TRS-Care Sustainability Study

TEACHER RETIREMENT SYSTEM OF TEXAS
September 1, 2012

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Contents

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TEACHER RETIREMENT SYSTEM OF TEXAS
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I. Executive Summary

Legislative Study Charge

In 2011, during the 82nd Texas Legislative session, funding projections for TRS-Care, the health care program for retired public educators, indicated that under the current funding structure the program would be solvent through the 2012-2013 biennium. At that time the financial shortfall for the 2014-2015 biennium was projected to be greater than $800 million. To begin to address this near-term insolvency, the Legislature directed the Teacher Retirement System of Texas (TRS) to conduct a study. The study is to include a comprehensive review of potential plan design and other changes that would improve the sustainability of the program with a report of the findings and recommendations due by September 1, 2012.

Plan Options

Chapter 1575 of the Texas Insurance Code requires that a basic health care plan be offered at no cost to the retiree. Optional plans may be offered, including coverage for eligible dependents. Retirees selecting an optional plan pay a premium based on the plan selected, years of service, number of dependents and Medicare status. TRS-Care currently offers three plan options. TRS-Care 1, the basic plan, provides catastrophic coverage. TRS-Care 2 and TRS-Care 3 offer more comprehensive benefits, including a carve-out prescription drug benefit.

Funding

Funding for TRS-Care comes from a variety of sources:

- The law provides that the state contribute 1.0% of active district payroll. The General Appropriations Act reduced this contribution to .5% for FY 2013.
- School districts contribute between .25% and .75% of active district payroll. The current contribution rate is .55%.
- Active school district employees contribute .65% of payroll.
- Retirees pay premiums for any plan option other than TRS-Care 1 retiree only coverage.
- Medicare Part D Retiree Drug Subsidy (RDS).
- Investment income.

Initiatives

To help address the imminent shortfall projected for the next biennium, TRS re-bid its existing contract for a Pharmacy Benefit Manager (PBM), evaluated the cost-savings of an alternative to the RDS option under Medicare Part D, and explored the possibility of offering Medicare Advantage plans to eligible members.

As a result of these efforts, a new PBM was selected, achieving more favorable prescription drug pricing, and the Board approved offering Medicare Part D and Medicare Advantage plans. Projected savings from these initiatives are significant, but results are conditioned on participation rates.

Assuming an 80% participation rate, the fund is now projected to be solvent through the next biennium. However, **the shortfall for the 2016-2017 biennium is projected to be approximately $1.2 billion**.

Considerations

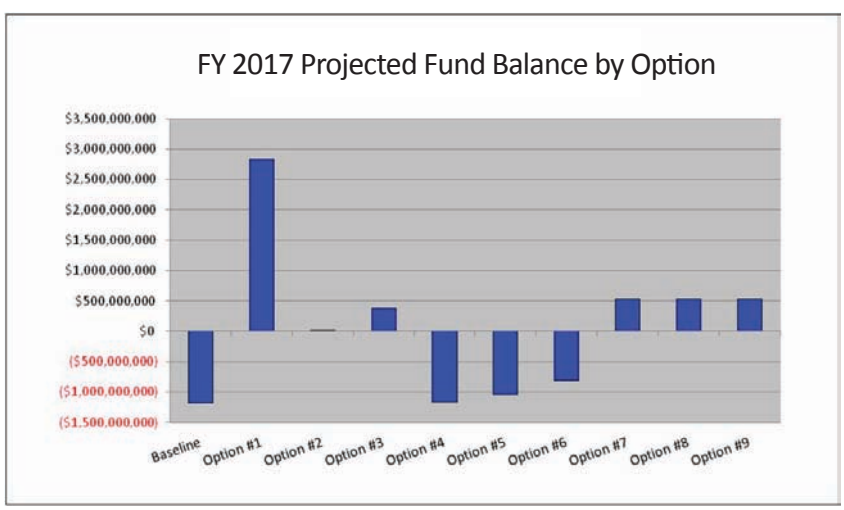
TRS-Care solvency can be looked upon as a three-legged stool representing the options available for extending the life of the program:

- Benefits/eligibility (including how benefits are managed)
- Retiree premiums
- Other contributions (state, school district, active employee, federal)

Non-Medicare retirees cost significantly more than Medicare eligible participants. Considering the savings attributable to the new Medicare Part D and Medicare Advantage plans, the plan costs for non-Medicare retirees are almost six times the costs of retirees with Medicare Parts A and B. Therefore, some of the options in the study focus separately on the two populations.

Summary of Options

The following is a summary of the options considered in the study and their impact on the financial condition of TRS-Care:



Many of the options presented in this study are not mutually exclusive. Some options may be combined to increase the positive financial impact on TRS-Care.

1. Pre-fund the long-term liability
2. Fund on a pay-as-you-go basis for the biennium
3. Retiree pays full cost for optional coverage
4. Require Medicare eligible enrollees to purchase Medicare Part B
5. Opt out consequence for participants eligible for the Medicare Advantage and Medicare Part D plans
6. Tighten eligibility requirements
7. TRS-Care 1 only for non-Medicare retirees
8. Defined contribution for non-Medicare retirees to shop in the private market
9. Move non-Medicare retirees to TRS-ActiveCare

II. Legislative Study Charge

In 2011, during the 82nd Texas Legislative session, funding projections for TRS-Care, the health care program for retired public educators, indicated that under the current funding structure the program would be solvent through the 2012-2013 biennium. At that time the financial shortfall for the 2014-2015 biennium was projected to be greater than $800 million. To begin to address this near-term insolvency, the Legislature directed TRS to conduct a study. The study is to include a comprehensive review of potential plan design and other changes that would improve the sustainability of the program with a report of the findings and recommendations due by September 1, 2012.

III. Background

TRS, as trustee, administers the Texas Public School Retired Employees Group Insurance Program, TRS-Care. At the inception of TRS-Care in FY 1986, funding was projected to last 10 years, through FY 1995. The original funding was sufficient to maintain solvency of the fund through FY 2000. Since that time, appropriations and contributions have been established to be sufficient to provide benefits for the biennium.

Eligibility

Generally, to be eligible to participate in TRS-Care, a retiree must have at least 10 years of service credit under TRS, and

- The sum of the retiree's age and years of service credit in the system is greater than or equal to 80; or
- The retiree has 30 or more years of service credit.

July 2012 Enrollment

TRS-Care 1	31,653
TRS-Care 2	41,911
TRS-Care 3	152,635
TOTAL	226,199

Plan Options/Enrollment

The law requires that a basic health care plan be offered at no cost to the retiree. Optional plans may be offered, including coverage for dependents. Retirees selecting an optional plan pay a premium based on the plan selected, years of service, number of dependents and Medicare status. TRS-Care currently offers three plan options. TRS-Care 1, the basic plan, provides catastrophic coverage. TRS-Care 2 and TRS-Care 3 offer more comprehensive benefits, including a carve-out prescription drug benefit.

Distribution by Medicare Status

Medicare Parts A & B	57%
Medicare Part B Only	9%
Non-Medicare	34%

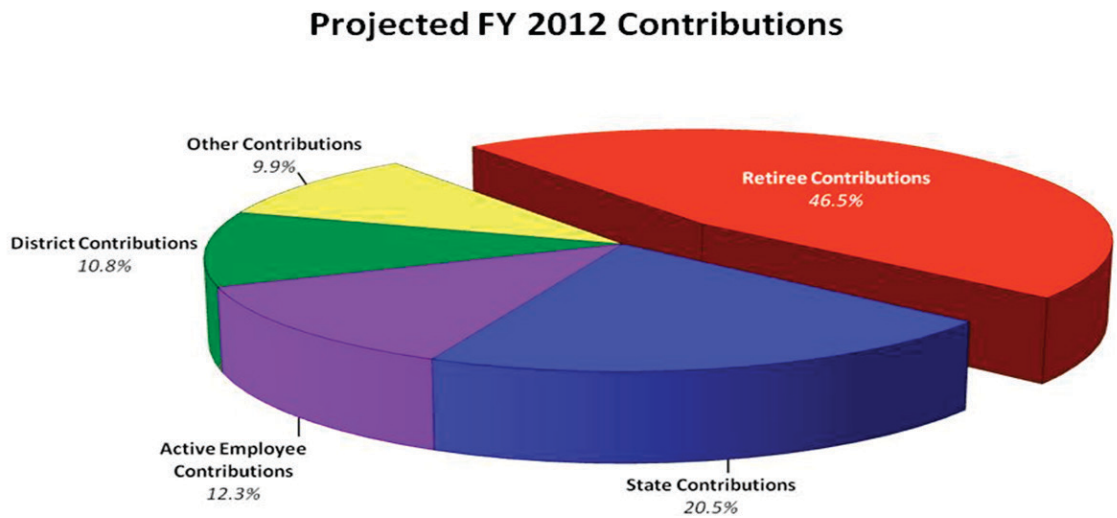
After a retiree's initial eligibility, there are no future open enrollment opportunities. However, when an enrolled retiree turns 65 years of age, the retiree may upgrade his or her level of coverage.

Funding

Funding for TRS-Care comes from a variety of sources:

- The law provides that the state contribute 1.0% of active district payroll. The General Appropriations Act reduced this contribution to .5% for FY 2013.
- School districts contribute between .25% and .75% of active district payroll. The current contribution rate is .55%.
- Active school district employees contribute .65% of payroll.
- Retirees pay premiums for any plan option other than TRS-Care 1 retiree only coverage.
- Medicare Part D Retiree Drug Subsidy (RDS).
- Investment income.

The law requires that the state pay no more than 55% and the retirees pay at least 30% of total costs. Assuming that the retirees' share of total costs includes both premiums and out-of-pocket costs, the projected retiree contribution for FY 2012 is 46.5% and the state contribution is 20.5%.



Inherent in the funding structure is a misalignment of funding with expenditures. Medical and prescription drug costs typically increase 8-10% per year while payroll generally increases about 5%. This disconnect is exacerbated in tight state budget years, such as the current economic environment in which payroll growth is projected to be flat.

Prior Solutions

This is not the first time TRS-Care has faced a funding shortfall. From FY 2001 through FY 2006, several changes were introduced to address insolvency. In FY 2001 through FY 2005, the state contributed supplemental appropriations. In FY 2004, a required contribution from school districts was established and from FY 2004 through FY 2006 increases were made to all or some of the contribution rates for the state, active district employees, and school districts. In addition, in FY 2005 the TRS-Care plan options and premiums were significantly restructured and eligibility rules were tightened. These actions successfully sustained the solvency of the program until the 2012-2013 biennium.

TRS Initiatives for FY 2013

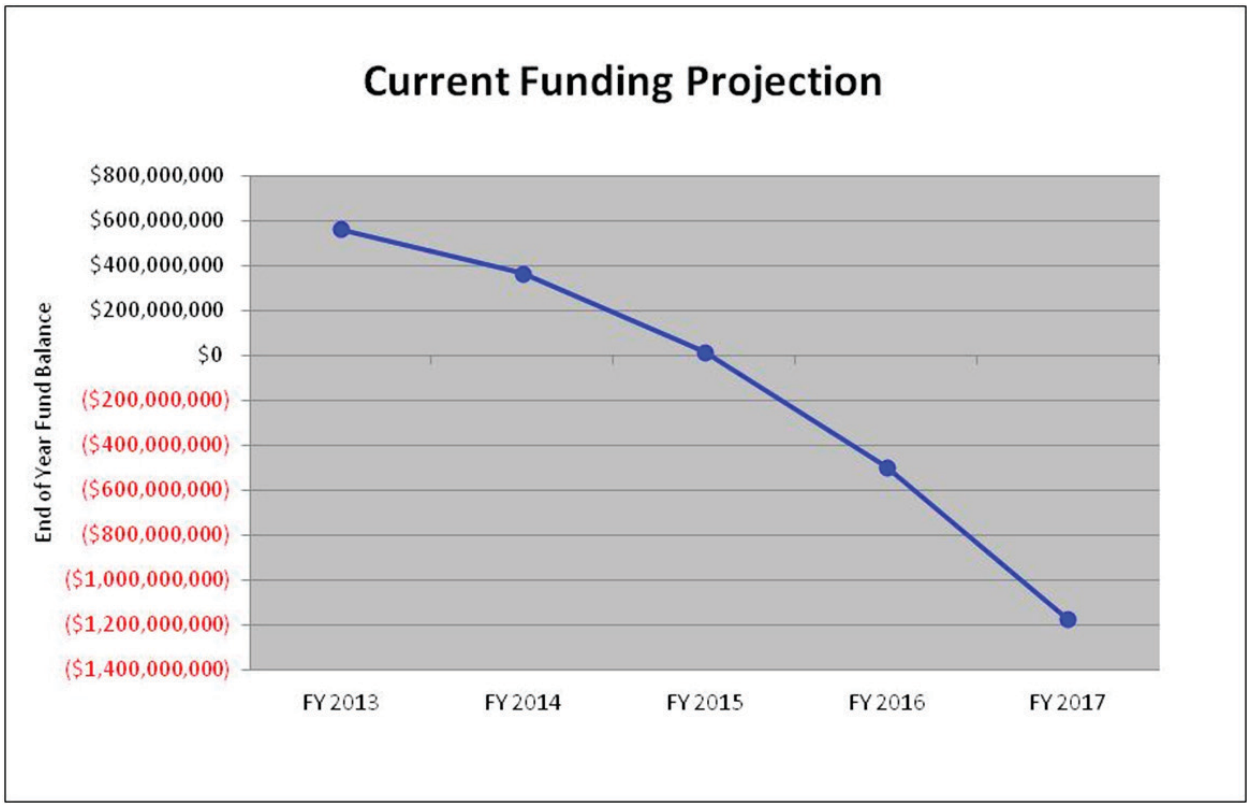
To help address the imminent shortfall projected for the 2014-2015 biennium, TRS explored two initiatives for FY 2013:

- Issued a Request for Proposal (RFP) for a PBM to determine whether better pricing was available in the market and also explored an alternative to the RDS option under Medicare Part D. Drug manufacturers are now providing funding to phase out the Coverage Gap, which is often called the "donut hole" in a Medicare Part D plan. This funding made the option of instituting a Medicare Part D plan potentially a better choice than the RDS option.
- Issued an RFP for fully-insured Medicare Advantage plan offerings.

As a result of these efforts, a new PBM was selected, achieving more favorable prescription drug pricing. Both the Medicare Advantage and Medicare Part D plan offerings were approved by the TRS Board of Trustees. Projected savings from these initiatives are significant, but results are conditioned on participation rates. To encourage participation, some of the savings will pass to participants in the form of incentives.

Assuming an 80% participation rate in the Medicare Advantage and Medicare Part D plans, along with the additional savings from more favorable PBM pricing, and updated projections for payroll growth and plan experience, **the fund is now projected to be solvent through the 2014-2015 biennium with a positive ending balance of $14.5 million**. This projection assumes the state contribution rate will return to 1% in FY 2014. If the participation rate falls short of 80%, supplemental appropriations may be necessary to sustain solvency through the 2014-2015 biennium. The Medicare Part D and Medicare Advantage plans will go into effect January 1, 2013 and more accurate projections can be made at that time once participation rates are known. For the purposes of the study, an 80% participation rate is assumed. TRS understands that there is a great deal of discussion about Medicare. Because TRS obtained locked in rates from the Medicare Advantage carrier for calendar years 2013 and 2014, any changes to Medicare will not impact the Medicare Advantage plans for these years. If there are changes to Medicare that impact the rates for years beyond calendar year 2014, TRS will reassess the value of the Medicare Advantage plans in view of these changes and will make appropriate adjustments, if necessary.

While these initiatives clearly improve the financial forecast for TRS-Care, insolvency for the 2016-2017 biennium is still looming. The shortfall for the 2016-2017 biennium is projected to be $1.2 billion.



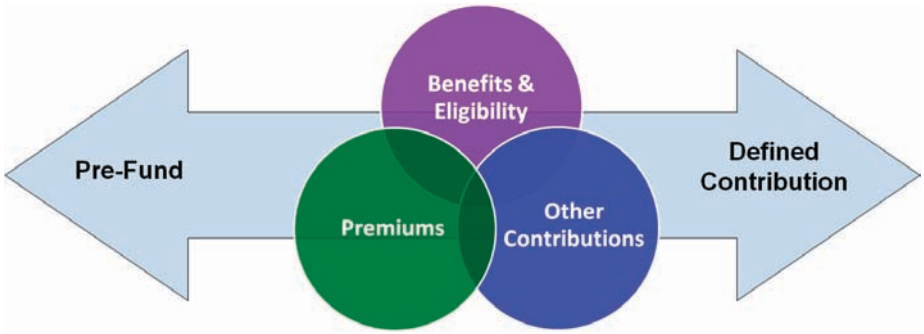
IV. Options to Improve Solvency

Considerations

TRS-Care solvency can be looked upon as a three-legged stool representing the options available for extending the life of the program:

- Benefits/eligibility (including how benefits are managed)
- Retiree premiums
- Other contributions (state, school district, active employee, federal)

Options to consider span the spectrum from pre-funding TRS-Care to a defined contribution arrangement where retirees receive a stipend and purchase coverage in the private market. Each leg of the stool can be altered to improve the sustainability of the program.



The initiatives just described for FY 2013 illustrate TRS' strategies to manage benefits. In addition to these strategies, TRS-Care has several extensive monitoring programs in place designed to help control costs. TRS-Care will also implement or continue other initiatives in FY 2013 such as a drug co-pay waiver program to encourage non-Medicare participants with certain chronic conditions to participate in a disease management program. Lastly, TRS will be working with the third-party administrator for TRS-Care to launch a pay-for-performance initiative called the "Bridges to Excellence Program for Diabetes." Under this program, clinicians who demonstrate high-quality performance based on specific measures qualify for annual performance payments.

The plan costs for non-Medicare retirees are almost six times the costs of retirees with Medicare Parts A and B.

While these programs will have some influence on curbing trend, it is clear that the subsidies and programs available for the Medicare population will have the most impact. The following chart illustrates the projected FY 2014 combined medical and drug cost (plus administrative fees) per retiree for TRS-Care 3, the plan with the majority of participants. Costs are shown for a retiree with Medicare Part A and Part B, a retiree with Part B only, and a non-Medicare retiree. This chart highlights the significant impact of the subsidies and programs available for the Medicare population. Because these same opportunities are not available for the non-Medicare population, some of the options in the study focus separately on the two populations.

Projected Per Member Per Year Costs			
For FY 2014			
Plan	Medicare Part A and Part B (1)	Medicare Part B Only (2)	Non-Medicare
TRS-Care 3	$2,259	$6,834	$13,313
(1) Assumes the retiree participates in both the TRS-Care Medicare Advantage and Medicare Part D plan options.			
(2) Assumes the retiree participates only in the TRS-Care Medicare Part D plan option.			

The options presented in this study attempt to provide the most meaningful solutions for consideration. Certain other ideas, such as:

- pill splitting,
- eliminating leveraging under a flat co-pay structure by indexing retiree benefits to inflation or trend, and
- establishing needs-based premiums (premiums based on retiree annuities)

were considered, but were determined to be inappropriate for this population or to have little value.

Options

The options presented in this study offer a menu of solutions. They may be considered independently or some may be combined to increase the positive financial impact on TRS-Care.

Many of the options presented in this study are not mutually exclusive. Some options may be combined to increase the positive financial impact on TRS-Care.

The first two options retain the same benefit structure and focus on funding and premiums. As detailed earlier, many of the funding sources for TRS-Care are based on payroll and therefore are not aligned with expenditure experience. These options attempt to adequately align the funding with expenditures.

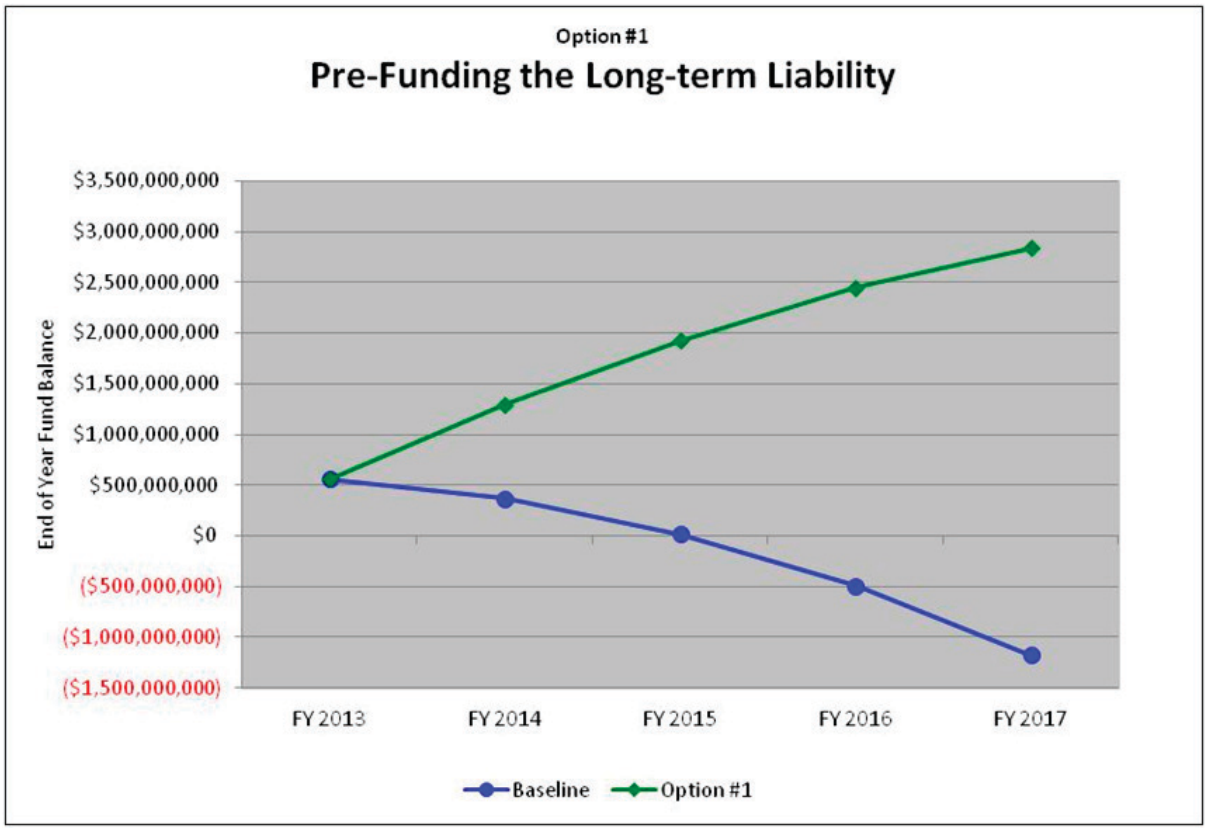
Option 1: Pre-fund the long-term liability

Pre-funding the long-term liability would essentially make TRS-Care operate in a similar manner to the pension fund, where investment income pays a substantial portion of the benefits. For the pension fund, 61.4% of funding comes from investment income.

Each year the actuary for TRS performs an analysis to determine the long-term unfunded liability of the program. As part of that analysis, the actuary also determines what the contribution rate would need to be for TRS-Care to become fully funded. The actuarial valuation for FY 2011 determined that to advance fund the program the combined annual required contribution (ARC) as a percentage of payroll would need to be 5.97%.

The current contributions from the state, the school districts, and active employees total 2.20%. Therefore, to advance fund TRS-Care the contribution rates would need to increase by 2.7 times the current rates. In addition, the retirees' share of the cost would need to increase each year to keep up with trend.

An updated projection was performed based on the assumption that 80% of eligible retirees and dependents will participate in the Medicare Part D and Medicare Advantage plans. Based on this assumption, the ARC would be 5.34%, about 2.4 times the current rates. Again, the retirees' share of the cost would need to increase each year to keep up with trend.



Although the graph only projects funding through FY 2017, pre-funding would extend the life of TRS-Care indefinitely.

Option 2: Fund on a pay-as-you-go basis for the biennium

Funding on a pay-as-you-go basis for the biennium can be accomplished by projecting expenditures for the biennium and adjusting contributions to maintain solvency.

Option 2(a)

Under option 2(a), the only funding change would be the contribution from the state. There would be no change in the contributions from active employees or school districts, and no change in premiums for retirees.

The chart to the right shows the required increase from the current 1% state contribution rate to achieve solvency through FY 2017 under two conditions: assuming the increase occurs beginning in FY 2014, and assuming the increase occurs beginning the following biennium, in FY 2016.

Required Contribution Rate (State Only)		
Biennium	Increase Begins FY 2014	Increase Begins FY 2016
FY 2014-15	2.07%	1.00%
FY 2016-17	2.07%	3.16%

This option would require that the state contribution rate more than double if the increase goes into effect FY 2014 and more than triple if delayed until FY 2016.

Option 2(b)

Under option 2(b), the needed funding would be shared proportionally by the state, the school districts, and active public educators. There would be no change in premiums for retirees.

The following chart shows the required increase from the current contribution rates to achieve solvency through FY 2017 under two conditions: assuming the increase occurs beginning in FY 2014, and assuming the increase occurs beginning the following biennium, in FY 2016.

Required Contribution Rates						
Biennium	Increase Begins FY 2014			Increase Begins FY 2016		
	State (Current Rate 1%)	Active Employee (Current Rate 0.65%)	District (Current Rate 0.55%)	State (Current Rate 1%)	Active Employee (Current Rate 0.65%)	District (Current Rate 0.55%)
FY 2014-15	1.49%	0.97%	0.82%	1.00%	0.65%	0.55%
FY 2016-17	1.49%	0.97%	0.82%	1.98%	1.29%	1.09%

This option would require that the state, active employee, and school district contribution rates increase by almost 50% if implemented in FY 2014 and almost double if delayed until FY 2016.

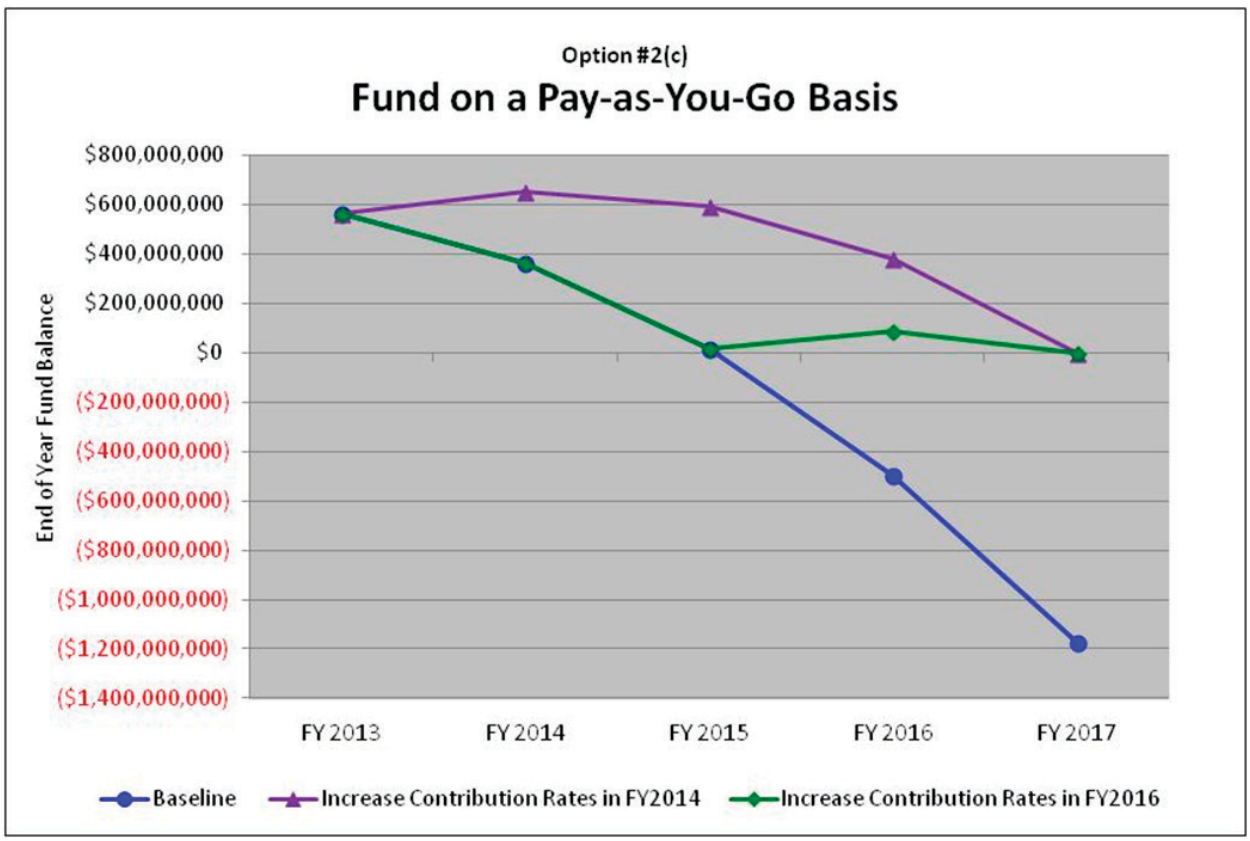
Option 2(c)

Under option 2(c), the needed funding would be shared proportionally and would include retiree premium increases.

The following chart shows the required increase from the current contribution rates to achieve solvency through FY 2017 under two conditions: assuming the increase occurs beginning in FY 2014, and assuming the increase occurs beginning the following biennium, in FY 2016.

Required Contribution Rates						
Biennium	Increase Begins FY 2014			Increase Begins FY 2016		
	State (Current Rate 1%)	Active Employee (Current Rate 0.65%)	District (Current Rate 0.55%)	State (Current Rate 1%)	Active Employee (Current Rate 0.65%)	District (Current Rate 0.55%)
FY 2014-15	1.29%	0.84%	0.71%	1.00%	0.65%	0.55%
FY 2016-17	1.29%	0.84%	0.71%	1.59%	1.03%	0.87%

This option would require that the state, active employee, and school district contribution rates and retiree premiums increase by 29% if implemented in FY 2014 and by 59% if delayed until FY 2016. An example of the impact to a retiree with 25 years of service enrolled in TRS-Care 3 and who is not Medicare eligible would be an increase from $295 per month to $382 per month if implemented in FY 2014 and to $468 per month if delayed until FY 2016.



All of the funding scenarios under Option 2 would extend the life of TRS-Care through FY 2017 and, if the commitment remains to fund the program each future biennium on a pay-as-you-go basis, it would extend the life of the program indefinitely. To continue solvency would require a recalculation of the contribution rates each biennium. It is possible that the rates would need to increase each biennium to keep pace with cost trend.

The remainder of the options presented in this study assumes that the contributions from the state, the school districts, and active employees remain constant at 1%, 0.55% and .65% of payroll, respectively.

Option 3: Retiree pays full cost for optional coverage

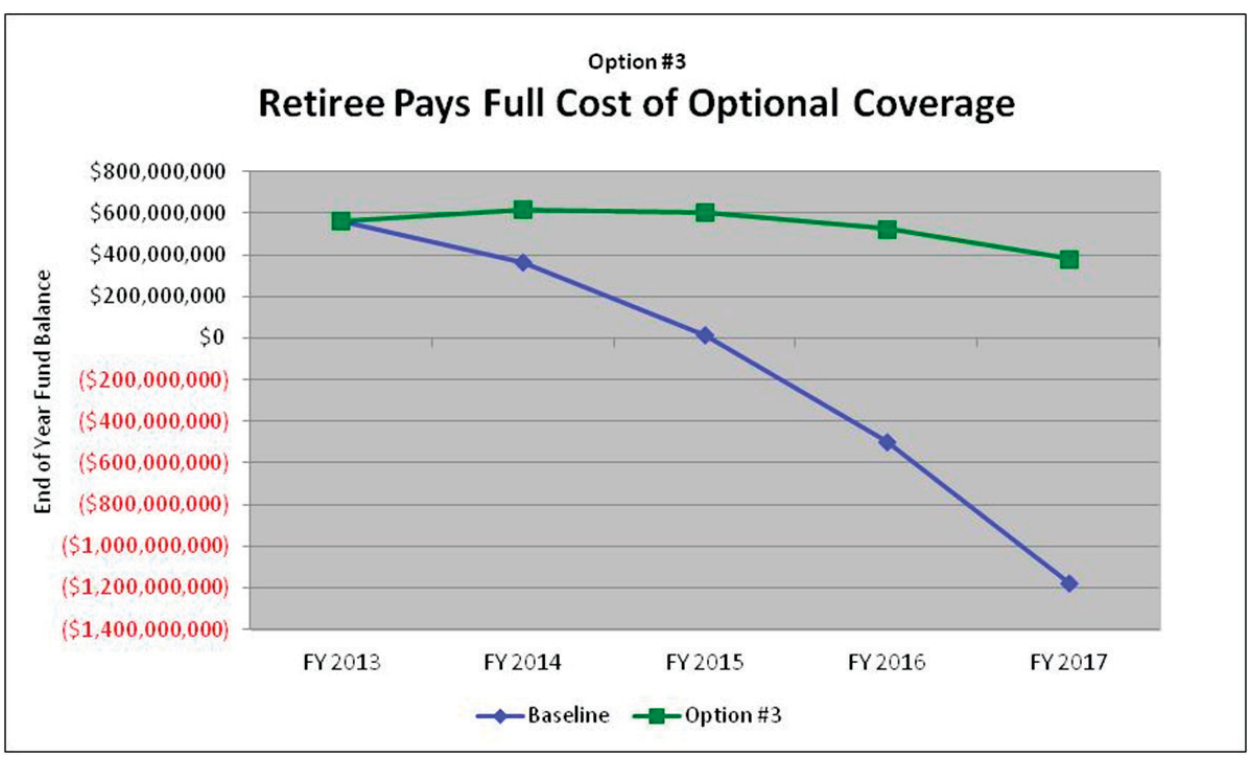
The law requires that TRS-Care 1, catastrophic coverage, be offered at no premium cost to the retiree. Retirees pay a premium for optional coverage, including coverage for dependents. Currently, the premiums for optional coverage are subsidized. One alternative would be to set premiums for optional coverage to reflect the full additional cost of this coverage.

If all retirees were enrolled in TRS-Care 1 at no premium cost, a substantial decrease in benefits would be required. The following chart shows the required benefit changes for retiree only TRS-Care 1 coverage for Medicare and non-Medicare retirees.

TRS-Care 1 Benefit Changes				
	Deductible		Coinsurance Maximum	
Eligibility	From	To	From	To
Medicare Part A & B	$1,800	$2,500	$3,000	$5,000
Medicare Part B Only	$3,000	$4,500		
Not Eligible for Medicare	$4,000	$7,500		

Note that even with the significant benefit reduction for retirees not eligible for Medicare, the claim cost to the program for a non-Medicare retiree would still be almost five times greater than the claim cost for a Medicare retiree. The premiums for optional coverage would also need to be substantially increased. For example, the premium in FY 2014 for TRS-Care 3 retiree only coverage for a non-Medicare retiree with 25 years of service would be increased from the current $295 per month to $616 and the premium for TRS-Care 3 coverage for a retiree and spouse, both non-Medicare would be increased from $635 per month to $1,690. Premium increases for optional coverage would be required each year to keep pace with cost trend.

Additionally, while surplus funding would temporarily provide for no further changes to the benefits for retiree only TRS-Care 1 coverage, eventually funds would be depleted and further benefit reductions would become necessary. It should also be noted that this option would create additional adverse selection as only those retirees who expect to have claims that exceed the high annual premiums would choose optional coverage.



The chart on page 7 clearly shows the significant difference in TRS-Care exposure for the Medicare population in contrast with the non-Medicare population. The remaining options address these two populations separately. Options 4 and 5 address the Medicare population.

Option 4: Require participants to purchase Medicare Part B

TRS does not currently require that Medicare-eligible participants actually purchase Part B. However, to be financially neutral, TRS-Care processes claims assuming that participants have Part B. The chart on page 3 does not distinguish those individuals who purchased Part B from those who could have but did not purchase Part B. Approximately 1% of Medicare eligible participants in TRS-Care have not actually purchased Part B.

In light of the implementation of the Medicare Advantage and Medicare Part D plan offerings, there is a financial advantage to TRS-Care to require the purchase of Medicare Part B. To be eligible to participate in a Medicare Advantage plan, an individual must have both Medicare Part A and Part B. To participate in a Medicare Part D plan, an individual must have Medicare Part A and/or Part B.

Medicare imposes a late enrollment penalty for people who do not purchase Part B when they are first eligible. The standard Part B premium is $99.90 per month for 2012, with those individuals classified as higher income paying an additional premium. The penalty is 10% for each twelve-month period that an individual was eligible for, but did not purchase Part B.

Option 4(a)

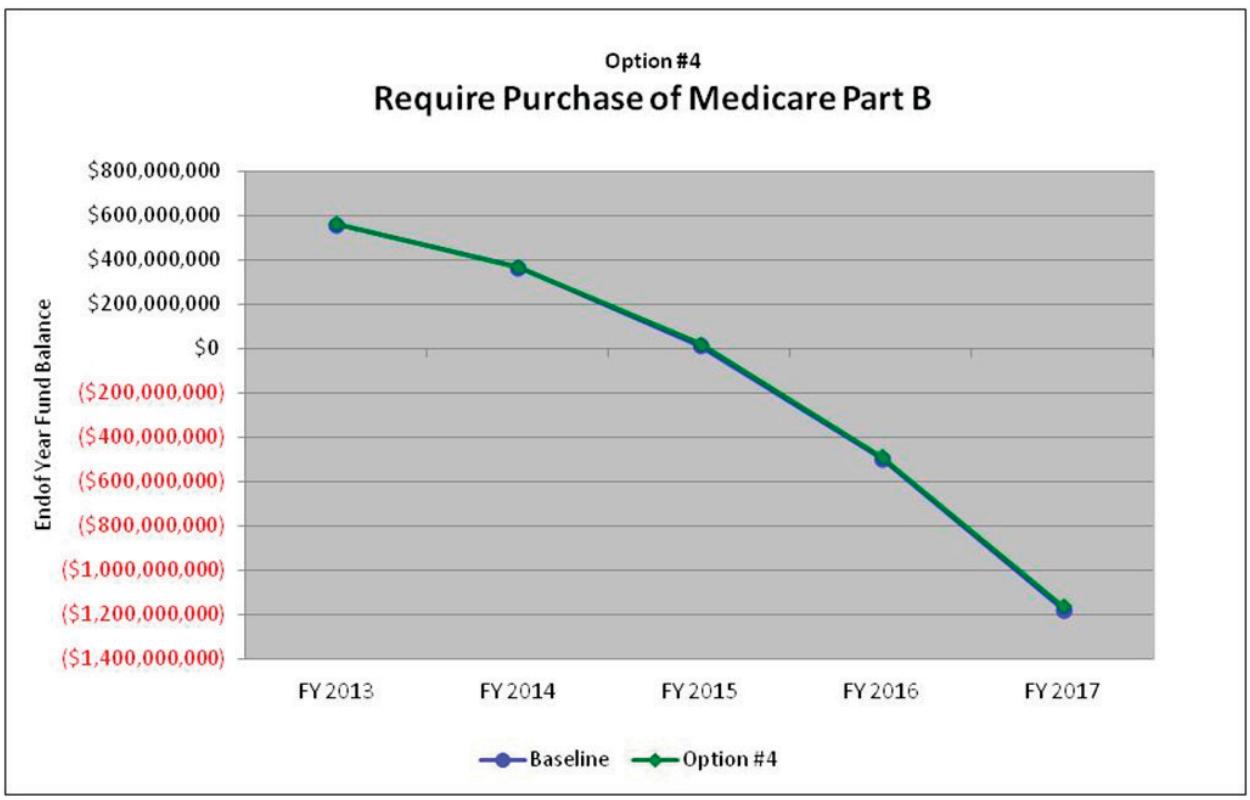
In order to be eligible to participate in TRS-Care 2 or TRS-Care 3, this option would require all retirees with a retirement date on or after September 1, 2013 and their dependents to purchase Part B when they are first eligible. Those who do not purchase Part B would be moved to TRS-Care 1, the catastrophic plan. Retirees with a retirement date prior to September 1, 2013 would be grandfathered from this requirement.

This would ensure that TRS-Care would be able to take advantage of all the subsidies available through the federal programs. Retirees would have additional coverage under Part B, which is currently paid for out of their own pockets. The average out-of-pocket cost for TRS-Care retirees for services that would otherwise be paid by Medicare Part B is approximately $315 per month. It is in the best interest of the retiree to pay the $99.90 Medicare Part B premium to cover the cost of these services.

Option 4(b)

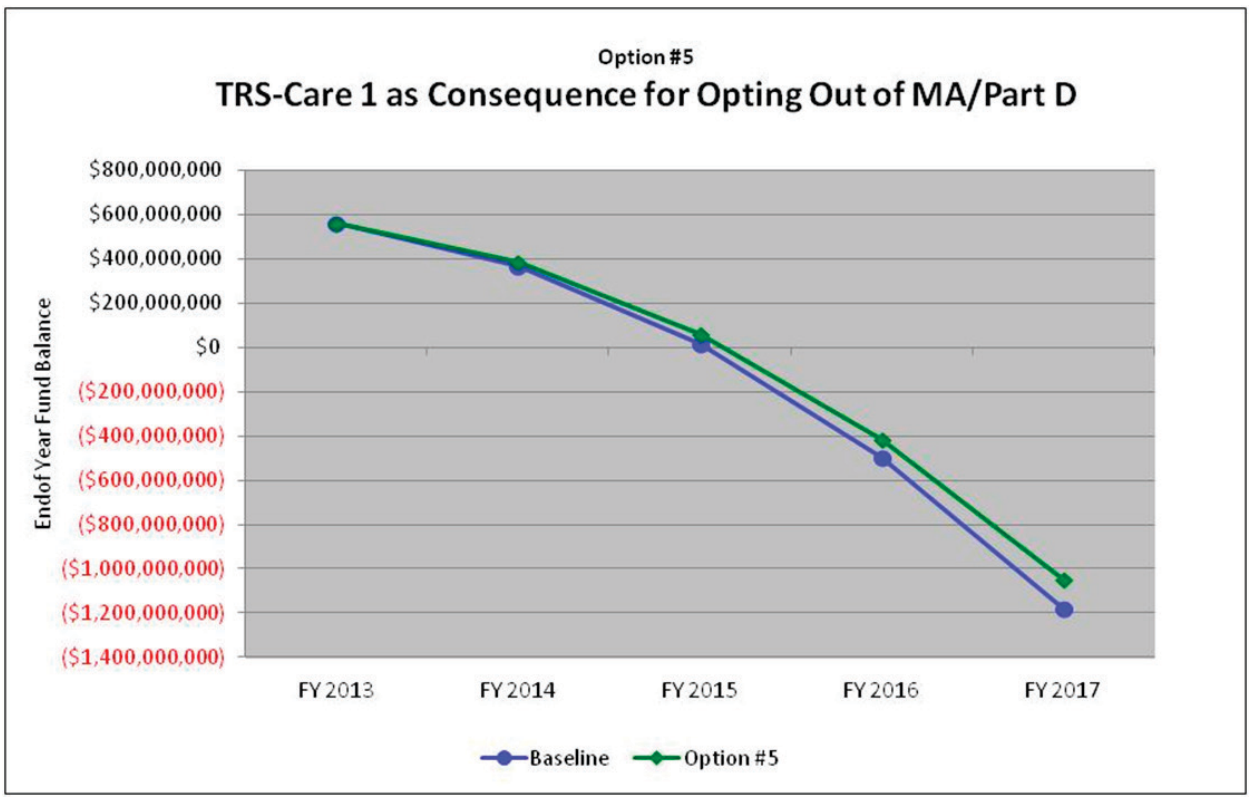
Similar to option 4(a), in order to be eligible to participate in TRS-Care 2 or TRS-Care 3, this option would require all retirees with a retirement date on or after September 1, 2013 and their dependents to purchase Part B when they are first eligible. Those who do not purchase Part B would be moved to TRS-Care 1, the catastrophic plan. Retirees with a retirement date prior to September 1, 2013 would be grandfathered if the penalty for Part B exceeds projected savings expected from participation in the Medicare Advantage and/or Medicare Part D plan options. Retirees for which the projected savings exceeds the penalty would be required to purchase Part B. TRS would reduce their TRS-Care premium by the amount of the Part B penalty.

Because almost 99% of retirees eligible for Part B actually do purchase it, Options 4(a) and 4(b) would not have a significant financial impact on TRS-Care. However, these options are included in the study for consideration so that federal subsidies and programs available to TRS-Care could be fully maximized. In addition, these options would benefit retirees. Not only would they have additional coverage for Part B services, they would be able to participate in both the Medicare Advantage and Medicare Part D plans, which offer richer benefits at a lower cost compared to the standard TRS-Care 2 or TRS-Care 3 plans.



Option 5: Opt out consequence

There are significant projected savings resulting from Medicare retirees remaining enrolled in the Medicare Advantage and Medicare Part D plan offerings. Medicare requires that people be allowed to opt out of these plans. However, there is no federal requirement that an alternative be offered to those opting out. For the initial year, the TRS Board voted on an incentive based implementation, with no consequence for opting out. Assuming an 80% participation rate for the initial year, the remaining 20% would be automatically enrolled in the Medicare plans in the following year and anyone wishing to opt out would be enrolled in TRS-Care 1, the catastrophic plan. To provide more Medicare Advantage plan choices, an RFP would be issued for regional Medicare Advantage Prescription Drug plans. The following chart assumes that 100% of TRS-Care participants eligible for the Medicare plan offerings would be enrolled.



This concludes the discussion of solutions for the Medicare population. The remaining options concern the non-Medicare population. Recall the chart on page 7, which shows that early retirees (non-Medicare) cost the plan almost six times the amount of retirees age 65 with both Medicare Parts A and B. The solutions provided for the non-Medicare population address bridging the gap between retirement and Medicare eligibility. The following chart shows the distribution of age for members who retired in FY 2011 and enrolled in TRS-Care.

Age at Retirement for TRS-Care Retirees			
FY 2011			
Age at Retirement	Number of Retirees	% of Retirees	Exposure (Non-Medicare Years)
48-54	1,104	10%	13,514
55-59	3,382	32%	26,303
60-64	4,066	38%	12,565
65+	2,096	20%	0
Total	10,648	100%	52,382

Early retirees are the most significant cost drivers for TRS-Care.

As is illustrated in the chart, only 20% of new enrollees in TRS-Care are Medicare eligible, age 65 or older, at the time of retirement. The vast majority, or 80%, are early age retirees, and more than half of the retirees in this category are younger than age 60. In FY 2011, 1,104 individuals retired between the ages of 48 and 54 and enrolled in TRS-Care. These individuals will not reach Medicare eligibility for another 11-17 years, which corresponds to 13,514 non-Medicare exposure years.

Option 6: Tighten eligibility requirements

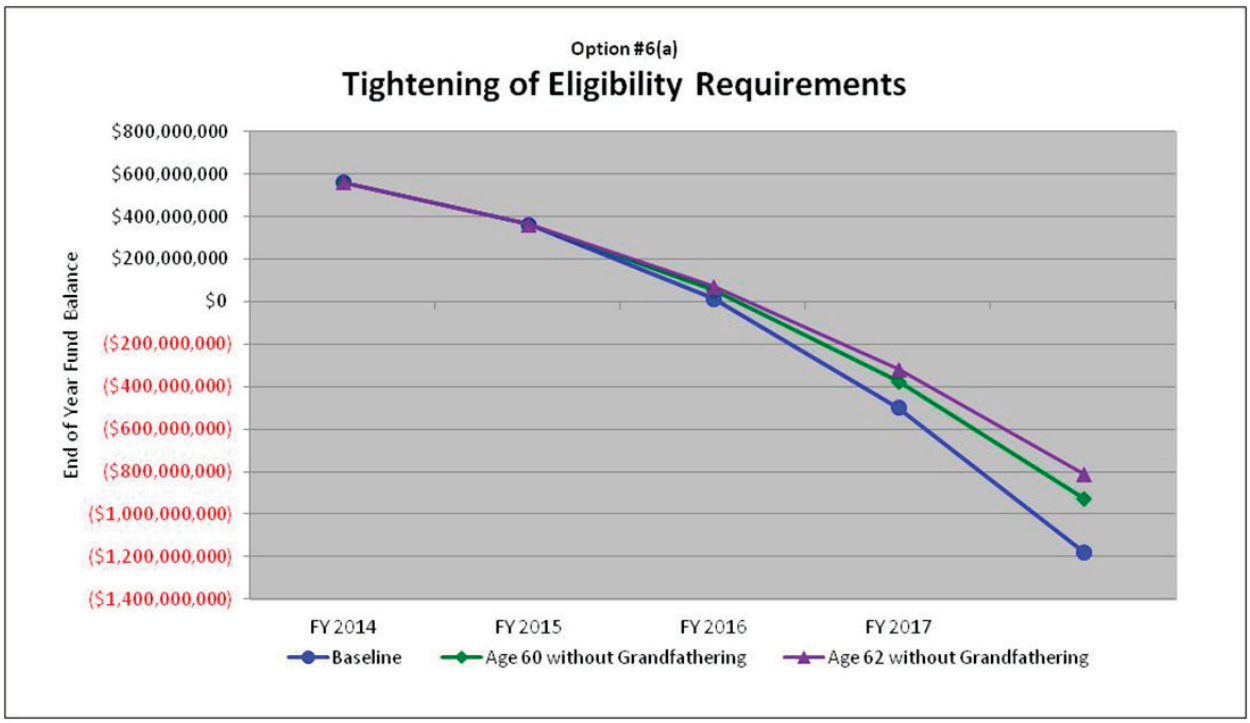
Generally, to be eligible to participate in TRS-Care, a retiree must have at least 10 years of service credit under TRS and

- The sum of the retiree's age and years of service credit in the system is greater than or equal to 80; or
- The retiree has 30 or more years of service credit.

Option 6(a)

Add a minimum age requirement of 62 or 60 for new retirees to enroll in TRS-Care, effective for members retiring after August 31, 2013. No grandfathering provision would apply to those members eligible to enroll in TRS-Care under the current eligibility requirements.

A minimum age requirement of age 62 with no grandfather provision would generate $365 million in savings over the next two biennia and a minimum age requirement of age 60 would generate $252 million. This option would continue to have a significant impact on the program in future biennia.

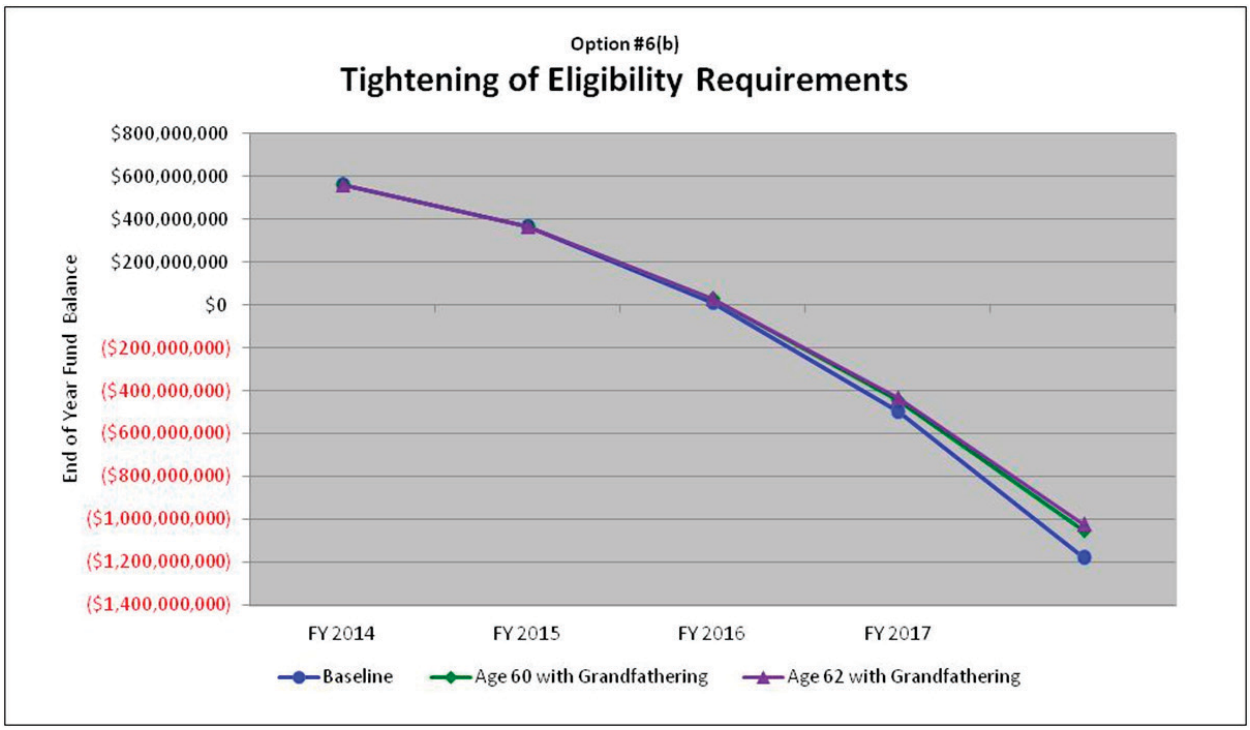


Note that the savings would potentially be partially offset by certain TRS members who are now eligible for TRS-Care under current eligibility requirements and who may retire sooner than they had planned as a result of the new age requirements.

Option 6(b)

Add a minimum age requirement of 62 or 60 for new retirees to enroll in TRS-Care. To prevent a potential wave of retirements, which would have a near-term negative impact on the program, members eligible to enroll in TRS-Care as of August 31, 2013 would be grandfathered under the current eligibility requirements.

A minimum age requirement of age 62 would generate $155 million in savings over the next two biennia and a minimum age requirement of age 60 would generate $124 million. The impact for future biennia would be more significant as non-grandfathered members retire into TRS-Care.

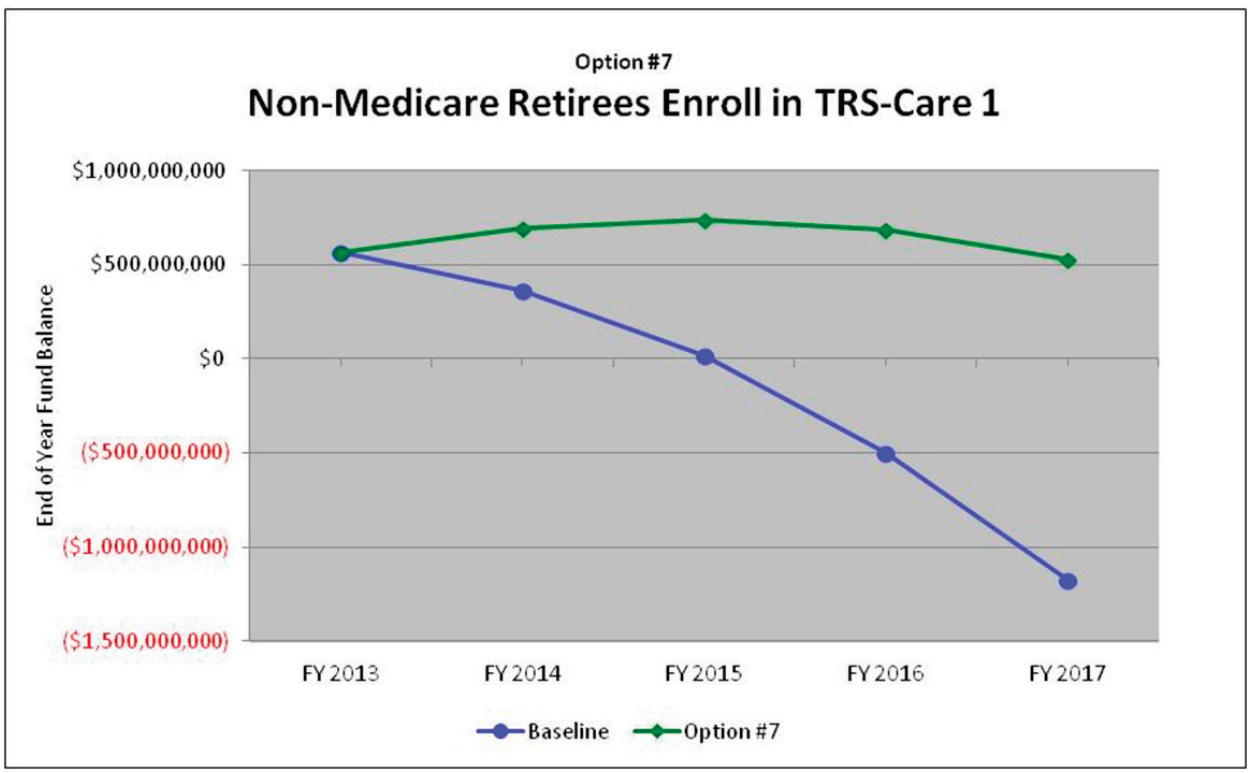


The next three options accumulate the projected annual funding from the state, the school districts, and active employees and translate that into a stipend or contribution per retiree. Based on projections for FY 2014, each retiree would have $266 per month toward the cost of coverage.

Option 7: TRS-Care 1 only

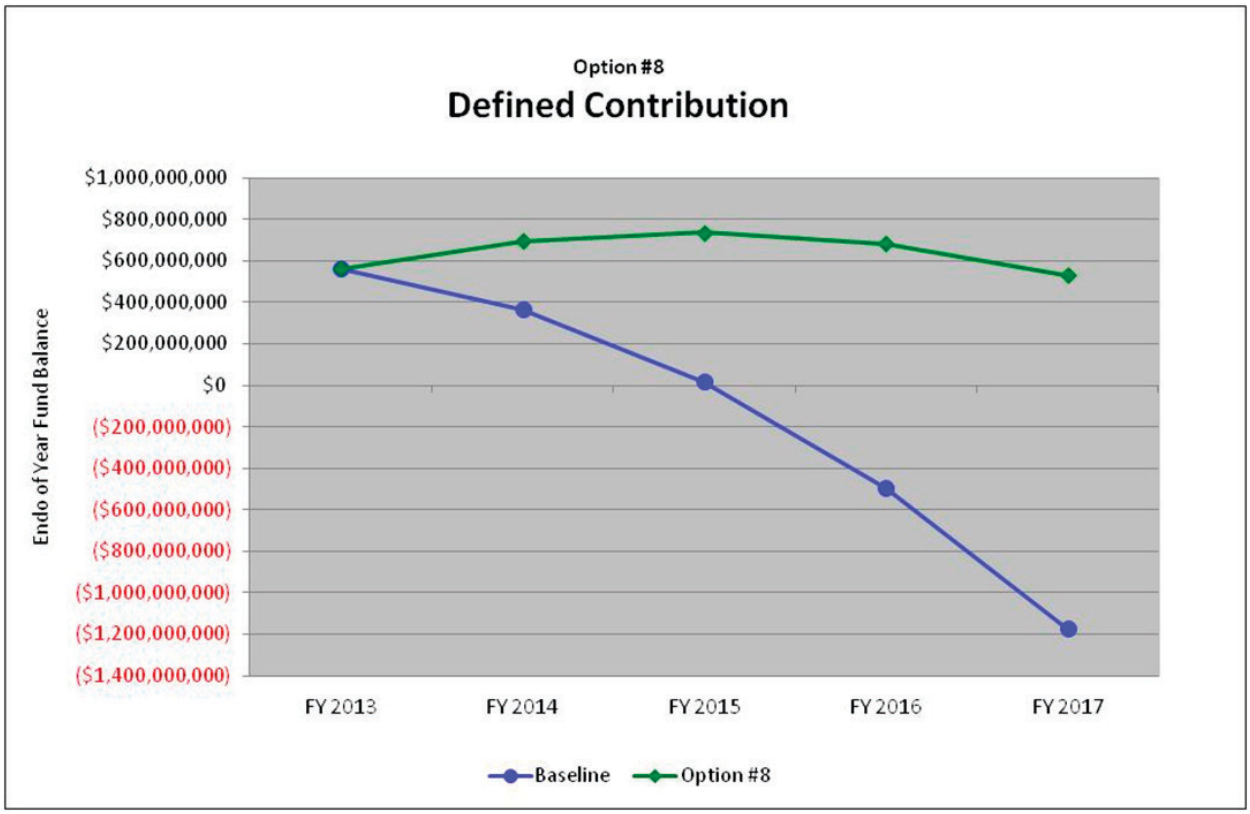
Allow non-Medicare retirees to enroll in TRS-Care 1, the catastrophic plan, until they reach 65. At that time they would be allowed to upgrade coverage. Non-Medicare retirees would have to pay a premium for TRS-Care 1 and benefits would be reduced. The deductible would need to be increased from $4,000 to $7,500 and the coinsurance maximum would need to be increased from $3,000 to $5,000. Benefits and premiums for the Medicare population would remain unchanged.

Recall that in Option 3, the benefit structure for TRS-Care 1 is determined assuming all retirees, both Medicare and non-Medicare, are enrolled in that plan. In Option 3, the risk for the non-Medicare retirees is spread over the entire population. Option 7 assumes that the non-Medicare retirees' risk is borne solely by the non-Medicare population. The premium for retiree only coverage would be $253; the premium for a retiree and spouse, both non-Medicare, would increase from $140 per month to $737 per month. Premium increases for the non-Medicare population would be required each year to keep pace with cost trend.



Option 8: Defined contribution

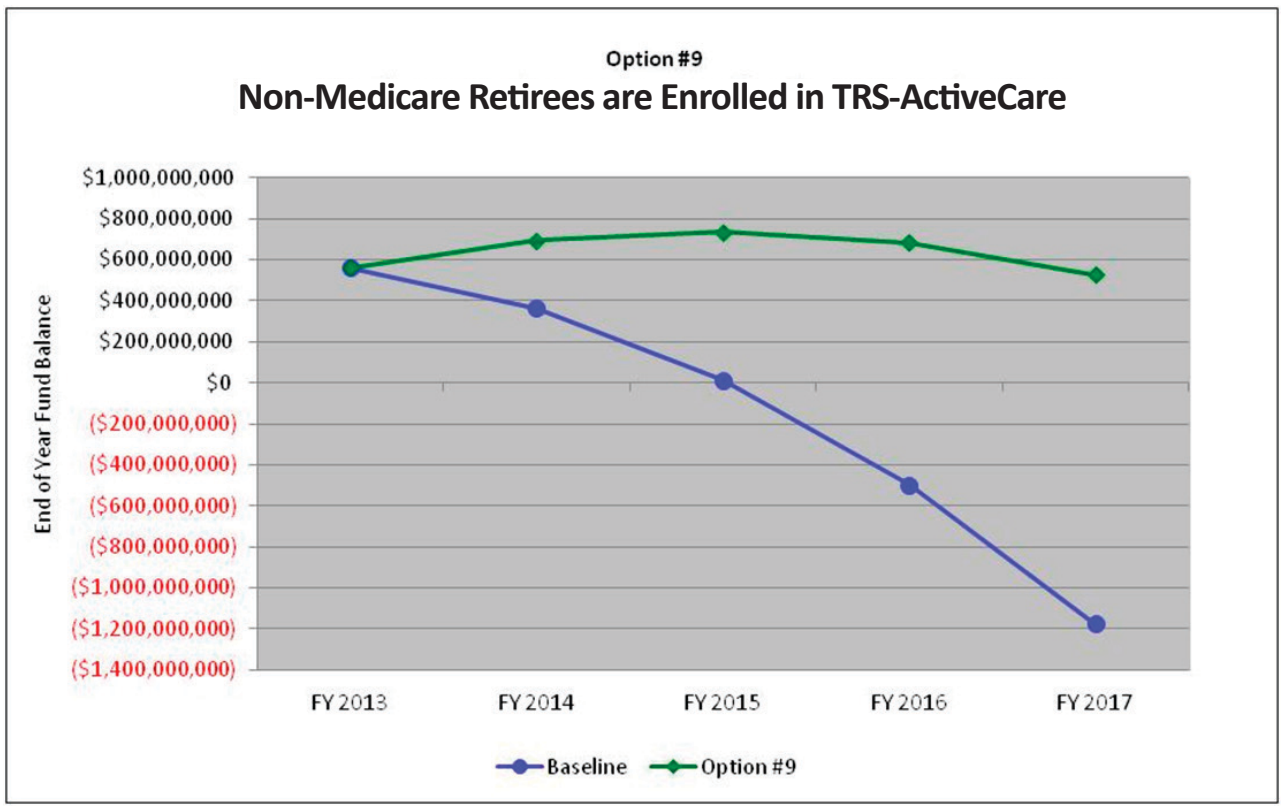
Establish a Health Reimbursement Account and deposit the stipend of $266 per month into that account until the retiree reaches age 65. An administrative fee would be required for this approach and could either be charged directly to the retiree or additional funding could be appropriated to cover the fee. The retiree would then be free to shop in the private insurance market for coverage. A typical policy with a $1,000 deductible and 80% coinsurance for a female age 60 residing in Texas averages $851 per month (the premium for a male age 60 is about $1,061 more per month). However, retirees with pre-existing conditions currently may not be able to obtain this level of coverage at an affordable cost, if at all, in the private market. Future changes in the market may emerge to make this a more viable option.



Option 9: TRS-ActiveCare

Keeping with the stipend approach, the non-Medicare retirees would be moved to the TRS-ActiveCare plan, a statewide health care program administered by TRS for active public school employees, until age 65. Current enrollment in TRS-ActiveCare is over 470,000 covered lives as compared to TRS-Care's 226,000 covered lives. The high-cost risk of the non-Medicare population would then be spread over a larger, younger and healthier population.

The stipend per retiree would be used toward the cost of the TRS-ActiveCare premium with the retiree paying the difference. This is very similar to what is done at the school district level for active employees. An active TRS member participating in TRS-ActiveCare gets a minimum contribution of $150 from the school district and $75 from the state, through school finance formulas, a total of $225 toward the cost of monthly coverage. The employee pays the remainder of the premium.



Under Option 9, non-Medicare retirees would no longer have access to retiree only coverage at no cost.

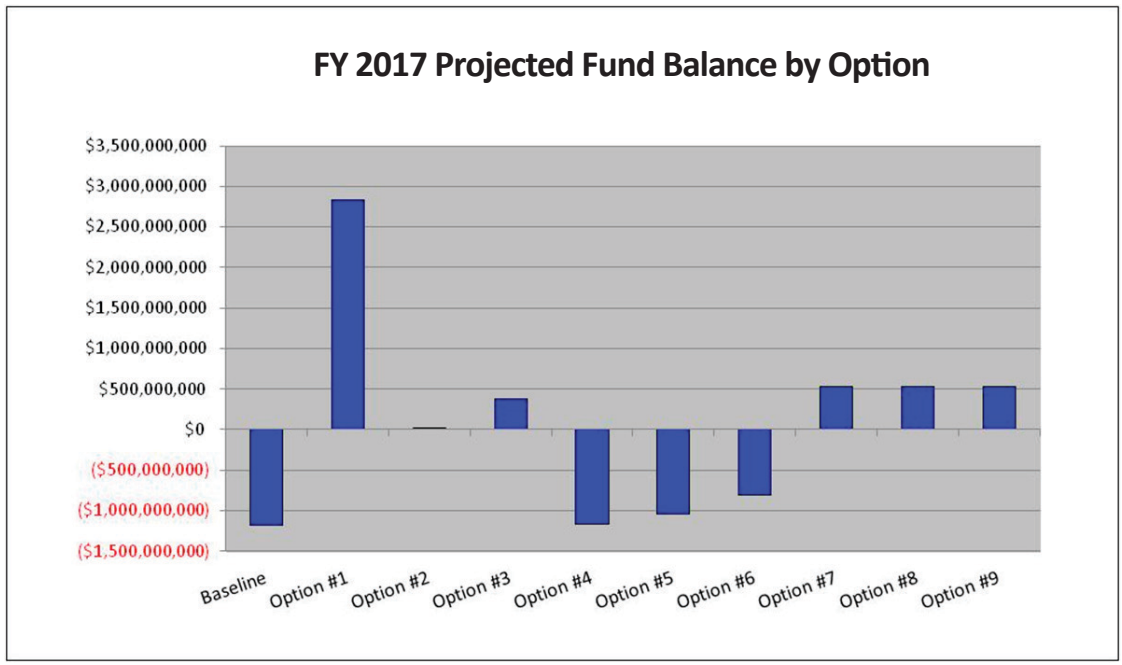
This would impact the premiums established for TRS-ActiveCare. Projections indicate that TRS-ActiveCare premiums would need an overall increase of 5% in FY 2014. While not all school districts participate in TRS-ActiveCare, retirees of non-participating districts would be enrolled in and covered by TRS-ActiveCare. Therefore, as an alternative to an overall 5% increase in TRS-ActiveCare premiums, consideration could be given to requiring non-ActiveCare school districts and their employees to absorb some of the risk.

For example, an overall increase in TRS-ActiveCare premiums of 3% could be implemented along with a 40% increase in TRS-Care contribution rates from these non-participating school districts and active employees. This would result in an increase in the contribution rate for school districts from .55% of payroll to .75% and an increase in the contribution rate for active employees from .65% of payroll to .90%. These incremental increases in contributions would be deposited into the TRS-ActiveCare fund and used toward offsetting premium increases. In addition, this option would provide parity between participating and non-participating TRS-ActiveCare districts and employees.

V. Conclusion

The following chart contains a side-by-side comparison of the fund balance projected as of August 31, 2017 for each of the options offered in this study. There are no simple answers to the approaching health care solvency crisis for TRS-Care in the 2016-2017 biennium. The options suggested do not solve the issue being faced nationwide as to how to successfully address rapidly increasing health care costs. Insolvency with a magnitude of $1.2 billion for the 2016-2017 biennium requires significant action to sustain the program. Each solution comes at a cost to somebody. The Legislature may want to consider combining several of the options to increase the positive financial impact on TRS-Care. For example, Option 2, which aligns funding with expenditures for the biennium, could be combined with Options 4 and 5, which maximize programs and subsidies available for the Medicare population, and with Option 6, which establishes a minimum age requirement to participate in TRS-Care.

TRS recommends that although TRS-Care is projected to be solvent through the 2014-2015 biennium, the Legislature consider taking action to implement one or more of the options presented in the study to be effective FY 2014. TRS also recommends that particular consideration be given to options addressing the non-Medicare population.



Option	Description	Impacted Parties					Annual Increase to State Appropriations
		State	District	Active Employees	Non-Medicare Retirees	Medicare Retirees	
Option #1:	Pre-fund the long-term liability	X	X	X	X	X	$352,707,883
Option #2:	Fund on a pay-as-you-go basis for the biennium						
	FY2014 – FY2017						
	Option 2(a):	X					$263,979,422
	Option 2(b):	X	X	X			$119,990,646
	Option 2(c):	X	X	X	X	X	$72,533,508
	FY2016 – FY2017						
	Option 2(a):	X					$533,264,831
	Option 2(b):	X	X	X			$242,393,105
	Option 2(c):	X	X	X	X	X	$145,341,810
Option #3:	Retiree pays full cost for optional coverage				X	X	$0
Option #4:	Require Medicare eligible enrollees to purchase Medicare Part B					X	$0
Option #5:	Opt out consequence for participants eligible for the Medicare Advantage and Medicare Part D plans					X	$0
Option #6:	Tighten eligibility requirements			X			$0
Option #7:	TRS-Care 1 only for non-Medicare retirees				X		$0
Option #8:	Defined contribution for non-Medicare retirees to shop in the private market				X		$0
Option #9:	Move non-Medicare retirees to TRS-ActiveCare		X	X	X		$0