



Federation of
Post-Secondary Educators
of BC

REPORT OF THE PENSION ADVISORY SUB-COMMITTEE ON RETIREE BENEFITS

PENSION ADVISORY SUB-COMMITTEE ON RETIREE BENEFITS

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Report Contents

1. Sub-Committee Assignment
2. A Brief History of Retiree Health & Welfare Benefits
 - 2.1 Teachers' Pension Plan Benefits
 - 2.2 CPP Health & Welfare Benefits
 - 2.3 Establishment of the IAA
 - 2.4 1994 Pension Regulation Amendments
 - 2.5 Economic and demographic changes force changes to retiree health & welfare benefits
3. Options for Improvement
 - 3.1 ASO vs. Insured
 - 3.2 Purchasing insurance from the employer
 - 3.3 Employer paid benefits
 - 3.4 Employee paid benefits
 - 3.5 Join a bigger group
 - 3.6 Change deductibles
 - 3.7 Establish a benefits trust
 - 3.8 Put the current plan out for tender
 - 3.9 Health & Welfare early contribution plan
4. Recommendations
5. Conclusion

1. Sub-Committee Assignment

The Presidents' Council approved the *June 2010 Standing & Ad Hoc Committees: Work Plans*, at the June 13-14, 2010 PC meeting, which included the following assignment for the Pension Advisory Committee:

- *Review and advise on strategies to provide better retiree health & welfare benefits*

At their fall 2010 meeting, the FPSE Pension Advisory Committee the "Sub-Committee on Retiree Benefits" was formed to fulfill the assigned task.

The Sub-Committee determined that in order to properly fulfill the assigned task, a report needed to be produced with the following elements:

- A review of what is currently available to retired or soon to be retiring FPSE members;
- A comparison of what health & welfare benefits are available to retired College Pension Plan (CPP) members with what is available for retiree members of the other three trusted BC public sector pension plans (Teachers, Public Service & Municipal);
- A review of the various options available to provide better retiree health & welfare benefits, including an analysis of the pros and cons of each; and,
- A set of options, based on the information provided within the report, regarding what the Sub-Committee believes is the best options to provide better retiree health & welfare benefits.

2. Brief History of Retiree Health & Welfare Benefits

By reviewing FPSE files, the already completed *PAC Sub-Committee on Inflation Protection* (March 11, 2011), and contacting knowledgeable people in the system, a general history of CPP retiree health & welfare benefits was generated and outlined below.

The CPP, which started in the late 1960's, is a relatively young plan when compared to other BC public sector pension plans. As such, other sectors and plans have been dealing with retiree health & welfare benefits for a much longer period.

2.1 Teachers' Pension Plan Benefits

Beginning in 1939, active and retired teachers in Vancouver received medical coverage through the Vancouver School Teachers/ Medical Services Association. Elsewhere, beginning in 1942, active and retired teachers received medical coverage through the Provincial Teachers' Medical Services Plan (PTMSP). In 1966, the Provincial Government began providing partial subsidies for retired teachers' medical premiums. In 1968, the two plans merged within the PTMSP and school board employees and trustees became eligible to participate. The PTMSP continued until 1971 when the BC Medical Services Plan (MSP) was introduced. Government subsidization was changed to 50% of MSP premiums. In the same year, the BC

Retired Teachers' Association (BCRTA) provided Extended Health Benefits, for which retirees paid 100% of the premiums.

2.2 CPP Health & Welfare Benefits

Although documentation has not been located to date, it is likely that retired members of the CPP also had their MSP premiums subsidized by 50% beginning in 1971. Whether the CPP or the Government subsidized the plan in the 1970's is not clear.

According to one document, in January 1, 1982, retired CPP members were provided with a group extended health care plan through the Medical Services Association, with retirees paying 100% of the premiums. Arrangements were made for payroll deductions with the Superannuation Commission.

2.3 Establishment of the IAA

It is known that the 50% subsidy of MSP premiums for CPP retirees was covered by the Inflation Adjustment Account (IAA) which appears to have been established in 1981 for each of the four BC public pension plans. The employees and the employer each contributed 1% of salary to the fund, which raised deductions for both from 6% to 7%. The primary purpose of the IAA was to provide annual increases to pensions to offset the impact of inflation.

Funds for the IAA came from three sources: contributions of 1.0% of pensionable earnings from active plan members (which are matched by members' employers), investment earnings on the IAA assets and transfer from the basic account of "excess interest" on the pensioners' portion of the basic pension liabilities. Excess interest is the amount of investment income that is in excess of the long term investment rate that is assumed by the plan actuary.

Similarly to the annual inflation adjustments, the MSP premium subsidy was not guaranteed and was to be paid for out of the IAA only if funds permitted. Given a number of factors and especially the low number of retirees compared to active members, the IAA had sufficient funds to provide inflation adjustments and MSP premium subsidy to retired members through the 1980's.

Eligibility for the 50% MSP subsidy for CPP retirees was not limited to time of service or amount of pension benefit. As a result, many retirees who chose to cash in their pensions left in a small amount to access the subsidy, which was often of greater value than the pension benefit they did or would eventually receive.

The IAA was seen to be at the time, "and for the foreseeable future, considerably overfunded." In the year ending August 31, 1981, the total cost for the IAA (inflation adjustment and MSP subsidy) was under \$540,000 while it took in \$1,100,000. In 1983, the IAA took in five times the amount of money required.

As a result, the CPP IAA contribution rates were eventually reduced from 1% each to 0.5% each in 1989. Subsequently, IAA contribution rates were increased over the years that moved the rate back up to 1.09% each.

2.4 1994 Pension Regulation Amendments

In 1994, the pension regulations were amended with new language regarding "Health Benefits." The new regulations specified the source of funding for any group health & welfare benefit premiums that retirees may be eligible for.

As a consequence of the new enabling regulations and healthy surpluses that came about as a result of investment diversification, at the request of plan member representatives, the health & welfare benefits for CPP retirees were changed in 1994. MSP premium coverage was raised up to 100%, and a subsidized Administrative Services Only Extended Health Benefit plan was introduced, paid for from employer IAA contributions (see 3.3 below). In 1995, Dental was introduced. Depending upon a retiree's length of service, the premiums for these new benefits could be covered up to 100% by the IAA.

2.5 Economic and demographic changes force changes to retiree health & welfare benefits

Unfortunately, the changing demographic and economic environment of the new millennium began to put serious pressure on the long term ability of the IAA to maintain inflation adjustments and health benefits. The ratio of retirees to actives continued to increase. At the same time, investment returns started dropping relative to the returns experienced through the 90's. As a consequence, the IAA grew much more slowly and the predicted longevity of the IAA fund started to shorten.

Below are excerpts from the PAC Sub-Committee on Inflation Protection report that has covered this period adequately enough that it is worth repeating here.

"2003-07 It became increasingly evident to the trustees that the longevity of the IAA was shortening dangerously. This was significant because the Plan rules stated that if the IAA Fund was predicted to run out of funds in twenty years or less the Plan could provide reduced indexing in order to extend the longevity of the fund past the twenty year mark. (In fact, by the time the trustees implemented the new sustainable indexing strategy, the IAA was expected to run out of money in 14 years; well inside the twenty year trigger point.)

The College Plan was clearly facing a crisis with the IAA. Not only was the IAA rapidly losing the ability to pay full indexing, health benefit costs were rapidly increasing. Those costs were paid using employer contributions to the IAA. However, the Plan Rules limited health benefit expenditures to a maximum of 1% of the employer IAA contributions. Health benefit costs were expected to exceed that limit by 2008. Over the short term, the trustees had to deal with health benefit costs. However, the overall health of the IAA was also a looming issue.

2008 *The Board decided to ask the Court whether the Plan rules allowed the Plan to provide less than full indexing even if the IAA had enough funds in a given year to do so. When the Partners were informed of the strategy they asked the trustees to hold off on the court application for a few months in order to allow the partners to try to offer solutions to the IAA issue. The Partners did offer to increase funding of the IAA by 0.5%.*

The trustees then developed a plan which was implemented over a two year period. In order to preserve the IAA and ensure some inter-generational equity, indexing would be capped at a sustainable amount starting January 1, 2011....The Trustees also decided to eliminate all subsidies of health and dental benefits and, instead, offer access to new voluntary health and dental benefit plans with retirees paying the full cost of premiums.

Sep.2009 *New voluntary benefit plan implemented. Employer and employee IAA contribution rates increased by 0.25% each."*

The CPP's new voluntary plan is similar to what other BC public sector pension plans have adopted. For instance, the Teacher's Pension Plan was under the same pressures as the CPP and on January 1, 2012, will no longer subsidize benefits and will offer a voluntary health benefits plan (see Section 3.5 below). The Municipal Plan however, does subsidize their retirees' health & welfare benefit premiums up to a maximum of 0.8% of the employers' 1.0% contribution to the IAA. Retirees are responsible for any premium costs not covered. How long this will continue is not known.

Weldon Cowan, CPP Trustee, in his work on the PAC Sub-Committee on Inflation Protection Report, reviewed the inflation protection and health benefits found in pension plans in other provinces. According to Mr. Cowan, it appears that few if any Canadian pension plans subsidize health benefits, as he did not come across any that did so.

3. Options for Improvement

Outlined below are seven options to consider for improving the health & welfare benefits for out retirees. Not all the options are mutually exclusive. The advantages and disadvantages are outlined within the discussion of each alternative, which is followed by a set of recommendation (see Section no.4 below), based on the information provided here.

3.1 ASO vs. Insured

An ASO (or administrative services only) health care benefit plan is a benefit plan where the entity managing the plan is paid a fee for managing the plan but that entity does not carry any risk. Prior to the termination of the subsidized EHB plan offered by the College Pension Plan, the EHB plan was an ASO plan and it was managed by Pacific Blue Cross (PBC).

Any member who had 10 years of pensionable service was fully subsidized. Based on the prior year's claim experience, PBC estimated a monthly "insurance" premium for those members who were not entitled to a full subsidy. However, with the ASO plan, if the premium was not enough then the College Pension Plan, and not PBC, had to pick up the shortfall. In effect, with the old ASO plan, the College Pension Plan took on the risk that premiums would not be enough to cover actual expenses for those members who did not receive a full subsidy.

The College Pension Plan was able to do that because the costs of the plan would not exceed the 1 percent of payroll paid from employer contributions that would otherwise have gone to the Inflation Adjustment Account.

When the employee contributions exceeded 9%, the tax rules forced the College Pension Board to stop using the employer contributions to subsidize the extended health plan. The reason was that only employer contributions that exceed the employee contributions can be used for non pension purposes and at the time, employer and employee contributions were equal so all employer contributions had to be used to produce pension income.

As a result, the College Pension Board cancelled the subsidized ASO extended health plan and replaced it with an unsubsidized insured plan. Because the College Pension Board did not have any latitude to use employer contributions to pay for retiree health care benefits, they could no longer carry the risk that "insurance" premiums would not fully cover the costs of the health care benefit.

As a result, the new benefit plan is an insured plan and not an ASO plan. The risk that the premiums do not fully cover all expenses of the plan is now carried by PBC (the insurer) and not by the College Pension Plan. The way insurance companies deal with the risk is to charge a "risk premium." Because of that risk premium, typically the cost of an insured plan is greater than the costs of an ASO plan providing the same benefit to the same group.

One way the Partners could reinstate an ASO plan is to provide a small subsidy through a new employer contribution that would cover the need for the "risk premium". That subsidy could be only a few basis points (perhaps 1/10th of one percent of payroll¹) but it would allow the College Pension Board to offer a benefit plan as an ASO plan.

While there is some dispute about whether an ASO plan is cheaper than an insured plan, it is very likely that an ASO plan would be between 2 and 5 percent cheaper than an insured plan with the same coverage.

The way the new ASO plan would work is the same way the old ASO plan worked for members who were not getting a subsidy. The plan administrator (currently PBC) would estimate monthly premium costs that all members would have to pay, but those costs would not include a risk premium. If the estimated costs were less than the actual costs, the extra employer contributions would pick up the difference. Any

¹ Note that the 1/10th of one percent is an estimate and would need to be verified by an actuary if this option was to be pursued.

of the new employer contributions that were not needed to cover health benefit costs would then go to the IAA or be refunded to the employer.

3.2 Purchasing insurance from the employer

Another alternative for providing insurance is by negotiating an agreement similar to what exists at Capilano University. At Capilano, a retiree is able to buy extended health coverage from their former employer at cost. Because the plan includes a large number of substantively younger people (who typically are much cheaper to insure) the costs of insurance would be less for the retiree than if that retiree was buying insurance as part of an older group.

The wide spread use of this provision would significantly increase the per member cost of the insurance. As a result, the employed members of the plan (or their employer if the plan is fully employer paid) would be subsidizing the insurance premiums of the retired members.²

3.3 Employer paid benefits

Unlike at Capilano University, most of the benefit plans for employees are fully covered by the employer. If retirees were included as being eligible for the benefits provided to active employees under the same terms, the employer would end up subsidizing the health care benefits of the retirees.

To achieve this goal, the inclusion of retirees into the employer paid benefit plan would need to be negotiated and be included as part of a compensation package. The downside to this option is that it may require prioritizing it above other bargaining priorities such as salaries, secondary scales, etc.

3.4 Employee paid benefits

Faculty members could choose to directly subsidize retiree benefits through increased premiums. Many members have expressed an interest in this option.

The obvious problem is that this scheme will face the same demographic pressures that forced the CPP to stop subsidizing retiree health & welfare benefits. The number of retirees per active member is growing and the benefit costs per active member would also continue to climb.

Full subsidization is not an option as it is not sustainable. Given demographic trends, there will be more retirees than active members, and as such, the cost to individual members will quickly increase beyond what can be afforded.

² Note that the Capilano Extended Health plan is part of a collection of plans that can be purchased from a health spending account that has a limited amount of money in it - so arguably, it is the employees who will be picking up the increased costs of the plan should there be a large number of retirees that join.

However, is partial subsidization a possibility? Is it possible to provide partial support for the health & welfare premiums like the Municipal Plan (see Section 2.5 above)?

It is unlikely that the Trustees would be able to agree to shift some of the IAA to benefits, even if it was capped. That would require additional funding or the reduction of inflation protection. If Partners specifically added contributions for retiree benefits than it would be viable for the Board to re-institute some form of subsidized retiree health benefits.

Another alternative may be for members to provide a capped subsidy for retiree benefits. For instance, a set amount might be deducted that is to be used to provide a partial subsidy for retiree benefit premiums. If the liability is capped, would members be more willing? Such contributions may not be eligible for tax deductions.

Members may be more inclined to support retiree benefits as outlined above if they knew the funds were being directed to those in most need. This would entail means testing which would require a new and possibly substantial administrative responsibility.

3.5 Join a bigger group

A third alternative for providing insurance is to join a bigger group. The larger number of plan members the greater potential for economy of scale cost savings. The approximate ADMINISTRATIVE and RISK SHARING cost savings achieved by joining a bigger group would be under 5% if joining such a plan was an option.

One obvious option is the new unsubsidized Teachers' Pension Plan extended health benefit. The Teachers' Pension Plan has announced that it intends to stop offering a subsidized extended health benefit in 2012. (see Attachment no. 1). It appears that the Teachers' Plan is superior to the plan that is available to CPP retirees.

Unfortunately, it appears that the utilization of services in the existing College Plan is far higher than the expected service utilization in the Teachers' plan. The good news for the Teachers is that their plan is significantly cheaper. Unfortunately, as a result, the Teachers may not want us to join their plan because they would be subsidizing us. The Teachers' Plan costs \$55 per month and the estimated cost of the equivalent plan for the College retirees would be approximately \$80 per month³.

3.6 Change deductibles

Are there any positive advantages to lowering the deductibles paid by CPP retirees for their health & welfare benefits? Unfortunately, such a move would not make the plan more affordable, as explained below, because the cost of lowering the

³ The current College EHB plan is \$65 per month, but that is because the benefit is not as good. The vast majority of the difference in costs arises from the difference in utilization

deductible will almost completely wipe out the savings to the retiree of reaching the deductible sooner. However, it would reduce the financial hardship of retirees having to pay for the entire deductible by spreading out the payments over the year.

The insurance carrier pays 80% of expenses above the deductible. The per person deductible is currently \$250. If that was lowered to \$100 then the monthly premiums would likely go up by just under \$10. In costing the increased premium, the insurer will estimate that almost all participants will reach the \$250 deductible during the year, so the carrier will estimate its costs will go up by 80% of the difference between the old deductible and the new deductible. 80% of \$150 is \$120, which divided by 12 months produces a monthly premium increase of \$10.

As such, the question about the level of the deductible becomes one of prepayment and budgeting. A lower deductible does not lower costs for retiree, but will spread the costs over the year.

3.7 Establish a benefits trust

Benefit trusts are agencies that administer health & welfare benefits for employees overseen by Trustees. A trust must conform to Canadian Revenue Agency (CRA) rules for tax purposes.

The CAUT Benefits Trust⁴ is overseen by five CAUT appointed Trustees with an advisory body (one rep from each member association). The Trust is to be funded by negotiated employer contributions, with any required increases subject to bargaining.

Another example is the Public Education Benefits Trust (PEBT)⁵ which holds and administers a trust fund for the purpose of providing LTD and other benefits to CUPE employees in the K-12 sector. There are twelve Trustees: six appointed by CUPE and six appointed by the BC Public School Employers' Association (BCPSEA).

The benefits of a trust are that it increases our control over benefit provisions, improves transparency and accountability, and hopefully cost savings with increased economy of scale. Of course, the benefits of scale are a benefit of any large benefit plan, in a trust or not. Therefore, this option would likely be less of an immediate and tangible improvement in the health & welfare benefits for retirees, but may allow for improved protection and control in the long-term.

3.8 Put the current plan out for tender

A final option is to put the current plan out to tender to determine if it is possible to achieve a better deal.

⁴ http://www.cautbulletin.ca/en_article.asp?articleid=2868

⁵ <https://www.pebt.ca/LandingPage.asp>

According to David Piasta, FPSE Staff Representative, going to market has a potential risk, in that the present insurer, Blue Cross, may feel that the current group of retirees is just too high a risk and may choose to not compete for the contract or bid higher than all the others. Additionally, other providers who want the contract may bid low, but then over time creep the cost up in subsequent years.

Further, the Teachers put their plan out to tender and ended up with the same insurance carrier. As such, given that the vast majority of the costs arise from service utilization, it is unlikely that the College Plan would derive any benefit from going out to tender.

3.9 Health & Welfare early contribution plan

One possible long term solution is for members (and employers?) to begin contributing to a health & welfare retiree benefit plan immediately upon enrollment in the CPP, which will become available upon retirement. Benefits would be based upon contribution rate and service. This option would obviously not help current retirees or those who will be retiring in the near future.

However, it may be a benefit to new members who can begin building towards benefits for when they eventually retire. Of course, this would require additional pay cheque deductions and would make any other possible contributions by active members for current retirees more difficult. Further, the tax treatment of such a scheme may make it less viable. Members can voluntarily do this kind of planning through RRSPs. The main advantage of doing this in a collective manner may be access to pooled investment, possibly bclMC.

4. Options

The options listed below are not all mutually exclusive.

- (1) Confirm with the Teachers' Pension Plan whether or not the CPP could have the option of having our members included in their new plan (see Section 3.5 above).
- (2) If no. 1 is not possible or worthwhile, discuss with the Partners the option of providing a "risk premium" subsidy to lower the plan's cost for retirees (see Section 3.1 above). Otherwise, maintain the current plan as an insured plan as it is sustainable.
- (3) Consider the feasibility of partial subsidization of retiree health & welfare premiums through an employee deduction (see Section 3.4 above).
- (4) Spread the cost of the deductibles over the year by lowering the deductibles (see Section 3.6 above).
- (5) Consider putting the current plan out to tender (see Section 3.8 above).
- (6) Consider creating a health & welfare benefit contribution plan for active members (see Section 3.7 above).
- (7) While not recommending it as a viable option, it is nevertheless recommended that discussions take place with employer representatives regarding the costs and feasibility of including retirees in the active members' health & welfare benefit plans (see Sections 3.4 and 3.5 above).

6. Conclusion

There is no magic bullet. While it is clear that FPSE members wish to have a comprehensive plan available for retired members that is inexpensive for those members, it seems it will be difficult to achieve.

However, despite the challenges, the Sub-Committee strongly recommends that FPSE actively and emphatically continue to take all necessary steps to seek an improvement in the health & welfare benefit options for our retired members.

Comparison of Retiree Health & Welfare Plans in BC Public Sector Pension Plans

	Teachers' new EHC plan	Teachers' current EHC plan	College current EHC plan	Public Sector EHC plan	Municipal
Funding	Insured	Administrative services only	Insured	Insured	Insured
Deductible	\$200	\$200	\$250 per person each calendar year	\$250	\$100
Coinsurance	80% to \$1000, 100% thereafter	70% to \$1000, 100% thereafter	80% to \$1000 per person, 100% thereafter	70% to \$2000, 100% thereafter	80% to \$1000, 100% thereafter
Lifetime max	\$200,000	\$100,000	\$150,000	\$100,000	\$100,000
Drugs	Generic substitution (Unless a brand name is required by a physician)	N/A	Subject to PharmaCare low cost alternative and reference drug program	Must be registered with Fair PharmaCare to maintain drug coverage	Must be registered with Fair PharmaCare to maintain drug coverage
Dispensing fee max	\$10	\$10	PharmaCare's current dispensing fee maximum	PharmaCare: current dispensing fee max	PharmaCare: current dispensing fee max
Markup max	8%	7%	7% over manufacturer's cost	7% over manufacturer's cost	7% over manufacturer's cost
Vision care & eye exams	\$300/ 2 years	\$150/2 years (no coverage for eye exams)	\$150/2 years (no deductible)	\$150/2 years	\$150/2 years
Paramedical per visit max	Reasonable and customary	Reasonable and customary	Reasonable and customary	\$10/visit 12 visits	Apparently reasonable and customary
Paramedical max	\$1,000 combined maximum	\$200 per type, \$10/visit for first 12 visits	\$250 per person per each paramedical practitioner, per calendar year	Depending on service 100 – 200: single 250 – 500: family	Depending on service 100 – 200: single 250 – 600: family
Hearing aids	\$1400/4 years (both ears)	\$700/4 years (per ear)	\$700/4 years (per ear, no deductible)	\$700/4 years (per ear)	\$700/4 years (per ear)
Hospital	Semi-private and private	Semi-private and private	Semi-private and private	Semi-private and private	Semi-private and private
Home care (RN & LPN)	\$50/day to a maximum of 10 days following a hospital stay	In hospital care only	In hospital care only	In hospital care only	In hospital care only
Dual coverage	Allowed	Not allowed	Allowed	Allowed: College Public Service, Teachers Not allowed: Municipal Public Sector dental	Allowed: Public Service and Teachers' dental
Premiums	Single \$55.60 Couple \$111.30 Family \$216.35 as of Feb.01.2012	Single \$55 Couple \$110 Family \$213 as of Feb.01.2011	Single \$66.51 Couple \$133.01 Family \$259.38 as of Feb.01.2011	Single \$48.00 Couple \$96.00 Family \$190.00 as of Jan.01.2011	Single \$76.00 Couple \$152.00 Family \$298.00 As of Feb 1, 2011