AUGUST 2016

EXECUTIVE DIRECTOR'S REPORT

Municipal Pension Board of Trustees review of group benefits for retired members

2014–16

Municipal Pension Plan

Contents

Executive director's report on the 2014–16 Municipal Pension Board of Trustees review of group benefits for retired members

INTRODUCTION

The group extended health and dental program for retired members of the Municipal Pension Plan (plan) is made available through a contract between the Municipal Pension Board of Trustees (board) and Pacific Blue Cross (PBC). The board recently completed a comprehensive review of the program.

After much analysis and consideration, the board concluded that fundamental changes to the program were required to contain group benefits costs within the available funding limit. The analysis shows prescription drug costs are the number one cost to the program. To ensure members continue to have protection from increasing health care costs, the board decided to update the extended health care (EHC) plan design and discontinue subsidizing dental benefits, as health care costs are typically less predictable and more catastrophic.

While group benefits are not part of the guaranteed pension benefits provided by the plan, the board remains committed to maintaining retired member access to group extended health and dental coverage and has updated the design of the EHC plan. The changes:

- ensure members continue to have access to valuable EHC and dental coverage without escalating premiums;
- ensure members continue to have protection from catastrophic health care costs, especially those at or near their current lifetime maximum, while refreshing deductibles and co-insurance to be more in line with industry norms;
- preserve healthy EHC subsidies for members (maximum subsidy is 75 per cent EHC premium);
- continue an administratively efficient and cost-effective program of group benefits;

- provide the plan with better protection from future cost pressures of expensive specialty drugs entering the market; and
- decrease the plan's EHC and dental costs by approximately 47 per cent, extending the funding threshold by four to five years.

This report provides a summary of the board's approach and analysis as part of its two-year comprehensive group benefits program review.

More information about changes to the group benefits program can be found on the plan's website and on the plan's page of the PBC website. Retired members have also received additional material by direct mail.

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GOVERNANCE

The board is responsible for managing the plan and the plan fund.

Trustees are appointed to the board by the following plan partners and appointing authorities:

- BC Government
- Union of BC Municipalities (UBCM)
- Health Employers Association of BC
- BC Public Schools Employers' Association
- Hospital Employees' Union
- Canadian Union of Public Employees BC Division
- Health Sciences Association of BC
- BC Nurses' Union
- BC Police Association and BC Professional Fire Fighters Association
- Council of Joint Organizations and Unions
- Plan member partner (Municipal Employees' Pension Committee)
- Plan employer partner (BC Government and UBCM)

Eight trustees and eight alternate trustees are appointed by employer representatives. Eight trustees and eight alternate trustees are appointed by employee representatives, including two retired plan members.

As fiduciaries, trustees act in the interests of all plan members. They are required to set aside all personal and outside interests in favour of undivided loyalty to the plan beneficiaries. While individual trustees are appointed by outside organizations under the trust agreement governing the plan, in their deliberations, each trustee must consider

fairly the interests of all plan members, former members and other beneficiaries to whom a duty is owed.

The breadth and diversity of the board means it has the benefit of multiple perspectives to find optimal solutions. At the time of this report, six retired members sit on the board, including a primary and an alternate trustee appointed by a plan member partner.

There are more than 900 employers participating in the plan and more than 300,000 plan members, including more than 80,000 retired members.

BOARD PRIORITIES

The board and the plan partners agree on the order of the board's priorities:

1. deliver the basic pension promise,
2. provide sustainable cost of living adjustments, and
3. provide access to group benefit coverage.

BASIC LIFETIME PENSION BENEFITS IS PRIORITY NUMBER ONE

The board's number one priority is delivering the lifetime pension benefit to plan members. The account that funds the basic pension benefit is prefunded with employer and member contributions, and earns investment returns (basic account). The basic account is healthy, and basic pensions are secure.

The board can say that basic pensions are secure because of how they are funded. Basic pensions are paid from the basic account, which is managed to ensure there is enough money to pay for current and future pensions. If a funding shortfall is anticipated, the board has the authority and obligation to increase contributions to ensure there will be sufficient funds to pay pensions. The plan's most recent valuation (at December 31, 2012) shows the basic benefit is fully funded and takes into account current contributions. The next valuation results (at December 31, 2015) will be available in fall 2016.

In 2015, the plan paid out $1.6 billion in pension and lump-sum benefits. Approximately 75 cents of every $1 in paid pension benefits originates from investment returns.

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SECONDARY PRIORITIES

The board's second and third priorities are to provide members with sustainable cost-of-living adjustments (COLA) and access to group health benefits, subject to available funds. COLA and extended health and dental benefits are not guaranteed as they are not prefunded and are subject to available funds. There is an inevitable trade-off between COLAs and group benefit subsidies, because, to a certain extent, they share a common funding source; money not used to fund group benefit subsidies is used to fund future COLAs.

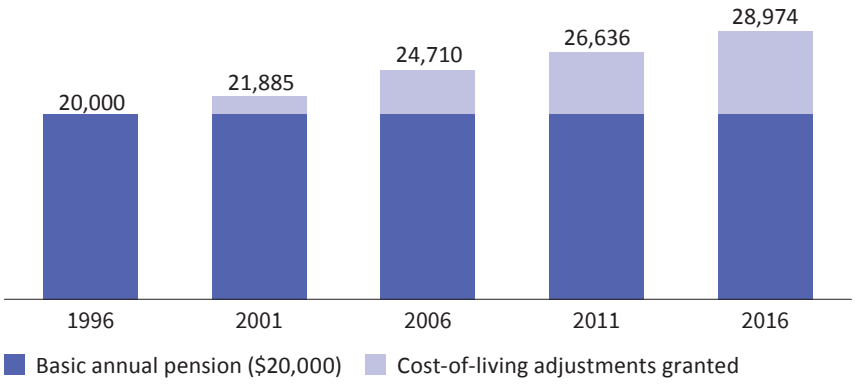
> Unlike the basic lifetime pension benefit, which is determined by a formula, COLA and group benefits subsidies are determined in part by available funds. These are contingent (non-guaranteed) benefits and paid only if there is sufficient funding. COLAs and group benefits are not part of the guaranteed pension benefits provided by the plan.
>
> In some ways, COLAs and group benefits can be best thought of more like defined contribution benefits. The benefit paid is based on the funds available, not a formula. Members, not the plan, bear the risks associated with this type of funding model.

COLA IS PRIORITY NUMBER TWO

All plan members receiving a pension payment, including terminated and deferred members, also receive annual cost-of-living adjustments (if granted). Once granted, these COLAs form part of the members' basic pension benefits and are guaranteed.

The following bar graph illustrates the important role that regular cost-of-living adjustments can have on the purchasing power of a member's pension over time.

Basic pensions plus cost-of-living adjustments[1]



1 This is an illustration of the value of COLA historically.

Current contributions—a portion of employer and member contributions—to the inflation adjustment account (IAA) are insufficient to provide full inflation protection indefinitely. As COLAs are partially prefunded, future COLAs are granted on a sustainable basis as permitted by the long-term funding capacity of the IAA.

COLAs are granted at the discretion of the board, which considers all relevant factors, including:

- COLA cannot exceed the September to September increase in the Canadian consumer price index,
- the amount granted for COLA cannot exceed the level of the COLA cap, and
- the cost of COLA cannot exceed the amount available in the IAA.

COLA of two per cent was granted on January 1, 2015, at a capitalized cost of $250 million. This amount was transferred from the IAA to the basic account. This COLA, once granted, becomes part of members' basic pension benefits and is guaranteed. COLA of one per cent was granted on January 1, 2016, at an estimated capitalized cost of $134 million.

The COLA cap has the effect of strengthening the long-term health of the IAA, ensuring that sustainable cost-of-living adjustments can be paid to current and future retirees.

For more information about sustainable COLA, see the *2014 Report to Members* and the summer 2014 edition of *AfterWork* in the Retired Member section under Publications on the Municipal Pension Plan website at **mpp.pensionsbc.ca**.

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ACCESS TO GROUP HEALTH BENEFITS IS PRIORITY NUMBER THREE

Currently, in addition to Medical Services Plan coverage, retired members have access to the following group benefits provided through the plan:

- extended health benefits, and
- dental benefits.

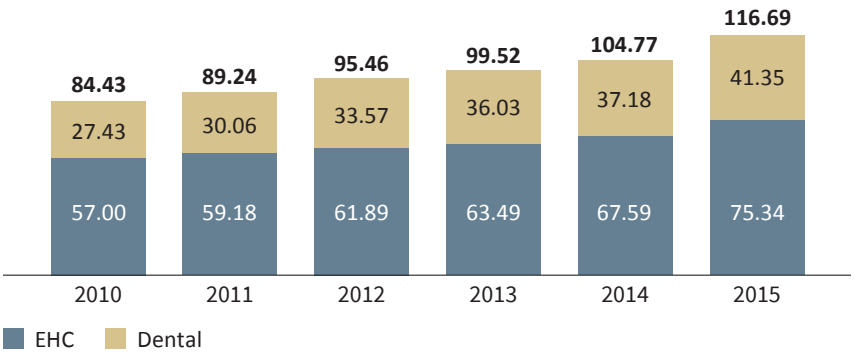
All plan members applying for a pension benefit can enroll in EHC and dental coverage through the pension plan at retirement. Retirees can also enroll their spouses and dependants. Group benefits are not part of the guaranteed pension benefits provided by the plan: group benefits are not pension benefits, are not prefunded and are not guaranteed. Access to, and subsidies of, retired member group benefits are subject to board policy and funding constraints. Coverage for these benefits can be increased, decreased or eliminated at the discretion of the board, including changes to annual deductibles, annual limits, maximum subsidies and premiums.

The plan currently provides members with partial subsidies for their individual EHC and dental premiums based on years of pensionable service. These subsidies come from limited employer contributions that would otherwise go to the IAA. The board's comprehensive review excluded Medical Services Plan coverage. The plan's group benefits program offers good value to retired members, regardless of whether premiums are subsidized. The purchasing power of the large group results in extended health and dental coverage that would be difficult or impossible for an individual to obtain. British Columbians who are members of large PBC group benefits plans (such as the plan) that are moving to voluntary dental coverage are eligible for lower premiums and additional benefits not included in standard individual plans.

GROUP BENEFITS PROGRAM COSTS

In 2010, EHC and dental program costs totaled $84.43 million. By 2015, EHC and dental program costs had risen to $116.69 million, an increase of 38 per cent.

Post-retirement group benefits program costs ($ millions)



Group benefits costs are rising significantly. There are a number of reasons for this:

- increasing number of retired members as baby boomers retire;
- improved longevity of retired members;
- increased use of prescription drugs by retired members;
- more chronic conditions among the population;
- increased prevalence of high-cost specialty drugs, especially for chronic conditions; and
- the cost inflation of eligible benefits (products and services).

Since 2010, group health benefits cost pressures have been offset by growing use of and decreasing prices for generic drugs, and lower than expected inflation, but these offsetting pressures are not expected to continue.

Prescription drugs continue to be the single biggest driver of increasing EHC claim dollars. This category represented 73 per cent of the overall EHC claims by dollar in 2015. This pattern is typical in EHC plans for older populations.

In reviewing the group benefit program, the board's goal was to provide retired members with access to valuable benefits coverage and make good use of the money available to offset coverage costs. Their goal was not to cut benefits; trustees understood that many of the program changes they were considering would have significant

cost implications for members. The board wanted to ensure they had access to meaningful data and analysis based on facts, not opinion, to inform their decision making. To that end, as part of its review process, the board contracted an independent third party, Cubic Health Inc. (Cubic), a drug plan management and health care analytics company, to work with the plan's current carrier, PBC, to conduct a thorough analysis of members' prescription drug use over a three-year period.

Cubic identified some troubling trends:

- the growth rate of specialty drug claim spending was almost 45 per cent between 2011 and 2013, and
- the growth rate of non-PharmaCare drugs was almost 29 per cent over the same period.

Both PBC and Cubic also expressed concern that certain plan design features and external factors suppressing drug costs over the past five years may no longer be effective enough to control drug costs going forward. This projection appears to be true, as total drug claim dollars increased 16 per cent in 2015 over 2013, compared to 2.5 per cent in 2013 over 2011.The next largest category of costs is medical aids and equipment. While the average cost per member for this category increased year-over-year, these expenses are typical for EHC plans with older populations, as the medical aids and equipment assist members with daily living as well as higher quality of life. This category is not yet a significant driver of total EHC costs, though the board noted both usage and costs are increasing.

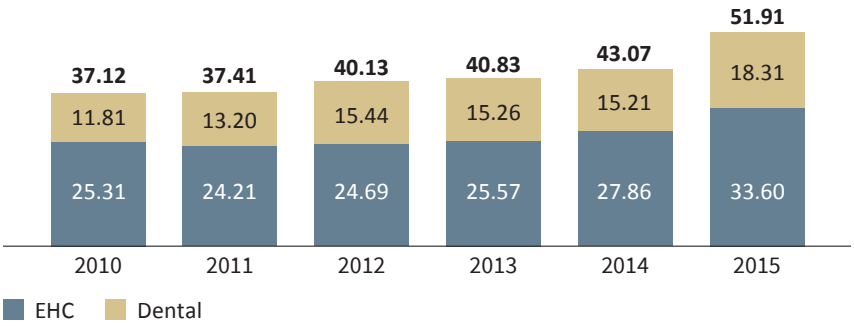
The third highest cost category is for paramedical practitioners, e.g., physiotherapists, massage therapists and naturopaths. While the average cost per member for this category increased year-over-year, these expenses are not yet significant drivers of total EHC costs, though the board noted both usage and costs are increasing.

GROUP BENEFITS PROGRAM FUNDING

Funding for group benefits comes from premiums paid by retired members and subsidies paid by the plan; they are not funded by investment returns or contributions that retired members paid to the plan while working.

Under the plan's funding policy, subsidies for EHC and dental premiums are limited to a portion of current employer contributions that would otherwise be allocated to providing cost-of-living protection for retired members. The funding limit is 0.8 per cent of the pensionable payroll. Because subsidies are not prefunded, this money does not accumulate any investment returns.

Post-retirement group benefits subsidies ($ millions)



In 2010, EHC and dental subsidies paid by the plan totaled $37.12 million. By 2015, the figure rose to $51.91 million, **an increase of almost 40 per cent**. In the same period, MSP subsidies rose from $19.56 million to $33.89 million, bringing the plan's costs for the total group benefits program to $85.8 million in 2015.

Because premiums are only partially subsidized, retired members share in funding the group benefits program costs. They pay for a portion, if not all, of their own premium(s) and 100 per cent of the premiums for spousal and dependant coverage.

During the last five years, EHC and dental subsidies paid by the plan increased 40 per cent. In the same period, single member premiums have increased an average of 8.5 per cent.

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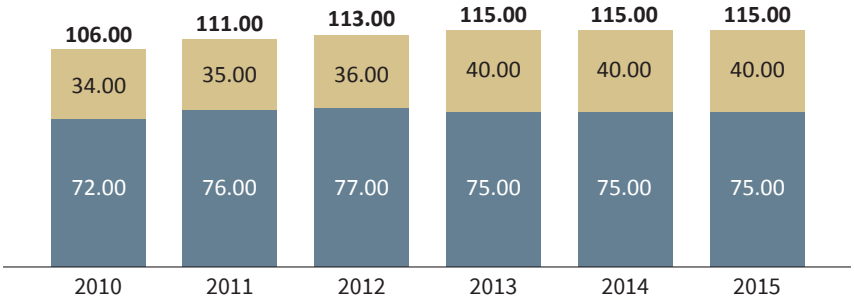
Post-retirement group benefits member costs ($)

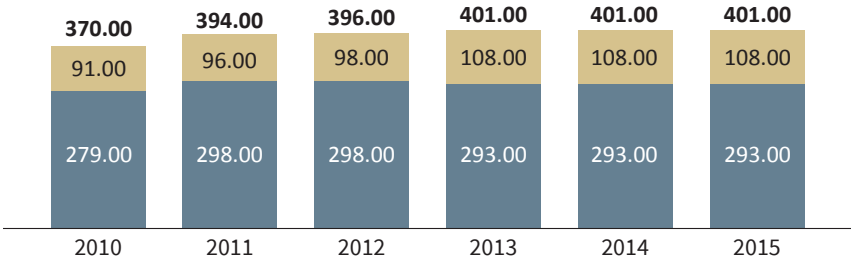
EHC Dental

Single premiums



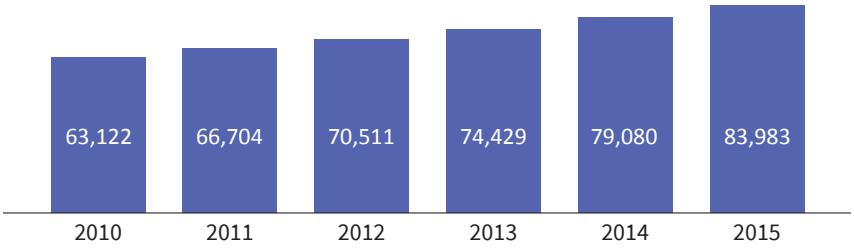
Couple premiums

Family premiums



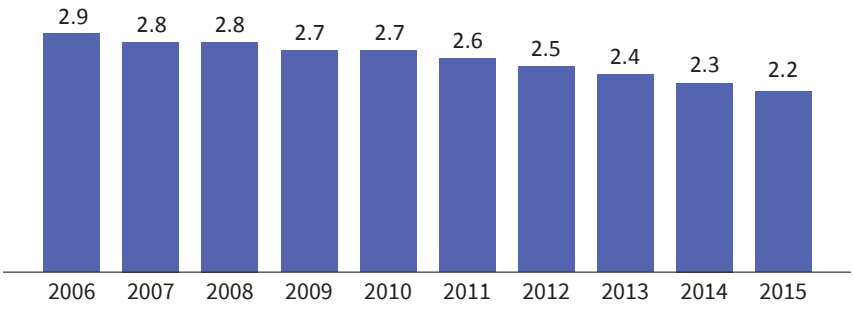
In the same period, the number of retired members increased 33 per cent.

Number of retired members



Over the past decade, active membership has increased 31 per cent, while retired membership increased 67 per cent.

Active members to retired members (ratio)



FUNDING CHALLENGES AND COST PRESSURES: THE PERFECT STORM

The current group benefits program for retired members is not sustainable; the plan's group benefits funding is not keeping pace with these rising costs. This is because the maximum funding for group benefits comes from employer contributions equal to 0.8 per cent of active member salaries. However, the number of active members and their salaries are not increasing at the same pace as the cost of group benefits.

The board needed to take action now to ensure the group benefits funding maximum is not exceeded. Its projections show the current funding arrangement cannot be sustained beyond 2018. As the board does not have the authority to increase funding—only the plan partners can do this—the board's decision-making was limited to how to control and restructure the plan's group benefit costs.

While the board wishes this was the end of these types of changes, as group benefits costs rise and the proportion of retired members grows faster than the active member population, maintaining subsidized group benefits premiums becomes more and more challenging. Even with the 2017 program changes, as costs for the benefits continue to rise and funding remains limited, the board expects there will be future group benefits plan design changes that could include:

- increasing annual deductibles and monthly premiums;
- limiting, decreasing or eliminating coverage, eligible expenses, co-insurance/reimbursement, maximum subsidies and annual limits; and
- other fundamental plan design changes.

What if the board's projections are wrong?

If the board's projections overestimate the cost pressures or underestimate the available funding for group benefits, then more employer contributions will flow into the IAA to provide more money for future COLAs for retired members. This aligns with the board's priorities, and is beneficial to current and future retired members.

If the projections underestimate the cost pressures or overestimate the available funding, then fewer employer contributions will flow into the IAA and provide less money for future COLAs for retired members.

BENEFIT IMPROVEMENTS

The board cares about the plan's members and the impact group benefit program design changes may have on them. The board wants to ensure retired member group benefits continue to deliver value for the money available. The board periodically receives suggestions from members on how to improve the program; these are considered during the board's next comprehensive program review.

In fact, the board considered a number of requests from members to improve coverage. The most popular suggestions included:

- increasing biennial (two-year) vision care limits,
- increasing quadrennial (four-year) hearing aid limits,
- combining and/or increasing annual paramedical limits,

- including composite fillings, and
- coverage for the shingles vaccine.

After deliberating, the board concluded it shouldn't increase funding pressure on the program, except as required to maintain the program's value to members. As a result, the board did not proceed with the benefit improvements requested by members.

FUNDING AND COST-CONTAINMENT STRATEGIES

i) Contributions

The board does not have the authority to increase the level of contributions paid by active members and employers to the plan. Only the plan partners can do this.

The plan partners—the Government of BC and the Union of British Columbia Municipalities together are the employer partner; the Municipal Employees' Pension Committee is the member partner—have the authority to increase the amount contributed to the IAA but have not indicated support for contribution rate increases to fund group benefits. This is, in part, because active plan members and current employers have seen their contribution rates increase in three of the last four valuation cycles.

Today, based on the 2012 valuation report, combined plan member and employer contributions are 4.29 per cent of pay higher than the entry-age normal cost of the benefit being earned by today's contributors. In other words, today's contributors (employers and members) are together paying 4.29 per cent of payroll more than is required to pay for the benefits that the members are currently earning. These additional contributions are to make up for historical deficits arising, mainly, from past investment returns being lower than anticipated, improvements in longevity, and reduced future investment return expectations.

ii) Premiums

The board sets premiums annually in conjunction with the group benefits carrier based on the plan's claims data. This allows the board to adjust cost sharing on an annual basis and for short-term

pressures. The board strives to minimize year-over-year premium volatility for retired members.

The current EHC and dental plans are administrative service only (ASO) contracts with PBC. Annual premiums are set based on actual costs of benefits claimed by members in the plan from the previous year as well as adding an allowance for anticipated cost increases. When plan costs escalate, monthly premiums are directly affected.

iii) Administrative costs

Concurrent with the review, the board negotiated a more cost-effective administrative fee structure with PBC, which helps control the overall group benefits program costs.

PBC has a long-standing relationship with the plan, is one of the few non-profit group benefit carriers in the market, and has worked closely with the board to improve their reporting and analysis. The board will continue to monitor the retiree benefit programs, including consideration of carriers, with upcoming reviews.

iv) Other cost control mechanisms

The board sought expert group benefits and financial advice from PBC, Cubic and Pension Corporation and considered a number of strategies to decrease costs for the group benefits program, including:

- cost-sharing shifts in the form of changes to deductibles, levels of co-insurance/reimbursement, annual limits and maximum subsidies; and
- cost containment strategies in the form of stop-loss insurance, drug formulary, tiered co-insurance harmonized with PharmaCare, therapeutic alternatives and dispensing fee management.

Cost-sharing strategies considered

Until this review, the board has not moved deductibles and co-insurance—EHC's deductible and co-insurance have not been updated since the board assumed responsibility for the program in 2004. In the meantime, industry norms have changed. See table below for comparison to other BC public service plans: College Pension Plan (CPP), Public Service Pension Plan (PSPP) and Teachers' Pension Plan (TPP).

	BC MPP	BC CPP	BC PSPP	BC TPP	PBC standard contract
EHC deductible	$100 per family	$250 per person	$250 per person	$200 per person	< $100 per person
Co-insurance	80%	80%	70%	80%	80%
Re-imbursement after $1,000 claims paid per person	100%	100%	100% (after $2,000)	100%	Flat co-insurance of 80%
Lifetime limit	$100,000	$150,000	$200,000	$200,000	$50,000–$100,000

The board considered the status quo and changes to the EHC's cost-sharing design, including:

- annual deductibles between $150 per family and $250 per person;
- reducing co-insurance from 80 per cent to 70 per cent, with 100 per cent reimbursement after $1,000 or $2,000 claims paid;
- 100 per cent reimbursement after $1,500–$5,000 claims paid; and
- flat co-insurance of 80 per cent.

The board determined it was reasonable to adjust the EHC's annual deductible and sliding co-insurance cost-sharing features to bring the program closer to industry standards. It elected not to move to flat co-insurance or raise the 100 per cent reimbursement threshold.

PBC advised that the number of claimants reaching the EHC lifetime maximum was growing, and more members were nearing the maximum than ever before. The board determined it was reasonable to adjust the lifetime limit upward to provide more protection for members. This was the only change it approved as part of the review that will increase the cost pressure on the group benefits program; however, the board felt this was reasonable given the protection it afforded members from catastrophic health care costs. This is of increasing importance with some new drug therapies costing $60,000 or more per claimant.

The board considered financial analysis from the Pension Corporation that adjusting the maximum EHC and dental subsidies from 75 per cent to 65 per cent of the premium would have the effect of extending the funding threshold by only one year; more drastic cuts to the maximum subsidy would be required to have a meaningful impact on the program's costs. PBC also advised that reducing the maximum subsidy below 50 per cent would jeopardize the program's

sustainability, as their experience suggests members select against the plan, driving up cost/member and premium costs when subsidies drop below 50 per cent of premiums.

Trustees considered the value of both the EHC and dental programs, recognizing that both bring value to retirees. To ensure members continue to have protection from increasing and potentially catastrophic health care costs, the board carefully considered the EHC plan design and to discontinue subsidizing dental. Dental costs are typically more predictable and less catastrophic than health care costs.

After much analysis and deliberation, the board decided to eliminate subsidies for dental coverage, preferring to protect subsidies for the EHC plan. It did not make any changes to the maximum EHC or MSP subsidies.

The board noted that the other three public sector pension plans appear to have prioritized increased COLA protection or EHC subsidies over dental subsidies. See table below.

	BC MPP		BC CPP		BC PSPP		BC TPP	
	2005	2015	2005	2015	2005	2015	2005	2015
MSP subsidy	Y	Y	N	N	Y	N	N	N
EHC subsidy	Y	Y	Y	N	Y	Y	Y	N
Dental subsidy	Y	Y	Y	N	N	N	Y	N

The board also considered a request from the Municipal Pension Retirees' Association to restore subsidies for surviving spouses. It declined the request after financial analysis showed restoring subsidies to surviving spouses currently participating in the group benefits program could increase EHC and dental costs by almost $4 million per year, and restoring subsidies to all surviving spouses could increase costs by almost $6.5 million per year.

Cost-containment strategies considered

In previous reviews, the board took steps to maintain the value of drug coverage available to members and their families. For example, in 2010, the board agreed to tie the maximum dispensing fee paid by the plan to PharmaCare's maximum so that the plan's limit rose

with the PharmaCare limit. Similarly, the board approved increasing the allowable drug markup limit from seven per cent to eight per cent. These decisions were important because the full cost of any dispensing fee or markup above the limits in the EHC policy is paid by retired members and taking these steps also helped the plan stay abreast of evolving industry norms.

Other board-approved plan design features have also helped control historical program costs, including:

- reimbursement of PharmaCare eligible drugs, subject to PharmaCare payment policies, including low-cost alternatives and reference-based pricing;
- reimbursement of non-PharmaCare eligible drugs, subject to low-cost generic drug pricing; and
- implementing PharmaCare special authority enforcement.

Cubic's analysis of claims data from 2011 to the end of 2013 validated some positive aspects of the EHC plan design, noting overall drug expenses increased only 2.4 per cent; however, it also identified emerging material challenges:

- generic prices are unlikely to move materially lower in the coming years,
- specialty drug spending grew by almost 45 per cent between 2011 and 2013, and
- non-PharmaCare drug claim spending increased almost 29 per cent over the same period.

Independent analysis from Cubic identified that specialty drug spending grew by almost 45 percent and non-Pharmacare drug claims increased by almost 29 per cent, between 2011 and 2013.

Cubic recommended the board explore the following opportunities to reduce EHC costs paid by the plan:

- limiting the number of dispensing fees paid for chronic medications,
- optimizing the use of therapeutic alternatives, and
- harmonizing the plan's coverage with PharmaCare formulary.

Independent analysis from Cubic identified that specialty drug spending grew by almost 45 percent and non-Pharmacare drug claims increased by almost 29 per cent, between 2011 and 2013.

The board looked closely at each of these opportunities and assessed the potential for containing plan costs and the impact on members. It concluded that:

- limiting the number of refills or rejecting claims for dispensing fees might save the plan money, but those costs would be directly passed to members; whereas, PBC's new Preferred Pharmacy Network might be a better way to optimize dispensing activities, with pharmacists educating members about dispensing fees and refills;
- the EHC plan already has five therapeutic substitution categories, defined by the PharmaCare formulary (acid blockers, three cardiovascular classes and anti-inflammatories), and while adding more therapeutic substitution classes might offer savings to the plan, potential savings could be offset by increased administration costs or be short-lived because of how quickly the drug market shifts;
- moving the EHC plan to harmonize with the PharmaCare formulary and providing lower levels of co-insurance for non-PharmaCare benefits would have a significant impact on members' out-of-pocket expenses and could indirectly impact health outcomes; many members would be directly impacted and unable to maintain current drug therapies.
- moving the EHC plan to the Blue Rx formulary was the better solution to managing escalating drug costs without compromising members' health outcomes while having a moderate impact on members' out-of-pocket costs. The number of members directly affected was significantly less than with a PharmaCare tie-in and the board had the ability to include grand-parenting and other processes to offset disruption for retirees.

Blue Rx provides broad drug coverage, balancing clinical necessity and cost-effectiveness, and targeting therapeutic alternatives, while minimizing the impact on members and maintaining administrative efficiency. The Blue Rx drug formulary:

- is managed by PBC, which has the necessary expertise in-house to do so efficiently;

- covers brand name and generic drugs used to treat all major diseases, including the vast majority of prescription drugs on the market, unlike the PharmaCare formulary, which only covers about half of the available prescription drugs;
- does not cover certain drugs when alternative less costly drugs are available with similar therapeutic benefits, providing the plan with better protection from future cost pressures of expensive specialty drugs entering the market (today there are approximately 100 drugs ineligible under BlueRx); and
- requires pre-approval from PBC or PharmaCare for approximately 110 drugs to ensure less expensive first-line or alternative therapies have been considered and the patient's condition matches the drug.

GROUP BENEFITS PROGRAM CHANGES EFFECTIVE JANUARY 1, 2017

The following changes are required to meet the board priority of providing access to group benefits for retired members.

At their meeting on March 31, 2016, the board approved changes to the group benefits program that will ensure the program continues to provide members with access to both extended health and dental coverage, and the best program value:

1. Effective January 1, 2017, retired member access to extended health care coverage will be amended to:
   a. increase the extended health care plan's lifetime maximum from $100,000 to $200,000 per person,
   b. increase the extended health care plan's annual deductible from $100 per family to $100 per person,
   c. reduce the level of co-insurance for the extended health care plan from 80 per cent to 70 per cent on the first $1,000 in claims paid, and
   d. move drug coverage to the PBC Blue Rx managed formulary.

2. Effective January 1, 2017, retired member access to dental coverage will be amended to:
    a. remove premium subsidies, and
    b. implement a new dental plan that has:
        i. an essential plan covering basic services only and reimburses 70 per cent of eligible expenses up to a calendar year maximum of $1,000 per person, and
        ii. an enhanced plan covering basic services plus major restorative services and reimburses 70 per cent of eligible expenses up to a calendar year maximum of $2,000 per person effective January 1, 2017.

The board carefully considered the impact of the 2017 changes on members, recognizing that:

1. The plan's group benefits program offers good value to retired members, regardless of whether premiums are subsidized.
2. Almost all members participating in the group benefit program will see their out of pocket expenses increase, due to the changes to group benefit program.
3. Blue Rx is expected to manage increasing drug costs, without negatively impacting health outcomes for members.
4. The increased EHC lifetime maximum will enable some members to re-obtain EHC coverage they may have lost, and protect others who are nearing their limit.
5. The changes allow current and future retired members continue to have access to valuable group benefit coverage at a competitive cost.

The board considered phasing-in the changes or grandparenting all retired members, however the cost pressures were too great. Changes needed to be applied to current and future retired members to achieve the required cost savings and maintain spending within the funding threshold. The board is also required to treat members with an even hand, meaning they need to be impartial between all members and not prefer one group over another. This does not mean treating members precisely equally, however it does mean ensuring that one group does not bear a burden that other beneficiaries with the same interest do not bear. For this reason, the board was unable to consider income-testing or means-testing members to determine

subsidies. Trustees also noted that the size of a member's pension reflects their salary and service with plan employers but does not reflect their retirement income from all services, making a means-test difficult to administer.

MEMBER COMMUNICATIONS AND CONSULTATION

The board is committed to governing the plan in accordance with best practices, including applying principles of transparency and accountability.

The board meets annually with plan members, employers and other stakeholders to share information about the plan's financial health and recent developments at the plan's annual general meeting (AGM). The next AGM will be October 13, 2016, from 10 a.m. to noon at the Anvil Centre, New Westminster. All plan members and employers are invited to join the board to learn more about the plan's financial health.

Since the board assumed responsibility for determining and administering the group benefits program in 2004, members have been advised at retirement that extended health and dental benefits remain contingent, non-guaranteed benefits that can be changed or eliminated.

The board has periodically advised members that:

- The board continues to be concerned about rising costs and limited funding for post-retirement group benefits.
- Group benefits are not pension benefits and are not guaranteed; they are contingent benefits provided only if adequate funding is available.
- Group benefits may be changed at any time in response to funding constraints.
- The board is looking for solutions to make these benefits available to current and future retirees.

As part of the group benefits program review, the board considered seeking member perspectives on the different options for cost sharing and cost containment. However, as the board completed its assessment, and in light of the decisions needing to be made,

the board was concerned that member consultation would create unobtainable expectations among the membership about what was possible within the funding constraints identified and limitations on contingent benefit funding set out in the Plan Rules and in plan legislation.

The board's review benefited from members' improvement suggestions, six retired members' perspectives on the board, the knowledge and experience of 32 trustees at the board table, independent detailed analytics of members' prescription drug use over three years of claims, expert group benefits advice from Cubic and PBC, and expert financial advice from Pension Corporation.

The board believed the detailed data analytics, and the analysis and advice it reviewed clearly pointed towards key program changes that must happen to ensure long-term value and sustainability for the group benefits program.

Furthermore, the 2015 program experience demonstrated costs were escalating faster than forecasted a year earlier. Given updated projections and the more rapidly approaching funding limit for group benefits, the board was not in a position to undertake further consultation before making a decision.

While consultation with members before making a decision is not a legal requirement, the board sees the value and usefulness of informing members, seeking member input and collaborating on solutions with stakeholders. To that end, it has committed to initiating a full review of the dental plan design and carrier with input from members after not more than 24 months of experience with the new dental plans. In practice, this means the board will be seeking member input before the end of 2018 regarding the new dental plans and experience with PBC, the dental carrier. The board has not yet considered an approach for collecting member feedback, and will determine how to gather member input closer to the 24 month timeframe.

CONCLUSION

The board recently completed a comprehensive review of the group benefits program.

After much analysis and consideration, the board concluded fundamental changes were required to the program to contain group benefits costs within the available funding limit. The analysis showed prescription drug costs were the number one cost to the program. To ensure members continue to have protection from increasing health care costs, the board decided to update the EHC plan design and discontinue subsidizing dental benefits, as dental costs are typically more predictable and less catastrophic than health care costs.

The board remains committed to maintaining retired member access to contingent, non-guaranteed group benefits. While retired member costs will increase with the program changes, the board believes the amended group extended health and dental coverage will continue to provide more value than that available to members as individuals.

The board continues to manage the plan based on the priorities agreed to with the plan partners:

1. deliver the basic pension promise,
2. provide sustainable cost of living adjustments, and
3. provide access to group benefit coverage.