2/15/07 PERS/TRS FUNDING STATUS & REVIEW

SFIN

FILE

PUBLIC POLICY INSTITUTE

#2004-08
July 2004

State Government Retiree Health Benefits: Current Status and Potential Impact of New Accounting Standards

by
Stan Wisniewski, Ph.D., J.D. and
Lorel Wisniewski, Ph.D.
Workplace Economics, Inc.

AARP

PUBLIC POLICY INSTITUTE

#2004-08
July 2004

State Government Retiree Health Benefits: Current Status and Potential Impact of New Accounting Standards

by
Stan Wisniewski, Ph.D., J.D. and
Lorel Wisniewski, Ph.D.
Workplace Economics, Inc.

AARP

#2004-08
July 2004

State Government Retiree Health Benefits: Current Status and Potential Impact of New Accounting Standards

by
Stan Wisniewski, Ph.D. J.D. and
Lorel Wisniewski, Ph.D.
Workplace Economics, Inc.

The AARP Public Policy Institute, formed in 1985, is part of the Policy and Strategy group at AARP. One of the missions of the Institute is to foster research and analysis on public issues of importance to older Americans. This publication represents part of that effort. The views expressed herein are for information, debate, and discussion, and do not necessarily represent formal policies of AARP.

Copyright 2004 AARP.
Reprinting with permission only
AARP, 601 E Street, NW, Washington, DC 20049
www.aarp.org/ppi

Foreword

The likelihood that an employer offers retiree health benefits varies by size of employer, region, and industry. State and local governments continue to offer retirees health coverage at a higher rate than any other industry. While there are some common factors that influence health benefit decisions of employers in both the public and private sectors, there are also factors that distinguish public and private sector employers.

One such distinction is that state and local governments follow accounting standards for financial reporting different from those followed by private companies. State and local governments follow standards set out by the Governmental Accounting Standards Board (GASB), whereas private companies follow those of the Financial Accounting Standards Board (FASB). In the early 1990s, FASB implemented accounting standards for retiree health benefits that changed how a company's costs for retiree health benefits have to be reported. The standards required a change from reporting the expense of retiree health benefits on the basis of the cost of benefits in the period in which they are paid to reporting the cost of benefits as they are earned, which involves estimating and accruing both the future cost of these commitments and current spending for these commitments. This change has been widely cited as one factor, along with rising cost of these benefits, that has led companies to revise their retiree health benefit programs. Although GASB did not implement similar standards at the same time, it is now issuing new standards for state and local governments to report the costs of their Other Postemployment Benefits (OPEB), i.e., benefits other than pensions. The new standards raise the question of how their implementation will affect retiree health benefits in the future.

The AARP Public Policy Institute commissioned Workplace Economics, Inc. to conduct this research on retiree health benefits in state governments. In addition to providing a snapshot of state government retiree health benefits under existing accounting rules, the report gives an overview of current accounting practices for these benefits and of the changes that the new standards require. Based on this information, the report discusses potential issues that the new standards may raise for governments, taxpayers, and retirees. For example, reports based on the new accounting standards will make information on the long-term costs of retiree health benefits to state and local governments more readily available. Such information may focus attention on the challenge of honoring past and future commitments for retiree health benefits.

We hope this report will help inform debates that implementation of the new GASB standards may stimulate.

Gerry Smolka
Senior Policy Advisor
AARP Public Policy Institute

Table of Contents

FOREWORD .... *i*

EXECUTIVE SUMMARY .... *iii*

INTRODUCTION *1*

OVERVIEW OF CURRENT STATE GOVERNMENT RETIREE HEALTH BENEFITS *3*

Key Characteristics of State Retiree Health Care Plans 3
State Retiree Health Care Program Financial Report Data 9

CURRENT STANDARDS APPLICABLE TO ACCOUNTING FOR STATE RETIREE HEALTH INSURANCE OBLIGATIONS AND THE IMPLICATIONS OF THE NEW OPEB STANDARDS FOR ACCOUNTING PRACTICE *13*

POTENTIAL IMPACT OF THE NEW GASB OPEB STANDARDS ON CURRENT AND FUTURE RETIREES, PUBLIC EMPLOYERS, TAXPAYERS AND POLICYMAKERS *19*

CONCLUSION *26*

REFERENCES *27*

APPENDIX A: KEY CHARACTERISTICS OF STATE GOVERNMENT RETIREE HEALTH INSURANCE PLANS *30*

Table A1: Number and Types of Plans, FY 2003 31
Table A2: Eligibility Requirements for Plan Participation, FY 2003 34
Table A3: State Government Retiree Monthly Health Insurance Premiums – Pre-Medicare, FY 2003 39
Table A4: State Government Retiree Monthly Health Insurance Premiums – Medicare-eligible, FY 2003 42
Table A5: Other Characteristics of State Government Retiree Health Plans – Pre-Medicare, FY 2003 45
Table A6: Other Characteristics of State Government Retiree Health Plans – Medicare-eligible, FY 2003 53
Table A7: Characteristics of Prescription Drug Coverage in State Government Retiree Health Plans – Pre-Medicare, FY 2003 61
Table A8: Characteristics of Prescription Drug Coverage in State Government Retiree Health Plans – Medicare-eligible, FY 2003 67

APPENDIX B: STATE RETIREE HEALTH INSURANCE PROGRAM FINANCIAL REPORT DATA *72*

Table B1: Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in FY2001 For Other Postemployment Retiree Health Insurance Benefits As Reported by State Governments 73
Table B2: Pay-As-You-Go or Prefunded Financing and Reported Annual Cost to State in FY 2001 for Other Postemployment Retiree Health Insurance Benefits As Reported by State Governments 89

Executive Summary

Purpose

The Governmental Accounting Standards Board (GASB) issued an Exposure Draft[1] early in 2003, and a revision to the draft in early 2004, detailing proposed new accounting standards for state and local government retiree health care and other non-pension benefits. The Board adopted Statement No. 43, *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans,* in May 2004 and a related Statement, *Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions,* in June 2004. The earliest these will go into effect is for fiscal years starting in December 2006. To the extent that the new GASB standards require changes in assumptions or methods currently used by public sector entities to account for and report the costs of retiree health care, decision-makers' consideration of the more comprehensive information developed may result in changes in behavior and practices by both providers and users of retiree health benefits. To assess the potential impact of the new GASB standards on public policy, this paper examines retiree health care benefits currently provided in state government employment by the 50 states excluding the District of Columbia and practices employed by state governments to account for and finance their retiree health benefit obligations. The results can be used as a baseline against which to gauge the implications of the changes in accounting standards.

Background

Current practices used by state governments to account for and report their retiree health benefit obligations diverge from private sector practice and are shaped by existing accounting standards such as GASB 12, 25, 26, and 27. The new standards for governmental employer reporting of OPEB are broadly similar to standards applicable to the private sector issued by the Financial Accounting Standards Board (FASB) in 1990; they understand that OPEB is deferred compensation and their objective is to achieve accrual of benefit costs and liabilities during periods when employees render services. However, the new GASB standards are modeled after previous GASB standards on employers' reporting of pension benefits and include differences from FASB requirements designed to address the accounting and reporting practices of the public sector. For many states, the new OPEB standards will require accrual accounting for such benefits for the first time.

Methodology

To provide a current snapshot of health benefits for retired employees, Workplace Economics, Inc. analyzed information in its proprietary database on benefits provided to state government employees in all 50 states (the District of Columbia is not part of the state government database). To provide the overview of current state financial reporting practices, Workplace Economics analyzed state governments' annual financial reports.

---

[1] Standards for "Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions" and "Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans" can be ordered from GASB at its internet website (www.gasb.org).

Findings

1. Many states play a substantial role in the provision of retiree health benefits. Current retiree health care programs available to state government retirees vary significantly by key plan characteristics such as number and type of plans offered; premium costs; cost-sharing features such as copayments, coinsurance, and deductibles; and prescription drug plan features. For example, total monthly premiums for individual coverage for pre-Medicare retirees range from $159.92 for the lowest-cost plan offering available among the 50 states to $925.42 for the highest-cost plan offered in any state. For Medicare-eligible retirees, total monthly premiums for single coverage range from $46.40 for the lowest-cost available plan to $448.52 for the highest-cost plan offered in any state.

2. State financial statement reports provide some insight into the dimensions of retiree health insurance programs and their aggregate cost. Significantly, 41 states report providing some contribution towards defraying the cost of state retiree health insurance through programs covering more than 1.7 million retirees. Of the 41 states that reported providing some contribution towards retiree health insurance, 30 finance the state costs on a pay-as-you-go basis, while only 11 reported a prefunding arrangement. In the aggregate, state spending on OPEB approximated $4.4 billion in FY2001. About $3.8 billion was financed on a pay-as-you-go basis.

3. There are currently four GASB standards that provide guidance for existing state government accounting and reporting for postemployment health insurance benefits. GASB 12, *Disclosure of Information on Postemployment Benefits Other Than Pension Benefits by State and Local Government Employers*, became effective June 15, 1990 and requires that all employers who finance all or some portion of their retiree health insurance should provide: (1) a description of the benefits provided, employee groups covered, and the employer and participant obligations to contribute; (2) a description of the statutory, contractual, or other authority under which the benefit provisions and obligations to contribute are established; (3) a description of the accounting and financing or funding policies followed for those benefits; and (4) the expenditures/expenses for those benefits recognized for the period. These disclosures are typically accomplished through a note to the governmental entity's financial statement. However, unlike the new OPEB standards, GASB 12 does not require that particular practices be employed in recognizing and measuring retiree health insurance benefits. Subsequently, three additional GASB standards were implemented which affected the treatment of retiree health care benefits when provided through a public employee retirement system. First, GASB 27, *Accounting for Pensions by State and Local Governmental Employers*, issued in late 1994 but not effective until mid-1997, provides guidance to employers that elect to apply their pension accounting standards to retiree health care. In June 1996, GASB 25, *Financial Reporting for Defined Benefit Pension Plans and Note Disclosures for Defined Contribution Plans*, and GASB 26, *Financial Reporting for Postemployment Health care Plans Administered by Defined Benefit Pension Plans*, became effective. GASB 25 and GASB 26 have delineated the applicable standards, not only for retiree health care plans that are advance funded through a public employee retirement system, but, more broadly, for any retiree health care plan administered by a governmental defined benefit pension plan, regardless of whether the health care plan is funded on an actuarially determined basis or by some other mechanism. In its OPEB project, the Board decided to apply the same overall approach adopted in GASB 25 and GASB 27 to the reporting of OPEB by employers and plans, with such modifications as the Board considered necessary to reflect differences between pension benefits and OPEB.

4. While GASB's new OPEB standards are similar to FAS 106 in requiring those government employers to accrue the costs of postretirement health insurance during the years of service of their employees just as private sector employers are required to accrue the costs of such benefits, it appears likely there will be some significant differences in the standards as well as differences in the impact of the standards.

Impact and Implications

Employer-sponsored retiree health care provided by public employers is an important component of our nation's system of health care insurance for retirees. Therefore, any significant changes to state government employer retiree health care insurance resulting from the new OPEB standards or from the impact of underlying cost drivers necessarily will call for a response from policymakers if insurance gaps arise.

1. The private sector experience with FAS 106 provides mixed lessons for trying to anticipate the outcome of the new OPEB standards as formulated by GASB.

2. State government employers are typically large employers, and large employers generally provide postemployment benefit programs that remain relatively stable over time.

3. The financial information produced by the application of the new OPEB standards may encourage state governments to think about reducing retiree health benefit programs in the future in order to avoid liabilities. Yet, while the new OPEB standards may result in the consideration of changes that would minimize adverse accounting effects on public budgets, health benefit program changes seem more likely to be prompted by the availability of a drug benefit through Medicare and the underlying cost drivers, e.g., health care inflation, an expanding retiree population relative to active employees.

4. The new OPEB standards may encourage greater prefunding of retiree health care benefits. Because prefunding typically produces higher short-term costs as compared to pay-as-you-go financing, it may add to state government financial obligations at an inopportune time for those states and may, therefore, prompt a reconsideration of the level of state commitments for future retirees. At the same time, states which do begin prefunding (and those already prefunding) may find that their direct employer costs will be lower in the long run and that their credit rating may be bolstered.

5. To the extent the new OPEB standards may encourage greater prefunding of retiree health care benefits, they may produce greater intergenerational equity for taxpayers. This is because each generation, at least in theory, can assure itself that it is paying only for the personnel costs associated with the services provided by employees active during the taxpayer's lifetime, not previous lifetimes.

Conclusion

Economic and demographic factors are putting upward pressure on the cost of retiree health insurance provided by state public employers and, unless adequately prefunded, increasing

retiree health insurance costs may result in mounting deferred liabilities for state employers with the potential for an adverse impact on credit ratings. The concern over the future potential effect of such liabilities has prompted an examination of current governmental accounting standards for financial reporting to determine if such reporting achieves a sufficient consideration of the impact of providing retiree health care benefits on overall government operations. However, the implementation of new governmental accounting standards concerning retiree health insurance and other postemployment benefits, while adding to short-term pressures on government employees, appears unlikely to change what are typically the stable benefit provision patterns of large state employers, unless coupled with significant health care cost inflation for the foreseeable future and a continued deterioration of the active-to-retiree workforce ratio.

Introduction

It is the widespread practice of state governments to provide health benefits to former employees when they retire. In fact, the share of public sector employers offering retiree health benefits remains high in comparison to private employers.

The Governmental Accounting Standards Board (GASB) issued an Exposure Draft early in 2003 detailing proposed new accounting standards for state and local government retiree health care and other non-pension benefits; the Board adopted Statement No. 43, *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans*, and a related statement, *Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions*, in June 2004. The new standards for employer reporting of Other Postemployment Benefits (OPEB) are broadly similar to standards applicable to the private sector issued by the Financial Accounting Standards Board (FASB) in 1990; they understand that OPEB is deferred compensation and their objective is to achieve accrual of benefit costs and liabilities during periods when employees render services. However, the new GASB standards are modeled after previous GASB standards on employers' reporting of pension benefits and include differences from FASB requirements designed to address the accounting and reporting practices of the public sector. Some additional differences from private sector requirements are associated with GASB's simplified alternative measurement method for small plans, e.g., single employer OPEB plans with fewer than 100 members.

To the extent that the new GASB standards require changes in assumptions or methods currently used by public sector entities to account for and report the costs of retiree health care, the introduction of these new standards may result in changes in behavior and practices by both providers and users of retiree health benefits. Faced with more comprehensive financial information and revised expectations regarding current and future health care costs, it is generally assumed that public employers, retiree health care plans, plan participants (including both retiree participants and actively employed future participants) and policymakers may alter their decision-making regarding the structure and level of postretirement health benefits.

Organization of Paper. This paper begins with a description of how retiree health care benefits are provided in state government employment in fiscal year 2003. This "current" state of retiree health care benefits provided by state government employers then can be used as a baseline against which the impact of any policy changes can be assessed. Next, this paper reviews the current practices used by state governments to account for and finance their retiree health benefit obligations. This involves a review of existing accounting standards, such as GASB 12, 25, 26, and 27, where relevant, and a delineation of how these standards have set the stage for movement to new OPEB standards. Then, this paper examines the potential impact of the new OPEB standards on accounting practices and contrasts the standards' likely effect with the impact of the adoption of FASB 106, highlighting the major similarities and differences between the standards. Finally, this paper concludes with an assessment of the potential impact of the new OPEB

standards on current and future state government retirees, public employers, taxpayers, and policymakers.

Methodology. In order to provide an overview of current state government retiree health insurance benefits, Workplace Economics, Inc. analyzed information in its proprietary database, developed over 15 years, on benefits provided to state government employees in all 50 states (the District of Columbia is not part of the state government database). The database is the product of an annual survey of state governments on their employee benefits as well as an analysis of state employee health insurance plan documents; the database includes information on health benefits for retired employees. The information in Appendix A comes from this database. To provide the overview of current state financial reporting practices and the information in Appendix B, Workplace Economics analyzed state governments' annual financial reports.

The discussions of the current and new standards are based on the authors' knowledge of the two sets of standards, and the section on the impact reflects the authors' own assessment of some of the potential effects of the implementation of new GASB accounting standards.

Overview of Current State Government Retiree Health Benefits

In order to properly assess the impact of any new OPEB standard, both the depth and breadth of retiree health care benefits received by state government retirees needs to be determined. That is, it is important to identify the scope of such state programs and to understand the share of the financial burden borne by each state government for such benefits. To shed light on these issues, Workplace Economics, Inc. undertook two data analyses in this paper: (1) an examination of the key plan characteristics of state retiree health care programs and (2) a review of state government annual financial reports on the scope and aggregate annual cost of state OPEB spending.

Key Characteristics of State Retiree Health Care Plans

Fiscal year 2003 data for each state were examined in order to determine: (1) the actual dollar amount of premiums paid for retiree health care coverage by the state and by the retiree, respectively; (2) the deductibles, coinsurance, physician co-payments, and out-of-pocket maximums associated with the plans reviewed; and (3) the key characteristics of any prescription drug plans offered as part of the retiree health care program. When more than two plans were offered, the lowest-cost and the highest-cost plans were included in the analysis.[1] As summarized below, retiree health care programs available to state government retirees varied significantly in design.

Plan Offerings. In fiscal year 2003, all 50 state government employers surveyed offered health care benefits for retirees under the age of 65, and 48 states—all but Indiana and Nebraska—offered health care benefits to retirees age 65 and older. (See Appendix Table A1.) Roughly one in five states offered a single plan statewide, while some others offered as many as 10 or more plans. However, in states with multiple options, generally no more than three or four plans were available statewide, while additional offerings—usually HMOs—were available only in limited service areas. A retiree therefore typically had no more than three or four options available, based on the location of his or her residence.

In a number of cases, health coverage options offered to pre-Medicare retirees were the same as or similar to those available to active employees. In some cases, pre-Medicare and/or Medicare-eligible retirees selected from either additional or different options offered by the state and the retirement system. In Arizona, for example, retirees could

[1] Because some states offer a large number of pre-Medicare and Medicare retiree health care plans that would make a complete inventory of the key characteristics of all such plans unwieldy, this analysis was limited to providing information on the key plan characteristics of the lowest-cost and highest-cost plans offered to retirees, where "lowest-cost" and "highest-cost" refers to the retiree premium cost in dollars for retiree-only coverage. These plans were selected for analysis because they set the lower and upper bounds for the premium costs for all available plans and because such plans often attracted the largest enrollments among available plans. For example, a survey of state plan sponsors revealed that, for 72% of the responding states, the retiree health plan with the largest enrollment was either the "lowest-cost" plan or the "highest-cost" plan that was described for that state in Appendix A.

select from separate sets of plans offered by the retirement system and by the state Department of Administration.

Upon reaching age 65, when retirees become eligible for Medicare, plan payment and/or coverage changed. Retirees of the states of Indiana and Nebraska were no longer covered under the state's health plan after age 65 and had to seek individual coverage elsewhere to supplement Medicare. In the remaining 48 states, many retirees were able to continue coverage in the same health plan that they had while working or as an early retiree, but in 20 states they were also offered options for Medicare supplement plans.[2] A few states offered only Medicare supplement plans to retirees over the age of 65. In either case, Medicare was the primary payer for retirees age 65 and over, so individuals had to sign up for Medicare as soon as they became eligible. Comprehensive plans were not explicitly designed to complement Medicare as were the supplement plans, but they all coordinated coverage with Medicare to avoid duplicate payment for services covered by both plans.[3]

The majority of states offered the two groups of retirees—pre-Medicare and Medicare eligible—the same number of plan options. Nevertheless, 14 states offered fewer options, and seven states offered more options to retirees age 65 and over than their younger counterparts.

Eligibility for Retiree Health Benefits. In most states, individuals eligible for pensions based on their years of service could opt for continued health care coverage, although 17 states had additional requirements such as some minimum number of years of active service with the state or prior coverage in the health plan as an active employee. (See Appendix Tables A2 and B1.) States also differed as to when the retiree could opt for coverage. A dozen states required the individual to enroll within a limited time period — usually 30 to 90 days — surrounding the retirement date. A few allowed the retiree to defer enrollment in specific situations, such as when the retiree was already covered as a dependent under a state-sponsored plan but later lost that coverage upon the spouse's death, or when an employee terminated employment prior to retirement but with specified service credit.

Premium Contribution. Eligibility requirements for state subsidization of the premium frequently differed from requirements for participation in the plan, i.e., a retiree who was eligible to participate in the health plan may not have been eligible for a premium

---

[2] The Centers for Medicare and Medicaid Services (CMS) and the National Association of Insurance Commissioners (NAIC) have defined 10 standardized "Medicare supplement" or "Medigap" plans that may be offered to Medicare-eligible retirees. Employers that offer Medicare supplement plans to retirees over age 65 conform to one of these types. The plans (designated "A" through "J") are designed to complement Medicare coverage by paying for varying degrees of deductibles, coinsurance, prescription drugs and other services not covered by Medicare.

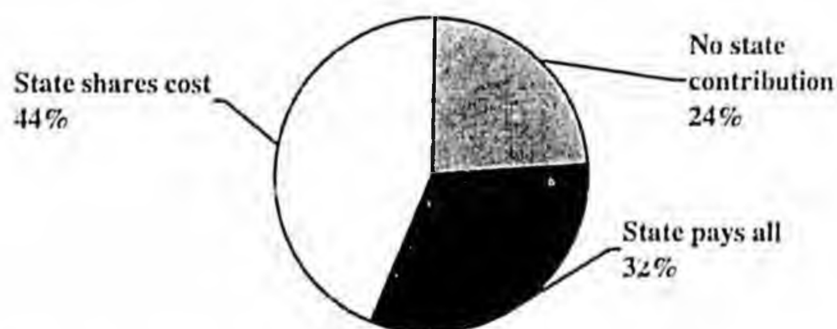
[3] Retirees who do not enroll in Medicare are effectively treated by state government health plans "as if" they were enrolled. Some plans make allowances for individuals not eligible for Medicare because their employer did not pay taxes into the program to retain some level of coverage. See Appendix Table A2.

subsidy. (See Appendix Tables A2 and B1 for details about eligibility for subsidies from health plan documents and financial reports, respectively, and also the notes to Tables A3 and A4 on premium costs for early retirees and Medicare-eligible retirees.) Almost one-third of states varied the portion of the subsidy based on the individual's years of credited service at retirement, with long-service employees (typically with 20 to 30 years) eligible for the maximum subsidy.

Figure 1 summarizes how states shared premium costs with pre-Medicare retirees for single coverage assuming the individual was eligible for the maximum subsidy.[4] For pre-Medicare retirees, 16 states (32%) paid the full amount of the premium for at least the lowest-cost plan offered and, in 12 states (24%), the retiree paid 100 percent of the premium.

Figure 2 summarizes premium cost-sharing requirements for Medicare-eligible retirees for single coverage assuming the individual was eligible for the maximum subsidy. Seventeen states (34%) paid the full premium for at least the lowest-cost plan offered to eligible retirees over the age of 65, while Medicare-eligible retirees in 11 states (22%) paid the full amount of the premium themselves. Of the remaining states, 20 states (40%) shared premium costs for individual coverage between the state and the retiree (shown in Appendix Tables A3 and A4), and two states (4%) had no plan.

Figure 1. Premium Cost Sharing For Pre-Medicare Retirees, FY 2003

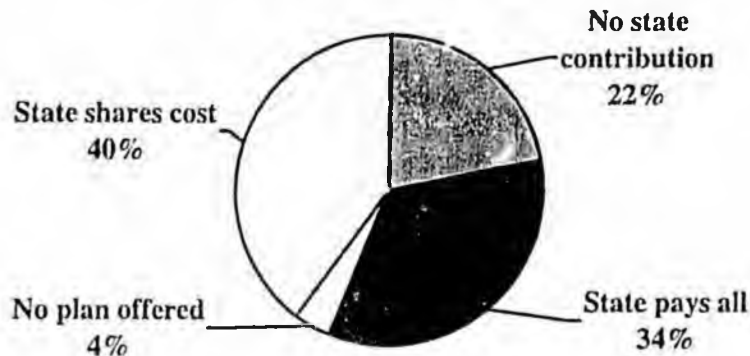


Note: Data are for single coverage and assumes maximum subsidy. Other conditions may apply, e.g., enrollment in the lowest-cost plan.
Source: Workplace Economics

---

[4] The information cited and provided in the Appendix tables applies to individual coverage for the retiree only. States vary in their practices regarding coverage and the extension of subsidies to dependents.

Figure 2. Premium Cost Sharing For Medicare-Eligible Retirees, FY 2003



Note: Data are for single coverage and assumes maximum subsidy. Other conditions may apply, e.g., enrollment in the lowest cost plan.
Source: Workplace Economics

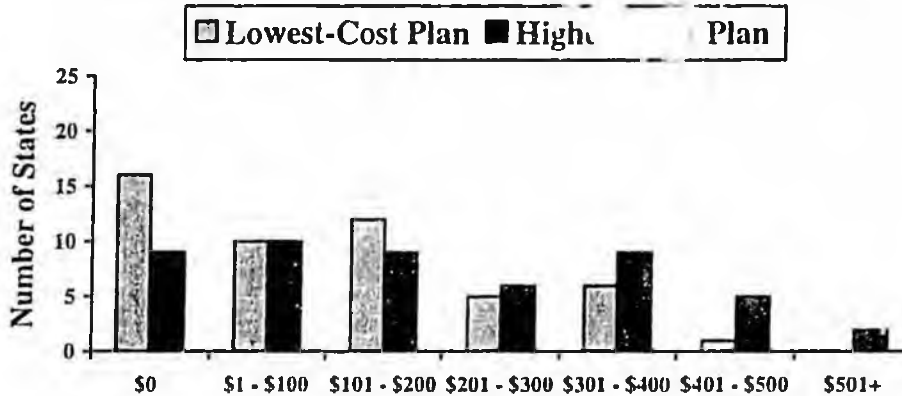
Across all 50 states, total monthly premiums for individual coverage for pre-Medicare retirees ranged from $159.92 in South Dakota for the state's low-option preferred provider plan (PPO) to a high of $925.42 for a PPO plan in Arizona. Among the 34 states where the pre-Medicare retiree paid either all or some portion of the premium costs, the monthly payment varied from $5.01 in Utah for an HMO to $795.40 for an indemnity plan in Wisconsin, assuming the retiree qualifies for the maximum subsidy. Figure 3 shows the distribution of pre-Medicare retiree premium contributions in $100 increments. The figure includes the highest-cost plan and the lowest-cost plan for each of the 50 states.

For Medicare-eligible retirees, total monthly premiums for single coverage ranged from $46.40 for an HMO in New Mexico to $464.23 for a regional HMO in New York. Among plans requiring retirees to pay all or a portion of premium costs, the monthly premium share for individual coverage paid by Medicare-eligible retirees varied from $10.00 in Georgia for a Medicare HMO to $448.52 for Iowa's open access plan, assuming the retiree qualifies for the maximum subsidy. Figure 4 shows the Medicare-eligible retiree premium contribution within $100 increments. The figure includes the highest-cost plan and the lowest-cost plan for each of the 50 states.

These findings clearly show the substantial role played by many states in the provision of retiree health care benefits in terms of the dollar amount of premium contributions that they made. It should also be noted that, in many cases, the health insurance premium applicable to pre-Medicare retirees might have been the same premium applicable to active employees. This may have been the case particularly where pre-Medicare retirees continued to be pooled for health insurance together with active employees. As a result, the premiums reported in such cases may have understated the actual claims costs incurred on behalf of the pre-Medicare participants. While such pooling of individuals

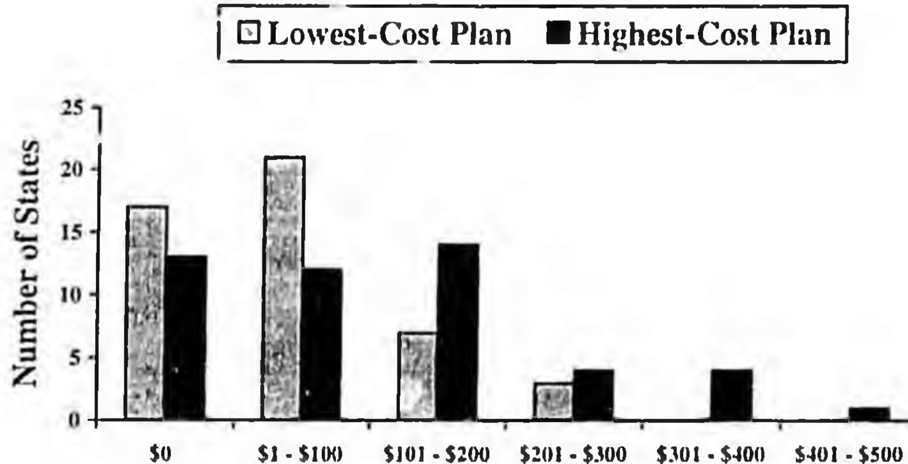
who are offered the same benefits (even though they may have different health or age characteristics) is at the heart of the insurance principle of spreading the risk, a few states took the position in their plan reporting that they were providing an implicit premium subsidy to their pre-Medicare retirees.

Figure 3. Premium Contributions Paid by Pre-Medicare Retirees by State, FY 2003



Note: Data are for single coverage and assumes maximum subsidy.
Source: Workplace Economics

Figure 4. Premium Amounts Paid by Medicare-Eligible Retirees by State, FY 2003



Note: Data are for single coverage and assumes maximum subsidy.
Source: Workplace Economics

Types of Plans and Cost-sharing Features. Key features of the lowest-cost and highest-cost plans available to retirees in each state are detailed in Appendix Tables A5 (pre-Medicare retirees) and A6 (Medicare-eligible retirees). Note that plan types in the tables — for example, HMO, PPO, and point-of-service (POS) — reflect the terminology of the particular state, i.e., the terms are not uniformly defined from state to state. Furthermore, the traditional distinctions between plan types have blurred as providers, plan administrators, and the state employers or retirement systems that offer the plans have altered plan features and added options to both minimize costs and provide alternatives.

Most common among the plans offered to pre-Medicare state retirees were plans that offer a different level of coverage and out-of-pocket payment depending on whether the member chooses to obtain care from in-network providers or out-of-network providers. Deductibles were common in most plans, except plans that only offer benefits when network providers were used. Many plans required copays that vary by the type of service obtained (e.g., specialty physicians, mental health, laboratory, physical therapy). Though not widespread, some plans (such as those that do not have deductibles) required hospital copays, typically from about $100 to $300 per admission, after which the plan paid all or most covered charges. A majority of plans reviewed had out-of-pocket maximums to limit the annual expenses paid by members. The per person maximums (using in-plan services where provider networks are part of the plan design) varied from $400 to $10,000 per year, but typical maximums were $1,000 or $2,000. Nonetheless, nearly a third of plans reviewed had no out-of-pocket maximum. Deductibles, copays, coinsurance and out-of-pocket maximums could vary considerably within a plan depending on whether the individual has obtained care from in-network or out-of-network providers.

Plan options available to Medicare-eligible retirees either were the same or similar in structure and characteristics to the options offered to pre-Medicare retirees, or were Medicare supplement plans (see Appendix Table A6). Yet plans without an out-of-pocket maximum were more likely in offerings to Medicare-eligible retirees. Plans that were not Medicare supplements differed from those described in the preceding paragraph only in how the benefit payment was calculated. Because Medicare was the primary payer, remaining charges were submitted to the insurance plan, which paid in accordance with the features of the plan. Copayments and out-of-pocket limits still applied (and, where applicable, continued to vary depending on whether the provider was part of the plan network). Medicare supplement plans, as noted previously, were explicitly designed to pay certain covered charges that are not paid by Medicare, such as all or part of the deductibles required under Medicare, or the retiree's 20 percent share of coinsurance for physician services.

In general, the lowest-cost plans were those requiring the retiree to pay the greatest share of covered benefits in the form of higher deductibles, copays or out-of-pocket maximums. In addition, plans with the greatest restrictions on where and how a member receives care tended to have lower premium costs.

Prescription Drug Benefits. Almost all of the highest- and lowest-cost state plans reviewed included some level of prescription drug coverage (see Appendix Tables A7 (pre-Medicare) and A8 (Medicare-eligible)). Since Medicare currently does not cover prescription drugs, this benefit was of particular importance to retirees over the age of 65. The majority of states offered the same drug benefit to early retirees and retirees on Medicare. However, in one state (South Dakota), both the lowest-cost and highest-cost Medicare-eligible plans did not include a drug benefit, although this benefit was available for early retirees. In a few other states, a drug benefit may have been available in one, but not both, of the plans examined in this study.

Many states offered a single prescription drug benefit as part of all (or most) of the health plans. Generally, under these plans, the retiree made a payment when purchasing the drug at a participating retail pharmacy. The vast majority of plans required copayments of a certain dollar amount, but a dozen or so plans required retirees to pay coinsurance of a certain percent of the drug price; the plan paid the balance. Some of these plans had a minimum or maximum coinsurance amount. Plans may have had different levels of copayments or coinsurance. The levels typically differed depending on whether the drug was classified as generic, brand name/formulary, or nonformulary. Of state government drug benefits reviewed, a small share had a single copayment level and a slightly larger share had two copayment levels. The majority had three levels of copayment. Among the plans reviewed, typical copayments were $5 or $10 for the lowest level; $15, $20, or $25 for the second level; and $30, $35, or $40 for a third level. The copays typically applied to a 30-34 day supply, and many plans offered further discounts for retirees who purchased maintenance or other medications by mail order (e.g., a requirement of two copays for a 90-day supply is typical). In addition, a few plans required a drug deductible or limit out-of-pocket payments for drugs. Limits on out-of-pocket payments be limited to generic and preferred drugs and drugs purchased in the plan's network. While benefits commonly included a mail order pharmacy option, this option was not included in at least one plan in about a dozen states.

State Retiree Health Care Program Financial Report Data

The analysis of health plan documents in the previous section provides information on the availability of, premiums for, and nature of benefits offered to state retirees. While that is an important part of the picture of current state retiree health benefits, it does not describe the current size, funding, or costs of these benefits to the state. To develop a picture of these aspects of state retiree health benefit plans and because, ultimately, any change in the OPEB accounting standards is most likely to be reflected in the comprehensive annual financial report (CAFR) of the state or the entity through which the benefit is provided (e.g., state retirement plan), each state's most recently available CAFR was reviewed with respect to OPEB reporting.

Each state's relevant annual reports were examined for the following categories of information: (1) the number of eligible retirees reported (generally as of mid-year

2001);[5] (2) the scope or nature of the retiree health care benefit program, particularly in terms of eligibility; (3) the reported percentage of employer contributions; (4) whether the state finances its retiree health care insurance obligations on a pay-as-you-go or prefunded basis; and (5) the most recent annual total cost reported by the state in connection with providing retiree health care insurance (details for items 1-3 and 4-5 are presented in Appendices B1 and B2, respectively).

Generally, the information of interest for each state was included in its CAFR in a note disclosure as required by applicable GASB reporting standards.[6] Some states did not include an OPEB disclosure note, usually indicating —as borne out by the absence of state contributions to retiree health insurance premiums— that the state determined that it had no OPEB impact to report. Of the 50 states, only six states (Arkansas, Indiana, Iowa, Nebraska, South Dakota, and Wyoming) did not include an OPEB disclosure; only one of these states (Arkansas) in fact provided some retiree health care insurance subsidy. On the other hand, Mississippi included an OPEB disclosure note in the CAFR, notwithstanding the fact that the state incurred no expense for retiree health care benefits. Vermont included a note disclosing a retiree health benefit obligation, but not the number of retirees, funding, or cost.

Wisconsin —— whose "contribution" to the financing of retiree health care benefits consisted solely of a program that converts accumulated sick leave to retiree health insurance credits[7]— reported these programs in an OPEB disclosure note. This last reporting approach arguably may have overstated Wisconsin's retiree health care contribution relative to other states that provided accumulated sick leave cash-out programs[8] inasmuch as these states' retirees receiving such lump sum payments at retirement could use the payments to finance some portion of their health insurance costs.[9]

Excluding the nonreporting states and the other exceptions noted above (Mississippi, Vermont, and Wisconsin), 41 states reported providing some contribution towards

---

[5] Data reported in state CAFRs typically follow a fiscal year format; not every state or relevant reporting entity follows the same fiscal year.

[6] See *infra* at pp. 13 to 16 for a discussion of currently applicable GASB reporting standards for state postemployment health benefit obligations.

[7] Upon retirement, all or some portion of accumulated sick leave, instead of being paid as cash termination benefit, is converted to credits to pay the retiree's own group health insurance premiums.

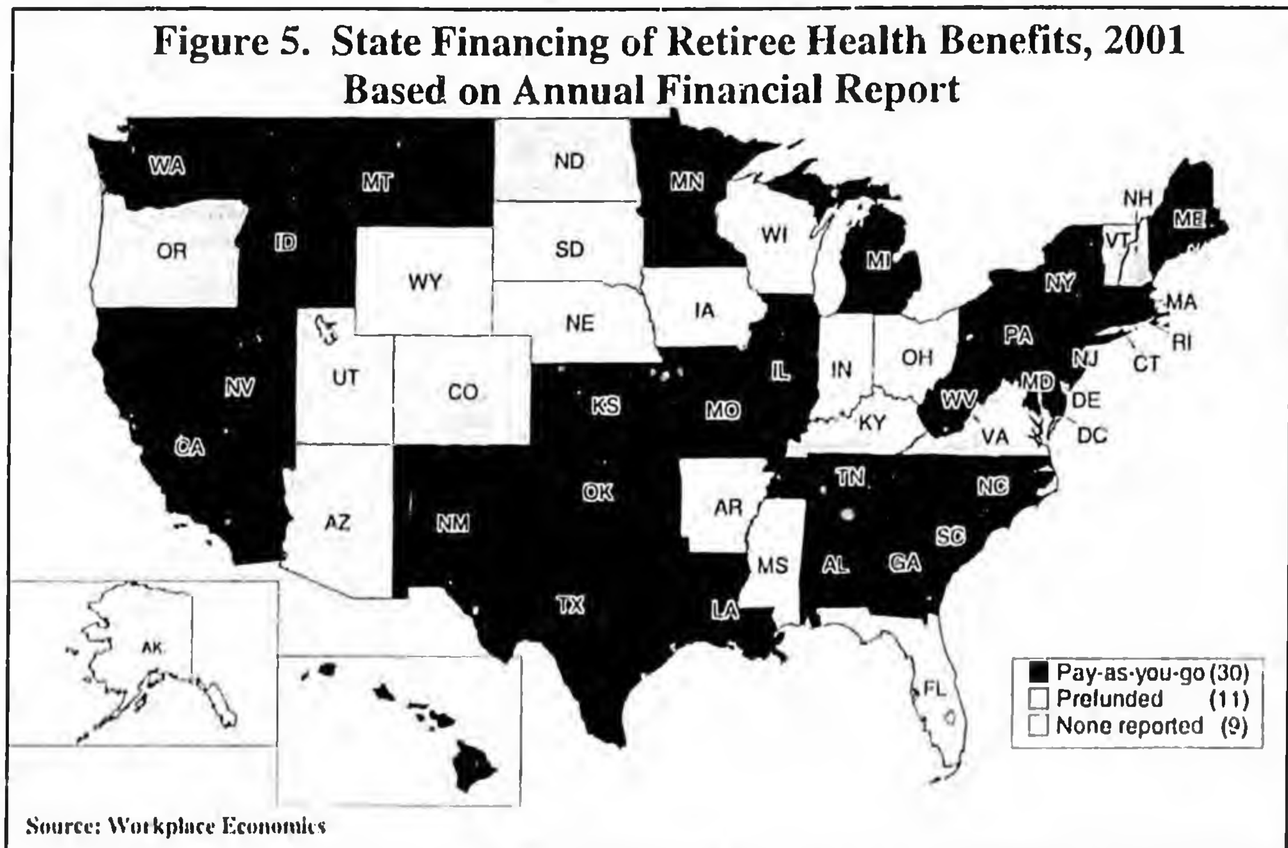
[8] In such programs, upon retirement, accumulated unused sick leave is converted at some rate to cash and paid to the retiring employee in a lump sum (typically, conversion is at a 25% rate, rather than a one-for-one or 100% rate).

[9] More consistent comparisons across states would appear possible in part if the dollar value of such sick leave conversion programs were reported only in the "compensated absences" disclosure note found in most state CAFRs along with lump sum sick leave and annual leave cash out programs. For a discussion of the governmental accounting treatment of sick leave conversion programs, see Governmental Accounting Standards Board Statement No. 16, *Accounting for Compensated Absences*.

defraying the cost of state retiree health insurance through programs covering more than 1.7 million retirees (see Figure 5). The OPEB disclosure note in the state CAFR provided some information about the dimensions of their postretirement health care programs.[10] In some cases, when the benefit was provided through a separate retirement system, the information was augmented by additional information presented in the state retirement system's CAFR.

Of the states that reported providing some contribution towards retiree health insurance (other than expenditures for sick leave conversion credits), 30 states financed these costs on a pay-as-you-go basis, while only 11 states percent reported a prefunding arrangement.

Figure 5. State Financing of Retiree Health Benefits, 2001 Based on Annual Financial Report



Source: Workplace Economics

Moreover, in states where retiree health benefits were prefunded separately from pension benefits, the funded levels reported for retiree health benefits often were lower than the funded levels reported for pension benefits. In short, both the predominance of pay-as-you-go financing among state retiree health care programs, as well as the low funded levels of many of those state retiree health care plans which are prefunded, could presage larger future cash outflows for such programs. This may be especially the case if the ratio of retired to active state employees continues to increase and retiree medical cost inflation continues to rise faster than the general rate of inflation.

---

[10] While providing some information about their programs, three states did not indicate the total fiscal year costs of the benefits provided in their OPEB disclosure notes.

Total annual spending on retiree health care benefits was reported by most of the 41 states that reported OPEB benefits.[11] In the aggregate, state spending on OPEB retiree health benefits approximated $4.4 billion in FY2001.[12] About $3.8 billion was financed on a pay-as-you-go basis. It should be noted that the remainder – roughly $600 million – that was financed on a prefunded basis represented the actual state contributions made to plan assets, rather than total expenditures made by those plans for the current provision of postemployment benefits.

Given the current prevalence of retirement health care benefits provided by state public employers, the substantial cost involved, and the relatively small number of states prefunding to meet their potential liabilities, it is not surprising that OPEB transactions have received GASB attention.

[11] Three states (Tennessee, Vermont and Washington) included an OPEB disclosure note in their 2001 comprehensive annual financial report but did not report an annual cost expense or total dollar amount of annual contribution in their OPEB disclosure notes.

[12] It should also be noted that not every state segregated retiree health care expenses from expenditures on other postemployment benefits provided such as life insurance. Such other expenditures are typically very modest relative to the cost of retiree health insurance. At the same time, some state reporting also included state expenditures for retiree health insurance subsidies provided to public employees other than state employees (e.g., teachers); usually such expenditures were reported as separate amounts from the amounts spent on state employee retirees.

Current Standards Applicable to Accounting for State Retiree Health Insurance Obligations and the Implications of the New OPEB Standards for Accounting Practices

Four GASB standards currently provide guidance regarding existing state government accounting and reporting for postemployment[13] health insurance benefits: GASB No. 12, 27, 25, and 26. This section describes the evolution of these standards which govern the current practices of state governmental entities that provide postemployment health benefits to retirees of various state government agencies. Since 1990, GASB standards have progressed from requiring financial disclosure by entities that finance some portion of retiree health benefits to providing guidance about how different types of entities might adapt pension accounting standards for the purposes of reporting on health benefits for all categories of retirees. Much of the content in the current standards is reflected in the new standards which will be implemented over the several years beginning in fiscal years starting in December 2006.

Not all of the standards apply to all governmental entities providing retiree health benefits. Retiree health benefits are provided through a number of different organizational/administrative arrangements (e.g., as part of the state employee benefit system, through a separate public employees retirement system, under the auspices of a defined benefit pension plan), and some of the standards are particular to the type of organizational arrangement responsible for the plan. Other standards are particular to the methods used to finance the health benefits, e.g., pay-as-you-go vs. prefunded basis.

Governmental Accounting Standards Board Statement No. 12, ***Disclosure of Information on Postemployment Benefits Other Than Pension Benefits by State and Local Government Employers***, became effective June 15, 1990 and requires that all governmental employers who finance all or some portion of their retiree health benefit costs should provide: (1) a description of the benefits provided, employee groups covered, and the employer and participant obligations to contribute; (2) a description of the statutory, contractual, or other authority under which the benefit provisions and obligations to contribute are established; (3) a description of the accounting and financing or funding policies followed for those benefits; and (4) the expenditures/expenses for those benefits recognized for the period.[14]

---

[13] While the focus of this paper is retiree health insurance benefits, it should be noted that the term postemployment as used by GASB is not synonymous with retirement. Rather, the term postemployment has a broader meaning that embraces not only retirement but also any period after termination but before retirement during which benefits may be provided.

[14] GASB 12 permits state government employers to simply state that OPEB expenditures/expenses "cannot be reasonably estimated" if a reasonable approximation of OPEB expenditures/expenses is not possible because OPEB expenditures cannot be separated from similar expenditures for active employees, e.g., where pre-Medicare retirees participate in the same health insurance plans offered to active employees.

These required disclosures are accomplished through a note to the governmental entity's financial statement. A GASB 12 footnote disclosure for OPEB financed on a pay-as-you-go basis might read as follows:

> "In addition to the pension benefits described in NOTE X, the State provides postretirement health care benefits, in accordance with State statutes, to all employees who retire from the State on or after attaining age 60 with at least 15 years of service. Currently, 25,000 retirees meet those eligibility requirements. The State reimburses 75 percent of the amount of validated claims for medical, dental, and hospitalization costs incurred by pre-Medicare retirees and their dependents. The State also reimburses a fixed amount of $25 per month for a Medicare supplement for each retiree eligible for Medicare. Expenditures for postretirement health care benefits are recognized as retirees report claims and include a provision for estimated claims incurred but not yet reported to the State. During the year, expenditures of $30 million were recognized for post-retirement health care. Approximately $500,000 of the $3 million increase in expenditures over the previous year was caused by the addition of dental benefits, effective July 1, 19XX" (Governmental Accounting Standards Board Statement No. 12, 1990, Appendix B).

If the retiree health program is prefunded, a GASB 12 footnote disclosure would include the employer's actuarially required contributions, the amount of net assets available for OPEB, and the actuarial accrued liability and unfunded accrued liability for OPEB according to the actuarial cost method in use.

GASB 12 is an interim standard pending the new OPEB standards. However, unlike the new OPEB standards, GASB 12 does not require that particular practices be employed when recognizing and measuring retiree health insurance benefits; therefore, when GASB 12 became effective in 1990, state and local government employers were not required to change their accounting for those benefits. In short, GASB 12 addresses only the disclosure of the nature and extent of retiree health insurance benefits, but does not establish recognition and measurement standards applicable to those benefits.

Moreover, GASB 12 permits employers that advance fund their retiree health insurance benefits on an actuarially determined basis through a public employee retirement system to elect to apply alternative disclosure standards applicable to public employee pension plans. Those alternative standards are part of **Governmental Accounting Standards Board Statement No. 5, *Disclosure of Pension Information by Public Employee Retirement Systems and State and Local Government Employers*.** The impact of electing this alternative is that: (1) the employer has to disclose its health care cost inflation assumption along with the other actuarial assumptions it is already disclosing for pension purposes; and (2) the employer has to calculate the funded status and funding progress of retiree health care benefits in a manner consistent with the requirements already applicable to pension benefits. While the disclosure of the funded status and

funding progress of retiree health care benefits separate from that of pension benefits is encouraged, such disclosure is not required.

Subsequently, three additional GASB standards were implemented which both move beyond disclosure requirements and affect how retiree health care benefits are to be treated for accounting purposes when provided through a public employee retirement system. First, **Governmental Accounting Standards Board Statement No. 27,** ***Accounting for Pensions by State and Local Governmental Employers***, issued in late 1994 but not effective until mid-1997, supersedes that part of GASB 12 that permits employers the option of reporting under GASB 5 standards if they prefund their retiree health care benefits through a public employee retirement system. GASB 27 provides guidance to employers that elect[15] to apply their pension accounting standards to retiree health care benefits on an interim basis pending the issuance of the OPEB standards. Essentially, employers who elect to apply GASB 27 to retiree health care benefits, are instructed to: (1) apply not only the measurement and recognition requirements of GASB 27 to those retiree health care benefits but also to provide notes to the financial statements required by GASB 27 instead of the note disclosures required by GASB 12; (2) to measure required supplementary information in the same manner as the pension plans if the retiree health benefits are administered through a defined benefit pension plan;[16] (3) to disclose the health care cost inflation assumption used in the valuation; and (4) to provide information on retiree health care benefits separately from information on pension benefits. While this elective standard governs *employer* reporting, other GASB standards address financial reporting by government defined benefit pension plans when such pension plans administer a retiree health care plan.

In June 1996, **Governmental Accounting Standards Board Statement No. 25,** ***Financial Reporting for Defined Benefit Pension Plans and Note Disclosures for Defined Contribution Plans***, and **Governmental Accounting Standards Board Statement No. 26,** ***Financial Reporting for Postemployment Health Care Plans Administered by Defined Benefit Pension Plans***, became effective. GASB 25 and GASB 26 delineate the applicable standards, not only for retiree health care plans that are prefunded through a public employee retirement system but also for any retiree health care plan administered by a governmental defined benefit pension plan, regardless of how the health care plan is funded, e.g., on a prefunded, pay-as-you-go, or partially prefunded basis. GASB 26 is an interim standard meant to apply until the new OPEB standards become effective; it basically requires that retiree health care benefit plans administered by defined benefit pension plans apply the reporting standards of GASB 25 which are also applicable to pension plans. Essentially, under GASB 26, retiree health care benefit plans are required to present a statement of plan net assets, a statement of changes in net assets, and note disclosures similar to those required of pension plans (providing for a brief description of benefit eligibility requirements and the required employer

---

[15] Employers are not required to apply GASB 27 pension accounting rules to retiree health benefits; the application remains an election.

[16] Required supplementary information under GASB 27 includes, among other information, such disclosures as the plan's funded ratio, the unfunded actuarial liability or funding excess as a percentage of covered payroll, and the actuarial methods and assumptions used in the plan valuation.

contribution rates). However, GASB 26 does not require that these retiree health plans provide the "required supplementary information" applicable to pension plans, i.e., a schedule of funding progress, a schedule of employer contributions, and related note disclosures such as valuation methodology and key assumptions employed in the valuation. GASB 26 simply says that, if such disclosures are elected for the retiree health care plan, they should mirror the disclosures required for the pension plan and such information should be presented separately for the retiree health care plan and for the pension plan.

GASB 26 applies to only retiree health insurance plans administered by retirement systems (rather than state and local government employers) and does not require the disclosure of the "required supplementary information" applicable to pension plans. Nevertheless, the reporting guidance it provides to such retiree health benefit plans that choose to report this information is a precursor of the GASB standards for reporting of OPEB plans generally.

In its **OPEB project**, charged with developing the standards, the Government Accounting Standards Board decided to apply the same overall approach adopted in GASB 27 and GASB 25 to the reporting of OPEB by employers and plans, with such modifications as the Board considered necessary to reflect differences between pension benefits and OPEB. For example, in early 2001, the Board decided to allow the use of the same six actuarial cost methods used for pension financial reporting, although it added the requirement that employers using the aggregate cost method for financial purposes should prepare the required supplementary schedule of funding progress using, as a surrogate, the entry age normal cost method.[17] Similarly, in 2002, the Board decided to require valuations of the largest OPEBs at least biennially, unless significant changes had occurred in benefit provisions or the population covered by the plan which would precipitate a more frequent valuation. Other GASB 27 and GASB 25 approaches have also been approved.

With regard to disclosures, staff's recommendations to the Board generally were that OPEB disclosure requirements track GASB 27 and GASB 25 disclosure requirements fairly closely. Although a number of disclosure modifications to the GASB 27 and 25 approach were considered by the Board, few were adopted. Those few adopted include: (1) disclosure of the health care cost trend rate; (2) the use of the entry age normal actuarial cost method as a surrogate for the aggregate cost method in presenting the schedule of funding progress; and (3) an indication that financial reporting is based on the current substantive plan as well as on an assumption of continuation of benefit coverage and historical patterns of cost sharing with employees. In short, the new OPEB regime may not so much produce new retiree health care disclosure or reporting standards as require the application of standards that are now elective, but which the authors' analysis of states' financial reports indicate are seldom applied.

[17] Unlike alternative cost methods such as the entry age normal cost method, the aggregate cost method does not separately measure or amortize an unfunded actuarial liability.

The Board adopted Statement No. 43, ***Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans***, in May 2004 and a related Statement, ***Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions***, in June 2004. The new standards will be phased in over a three-year period with the effective date dependent upon the size of the governmental unit sponsoring the plan. The standards will become effective for the largest governmental units first; the earliest effective date under the proposal would be in 2006.[18]

GASB's new OPEB standards appear likely to impact current governmental accounting practice in some important ways. Those government employers who are currently recording the costs of postretirement health insurance on a pay-as-you-go basis will be required to accrue the future costs during the years of active service of their employees for financial reporting purposes, just as private sector employers were required to accrue the cost of postretirement health care benefits by the Financial Accounting Standards Board's Statement 106, *Employers' Accounting for Postretirement Benefits Other Than Pensions*. However, to the extent that state governments are advance funding OPEB plans[19] or providing them through state retirement systems, they may already be meeting what new OPEB standards require.

In addition, the discount rate used in such valuations (i.e., the investment return assumption) is identified in current GASB 27 as being "based on an estimated long-term investment yield for the plan, with consideration given to the nature and mix of current and expected plan investments." This discount rate sharply contrasts with the FAS 106 discount rate. The latter standard calls for use of the current low-risk investment rate of return and may change substantially from year to year, whereas the GASB 27 discount rate is less volatile and produces more level employer contribution rates.

The FAS 106 paradigm of a "substantive plan" has been adopted by the Board for the new OPEB standards rather than the GASB 27 approach to determining the nature of the retiree health care benefit plan. The former requires actuaries to consider evidence other than just written plan documentation when determining the benefits provided by the plan. The GASB has determined that this approach will be employed in the OPEB standards so that actuaries will be required to consider not only the written plan document (as they are today), but also other communications between the employer and employees and the employer's historical pattern of sharing costs with the employees. Such an approach may well capture costs that a consideration of only written documents might minimize.

[18] GASB is phasing in the implementation of the new OPEB standards. Public employers would be required to implement the standards for fiscal years beginning after either December 15, 2006, December 15, 2007, or December 15, 2008. The magnitude of a government's revenues determines in which year the standard will apply. The governments with the largest revenues will implement the standard first.

[19] As noted *supra* at p.11, of the 41 states that reported providing some contribution towards retiree health insurance (other than expenditures for sick leave conversion credits) in FY2001, 11 states reported a prefunding arrangement.

Given such similarities and differences of the new OPEB standards with FAS 106, can the impact of that standard in the private sector translate directly to the public sector? The answer is obviously mixed. For most large state employers, shifting to the notion of a "substantive plan" does not seem likely to produce a very large difference in the value of retiree health insurance benefit liabilities inasmuch as most statewide benefits programs are well documented, rather than based on historical cost-sharing patterns. Indeed, many retiree health care benefit programs have been statutorily amended to specifically change benefit levels for groups of state employees hired at different times.[20] On the other hand, as shown earlier, the overwhelming majority of states offering retiree health care benefits currently are funding such benefits on a pay-as-you-go basis. Shifting to an accrual basis will certainly raise the amount of long-term obligations reported by the states.[21] Further, assuming that the current level of benefits remains unchanged and the number of state government retirees grows faster than the state's active employee workforce, then shifting to accrual reporting will accelerate the relative proportion of state funds reported annually to finance retiree health care benefits.

---

[20] Moreover, guided particularly by developments in private sector litigation in recent years (e.g., courts in public plan litigation may recognize ERISA decisions as persuasive authority), public employers no doubt have noted the significance of defining, by statute or other formal action taken by the plan's governing body, what benefits are being promised and how and by whom those promises may be limited. In the private sector, courts have been reluctant to find that a lifetime benefits commitment has been made by an employer absent clear and express language in a contract, summary plan description, or formal plan document; nevertheless, courts have upheld obligations to employees based on alternative theories such as the breach of a fiduciary duty to accurately disclose the level of obligations assumed by the employer. The latter theory can be traced to the Supreme Court decision in *Verity v. Howe*, 516 U.S. 489, 116 S. Ct. 1065 (1996) which held that an employer acted as a fiduciary when it communicated about benefits to its employees and thus had a fiduciary duty not to misrepresent plan benefits. In short, even absent any OPEB reporting requirements, state government employers have had greater incentive in recent years to formally define their retiree health benefit programs. By contrast, private employers did not have quite the same amount of litigation experience on which to draw when FAS 106 was implemented.

[21] Once the new standard is implemented, all states with such programs will start reporting as a liability the cumulative difference between the amounts accrued as expense and the amounts actually paid or contributed each year. They also would disclose the full actuarial accrued liability (the portion of the present value of projected benefits attributed by an actuarial cost method to services already rendered) and the unfunded actuarial accrued liability in a note to the financial statements and in a required multi-year trend schedule of funding progress.

Potential Impact of the New GASB OPEB Standards on Current and Future Retirees, Public Employers, Taxpayers and Policymakers

Employer-sponsored retiree health benefits provided by public employers are an important component of our nation's system of health insurance for retirees. Therefore, any significant changes to such benefit programs may consequentially impact current and future retirees, public employers, taxpayers and public policy. The relevant question is in what way and to what degree might the new OPEB standards have an impact.

1. The private sector experience with FAS 106 provides mixed lessons for trying to anticipate the outcome of the new OPEB standards as formulated by GASB.

In December 1990, the Financial Accounting Standards Board (FASB) approved Statement 106 (FAS 106), which required employers, who previously merely recorded the existence of a postretirement medical benefit and the cost for the current period, to report unfunded retiree health benefit liabilities on their financial statements beginning with the fiscal years after December 15, 1992. In other words, firms which largely reported retiree health insurance on a pay-as-you-go basis prior to 1991 were required to report their postretirement benefit liabilities on an accrual basis, often resulting in reported liabilities far in excess of those costs reported prior to the implementation of FAS 106.

As Fronstin notes, FAS 106 "caused many employers to reexamine their role in providing health benefits for current and future retirees" (Fronstin, 1995). Yet, while fewer private sector employees received employer-financed retiree coverage as a benefit after 1993, the role that FAS 106 implementation played in this trend is not clear. For example, the U.S. Bureau of Labor Statistics (BLS) surveys of retiree health benefit incidence among employees of medium and large establishments showed that, for plans covering retirees under age 65, employer-related coverage dropped from 45 percent in 1988 to 35 percent in 1997; between 1991 and 1993 (the period between the approval of FAS 106 and its required implementation date), coverage actually increased from 43 percent to 44 percent (U.S. Department of Labor, BLS, 1989, 1990, 1993, 1995, 1997, 1999). Employer-sponsored coverage of retirees age 65 and over reached its highest level during 1991 and 1993 as compared to the rest of the 1988-97 period. For both retirees under age 65 and age 65 and over, BLS reported that the percentage of employees participating in retiree health plans for whom the employer paid the full cost fell between 1991 and 1993 (from 16 percent to 13 percent and from 17 percent to 14 percent, respectively), but this downward trend appears to represent a continuation of a pattern largely evident throughout the 1988-97 period (U.S. Department of Labor, BLS, 1989, 1990, 1993, 1995, 1997, 1999). Using a different data source, Fronstin reports that between 1994 and 2000, the percentage of retirees ages 55 through 64 covered by health benefits through a former employer or union was largely unchanged (Fronstin; August 2001 and August 2002).

Kalman and Anderson describe the aftermath of FAS 106 as follows:

> ". . . once the transition obligation was recognized (and the significant pain it inflicted on some income statements), the furor over FASB Statement 106 subsided. Plan designs did change, but the seeds for that came from annual double-digit increases in health care costs and the possibility that the federal government would step in to take a far larger role in ensuring that all Americans had access to health care" (Kalman and Anderson, 1997).

In short, it is difficult to pinpoint the extent to which the change in the FASB standard was responsible for employer decisions on benefit reductions.[22] In part, that difficulty lay in putting a value on the informational consequences of the new accounting standard, rather than any increase in real costs generated by the standard. After all, the standard simply requires reporting estimates of full liability based on promises already made to employees; assuming such promises are intended to be honored, the standard imposes no "new" benefit costs on the employer that were not already envisioned.

Nevertheless, private employers were concerned that, as the FAS 106 accounting changes were implemented, there would be large changes in reported corporate income and net worth, with negative implications for stockholder values. Some research has shown that retiree health benefit liabilities impact stock prices, but the same research suggests that, if such liabilities have already reduced share prices in a manner similar to other liabilities, then the introduction of new, even more revealing, accounting standards for these benefits would not lead to great financial pressure to reduce or cancel the benefits (Warshawsky and Mittelstaedt, 1993). One study of the impact of FAS 106 found that near the time of the issuance of the exposure draft for the new standard in February 1989, a group of 143 firms offering retiree benefits suffered a decline in equity values of about 3 percent, while a control group of 100 firms not offering the benefits did not experience similar losses (Espahbodi, Strock, and Tehranian, 1991). Other research conducted after implementation of FAS 106 failed to show any significant negative impact on stock prices and led the authors to conclude that "in efficient markets, adoption of an accounting rule should not affect stock prices since cash flows and other investor relevant factors would not be influenced" (Haddad, et al., 1995).

<u>2. State government employers are typically large employers and large employers generally provide postemployment benefit programs that remain relatively stable over</u>

---

[22] It is not clear how many employers changed their existing plans versus how many new or growing employers did not offer a plan. For example, based on Current Population Survey (CPS) data reviewed for the period 1994-99, Paul Fronstein reported that "(o)verall, there have been no statistically significant changes in sources of health insurance for early retirees since 1994. In addition, the likelihood of their being uninsured remains statistically unchanged since 1994." The percentage of early retirees with retiree health benefits largely fluctuated in a narrow band ranging from 36 percent to 39 percent. This apparent stability may be explained by the movement of workers from smaller firms without such benefits to larger firms that more typically have such programs. See Paul Fronstin, "Employment-Based health Benefits: Trends and Outlook," *EBRI Issue Brief*, May 2001, pp. 1-23 at pp.14-15.

time. More than an OPEB accounting standard effect would appear to be necessary to prompt major changes to the patterns of benefits provided by large state employers.

One important measure of employment health insurance program stability is premium sharing over time. State employee retiree health insurance programs have been fairly stable over the past decade with respect to the share of premium contributed by the sponsor. In 1992, 17 states reported contributing as much as 100 percent of the premium costs for pre-Medicare state government retirees and 20 states reported contributing as much as 100 percent of the premium costs of Medicare-eligible state retirees.[23] A decade later, 17 states reported contributing 100 percent of the premium costs of pre-Medicare state retirees, while 21 states reported contributing 100 percent of the premium costs of Medicare-eligible state retirees. In other words, the number of states paying 100 percent of the premium costs of retiree health insurance was virtually unchanged.[24] Similarly, in 1992, some 12 states reported making no contribution toward pre-Medicare retiree premium costs and 15 states reported making no contribution toward Medicare-eligible premium costs. As of 2002, the number of states reporting no contribution toward pre-Medicare premiums remained unchanged at 12, and the number of states reporting no contribution toward Medicare eligible premiums fell by one to 14. The remaining states share premium costs with their retirees in varying amounts, but overall pre-Medicare and Medicare-eligible premium sharing patterns for these states as a group also appear relatively stable over the past ten years (Workplace Economics, Inc., 1992, 1997, and 2002).

This relative stability in premium sharing patterns is not surprising as state employers are more typically large employers, which are more likely to offer retiree health insurance benefits (Bokemaier, et al., 1990; Kohler and Sutch, 1994) and to not change premium cost-sharing dramatically from year to year. Nor do large employers tend to totally abandon such programs completely, even when faced with challenges. For example, notwithstanding the implementation of FAS 106, the number of retirees covered by large private employers has changed very slowly.[25]

3. The financial information produced by the application of the new OPEB standards may encourage state governments to think about reducing retiree health benefit programs (and their associated liabilities) in the future. Yet, while the new OPEB standards may lead to the consideration of changes that would minimize adverse accounting effects, health benefit program changes seem more likely to be prompted by the availability of a

---

[23] In some states, the contribution rate varies by plan selected and/or retiree length of service so that, while a retiree has the potential to receive fully paid health insurance at retirement, the choice of plan selected and service at retirement may result in an employer contribution of less than 100% of the premium.

[24] It should be noted that while premium shares are a broad measure of cost-sharing stability, premiums alone do not capture all relevant costs. For example, other aspects of plan costs such as participant copays, deductibles and out-of-pocket maximums and plan sponsor administrative costs are also relevant. Moreover, stable premium sharing may have been preserved by substituting managed care plan designs for traditional indemnity plan designs.

[25] See *infra* at p.19.

drug benefit through Medicare and the underlying cost drivers, e.g., health care inflation, an expanding retiree population relative to active employees.

The potential impact of new OPEB standards should not be evaluated in a vacuum, given that other important factors may more fundamentally influence the provision of retiree health care benefits by state employers. The cost of these benefits is a critical factor and cost, in turn, depends on factors such as health care cost inflation and demographic trends and how the state responds to the addition of a drug benefit in Medicare. Indeed, the interest in establishing new OPEB reporting standards may well have been prompted, in part, by concern over these same factors.

A recent Kaiser Family Foundation survey of public and private employee health insurance costs showed that the premium costs of private and public employer-based health insurance programs rose 13.9 percent in 2003, following a 12.9 percent increase in 2002, and a 10.9 percent increase in 2001(Kaiser Family Foundation, 2003). Double-digit medical care inflation rate, which characterized the late 1980s and early 1990s but had been quiescent during the spread of managed care plans in the mid 1990s, has apparently returned, as the rate of medical inflation has accelerated from its nadir in 1996. Costs have increased due to a combination of factors such as an aging population, pharmaceutical prices, utilization (generally higher with age, particularly with respect to prescription drugs), and new technology (Miller, 2001).

In addition, like the U.S. population generally, the public sector has a growing retiree population that is living longer. As a result, the ratio of active employees to retirees has become less favorable in recent years. For example, in 1996, the ratio of active employees to retirees in large public pension plans covering state employees was 2.8 to 1. By 2002, that ratio had declined to 2.4 to 1 (National Education Association, 1996 and 2002).

In short, both recent trends in medical inflation and long-term declines in the number of active employees to retired employees represent a significant challenge for state governments that help finance their retirees' health insurance costs.

Adding the new OPEB standards into this mix may encourage state governments to reduce retiree health benefit programs in the future in order to reduce liabilities. Yet it seems unlikely that the adoption of the new accounting standards alone will produce a wholesale abandonment of these programs. It seems more likely that other factors that impinge on whether retiree health benefits are offered and the level at which they are offered will ultimately prove more important to the continuation of benefit programs. For example, if health care insurance costs were to continue to climb at current double-digit levels for the foreseeable future, this alone will prompt public employers to reexamine the levels of continued commitment that they can afford. In such an inflationary environment, the new OPEB standards may bring added pressure but, even without the new OPEB standards, employers will feel considerable pressure to contain health insurance expenditures. To the extent that employers respond to this pressure by reducing

their retiree health insurance commitments, policymakers may become increasingly concerned with how to address these gaps.

4. The new OPEB standards may encourage greater prefunding of retiree health care benefits. Because prefunding typically produces higher short-term costs as compared to pay-as-you-go financing, it may add to state government financial obligations at an inopportune time for those states and may, therefore, prompt a reconsideration of the level of state commitments for future retirees. At the same time, states that do begin prefunding (and those already prefunding) may find that their direct employer costs will be lower in the long run and that their credit rating may be bolstered.

Generally, if state employers begin to prefund the cost of postretirement health insurance benefits that were previously financed on a pay-as-you-go basis, then their short-term contributions will likely be higher because part of future cash flow requirements for retiree benefits will be financed by current period contributions. For states already faced with fiscal crises — and many currently are[26] — a higher outlay in the short-term may not be attractive and may prompt these states to look at curbing benefits rather than prefunding existing levels of benefits.[27]

On the other hand, states that do begin prefunding retiree health benefits, in time may see investment income from the fund paying for a significant portion of the benefits cost that they otherwise would have shouldered. This long-term result coupled with the stability of an annual prepayment and the more accurately disclosed long-term obligation may also have a salutary, rather than a negative, effect on the state's bond rating. Harris, Raymond and Zorn describe the benefits of prefunding as follows:

> "Advance funding reduces direct employer costs over time, increases security for employees, and stabilizes the cash flow commitment for benefits. By recognizing these costs and implementing a plan to prefund them, a jurisdiction can increase its long-term financial strength, possibly improving its credit rating" (Harris, Raymond, and Zorn, 1998).

As previously noted, of 41 states that reported contributing to the cost of state retiree health insurance costs, 11 already prefund their retiree health insurance programs. It is

---

[26] For example, the Wall Street Journal reported that at least 46 states struggled to close a combined budget gap of $37 billion in a recently completed fiscal year and that the subsequent year's gap was an even wider $58 billion, as the economy continues to maintain a sluggish pace and state revenues feel the consequences. See Russell Gold and Robert Gavin, "Fiscal Crises Force States To Endure Painful Choices," *The Wall Street Journal*, October 7, 2002 at pp. A1, A14. Similarly, the National Conference of State Legislatures reported that two-thirds of the states indicated declining revenues and that more than half of the states face budget deficits. See National Conference of State Legislatures, *State Budget Update*, November 2002.

[27] At the same time, state employers who choose to reduce retiree health benefits may prompt affected active and retired employees to seek stronger guarantees of security such as mandatory prefunding and vesting through collective bargaining or the legislative process. In other words, the ultimate outcome of a state's consideration of reducing such benefits is not necessarily determined unilaterally by the employer.

the remaining 30 that will be faced with determining whether they can manage these costs in the short-run.

Yet it should be noted that the current fiscal difficulties faced by many states, to the extent they are cyclical rather than structural in nature, may be alleviated if the general state of the economy improves over the next several years. Because large governments probably will have until their fiscal year 2007 to implement the new OPEB standards, the economic environment in which they make their consequent decisions regarding their retiree health care programs may be improved over current conditions.

5. To the extent the new OPEB standards may encourage greater prefunding of retiree health care benefits, it may produce greater intergenerational equity for taxpayers. This is because each generation, at least in theory, can assure itself that it is paying only for the personnel costs associated with the services provided by employees active during the taxpayer's lifetime, not previous lifetimes.

Employer-financed retiree health care benefits, like employer-financed pension benefits, represent deferred compensation for services provided by state employees while active. To the extent that employers currently finance deferred compensation benefits on a pay-as-you-go basis, they are paying for the deferred compensation costs of past employees. That is, current generations of taxpayers are paying for services rendered to previous generations of taxpayers. At the same time, current taxpayers are shifting to future taxpayers the burden of paying for the benefits costs associated with services currently received. This arrangement might advantage or disadvantage current taxpayers, depending upon the relative level of services previously provided as compared to the level of services currently provided.[28]

By encouraging more prefunding of retiree health care benefits, the new OPEB standards could result in taxpayers paying for the deferred compensation of state government employees who provide the public services that these taxpayers receive. Better intergenerational tax equity would result. Of course, while some may argue strongly in favor of intergenerational equity, others would argue that allocating the burden of retiree health care costs accurately across generations may be difficult in practice, i.e., who should pay for what service and when raise thorny issues. Arriving at accurate assumptions about the trends in retiree health care costs and state government employment growth over several generations may prove to be challenging. Moreover, even if current and future costs can be satisfactorily allocated across generations of taxpayers, there remains the question of which generation will be burdened with the cost of transitioning to the new system. Should the cost of past services currently being paid for be fully assumed by the current generation together with the cost of current services or should it be spread over all future generations to some degree? Then too, the effects of

---

[28] Only the initial generation of taxpayers clearly gains from a pay-as-you-go approach that postpones full payment for current benefits because only that generation of taxpayers has inherited no bills to pay from a prior generation. Each successive generation is either a winner or loser depending on whether the bills it creates are higher or lower than the bills it has inherited.

decisions to prefund are unlikely to be incurred instantaneously. Because the contribution the new OPEB standards might make toward achieving intergenerational equity may be difficult to assess practically and may never fully be achieved, this potentially worthwhile impact should not be overstated.

Conclusion

Economic and demographic factors are putting upward pressure on the cost of retiree health insurance provided by state public employers and, unless adequately prefunded, increasing retiree health insurance costs may result in mounting deferred liabilities for state employers with the potential for an adverse impact on credit ratings. The concern over the future potential effect of such liabilities has prompted GASB's examination of current governmental accounting standards for financial reporting and adoption of new reporting standards that achieve sufficient consideration of the impact of providing retiree health care benefits on overall government operations. However, the implementation of that new governmental accounting standards for retiree health insurance and other postemployment benefits, while adding to short-term pressures on government employers, appears unlikely to change what are typically the stable benefit provision patterns of large state employers, unless coupled with significant health care cost inflation for the foreseeable future and a further deterioration of the active-to-retiree workforce ratio. In short, the continued prevalence of retiree health benefits among large employers will be based on the strength of real economic pressures. To the extent that employers respond to economic pressures by reducing their retiree health insurance commitments, policymakers will need to determine how to meet these gaps, inasmuch as the benefits now provided by these employers are an important component of the nation's system of health insurance for retirees.

References

Bokemaier, L. Charles, Van Daniker, Relmond P. and Parish, Sharon, *Other Postemployment Benefits in State and Local Governmental Units,* (Norwalk, CT: GASB, 1990).

Espahbodi, H., Strock, E. and Tehranian, H., "Impact on Equity Prices of Pronouncements Related to Nonpension Postretirement Benefits," *Journal of Accounting and Economics*, Volume 14 (December 1991), pp. 323-346.

Financial Accounting Standards Board's Statement 106, *Employers' Accounting for Postretirement Benefits Other Than Pensions,* (Norwalk, CT: FASB, December 1990).

Fronstin, Paul, "The Availability of Retiree Health Insurance," *Employee Benefit Research Institute Notes*, Vol.16, Number 1 (January, 1995), pp. 3-6.

Fronstin, Paul, "Employment-Based Health Benefits: Trends and Outlook," *EBRI Issue Brief,* May 2001, pp. 1-23.

Fronstin, Paul, "Health Insurance Coverage and the Near Elderly, 2000," *Employee Benefit Research Institute Notes*, Vol.23, Number 8 (August 2002), pp. 5-9.

Fronstin, Paul, "Retiree Health Benefits: Trends and Outlook," *EBRI Issue Brief* (August 2001), pp. 1-27.

Governmental Accounting Standards Board Statement No. 12, *Disclosure of Information on Postemployment Benefits Other Than Pension Benefits by State and Local Government Employers*, (Norwalk, CT: GASB, May 1990).

Governmental Accounting Standards Board Statement No. 16, *Accounting for Compensated Absences,* (Norwalk, CT: GASB, November 1992).

Governmental Accounting Standards Board Statement No. 25, *Financial Reporting for Defined Benefit Pension Plans and Note Disclosures for Defined Contribution Plans,* (Norwalk, CT: GASB, November 1994).

Governmental Accounting Standards Board Statement No. 26, *Financial Reporting for Postemployment Health care Plans Administered by Defined Benefit Pension Plans,* (Norwalk, CT: GASB, November 1994).

Governmental Accounting Standards Board Statement No. 27, *Accounting for Pensions by State and Local Governmental Employers,* (Norwalk, CT: GASB, November 1994).

Gold, Russell and Gavin, Robert, "Fiscal Crises Force States To Endure Painful Choices," *The Wall Street Journal*, October 7, 2002, pp. A1, A14.

Haddad, Mahmoud M., Bar, Saul Z., Redman, Arnold L., and Cowan, Arnold, "Adoption of FASB 106 and Stock Prices," *International Advances in Economic Research*, Volume 1, Issue 2 (May, 1995), pp. 156-164.

Harris, Jennifer D., Raymond, Jeannine Markoe, and Zorn, Paul, *Prefunding Retiree Health Benefits,* (Chicago: Government Finance Officers Association, 1998).

Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2003 Annual Survey,* (Menlo Park, CA, KFF/HRET, September 2003 p. 21).

Kalman, Robert, and Anderson, Thomas R., *Post-Retirement Health Care Benefits: Key Issues For Decision Makers In The Public Sector* (Chicago: Government Finance Officers Association, 1997).

Kohler, Dan, and Sutch, Michelle, "Retiree Health Care: GFOA Members' Perspectives," *Government Finance Review* (December 1994), pp. 45-47.

Labor, U.S. Department of, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms, 1988* (Washington, D.C., U.S. Government Printing Office, 1989).

Labor, U.S. Department of, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms, 1989* (Washington, D.C., U.S. Government Printing Office, 1990).

Labor, U.S. Department of, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Private Establishments, 1991* (Washington, D.C.: U.S. Government Printing Office, 1993).

Labor, U.S. Department of, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Private Establishments, 1993* (Washington, D.C.: U.S. Government Printing Office, 1995).

Labor, U.S. Department of, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Private Establishments, 1995* (Washington, D.C.: U.S. Government Printing Office, 1997).

Labor, U.S. Department of, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Private Establishments, 1997* (Washington, D.C.: U.S. Government Printing Office, 1999).

Miller, Joel E., *Déjà Vu All Over Again: The Soaring Cost of Private Health Insurance and Its Impact on Consumers and Employers* (Washington, D.C.: National Coalition on Health Care, May 2000).

National Conference of State Legislatures, *State Budget Update,* (Denver, CO: NCSL, November 2002).

National Education Association, *1996 Characteristics of 100 Large Pension Plans*, (Washington, D.C.: NEA, August 1996).

National Education Association, *2002 Characteristics of 100 Large Pension Plans*, (Washington, D.C.: NEA, September 2002).

U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms, 1988,* (Washington, D.C., U.S. Government Printing Office, 1989).

U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms, 1989* (Washington, D.C., U.S. Government Printing Office, 1990).

U.S. Department of Labor Bureau of Labor Statistics, *Employee Benefits in Medium and Large Private Establishments, 1991,* (Washington, D.C.: U.S. Government Printing Office, 1993).

U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Private Establishments, 1993* (Washington, D.C.: U.S. Government Printing Office, 1995).

U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Private Establishments, 1995,* (Washington, D.C.: U.S. Government Printing Office, 1997).

U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Private Establishments, 1997,* (Washington, D.C.: U.S. Government Printing Office, 1999).

Verity v. Howe, 516 U.S. 489, 116 S. Ct. 1065 (1996).

Warshawsky, Mark J., and Mittelstaedt, H. Fred, "The Impact of Liabilities for Retiree Health Benefits on Share Prices," *The Journal of Risk and Insurance*, Vol. 60, No.1 (1993), pp. 13-35.

Workplace Economics, Inc., *1992 State Employee Benefit Survey*, (Washington, D.C., 1992).

Workplace Economics, Inc., *1997 State Employee Benefit Survey*, (Washington, D.C., 1997).

Workplace Economics, Inc., 2002 *State Employee Benefit Survey*, (Washington, D.C., 2002).

Appendix A:

Key Characteristics Of State Government Retiree Health Insurance Plans

The information in this Appendix is taken directly from survey responses and documen provided by state governments. The terms used are those that the states themselves use to describe their benefits. As such, not all of the acronyms and terms may be ones in general use.

Table A1: Number and Types of Plans, FY 2003

State	Number of Plans		Types of Plans	
	Pre-Medicare	Medicare-eligible Plans	Pre-Medicare	Medicare-eligible Plans
Alabama	1	1	PPO with out-of-network option	PPO with out-of-network option
Alaska	1	1	Traditional indemnity.	Traditional indemnity.
Arizona[1]	5	6	2 HMOs, 2 PPOs, 1 POS	3 Medicare plans, 1 PPO, 1 POS, 1 HMO
Arkansas	5	5	1 PPO (BCBS), 2 POS, 2 HMO	1 PPO (BCBS), 2 POS, 2 HMO
California	8	7	HMOs, PPOs, EPOs (Exclusive Provider Organizations)	Medicare supplement, managed care
Colorado	16	4	3 POS, 9 HMOs (3 providers), 4 PPOs	2 Medicare supplement, 2 HMO
Connecticut	10	10	4 POS, 4 HMOs, 2 POE (Point of Enrollment plan, with services available from defined network of providers only)	4 POS, 4 HMOs, 2 POE (Point of Enrollment plan, with services available from defined network of providers only)
Delaware	5	8	3 traditional, 2 HMOs	3 traditional, 2 HMOs, 3 Medicare supplements
Florida	2	2	PPO and HMO	PPO and HMO
Georgia	10	11	2 PPOs, 1 Indemnity, 7 HMOs	2 PPOs, 1 Indemnity, 7 HMOs, 1 Medicare HMO
Hawaii[2]				
Idaho	1	1	Traditional	Traditional
Illinois	12	12	1 indemnity, 11 managed care options (HMO, POS, open access) that vary by county	1 indemnity, 11 managed care options (HMO, POS, open access) that vary by county
Indiana	6	0	1 indemnity, 5 HMOs	None
Iowa[3]	10	10	2 indemnity, 2 PPOs, 6 managed care	2 indemnity, 2 PPOs, 6 managed care
Kansas	7	8	1 managed indemnity, 4 HMOs, 2 PPOs	1 managed indemnity, 4 HMOs, 2 PPOs, 1 Medicare Plan C Supplement
Kentucky	14	3	4 HMOs, 3 POS, 4 PPOs, 4 EPOs; offerings vary by county	1 Medicare supplement, 1 PPO, 1 traditional; each with low and high options
Louisiana	7	7	1 PPO and EPO statewide; 5 other plans in limited areas	1 PPO and EPO statewide; 5 other plans in limited areas
Maine	1	1	HMO	Medicare HMO companion
Maryland	8	8	2 PPOs, 3 POS, 3 HMOs	2 PPOs, 3 POS, 3 HMOs
Massachusetts	10	6	3 indemnity, 1 PPO, 6 HMOs	2 Medicare indemnity, 4 Medicare HMOs

[1] Arizona: For Maricopa County. Arizona State Retirement System and state Department of Administration each offer separate sets of plans.

[2] Hawaii: The state of Hawaii has created an Employer-Union Health Benefits Trust Fund, effective July 1, 2003. The Fund will offer multiple options for pre-Medicare and Medicare-eligible retirees. The Fund replaces the current system under which retirees can select from a variety of plans offered by both the state and the state employee unions.

[3] Iowa: Options may vary by bargaining unit status while active employee.

Table A1: Number and Types of Plans, FY 2003

State	Number of Plans		Types of Plans	
	Pre-Medicare	Medicare-eligible Plans	Pre-Medicare	Medicare-eligible Plans
Michigan	11	11	State PPO, 12 HMOs in limited areas	State PPO, 12 HMOs in limited areas
Minnesota	1	1	Single network-type State Health Plan with 3 administrators	Medicare plans coordinated with State Health Plan
Mississippi	1	1	Single network-type plan	Medicare coordinated network plan
Missouri	8	8	"Copay plan" (similar to PPO with non-network option), 7 HMOs vary by region	"Copay plan" (similar to PPO with non-network option), 7 HMOs vary by region
Montana	5	5	Traditional and basic indemnity, 3 HMOs in limited areas	Traditional plan or its Medicare supplement, 3 HMOs in limited areas
Nebraska	3	0	1 POS, 1 PPO, 1 HMO	None
Nevada	2	2	State PPO, 1 HMO (limited service area)	State PPO, 1 Medicare HMO (limited service area)
New Hampshire	1	1	POS plan	Medicare supplement plan
New Jersey	7	7	1 traditional, 1 managed care, 5 HMOs	1 traditional, 1 managed care, 5 HMOs
New Mexico	4	6	2 POS, 2 HMOs	2 traditional, 2 supplement, 2 HMO
New York	7-8	7-8	1 traditional plan, 6-7 HMOs per regions	1 traditional plan, 6-7 HMOs per region
North Carolina	1	1	State comprehensive major medical plan	State comprehensive major medical plan
North Dakota	1	1	PPO (basic benefits)	NDPERS Retiree Plan (PPO)
Ohio	6	6	1 traditional (2 administrators), 5 HMOs in limited areas	1 traditional (2 administrators), 5 HMOs in limited areas
Oklahoma	6	5	Indemnity, 2 HMOs; all plans with high and low options	Medicare supplements: 2 indemnity with high and low options and 1 HMO
Oregon	10	5	Through state: PPO high and low option, HMO high and low option, 1 HMO/POS. Through retirement system: 1 indemnity, 1 PPO, 1 POS, 2 HMO/managed care	1 indemnity, 1 PPO, 1 POS, 2 HMO/managed care
Pennsylvania	3	3	Basic Option (indemnity), regional HMO and PPO options	Medicare supplement with major medical; HMO and PPO option in some areas
Rhode Island	1	2	PPO	1 indemnity, 1 Medigap
South Carolina	7	7	2 indemnity (state plans), 2 HMO, 2 managed care (HMO/POS)	1 indemnity, 1 Medicare supplement, 2 HMO, 2 managed care (HMO/POS)
South Dakota	3	1	3 PPOs	Medicare supplement
Tennessee	4	3	1 PPO, 1 POS, 2 HMOs	2 Medigap plans, 1 PPO
Texas	4	4	1 PPO with HMO option, 3 HMOs in limited areas	1 indemnity, 3 HMOs in limited areas
Utah	4	2	1 PPO, 2 HMOs, 1 indemnity	2 Medicare supplements

Table A1: Number and Types of Plans, FY 2003

State	Number of Plans		Types of Plans	
	Pre-Medicare	Medicare-eligible Plans	Pre-Medicare	Medicare-eligible Plans
Vermont	4	2	1 indemnity, 1 POS, 1 PPO, 1 catastrophic	1 indemnity, 1 PPO
Virginia	7	1	3 statewide, 4 regional HMOs & POS	Medicare supplement; 2 additional supplements no longer available to new enrollees.[4]
Washington	7	9	4 HMOs, 2 POS, 1 PPO	4 HMOs, 2 POS, 1 PPO, plus 2 Medicare supplement plans (E and J)
West Virginia	3-5	1	1 PPO, 2-4 HMOs depending on region	1 Medicare supplement
Wisconsin	21	21	17 HMOs, 4 fee-for-service	17 HMOs, 4 fee-for-service (1 Medicare supplement in place of standard plan)
Wyoming	1	1	PPO	PPO

[4] Virginia: Drug-only, dental/vision-only, or drug/dental/vision-only plans available in place of medical plan.

Table A2: Eligibility Requirements for Plan Participation, FY 2003

State	Eligibility Requirements	Medicare Enroll-ment Required[1]
Alabama	Those with 10 yrs state service and receiving monthly benefit from Employees' Retirement System, Teachers' Retirement System or Judicial Retirement System.	Yes
Alaska	PERS retirees. No cost to retiree if hired before 7/1/86 or to anyone age 65 or greater. Retirees first hired after 6/30/86 who retire prior to age 60 (or prior to age 65 with less than ten years of credited service for those first hired after 7/1/96) may receive retiree health care insurance by paying the full cost of the premium. Retirees first hired after 6/30/86 who retire at age 60-64 (or prior to age 65 with more than ten years of credited service) may receive retiree health insurance by paying half of the premium cost.	Yes
Arizona	Those retired and collecting a pension from an Arizona state retirement system.	Yes
Arkansas	State retirees.	Yes
California	Those retired within 120 days of separation from state job in which were employed at least ½ time for at least 6 months and one day. Retirees hired before 1/1/85 or retiring with at least 20 years service receive 100% of the state subsidy.	Yes
Colorado	Those receiving a benefit from the Colorado Public Employee Retirement System.	Yes
Connecticut	Health care benefit provided to all retirees.	Yes
Delaware	State pays 100% for retirees hired before 7/1/91. For those hired 7/1/91 or later, state pays portion based on service at retirement; retirees with less than 10 years service pay 100%.	Yes
Florida	Retirees eligible upon retirement from state service and enrollment in retire health plan. Eligible for subsidy upon proof of insurance coverage, which can include Medicare.	Yes
Georgia	Retired teachers, school personnel, state employees and dependents.	Yes
Hawaii	Retired members of state employee retirement system	Yes
Idaho	State employees eligible to retire under Public Employee Retirement System of Idaho (PERSI), whose unreduced regular retirement allowance at the time of retirement must equal or exceed the single retiree health insurance premium. Must enroll within 60 days of retirement.	Yes
Illinois	Those retired from state service with at least 8 years creditable service. State pays 100% of premium for retirees with at least 20 years service, and pays 5% per year of service for those retiring with less than 20 years.	Yes
Indiana	Pre-Medicare retirees may purchase continued coverage in state plan. No coverage in state plan past age 65.	N/A
Iowa	State retirees	Yes
Kansas	Recipients of retirement benefit through State of Kansas.	Yes
Kentucky	Retirees drawing a check from the KY Retirement Systems, Teachers Retirement System, Judicial Retirement Plan or Legislators Retirement Plan	Yes
Louisiana	Retirees of participant employers. Retirees must be vested in health insurance plan prior to retirement to receive maximum state subsidy of 75%.[2]	Yes[1]

[1] A "Yes" answer indicates that Medicare-eligible retirees who do not enroll are treated "as if" they had enrolled in Medicare under the state health plan. "N/A" answer indicates that either the information was not available or not applicable to this state (e.g., the state offers no Medicare-eligible plan, therefore the question of required Medicare enrollment for plan eligibility is moot.

[2] Louisiana: Those enrolled prior to 12/31/01 receive maximum (75%) subsidy. Later enrollees receive retiree health care subsidy according to the following vesting schedule: 10 or fewer years-19%, 10 up to 15 years-38%, 15 up to 20 years-56%, 20 or more years 75%.

Table A2: Eligibility Requirements for Plan Participation, FY 2003

State	Eligibility Requirements	Medicare Enrollment Required[1]
Maine	State funds postretirement health care benefits for most state employees, legislators and portion of teachers' premium. State pays 100% of premium for retirees hired before 7/1/91 or for those with 10 or more years coverage in the state health plan.	Yes
Maryland	Health care coverage for those retired before 7/1/84, or those retired 7/1/84 or later with at least 5 years creditable service. State subsidy for retirees with at least 16 years creditable service, for those who directly retire from the state with at least 5 years and for employees who leave state service within 5 years of normal retirement age and with at least 10 years of creditable service. For less than 16 years, state pays 0.52% of subsidy for each month of creditable service; for 16 or more years of service state pays full subsidy equal to the amount of subsidy paid by the state for active employees.	Yes
Massachusetts	State retirees.	Yes
Michigan	Retirees of State Employee Retirement System, Judges Retirement System, State Police Retirement System and Legislative Retirement System. State pays 100% for retirees who were hired before 4/1/97 and are Medicare-eligible; 95 % if under 65. State pays 3% per year of service for retirees hired 4/1/97 or later. State pays 100% of premium for pre-Medicare retirees in the Legislative Retirement System.	Yes
Minnesota	State retirees. Must enroll within 60 days preceding retirement date.	Yes[4]
Mississippi	Retirees who, as active employees enrolled in plan, participate in retirement plan approved by Public Employees' Retirement System and have at least 25 years of creditable service, or are at least age 60 with 4 or more years service, or are approved for disability retirement benefits. Must enroll within 31 days of retirement date.	Yes
Missouri	Retirees who, at time of termination of state employment, were eligible to receive retirement benefit from Missouri State Employees' Retirement System or Public School Employees' Retirement System for State Employees, and have been covered under the state plan at least since the last enrollment period or have proof of coverage elsewhere for the prior 6 months. Must enroll no later than 31 days after retirement date.	Yes
Montana	Any employees eligible to retire from the Montana Public Employees Retiree Administration.	Yes
Nebraska	Pre-Medicare retirees may purchase continued coverage in state plan. No coverage in state plan past age 65.	N/A
Nevada	Retired state employees receiving a benefit from the Public Employees' Retirement System, Retirement Plan Annuities, Judges Retirement, Legislative Retirement, LTD plan, or their surviving dependents. Must enroll within 60 days.	Yes
New Hampshire	Those retired with at least 30 years of service at any age, or retired with 10 or more years of service if at least age 60, or retired from vested deferred retirement and are at least age 60, or attained age 60 after early retirement. For certain employees, retired from vested deferred retirement, at point when 20 years of service would have been completed but not before the age of 45. Effective 7/1/02, post-retirement medical plan subsidy was extended to state retirees age 60 with 20 or more years of service, or age 55-59 with 30 or more years of service.	Yes

[1] Louisiana: Plan requires written confirmation from Social Security Administration if retiree is *not* eligible for Medicare; otherwise charges will be reduced by Medicare payment amounts.

[4] Minnesota: Retirees not eligible for Medicare may remain with the state group but pay premiums directly to the carriers at the same rate as under age 65 retirees.

Table A2: Eligibility Requirements for Plan Participation, FY 2003

State	Eligibility Requirements	Medicare Enrollment Required[1]
New Jersey	State retirees. Retirees with 25 or more years of service receive 100% premium subsidy.	Yes
New Mexico	Those retired with normal or disability pension from public service before employers' effective participation date in the NM Retiree Health Care Authority, or with retiree and/or employer contribution to NM Retiree Health Care Authority for at least 5 years before retirement date, or retiree and/or employer contribution to NM Retiree Health Care Authority from date of employer's participation in program until retirement date. Must enroll within 31 days of retirement date.	Yes[5]
New York	Those qualified to retire as member of a retirement system administered by NY State, with minimum 5 years state service if hired before 4/1/75 or minimum 10 years state service if hired 4/1/75 or later, and enrolled in state health plan at time of retirement. May defer coverage and reenroll later.	Yes
North Carolina	Retired state employees.	Yes[6]
North Dakota	State pre-Medicare retirees can continue coverage in EPO through COBRA, then participate in state PPO at basic level if receiving retirement benefits. Medicare-eligible retirees may participate in ND Public Employee Retirement System Retiree Health Plan. Retirees with PERS, Highway Patrolman's Retirement System or the Defined Contribution Retirement Plan are eligible for credit.	Yes
Ohio	State retirees with at least 10 years service.	Yes[7]
Oklahoma	Former employees already enrolled in one of the health plans. Must apply 90 days before retirement	Yes
Oregon	Pre-Medicare individuals receiving or eligible to receive a service retirement allowance may enroll in health plans through the Public Employee Benefits Board or through the Public Employee Retirement System (PERS). Pre-Medicare state retirees may receive subsidy based on years of service. Upon attaining Medicare eligibility, retirees lose eligibility for health care through PEBB, but may enroll in a health plan through PERS. Medicare-eligible retirees may enroll in a health plan through PERS within 90 days following retirement or after date of Medicare eligibility, or after 24 months of consecutive coverage under another group plan. Medicare-eligible recipients of PERS pension benefit with at least 8 years service at retirement may receive subsidy from Retirement Health Insurance Account.	Yes
Pennsylvania	State annuitants who were covered under the health plan as an employee or dependent on his/her last day of work may enroll in the Retired Employees Health Program. State annuitants who become dependent subscribers under a spouse's coverage may re-enroll if the spouse's coverage ceases. Most state retirees with 25 years service and those retiring at the normal retirement age with 15 or more years of service qualify for the full state subsidy (100%).	Yes

[5] New Mexico: Retirees not eligible for Part A may purchase Part B and enroll in a pre-Medicare plan if they provide the NM Retiree Health Care Authority with written notice from the Social Security Administration confirming the retiree's non-eligibility for Medicare. Those not purchasing Part B will remain enrolled in the BCBS Triple Option POS plan with state payments made as if the retiree were covered by Medicare Part A.

[6] North Carolina: Retirees not eligible for Medicare must provide written documentation from the Social Security Administration in order to retain coverage.

[7] Ohio: Retirees not eligible for Medicare Part A may participate in traditional plans only at additional cost upon submission of written confirmation from the Social Security Administration of ineligibility for Medicare Part A.

Table A2: Eligibility Requirements for Plan Participation, FY 2003

State	Eligibility Requirements	Medicare Enrollment Required[1]
Rhode Island	Retired state employees. State subsidy depends on age and service at retirement. Pre-Medicare subsidies: retirees with less than 28 years service must be age 60 to receive any subsidy; retirees with 28 years but less than age 60 receive 90% subsidy. Full subsidy (100%) for retirees with at least 28 years and age 60 or older, or for retirees with 35 years service at any age. Medicare-eligible retirees receive full subsidy at age 65 with 28 or more years.	Yes[8]
South Carolina	Covered employees may enroll within 31 days of retirement or during later open enrollment periods. To receive state funded benefits, must be eligible to retire with at least 5 years service with a participating state entity.	Yes[9]
South Dakota	Former employees covered under the state health plan and who are entitled to immediate retirement benefits may continue coverage in the state health plan until age 65, then they may convert to the state sponsored Medicare supplement plan.	Yes
Tennessee	State retirees may retain coverage until age 65. At age 65, retirees may enroll in state sponsored Medicare supplement plans. For Medicare-eligible retirees, state pays $40/month for retirees with 30 or more years service, $30/month for retirees with 20-29 years service, $20/month for retirees with 15-19 years service and $0 for retirees with less than 15 years. Pre-Medicare retirees receive state contribution on same basis as active employees.	Yes
Texas	Retirees with at least 10 years of state service; state subsidizes full cost for individual coverage.	Yes
Utah	Retirees under 65 may continue coverage on same basis as active employees; coverage ends when retiree attains age 65 or after 5 years. Retirees attaining age 65 may enroll in high- or low-option Medicare supplement plan for which retiree pays full premium. Medicare members may only switch between low- and high-option every 2 years.	Yes
Vermont	Retiring employees may continue coverage by paying 20% share of premium.	Yes
Virginia	Retiring state employees who are eligible for annuity and will receive (not defer) annuity immediately upon retirement may enroll in health plan within 31 days of retirement. Retirees are automatically enrolled in Advantage 65 Medicare supplement plan upon attaining age 65. Minimum 15 years of service at retirement required to receive commonwealth subsidy.	Yes
Washington	Retiring state, higher education, school district or political subdivision employees. Employees retiring under most state retirement plans must immediately begin receiving a retirement allowance. Employees retiring under PERS III, TRS III or SERS III must be age 55 with 10 years of service, and higher education employees must be age 55 with 10 years or age 62 or immediately begin receiving a retirement benefit in order to enroll in a state health plan.	Yes
West Virginia	Those meeting minimum eligibility requirements for retirement of applicable state retirement system, and whose last employer prior to retirement was participant in state health plan. Must enroll within 2 months after retirement. Maximum state subsidy for retirees with 25 or more years of service or those retiring before 7/1/97. Retirees with 20 or more years service may defer enrollment in health plan for up to 2 years following separation, but will be required to pay 105% of premium upon reenrollment.	Yes

[8] Rhode Island: If ineligible for Medicare with documented proof, state will pay an amount equal to the cost of the basic plan for under 65.

[9] South Carolina: Enrollment required if Medicare-eligible. Retirees who are not Medicare-eligible may choose coverage in the Standard or Economy plans.

Table A2: Eligibility Requirements for Plan Participation, FY 2003

State	Eligibility Requirements	Medicare Enroll-ment Required[1]
Wisconsin	State retirees participating in a health plan at the time of retirement and who receive an annuity within 30 days of retirement will be automatically enrolled for continued coverage. Insured employees who terminate service with 20 years of creditable service but who are not immediately eligible for a retirement annuity, or who defer their retirement annuity may enroll by submitting an application with 90 days of termination of state service.	Yes
Wyoming	Retirees who had medical coverage under the state employer's plan for at least one year prior to retirement, and either: are at least age 50 on the retirement date, or have at least 20 years of service, or are eligible for state retirement benefits.	Yes

Table A3: State Government Retiree Monthly Health Insurance Premiums—Pre-Medicare, FY 2003

State	Total Premium[1]		Retiree Pays	
	Lowest-cost	Highest-cost	Lowest-cost	Highest-cost
Alabama[2]	$248.00		$138.00	
Alaska[3]	$485.00		$0	
Arizona[4]	$269.97	$925.42	$119.97	$775.42
Arkansas	$368.40	$523.70	$192.30	$347.60
California[5]	$208.90	$548.00	$0	$260.00
Colorado[6]	$373.00	$699.00	$143.00	$469.00
Connecticut	N/A	N/A	$0	$20.60[7]
Delaware	$293.62	$332.12	$0	$38.50
Florida	$290.82		$140.82[8]	
Georgia	N/A	N/A	$47.91	$183.31
Hawaii[9]	N/A	N/A	$0	$0
Idaho[10]	$332.72		$332.72	
Illinois[11]	$283.28	$521.26	$0	$0

[1] Monthly premiums are for single coverage as of 1/1/03, except as noted. See Tables A5 and A7 for plan details. An "N/A" answer indicates that either the information was not available or not applicable to this state (e.g., there may be no stated total premium because the state plan is self- funded). A single entry for merged "highest-cost" and "lowest-cost" cells indicates that there is only one plan, which by default is both the "highest-cost" and "lowest-cost" plan.

[2] Alabama: Total premium is for 2002. Retiree share applies to both 2002 and 2003.

[3] Alaska: 2003 rates; composite rate for all retirees. Retiree pays $0 if retired prior to 7/1/86 or is at least age 65; $450 if retired 7/1/86 or later and under age 60, or if retired 7/1/96 or later with less than 10 years service regardless of age.

[4] Arizona: For Maricopa County. Retiree rates shown include $150 subsidy for pre-Medicare retiree with 10 or more years service, $100 subsidy for Medicare-eligible retiree with 10 or more years service. Additional state subsidy available for in-state retirees living in areas where no HMO is offered.

[5] California: State employer subsidy of $288/month.

[6] Colorado: Rates vary by region; highest and lowest rates for Denver metro area (including statewide offerings) shown in table. Retiree rates include maximum subsidy of $230/month for retirees with at least 20 years of service. Subsidy reduced by 5% for each year of service less than 20.

[7] Connecticut: For those retiring 7/1/99 or later. State pays full cost for those retiring before 7/1/97, and pays full cost of most plans for those retiring between 7/1/97 and 7/1/99.

[8] Florida: State subsidy of $5/mo per year of service at retirement; minimum $30, maximum $150. Retiree rates shown assume maximum subsidy (retiree with 30 years service).

[9] Hawaii: Under the newly created Employer-Union Health Benefits Trust Fund (effective 7/1/03), the state is projected to pay up to $342/month for pre-Medicare and $218/month for Medicare-eligible retirees with at least 25 years service at retirement or for those hired before 7/1/96 with at least 10 years of service at retirement; retirees pay any remaining amounts. Individuals hired 7/1/96 or later with 15-25 years of service at retirement will receive 75% of the subsidy, those retiring with 10-15 years service will receive 50% of the subsidy, and those retiring with less than 10 years service will receive no state subsidy.

[10] Idaho: Retiree pays majority of premium. State contributes $7 per active employee per month, and the active employee contributes an equal amount into a reserve fund that may be used to offset retiree premiums.

[11] Illinois: State pays 100% of premium for those retiring with at least 20 years creditable service.

Table A3: State Government Retiree Monthly Health Insurance Premiums—Pre-Medicare, FY 2003

State	Total Premium[1]		Retiree Pays	
	Lowest-cost	Highest-cost	Lowest-cost	Highest-cost
Indiana	$315.76	$486.27	$315.76	$486.27
Iowa	$275.84	$419.62	$275.84	$419.62
Kansas	$317.82	$369.64	$317.82	$369.64
Kentucky[12]	$211.04	$467.76	$0	$198.32
Louisiana[13]	$724.58	$737.18	$123.12	$142.00
Maine	$456.20		$0	
Maryland	N/A	N/A	$31.58	$65.12
Massachusetts	$211.32	$483.01	$31.70	$90.65
Michigan[14]	$287.21		$14.36	
Minnesota	$304.16		$304.16	
Mississippi	$252.00		$252.00	
Missouri[15]	$434.00	$625.00	$174.00	$365.00
Montana	$308.00	$335.00	$308.00	$335.00
Nebraska	$257.97	$294.98	$257.97	$294.98
Nevada[16]	N/A	N/A	$0	$104.55
New Hampshire	$540.16		$0	
New Jersey[17]	$314.87	$564.20	$0	$141.05
New Mexico[18]	$393.47	$422.98	$86.31	$211.49
New York[19]	$338.38	$464.23	$33.84	$159.69
North Carolina[20]	$244.38		$0	
North Dakota[21]	$285.25		$195.25	

[12] Kentucky: Retirement system contribution varies by service, as follows: less than 4 years-0%, 4-9 years-25%, 10-14 years-50%, 15-19 years-75%; 20 years or more-100%; with a maximum 2003 contribution from $269.44 to $397.08, depending on county of residence. Rates in table reflect retiree receiving 100% contribution at $269.44 maximum.

[13] Louisiana: Rates shown apply to statewide PPO (low cost) and EPO (high cost). Other plans available in limited service areas have retiree rates ranging from $98.88 ($592.88 total premium) to $238.82 (840.28 total premium).

[14] Michigan: Rates are for State Health Plan for retirees hired before 4/1/97. State pays 3% per year of service for post-4/1/97 hires.

[15] Missouri: Retiree rates reflect maximum state subsidy for individuals retiring 7/1/02 or later and residing in East Region (includes St. Louis metro area). Subsidy is 2.5% times years of credited service at retirement, to maximum of 75%, subject to appropriations. Current maximum is 60%. Percentage is applied to lowest-cost plan in region where retiree resides; retiree pays remainder. Individuals retiring before 7/1/02 receive greater of former subsidy and subsidy calculated under new formula.

[16] Nevada: State subsidy for 2003 retirees will average $263.89/month. Retiree rates show individual retiring before 1/1/94, or after 1/1/94 with 15 years of service. Subsidy based on years of service for those retiring 1/1/94 or later, with retirees with 15 years service receiving the average subsidy amount. Those retiring with 20 or more years of service receive maximum subsidy of 137.5% of base (average) amount.

[17] New Jersey: Retiree rates shown are for retirees attaining 25 years of credited service between 7/1/00 and 6/30/03.

[18] New Mexico: Retiree rates shown apply to those retiring before 7/1/01 or those retiring 7/1/01 or later with at least 20 years service. Subsidy for individuals retiring 7/1/01 or later depends on years of service at retirement, with maximum subsidy provided to those with 20 or more years.

[19] New York: State pays no more than 90% of Empire Plan premium for employees retiring after 1/1/83.

[20] North Carolina: 2002 rates.

Table A3: State Government Retiree Monthly Health Insurance Premiums—Pre-Medicare, FY 2003

State	Total Premium[1]		Retiree Pays	
	Lowest-cost	Highest-cost	Lowest-cost	Highest-cost
Ohio	$627.74	$642.97	$0	$15.23
Oklahoma	$328.50	$414.14	$223.50	$309.00
Oregon[22]	$353.71	$553.18	$175.72	$375.19
Pennsylvania[23]	$445.81		$0	
Rhode Island[24]	$249.50		$0	
South Carolina	$252.24	$277.43	$45.54	$70.73
South Dakota	$159.92	$212.96	$159.92	$212.96
Tennessee[25]	$343.45	$369.10	$68.69	$73.82
Texas	$238.54	$306.61	$0	$0
Utah	$250.60	$269.47	$5.01	$18.87
Vermont	$261.51	$464.70	$52.30	$92.94
Virginia[26]	$260.00	$544.00	$140.00	$424.00
Washington	$279.35	$334.46	$279.35	$334.46
West Virginia[27]	$300.00	$312.75	$158.00	$253.00
Wisconsin	$320.20	$795.40	$320.20	$795.40
Wyoming	$406.60		$406.60	

[21] North Dakota: Retiree rate reflects retiree with 20 years service receiving Retiree Health Insurance Credit of $4.50 per year of service ($90).

[22] Oregon: Retiree rates reflect maximum state subsidy for pre-Medicare retirees with 30 years of service.

[23] Pennsylvania: State pays into Pennsylvania Employee Benefit Trust Fund. Rate shown is composite rate for pre-Medicare and Medicare-eligible retirees.

[24] Rhode Island: Rates in effect from 7/1/02 to 12/31/02. Rate reflects 100% subsidy for age 60 and 28 years of service.

[25] Tennessee: Retiree rates reflect maximum state subsidy for under age 65 retiree with 30 years of service.

[26] Virginia: Retiree rates reflect maximum commonwealth contribution of $120/month ($4/year of service to 30 years maximum yearsyears maximum).

[27] West Virginia: Retiree rates apply to retirees with at least 25 years service or those retiring before 7/1/97. Retiree premium assistance available to retirees with incomes below 250% of the federal poverty level.

Table A4: State Government Retiree Monthly Health Insurance Premiums—Medicare-Eligible, FY 2003

State	Total Premium[1]		Retiree Pays	
	Lowest-cost	Highest-cost	Lowest-cost	Highest-cost
Alabama[2]	$110.00		$0	
Alaska[3]	$485.00		$0	
Arizona[4]	$137.48	$424.77	$37.48	$324.77
Arkansas	$152.20	$193.60	$97.30	$138.70
California[5]	$180.69	$340.00	$0	$52.00
Colorado[6]	$127.00	$227.00	$12.00	$112.00
Connecticut	N/A	N/A	$0	$12.41[7]
Delaware	$223.35	$332.12	$0	$38.50
Florida	$154.67		$4.67[8]	
Georgia	N/A	N/A	$10.00	$183.31
Hawaii[9]	N/A	N/A	$0	$0
Idaho[10]	$157.90		$157.90	

[1] Monthly premiums for single coverage as of 1/1/03, except as noted. See Tables A6 and A8 for plan details. An "N/A" answer indicates that either the information was not available or not applicable to this state (e.g., there may be no stated total premium because the state plan is self-funded). A single entry for merged "highest-cost" and "lowest-cost" cells indicates that there is only one plan, which by default is both the "highest-cost" and "lowest-cost" plan.

[2] Alabama: Total premium is for 2002. Retiree share applies to both 2002 and 2003.

[3] Alaska: 2003 rates; composite rate for all retirees. Retiree pays $0 if retired prior to 7/1/86 or is at least age 65; $450 if retired 7/1/86 or later and under age 60, or if retired 7/1/96 or later with less than 10 years service regardless of age.

[4] Arizona: For Maricopa County. Retiree rates shown include $150 subsidy for pre-Medicare retiree with 10 or more years service, $100 subsidy for Medicare-eligible retiree with 10 or more years service. Additional state subsidy available for in-state retirees living in areas where no HMO is offered.

[5] California: State subsidy of $288/month. If subsidy exceeds monthly premium, Medicare-eligible retiree will be reimbursed for excess up to amount of Medicare Part B premium.

[6] Colorado: Rates vary by region; highest and lowest rates for Denver metro area (including statewide offerings) shown in table. Retiree rates include maximum subsidy of $115/month for retirees with at least 20 years of service. Subsidy reduced by 5% for each year of service less than 20.

[7] Connecticut: For those retiring 7/1/97 or later selecting Anthem Preferred. State pays full cost of all other health plans for Medicare-eligible retirees.

[8] Florida: State subsidy of $5/month per year of service at retirement; minimum $30, maximum $150. Retiree rates shown assume maximum subsidy (retiree with 30 years service). HMO rates vary by county from $150.58 to $187.05 (total premium).

[9] Hawaii: Under the newly created Employer-Union Health Benefits Trust Fund (effective 7/1/03), the state is projected to pay up to $342/month for pre-Medicare and $218/month for Medicare-eligible retirees with at least 25 years service at retirement or for those hired before 7/1/96 with at least 10 years of service at retirement; retirees pay any remaining amounts. Individuals hired 7/1/96 or later with 15-25 years of service at retirement will receive 75% of the subsidy, those retiring with 10-15 years of service will receive 50% of the subsidy, and those retiring with less than 10 years of service will receive no state subsidy.

[10] Idaho: Retiree pays majority of premium. State contributes $7 per active employee per month, and the active employee contributes an equal amount into a reserve fund that may be used to offset retiree premiums.

Table A4: State Government Retiree Monthly Health Insurance Premiums—Medicare-Eligible, FY 2003

State	Total Premium[1]		Retiree Pays	
	Lowest-cost	Highest-cost	Lowest-cost	Highest-cost
Illinois[11]	$179.68	$249.50	$0	$0
Indiana	N/A	N/A	N/A	N/A
Iowa	$150.22	$448.52	$150.22	$448.52
Kansas	$277.53	$385.92	$277.53	$385.92
Kentucky[12]	$82.70	$286.53	$0	$0
Louisiana[13]	$205.36	$208.92	$51.34	$54.90
Maine	$219.86		$0	
Maryland	N/A	N/A	$16.66	$32.57
Massachusetts	$176.87	$325.42	$26.53	$55.74
Michigan[14]	$272.84		$0	
Minnesota	$194.51	$376.39	$194.51	$376.39
Mississippi	$164.00		$164.00	
Missouri[15]	$232.00	$285.00	$93.00	$146.00
Montana	$177.00	$209.00	$177.00	$209.00
Nebraska	N/A	N/A	N/A	N/A
Nevada[16]	N/A	N/A	$0	$0
New Hampshire	$308.21		$0	
New Jersey[17]	$297.07	$325.96	$0	$81.49
New Mexico[18]	$46.40	$261.67	$23.20	$129.25
New York[19]	$338.38	$464.23	$33.84	$159.69
North Carolina[20]	$186.04		$0	
North Dakota[21]	$173.45		$83.45	

[11] Illinois: State pays 100% of premium for those retiring with at least 20 years creditable service.

[12] Kentucky: Retirement system contribution varies by service, as follows: less than 4 years-0%, 4-9 years-25%, 10-14 years-50%, 15-19 years-75%; 20 or more-100%.

[13] Louisiana: Rates shown apply to statewide PPO (low cost) and EPO (high cost). Other plans available in limited service areas with retiree rates ranging from $43.84 ($175.36 total premium) to $109.76 ($263.78 total premium).

[14] Michigan: Rates are for State Health Plan for retirees hired before 4/1/97. State pays 3% per year of service for post-4/1/97 hires.

[15] Missouri: Retiree rates reflect maximum state subsidy for individuals retiring 7/1/02 or later and residing in East Region (includes St. Louis metro area). Subsidy is 2.5% times years of credited service at retirement, to maximum of 75%, subject to appropriations. Current maximum is 60%. Percentage is applied to lowest-cost plan in region where retiree resides; retiree pays remainder. Individuals retiring before 7/1/02 receive greater of former subsidy and subsidy calculated under new formula.

[16] Nevada: State subsidy for 2003 retirees will average $263.89/month. Retiree rates show individual retiring before 1/1/94, or after 1/1/94 with 15 years of service. Subsidy based on years of service for those retiring 1/1/94 or later, with retirees with 15 years service receiving the average subsidy amount. Those retiring with 20 or more years of service receive maximum subsidy of 137.5% of base (average) amount.

[17] New Jersey: Retiree rates shown are for retirees attaining 25 years of credited service between 7/1/00 and 6/30/03.

[18] New Mexico: Retiree rates shown apply to those retiring before 7/1/01 or those retiring 7/1/01 or later with at least 20 years service. Subsidy for individuals retiring 7/1/01 or later depends on years of service at retirement, with maximum subsidy provided to those with at 20 or more years.

[19] New York: State pays no more than 90% of Empire Plan premium for employees retiring after 1/1/83.

[20] North Carolina: 2002 rates.

Table A4: State Government Retiree Monthly Health Insurance Premiums—Medicare-Eligible, FY 2003

State	Total Premium[1]		Retiree Pays	
	Lowest-cost	Highest-cost	Lowest-cost	Highest-cost
Ohio	$273.22	$273.22	$0	$0
Oklahoma	$156.40	$247.96	$51.40	$142.96
Oregon[22]	$107.11	$174.55	$47.11	$114.55
Pennsylvania[23]	$445.81		$0	
Rhode Island[24]	$72.00	$124.18	$72.00	$124.18
South Carolina	$252.24	$277.43	$35.74	$70.73
South Dakota	$137.58		$137.58	
Tennessee[25]	$108.19	$191.73	$68.19	$151.73
Texas	$238.54	$306.61	$0	$0
Utah	$93.00	$275.00	$93.00	$275.00
Vermont	$187.63	$198.68	$37.53	$39.74
Virginia[26]	$236.00		$116.00	
Washington	$144.72	$368.12	$51.98	$275.38
West Virginia[27]	$339.00		$52.00	
Wisconsin	$257.10	$360.00	$257.10	$360.00
Wyoming	$255.72		$255.72	

---

[21] North Dakota: Retiree rate reflects retiree with 20 years service receiving Retiree Health Insurance Credit of $4.50 per year of service ($90).

[22] Oregon: Retiree rates reflect $60 subsidy through Retiree Health Insurance Account for Medicare-eligible retirees.

[23] Pennsylvania: State pays into Pennsylvania Employee Benefit Trust Fund. Rate shown is composite rate for pre-Medicare and Medicare-eligible retirees.

[24] Rhode Island: Rates in effect 7/1/02 through 12/31/02. Rate reflects 100% subsidy for age 65 and 28 years of service.

[25] Tennessee: Retiree rate for retiree with 30 or more years of service receiving the maximum state contribution.

[26] Virginia: Retiree rates reflect maximum commonwealth contribution of $120/month ($4/year of service to 30 years maximum).

[27] West Virginia: Rates apply to retirees with at least 25 years of service or those retiring before 7/1/97. Retiree premium assistance available to retirees with incomes below 250% of the federal poverty level.

Table A5: Other Characteristics of State Government Retiree Health Plans—Pre-Medicare, FY 2003

State	Plan: ► Lowest-cost ► Highest-cost	Deductibles	Coinsurance Paid By Plan Copays Paid by Patient	Office Visit Copay	Out-of-Pocket Maximum	Rx
Alabama	SEHIP: In network	$100/person; 3-member family maximum	100% inpatient, outpatient and physician services; 80% mental health, substance abuse, other	$20	$400/person; 3-member family maximum	Yes
	SEHIP: Out of network	$100/person; 3-member family maximum	80% most services	N/A	$400/person; 3-member family maximum	No
Alaska	State Retiree Health Plan	$150/person; 3 per family	80% most medical and chemical dependency; 100% other	N/A	$800/person	Yes
Arizona	Cigna HMO	N/A	N/A	$10	N/A	Yes
	Pacificare PPO	$500/person $1,500/family	80% most services in-plan; 60% out-of-plan	$15	$4,000/person in-plan; $8,000/person out-of-plan	Yes
Arkansas	QualChoice HMO	$0	90%; $250 copay inpatient hospital per admission	$20 primary care	$1,000/person $1,500/family	Yes
	BCBS PPO	$500/person $1,000/family in-plan; $750/person $1,500 family out-of-plan	80% in-plan, 70% out-of-plan	N/A	$2,000/person $4,000/family in-plan; $2,500/person $5,000/family out-of-plan	Yes
California	Western Health Advantage	N/A	100% inpatient; $10 copay outpatient	$10	$1,000/person $2,500/family	Yes
	PERSCare	$500/person $1,000/family	90% most services in PPO; 60% non-PPO	$20	$2,000/person $4,000/family	Yes
Colorado	Kaiser Permanente HMO #3	N/A	$1,000 copay per hospital admission; then 100%	$25	$3,000/person $6,000/family	Yes
	Rocky Mountain HMO #1	N/A	$300 hospital copay per admission; then 100%	$10	$1,000/person $3,000/family	Yes

Note: For monthly premiums for the plans shown in this table see Table A3. An "N/A" answer indicates that either the information was not available and/or not applicable to the plan shown.

Table A5: Other Characteristics of State Government Retiree Health Plans—Pre-Medicare, FY 2003

State	Plan: ►Lowest-cost ►Highest-cost	Deductibles	Coinsurance Paid By Plan Copays Paid by Patient	Office Visit Copay	Out-of-Pocket Maximum	Rx
Connecticut	POS in-plan, POE[1]	N/A	100% hospital coverage	$ 5[2]	N/A	Yes
	POS out-of-plan	$300/person $900/family	80% coinsurance	20%	$2,000/person $4,000/family	Yes
Delaware	BCBS Basic	$400/person $800/family	100% hospital coverage; 80% physician inpatient coverage	N/A	$1,000/person $2,000/family	No
	BCBS Comprehensive	$200/person $500/family	100% most services	20%	N/A	Yes
Florida	State PPO	$150 in-plan, $300 out-of-plan	90% in-plan, 70% out-of-plan most services. $100 hospital copay in-plan, $300 out-of-plan.	$10 + 10% in-plan; $20 + 30% out-of-plan	$2,500/person $5,000/family	Yes
Georgia	Blue Choice HMO	N/A	100% most services; $200 hospital admission copay	$15	N/A	Yes
	Indemnity	$300/person $900/family	90% most services; $100 hospital admission deductible	10%	$2,000/person $4,000/family	Yes
Hawaii[3]						
Idaho	State plan	$400/person $1,200/family	80% most services	20%	$4,800/person $9,600/family	Yes
Illinois	HMO	N/A	$150 hospital copay, then 100%	$10	N/A	Yes
	Indemnity	$200/person $300/family	90% hospital services in-plan; $200 per admission deductible for out-of-plan hospitals	10% in-plan; 20% U&C other	$800/person, $2,000/family in-plan; $3,000/person, $7,000/family out-of-plan	Yes

[1] Connecticut: In POE or Point of Enrollment plan, services are available from defined network of providers only.

[2] Connecticut: POS in-plan office visit copay is $10 for those retiring 7/1/99 or later.

[3] Hawaii: The state of Hawaii has created an Employer-Union Health Benefits Trust Fund, effective July 1, 2003. The Fund will offer multiple options for pre-Medicare and Medicare-eligible retirees. Details have not been finalized at this time.

Table A5: Other Characteristics of State Government Retiree Health Plans—Pre-Medicare, FY 2003

State	Plan: ► Lowest-cost ► Highest-cost	Deductibles	Coinsurance Paid By Plan Copays Paid by Patient	Office Visit Copay	Out-of-Pocket Maximum	Rx
Indiana	Anthem Traditional	Varies by salary[4]	Most services covered at 80% in-plan, 60% out-of-plan	20% in-plan, 40% out of-plan	$1,000/person $2,400/family	Yes
	Humana HMO	$0	Most services covered at 100%	$5	$1,000/person $2,000/family	Yes
Iowa	Blue Advantage	N/A	Authorized hospital services covered at 100%. Primary care physician referral required	$10	$750/person $1,500/family	Yes
	Wellmark Program 3 Plus	$300/person $400/family	80% covered charges	20%	$600/person $800/family	Yes
Kansas[5]	Premier Blue HMO	$200/person $400/family; inpatient services only	100% inpatient services	$10	N/A	Yes
	Preferred Health Systems PPO	$200/person $400/family	90% in-plan, 70% out-of-plan	$15	$1,000/person $2,000/family in-plan; $3,000/person, $6,000/family out-of-plan	Yes
Kentucky	CHA Health EPO	N/A	$1,500 per admission hospital copay, then 100%	$25	$4,000/person $8,000/family	Yes
	Humana POS-A	$0 in-plan; $500/person, $1,000/family out-of-plan	$100 hospital copay per admission, then 100% in-plan, 60% out-of-plan	$10 in-plan; 40% out-of-plan	$1,000/person $2,000/family in-plan; $2,500/person $5,000/family out-of-plan	Yes

[4] Indiana: $0 deductible for annual salary less than $25,000; $125/person or $400/family for salaries $25,000-$35,000; $500/person or $1,000/family for salaries over $35,000.
[5] Kansas: All Kansas plans include dental.

Table A5: Other Characteristics of State Government Retiree Health Plans—Pre-Medicare, FY 2003

State	Plan: ►Lowest-cost ►Highest-cost	Deductibles	Coinsurance Paid By Plan Copays Paid by Patient	Office Visit Copay	Out-of-Pocket Maximum	Rx
Louisiana	PPO	$300/person $900/family	Plan pays 90% PPO services (or non-PPO out-of-state); 70% non-PPO	N/A	$10,000/person	Yes
	EPO	$0 ($300/personor $900/family)	$100/day hospital copay ($300 maximum); then 100% hospital and other services in-plan	$15	N/A in-plan	Yes
Maine	Anthem HMO	N/A	Plan provides hospitalization plus major medical	$10	$2,000/person $4,000/family	Yes
Maryland[6]	Kaiser Permanente HMO	N/A	100% in-plan coverage; 0% out-of-plan	$5	N/A	No
	MLH-Eagle PPO	$0 in-plan; $250/person or $500/family out-of-plan	100% coverage in-plan; 80% out-of-plan	$15	N/A in-plan; $3,000/person $6,000/family out-of-plan	No
Massachusetts	Fallon Community Health Plan HMO	N/A	N/A	$15	N/A	Yes
	GIC (state) indemnity comprehen-sive	$75/person $150/family	100% coverage most services; $150/quarter hospital deductible	$10	N/A	Yes
Michigan	State PPO	$200/person or $400/family in-plan; $500/person or $1,000/family out-of-plan	100% most services in-plan; 90% out-of-plan	$10	$1,000/person $2,000/family in-plan; $2,000/person $4,000/family out-of-plan	Yes
Minnesota	State Health Plan[7]	$100/person cost level 1; $150/person cost level 2; $300/person cost level 3; 2-person family maximum	100% hospital services. Per admission copays: $200 for cost level 2 and $400 for cost level 3. Other services covered at 100% cost level 1, 95% cost level 2, 90% cost level 3	$5/$10/$20	$500/person $1,000/family	Yes

[6] Maryland: Separate prescription drug plan available at $32.07/month.
[7] Minnesota: Primary Care Clinics assigned to one of three cost levels; copays for some services vary by cost level.

Table A5: Other Characteristics of State Government Retiree Health Plans—Pre-Medicare, FY 2003

State	Plan: ► Lowest-cost ► Highest-cost	Deductibles	Coinsurance Paid By Plan Copays Paid by Patient	Office Visit Copay	Out-of-Pocket Maximum	Rx
Mississippi	State Health Plan	$450/person or $900/family in-plan; $900/person $1,800/family out-of-plan	Most services covered at 80% in-plan; 60% out-of-plan	N/A	$2,000/person in-plan, $3,000/person out-of-plan	Yes
Missouri	Mercy HMO standard	N/A	$400 hospital per admission copay, then 100%	$30	N/A	Yes
	Copay plan	$500/person $1,000/family	$200 hospital per admission copay, then 100% in-plan; 30% coinsurance out-of-plan	$25	N/A	Yes
Montana	Basic indemnity	$1,305/person $2,610/family	80% preferred hospital coinsurance, 65% nonpreferred hospital coinsurance; 75% most other services	$15	$2,500/person $5,000/family	Yes
	Blue Choice HMO	$300/person $600/family	75% coinsurance most services	$15	$2,000/person $4,000/family	Yes
Nebraska	BlueChoice Advantage POS	$0 in-plan; $500/person $1,000/family out-of-plan	80% hospital charges covered in-plan, 60% out-of-plan	$10 in-plan; 40% out-of-plan	$1,500/person $3,000/family in-plan; $3,000/person $6,000/family out-of-plan	Yes
	Blue Preferred PPO	$400/person $800/family in-plan; $600/person $1,200/family out-of-plan	80% hospital charges covered in-plan, 70% out-of-plan	20% in-plan; 30% out-of-plan	$1,400/person $2,800/family in-plan; $4,000/person $6,400/family out-of-plan	Yes
Nevada	HMO	N/A	$200 hospital copay, then 100%	$15	$1,200/person $2,700/family	Yes
	PPO	$250/person $500/family	80% most services in-plan, 50% out-of-plan	$15 in-plan; 50% out-of-plan	$2,400/person $4,800/family in-plan; $8,500/person $17,000/family out-of-plan	Yes
New Hampshire	Anthem POS	N/A	100% most services in-plan; 80% out-of-plan	$10	N/A	Yes

Table A5: Other Characteristics of State Government Retiree Health Plans—Pre-Medicare, FY 2003

State	Plan: ▶Lowest-cost ▶Highest-cost	Deductibles	Coinsurance Paid By Plan Copays Paid by Patient	Office Visit Copay	Out-of-Pocket Maximum	Rx
New Jersey	Oxford HMO	N/A	100% most services after copays	$5	N/A	Yes
	Traditional	$100/person, 2-person maximum	80% most services	20%	$400/person	Yes
New Mexico	HMO	N/A	100% hospital charges after $250 admission copay	$20	$2,000/person $6,000/family	Yes
	BCBS Triple Option POS	$0 for primary coordinated care; otherwise $200/person, $400/2-party, $600/family in-plan and $300/person, $600/2-party or $900/family out-of-plan	Most services 100% after copay ($250 hospital admission copay) if through primary coordinated care. For self-coordinated care, plan pays 80% most services in-plan, 30% out-of-plan.	$20 for primary coordi-nated care; or 20% in-plan, 30% out-of-plan	$2,000/person, $6,000/family in-plan; $3,500/person, $10,500/ family out-of-plan	Yes
New York	Empire Plan	$283/enrollee	Basic hospital services covered at 100%	$12	$1,362/family	Yes
	HMO Blue (160)	N/A	100% most services	$10	N/A	Yes
North Carolina	State plan	$350/person $1,050/family	Plan pays 80%. $100 inpatient copay	$15	$1,500/person $4,500/family	Yes
North Dakota	PPO basic	$250/person $750/family	Plan pays 80% most services	$25	$1,250/person $2,500/family	Yes
Ohio	PERS Health Care Plan	$100/person $200/family in-plan; $150/person $300/family out-of-plan	Plan pays 80% most services in-plan, 70% UCR out-of-plan	$10 in-plan; 70% UCR out-of-plan	$500/person $750/family in-plan; $750/person $1,125/family out-of-plan	Yes
Oklahoma	Health Choice indemnity-low	$1,500/person $4,500/family	Plan pays 80% most charges in-plan, 75% out-of-plan	$20 in-plan; 25% out-of-plan	$3,500/person in-plan; $4,000/person out-of-plan	Yes
	PacifiCare HMO-high	N/A	$50 hospital admission copay, then 100%	$10	N/A	Yes

Table A5: Other Characteristics of State Government Retiree Health Plans—Pre-Medicare, FY 2003

State	Plan: ►Lowest-cost ►Highest-cost	Deductibles	Coinsurance Paid By Plan Copays Paid by Patient	Office Visit Copay	Out-of-Pocket Maximum	Rx
Oregon	Kaiser Permanente HMO	N/A	$200 per admission hospital copay, then 100%	$15	$1,000/person $2,000/family	Yes
	Clear Choice PPO	$200/person $600/family	80% most services in-plan, 70% out-of-plan	$15 in-plan; 30% out-of-plan	N/A	Yes
Pennsylvania	HMO	$0	100% for most services	$15	N/A	Yes
	Basic Option	$200/person, 3 deductible per family maximum for major medical	Major medical covers 80% of first $1,900 covered charges, then 100%	20% to major medical maximum	$380/person	Yes
Rhode Island	Blue Cross PPO	$100/person $200/family	100% most services in-plan; 80% for prescription drugs	N/A	N/A	Yes
South Carolina	Companion HMO	$0	$250 per hospital admission; then 90% coverage	$15	$1,500/person $3,000/family	Yes
	Cigna POS	N/A	N/A	N/A	N/A	
South Dakota	State plan – low option	$1,000/person $2,500/family of 3 or more	Plan pays 75% covered charges in-plan, 65% out-of-plan	N/A	$3,500/person in-plan; $5,000/person out-of-plan	Yes
	State plan – high option	$500/person $1,200/family or 3 or more	Plan pays 75% covered charges in-plan, 65% out-of-plan	N/A	$3,000 in-plan; $5,000 out-of-plan	Yes
Tennessee	HMOs	N/A	$100 per admission hospital copay, then 100%	$10	N/A	Yes
	BCBS PPO	$250/person $625/family	Most services covered at 90% in-plan, 70% out-of-plan	10% in-plan; 30% out-of-plan	$1,250/person $2,500/family in-plan; $3,750/person $7,500/family out-of-plan	Yes
Texas	HMOs	N/A	Inpatient services covered at 100%	$10	N/A	Yes
	HealthSelect PPO	$0 in-plan; $500/person $1,500/family out-of-plan	Inpatient services covered at 90% in-plan, 70% out-of-plan	$15 in-plan; $30 out-of-plan	$500/person in-plan; $1,500 out-of-plan	Yes

Table A5: Other Characteristics of State Government Retiree Health Plans—Pre-Medicare, FY 2003

State	Plan: ►Lowest-cost ►Highest-cost	Deductibles	Coinsurance Paid By Plan Copays Paid by Patient	Office Visit Copay	Out-of-Pocket Maximum	Rx
Utah	PEHP Exclusive HMO	N/A	Plan pays 100%	$15	$1,500/person $3,000/family	Yes
	PEHP Preferred PPO	N/A	Plans pays 90% of benefits schedule amount	$20	$1,500/person $3,000/family	Yes
Vermont	SafetyNet catastrophic	$2,000/person; no family maximum	Plan pays 70% most services	30%	$6,000/person; no family maximum	No
	TotalChoice indemnity	$300/person $600/family	Plan pays 90% inpatient hospital services; 80% most other services	20%	$750/person $2,250/family	Yes
Virginia	Kaiser Permanente HMO	N/A	100% covered	$5	N/A	Yes
	Cost Alliance	N/A	$100/day hospital copay to $500 maximum per admission	$20	$2,500 per covered person	Yes
Washington	Kaiser Permanente HMO	N/A	$200/day copay for inpatient hospital services to $600/person annual maximum, then 100%	$10	$750/person $1,500/family	Yes
	Premera Blue Cross Foundation	N/A	100% hospital services after inpatient hospital copayment	$10	$750/person $1,500/family	Yes
West Virginia	State PPO	$375/person; $750/family	Plan pays 80% in-plan, 60% out-of-plan	$10	$1,500 in-plan; $3,000 out-of-plan	Yes
	Health Plan HMO A	$0	100% for most services	$10	$2,000/person	Yes
Wisconsin	Mercycare HMO	N/A	100% coverage inpatient services	$0	N/A	Yes
	Standard	$25/person, 2 per family maximum (for major medical only)	Hospital and most other services covered at 100%	$0	N/A	Yes
Wyoming	PPO Option II	$750/person $1,000/family	In-plan hospital and physicians services covered at 85%; out-of-plan 80%	15% in-plan; 20% out-of-plan	$10,000/person $20,000/family	Yes

Table A6: Other Characteristics of State Government Retiree Health Plans—Medicare-Eligible, FY 2003

State	Plan: ►Lowest-cost ►Highest-cost	Deductibles	Coinsurance Paid By Plan Copays Paid by Patient	Office Visit Copay	Out-of-Pocket Maximum	Rx
Alabama	SEHIP: In network	$100/person; 3-member family maximum	100% inpatient, outpatient and physician services; 80% mental health, substance abuse, other	$20	$400/person; 3-member family maximum	Yes
	SEHIP: Out of network	$100/person; 3 member family maximum	80% most services	N/A	$400/person; 3-member family maximum	No
Alaska	State Retiree Health Plan	$150/person; 3 per family	80% most medical and chemical dependency; 100% other	N/A	$800/person	Yes
Arizona	Medicare + Choice HMO	N/A	N/A	$10	N/A	Yes
	Cigna PPO	$0 in-plan, $300/person $600/family out-of-plan	100% most services in-plan, 70% out-of-plan	$10 in-plan, 30% out-of-plan	$1,000/person $2,000/family in-plan; $3,000/person $6,000/family out-of-plan	Yes
Arkansas	QualChoice HMO	$0	90% hospital, $250 copay inpatient hospital per admission	$20 primary care	$1,000/person $1,500/family	Yes
	BCBS PPO	$500/person $1,000 family in-plan; $750/person $1,500/family out-of-plan	20% in-plan, 30% out-of-plan	N/A	$2,000/person $4,000/family in-plan; $2,500/person $5,000/family out-of-plan	Yes
California	Western Health Advantage	N/A	Hospital inpatient services covered in full. $10 copay outpatient services	$10	N/A	Yes
	PERSCare	N/A	Pays Medicare Part A and B. 100% hospital inpatient and outpatient services	$0	N/A	Yes

Table A6: Other Characteristics of State Government Retiree Health Plans—Medicare-Eligible, FY 2003

State	Plan: ▶Lowest-cost ▶Highest-cost	Deductibles	Coinsurance Paid By Plan Copays Paid by Patient	Office Visit Copay	Out-of-Pocket Maximum	Rx
Colorado	Kaiser Permanente	N/A	$300 copay per hospital admission, then 100%	$15	$2,500/person	Yes
	Mutual of Omaha	$500 if no Medicare Part A coverage	100% hospital charges, 70% hospital coinsurance for individuals with no Medicare Part A coverage	N/A	$1,000 if Medicare Part A & B; $1,500 if only Part B coverage	Yes
Connecticut	POS in-plan, POE	N/A	100% inpatient services	$5[1]	N/A	Yes
	POS out-of-plan	$300/person $900 family	80% coinsurance	20%	$2,000/person $4,000/family	Yes
Delaware	BlueCare Carveout	Yes	100% coverage in-plan	N/A	N/A	Yes
	BCBS Comprehen-sive	$200/person $500/family	100% hospital coverage. Traditional indemnity covering hospital, preventive, and extended services	N/A	N/A	Yes
Florida	State PPO	$150 in-plan, $300 out-of-plan	90% in-plan, 70% out-of-plan most services. $100 hospital copay in-plan, $300 out-of-plan	$10 + 10% in-plan; $20 + 30% out-of-plan	$2,500/person $5,000/family	Yes
Georgia	Kaiser Permanente Medicare + Choice HMO	N/A	100% most services; $200 hospital admission copay	$15	$1,500/person $4,500/family	Yes
	Indemnity	$300/person $900/family	90% most services; $100 hospital admission deductible	10%	$2,000/person $4,000/family	Yes
Hawaii[2]						
Idaho	State plan	$400/person $1,200/family	[illegible]0% most services	20%	$4,800/person $9,600/family	Yes

[1] Connecticut: POS in-plan office visit copay is $10 for those retiring 7/1/99 or later.

[2] Hawaii: The state of Hawaii has created an Employer-Union Health Benefits Trust Fund, effective 7/1/03. The Fund will offer multiple options for pre-Medicare and Medicare-eligible retirees. Details have not been finalized at this time.

Table A6: Other Characteristics of State Government Retiree Health Plans—Medicare-Eligible, FY 2003

State	Plan: ►Lowest-cost ►Highest-cost	Deductibles	Coinsurance Paid By Plan Copays Paid by Patient	Office Visit Copay	Out-of-Pocket Maximum	Rx
Illinois	Indemnity	$200/person $300/family	90% in-plan hospital services; $200 per admission deductible for non-plan hospitals	10% in-plan; 20% U&C other	$800/person, $2,000/family in-plan; $3,000/person, $7,000/family out-of-plan	Yes
Indiana	No coverage in state health plan past age 65					
Iowa	Blue Advantage	N/A	100% authorized hospital services. Primary care physician referral required	$10	$750/person $1,500/family	Yes
	John Deere Open Access	N/A	100% authorized hospital services	$10	$750/person $1,500/family	Yes
Kansas[1]	Kansas Senior Plan C	N/A	Retiree pays excess of Medicare-approved Part B charges	N/A	N/A	Yes
	Preferred Health Systems PPO	$200/person $400/family	90% in-plan, 70% out-of-plan	$15	$1,000/person $2,000/family in-plan; $3,000/person, $6,000/family out-of-plan	Yes
Kentucky	Bankers Life Medicare Supplement	N/A	N/A	N/A	N/A	N/A
	Anthem Blue Senior	N/A	N/A	N/A	N/A	N/A
Louisiana	PPO	$300/person $900/family	Plan pays 80% after Medicare reduction	N/A	$10,000 per person	Yes
	EPO	$0 ($300/person or $900/family)	$100/day hospital copay ($300 maximum); then 100% hospital and other services in-plan	$15	N/A in-plan	Yes
Maine	Anthem companion	$100/person $200/family	Plan pays 80% for most services	$0	N/A	Yes

[1] Kansas: All Kansas plans include dental.

Table A6: Other Characteristics of State Government Retiree Health Plans—Medicare-Eligible, FY 2003

State	Plan: ►Lowest-cost ►Highest-cost	Deductibles	Coinsurance Paid By Plan Copays Paid by Patient	Office Visit Copay	Out-of-Pocket Maximum	Rx
Maryland[4]	Blue Choice HMO	N/A	100% in-plan coverage. 0% out-of-plan	$5	N/A	No
	MLH-Eagle PPO	$0 in-plan; $250/person or $500/family out-of-plan	100% coverage in-plan; 80% out-of-plan	$15	N/A in-plan; $3,000/person or [illegible]/family [illegible]t-plan	No
Massachusetts	Fallon Senior Plan Preferred HMO	N/A	100% most services	$5	N/A	Yes
	GIC (state) indemnity Medicare extension (comprehen-sive)	N/A	100% coverage inpatient services after $50/quarter deductible	100% after $35 deductible; $5 copay preventive	N/A	Yes
Michigan	State PPO	$200/person or $400/family in-plan; $500/person or $1,000/family out-of-plan	100% most services in-plan, 90% out-of-plan	$10	$1,000/person or $2,000/family in-plan; $2,000/person or $4,000/family out-of-plan	Yes
Minnesota	State Health Plan[5]	$100/person cost level 1; $150/person cost level 2; $300/person cost level 3; 2-person family maximum	100% hospital services. Per admission copays $200 for cost level 2 and $400 for cost level 3. Other services covered at 100% for cost level 1, 95% for cost level 2, and 90% for cost level 3	$5, $10, or $20 depending on cost level	$500/person $1,000/family	Yes
Mississippi	State Health Plan	$450/person $900/family in-plan; $900/person $1,800/family out-of-plan	Most services covered at 80% in-plan, 60% out-of-plan	N/A	$2,000/person in-plan, $3,000/person out-of-plan	Yes

[4] Maryland: Separate prescription drug plan available at $32.07/month.

[5] Minnesota: Primary care clinics assigned to one of three cost levels; copays for some services vary by cost level.

Table A6: Other Characteristics of State Government Retiree Health Plans—Medicare-Eligible, FY 2003

State	Plan: ►Lowest-cost ►Highest-cost	Deductibles	Coinsurance Paid By Plan Copays Paid by Patient	Office Visit Copay	Out-of-Pocket Maximum	Rx
Missouri	Mercy HMO standard	N/A	$400 hospital per admission copay, then 100%	$30	N/A	Yes
	Copay plan	$500/person $1,000/family	$200 hospital per admission copay, then 100% coverage in-plan; 70% coinsurance out-of-plan	$25	N/A	Yes
Montana	Traditional/Medicare Coordinated	$435/person $1,305/family	80% preferred hospital coinsurance, 65% nonpreferred hospital coinsurance; 75% most other services	25%	$1,500/person $3,000/family	Yes
	Blue Choice HMO	$300/person $600/family	75% coinsurance most services	$15	$2,000/person $4,000/family	Yes
Nebraska	No coverage in state health plan past age 65					
Nevada	HMO	N/A	$200 hospital copay, then 100%	$15	$1,200/person $2,700/family	Yes
	PPO	$250/person $500/family	80% most services in-plan, 50% out-of-plan	$15 in-plan; 50% out-of-plan	$2,400/person $4,800/family in-plan; $8,500/person $17,000/family out-of-plan	Yes
New Hampshire	Medicare supplement	N/A	N/A	N/A	N/A	Yes
New Jersey	Oxford HMO	N/A	100% most services after copays	$5	N/A	Yes
	Traditional	$100/person, 2-person maximum	80% most services	20%	$400/person	Yes
New Mexico	St. Joseph Medicare Plus Silver HMO	N/A	$100/year hospital copay, then 100%	$10	N/A	Yes
	BCBS Carveout Plus	$0; or $100 for non-Medicare providers/services	100% coverage for Medicare providers/services; 80% for services not covered by Medicare but covered by plan	$0; or 20% for non-Medicare providers	$500/person	Yes
New York	Empire Plan	$283/enrollee	Basic hospital services covered at 100%	$12	$1,362/family	Yes
	HMO Blue (160)	N/A	100% most services	$10	N/A	Yes

Table A6: Other Characteristics of State Government Retiree Health Plans—Medicare-Eligible, FY 2003

State	Plan: ▶Lowest-cost ▶Highest-cost	Deductibles	Coinsurance Paid By Plan Copays Paid by Patient	Office Visit Copay	Out-of-Pocket Maximum	Rx
North Carolina	State plan	$350/person $1,050/family	Plan pays 80%. $100 inpatient copay	$15	$1,500/person $4,500/family	Yes
North Dakota	PPO	$250/person $750/family	Plan pays 85% in-plan, 80% out-of-plan for balance of Medicare-covered charges	N/A	$1,000/person $2,250/family in-plan; $1,500/person $3,250/family out-of-plan	Yes
Ohio	PERS Health Plan	$100/person $200/family	Most services covered at 80%	20%	$500/person $750/family	Yes
Oklahoma	All Medicare supplements	$0	Plan pays 100% Medicare-eligible expenses	Member pays Part B deductible	N/A	Yes
Oregon	Kaiser PermanenteHMO	N/A	$200 per admission hospital copay, then 100% hospital coverage	$15	N/A	Yes
	ODS	$100/person	Plan pays 20% of the Medicare allowable amount	80%	N/A	Yes
Pennsylvania	Medicare supplement + Major medical	N/A	Supplement pays excess of most Medicare covered charges; major medical pays additional medically necessary charges and Part B deductible	N/A	N/A	Yes
Rhode Island	Blue Chip Medigap	N/A	Medicare supplement	N/A	N/A	
	Blue Cross Plan 65 indemnity	Yes	80% covered charges	N/A	N/A	
South Carolina	State Plan-standard	$250/person $500/family	80% most services	N/A	$1,500/person $3,000/family	Yes
South Dakota	Medicare supplement	Medicare Part A & B deductibles	Medicare Plan "F" supplement; pays Part A and B coinsurance	N/A	N/A	No
Tennessee	Tennessee Plan 1	Medicare Part A deductible	Medicare Plan "D" supplement; pays Part A and B coinsurance	N/A	N/A	No
	Tennessee Plan 3 PPO	$250 single	Plan pays 90% maximum allowable charges in-plan, 70% out-of-plan	10% in-plan; 30% out-of-plan	$1,250 single in-plan $3,750 single out-of-plan	Yes

Table A6: Other Characteristics of State Government Retiree Health Plans—Medicare-Eligible, FY 2003

State	Plan: ▶ Lowest-cost ▶ Highest-cost	Deductibles	Coinsurance Paid By Plan Copays Paid by Patient	Office Visit Copay	Out-of-Pocket Maximum	Rx
Texas	HMOs	N/A	100% inpatient services	$10	N/A	Yes
	HealthSelect PPO	$0 in-plan; $500/person $1,500/family out-of-plan	Inpatient services covered at 90% in-plan, 70% out-of-plan	$15 in-plan; 30$ out-of-plan	$500/person in-plan; $1,500/person out-of-plan	Yes
Utah	Low option	N/A	Medicare Part A charges covered in full. Plan pays 20% of Part B deductible and 20% of most approved charges thereafter	N/A	N/A	No[6]
	High option	N/A	Medicare Part A charges covered in full. Plan pays 20% of Part B deductible and 20% of most approved charges thereafter	N/A	N/A	Yes
Vermont	HealthGuard PPO	$300/person $600/family in-plan; $500/person $1,000/family out-of-plan	Plan pays 80% in-plan, 60% out-of-plan most services	20% in-plan; 40% out-of-plan	$2,000/person $6,000/family in-plan; $4,000/person $6,000/family out-of-plan	Yes
	TotalChoice indemnity	$300/person $600/family	90% inpatient hospital; 80% most other services	20%	$750/person $2,250/family	Yes
Virginia	Advantage 65	$100 of Medicare Part A deductible; All of Part B deductible	Pays Medicare Part A deductible except $100; pays Part A and B coinsurance	N/A	N/A	Yes
Washington	Medicare supplement	$100 (Medicare Part B deductible)	Medicare Plan E supplement pays Part A deductible and balance of coinsurance; also pays 20% of Part B approved medical expenses	N/A	N/A	No
	Premera Blue Cross Foundation	N/A	100% inpatient coverage after inpatient hospital copay	$10	$750/person $1,500/family	Yes

[6] Utah: Discount available if using prescription drug card.

Table A6: Other Characteristics of State Government Retiree Health Plans—Medicare-Eligible, FY 2003

State	Plan: ► Lowest-cost ► Highest-cost	Deductibles	Coinsurance Paid By Plan Copays Paid by Patient	Office Visit Copay	Out-of-Pocket Maximum	Rx
West Virginia	Medicare supplement	$150/person $300/family	Plan generally pays balance of Medicare-approved amount not covered by Medicare	N/A	$1,000/person	Yes
Wisconsin	Mercycare HMO	N/A	100% inpatient services	$0	N/A	Ye
	Medicare Plus $100,000	$0	100% coverage for physician and hospital services. Provides reimbursement for all Medicare deductibles for covered services. Plan provides maximum $100,000 per injury or illness in addition to Medicare payments	N/A	N/A	Yes
Wyoming	PPO Option II	$750/person $1,000/family	85% hospital and physicians services in-plan; 80% out-of-plan	15% in-plan; 20% out-of-plan	$10,000/per-son $20,000/family	Yes

Table A7: Characteristics of Prescription Drug Coverage in State Government Retiree Health Plans—Pre-Medicare, FY 2003

State	Plan: ►Lowest-cost ►Highest-cost	Patient Copayments	
		At Pharmacy	Mail Order
Alabama	SEHIP	$5 generic, $15 preferred brand ($20 for maintenance drugs), $35 other brands. 60 day supply of maintenance drugs $50/person deductible	N/A
Alaska	State Retiree Health Plan	Generic: $5 for 30 day supply, $10 for 31-90 days Brand: $10 for 30 days, $20 for 31-90 days	Generic: $0 Brand: $2
Arizona	Cigna HMO	$10 generic, $20 brand, $40 non preferred brand; 30 day supply	N/A
	Pacificare PPO	$10 generic, $20 brand	$20 generic, $45 brand; 90 day supply
Arkansas	QualChoice HMO, BCBS PPO	$10 generic, $25 brand, $50 nonformulary brand; 34 day supply	$20 generic, $50 brand, $100 nonformulary brand; 90 day supply
California	Western Health, PERSCare	$5 generic, $15 brand, $30 nonformulary; 30 day supply	$10 generic, $25 brand, $45 nonformulary brand; 90 day supply
Colorado	Kaiser Permanente HMO #3	50% copay to $30 for 60 day supply	50% copay to $30 for 60 day supply
	Rocky Mountain HMO #1	$10 generic, $20 preferred brand, $40 nonpreferred brand; 31 day supply	$20 generic, $40 preferred brand, $80 nonpreferred brand; 90 day supply
Connecticut	POS in-plan, POE	$3 generic, $6 brand; 34 day supply, or 90 days for maintenance drugs	$3 generic, $6 brand; 90 day supply
	POS out-of-plan	80% coinsurance	No mail order
Delaware	BCBS Comprehensive	$5 minimum copay; multisource brands covered at 30%; single source brands covered at 20%.	No mail order
Florida	State PPO	$7 generic, $20 preferred brand, $35 nonpreferred; 30 day supply	$10.50 generic, $30 preferred brand, $52.50 nonpreferred; 90 day supply
Georgia	Blue Choice HMO	$10 generic, $20 preferred brand, $35 nonpreferred brand	90 day supply covered in full after 2 copays: $10 generic, $20 preferred brand, $35 nonpreferred brand
	Indemnity	$10 generic, $20 preferred brand, 20% coinsurance for nonpreferred brand with $35 minimum, $75 maximum. Monthly maximum $100/person, $200/family for generic and preferred brand	N/A

Note: The prescription drug benefits shown in this table are part of the health care plans detailed in Table A5. An "N/A" answer indicates that either the information was not available and/or not applicable to the plan shown.

Table A7: Characteristics of Prescription Drug Coverage in State Government Retiree Health Plans—Pre-Medicare, FY 2003

State	Plan: ▶Lowest-cost ▶Highest-cost	Patient Copayments	
		At Pharmacy	Mail Order
Hawaii[1]			
Idaho	State Plan	$12 generic, $18 brand if generic not available, $40 brand if generic is available; 34 day supply, or 90 day supply of maintenance drugs, subject to 2 copays. $10 copay for diabetic supplies. $25 copay + 20% from non-network pharmacy	No mail order
Illinois	Indemnity	$7 generic, $14 formulary brand, $28 non-formulary brand; 30 day supply	$14 generic, $28 formulary brand, $56 nonformulary brand; 90 day supply
Indiana	Anthem Traditional	$25 deductible, then 10% generic, 20% brand in-plan; 30% generic, 40% brand out-of-plan; 34 day supply.	Deductible applies. 10% generic, 20% brand in-plan; 30% generic, 40% brand out-of-plan; 90 day supply
	Humana HMO	$5 generic, $10 brand, $15 nonformulary	N/A
Iowa	Managed care options	$5 preferred generic, $15 preferred brand, greater of $30 or 25% for nonpreferred brand or nonpreferred generic	$10 generic, $30 preferred brand, $60 nonpreferred brand or nonpreferred generic; 90 day supply
	Indemnity plans	$5 preferred generic, $15 preferred brand, $30 nonpreferred brand or nonpreferred generic. Separate $250/person, $500/family out-of-pocket maximum	No mail order
Kansas	Premier Blue HMO, Preferred Health Systems PPO	Member pays 20% generic, 30% preferred brand, 50% nonpreferred brand; 30 day supply. $70 special case drugs. $2,400/person maximum; excludes nonpreferred brand	Available at lower cost
Kentucky	CHA EPO	$25 generic, $35 brand, $50 nonformulary; 30 day supply	$50 generic, $70 brand, $100 nonformulary; 90 day supply of maintenance drugs only
	Humana POS—A	$10 generic, $15 brand, $30 nonformulary; 30 day supply in-plan; Member pays 40% out-of-plan	$20 generic, $30 brand, $60 nonformulary; 90 day supply of maintenance drugs only
Louisiana	POS, EPO	50% at network pharmacies, $40/prescription maximum, to $1,000/person annual maximum. Thereafter, $0 copay generic, $15 brand. Nonnetwork: reimbursement to 50% of network rat.	No mail order
Maine	Anthem HMO	$10 generic, $20 name brand	N/A
Maryland	Prescription drugs not included in health plan		

[1] Hawaii: The state of Hawaii has created an Employer-Union Health Benefits Trust Fund, effective 7/1/03. The Fund will offer multiple options for pre-Medicare and Medicare-eligible retirees. Details have not been finalized at this time.

Table A7: Characteristics of Prescription Drug Coverage in State Government Retiree Health Plans—Pre-Medicare, FY 2003

State	Plan: ►Lowest-cost ►Highest-cost	Patient Copayments	
		At Pharmacy	Mail Order
Massachusetts	Fallon Community Health Plan HMO	$5 tier I, $15 tier [illegible], $35 tier III; 30 day supply	$9 tier I, $39 tier II, $99 tier III; 90 day supply maintenance drugs
	State indemnity	$7 generic, $20 preferred brand, $40 nonpreferred brand; 30 day supply; no out of network coverage	$14 generic, $40 preferred brand, $70 nonpreferred brand; 90 day supply of maintenance drugs
Michigan	State PPO	$7 generic, $12 brand	$5 generic, $10 brand; 90 day supply, maintenance drugs
Minnesota	State Health Plan	$12 formulary, $25 nonformulary; 3 day supply. $300/person, $600/family out-of-pocket maximum	$24 formulary, $50 nonformulary; 102 day supply. Out-of-pocket maximum applies.
Mississippi	State Health Plan	$50 deductible, then $10 generic, $25 preferred brand, $35 other; 30 day supply	Deductible applies $20 generic, $50 preferred brand, $70 other; 90 day supply
Missouri	Mercy HMO standard	$10 generic, $25 brand formulary, $40 nonformulary; 30 day supply	$20 generic, $50 brand formulary, $80 nonformulary; 90 day supply
	Copay Plan		
Montana	Basic indemnity, Blue Choice HMO[2]	10% ($8 minimum) generic; 20% ($16 minimum) formulary brand; 30% ($24 minimum) nonformulary brand; 30 day supply	$20 + 10% of charges over $400 generic; $40 + 20% of charges over $400 formulary; $60 + 30% of charges over $400 nonformulary; 90 day supply
Nebraska	BlueChoice Advantage POS	$15 generic, $30 brand; 30 day supply	$70 each 180 day supply
Nevada	PPO	$5 generic, $22 preferred brand, $40 nonpreferred brand;	$15 generic, $55 preferred brand, $100 nonpreferred brand;
	HMO	$7 generic, $14 preferred brand, $50 nonpreferred generic or brand	$14 generic, $60 preferred brand
New Hampshire	Anthem POS	$50 deductible, then 20% copay to $2,000/person annual maximum	$4/order for maintenance drugs
New Jersey	HMO	$5 generic, $10 preferred brand, $20 other; 30 day supply	$15 generic, $25 brand; 90 day supply
	Traditional	$6 generic, $11 preferred brand, $23 other; 30 day supply	$6 generic, $17 preferred brand, $28 other; 90 day supply
New Mexico	HMO, BCBS Triple Option POS	20% generic copay, 30% brand formulary, 40% brand nonformulary	$15 generic formulary, $20 generic nonformulary, $25 brand formulary; 90 day supply
New York	Empire plan	$5 generic, $15 brand (with no generic equivalent); 90 day supply	$5 generic, $15 brand (with no generic equivalent); 90 day supply
	HMO Blue	$5 generic, $15 brand formulary, $30 nonformulary; 30 day supply.	Can order 90 day supply with 3 copayments (e.g., $15 for 90 day supply of generic drug)
North Carolina	State Plan	$10 generic, $25 preferred brand with no generic equivalent, $35 preferred brand with generic equivalent, $40 nonpreferred brand; 34 day supply. $2,500/person copay limit per year	N/A

[2] Montana: Eckerd Health Services pharmacy plan is an automatic add-on to medical plan selected.

Table A7: Characteristics of Prescription Drug Coverage in State Government Retiree Health Plans—Pre-Medicare, FY 2003

State	Plan: ▶Lowest-cost ▶Highest-cost	Patient Copayments	
		At Pharmacy	Mail Order
North Dakota	PPO Basic	$5 + 15% generic, $15 + 25% formulary brand, $25 + 25% nonformulary brand; 34 day supply	N/A
Ohio	PERS Health Care	$4.50 generic, $9 brand with no generic equivalent, $12 brand with generic equivalent; 34 day supply. 60% reimbursement at non-plan pharmacies	$4.50 generic, $9 brand with no generic equivalent, $12 brand with generic equivalent; 120 day supply
Oklahoma	Health Choice low option	In-plan: up to $25 for prescriptions of less than $100 (i.e., plan pays 100% of cost above $25 for prescriptions less than $100); 25% up to $50 maximum for prescriptions of more than $100; generic/preferred network mandated; 34 day supply or 100 units; $2,500/person out-of-pocket maximum. Out-of-plan: member pays cost to $75 plus dispensing fee; no out-of-pocket maximum for nonpreferred/out of network.	N/A
	PacifiCare HMO-high	$10 tier 1, $25 tier 2, $45 tier 3; 30 day supply or 100 units	N/A
Oregon	Kaiser Permanente	50% to $150 maximum, plus $2 per prescription for 30 day supply.	50% to $300 maximum, plus $2 per prescription for 90 day supply of maintenance drugs
	Clear Choice	50% to $150 maximum, plus $2 per prescription for 30 day supply or for 90 day supply of generic drugs	50% to $150 maximum, plus $2 per prescription for 30 day supply or for 90 day supply of generic drugs
Pennsylvania	BCBS traditional	$7 generic or brand when generic not available; 30 day supply. $15 for maintenance prescriptions from 30-100 days.	$15 per prescription for chronic conditions; up to 100 day supply
Rhode Island	BCBS PPO	20%+$7 generic, $25 formulary brand, $40 nonformulary brand	N/A
South Carolina	Companion HMO	$10 generic, $25 preferred brand, 40 nonpreferred brand; 31 day supply. $1,000/person annual copayment maximum	N/A
South Dakota	State plan – low and high options	$11 generic, $22 brand formulary, $31 for higher-priced brand; 30 day supply. $800/person, $2,000/family out-of-pocket maximum	$17 generic, $31 brand formulary, $48 for higher-priced brand; 31-90 day supply of approved maintenance drugs. Out-of-pocket maximum applies
Tennessee	HMOs	$5 generic, $15 brand	N/A
	PPO	$5 generic, $15 preferred brand, $25 nonpreferred brand in-plan; member pays maximum allowable charge in addition to $25 copay for nonpreferred brand drugs. $720/person maximum	N/A

Table A7: Characteristics of Prescription Drug Coverage in State Government Retiree Health Plans—Pre-Medicare, FY 2003

State	Plan: ►Lowest-cost ►Highest-cost	Patient Copayments	
		At Pharmacy	Mail Order
Texas	HMOs, HealthSelect PPO	$5 generic, $20 preferred brand, $35 nonpreferred brand; 30 day supply. 70% reimbursement–copay, out-of-plan for PPO (no out-of-plan coverage at HMOs)	$10 generic, $40 preferred brand, $70 nonpreferred brand; 90 day supply.
Utah	PEHP Exclusive HMO	Member pays 20% of discounted cost of preferred drugs, $5 minimum copay, no maximum; 30 day supply. Member pays 50% of nonpreferred drug cost, $5 minimum, no maximum	Member pays 20% of discounted cost of preferred drugs, $5 minimum, $50 maximum; 90 day supply. Member pays 50% of nonpreferred drug cost, $5 minimum, no maximum
	PEHP Preferred PPO	Member pays 20% of discounted cost of preferred drugs, $5 minimum copay, no maximum; 90 day supply. Member pays 50% of nonpreferred drug cost, $5 minimum, no maximum	Member pays 20% of discounted cost of preferred drugs, $5 minimum, $50 maximum; 90 day supply. Member pays 50% of nonpreferred drug cost, $5 minimum, no maximum
Vermont	TotalChoice indemnity	Annual fee: $25/person, $75/family as deductible. 20% copay per prescription. Maximum copay: $300/covered member for mail order and retail combined; thereafter plan pays 100% for rest of year	
Virginia	Kaiser Permanente HMO	$5 at Kaiser pharmacy; $15 at participating community pharmacy; 60 day supply, generic mandated	$3 for up to 90 day supply; generic mandated
	Cost Alliance	$17 for up to 34 day supply; $34 for 34-90 day supply; generic mandated	$25 for up to 90 day supply; generic mandated
Washington	Kaiser Permanente HMO	$10 formulary generic, insulin and diabetic supplies; $25 formulary brand; 30 day supply	$20 generic, insulin and diabetic supplies; $50 formulary brand; 90 day supply
	Premera Blue Cross Foundation	$10 generic, insulin and disposable diabetic supplies; $25 formulary brand; $40 nonformulary brand; 30 day supply	$20 generic, insulin and disposable diabetic supplies; $50 formulary brand; $80 nonformulary brand; 90 day supply

Table A7: Characteristics of Prescription Drug Coverage in State Government Retiree Health Plans—Pre-Medicare, FY 2003

State	Plan: ►Lowest-cost ►Highest-cost	Patient Copayments	
		At Pharmacy	Mail Order
West Virginia[3]	State PPO	$5 generic, $15 preferred brand, $30 nonpreferred brand; 34 day supply. 90 day supply of maintenance drugs available for 2 copayments. $75/person, $125/family deductible. $1,750/person, $3,500/family out-of-pocket maximum	$5 generic, $15 preferred brand, $30 nonpreferred brand; 34 day supply or 35-90 day supply for 2 copayments. Maintenance drugs only. Deductibles, out-of-pocket maximums apply
	Health Plan HMO A	$10 generic, or member pays 40% for brand when generic not available. Nonformulary brand not covered. $5,000 annual maximum	No mail order
Wisconsin	Mercycare HMO	$5 generic, $17.25 brand; 30 day supply. $300/person, $600/family out-of-pocket maximum	No mail order
	Standard	$7 generic, $14 brand	N/A
Wyoming	POS Option II	$10 generic, $20 preferred, $40 nonpreferred; 30 day supply	$10 generic, $20 preferred, $40 nonpreferred; 60 day supply

[3] West Virginia: Retirees with incomes below 250% of the federal poverty level are eligible for assistance with drug copayments.

Table A8: Characteristics of Prescription Drug Coverage in State Government Retiree Health Plans—Medicare-Eligible, FY 2003

State	Plan ► Lowest-cost ► Highest-cost	Patient Copayments	
		At Pharmacy	Mail Order
Alabama	SEHIP	$50/person deductible, $5 generic, $15 preferred brands ($20 for maintenance drugs), $35 other brands; 60 day supply of maintenance drugs.	N/A
Alaska	State Retiree Health Plan	Generic: $5 for 30 day supply, $10 for 31-90 days Brand: $10 for 30 days, $20 for 31-90 days	Generic: $0 Brand: $2
Arizona	Medicare + Choice HMO	$10 generic, $20 brand	$20 generic, $40 brand; 90 day supply
	Cigna PPO	$10 generic, $20 brand, $40 nonpreferred brand; 30 day supply	N/A
Arkansas	QualChoice HMO, BCBS PPO	$10 generic, $25 brand, $50 nonformulary brand; 34 day supply	$20 generic, $50 brand, $100 nonformulary brand; 90 day supply
California	Western Health, PERSCare	$5 generic, $15 brand, $30 nonformulary brand; 30 day supply	$10 generic, $25 brand, $45 nonformulary brand; 90 day supply
Colorado	Kaiser Permanente	50% copay to $30 for 60 day supply	50% copay to $30 for 60 day supply
	Mutual of Omaha	$100 deductible, then 50% copay with $7 minimum, $50 maximum copay for 30 day supply	$15 generic, $50 brand; 90 day supply
Connecticut	POS in-plan, POE	$3 generic, $6 brand; 34 day supply, or 90 days for maintenance drugs	$3 generic, $6 brand; 90 day supply
	POS out-of-plan	80% coinsurance	No mail order
Delaware	BlueCare Carveout	$5 minimum copay; multisource brands covered at 35%; single source brands covered at 25%	No mail order
	BCBS Comprehen-sive	$5 minimum copay; Multisource brands covered at 30%; Single source brands covered at 20%	No mail order
Florida	State PPO	$7 generic, $20 preferred brand, $35 nonpreferred brand; 30 day supply	$10.50 generic, $30 preferred brand, $52.50 nonpreferred brand; 90 day supply

Note: Prescription drug benefits shown in this table are part of the health care plans detailed in Table A6. An "N/A" answer indicates that either the information was not available and/or not applicable to the plan shown.

Table A8: Characteristics of Prescription Drug Coverage in State Government Retiree Health Plans—Medicare-Eligible, FY 2003

State	Plan ▶Lowest-cost ▸ Highest-cost	Patient Copayments	
		At Pharmacy	Mail Order
Georgia	Kaiser Permanente Medicare + Choice HMO	At Kaiser Permanente pharmacy: $10 generic, $15 preferred brand; at Eckerd's pharmacy: $16 generic, $21 preferred brand	May order up to 90 day supply by mail at same price as retail, plus $1.50 shipping
	Indemnity	$10 generic, $20 preferred brand, 20% coinsurance for nonpreferred brand with $35 minimum, $75 maximum. Monthly maximum $100/person, $200/family for generic and preferred brand	No mail order
Hawaii[1]			
Idaho	State Plan	$12 generic, $18 brand if generic not available, $40 brand if generic is available; 34 day supply, or 90 day supply of maintenance drugs, subject to 2 copays. $10 copay for diabetic supplies. $25 copay + 20% from non-network pharmacy	No mail order
Illinois	Indemnity	$7 generic, $14 formulary brand, $28 nonformulary brand; 30 day supply	$14 generic, $28 formulary brand, $56 nonformulary brand; 90 day supply
Indiana	No coverage in health plan after age 65		
Iowa	Managed care options	$5 preferred generic, $15 preferred brand, greater of $30 or 25% for nonpreferred brand or nonpreferred generic	$10 generic, $30 preferred brand, $60 nonpreferred brand or nonpreferred generic; 90 day supply
Kansas	All plans	Member pays 20% generic, 30% preferred brand, 50% nonpreferred brand; 30 day supply. $70 special case drugs. $2,400/person maximum out-of-pocket limit on generic, preferred brand and special case drugs only (i.e., no limit applies to co-insurance for nonpreferred brand drugs).	Available at lower cost
Kentucky	N/A	N/A	N/A

[1] Hawaii: The state of Hawaii has created an Employer-Union Health Benefits Trust Fund, effective 7/1/03. The Fund will offer multiple options for pre-Medicare and Medicare-eligible retirees. Details have not been finalized at this time.

Table A8: Characteristics of Prescription Drug Coverage in State Government Retiree Health Plans—Medicare-Eligible, FY 2003

State	Plan ►Lowest-cost ►Highest-cost	Patient Copayments	
		At Pharmacy	Mail Order
Louisiana	POS/EPO	50% at network pharmacies, $40/prescription maximum, to $1,000/person annual maximum. Thereafter, $0 copay generic, $15 brand. Non-network: reimbursement to 50% of network rate	No mail order
Maine	Anthem HMO	$10 generic, $20 name brand	N/A
Maryland	Prescription drugs not included in health plan		
Massachusetts	Fallon Senior Preferred	$8 tier I, $15 tier II, $35 tier III; 30 day supply	$18 tier I, $39 tier II, $99 tier III; 90 day supply of maintenance drugs
	GIC indemnity Medicare extension	$7 generic, $20 preferred brand, $40 nonpreferred brand; 30 day supply	$14 generic, $40 preferred brand, $70 nonpreferred brand; 90 day supply of maintenance drugs
Michigan	State PPO	$7 generic, $12 brand	$5 generic, $10 brand; 90 day supply of maintenance drugs
Minnesota	State Health Plan	$12 formulary, $25 nonformulary; 34 day supply. $300/person, $600/family out-of-pocket maximum	$24 formulary, $50 nonformulary; 102 day supply. Out of pocket maximum applies
Mississippi	State Health Plan	$50 deductible, then $10 generic, $25 preferred brand, $35 other; 30 day supply	Deductible applies. $20 generic, $50 preferred brand, $70 other; 90 day supply
Missouri	Mercy HMO standard,	$10 generic, $25 formulary brand, $40 nonformulary brand; 30 day supply	$20 generic, $50 formulary brand, $80 nonformulary brand; 90 day supply
	Copay plan		
Montana	Basic indemnity, Blue Choice HMO[2]	10% ($8 minimum) generic; 20% ($16 minimum) formulary brand; 30% ($24 minimum) nonformulary brand; 30 day supply	$20 + 10% of charges of more than $400 generic; $40 + 20% of charges of more than $400 formulary brand; $60 + 30% of charges over $400 nonformulary brand; 90 day supply
Nebraska	No coverage in health plan past age 65		
Nevada	PPO	$5 generic, $22 preferred brand, $40 nonpreferred brand;	$15 generic, $55 preferred brand, $100 nonpreferred brand;
	HMO	$7 generic, $14 preferred brand, $50 nonpreferred generic or brand	$14 generic, $60 preferred brand
New Hampshire	Medicare supplement	$50 deductible, then 20% copay to $2,000/person annual out-of-pocket maximum	$4/order for maintenance drugs
New Jersey	HMO	$5 generic, $10 preferred brand, $20 other; 30 day supply	$15 generic, $25 brand; 90 day supply
	Traditional	$6 generic, $11 preferred brand, $23 other; 30 day supply	$6 generic, $17 preferred brand, $28 other; 90 day supply

[2] Montana: Eckerd Health Services pharmacy plan is an automatic add-on to medical plan selected.

Table A8: Characteristics of Prescription Drug Coverage in State Government Retiree Health Plans—Medicare-Eligible, FY 2003

State	Plan ►Lowest-cost ►Highest-cost	Patient Copayments	
		At Pharmacy	Mail Order
New Mexico	St. Josephs HMO	$7 generic, $14 brand; $750 annual maximum benefit formulary brand, but no limits on generic drugs	N/A
	BCBS carveout	20% generic copay, 30% formulary brand, 40% nonformulary brand	$15 formulary generic, $20 nonformulary generic, $25 formulary brand; 90 day supply
New York	Empire plan	$5 generic, $15 brand (with no generic equivalent); 90 day supply	$5 generic, $15 brand (with no generic equivalent); 90 day supply
	HMO Blue	$5 generic, $15 formulary brand, $30 nonformulary brand; 30 day supply.	Can order 90 day supply with 3 copayments (e.g., $15 copay for 90 day supply of generic drug)
North Carolina	State Plan	$10 generic, $25 preferred brand with no generic equivalent, $35 preferred brand with generic equivalent, $40 nonpreferred brand; 34 day supply. $2,500/person copay limit per year	N/A
North Dakota	PPO	$5 + 15% generic, $15 + 25% brand, $25 + 25% nonformulary	N/A
Ohio	PERS Health Plan	$4.50 generic, $9 brand with no generic equivalent, $12 brand with generic equivalent; 34 day supply. 40% copay at non-plan pharmacies	$4.50 generic, $9 brand with no generic equivalent, $12 brand with generic equivalent; 120 day supply
Oklahoma	Low option	$10 generic, $25 formulary brand, $50 nonformulary brand; 34 day supply or 100 units. $250 deductible; $1,500 out-of-pocket maximum	N/A
	Health Choice high option	In-plan: up to $25 for prescriptions of less than $100 (i.e., plan pays 100% of cost above $25 for prescriptions of less than $100); 25% up to $50 maximum for prescriptions of more than $100; generic/preferred network mandated; 34 day supply or 100 units. $2,500 out-of-pocket maximum; no maximum for nonpreferred/out-of-network	N/A
Oregon	Providence HMO, Clear Choice	50% to $150 maximum, plus $2 per prescription for 30 day supply or for 90 day supply of generic drugs	Available; same price as retail.

Table A8: Characteristics of Prescription Drug Coverage in State Government Retiree Health Plans—Medicare-Eligible, FY 2003

State	Plan ►Lowest-cost ►Highest-cost	Patient Copayments	
		At Pharmacy	Mail Order
Pennsylvania	Medicare supplement with major medical	$7 generic or brand when generic not available; 30 day supply. $15 for maintenance prescriptions from 30-100 days	$15 per prescription for chronic conditions; up to 100 day supply
Rhode Island			
South Carolina	State Plans	$7 generic, $22 brand; 31 day supply. $1,100/person copayment maximum	$16 generic, $50 brand; 90 day supply. Maximum applies
South Dakota	Prescription drugs not included in health plan		
Tennessee	Tennessee PPO	$5 generic, $15 preferred brand, $25 nonpreferred brand	N/A
Texas	HMOs, Health Select PPO	$5 generic, $20 preferred brand, $35 nonpreferred brand; 30 day supply. 70% reimbursement–copay, out-of-plan for PPO (no out-of-plan coverage at HMOs)	$10 generic, $40 preferred brand, $70 nonpreferred brand; 90 day supply
Utah	High Option	$200 deductible, then copays. With card: 20% of discounted fee for generic, 40% of discounted fee for brand, 50% of discounted fee for nonpreferred brand. Without card: applicable copay + difference between full cash price and discounted fee	Member pays 20% up to $50 maximum for generic and brand; 50% for nonpreferred brand; 90 day supply
Vermont	Health Guard PPO, Total Choice indemnity	Annual fee $25/person, $75/family as deductible. 20% copay per prescription. Maximum copay $300/covered member for mail order and retail combined; thereafter plan pays 100% for rest of year	
Virginia	Advantage 65	$27 copay for up to 34 day supply; $54 copay for 35-90 day supply	$32 copay for up to 90 day supply
Washington	Premera Blue Cross Foundation	$10 generic, insulin and disposable diabetic supplies; $25 formulary brand; $40 nonformulary brand; 30 day supply	$20 generic, insulin and disposable diabetic supplies; $50 formulary brand; $80 nonformulary brand; 90 day supply
West Virginia	Medicare supplement	$75/person, $125/family deductible, then $5 generic, $15 preferred brand, $30 nonpreferred brand; 34 day supply. 90 day supply of maintenance drugs available for 2 copayments. $1,750/person, $3,500/family out-of-pocket maximum	Deductibles, out-of-pocket maximums apply. $5 generic, $15 preferred brand, $30 nonpreferred brand; 34 day supply; or 35-90 day supply for 2 copayments. Maintenance drugs only
Wisconsin	Mercycare HMO	$5 generic, $17.25 brand; 30 day supply. $300/person, $600/family out-of-pocket maximum.	No mail order
	Medicare Plus	$7 generic, $14 brand	N/A
Wyoming	PPO Option II	$10 generic, $20 preferred, $40 nonpreferred; 30 day supply	$10 generic, $20 preferred, $40 nonpreferred; 60 day supply

Appendix B:

State Retiree Health Insurance Program Financial Report Data

Table B1. Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in FY2001 for Other Postemployment Retiree Health Insurance Benefits as Reported by State Governments.

State or Alternate Reporting Entity	Number of Eligible Retirees Reported	Scope/Nature of State Retiree Health Benefits Program	Percentage State Contributed in FY2001
Alabama	9,018 for age 65+ enrollees; 4,463 for retirees under 65	All retired state employees covered by the State Health Insurance Plan (SEHIP)	100% of the premium for retirees over age 65 and eligible for Medicare; portion of the premium for a retiree who is under 65
Alaska	Number of state government employee retirees receiving health care benefits not reported in state CAFR. The number of Public Employees Retirement System (PERS) retirees and beneficiaries (state employees + other nonteacher public employees) reported in PERS CAFR as of 6/30/01 was 14,185.	Health care benefits provided to retirees without cost for all employees hired before 7/1/86 and all employees who are disabled or age 65+, regardless of their initial hire dates; employees first hired after 6/30/86 (or those with less than 10 years of credited service if hired after 7/1/96) may receive postemployment health care benefits prior to age 60 by paying the full monthly premium; and employees first hired after 6/30/86 (or those with 10 years or more of credited service if hired after 7/1/96) may receive postemployment health care benefits by paying half of the monthly premium if they are between the ages of 60 and 65	100% of the premium for retirees over age 65 and eligible for Medicare; portion of the premium for a retiree who is under 65
Arizona	State CAFR reported approximately 38,000 coverage agreements for retired and disabled members and their families; group health insurance made available through Arizona State Retirement System (ASRS), a consolidated retirement system covering state employees, teachers, and local public employees. (It is estimated from ASRS's data that state employee retirees make up less than 1/3 of the system's total retirees)	Not reported in state CAFR. However, ASRS reports that for ASRS members electing ASRS health insurance coverage (only eligible for coverage and subsidy if retiree health insurance not available from former employer and retiree elects ASRS coverage), state retirement system offers a subsidized plan. Health insurance subsidy is graded depending on the retiree's length of service	Not reported in state CAFR. Percentage subsidy reported by ASRS varies with employees' length of service, with highest amount paid for those retirees with 10 years or more of service—such retirees receive $150/month for retiree-only pre-Medicare coverage and $260/month for pre-Medicare family coverage (but rural, non-HMO accessible members receive $300/month and $600/month respectively) and $100/month for retiree-only Medicare coverage and $170/month for family Medicare coverage (but rural, non HMO accessible members receive $170/month and $350/month, respectively)

Table B1. Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in FY2001 for Other Postemployment Retiree Health Insurance Benefits as Reported by State Governments.

State or Alternate Reporting Entity	Number of Eligible Retirees Reported	Scope/Nature of State Retiree Health Benefits Program	Percentage State Contributed in FY2001
Arkansas	Not reported in state CAFR (but state does subsidize retiree health care benefits for state employees)	Not reported in state CAFR (but state does subsidize retiree health care benefits for state employees)	Not reported in state CAFR (but state does subsidize retiree health care benefits for state employees)
California	110,132 annuitants are enrolled to receive health benefits and 89,134 annuitants are enrolled to receive dental benefits. In addition, 35,900 retirees of the University of California, a discretely presented component unit of state government, receive University of California contributions for retiree medical and dental benefits	Health care and dental benefits are provided by the primary government to annuitants of retirement systems to which the primary government contributes as an employer (CALPERS). To be eligible, first-tier plan annuitants must retire on or after age 50 with at least 5 years of service and second-tier annuitants must retire on or after age 55 with at least 10 years of service	In FY2001 the state CAFR reported that the primary government generally paid 100% of the health insurance cost for annuitants, plus 90% of the additional premium required for the enrollment of family members and 100% of the dental insurance premium for annuitants
Colorado	State retirees, together with the retirees of the other public employers such as schools and municipalities, participate in the Colorado Pubic Employees' Retirement Association (PERA), a statewide multi-public employer pension system that also provides a health care program, primarily to annuitants. At year-end 2001, the health care program had 35,235 enrollees of whom 10,798 were under age 65 and 24,437 were over age 65	Enrollment is voluntary for PERA benefit recipients and includes all contributors to the plan, whether members of the state and school division of the Colorado PERA, the municipal division, or the judicial division. The Health Care Trust Fund of PERA provides a health care premium subsidy to participating PERA benefit recipients and their eligible beneficiaries who choose to enroll in the program	The PERA Health Care Trust Fund provides a subsidy of up to $230/month for pre-Medicare enrollees and $115/month for Medicare enrollees. The maximum subsidy is based on the recipient having 20 years of service credit and the subsidy is reduced by 5% for each year of service credit under 20 years.

Table B1. Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in FY2001 for Other Postemployment Retiree Health Insurance Benefits as Reported by State Governments.

State or Alternate Reporting Entity	Number of Eligible Retirees Reported	Scope/Nature of State Retiree Health Benefits Program	Percentage State Contributed in FY2001
Connecticut	32,101 retirees of the State Employees Retirement System	Health care benefits provided to all retirees; amount of state payment determined by plan chosen by retiree; state also pays 100% of premium cost for a portion of employees' life insurance if continued after retirement.	State may pay up to 100% of retiree health care insurance premium, including dependent's coverage, based on the plan chosen by the retiree and the date of retirement
Delaware	16,308 state retirees	State reimburses substantially all validated claims for medical and hospitalization costs incurred by pre-Medicare retirees and their dependents. The state also paid a fixed amount of $237.37/month in 2001 for Medicare supplements for Medicare-eligible retirees.	State pays 100% for pre-Medicare retirees who retired prior to 7/91 and a portion that varies with length of on service for pre-Medicare retirees who retired after 7/91; those retirees who retired with 10 years or less of service credit are allowed to participate in the plan, but state pays no part of their premium costs. In FY2001, the state paid costs of up to $237.37 for Medicare supplements for Medicare-eligible retirees (i.e., 100% of supplement premium costs in that year).
Florida	166,111 Health Insurance Subsidy (HIS) recipients are retirees of the Florida Retirement System, a cost-sharing, multiple-employer pension system administered by the state that covers state employees, teachers, and other participating local public employers	Retirees may participate in their former employers' group health insurance programs; in general, premiums are paid by retirees but retirees receive Health Insurance Subsidies of at least $50 but not more than $150 per month ($5/month for each year of creditable service at retirement to maximum of 30 years). Retirees are eligible for HIS upon proof of health insurance, which can include Medicare	Percent varies with plan to which fixed dollar amount of subsidy is applied

Table B1. Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in FY2001 for Other Postemployment Retiree Health Insurance Benefits as Reported by State Governments.

State or Alternate Reporting Entity	Number of Eligible Retirees Reported	Scope/Nature of State Retiree Health Benefits Program	Percentage State Contributed in FY2001
Georgia	60,935 retired employees received postretirement health care benefits through the State Health Benefits Plan	A retiree is eligible for post-retirement health care benefits if he/she was a full-time employee at the time of retirement of either the state of Georgia or a county social service agency and is receiving monthly benefits from either the Employees' Retirement System of Georgia or a county employees' retirement system	Employees and retirees subject to the State Health Benefits Plan contribute amounts determined by the State Personnel Board for various insurance plans (in 2001, the ratio of state-recognized expenditures net of retiree contributions to state-recognized expenditures including retiree contributions was approximately 72%). The various agencies of the state contribute to the health insurance fund based on amounts recommended by the State Personnel Board and set forth in the Appropriations Act
Hawaii	State CAFR reported 22,100 state retirees receiving benefits.	State CAFR reported that as of 2001, the state paid all or a portion of pre-Medicare and Medicare-eligible health insurance premiums for retirees, depending on the retirees' retirement dates and length of active service	For employees hired before 7/1/96, the state pays 100% of the monthly health care premium (Medicare or pre-Medicare) for retirees with 10 or more years of credited service, and 50% of the monthly health care premium for retirees with less than 10 years of credited service. For employees hired after 7/1/96, the state pays 100% of the monthly health care premium for retirees with 25 or more years of credited service, 75% for employees with at least 15 years of service but less than 25 years, 50% for employees with at least 10 years of service but less than 15 years, and 0% for employees with less than 10 years. Retirees covered by the medical portion of Medicare are also eligible to receive a reimbursement of the basic medical coverage premium

Table B1. Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in FY2001 for Other Postemployment Retiree Health Insurance Benefits as Reported by State Governments.

State or Alternate Reporting Entity	Number of Eligible Retirees Reported	Scope/Nature of State Retiree Health Benefits Program	Percentage State Contributed in FY2001
Idaho	2,885 retired state employees receive retiree subsidies for health insurance	State employees who are eligible to retire under the Public Employee Retirement System of Idaho (and whose unreduced monthly pension benefit at the time of retirement would meet or exceed the monthly cost of single retiree health insurance may elect to have the state's retiree health insurance) coverage for themselves and eligible dependents. There is also a separate sick leave/insurance conversion program available to reduce retiree costs	Retirees pay the majority of the premium costs (unless they are participating in the sick leave/insurance reserve fund). For the subsidy program, the state contributes $7 per active non-retired employee per month and active employees contribute an equal amount that goes to a reserve to offset the monthly costs of the retirees' benefits. A separate benefit is available to retirees based on unused accumulated sick leave at retirement and is financed by state employer contributions of 0.65% of payroll to cover future insurance premiums.
Illinois	79,300 state employee annuitants	State Employees Group Insurance Act requires that the state pay the cost of basic noncontributory health, dental, and life insurance benefits to annuitants who are former state employees; this includes annuitants of all of the state's retirement systems, except the non-state employee members of the Teacher's Retirement System (TRS) (although since 1996, the state has contributed to a separate subsidy program available for TRS annuitants)	State pays for 100% of the cost of basic health and dental insurance. (Retirees with less than 20 years of service receive 5% per year of service)
Indiana	Not reported in state CAFR.	Not reported in state CAFR.	Not reported in state CAFR (state contributes 0% for retiree health care coverage)
Iowa	Not reported in state CAFR	Not reported in state CAFR.	Not reported in state CAFR (state contributes 0% for retiree health care coverage)

Table B1. Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in FY2001 for Other Postemployment Retiree Health Insurance Benefits as Reported by State Governments.

State or Alternate Reporting Entity	Number of Eligible Retirees Reported	Scope/Nature of State Retiree Health Benefits Program	Percentage State Contributed in FY2001
Kansas	9,400 retirees	Benefits provided in accordance with rules and regulations of the Kansas State Employees Health Care Commission (HCC)	The HCC is responsible for the determination of the allocation of premium costs between participants and the state each contract year. (In-plan year 1996 the HCC made the decision that retiree participants should pay 100% of the costs of coverage; however, in view of rate increases assessed to participants, the HCC continued to use plan excess reserves to provide subsidies in-plan year 2001 ranging from $0 to $115 per month, depending on the level of coverage selected).
Kentucky	7,744 pre-Medicare and 13,683 Medicare hospital and medical contracts were reported in Kentucky Retirement Systems 2001 CAFR	The Kentucky Retirement Systems Insurance Fund provides insurance for members receiving benefits from the Kentucky Employees Retirement System (state employees), the County Employees Retirement System (county employees), and the State Police Retirement System (state employees)	The Kentucky Retirement Systems Insurance Fund pays a prescribed contribution for whole or partial payment of required premiums to purchase retiree health insurance. The amount of contribution paid by the Fund is based on years of service, with 100% paid for retirees with 20 or more years of service; 75% paid for retirees with 15 through 19 years of service; 50% paid for retirees with 10 through 14 years of service; 25% paid for retirees with 4 through 9 years of service; and 0% paid for retirees with less than 4 years of service
Louisiana	26,840 retirees	State provides retiree health care benefits largely through the self-insured and self-funded State Employee Group Benefits Program (SEGBP). The SEGBP provides health care insurance or HMO coverage for both active and retired employees; it is financed by contributions from the state and participating employees. Upon retirement, substantially all employees become eligible for continuing health care benefits if they reach normal retirement age while working for the state	Not reported in state CAFR. (Estimated at approximated 75% in 2001)

Table B1. Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in FY2001 for Other Postemployment Retiree Health Insurance Benefits as Reported by State Governments.

State or Alternate Reporting Entity	Number of Eligible Retirees Reported	Scope/Nature of State Retiree Health Benefits Program	Percentage State Contributed in FY2001
Maine	7,039 retired eligible state employees and 6,027 retired eligible teachers	The state funds postretirement health care benefits for most retired state employees and legislators and for a portion of the premiums of teachers. Retirees eligible for Medicare are covered under supplemental insurance policies; retirees must pay for Medicare Part B coverage to be eligible to participate in the state-funded plan; coverage for retirees who are not eligible for Medicare includes basic hospitalization, supplemental major medical and prescription drugs, and costs for treatment of mental health problems, alcoholism, and substance abuse	The state pays 100% of the health insurance premiums of state retirees who were first employed before 7/1/91 and, for retirees first employed after 7/1/91, a pro rata portion is paid, ranging from 0% for retirees with less than 5 years of service to 100% for retirees with 10 years or more of service. The state pays 30% of the health insurance premiums of retired teachers
Maryland	29,792 total participants reported	Health care benefits provided to employees who retired before 7/1/84, employees who retired on or after 7/1/84 with at least 5 years of service, and employees who receive disability retirement allowances or special death benefits	The state subsidizes approximately 50% to 90% of covered medical and hospitalization costs, depending on the type of insurance plan
Massachusetts	46,000 participants eligible to receive benefits	The Commonwealth is required to provide certain health care benefits for its retired employees; substantially all of its employees may become eligible for these benefits if they reach retirement age while working for the Commonwealth	Eligible retirees are required to contribute a specified percentage of the health care benefit costs, which is comparable to contributions required from active employees (state pays 90% of premiums for retirees before 7/2/94 and more than 80% for retirees thereafter)

Table B1. Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in FY2001 for Other Postemployment Retiree Health Insurance Benefits as Reported by State Governments.

State or Alternate Reporting Entity	Number of Eligible Retirees Reported	Scope/Nature of State Retiree Health Benefits Program	Percentage State Contributed in FY2001
Michigan	40,369 total eligible state retiree participants	Health, dental, and vision benefits provided to retirees of the State Employees Retirement System (SERS), the Judges' Retirement System (JRS), the State Police Retirement System (SPRS), and the Legislative Retirement System (LRS)	The state CAFR reports that the state pays 95% of the pre-Medicare premiums for SERS, JRS, and SPRS retirees and 100% of the pre-Medicare premiums for LRS retirees. (For employees hired before 4/1/97, the state pays 95% of the pre-Medicare premiums and 100% of the premiums for retirees who are over the age of 65 and Medicare-eligible; for retirees hired after 4/1/97 the state pays 3% of the premiums for each year of credited service at retirement)
Minnesota	1,100 former employees	For certain employees, post-retirement benefits are available upon retirement at age 55 under the terms of their employment contracts, other employees are eligible for limited window early retirement incentive programs; the state pays the employer's share of health insurance benefits until employees reach age 65. (Other retirees pay full premium costs of retiree health care coverage)	Not reported in state CAFR. (Other than in the case of early retirement incentive plans, the state contributes 0% for retiree health care coverage)
Mississippi	Not reported in state CAFR. Estimated 14,000 retirees covered by Mississippi State and School Employee's Health Insurance Plan (MSSEHIP)	State law mandates that all state, public education, library, junior and community college, and retiring employees be offered health and life benefit coverage through the state's self-insured (MSSEHIP). In addition, the state's consolidated PERS offers a separate Medicare supplement plan	Retirees and beneficiaries have option of maintaining health coverage at their own expense; the state incurs no expense for retirement health benefits according to state CAFR (i.e., the state contributes 0% for retiree health coverage)
Missouri	2001 Annual Report of the Missouri Consolidated Health Care Plan (MCHCP) showed 13,111 retirees meeting eligibility requirements	Retirees who have state-sponsored medical insurance coverage for at least 2 years (or since first eligible) before they are eligible to retire may continue coverage into retirement.	Actual dollar amount of premiums paid varies by regional plan and length of employee service

Table B1. Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in FY2001 for Other Postemployment Retiree Health Insurance Benefits as Reported by State Governments.

State or Alternate Reporting Entity	Number of Eligible Retirees Reported	Scope/Nature of State Retiree Health Benefits Program	Percentage State Contributed in FY2001
Montana	3,156 state retirees (does not include 1,413 retirees enrolled in Montana University System plan)	State provides optional postemployment health care benefits to retirees and surviving dependents of deceased employees who elect to continue coverage and pay administratively established premiums that vary with the medical and dental plan selected.	0% premium contribution, but state does reimburse all validated medical claims less the annual deductibles and coinsurance of the plan selected
Nebraska	Not reported in state CAFR.	Not reported in state CAFR.	Not reported in state CAFR (state contributes 0% for retiree health care coverage)
Nevada	5,181 retirees covered	Any retiree of the state who meets the eligibility requirements for retirement and at the time of retirement is covered, or has his/her dependents covered by any group insurance or medical and hospital service, has the option upon retirement of continuing that group insurance. His/her employer may pay all or any part of the cost of retiree health care coverage, but may not pay more than it does for its active employees	State and retiree contributions varied in 2001 by years of service and plan selected; for retirements prior to 1/1/94 state paid 100% of the "base" state contribution rate; for subsequent retirements, the state paid 25% of the base amount for a retiree with 5 years of service plus 7.5% for each additional year of service to a maximum of 137.5% of the base rate; the retiree paid the remainder
New Hampshire	7,465 state retirees and covered dependents	Substantially all of the state's employees may become eligible for retiree health care insurance if they reach normal retirement age while working for the state (age 60) and receive their pensions on a periodic basis rather than in a lump sum. The state recognizes the cost of providing these benefits by paying the entire annual insurance premiums, with a portion paid by the New Hampshire Retirement System's (NHRS)medical premium subsidy	State pays 100% of the premium; any payment of the subsidy may be "invisible" to the retiree as it is a transaction between the state and NHRS. (Effective 7/1/02, the NHRS postretirement medical plan subsidy is extended to state retirees who retire at age 60 with 20 or more years of service, or who retire at ages 55 through 59 with 30 or more years of service; this subsidy is a fixed dollar amount that is greater for pre-Medicare retirees than for Medicare-eligible retirees and the premium subsidy increases by 8% each July 1)

Table B1. Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in FY2001 for Other Postemployment Retiree Health Insurance Benefits as Reported by State Governments.

State or Alternate Reporting Entity	Number of Eligible Retirees Reported	Scope/Nature of State Retiree Health Benefits Program	Percentage State Contributed in FY2001
New Jersey	51,482 retirees of the Public Employees Retirement System (PERS) and the Teachers' Pension and Annuity Fund (TPAF) retirees eligible for postretirement medical benefits; 4,236 state retirees who do not have their retiree health care benefits financed through PERS or TPAF; and 6,917 members of PERS and the Alternate Benefit Program who retired from a board of education or county college	PERS and TPAF are required by law (Chapter 384, P.L. 1987 and Chapter 6, P.L. 1990) to fund postretirement medical benefits for those state employees who retire after accumulating 25 years of credited service or on a disability retirement. State law (Chapter 136, P.L. 1977) also requires coverage for those state retirees with 25 years or more of service who are not covered by PERS and TPAF funding. In addition, the state is responsible under Chapter 126, P.L. 1992 for providing free health benefits to members of PERS and the Alternate Benefit Program who retire from a board of education or county college with 25 years of service	Generally 100% for employees with 25 or more years of service
New Mexico	N/A	Retiree health care insurance provided through New Mexico Retiree Health Care Authority (NMRHCA). Eligible retirees are those who retired prior to 7/1/90 or those whose employer contributed to NMRCHA for at least 5 years prior to their retirement	Subsidy for retirees with 20 or more years of service covers 50% to 78% of retiree-only premiums, depending on plan selected. Retirees receive prorated percentage of subsidy depending on their length of service (20 or more years of service qualifies retirees for full subsidy amount)
New York	113,888 retirees and dependents	Substantially all of the state's employees become eligible for retiree health insurance if they reach normal retirement age while working for the state	For employees retiring prior to 1/1/83, the state pays 100% of retiree-only coverage and 75% of the cost of dependent coverage; for employees retiring after 1/1/83, the state pays 90% of retiree-only coverage and 75% of dependent coverage

Table B1. Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in FY2001 for Other Postemployment Retiree Health Insurance Benefits as Reported by State Governments.

State or Alternate Reporting Entity	Number of Eligible Retirees Reported	Scope/Nature of State Retiree Health Benefits Program	Percentage State Contributed in FY2001
North Carolina	44,459 members of the Teachers' and State Employees' Retirement System and the Disability Income Plan of North Carolina, 258 members of the Consolidated Judicial Retirement System, 129 members of the Legislative Retirement System, and 705 members of the University Employees' Optional Retirement Program.	The state health plan provides postemployment health insurance to former employees of the state, the University of North Carolina system, community colleges, certain proprietary component units, and local education agencies that are not part of the reporting entity. These former employees are eligible to participate in either the self-funded comprehensive medical plan or one of the HMO plans. The health insurance is the same as for active employees, except that coverage becomes secondary when the former employees become eligible for Medicare	State pays 100% of the premiums for pre-Medicare and Medicare retiree-only coverage, while the retiree pays for entire cost of spouse and dependent care coverage
North Dakota	3,306 retirees receive benefits.	A retiree who is receiving benefits from the PERS, the Highway Patrolmen's Retirement System, or the Defined Contribution Retirement Plan is eligible to receive a credit based upon the retiree's years of service toward his/her monthly health insurance premiums under the state plan. The retiree health insurance credit is also available for early retirement	Varies by length of retiree's service; benefits are equal to $4.50 per month for each year of credited service, not to exceed the premium in effect for the selected coverage
Ohio	Number of state retirees receiving retiree health care benefit was not reported 2001 state CAFR. The number of PERS members (state and local government, excluding teachers) eligible for OPEB as of 12/31/00 was 122,343	All state age and service retirees with 10 or more years of service credit qualify for health care coverage under PERS. In addition, the State Highway Patrol Retirement System pays health insurance claims on behalf of all persons receiving monthly pensions or survivor benefits.	PERS plan pays 100% of the least expensive plan offered for pre-Medicare and Medicare retirees and most of the cost of spouse or dependent coverage

Table B1. Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in FY2001 for Other Postemployment Retiree Health Insurance Benefits as Reported by State Governments.

State or Alternate Reporting Entity	Number of Eligible Retirees Reported	Scope/Nature of State Retiree Health Benefits Program	Percentage State Contributed in FY2001
Oklahoma	13,543 eligible participants of the Oklahoma Public Employees Retirement System (OPERS), 402 eligible participants of the Oklahoma Law Enforcement Retirement System (OLERS), 90 participants of the Uniform Retirement System for Judges and Justices (URSJJ), 24,708 eligible participants of the Teachers Retirement System (TRS)of Oklahoma, and 2,142 eligible participants in 17 Higher Education institutions.	OPERS, OLERS, and URSJJ pay an amount equal to the Medicare supplement premium or $105 per month, whichever is less, for all retirees (pre-Medicare and Medicare-eligible) who elect coverage at the time of retirement through the Oklahoma State and Education Employees Group Insurance Board. TRS pays between $100 and $105 per month for each retiree, depending on the member's service. Seventeen institutions of higher education provide postemployment health, dental, and life insurance benefits as authorized by each institution's board of regents; the eligibility requirements differ by institution	Percentage varies by plan selected, inasmuch as state generally pays a fixed amount ($105)
Oregon	32,716 Retirement Health Insurance Account (RHIA) participants and 739 Retirement Health Insurance Premium Account (RHIPA) participants	Oregon PERS members and their dependents are eligible for health coverage if they are receiving retirement allowances or benefits under PERS. To qualify for the RHIA premium subsidy, members must: (1) have 8 or more years of qualifying service in the PERS system at the time of retirement, (2) have coverage under both Medicare Part A and B, and (3) enroll in a PERS-sponsored health plan. State retirees, depending on length of service, who are not Medicare-eligible may receive a RHIPA premium subsidy equal to the average difference between the health insurance premiums paid by retired state employees and active state employees.	RHIA subsidy varies by plan selected, inasmuch as the state generally pays a fixed amount ($65 per month). RHIPA subsidy also varies by plan selected inasmuch as the state pays the average difference between the health insurance premiums paid by retired state employees and active state employees

Table B1. Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in FY2001 for Other Postemployment Retiree Health Insurance Benefits as Reported by State Governments.

State or Alternate Reporting Entity	Number of Eligible Retirees Reported	Scope/Nature of State Retiree Health Benefits Program	Percentage State Contributed in FY2001
Pennsylvania	State provides retiree health care benefits for retired employees who meet certain specified length of service and age requirements. State CAFR reported that approximately 84,000 individuals were covered by these benefits in fiscal 2001	State retirees are generally eligible for fully paid retiree health care if retired at age 60 with 15 years of service or if retired at any age with 25 years of service. Retiree health care program provided through Pennsylvania Employees Benefit Trust Fund	State pays 100% of the cost for retirees at age 60 with 15 years of service or retirees at any age with 25 years of service
Rhode Island	3,517 retirees receiving benefits	Benefits cover medical and hospitalization costs for pre-Medicare retirees and Medicare supplements for Medicare-eligible retirees (retired state employees who are members of Employees' Retirement System of Rhode Island)	State share varies with years of service and ranges from 50% for retirees with 10 to 15 years of service to 100% for retirees with 35 years of service
South Carolina	22,000 eligible retirees	Retirees are generally eligible for pre-Medicare and Medicare health benefits if they have established at least 5 years of retirement service credit. The state also provides postretirement dental benefits	Percentage varies by retiree health care plan, inasmuch as state generally pays a fixed amount; however, state contribution generally exceeds 85% of the cost of retiree-only premiums.
South Dakota	Not reported in state CAFR	Not reported in state CAFR	Not reported in state CAFR (state contributes 0% for retiree health care coverage)

Table B1. Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in FY2001 for Other Postemployment Retiree Health Insurance Benefits as Reported by State Governments.

State or Alternate Reporting Entity	Number of Eligible Retirees Reported	Scope/Nature of State Retiree Health Benefits Program	Percentage State Contributed in FY2001
Tennessee	5,918 pre-Medicare retirees and 20,739 Medicare retirees	Retirees not eligible for Medicare may continue participation in state's Employee Group Insurance Fund (EGIF) plan covering active employees. Upon Medicare eligibility, the retirees are afforded the opportunity to participate in Medigap plans offered through a separate Medicare Supplement Insurance Fund	For pre-Medicare retiree members of EGIF plan, percentages vary because retiree premium amounts vary by health care plan selected and retiree length of service, while state contribution is fixed at same dollar amount as for active employees (estimated to cover 60% to 80% of retiree-only premiums). For Medicare supplement, percentages vary because state contribution varies by retirees' length of service and retirees' premiums vary by plan selected ($40 per month maximum state contribution for retirees with 30 or more years of service)
Texas	57,953 Employee Retirement System (ERS) retirees, 10,990 University of Texas System retirees, 5,119 Texas A&M University retirees, and 138,040 Teacher Retirement System (TRS) retirees	The state contributes a monthly amount for health care and life insurance for state (not school district) employee retirees covered by ERS or TRS; retirees with at least 10 years of state service are eligible for health and life insurance benefits. The University of Texas System and the Texas A&M University System provide separate postemployment health care and life insurance coverage to their retirees, surviving spouses, and beneficiaries. TRS administers a program that provides benefits to school district retirees with at least 10 years of service	Generally, state pays 100% of retiree-only coverage for state employee retirees. TRS school district employee retiree-only coverage (TRS-Care) is fully covered at a basic level of coverage through contributions based on active payroll shared by the state and active school district employees. (FY2001 state contribution rate was 0.50% of school district payroll and the active school employee contribution rate was 0.25% of school district payroll)

Table B1. Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in FY2001 for Other Postemployment Retiree Health Insurance Benefits as Reported by State Governments.

State or Alternate Reporting Entity	Number of Eligible Retirees Reported	Scope/Nature of State Retiree Health Benefits Program	Percentage State Contributed in FY2001
Utah	State CAFR reports 1,387 individuals in the program	If retired before age 65, the state continues to pay health insurance costs on same basis as for active employees until age 65 or for 5 years, whichever comes first; retirees may then use accumulated sick leave to pay for retiree-only health insurance coverage until age 65, spouse health insurance coverage until age 65, or after age 65, Medicare supplemental insurance for retirees or spouses.	State pays substantial portion of pre-Medicare premiums, but 0% of Medicare premiums.
Vermont	N/A	A retiree (disability, early, or normal) is entitled to receive medical coverage for himself/herself and their dependents over the lifetime of the retiree, with a portion of the cost paid by the retiree. If the retiree chooses the joint and survivor pension option and predeceases his/her spouse, the medical benefits also continue for the spouse along with the pension, however, the surviving spouse must pay 100% of the cost	State pays 80% of the premium for both pre-Medicare and Medicare retirees.
Virginia	25,813 state retirees receive health insurance credits	The Retiree Health Insurance Credit Plan provides health insurance credits against the monthly health insurance premiums for pre-Medicare and Medicare-eligible retired state employees, state police officers, and judges with at least 15 years of creditable pension service	Percentage varies by retiree. State contributes $4 per month per year of service for a retiree with at least 15 years of service, up to a maximum of 30 years of service (or $120 per month)

Table B1. Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in FY2001 for Other Postemployment Retiree Health Insurance Benefits as Reported by State Governments.

State or Alternate Reporting Entity	Number of Eligible Retirees Reported	Scope/Nature of State Retiree Health Benefits Program	Percentage State Contributed in FY2001
Washington	Not reported in state CAFR. (Approximately 8,848 pre-Medicare and 24,300 Medicare estimated non-K-12 Public Employee Benefit Board (PEBB) plan members and 9,819 pre-Medicare and 21,406 Medicare K-12 retiree members)	Retirees "self-pay" their insurance premiums for plans provided by the PEBB, a part of the Washington Health Care Authority. However, eligible Medicare retirees (generally vested state retirement system members) receive fixed subsidies from the state towards the cost of premiums, while pre-Medicare employees receive "implicit subsidies" from pooling with active employees.	State pays 0% for pre-Medicare retirees. For Medicare retiree members of PEBB plan, percentages vary because retirees' premium amount vary by health care plan selected, while state contribution is a fixed dollar amount
West Virginia	2,200 eligible retirees	State provides health care credits against the monthly health insurance premiums of certain retirees based on various factors (including unused sick leave at the time of retirement). Substantially all employees may become eligible for these benefits if they reach normal retirement age while working for the state	Not reported in state CAFR. (In addition to the sick leave conversion program, there is a varying amount of state subsidy depending on length of service and retirement date)
Wisconsin	8,754 annuitants receive health insurance coverage through sick leave conversion credits	At the time of eligibility for an immediate pension, the employee's accumulated sick leave balance may be converted at his/her current rate of pay to credits for the payment of health insurance premiums for the employee or the employee's surviving dependents. The program also provides partial matching of sick leave accumulation depending on years of service and employment category	Not reported in state CAFR (generally 0%, except for application of sick leave conversion program)
Wyoming	Not reported in state CAFR.	Not reported in state CAFR.	Not reported in state CAFR (generally 0%).

Table B2. Pay-As-You-Go or Prefunded Financing and Reported Annual Cost to State in FY2001 for Other Postemployment Retiree Health Insurance Benefits as Reported by State Governments.

State or Alternative Reporting Entity	Pay-As-You-Go or Prefunded Financing	Reported Annual Cost to State
Alabama	Under the SEHIP statute, the fixed amount per month per retiree is funded on a pay-as-you-go basis through the employee premiums each agency pays for its active employees	Total FY2001 cost for age 65+ Medicare enrollees was $11,904,310; total cost for pre-Medicare enrollees was $5,891,380
Alaska	Health care benefits are pre-funded. Beginning 7/1/97, postemployment health benefits are provided through the Retiree Health Fund (RHF), an internal service fund of the state. The RHF is self-funded and provides major medical coverage to retirees. Retirees of 3 other state retirement plans also participate in RHF (Teachers Retirement System, Judicial Retirement System, and Elected Public Officers' Retirement System). The retirement plans retain the risk of loss of allowable claims. The schedule of funding progress for the state of Alaska (state employees only) for postemployment health benefits showed a funded ratio of 105.6% funded for the year that ended 6/30/99. The actuarial value of plan assets was $1,242,503,000, compared to actuarial accrued liabilities of $1,176,563,000 according to the state's 2001 CAFR. For all Alaska nonteacher public employees covered by the Alaska PERS who receive postemployment retiree health benefits (state employees plus the public employees of 149 other participating public employers such as municipalities), funding progress for postemployment health benefits reported by PERS in 2001 showed a funded ratio of 105.5% funded for the year that ended 6/30/99. The actuarial value of plan assets was $2,209,146,000, compared to actuarial accrued liabilities of $1,917,832,000 according to the PERS 2001 CAFR; for the actuarial valuation for the year 2000, PERS reported that although the funding ratio had declined, the plan still remained fully funded at 101.1%	Costs to Alaska for state-only retiree health benefits were not reported separately from pension benefits in state CAFR. Total retiree health benefit expenses for all PERS-covered retirees in 2001 were $103,846,000, according to the PERS CAFR. Because the plan was fully funded, employer contributions to PERS for retiree health were only $27,880,000 (105.3% of the actuarially required employer contribution for the year). Net assets held in trust by PERS for postemployment health benefits were $2,292,193,000. The PERS actuarial valuation is performed using a projected unit credit method with the unfunded accrued benefit liability or funding surplus amortized over a rolling 25 years. The health cost trend assumed in the PERS plan valuation was as follows: FY00 – 8.5%; FY01 – 7.5%; FY02 – 6.5%; FY03 – 5.5%; FY04 through FY08 – 5%; FY09 through FY13 – 4.5%; and FY14 and later – 4%

Table B2. Pay-As-You-Go or Prefunded Financing and Reported Annual Cost to State in FY2001 for Other Postemployment Retiree Health Insurance Benefits as Reported by State Governments.

State or Alternative Reporting Entity	Pay-As-You-Go or Prefunded Financing	Reported Annual Cost to State
Arizona	Not reported in state CAFR. The Arizona State Retirement System actuarial valuation shows that the health benefits subsidy was prefunded along with pension benefits as part of the retirement program. Cost of retiree medical subsidy is part of normal cost calculation that determines required annual pension contribution rates shared equally by the employer and employee. Current pension contribution rates are 2.49% for the employer and 2.49% for the employee. The pension plan (including the graded retiree health insurance subsidy cost) reported a funded ratio of 120% as of 6/30/01, with the actuarial valuation performed using a projected unit credit method)	State CAFR reported that ASRS remitted approximately $40.5 million to health insurance carriers for premium payments for retiree health care insurance during the year
Arkansas	Not reported in sate CAFR (but state does subsidize retiree health care benefits for state employees)	Nor reported in state CAFR (but state does subsidize retiree health care benefits for state employees).
California	The primary government recognizes the cost of providing health and dental insurance to annuitants on a pay-as-you-go basis	Cost for providing health and dental insurance for non-university annuitants was $409 million. In addition, the cost of providing these benefits to University of California annuitants was $124 million

Table B2. Pay-As-You-Go or Prefunded Financing and Reported Annual Cost to State in FY2001 for Other Postemployment Retiree Health Insurance Benefits as Reported by State Governments.

State or Alternative Reporting Entity	Pay-As-You-Go or Prefunded Financing	Reported Annual Cost to State
Colorado	Health care benefits are prefunded. The Public Employees' Retirement Association (PERA) Health Care Trust Fund (HCTF) is financed by amounts contributed by participating employers during an employee's working life based on a percentage of pay. According to the PERA CAFR, in 2001 the HTCF was funded by affiliated employer contributions equal to 1.42% of covered salaries in the State and School Division, 1.96% in the Municipal Division, and 4.37% in the Judicial Division. Once a division's pension trust fund becomes fully funded, 30 % of the 10-year amortization of the overfunding is allocated to the HCTF. At year-end 2001, the state and school division funded ratio was 98.2%, the municipal division funded ratio was 104.3%, the judicial division funded ratio was 109.4%, while the HCTF was only 17.7% funded	The state CAFR reported state contributions of $21.3 million to the HCTF for calendar year 2001. The PERA CAFR reported that total public employer contributions to the HCTF for calendar year 2001 were $74,324,000
Connecticut	State finances the cost of postretirement health care and life insurance benefits on a pay-as-you go basis through an appropriation in the General Fund	$174 million paid in postretirement benefits
Delaware	State finances the cost of postretirement health care and life insurance benefits on a pay-as-you go basis through the State's General Fund.	$47,862,816 was recognized in the General Fund for postretirement health care
Florida	Health Insurance Subsidy (HIS) benefits prefunded by employer contributions as a percentage of payroll for all active Florida Retirement System employees; these are added to the amount submitted for pension contributions. For the fiscal year that ended 6/30/01, the contribution rate was 0.94% of payroll	HIS contributions for the fiscal year that ended 6/30/01 were $196,699,884 and HIS payments over the same period were $207,366,19[illegible], leaving a net balance in the HIS trust fund of $76,929,351 as of 6/30/01
Georgia	The state Health Benefit Plan is a public entity risk pool funded by employee and employer contributions on a "pay-as-you-go" basis	For the fiscal year that ended 6/30/01, the state recognized expenditures of $200,368,341, which was net of retiree contributions of $77,240,601

Table B2. Pay-As-You-Go or Prefunded Financing and Reported Annual Cost to State in FY2001 for Other Postemployment Retiree Health Insurance Benefits as Reported by State Governments.

State or Alternative Reporting Entity	Pay-As-You-Go or Prefunded Financing	Reported Annual Cost to State
Hawaii	Contributions financed on a pay-as-you-go basis	During fiscal 2001, expenditures of $106,770,000 were recognized for postretirement health care and life insurance; approximately $22,363,000 of which was attributable to component units of the state
Idaho	The state retiree health care subsidy program benefits are pay-as-you-go. The retiree sick leave insurance conversion program is prefunded by employer contributions on an actuarially determined basis, using the entry age actuarial cost method; as of 7/1/01 there were total net assets available for future state retiree payments of $47.3 million and an actuarially accrued liability of $63.4 million. Postretirement health insurance premiums are paid from a retiree's sick leave account until the account leave balance is exhausted	The state retiree health care subsidy program benefits cost the state $1,555,309 in contributions in fiscal 2001. The state contributed $8,180,582 in fiscal 2001 to the retiree sick leave insurance conversion program fund
Illinois	The total cost of all members for retiree health and dental insurance benefits is recognized as an expenditure in state financial statements as claims are reported; the cost is financed on a pay-as-you-go basis	Cost of providing health and dental insurance benefits for fiscal 2001 was estimated to be $259.2 million
Indiana	Not reported in state CAFR.	Not reported in state CAFR.
Iowa	Not reported in state CAFR.	Not reported in state CAFR.
Kansas	Benefits funded on a pay-as-you-go basis	During FY2001, the state's portion of the allocated cost was $1.3 million

Table B2. Pay-As-You-Go or Prefunded Financing and Reported Annual Cost to State in FY2001 for Other Postemployment Retiree Health Insurance Benefits as Reported by State Governments.

State or Alternative Reporting Entity	Pay-As-You-Go or Prefunded Financing	Reported Annual Cost to State
Kentucky	State retiree health care benefits provided through the Kentucky Retirement Systems Insurance Fund are prefunded as part of the state retirement contribution rates. The Kentucky Retirement System (KRS) maintains separate accounting records for each component retirement system; as of 6/30/01 KRS reported that the Kentucky Non-Hazardous Employees Insurance Fund was 25.4% funded, the Kentucky Hazardous Employees insurance fund was 55.7% funded; and the State Police Retirees Insurance Fund was 50.5% funded. The board of trustees has adopted a policy to increase the insurance contribution rate by the amount needed to achieve the target rate for full entry age normal funding within 20 ye rs.	For the year that ended 6/30/01, KRS reported that the Kentucky Non-Hazardous Employees Insurance Fund contribution was $66,874,871, the Kentucky Hazardous Employees Insurance Fund contribution was $13,226,298; and the State Police Retirees Insurance Fund contribution was $8,113,391
Louisiana	Other postemployment benefits administered through the State Employees Group Benefits Program are financed on a pay-as-you-go basis	The cost of the state providing insurance benefits (health and life) to retirees and their eligible dependents for the year that ended 6/30/01 was $93,326,921
Maine	Retiree health care benefits are funded on a pay-as-you-go basis	In the 2001 fiscal year, the state paid $27.4 million for retired state employees and $4.3 million for retired teachers into the Retiree Health Insurance Fund. Premium charges paid were $20.5 million and $5 million respectively, so that overall fund equity increased by $11.2 million to a balance of $36.2 million as of 7/1/01. (The most recently available state-sponsored actuarial study was issued for FY2000 and it estimated the amount of liability for current and future retirees at $725.3 million)
Maryland	Health care benefits are financed on pay-as-you-go basis	During FY2001, retiree health care benefits paid amounted to $95,447,000
Massachusetts	Financed on a pay-as-you-go basis	Payments totaled approximately $209,643,000 for the fiscal year that ended 6/30/01
Michigan	Benefits are funded on a pay-as-you-go basis	The total expense for state retirees for the fiscal year ending 9/30/01 was $274.7 million
Minnesota	The cost of benefits is recognized when paid. The long-term liability is reported in the state's general long-term obligation account group	The cost of these benefits was $6,496,529 during FY2001

Table B2. Pay-As-You-Go or Prefunded Financing and Reported Annual Cost to State in FY2001 for Other Postemployment Retiree Health Insurance Benefits as Reported by State Governments.

State or Alternative Reporting Entity	Pay-As-You-Go or Prefunded Financing	Reported Annual Cost to State
Mississippi	Not applicable. Financing is not reported in state CAFR because premiums fully paid by retirees for both the Mississippi State and School Employees Health Insurance Plan (MSSEHIP) and the PERS retiree health insurance plan	No financing is reported in state CAFR because premiums are fully paid by retirees for both the MSSEHIP and PERS retiree health insurance plan. (However, MSSEHIP may provide an implicit subsidy to retirees because of statutory limits on early retiree premium amounts relative to active premiums)
Missouri	Funded on a pay-as-you-go basis through state appropriations	Cost is estimated from 2001 Annual Report of the Missouri Consolidated Health Care Plan at $30,837,072 for FY2001 based on the stated number of plan participants and state contribution per month per participant
Montana	The state funds claims on a pay-as-you-go basis	During the 2001 fiscal year, expenditures of $15,191,516 were recognized for postemployment health care benefits; premium contributions from former employees amounted to $10,730,566, leaving $4,460,950 in claims paid in excess of premium revenue received by the state
Nebraska	Not reported in state CAFR.	Not reported in state CAFR.
Nevada	Financed on a pay-as-you-go basis. The state allocates funds for payment of insurance benefits as a percentage of payroll; the costs of the employer contribution are recognized in the year the costs are charged and any unused funds are carried forward to the next fiscal year	For the year that ended 6/30/01, retirees were covered at a cost of $12,543,164, which represented 67% of total costs

Table B2. Pay-As-You-Go or Prefunded Financing and Reported Annual Cost to State in FY2001 for Other Postemployment Retiree Health Insurance Benefits as Reported by State Governments.

State or Alternative Reporting Entity	Pay-As-You-Go or Prefunded Financing	Reported Annual Cost to State
New Hampshire	In part, the state finances annual retiree health insurance premiums on a pay-as-you-go basis; however, the health insurance premium subsidy provided by the New Hampshire Retirement System (NHRS) is prefunded through an employer contribution as a percent of covered active payroll. Funding for the NHRS subsidy is considered together with pension funding in determining the funding progress of NHRS. The system determines the annual required contribution using the open group aggregate funding method, which does not identify or separately amortize unfunded actuarial liabilities—therefore no schedule of funding progress is presented as part of NHRS' financial statements. However, the trend data or assumptions used by this valuation method to determine employer contributions includes an 8% annual increase in medical premiums	The state paid approximately $26.4 million of annual retiree health insurance premiums for the fiscal year that ended 6/30/01.
New Jersey	Funding of PERS and the Teachers' Pension and Annuity Fund (TPAF) post-retirement medical premiums changed from a prefunding basis to a pay-as-you-go basis beginning in FY1994, with an additional contribution beginning in FY1996 to maintain a medical reserve of 1/2 of 1 percent of the active state payroll each year. Chapter 136 and Chapter 126 benefits are funded on a pay-as-you-go basis	The state contributed $85.4 million to PERS and $175.6 million to TPAF in FY2001 for postretirement medical benefits; actual total pension trust fund expenditures on such benefits totaled $282,639,000, and net assets of the post-retirement medical fund at the end of the year were $493,863,175. For FY2001, the state contributed $28.5 million for Chapter 136 benefits and $34.5 million for Chapter 126 benefits
New Mexico	Monies flow to the New Mexico Retiree Health Care Authority (NMRCHA) on a pay-as-you-go basis. Active employee payroll deductions of 0.65% of monthly salary, participating employers' contributions of 1.3% of monthly payroll, monthly premium contributions of enrolled participants, and an amount provided annually from the Tax and Revenue Suspense Fund make up NMRHCA's funding base	N/A

Table B2. Pay-As-You-Go or Prefunded Financing and Reported Annual Cost to State in FY2001 for Other Postemployment Retiree Health Insurance Benefits as Reported by State Governments.

State or Alternative Reporting Entity	Pay-As-You-Go or Prefunded Financing	Reported Annual Cost to State
New York	The state finances annual retiree health insurance premiums on a pay-as-you-go basis; the state recognizes the cost of providing health insurance by recording its share of insurance premiums as an expenditure in the General Fund in the year paid	FY2001 costs recorded by the state were $486 million
North Carolina	Financed on a pay-as-you-go basis; employer costs are funded by employer contributions as a percent of active payroll established in the biennial appropriation bill by the General Assembly to the General Fund's Reserve for Retirees' Health Premium Account	For the fiscal year that ended 6/30/01, $33,385,104 was contributed on behalf of the former employees of primary government, $23,229,917 was contributed on behalf of former employees of the University of North Carolina system, $6,158,426 was contributed on behalf of former employees of community colleges, and $222,407 was contributed on behalf of former employees of certain participating proprietary component units
North Dakota	The state Retiree Health Benefits Fund is prefunded on an actuarially determined basis through a 1% of covered compensation employer contribution (3% for judges). The actuarial cost method is the projected unit actuarial credit cost method with an inflation assumption of 4.5% per annum. The plan's actuarial accrued liability as of 6/30/01 was $65,467,465, while net assets available for benefits were $24,776,548, leaving an "unfunded" accrued liability of $40,690,917 and a "benefit security ratio" of 37.8%	Employer contributions totaling $4,191,541 were made for the year that ended 6/30/01, while the cost of benefits incurred for the fund was $3,598,019
Ohio	Health care benefits are prefunded through employer contributions (4.3% of covered payroll for PERS and 4.75% for State Highway Patrol Retirement System [SHPRS])	The states' actual contribution was $108,945,000 for the PERS retiree health care plan for regular employees of primary government (state employees) for the year that ended 12/31/00 and approximately $3 million for the SHPRS retiree health care benefits

Table B2. Pay-As-You-Go or Prefunded Financing and Reported Annual Cost to State in FY2001 for Other Postemployment Retiree Health Insurance Benefits as Reported by State Governments.

State or Alternative Reporting Entity	Pay-As-You-Go or Prefunded Financing	Reported Annual Cost to State
Oklahoma	The Oklahoma Law Enforcement Retirement system (OLERS), Oklahoma Public Employees Retirement System (OPERS), Uniform Retirement System for Judges and Justices (URSJJ) and Teachers Retirement System (TRS) fund postemployment health care benefits on a pay-as-you-go basis as part of the overall retirement benefit. (The retirement systems are required by statute to remit this payment for eligible members to the Oklahoma State and Education Employees Group Insurance Board (OSEEIB), but no portion of the contribution amounts of either active employees or state or local agencies is specifically identified by statute as relating to such payment; however, this liability is considered by plan actuaries in determining pension plan funding.) The 17 institutions of higher education fund their postemployment benefits on a pay-as-you-go basis	The state reported 2001 fiscal year postemployment benefit expenditures of $16,828,000 for OPERS, $524,000 for OLERS, $112,000 for URSJJ, $29,160,000 for TRS, and $3,639,000 for 17 institutions of higher education
Oregon	Retirement Health Insurance Account (RHIA) costs are prefunded through employer contributions to PERS made on an actuarially determined basis. For 2001, all PERS employers contributed 0.70% of covered payroll to fund RHIA benefits; this contribution covered the normal cost payment and an amount to amortize the unfunded accrued liability. Using an entry age normal valuation, RHIA was 11 1% funded as of 12/31/00. Retirement Health Insurance Premium Account (RHIPA) costs are prefunded through state agency contributions to PERS made on an actuarially determined basis. Using an entry age normal valuation, RHIPA was 12.6% funded as of 12/31/00. (Pension benefits for PERS were 97.6% funded as of the same date)	The employers' aggregate actual contribution for RHIA for the year that ended 6/30/01 totaled $42,294,496. State agencies actual contributions for RHIPA for the year that ended 6/30/01 totaled $1,178,373
Pennsylvania	The state funds on a pay-as-you-go basis, recognizing the cost of providing these benefits when paid	The cost to the state totaled $253 million for the fiscal year that ended 6/30/01

Table B2. Pay-As-You-Go or Prefunded Financing and Reported Annual Cost to State in FY2001 for Other Postemployment Retiree Health Insurance Benefits as Reported by State Governments.

State or Alternative Reporting Entity	Pay-As-You-Go or Prefunded Financing	Reported Annual Cost to State
Rhode Island	Benefits are financed on a pay-as-you-go basis. (During fiscal 2001, the state contributed 0.98% of covered payroll for retiree health care benefits; the contribution rates were not actuarially determined.)	Postretirement health care expenses for the fiscal year that ended 6/30/01 were $5,189,298, net of retiree contributions
South Carolina	Retiree health insurance plans and the dental plan are financed on a pay-as-you-go basis	During the fiscal year that ended 6/30/01, the state recognized expenses of $94,507,000 to provide retiree health and dental benefits
South Dakota	Not reported in state CAFR	Not reported in state CAFR
Tennessee	The Employee Group Insurance Fund (EGIF) plan premiums fund benefits on a pay-as-you-go basis and no specified reserves have been established to fund retiree health care benefits. The state's contributions to the Medicare Supplement Insurance Fund (MSIF) are financed on a pay-as-you-go basis	State total contribution costs for retiree members of EGIF and MSIF are not reported in the state CAFR
Texas	The cost of state retiree health and life insurance benefits and Teacher Retirement System-Care (TRS) are financed on a pay-as-you-go basis.	In FY2001, retiree health care and life insurance benefit costs were $171,653,000 for benefits provided to Employee Retirement System retirees, $12,544,000 for benefits provided to University of Texas System retirees, $20,204,000 for benefits provided to Texas A&M University retirees, and $166,367,000 for benefits provided to TRS public school district retirees
Utah	Of the liability for postemployment benefits and compensated absences, $260,268,000 is funded from designated accrued taxes and $41,234,000 is unfunded and reported in the General Long-Term Obligation Account Group	For the year that ended 6/30/01, the governmental fund postemployment benefits portion of the cumulative liability was $205,091,000 and $14,074,000 million in postemployment benefits were recognized
Vermont	N/A	N/A
Virginia	The Retiree Health Insurance Credit Plan benefit is prefunded as part of the actuarial valuation that determines pension plan contribution rates	The state recognized Retiree Health Insurance Credit expenses of $48 million during the fiscal year that ended 6/30/01
Washington	Medicare retiree subsidy amounts are funded on a pay-as-you-go basis by the legislature each year	Not reported in state CAFR

Table B2. Pay-As-You-Go or Prefunded Financing and Reported Annual Cost to State in FY2001 for Other Postemployment Retiree Health Insurance Benefits as Reported by State Governments.

State or Alternative Reporting Entity	Pay-As-You-Go or Prefunded Financing	Reported Annual Cost to State
West Virginia	The cost of retiree health care benefits is recognized as an expenditure/expense as related premiums are paid	Expenditures for the sick leave conversion program for the fiscal year that ended 6/30/01 were approximately $4 million. An actuarial study of the sick leave conversion program as of the same date resulted in a projection of the sick leave liability for the primary government of $179 million which was recorded in the General Long-Term Debt Account
Wisconsin	The accumulated sick leave conversion program is prefunded based on an actuarially determined percentage of payroll, using the entry age actuarial cost method. The accrued liability for these benefits as of 12/31/01 was $1,039,600,000 while net assets for the program were $612.8 million	The state's actual CY2001 contribution for the sick leave conversion program was $74 million
Wyoming	Not reported in state CAFR	Not reported in state CAFR