state support of free public education.<sup>47</sup>

## New Jersey

New Jersey added a “buy-in” provision to the New Jersey FamilyCare program that allows all families access to an affordable health care. Until now families with income above 350 percent of the FPL could not participate.<sup>48</sup> Families under the new provision, which is budget neutral to the State, pay lower premiums than available normally because the State can secure the lower premiums through its purchasing power. There are a few restrictions including that all children in a family must be enrolled and the family must demonstrate that the children have been without insurance for six months. This second provision is to ensure that families that presently have insurance do not drop it to participate in this program. There have been estimates that as many as 60,000 uninsured children are eligible for this new program.<sup>49</sup>

## Ohio

State legislation is being drafted that would require all Ohioans to have health insurance. The plan would help cover the 1.3 million without insurance by

- Requiring that insurance companies allow individuals through the age of 29 to remain on their parents insurance;
- Changing Medicaid eligibility rules to cover more low-income individuals; and
- Allowing individuals to purchase a private health-care plan negotiated through the Department of Insurance with state and federal funds subsidizing some monthly premiums.

The plan, which would cost \$4.1 to \$4.5 billion, would be financed through new health-care fees paid by people joining the state-negotiated plan, additional federal Medicaid funds, premiums, and new tax revenue generated by the increase in insurance business.

It is not yet clear whether this plan will gain the support of the Governor or the house leadership.<sup>50</sup>

### Rhode Island

In 2006, a number of new health initiatives were signed into law, including several coverage expansions that focus on providing premium relief for small businesses. The insurance commissioner is empowered to work with all involved stakeholders to develop a new, affordable health plan, called “WellCare,” which is expected to reduce premiums for small businesses by approximately 25 percent through a combination of state mandated benefit flexibility, premium rating restrictions, and consumer cost sharing. Low-wage small businesses with average wages in the bottom quartile will be able to save an additional 10 percent of the premium through a state sponsored reinsurance program that passed into law but is contingent upon the identification of a new funding source during the coming year. The insurance commissioner is also authorized to seek federal funds for the creation of a high-risk pool in the individual market.

The program promotes wellness through the restriction of the sale of sweetened beverages in school vending machines, the creation of an adult flu vaccination program, and the encouragement of insurance coverage for tobacco cessation products. There is also an expansion of quality and cost data reporting by all licensed health facilities in the state to enable patients with deductibles and co-insurance to make informed decisions. In addition, the package created the Massachusetts Reform Review Task Force that will explore the potential transferability of the Massachusetts reforms to Rhode Island.

### Tennessee

Senate Bill 3895 was enacted in 2006 and contained several coverage components.

The Cover Kids Act creates a separate, stand-alone health care program for all children under the age of 18, which will be a State Children’s Health Insurance Program (SCHIP). It uses \$7 million in state funds for Fiscal Year 2007 (six months) and Title XXI funds (SCHIP) from the federal government to cover children and pregnant women up to 250 percent of the FPL. Eligibility is layered over current TennCare levels and offers a buy-in program for children who do not qualify for the subsidized product.

Cover Tennessee, the second component, aims to provide a new, portable, and affordable product for the working uninsured who earn less than 250 percent

FPL, as well as for small firms that do not currently offer insurance. It allows workers to keep their policy if they switch employers. It is based on a “three share concept” in which participating employers and the state each pay \$50 per member per month and the individual covers the rest of the premium. Premium amounts charged to employers, employees, and individuals will not increase more than 10 percent per year, for the first three years, to maintain affordability. The state will contract with at least two carriers to offer a product at \$150 per member per month with low or zero dollar deductibles for preventative health services. The procurement process to contract with those health plans is under development.

The third component, Access Tennessee, is a high-risk pool that pool covers state residents who are uninsured for six months or longer, and who do not have access to other forms of public or private insurance due to a medical condition and those who qualify under federal HIPAA and COBRA laws.

The AccessTN Board may elect to enroll any TennCare Standard recipient who lost coverage after August 1, 2005, and others as determined eligible and develop two benefit packages, one modeled after the state employees PPO plan, and a second option that is a high-deductible health plan coupled with a health savings account. Access Tennessee will be funded by a combination of premiums, assessments on carriers and third party administrators, state appropriations, and possible federal funds pending grant release from the Centers for Medicare and Medicaid Services. Premiums charged to pool enrollees will be capped between 150 and 200 percent of a commercial benchmark plan after moderate medical underwriting and there is a premium assistance program for those who cannot afford the premiums.

There are two other programs. The Safety Net Program, which provides affordable prescription drugs for high priority populations with chronic diseases, will be available for adults who earn less than 250 percent of the FPL. Project Diabetes Program funds endowment grants to high schools and health care entities to combat the epidemic of diabetes and obesity in the state.

### **Vermont**

A new program for Vermont’s uninsured, called Catamount Health, was established in 2006 with the goal of assuring insurance coverage for 96 percent of Vermont’s adults. The subsidized health plan is available only to Vermont’s uninsured. The State will subsidize premiums and cost sharing on a sliding scale for individuals under 300 percent of the FPL. The benefit package will resemble the standard Blue Cross Blue Shield Preferred Provider Organization

(PPO) with a \$250 deductible and will be financed through a combination of individual premiums, an assessment on employers who do not offer health insurance, new tobacco taxes, and possible federal matching funds.

The health care debate in Vermont acknowledged the fact that the majority of health care dollars are consumed by individuals with chronic diseases such as asthma and diabetes. The legislature and the governor recognized the potential to control the growth of health care costs and improve the quality of care delivered in the state by making chronic care management a focus of reform efforts. Therefore, the insurance must align with the Vermont Blueprint for Health's Chronic Care Initiative, a collaborative approach that seeks to improve the health of Vermonters living with chronic diseases and prevent the spread of chronic disease utilizing the Chronic Care Model as the framework for system changes.

Employer premium contribution assessment requires employers that do not currently contribute to their employees' health care costs to help pay for the program costs. These employers are assessed \$365 per full time equivalent employee in the first year (with increases allowed as premiums change) on three groups of employees:

- Those who are not offered health insurance by their employer;
- Those who are not eligible for the health insurance offered by their firms; and
- Those who are eligible for coverage through their employer plans but choose not to enroll and are therefore uninsured.

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## CALIFORNIA LEGISLATIVE PROPOSALS

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In 2007 and 2008, there were numerous health care legislative proposals in California. During the 2007 normal legislative session, three major reform proposals were considered seriously: Senator Kuehl's single payer health insurance bill (SB 840), Assemblymember Nunez and Senator Perata's combined proposal (AB 8), and the Governor's proposal, which was never formally placed in legislation. AB 8 passed both houses of the legislature, but the Governor vetoed it. The Governor then called a special session to cover health care. Assemblymember Nunez and the Governor came to agreement on a program placed in ABX1 1, which contains elements from AB 8 and the Governor's proposal. The Assembly passed the measure, but when the California Senate Health Committee considered the measure in late January 2008, it did not pass.

Although the details of the four proposals vary, common factors include preventive care and disease management; covering more residents, particularly children; mandates for coverage either through employers or by individuals; and projected savings through the use of state purchasing power. How the basic dilemma of using market forces versus expanding government programs is handled may impact passage or acceptance of the agreed upon plan.

Funding is also a major hurdle. The four California proposals include the use of additional federal funds, but that has yet to be agreed upon. There is also controversy about whether some funding mechanisms are fees or taxes, which would create a different voting threshold. Legal uncertainties include whether the state can mandate coverage under federal ERISA provisions.

In this section, we outline selected features of each proposal.<sup>51</sup>

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### **SB 840 – SENATOR SHEILA KUEHL**

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This proposal achieves universal coverage through a single payer health system administered by a government agency, California Health Insurance System. The System replaces all private health insurance and existing government insurance programs. However, the System's responsibility for providing health care services shall be secondary to existing federal, state, or local governmental programs for health care services to the extent that funding for these programs is not transferred to the Healthcare Fund or that the transfer is delayed beyond the date on which initial benefits are provided.

Senator Kuehl introduced this legislation five years in a row. It passed both houses of the legislature in 2006, but was vetoed by the Governor. She hopes to have the bill considered again in 2008.

#### **Who will be covered?**

This is universal coverage for all California residents, including undocumented immigrants.

#### **Portability of coverage**

Because there is universal coverage, there are no portability issues.

#### **Benefits**

The comprehensive benefit package includes the usual range of inpatient and outpatient services plus dental, vision, chiropractic and mental health services,

adult day care and 100 days of skilled nursing care following hospitalization. It excludes long-term care. Consumer cost sharing through deductibles or co-payments would be permitted for other than preventative care.

### Administration

An elected health insurance commissioner assisted by a health insurance policy board would set system goals and priorities and determine scope of services. New agencies and offices, such as public advisory and technology advisory committees, an office of consumer advocacy, offices of health care planning and quality, chief medical officer and an office of the Inspector General, would be established. The commissioner would control total expenditures, allocate resources, and use the state's purchasing power to negotiate for provider services. For example, the state would acquire drugs and medical devices on a bulk-purchasing basis. System administrative costs would be legally limited, initially to 10 percent and later to five percent.

### Financing

A companion bill (SB 1014) was introduced that included financing provisions. A tax on wages (including self-employed individuals) to be paid equally by employees and employers would be imposed. Wages below \$7,000 and above \$200,000 would be exempt. However, there would be an additional personal income tax on wages above \$200,000. All state, county, and federal funds that support California public programs—including Medi-Cal, Healthy Families and Medicare—would be redirected to pay for the program.

### Key Trade-Offs

There is universal coverage, but costs are high. This proposal eliminates problems related to uncompensated care, but limits providers' autonomy with payment rates and capital investment and adds data reporting regulations. Some see the substitute of public financing for private financing troublesome. It eliminates most private insurers but extends governmental authority and control. This proposal would make major changes to the present system.

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### AB 8 – ASSEMBLYMEMBER NUNEZ AND SENATOR PERATA

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The two Democratic leaders introduced separate, but similar bills early in the 2007 legislative session. In June, they combined their proposals in AB 8. The bill, significantly amended the week before the regular session ended, passed both houses, but was vetoed by the Governor.

This proposal would have extended Medi-Cal and Healthy Families eligibility, required employers that do not spend a minimum amount for coverage to pay a fee to the state, revised insurance market rules, and established a purchasing pool to provide coverage for employees who work for firms that do not offer health insurance coverage.

### **Who will be covered?**

If families' incomes are at or below 300 percent of the FPL, children (including undocumented immigrants) would be eligible for Medi-Cal or Healthy Families. Parents (if not undocumented) of these children would be eligible for a plan under the purchasing pool. Premiums could not exceed five percent of income. The program would not cover childless adults with low income. For those above 300 percent of the FPL, only those individuals whose employers did not offer coverage would be mandated to buy coverage. Newly covered are estimated to be 3.4 million (more than two thirds of the uninsured). All employers would be required to establish Section 125 plans.

### **Portability of coverage**

Portability of coverage would improve for low-income people, but it would remain the same for most people. New coverage would always be available because no one could be denied coverage in the individual or group market.

### **Benefits**

The benefits for people newly eligible for Medi-Cal and Health Families would be comprehensive. Families covered under the purchasing pool could choose from five plans that would be relatively comprehensive, but would vary with respect to the amount of consumers' cost sharing. Individuals, whose treatments cost in the top three to five percent, would be eligible for the State's high risk pool.

### **Administration**

The current law, which requires health insurance carriers to provide coverage to firms with 50 or few employees on a guaranteed-issue basis and limits insurers' ability to vary rates, would be extended to employers with up to 250 employees. Insurers would be required to maintain a minimum medical loss ratio (the proportion of premium spent on health care services) of 85 percent.

The Managed Risk Medical Insurance Board (MRMIB) would establish a purchasing pool to provide a cost-effective source of coverage for families

of employees whose employers do not offer coverage and for those who are eligible for Medi-Cal and Healthy Families and whose employers do offer coverage. MRMIB would also define at least five uniform plans that all participating insurers would be required to offer. A new health Care Cost and Quality Transparency Commission would be established to develop a cost, quality and transparency plan.

### Financing

The program would be financed by employer contributions for those not offering coverage and by federal matching funds for Medi-Cal and Healthy Families. Employers that do not spend at least 7.5 percent of Social Security wages (up to \$102,000 in 2008) for health coverage for employees would be required to pay 7.5 percent of payroll to the state. Their employees and their dependents will be required to secure coverage through a new state purchasing pool unless the cost of coverage exceeds five percent of wages. Counties' obligation to serve the indigent is unchanged.

### Key Trade-Offs

Substantially more people are covered. The higher costs would be offset by an assessment on employers not offering coverage. Even though there would be significantly more medical services consumed by newly insured, there are no increases in provider payments. This approach would not be highly disruptive to present practices and organizational structures, but the provisions may prove insufficient to prevent longer-term cost escalation.

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## GOVERNOR'S PROPOSAL

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The Governor's proposal was never placed in legislation. It would have achieved universal coverage by mandating that all residents obtain health insurance. It also would have extended the Medi-Cal and Healthy Families eligibility, provided subsidies for other low-income individuals, required employers of 10 or more employees<sup>52</sup> that do not spend a minimum amount for coverage to pay a fee to the state, required that doctors and hospitals pay a fee, and established a purchasing pool to provide coverage for employees who work for firms that do not offer health insurance coverage.

### Who will be covered?

If the mandate is strictly enforced, this plan covers almost everyone. However, penalties have yet to be defined. Newly covered are estimated at 4.1 million

(more than three fourths of the uninsured). Adults and children with incomes below 100 percent of the FPL would be enrolled in Medi-Cal. All children in families with income between 100 and 300 percent of FPL would be covered by Healthy Families. Adults with income between 100 and 250 percent of FPL would be eligible for partially subsidized coverage after paying from three to six percent of gross income for premiums. Counties would have responsibility for ensuring access for undocumented immigrant adults who do not have other coverage. All employers would be required to establish Section 125 plans. Employers with 10 or more employees who do not provide coverage would pay a fee equal to four percent of payroll.

### **Portability of coverage**

Employer based covered would not be portable. However, those receiving coverage through the pool would have portable coverage. New coverage would always be available because no one could be denied coverage in the individual or group market.

### **Benefits**

The minimum services covered would be relatively comprehensive. However, there could be substantial cost sharing: a \$5,000 deductible and a maximum out-of-pocket of \$7,500 per individual or \$10,000 per family.

### **Administration**

The MRMIB would establish a purchasing pool to provide a cost-effective source of coverage for people eligible for subsidies plus some others. Health plans and insurers would be required to provide coverage on a guaranteed-issue basis in the individual and small-group market and would be limited in how much they can vary the rates. Insurers' administrative costs and profits could not exceed 15 percent of the premiums.

### **Financing**

Employers with more than 10 employees that do not offer coverage would be required to pay a fee equal to four percent of payroll. Hospital would pay a fee equal to four percent of net patient revenue and physicians would be assessed a fee equal to two percent of gross receipts. However, hospital and physician Medi-Cal payment rates would be substantially increased. Federal matching funds for Medi-Cal and Healthy Families would also be used. Counties would

be expected to pay to cover undocumented immigrants and return funds saved by not having to pay for other uninsured people.

### Key Trade-Offs

Even though this proposal would achieve universal coverage, it does so by mandating individuals to obtain health insurance. There are high costs with this program. Hospitals and physicians are required to pay fees, but provider rates would be increased. It includes some cost containment measures, but they may not be sufficient to control future cost increases. There is not much disruption to the status quo and the administrative burdens are modest, but not insignificant.

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### ABX1 1 – ASSEMBLYMEMBER NUNEZ AND GOVERNOR SCHWARZENEGGER

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Assemblymember Nunez and Governor Schwarzenegger reached agreement on this proposal that was introduced and passed the Assembly during the special session. They also filed an initiative for the November 2008 ballot that would ask voters to approve a majority of the \$14 billion to secure a better health system including some of the financing of ABX1 1. The bill would not take effect until the initiative was passed.<sup>53</sup> However, in late January the Senate Health Committee did not forward the legislation to the full Senate.<sup>54</sup>

This proposal, along with the voter initiative, required all Californians (with affordability-related exceptions) to acquire coverage, extends Medi-Cal and Healthy Families eligibility, provided tax credits for some, established a purchasing pool as a source of cost-effective coverage for employees of firms that do not offer coverage and others, revised insurance market rules, and required employers that do not offer coverage to pay a fee to the State. Before this proposal could have become operational voters would have to approve the plan in an initiative that has been filed with the hope to have sufficient signatures to appear on the November 2008 ballot.

### Who will be covered?

The program would extend coverage to 3.6 million, about 70 percent of the uninsured. Beginning July 2010, every resident would be required to maintain a minimum level of health insurance, as established by MRMIB. Exemptions to the mandate would be given to individuals or families, based on income levels and hardships. If families' incomes are at or below 300 percent of the FPL, children (regardless of immigration status) would be eligible for Healthy

Families. It also expands Medi-Cal coverage to parents and adults without children at home to 250 percent of FPL. It also extends tax credits to families between 250 and 400 percent of the FPL so the cost of coverage does not exceed 5.5 percent of income and to early retirees (ages 50 to 64). Newly covered are estimated to be approximately two thirds of the uninsured. All employers would be required to establish Section 125 plans.

### **Portability of coverage**

Portability of coverage would improve for low-income people, but it would remain the same for most people. Because coverage under the public programs is extended to higher income scale, fewer people would be faced with their eligibility status change as their incomes vary. New coverage would always be available because no one could be denied coverage based on age or medical condition. Prices of policies could be based upon age, family size and region of the state in which the insured lives.

### **Benefits**

The benefits for people newly eligible for Medi-Cal and Healthy Families would be comprehensive. MRMIB would determine the minimum level of coverage that residents would have to obtain. It would also require each insurance company to offer five different tiers of coverage. The most limited and low-cost policies would cover preventive care and routine physician visits but include a \$2,500 deductible for other services. The plan would also offer programs for smoking cessation, diabetes management and other issues as well as encourage the use of electronic health records.

### **Administration**

The current law, which requires health insurance carriers to provide coverage to firms with 50 or few employees on a guaranteed-issue basis and limits insurers' ability to vary rates, would be extended to employers with up to 250 employees. Insurers would be required to maintain a minimum medical loss ratio (the proportion of premium spent on health care services) of 85 percent.

The proposal includes an increase in the rates paid to Medi-Cal providers. The State would establish a purchasing pool, the California Cooperative Health Insurance Purchasing Program (CalCHIPP), administered by MRMIB.

## Financing

The plan would require all businesses to provide health care coverage or contribute toward a state pool for purchasing insurance. Employers that do not provide coverage and have payrolls:

- Up to \$250,000 would contribute 1 percent of payroll toward coverage;
- From \$250,000 to \$1 million would contribute 4 percent toward coverage;
- From \$1 to \$15 million would contribute 6 percent; and
- Above \$15 million would contribute 6.4 percent.

The plan would also be funded through a tobacco tax increase of \$1.75 per pack and a 4 percent tax on hospital revenue as a way to generate state revenues to increase rates paid by Medi-Cal. About \$5 billion is also anticipated in new federal funding for Medi-Cal. Counties would share in the cost for caring for medically indigent.

## Key Trade-Offs

Substantially more people are covered. The higher costs would be offset by an assessment on employers not offering coverage, hospital taxes, and increased cigarette taxes. There would be significantly more medical services consumed by newly insured. The administrative changes for government would be significant but relatively modest for insurers. This approach would not be highly disruptive to present practices and organizational structures, but it is uncertain if the provisions to contain costs would be sufficient to prevent longer-term cost escalation.

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## HEALTH CARE SCHOOL POOL STUDY

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The Task Force considered accessibility very specifically for California educators. CalSTRS plays no role in the health benefits provided to active CalSTRS members because unlike pensions, provision of health insurance is a collective bargaining issue addressed at the local district level. Each school employer provides health benefits to current employees and retired employees, if applicable. California school employers secure health insurance through a variety of different vehicles. Approximately 115 school districts contract with the California Public Employees' Retirement System health benefits program, known as the Public Employees Medical and Hospital Care Act or PEMHCA. Most districts join together to form trusts or joint power agencies to purchase health insurance as a large block. There also are districts that individually purchase their own health insurance.

Over the past several years, there have been efforts to create a statewide health benefits program in which all school employers would participate and provide coverage to retired school employees. The largest obstacle to this is that with 1,400 different school districts making their own decisions about the level of benefits provided, creating a single health benefits program that would appeal to everyone would be very difficult to accomplish.

In the 2006 CalSTRS health care survey, 51 percent of the responding employers indicated that they would be interested in participating in a statewide pool for health insurance. Districts that indicated a desire to participate in a statewide pool were asked to rank their reasons to participate in such a pool. In order of descending importance, their responses were the following:

- Potential for lower employer and employee costs;
- Possibility of lower co-payments or deductibles;
- More types of health plans or insurance carriers available;
- More potential vendors which would mean more options for employees; and
- Elimination of administrative burden.

Thirty seven percent of the responding employers indicated that they were not interested in participating in a statewide pool primarily because they either are already in a pool (such as a trust) or they did not want to give up control over the benefit structure. Thirteen percent either did not respond to the health care question or were not sure if they would be willing to participate in a pool.

Chapter 708, Statutes of 2005 (AB 256—De La Torre) required CalPERS, in consultation with CalSTRS, to conduct a health care school pool study to examine the feasibility and cost-effectiveness of creating a single statewide health care pool that would cover all public school active and retired employees working in school districts, county offices of education, community colleges.

A Mercer representative provided an oral presentation and the Task Force reviewed the report at its April 2008 meeting. Rather than delay the submission of the full report, the Task Force deferred making any findings or recommendations concerning accessibility pending a more thorough review of the study. In addition, it is interested in hearing from the California Education Coalition for Health Care Reform about its efforts to develop more specific details about a possible program.

# VI

## Improving the Affordability of Health Care

The Task Force concentrated on the third charge from the Board: affordability. It considered various approaches that CalSTRS could take to assist members with the affordability of health care, particularly a tax-free health benefit if possible. Because the biggest concern is that few retired members receive employer assistance for health benefits after age 65, the Task Force focused on programs that would be helpful to this group.

In its deliberation, the Task Force realized that employers are already taking a broad range of actions and that none of the options selected would apply equally to all school districts or even to all members. Accounting and bargaining at the district level could be more complicated by some of the proposed programs.

In evaluating each possible benefit, five issues were considered by the Task Force:

- How much will the program provide in benefits?
- How much will the program cost, as determined by the System Actuary?
- Will the benefit be made available to current and future active members?
- Will the benefit be made available to current and future retired members?
- What, if any, eligibility requirements, including minimum years of service and age at distribution, will there be?

The four programs on which the Task Force focused were: payment of monthly health allowances, payment of Medicare Part B premiums, medical purchasing power payments, and health care security accounts. On-going costs for the benefits would be supported by district, member or redirection of future State contributions. The costs to develop these programs would come from a redirection of employer Defined Benefits contributions and reimbursements to the fund.

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## ADMINISTRATION OF THE PROGRAMS

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CalSTRS already has the capability to administer a portion of all four programs. The collection and tracking of contributions and earnings during the members' employment are very similar to functionality required for the pension programs currently administered by CalSTRS. However, there would be some cost to make required IT modifications.

The second administrative component is paying insurance deductions or paying claims from the monthly health allowances, medical purchasing power payments or health care security accounts. If allowable medical expenses are very limited, such as for the payment of health benefit premiums only, CalSTRS staff could administer that responsibility in a cost-effective manner, although additional staff would be required. Such a restriction would, however, severely limit the value of the programs and is not favored by the Task Force. This limitation would prevent members from using the addition funds to pay deductibles, co-payments and other out-of-pocket expenses. The Task Force prefers to permit maximum use of the programs by allowing program funds to reimburse any medical expense that is deductible under the Internal Revenue Code. Processing such claims would impose a substantial workload, and duties that are not comparable to any currently held by CalSTRS staff. Therefore, it is expected that CalSTRS would contract with an outside entity with this expertise to process claims, monitor expenditures against the allowance and make reimbursements to the members. The costs of such an arrangement will be determined prior to the introduction of any formal legislative proposal.

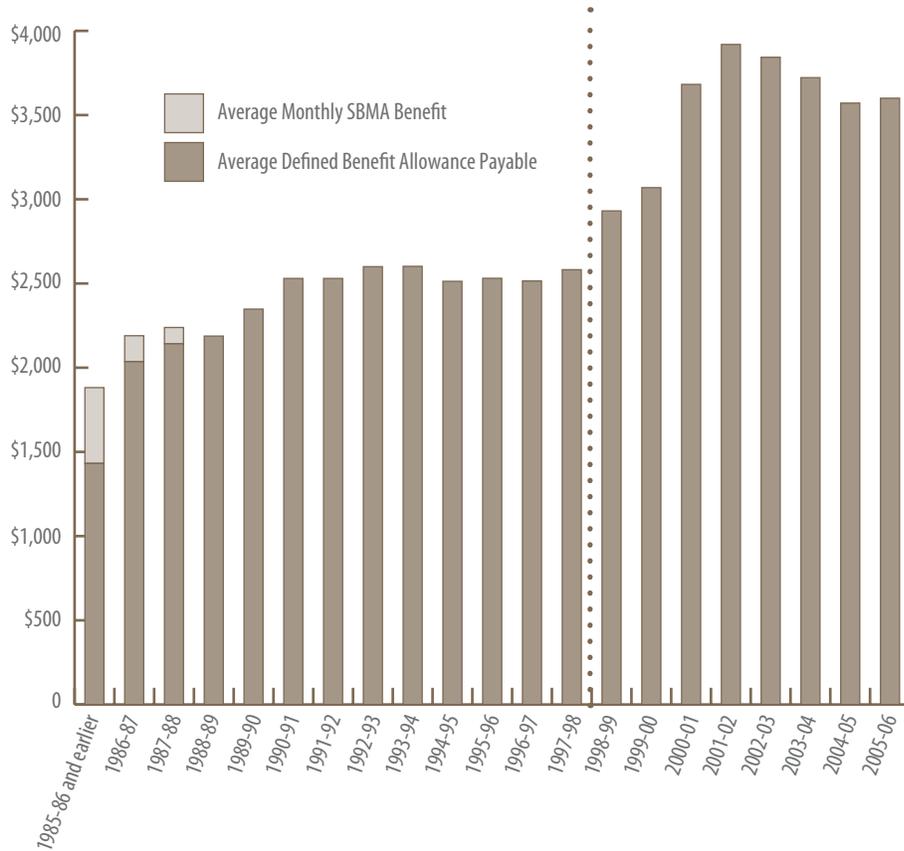
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## MONTHLY HEALTH ALLOWANCES

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The benefit is a specific dollar amount or allowance per month that would be available to retired members with the use of the funds limited to allowable medical expenses. Initially, the Task Force recommends adoption of this program with a benefit of \$100 per month, representing the approximate amount required to pay the Medicare Part B premium, for members who retire after implementation of the program. The benefit would be \$300 per month for retired members who retired in 1999 or after. This amount represents the approximate amount required to pay a Medicare supplement insurance premium. The benefit increases to \$400 per month for members who retired prior to 1999 recognizing the higher benefits being paid to members who retired after 1998 due to legislated benefit enhancements.

### Members Retiring Before 1999 Have Fewer Resources to Pay for Health Care



The Task Force's goal is to reach a benefit of \$300 per month for presently active members when they retire and reach age 65. However, costs, particularly employer contributions, are high for immediate implementation. Therefore, the Task Force recommends starting with a lesser benefit with a plan to increase active members' benefit over time.

The base monthly health allowance per month would be available to members depending on their years of service. Members with 10 years of service would receive 25 percent of the base monthly health allowance. Approximately 90 percent of the retired members have 10 or more years of service. The benefit would increase 2.5 percentage points per year until members with 20 years service would receive 50 percent of the base. Approximately 70 percent of the retired members have 20 years of service. At that point, the allowance would increase five percentage points for each year of service until the maximum 100 percent of base monthly allowance at 30 years of service. Service credit used to determine monthly health allowance eligibility would be the same as

used for the career factor and longevity bonus. For example, up to .2 years of sick leave could be used. A member could not buy “air time” to count as years of service for this benefit.

Allowances would be made available when members reach age 65 and increase annually by the lesser of a determined medical care component of the CPI, or five percent. The increase in the benefit would be compounded. If the increase is less than five percent, the unused portion would be available for the future. The following table illustrates the allowance amounts for future years assuming the maximum of a five percent increase per year.

#### Projected Monthly Health Allowances

	Retired <i>prior to 1999</i>	Retired <i>in or after 1999</i>	Presently Active
Year 1	\$400	\$300	\$100
Year 3	441	330	110
Year 7	563	422	141

Medical inflation rates vary throughout California with health care costing more in the northern half of the state. Approximately 60 percent of our members live in the southern half of the state. Therefore, the increase of the medical care components of the Los Angeles-Riverside-Orange County CPI and the San Francisco-Oakland CPI would be weighted on a 60/40 percent basis.

Retired members would be allowed to designate a beneficiary to receive their monthly health allowance. Members would be given as much latitude as possible in selecting their beneficiary including the ability to designate a different beneficiary than they choose for their Defined Benefit. Similar to their DB benefit, members could choose a 100, 75, or 50 percent option, with the members’ monthly health allowance reduced in equivalent fashion to DB benefit. Beneficiaries would not have access to the monthly health allowances until they reach age 65.

The benefit will be treated the same way as the longevity bonus, in which the amount due to a member due to service earned, even if segregated, gets distributed proportionately pursuant to a divorce decree.

The member can also designate a death beneficiary to receive funds remaining in the account if the member dies without a beneficiary or when both the member and the beneficiary die. There will likely be tax consequences for this death beneficiary or if the funds are placed in a member’s estate.

### Projected Monthly Health Allowances

Years of service	% of Base	Presently Active			Retirement <i>1999 or later</i>			Retirement <i>Prior to 1999</i>		
		Year			Year			Year		
		1	3	7	1	3	7	1	3	7
		\$100 Base	\$110 Base	\$141 Base	\$300 Base	\$331 Base	\$422 Base	\$400 Base	\$441 Base	\$563 Base
10	25.0%	\$25	\$28	\$35	\$75	\$83	\$106	\$100	\$110	\$141
11	27.5	28	30	39	83	91	116	110	121	155
12	30.0	30	33	42	90	99	127	120	132	169
13	32.5	33	36	46	98	108	137	130	143	183
14	35.0	35	39	49	105	116	148	140	154	197
15	37.5	38	41	53	113	124	158	150	165	211
16	40.0	40	44	56	120	132	169	160	176	225
17	42.5	43	47	60	128	141	179	170	187	239
18	45.0	45	50	63	135	149	190	180	198	253
19	47.5	48	52	67	143	157	200	190	209	267
20	50.0	50	55	71	150	166	211	200	221	282
21	55.0	55	61	78	165	182	232	220	243	310
22	60.0	60	66	85	180	199	253	240	265	338
23	65.0	65	72	92	195	215	274	260	287	366
24	70.0	70	77	99	210	232	295	280	309	394
25	75.0	75	83	106	225	248	317	300	331	422
26	80.0	80	88	113	240	265	338	320	353	450
27	85.0	85	94	120	255	281	359	340	375	479
28	90.0	90	99	127	270	298	380	360	397	507
29	95.0	95	105	134	285	314	401	380	419	535
30	100.0	100	110	141	300	331	422	400	441	563

The table above shows the proposed monthly health allowance dollar amount for each year of service for the first, third and seventh year of the program assuming the maximum five percent increase in benefits each year. Monthly dollar amounts are rounded to the nearest dollar.

Members would not get a monthly health allowance check each month or quarter, but would submit paperwork to get premiums paid or reimbursements for allowable expenses. Unused funds in one month could be accumulated for later use. However, each member's account would not gain interest. CalSTRS would retain the interest thereby reducing the cost of the program.

The funds in the monthly health care allowance could be used for any allowable health care costs which are deductible under the Internal Revenue Code and listed in IRS Publication 502, *Medical and Dental Expenses*. Insurance premiums including health, dental and Medicare Part B premiums and expenses such as deductibles and co-payments are allowed. Long-term care insurance premiums, with some limitations, can also be paid from a monthly health allowance. Many other expenses, such as for dental treatment, special equipment or to modify a home, hearing aids, medicines, glasses, and some transportation costs are also allowable. However, there are some expenses that cannot be reimbursed. Examples include health club dues, household help, nonprescription medicines and prescriptions from other countries.

Medical expenses paid for a spouse or a dependent can also be paid from a monthly health allowance if the person was the member's dependent either at the time the medical services were provided or at the time the medical expenses are paid. A person generally qualifies as a dependent for purposes of the medical expense deduction if the person was a qualifying child or a qualifying relative, and was a U.S. citizen or national or a resident of the United States, Canada, or Mexico.

Regular payments, such as insurance premiums, will be established as monthly payments without a separate request each month. For example, CalSTRS could pay Medicare premiums directly to the Centers for Medicare and Medicaid Services, the federal agency that administers Medicare. If funds were used for other health care premiums, such as Kaiser or Blue Shield, CalSTRS would send the payment to the insurance carrier. Members would be required to submit requests for payments, with receipts for non-regular payments. A total expense of \$100, or some designated amount, would be required prior to the member receiving payment, but members could request reimbursement up to the maximum in his or her account at any interval.

### Cost

The Task Force proposes that the cost of this benefit for members who are currently active, or will be active in the future, would be paid from an increase in the employer contribution. Employee contributions cannot be used without affecting the tax favorable status of the program. The impact on members of that increased contribution would be dealt with through the collective bargaining process. The assumptions used by the actuary are included in the appendices. The contributions required to fund the benefit for those currently retired would be paid by the State. One way to accomplish this would be to reduce the state's current contribution to Supplemental Benefit Maintenance

Account (SBMA) and redirect that reduction to pay for this benefit. Under this scenario, the State would not make a larger contribution to the SBMA, but there would be less funds coming into the SBMA.

It was determined that the required reduced contribution to SBMA would not affect the viability of the SBMA to continue the *present* purchasing power program at 80 percent (under the present assumptions of 3.25 percent rate of inflation, an eight percent investment return, and the DB plan's normal mortality assumptions about our membership). However, the margin of error is small. We estimate that there is only a 43 percent probability of being able to sustain the current 80 percent purchasing power benefit for 75 years if the cost of the monthly health allowances for existing retired members is paid by redirecting some of the State's SBMA contributions.

Redirecting the State's contribution to the SBMA may no longer be realistic because proposals to raise purchasing power protection are being considered. Unfortunately, if purchasing power is increased, it is not likely that this benefit could be paid by the SBMA.

The table below shows the benefits and the source of funds for proposed monthly health allowances.

#### Monthly Health Allowance Benefits and Source of Funds

Date of Retirement	Maximum Benefit (Scaled by years of service)	Source of Funds	Notes
Pre-1999	\$400/m	State Contribution or redirection of SBMA funds	
1999 to the date of the implementation of the program	\$300/m	State Contribution or redirection of SBMA funds	
After the date of the implementation of the program	\$100/m	Employer Contributions	Benefit to be increased up to \$300/month based on targets

The Task Force would like to increase the monthly health allowance for members who retire after the implementation of the program to \$300 per month, but recognizes that establishment of this benefit at this higher level would

require a significant increase in employer contributions, which is not viable immediately. Therefore, it is acceptable to initially implement this program at a lesser amount with a plan to more forward to increase active members' benefit over time.

Below is a table showing the increase in the required contribution for the benefit. It assumes an inflation rate of five percent. It shows the cost for \$300 for all retired members, the cost of the additional \$100 for members who retired prior to 1999 and the cost of a \$100 benefit for active members. The second portion of the table shows the required contributions for a lesser benefit: \$200 per month for all retired members with the additional \$100 per month for members who retired prior to 1999 and a \$50 per month benefit for active members.

#### Increase of Contributions (as Percent of Payroll) for Monthly Health Allowances

Group	Retired Members			Active Members	All Members
	All retired members	Retired prior to 1999	All	Retire after 2007	Total Cost
Monthly Benefit Amount	\$300	Additional \$100		\$100	
Cost	1.470%	0.247%	1.717%	1.788%	3.505%
Monthly Benefit Amount	\$200	Additional \$100		\$50	
Cost	0.980%	0.247%	1.227%	0.894%	2.121%

For retired members, there is no employer contribution, just a State contribution. Further, there will be a time in the future, when the State will no longer have to make contributions for members who are already retired because this is a finite group.

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## MEDICARE PART B PREMIUM PAYMENT

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This program was designed for Defined Benefit Program retired members (both service and disability) with no benefit paid before age 65. Those few members who receive Medicare before age 65 would not receive the benefit until age 65. To avoid the unintended impact of encouraging early retirement because members must be retired in order to get the benefit, the program could be designed to apply only to currently retired members or members within 10 years of normal retirement age.

A percentage of the Medicare Part B *base* premiums would be paid based on the years of service, similar to the schedule proposed for the monthly health allowance. It is important to be specific about using the base Medicare premium because under the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Medicare beneficiaries with higher incomes must pay higher Medicare Part B premiums. For example, in 2008 a Medicare beneficiary who made between \$82,000 and \$102,000 in 2006 must pay \$122.20 rather than \$96.50 per month for the Medicare Part B premium. The Task Force felt strongly that CalSTRS should not pay additional premiums for members with higher incomes.

CalSTRS would pay 25 percent of the base monthly Medicare Part B premium for members with 10 years of service. The portion of the premium paid would increase 2.5 percentage points of the premium per year to 20 years. CalSTRS would pay 50 percent of the base monthly premiums for members with 20 years service. At that point, the allowance would increase five percentage points for each year of service until the maximum 100 percent of the base premium is paid for members with 30 years of service. The unreimbursed portion of the Medicare Part B premiums would be deducted from the members' retirement allowances.

The following illustration shows the portion of the Medicare Part B premium that would be paid under the program based on the 2008 Medicare Part B premium of \$96.40 per month and assuming a five percent increase in premiums each year.

### Projected Medicare Part B Payment Based on Years of Service

		2008	2010	2014
		Base Monthly Premium		
Years of service	% of Base Premium	\$96.40	\$106.30	\$135.60
10	25.00%	\$24.10	\$26.58	\$33.90
11	27.50	26.51	29.23	37.29
12	30.00	28.92	31.89	40.68
13	32.50	31.33	34.55	44.07
14	35.00	33.74	37.21	47.46
15	37.50	36.15	39.86	50.85
16	40.00	38.56	42.52	54.24
17	42.50	40.97	45.18	57.63
18	45.00	43.38	47.84	61.02
19	47.50	45.79	50.49	64.41
20	50.00	48.20	53.15	67.80
21	55.00	53.02	58.47	74.58
22	60.00	57.84	63.78	81.36
23	65.00	62.66	69.10	88.14
24	70.00	67.48	74.41	94.92
25	75.00	72.30	79.73	101.70
26	80.00	77.12	85.04	108.48
27	85.00	81.94	90.36	115.26
28	90.00	86.76	95.67	122.04
29	95.00	91.58	100.99	128.82
30	100.00	96.40	106.30	135.60

On the next page is a table showing the increase in the required contribution assuming a five percent medical inflation rate and based on the current basic Medicare Part B premium of \$96.40 per month. The required increased contribution for currently retired members assumes benefits would be paid to members who retired on or before January 1, 2008. A benefit paid to members currently retired would be funded by the State.

### Contributions Required for Payment of Medicare Part B Premiums

Payment of Basic Medicare Part B Premiums	Required Increased Contribution
All members with 20+ years	1.047%
All members with 10+ years	1.161
Currently retired members with 20+ years	0.227
Currently retired members with 10+ years	0.252

The Task Force acknowledges that Federal action with regards to Medicare is unknown and could affect the Medicare program proposed here. Therefore, any action taken with regards to Medicare should be for a short-term program.

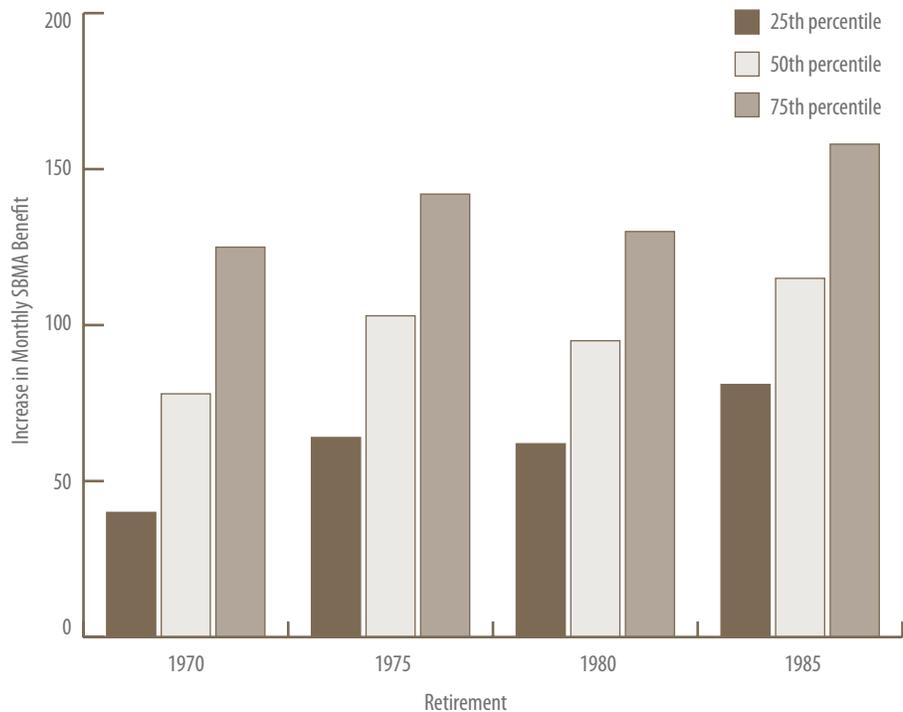
### MEDICAL PURCHASING POWER PAYMENT

The program is designed so that members would receive a health benefit allowance when the purchasing power of their current Defined Benefit allowance is reduced below 85 percent of initial allowance. The present 80 percent purchasing power applies to members who retired in 1988 and earlier. An 85 percent level would apply to those who retired in 1990 or earlier. One option would be to increase the allowance to a 90 percent level for those retired prior to 1999. Health benefit allowances could be applied to any allowable medical expense. Similar to the present purchasing power payment, the increase would be made available quarterly.

The benefit would be guaranteed only to the extent that funds in SBMA were available to pay the benefits. Increasing the payments from the SBMA increases the probability that funds will not be sufficient to pay the higher benefit.

The Task Force is not enthusiastic about this option because, as shown on the graph on the next page, the oldest and least compensated retired members receive less. Therefore it does not provide significant assistance toward their health care costs.

### Impact of 85 Percent Purchasing Power



## HEALTH CARE SECURITY ACCOUNTS

The major advantage of health care security accounts is the tax advantage. Both contributions and distributions are tax free if the distributions are spent on allowable medical expenses. The program would be geared for current and future employees. All employees performing creditable service would participate in this program. Because health security accounts primarily benefit members who have sufficient time to accumulate funds, it creates the need for a separate program to assist retired members and active members approaching retirement.

Individual accounts with immediate vesting would be established for each employee. These accounts would be subject to a minimum interest rate set by the Teachers' Retirement Board prior to the fiscal year. Similar to the Defined Benefit Supplement Program and the Cash Balance Benefit Program, the Board would also have authority to add earnings credit.

Contributions must be paid by employers because voluntary employee contributions cannot be tax-free. The employer contribution percentage would be based on all compensation creditable to the program. Staff suggested a mandatory minimum contribution rate of one percent for all eligible employees to ensure that there was sufficient participation to warrant the administrative

expense of developing the program. Increases in contributions would be in one percent intervals for ease of CalSTRS' administration. To ensure equity, the contribution rates paid for classroom teachers could not be lower than the rate employers paid for any other employee. If necessary, contributions could be flat dollar amounts instead of percentages. Funds on account until age 60 continue to accrue investment interest.

Account distribution would be made upon retirement or disability. Employees would be required to make an irrevocable election at the time of distribution. The employee could receive lifetime medical benefits at a constant amount that would be annuitized similar to Defined Benefit Supplement and Cash Balance. As a second option, the employee could begin to draw down funds as needed. In this case, once an account is expended, the member could make no further claims.

Upon the members' death, the funds could be used to pay allowable medical expenses for surviving dependents. If there are no surviving dependents, funds would be distributed to the members' estate, but it would be a taxable event.

If a member leaves the system prior to retirement or disability, distribution could be made at age 60 or 65. The program could be designed to not allow distributions until age 65, which would result in more money being available to the member because there is more investment interest accrued. Because non-CalSTRS members could participate, additional coordination would be required for distribution to these employees.

Staff determined the contribution rate to pay \$400 per month (in 2007 dollars) and account value at age 65 (in current dollars). The examples including members beginning to work at ages 25, 30, 35 or 45, retiring at age 61, no distributions until age 65, and living to age 85. There were three medical inflation levels (4.5 percent, 6 percent or 7.5 percent) and three account crediting rates (6 percent, 7 percent or 8 percent).

Contribution rates ranged from 2.24 percent for the member starting at age 25 with the lowest medical inflation rate and the highest interest rate to over 32 percent for a member who started making required contributions at age 45 with the highest inflation rate and the lowest interest rate.

### Health Security Account Costs

Rate = Required Contribution Rate

Value = Account Value at Age 65

Dollars in thousands

	4.5% Medical Inflation			6% Medical Inflation			7.5% Medical Inflation		
	Interest								
	6%	7%	8%	6%	7%	8%	6%	7%	8%
<b>Age 25</b>									
Rate	4.04%	3.02%	2.24%	8.21%	6.10%	4.51%	16.64%	12.29%	9.06%
Value	\$525.6	\$484.7	\$446.9	\$1,067.4	\$975.1	\$899.8	\$2,163.5	\$1,972.6	\$1,807.5
<b>Age 30</b>									
Rate	5.13%	3.92%	3.00%	9.70%	7.39%	5.62%	18.33%	13.89%	10.51%
Value	\$421.9	\$388.0	\$359.1	\$797.7	\$731.4	\$672.7	\$1,507.3	\$1,374.7	\$1,258.0
<b>Age 35</b>									
Rate	6.82%	5.34%	4.19%	12.02%	9.37%	7.31%	21.16%	16.42%	12.75%
Value	\$338.5	\$311.4	\$288.0	\$596.5	\$546.4	\$502.5	\$1,050.1	\$957.5	\$876.4
<b>Age 45</b>									
Rate	13.81%	11.35%	9.36%	21.09%	17.26%	14.17%	32.27%	26.28%	21.47%
Value	\$218.0	\$200.5	\$185.4	\$332.9	\$305.1	\$280.7	\$509.4	\$464.6	\$425.4

# VII Recommendations

As requested by the Teachers' Retirement Board, the Task Force focused on three issues: compliance with Governmental Accounting Standards Board disclosure requirements, accessibility to health care, and affordability of health care. Further, the Task Force worked under the Board's earlier determination that it was not appropriate for CalSTRS to provide health insurance, but that it might finance health insurance in the future when funds became available.

Because CalPERS was successful in pursuing legislation to give it the authority to extend assistance to comply with GASB standards to all public employers, including school districts, the Task Force felt that it is not necessary for CalSTRS to provide similar services. As a result, it elected not to focus on this issue. The Task Force also deferred any action at this time on recommendations concerning accessibility pending a more thorough review of the health care school pool study conducted by CalPERS, in consultation with CalSTRS.

The Task Force concentrated on various approaches that CalSTRS could take to assist members with the affordability of health care, particularly a tax-free health benefit if possible. Because the biggest concern is that few retired members receive employer assistance for health benefits after age 65, the Task Force focused on programs that would be helpful to this group. The four programs on which the Task Force focused were: payment of a monthly health allowances, payment of Medicare Part B premiums, medical purchasing power payments, and health care security accounts.

Funding any additional benefits will be difficult, particularly in these times of state budget deficits and limited resources for school districts. However, the Task Force wants to move forward on its proposal with the full appreciation that action will likely be delayed until an appropriate funding mechanism can be developed.

**The Task Force recommends adoption of monthly health allowances.** The benefit is a specific dollar amount or allowance per month that would be paid to retired members with the use of the funds limited to allowable medical expenses. The Task Force recommends adoption of this program with an initial benefit of \$100 per month for currently active members, \$300 per month for members who retired in 1999 and later, and \$400 per month for members who retired prior to 1999. The reason for the higher payments for those retiring prior to 1999 is to provide some pension equity to those members who retired prior to benefits enhancements. One hundred dollars represents the approximate amount required to pay the Medicare Part B premium, while \$300 per month represents the approximate cost of a Medicare supplemental plan. The Task Force envisions this as a required, not voluntary, program in which all districts, and therefore all eligible members would be covered.

The Task Force chose the monthly health allowance over other possible benefits because it allows members maximum flexibility. The program provides portability for the members. Service credit includes all the time members are within CalSTRS, not limited to the time in one district. The expense of Medicare Part B premiums is just one of scores of expenses that are allowed as defined by the Internal Revenue Code. The cost of administering one large program is likely to be smaller per capita than the cost associated with multiple programs run by individual districts. This program also helps a bit with pre-funding a benefit and there is no GASB implication for districts. Further, this meets the Task Force's goal of providing a tax-free benefit to members and is designed to assist the members that need to most support, those who retired prior to 1999. It also does not encourage early retirement because members cannot make a decision to retire earlier.

CalSTRS already has the capability to administer the collection and tracking of contributions and earnings during the members' employment because it is very similar to the functionality required for the Defined Benefit program. However, there would be some cost to make required IT modifications. The second administrative component, paying claims from the monthly health allowance once the retired member reaches age 65, is outside of CalSTRS' normal scope. To address potential workload implications of this recommendation, the Task Force also recommends that CalSTRS contract with an outside entity with this expertise to process claims, monitor expenditures against the allowance and make reimbursements to the members. The costs of such an arrangement will be determined prior to the formal legislative proposal.

**The Task Force does not endorse the other three programs that it considered seriously.** The Task Force determined that payment of Medicare Part B premiums is its second choice because it is so limited. Expenses for many medical expenses, including payment of Medicare Part B premiums can be reimbursed as part of monthly health allowance. In addition, the Task Force was concerned about establishing a benefit with uncertain future costs. Health care costs, including Medicare Part B premiums, have increased much more than inflation. For example, the Medicare Part B premium has increased almost 93 percent since 2001 when CalSTRS' Medicare Premium Payment Program started.

The Task Force is not enthusiastic about Medical Purchasing Power Payment because it does not provide significant assistance to the oldest and least compensated retired members for their health care costs. The Task Force rejected health security accounts because they primarily benefit members who have sufficient time to accumulate funds thereby creating the need for a separate program to assist retired members and active members approaching retirement. Additionally, the cost is very high. However, this may be a benefit that the Board will want to consider at a later time to assist presently active members accumulate funds to cover health care costs.

### Future Actions

If the Board chooses to proceed with the Task Force recommendation, the following additional steps are suggested.

- Prior to further development of the monthly health allowance program, the Task Force requests that CalSTRS gather additional feedback about specific design elements and likely acceptance from employee and employer groups.
- In addition CalSTRS will secure a ruling from the IRS to ensure that members' tax status is not adversely affected by providing monthly health allowances.
- Staff will refine administrative requirements and associated costs.
- Staff recommend that establishment of monthly health allowance be incorporated into the larger funding strategy, rather than on a separate track. However, staff could begin to develop the specific legislation that would be required to establish the recommended program.

The Public Education Health Benefits Task Force also plans to thoroughly review the health care school pool study and may make recommendations concerning accessibility. In addition, the Task Force will continue to monitor the status of national and state health care legislation.

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## Endnotes

- <sup>1</sup> Public Employee Post-Employment Benefits Commission, (2008, January) Funding Pensions & Retiree Health Care for Public Employees, p. 19.
- <sup>2</sup> Ibid, p. 5.
- <sup>3</sup> Center for Collaborative Solutions. (2007, June 25) Release: Public Education Lab-Management Partnership Secures Two Grants To Continue Healthcare Efforts.
- <sup>4</sup> Hulse, W. E. (1987, December) Health Care Benefit Program: An Overview Discussion of Issues and Concerns, Prepared in Response to Recent Health Care Benefits Proposals, California State Teachers Retirement System, p. 27.
- <sup>5</sup> Ibid, pages D-5 through D-34.
- <sup>6</sup> CalSTRS, (2001, May) A Review Of Potential Health Care Benefit Programs Provided by The California State Teachers' Retirement System, p. 3.
- <sup>7</sup> Ibid, page 5.
- <sup>8</sup> Ingram, R., Schlotz, J., and Young, C., School Management and Labor Unions Together Are Attacking Escalating Healthcare Costs, presentation to the California Public Education Health Benefits Task Force on September 15, 2006.
- <sup>9</sup> Markov, J. L., (2007, March 16) Elk Grove Unified School District, Retiree Health Benefits, EGBERT, presentation to the CalSTRS Public Education Health Benefits Task Force.
- <sup>10</sup> Smith, T.L., (2006, September 25) California Debt and Investment Advisory Commission "Revealing OPEBs in Your Financials: Where the Rubber Meets the Road". California Case Studies: Peralta Community College District \$150,000,000 2005 OPEB Bonds.
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- <sup>12</sup> California Public Employees' Retirement System (2008, January). List of Agencies Participating in the Trust. Retrieved on March 8, 2008 from the CalPERS website at <http://www.calpers.ca.gov/index.jsp?bc=/employer/retiree-ben-trust/list-part-agencies.xml>.

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<sup>14</sup> Centers for Medicare and Medicaid Services (2008, January). CMS Reports U.S. Health Care Spending Growth Accelerated Only Slightly in 2006. Retrieved on January 8, 2008 on the CMS website at <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=2810&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date>

<sup>15</sup> Keehan, S., Sisko, A., Truffer, S., Smith S., Cowan, C., Poisal, J., Clemens, M.K., and the National Health Expenditure Accounts Projections Team, (2008, February 26) Health Spending Projections Through 2017: The Baby-Boom Generation Is Coming to Medicare. Retrieved on February 28, 2008 from the Health Affairs website <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.27.2.w145v1>

<sup>16</sup> Mulkey, M., California HealthCare Foundation (2007, June) Health Care Reform 2007: Defining The Problems, Examining Proposed Solutions. Speech presented to the California Teachers' Retirement Board, Sacramento, CA., slides 10 and 11.

<sup>17</sup> Klesius, M. (2007, June). Life After 50 Is Getting Longer and Longer, AAPR Bulletin, p. 39.

<sup>18</sup> Society of Actuaries, Annuity 2000 Mortality Table. Retrieved on June 11, 2007, from Fidelity Investments.

<sup>19</sup> Fronstin, P. (2007, January). Health Insurance Coverage of the Near Elderly, 1994-2005: and IRA Assets, Contributions, and Market Share. Employee Benefit Research Institute Notes (Vol. 28 No. 1).

<sup>20</sup> Plan Sponsor, (2008, March 5) Retiree Health-Care Costs Up 4.7% in 2008. Retrieved on March 7, 2008 from [http://www.plansponsor.com/pi\\_type10\\_print.jsp?RECORD\\_ID=40564](http://www.plansponsor.com/pi_type10_print.jsp?RECORD_ID=40564)

<sup>21</sup> Fronstin, P. (2006, July). Savings Needed To Fund Health Insurance and Health Care Expenses in Retirement. Employee Benefit Research Institute Issue Brief (295).

<sup>22</sup> California HealthCare Foundation, Snapshot California Uninsured, 2007., p. 2.

- <sup>23</sup> Ibid.
- <sup>24</sup> Mulkey, 2007, slide 9.
- <sup>25</sup> Cantor, J.C., Belloff D., Schoen C., How S.K.H., & McCarthy, D. (2007, June) Aiming Higher Results from A State Scorecard on Health System Performance, p.5.
- <sup>26</sup> Ibid, p. 8.
- <sup>27</sup> Ibid, p. 11.
- <sup>28</sup> Ibid, p. 10.
- <sup>29</sup> Ibid, p. 16.
- <sup>30</sup> Ibid, p. 17
- <sup>31</sup> Simmons, H. 2006, p. 5.
- <sup>32</sup> Mulkey, 2007, slides 14-24.
- <sup>33</sup> Community Catalyst. (2007, December) Revisiting Massachusetts Health Reform: 18 Months Later. p. 6.
- <sup>34</sup> Wright, A. (2006, June) Massachusetts' Health Care Law: Model, Mirage, or Momentum? Health Access Foundation.
- <sup>35</sup> Community Catalyst. p. 6.
- <sup>36</sup> Ibid.
- <sup>37</sup> Ibid, p. 4.
- <sup>38</sup> Ibid, p. 6.
- <sup>39</sup> Ibid, pp. 4 and 5.
- <sup>40</sup> Ibid.
- <sup>41</sup> CaliforniaHealthline (2008, February 4) Cost of Massachusetts Health Overhaul to Double Over Three Years. Retrieved on February 4, 2008 from CaliforniaHealthline website at <http://www.californiahealthline.org/articles/2008/2/4/Cost-of-Massachusetts-Health-Overhaul-To-Double-Over-Three-Years.aspx?topicID=37>
- <sup>42</sup> Seward, Z. M. (2007, July 25) Doctor Shortage Hurts a Coverage-For-All Plan. Wall Street Journal, pp B1-B2.
- <sup>43</sup> Centers for Medicare and Medicaid Services. Health Insurance Flexibility and Accountability Demonstration Initiative Retrieved on July 25, 2007 from the CMA website.

<sup>44</sup> CaliforniaHealthline, (2007, December 17) Indiana to Offer Health Savings Accounts to Low-Income Residents, Retrieved on December 17, 2007

<sup>45</sup> The Indianapolis Star (2007, December 28) Thousands Enroll in New Health Plan. Retrieved from <http://www.indystar.com/apps/pbcs.dll/article?AID=/20071228/LOCAL19/712280446&t>

<sup>46</sup> Michigan Universal Health Care Access Network website <http://michuhcan.com/AboutUs.aspx> . Retrieved on December 28, 2007.

<sup>47</sup> Detroit Free Press. (2007, December 19) Petition to Ask Michigan Voters to Pass Universal Health Care. Retrieved on December 20, 2007.

<sup>48</sup> State of New Jersey Office of the Governor. (2007 December 19) Governor Corzine Expands Access to NJ FamilyCare Program. Retrieved on December 28, 2007 from <http://www.nj.gov/governor/news/news/approved/20071219a.html>

<sup>49</sup> Real-Time News: New Jersey news 24 hours, everyday (2007, December 18). NJ to Offer Low-Cost Health Care for Uninsured Kids. Retrieved on December 20, 2007 from [http://www.nj.com/news/index.ssf/2007/12/nj\\_to\\_announce\\_families\\_can\\_bu.html](http://www.nj.com/news/index.ssf/2007/12/nj_to_announce_families_can_bu.html)

<sup>50</sup> Naymik, M. (2007, July 27) Ohio Health Insurance Plan Proposed. The Plain Dealer. Retrieved on July 27, 2007.

<sup>51</sup> Most of the information on SB 840, AB 8, and the Governor's proposal comes from Elliot Wicks' Framework Assessment of Major Health Reform Proposal in California, prepared for the California HealthCare Foundation, June 2007 with revisions in July 2007.

<sup>52</sup> For perspective purposes, there are approximately 40 California school districts that employ fewer than 10 employees.

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<sup>54</sup> Most of the information about ABX 1 1 comes from Wicks, E.K. (February 2008) Framework Assessment of ABX1 1 (as Considered and Rejected by the Senate Health Committee on January 28, 2008) Retrieved on February 11, 2008 at <http://www.calhealthreform.org/>.

## VIII

## Appendices

**A. List of Participants**Health Benefits Task Force Members

*(All individuals who attended one or more of the meetings are listed.)*

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Joe Dion, CRTA

Jonathan Lightman, FACCC

Karen Russell, *CTA Retired*

Ken Marzion, *CalPERS*

Kenya Spearman, *CTA – Retired*

Lee Jernigan, CRTA

Linda Protine, CCSESA

Lois Shive,  
*Southern Calif. Schools VEBA*

Loretta Toggenburger,  
*UTLA-Retired*

Lori Easterling, CTA

Malcolm Tucker, *CRTA Legislative*

Mark MacDonald, *LACFG*

Mark Quillici, *CalPERS*

Marvin Talso,  
*Self Funded Health Ins. Rep.*

Mel Roseman

Michael Crass

Naomi Hyman, *ART*

Pat Geyer, *CRTA*

Pat Miller-Fee, *CTA*

Patrick McCallum,  
*LA Faculty Guild, AFT 1521*

Richard Hansen, FACCC  
 Richard Krolak, CalPERS  
 Ruben Ingram, SEAC and ACSA  
 Rusty Selix, ART  
 Sal Villasenor, ACSA  
 Sam Kresner, CTLA  
 Sam Lucero,  
*Southern Calif. Schools VEBA*  
 Sandy Keaton, UTLA  
 Stephanie Cain,  
*SFUSD Labor Relations*  
 Steve Depue, CTA – Retired  
 Steve Henderson, CSEA  
 Suzi Rader, CSBA  
 Yolanda Smith, Kaiser Permanente  
 Zoe Ann Murray, CRTA Insurance

CalSTRS Board Members present:

Amy Cameron,  
*representing the Superintendent of  
 Public Instruction, Jack O’Connell*  
 Amanda Wallace,  
*representing Director of Finance,  
 Michael Genest*  
 Carolyn Widener,  
*Chair and now member of the  
 Teachers’ Retirement Board*  
 Dana Dillon,  
*Vice Chair and now Chair of the  
 Teachers’ Retirement Board*  
 Dennis Trujillo,  
*representing the State Treasurer,  
 Phillip Angelides*  
 Jennifer Bitondo,  
*State Treasurer’s Office*  
 Jerilyn Harris,  
*Retiree Representative and now  
 Vice Chair of the Teachers’  
 Retirement Board*

Jim Zerio,  
*representing the State Treasurer,  
 Phillip Angelides & Bill Lockyer*  
 Karen Greene Ross,  
*representing State Controller,  
 John Chiang*  
 Ruth Holton-Hobson,  
*representing State Controller,  
 John Chiang*  
 Tom Dithridge,  
*representing Director of Finance,  
 Michael Genest*

Visitors

Carolyn Robinson,  
*Senator Vincent’s Office*

CalSTRS staff present:

Carmen Atkins-Wasi,  
*Plan Design and Communication*  
 Christopher Ailman,  
*Chief Investment Officer*  
 Ed Derman,  
*Deputy Chief Executive Officer*  
 Gerri Kidson,  
*Planning & Research*  
 Jack Ehnes,  
*Chief Executive Officer*  
 Jennifer Baker,  
*Director of Governmental Affairs  
 & Program Analysis*  
 John Symkowick,  
*Planning & Research*  
 Julie Gallego,  
*Planning & Research*  
 Mike Hardin,  
*Research and Development*  
 Peggy Plett,  
*Deputy Chief Executive Officer*  
 Rick Reed, System Actuary

Steve Cernicky,  
*Planning and Research*

Valorie Farris, *Ombudsman*

Virginia Johnson,  
*Planning and Research*

Will Turner, *Legislative Affairs*

<b>Abbreviation</b>	<b>Organization</b>
ACCCA	Association of California Community College Administrators
ACSA	Association of California School Administrators
AFT	American Federation of Teachers
ART	Association of Retired Teachers
CalPERS	California Public Employees' Retirement System
CalSTRS	California State Teachers' Retirement System
CASBA	California Association of School Board Administrators
CASBO	California Association of School Business Officials
CCSESA	California County Superintendents Education Services Association
CFA	California Faculty Association
CFT	California Federation of Teachers
CPFA	California Part-time Faculty Association
CRTA	California Retired Teachers Association
CSBA	California School Boards Association
CSEA	California School Employees Association
CTA	California Teachers Association
CTA/NEA – Retired	California Teachers Association/ National Education Association – Retired
FACCC	Faculty Association of California Community Colleges
LACFG	Los Angeles College Faculty Guild, Local 1521
LAFG	Los Angeles Faculty Guild
SEAC	School Employers Association of California
SEIU	Service Employees International Union
SFUSD	San Francisco Unified School District
SSC	School Services of California
SSDA	Small School Districts' Association
UESF – Retired	United Educators of San Francisco – Retired
UTLA	United Teachers Los Angeles
VEBA	Voluntary Employer Benefits Association

## B. Presentations Provided to the Public Health Benefits Task Force

There were a number of presentations made to the Task Force. There is an accompanying CD that provides copies of material presented to the Task Force for those presentations in which material was provided.

### Education Coalition for Health Care Reform

Ruben Ingram, *Executive Director, School Employers Association of California*

Jim Schlotz, *Bargaining Specialist, California Teachers Association*

Cindy Young, *Senior Membership Benefits Coordinator,*

*California School Employees Association*

The primary focus of the Education Coalition for Health Care Reform, a Joint Labor-Management Committee, is to educate school districts and school employers on healthcare concerns. The overall goal of the Coalition is to reduce the rate of increase in health care costs in public education, focusing on protecting and enhancing the quality of education for California students and maintaining and increasing the real income of public education employees.

### National Coalition on Health Care

Dr. Henry Simmons, *President, National Coalition on Health Care*

The National Coalition on Health Care is a nonpartisan organization whose members include representatives of large and small business, labor, religious organizations, primary care provider groups and large pension funds, including CalSTRS, with a goal of providing more affordable health care for all Americans provided a thorough overview of the health care crisis today and recommended steps for improvement.

### Massachusetts Health Care Law: Model, Mirage or Momentum?

Anthony Wright, *Executive Director, Health Access California*

Health Access California is a statewide health care consumer advocacy coalition, working on behalf of the insured and uninsured. Over 200 organizations representing seniors, children, working families, people with disabilities, immigrants, people of faith, labor, and communities of color are part of the organization.

Mr. Wright's paper on which his talk was based is included.

### Update on Elk Grove Model

Jeffrey Markov, *Director of Fiscal Services, Elk Grove Unified School District and co-chair of the Elk Grove Benefit Employee Retirement Trust (EGBERT)*

Established in 1995, EGBERT was the first health benefits trusts to pay for retiree health care established by a school district in California. It is run by a joint labor-management trust and consultants (an Attorney, Investment Advisor, Actuary, and Auditor) who provide guidance. The Trust provided benefits to the first group of retirees in July 2000.

### C. Public Education Health Benefits Task Force Funding Alternatives: List of Major Assumptions Used for Actuarial Cost Estimates

#### I. Economic Assumptions

- A. Investment Return . . . . . 8.0%
- B. Maximum Annual Benefit Inflation . . . . . 5.0%
- C. US Price Inflation . . . . . 3.25%
- D. Wage Growth . . . . . 4.25%
- F. Interest on Member Accounts . . . . . 6.00%

#### II. Demographic Assumptions

A. Mortality			
			Table
(1) Active	M	1999 CALSTRS Retired – M (- two years)	B.2
	F	1999 CALSTRS Retired – F (- two years)	B.2
(2) Retired*	M	1999 CALSTRS Retired – M	B.2
	F	1999 CALSTRS Retired – F	B.2
(3) Beneficiary*	M	1999 CALSTRS Beneficiary – M	B.2
	F	1999 CALSTRS Beneficiary – F	B.2
(4) Disabled*	M	1994 GAM-M (minimum 2.5% with select rates in first three years)	B.2
	F	1994 GAM-F (minimum 2.2% with select rates in first three years)	B.2
*Future retirees and beneficiaries are valued with a 2-year age setback			
B. Service Retirement	Experience Tables		B.3
C. Disability Retirement	Experience Tables		B.4
D. Withdrawal	Experience Tables		B.5
Probability of Refund	Experience Tables		B.6

### Study Data

The membership data for these studies was supplied by CALSTRS' Actuarial Resources office and is as of June 30, 2005. It is the same data used by Milliman for their Actuarial Valuation of the DB Program. Actuarial Resources has reviewed, but not audited the data. We have examined the data for reasonableness and consistency with prior data used for studies.

Based on these tests, we believe the data to be sufficiently accurate for the purposes of these funding alternatives. Since the results are dependent on the integrity of the data supplied, the results can be expected to differ if the underlying data is incomplete or missing. It should be noted that if any data or other information is inaccurate or incomplete, our calculations may need to be revised.

### D. Glossary of Terms Used in the Report

**AB 528 benefits** are named after the bill passed in 1985. Under California Government Code Sections 7000-7008, districts must offer retiring members and their spouses the opportunity to enroll in health and dental insurance. The district may charge the retiring member the full cost of benefits. Further, the plan for retired members may be underwritten separately.

**Activities of daily living** are those activities performed as part of an individual's daily self-care routine. These include bathing, dressing, eating, transference and toileting. These are commonly used as a gauge for disability benefits.

**Benefits** are the money or health services to which an individual is entitled under his/her insurance plan.

**Cafeteria Plan**—See flexible benefit plan.

**Centers for Medicare and Medicaid Services (CMS)** is the federal agency within the U.S. Department of Health and Human Services that administers Medicare, Medicaid, the Health Insurance Portability and Accountability Act, and other programs. It was formerly called the Health Care Financing Administration (HCFA).

**COBRA** refers to the Consolidated Omnibus Budget Reconciliation Act of 1985. It is the federal law that obligates employers to offer continued health insurance coverage to terminated employees and their dependants for designated periods of time. The former employee or dependent typically pays the premium plus an administrative cost.

**Coinsurance** is the percentage of the cost of medical services amount that the individual has to pay after the deductible has been satisfied.

**Co-payments** is a cost-sharing arrangement of a health plan in which the individual pays a fixed fee for a specific service (such as \$10 for an office visit) in addition to deductibles and coinsurance, often on a per service basis. Co-payments are used to discourage inappropriate use of benefits and to help finance health benefit plans.

**Cost sharing** is the split in payments between the insurance and the individual, generally after the individual has paid a deductible.

**Custodial Care** is non-skilled, personal care, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving round, and using the bathroom. It may also include care that most people do themselves, like using eye drops. In most cases, Medicare does not pay for custodial care.

**Deductible** is an amount that the individual must pay prior to receiving any reimbursement from insurance. Some deductibles are per services while other deductibles are computed annually.

**Disease management** is an information-based process involving the continuous improvement of value in all aspects of care (prevention, treatment and management) throughout the continuum of health care delivery. Ultimately it attempts to control costs by using the most effective treatments as early as possible.

**ERISA** refers to the Employee Retirement Income Security Act of 1974, a federal law governing pensions and other employee benefits offered by private employers and unions. Federal law does not regulate public sector employee programs including pensions. ERISA contains a “preemption clause” providing that it supersedes all state laws that relate to private-sector employee pension and benefits programs.<sup>1</sup>

**Financial Accounting Standards**, promulgated by the Financial Accounting Standards Board, govern the preparation of financial reports for private entities and are officially recognized as authoritative by the Securities and Exchange Commission and the American Institute of Certified Public Accountants.

**Financial Accounting Standards Board (FASB)** is the designated organization in the private sector for establishing standards of financial accounting and reporting for private entities.

**Federal Poverty Level (FPL)** is the minimum amount of income that an individual or family needs for food, clothing, transportation, shelter, and other necessities as defined by U.S. Health and Human Services. The 2008 U.S. HHS Poverty Guidelines (annual dollars) are in the table below.<sup>2</sup>

% of FPL	Family Unit				Add for each additional person
	1	2	3	4	
100	\$10,400	\$14,000	\$17,600	\$21,200	\$3,600
133	\$13,832	\$18,620	\$23,408	\$28,196	\$4,788
150	\$15,600	\$21,000	\$26,400	\$31,800	\$5,400
200	\$20,800	\$28,000	\$35,200	\$42,400	\$7,200
250	\$26,000	\$35,000	\$44,000	\$53,000	\$9,000
300	\$31,200	\$42,000	\$52,800	\$63,600	\$10,800
400	\$41,600	\$56,000	\$70,400	\$84,800	\$14,400
500	\$52,000	\$70,000	\$88,000	\$106,000	\$18,000

**Flexible benefit plan** is a plan in which participants may choose among two or more benefits containing taxable or nontaxable compensation elements, i.e., cash or “qualified benefits”. Participants may choose qualified benefits by electing not to receive taxable cash compensation or currently taxable benefits treated as cash.

**Governmental Accounting Standards Board (GASB)** is the independent, not-for-profit organization formed to establish and improve financial account and reporting standards for state and local government.

**Health and Human Services** is the U.S. government’s principal agency for protecting the health of all Americans and providing essential human services. It includes the National Institutes of Health, the Food and Drug Administration, and Center for Disease Control and Prevention as well as the Centers for Medicare and Medicaid Services and the Administration on Aging.

**Health Insurance Counseling and Advocacy Program (HICAP)**, under the auspices of the California Department of Aging, provides free information and assistance on Medicare, Medi-cal, Medi-gap, long-term care and other insurance benefits.

**Health Insurance Portability and Accountability Act (HIPAA)** is the law passed in 1996 that expands health care coverage for individuals who have lost their jobs or have moved from one job to another. HIPAA protects people who have pre-existing medical conditions or problems getting health coverage. HIPAA also:

- limits how companies can use pre-existing medical conditions to keep an individual from getting health insurance coverage;
- usually gives people credit for health coverage they have had in the past;
- may give people special help with group health coverage when they lose coverage or have a new dependent; and
- generally, guarantees the right to renew health coverage.

**Health Maintenance Organization (HMO)** is a health plan, paid for through a prepaid premium, which offers individuals a range of health benefits, including preventative care, for a monthly fee and a range of co-payments. Members of an HMO must use the designated physicians and providers, other than with the referral of members' primary care physician or in an emergency.

**Healthy Families** is California's version of the State Children's Health Insurance Program (SCHIP). Jointly funded by the federal and state governments, it provides low-cost health, dental, and vision coverage to California children in families with income up to 250% of the FPL.

**High Deductible Plan** is health insurance that does not cover most medical expenses until the individual has met an annual deductible of at least \$1,000 for individual coverage or \$2,000 for family coverage. In addition, annual out-of-pocket expenses under the plan (including deductibles, co-payments, and co-insurance) cannot exceed \$5,100 per individual or \$10,200 for a family. Regulations allow health plans to cover preventative care without meeting the deductible.

**Internal Revenue Service (IRS)** is the nation's tax collection agency that administers the Internal Revenue Code.

**Long Term Care** is assistance and care for persons with chronic, often deteriorating health conditions and those having difficulty with activities of daily living. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities. Most long-term care is custodial care. Medicare does not pay for this type of care if this is the only kind of care needed.

**Long-Term Care Insurance** is a private insurance policy to help pay for some long-term medical and non-medical care, like help with activities of daily living. Because Medicare generally does not pay for long-term care, this type of insurance policy may help provide coverage for long-term care that may be needed in the future. Some long-term care insurance policies offer tax benefits; these are called “Tax-Qualified Policies”.

**Managed Risk Medical Insurance Board (MRMIB)** is the state agency that provides and promotes access to affordable coverage for comprehensive, high quality, cost effective health care services to improve the health of Californians. It oversees the Healthy Families Program, Access for Infants and Mothers (AIM), the Major Risk Medical Insurance Program, and the County Children’s Health Initiative Program.

**Medi-Cal (in other states Medicaid)** is a federal and state health insurance program designed to provide access to health services for persons below a certain income level including elderly persons who are poor.

**Medicare Premium Payment Program** was established in 2000 with first payments in July 2001. CalSTRS pays the Medicare Part A premiums for eligible retired Defined Benefit Program members who do not receive Medicare Part A premium-free from another source. CalSTRS also pays Medicare Parts A and B surcharges assessed by CMS for eligible DB members who enrolled in Medicare prior to July 1, 2001, and for whom CalSTRS is paying the Medicare Part A premium.

**Medi-gap Policy** is a Medicare supplemental policy, sold by private insurance companies, designed to pay for services not covered by Medicare. In most states, there are standard plans, labeled A through J. With the implementation of Medicare Part D, the design of these some of these plans has changed and prescription drug benefits are not part of Medi-gap policies.

**Medicare** is the federal health insurance program for citizens and permanent residents age 65 or more. In addition, individuals who are judged to be disabled and received Social Security disability for 24 or more months may also

receive Medicare as will people with other specific disabilities such as End-Stage Renal disease.

**Out-Of Pocket** are the funds, including deductibles, co-payments, or coinsurance, that individuals must pay for their health care.

**Public Employees Medical and Hospital Care Act (PEMHCA)** is CalPERS' statewide health care program. Approximately 115 school districts contract with the CalPERS for their health care.

**Preferred Provider Organization (PPO)** is a managed care plan in which individuals use doctors, hospitals, and providers that belong to the network. Individuals can use providers outside the network for an additional cost. Members of a PPO can generally choose their own physician and do not need a referral from their primary care physician to see a specialist.

**Pre-existing Condition** is a health problem one had before the date that a new insurance policy starts.

**Premium** is the amount of money an employer or individual pays for insurance coverage.

**Primary Care** is basic or general health care traditionally provided by physicians who specialize in family practice, pediatrics or internal medicine.

**Primary Care Physician** is a doctor who is trained to provide basic care and is the first physician people see for most health care. In many HMOs, individuals must see or get a referral from their primary care doctor before seeing any other health care provider.

**State Children's Health Insurance Program (SCHIP)** is jointly funded by the federal and state governments and provides low-cost health, dental, and vision coverage to families under a designated percentage of the federal poverty level. The California program is called Healthy Families.

**Section 125 Plan** is synonymous with flexible benefit plans. It refers to the IRS code which defines such plans and establishes that employee contributions may be made with pretax dollars.

**Section 213(d) of the IRS code** is the portion of the IRS code that defines medical care, including costs for diagnosis, mitigation, treatment or prevention of disease, transportation primarily for and essential to medical care, and insurance costs.

**Skilled Care** is a type of health care given when skilled nursing or rehabilitation staff are required to manage, observe, and evaluate care.

**Skilled Nursing Care** is the level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse).

**Voluntary employee beneficiary association (VEBA)** is a tax-exempt welfare benefit fund, regulated by the IRC, which pays death, sickness, accident or other benefits to members, dependents or beneficiaries.

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Wright, A. (2006, June) *Massachusetts' Health Care Law: Model, Mirage, or Momentum?* (Available from Health Access Foundation, 414 13<sup>th</sup> Street, Suite 450, Oakland, CA 94612)

Wright, A. (2007, December 28), *First Take at the Ballot Measure*. Retrieved on December 31, 2007 from [http://www.health-access.org/blogger.html?emc=\\$m=3687197&v=1025149769&1=1](http://www.health-access.org/blogger.html?emc=$m=3687197&v=1025149769&1=1).

## F. Resources

The following resources are available on the CalSTRS website at [www.calstrs.com](http://www.calstrs.com). To find these resources, click “Learn About CalSTRS” in the left hand column. Then look at the Public Education Health Benefits Task Force CalSTRS Resources.

### California State Teachers' Retirement System

- *Health Care Benefit Program: An Overview Discussion of Issues and Concerns, Prepared in Response to Recent Health Care Benefits Proposals*, Weston E. Hulse, Research Program Specialist, December 1987 (Includes as Appendix D. ACR-62 Study Panel, *Issue Paper on Health Care Benefits*, September 1984)
- *A Review of Potential Health Care Benefit Programs Provided by the California State Teachers' Retirement System*; May 2001
- *CalSTRS Role in Health Care*, Item 7 for the Benefits and Service Committee of the California Teachers' Retirement Board; May 7, 2003
- *Impact of Medicare Prescription Drug Legislation*, item 5 for the Benefits and Services Committee of the California Teachers' Retirement Board; February 4, 2004

- *Results from Health Benefits Survey of Employers*, item 6 for the Benefits and Services Committee of the California Teachers' Retirement Board; February 4, 2004
- *Retirement Benefits Comparison and Adequacy Study*, November 2004
- *2006 Health Benefits Survey of Employers*, Item 3 for the Benefits and Service Committee of the California Teachers' Retirement Board; February 8, 2007
- *Health Care and California Educators*. Jack Ehnes, CalSTRS Chief Executive Officer, presentation at a meeting of the Public Employee Post-Employment Benefits Commission, May, 2007
- *Health Care Coverage Worsens for Retired Educators; Uncertain Coverage Spells an Uncertain Retirement, Policy Report*, (Vol. 1, Issue 1); May 2007

#### Presentations to the Public Education Health Benefits Task Force

- *School Management and Labor Unions Together are Attacking Escalating Healthcare Costs*, Ruben Ingram, Executive Director, School Employers Association of California, Jim Schlotz, Bargaining Specialist, California Teachers Association, and Cindy Young, Senior Membership Benefits Coordinator, California School Employees Association; September 15, 2006
- *The Health Care Crisis, the Prospects for Reform, and CalSTRS*. Dr. Henry E. Simmons, President, National Coalition on Health Care; December 8, 2006
- *Massachusetts' Health Care Law: Model, Mirage, or Momentum?* Anthony Wright, Executive Director of Health Access California; January 19, 2007 (Presentation based on paper dated June 2006)
- *Elk Grove Unified School District, Retiree Health Benefits, EGBERT*, Jeffrey L. Markov, Director of Fiscal Services, Elk Grove Unified School District and co-chair of the Elk Grove Benefit Employee Retirement Trust (EGBERT); March 16, 2007.

#### Presentations to the CalSTRS Teachers' Retirement Board

- *Health Care Reform 2007: Defining the Problems, Examining Proposed Solutions*. Marian Mulkey, M.P.P., M.P.H., Senior Program Officer, California HealthCare Foundation; June 7, 2007

- *The Health Care Crisis, the Prospects for Reform*. Dr. Henry E. Simmons, President, National Coalition on Health Care; June 7, 2007.

### Resources from Other Entities

- *Medical and Dental Expenses, for Use in Preparing 2007 Returns* (IRS Publication No. 502 No. 15002Q). Also available at the IRS website, [www.irs.gov](http://www.irs.gov)
- *Ninety Years of Health Insurance Reform Efforts in California*, Michael Dimmitt, Ph.D., October 2007 (ISMN 1-58703-230-9) California State Library Foundation. Also available at the California State Library's website at [www.library.ca.gov/crb/07/07-013.pdf](http://www.library.ca.gov/crb/07/07-013.pdf)
- *Feasibility of Offering Health Care Coverage to School Employees as Outlined in AB 256: CalPERS and CalSTRS*, Mercer Marsh Mercer Kroll; December 17, 2007.
- *Funding Pensions & Retiree Health Care for Public Employees*, Public Employee Post-Employment Benefits Commission, January 2008

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### Endnotes

<sup>1</sup> Butler, P.A. (2007, July 17) Fact sheet: ERISA implications for state pay or play laws. p.1.

<sup>2</sup> Health Access 2008 U.S. HHS Poverty Guidelines.

Other sources include the following:

International Foundation of Employee Benefit Plans, Certificate of Achievement in Public Plan Policy in Employee Health Booklets, Glossary of Terms, October 2001 and August 2002

Internal Revenue Service website at [www.irs.gov](http://www.irs.gov) as retrieved in May 2005

Medicare glossary at [www.medicare.gov](http://www.medicare.gov) as retrieved in April 2005



# IX

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*Public Employees Education Health Benefits Task Force  
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