Proposed ATU Contract Changes to Active and Retiree Health Coverage

Metropolitan Council and ATU Local 1005 Contract Negotiations

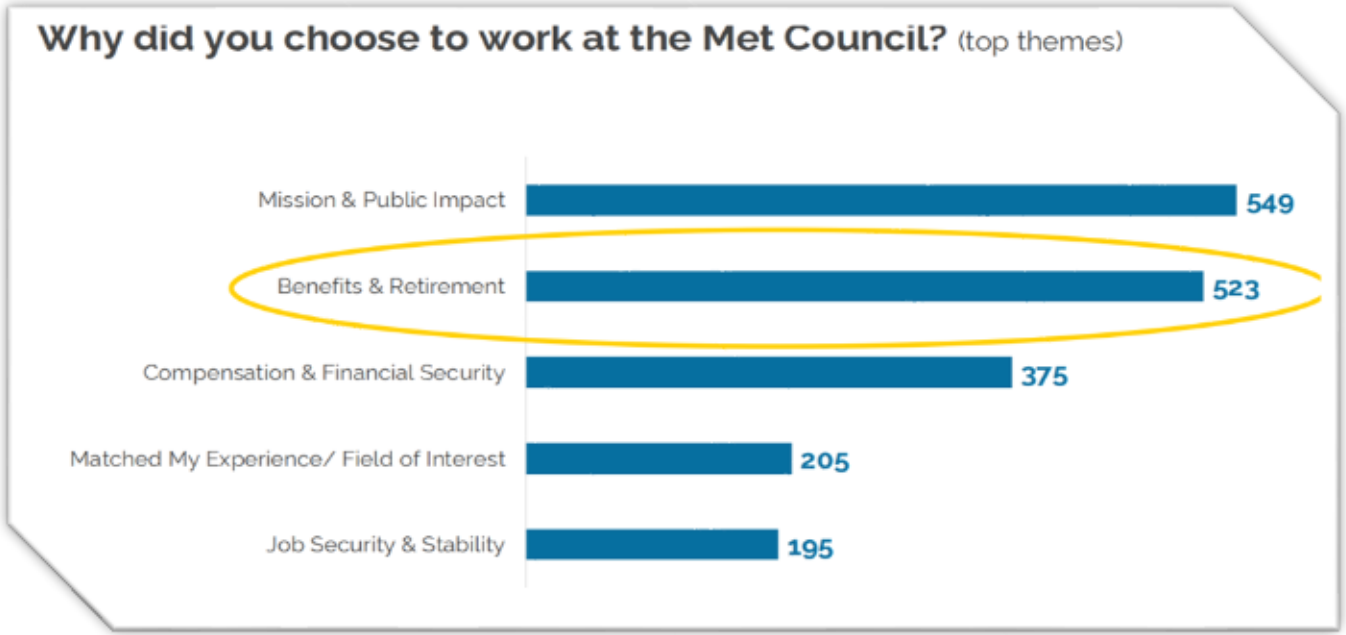
August 2026

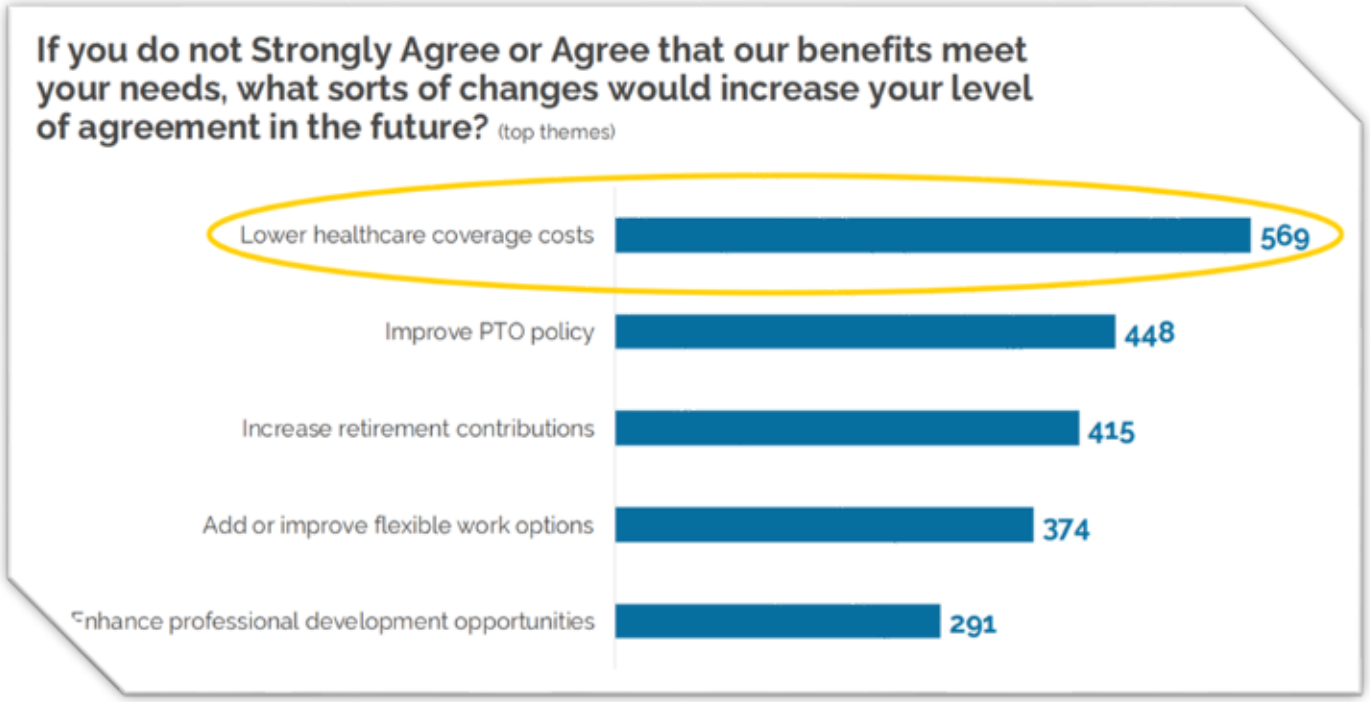
Why This Matters to Employees

In the Culture Survey, employees consistently told us two things:

1. They value the Council because of its strong benefits.
2. They want lower health care premiums.

These proposals aim to address both.





The Proposal

Article 35.5 Group Insurance – Retirees,
Section 3. Retiree Health Insurance Benefits

"Upon reaching age 65, the medical plan option available is limited to an Employer-sponsored Medicare plan only. This requirement does not change a retiree's eligibility for health benefits or applicable Employer contributions."

What is a Retiree under the Contract?

The **current contract** impacts **less than 10%** of ATU bargaining unit members and reads as follows:

Article 35.5 Group Insurance - Retirees Section

1. All employees must meet the following criteria to be eligible for retiree medical benefits:
   (a) be **hired prior to April 17, 2004**;
   (b) have a minimum of **three (3) years consecutive full-time** employment during the years immediately prior to retirement;
   (c) be **at least 55** years of age; and
   (d) be eligible to receive an annuity.

In addition:

• Employees hired before October 27, 1995 must have a minimum of ten (10) full years of service with the employer to be eligible for retiree benefits.

• Employees hired after October 27, 1995 must have a minimum of fifteen (15) full years of service with the employer to be eligible for retiree insurance benefits.

• Employees hired after October 25, 2000, must complete seventeen (17) years of service to be eligible for retiree insurance benefits.

Years of service means: The number of years of continuous service from the first day of employment until retirement.

Article 35.5, Section 4(a) and 4(b)

Plan A	Plan B
30 Years of Service (Age 60–64) • Highest employer contribution toward retiree health insurance.	**30 Years of Service (Age 60–64)** • Open Access & Distinctions: **Same employer contribution as active employees.** • Disability retirees receive the same benefit.
All Other Eligible Retirees • Employer pays **66⅔%** of the Plan A premium.	**Age 65+ & Other Eligible Retirees** • Employer generally pays **70–75%** of single coverage. • Employer generally pays **72–80%** of family coverage, depending on the plan and Medicare eligibility.

What About All Other Retirees?

Minnesota Law Requires:

Employees who retire and qualify for a public pension (such as **PERA** or **MSRS**) must be allowed to **stay on their employer's group health insurance plan (ie. Open Access, Distinctions or Empower HRA)** after they retire until age 65 when they become eligible for Medicare, if they properly elect continued coverage and pay premiums.

What Happens at Age 65

For retirees, at age 65:

- Medicare becomes the primary insurance
- Most retirees also enroll in Medicare Part B

Together, these two plans already cover the majority of medical costs.

Maintaining the active employee health plan (ie: Open Access, Distinctions, or Empower HRA) on top creates **overlapping coverage – not better coverage and results in extra unnecessary costs for retirees**.

What is Medicare?

 Part A – Hospital Insurance

- Covers hospital stays, skilled nursing, hospice, and some home health care.
- Think of it as **insurance for when you're admitted to a hospital.**

 Part B – Medical Insurance

- Covers doctor visits, outpatient care, preventive services, lab work, and medical equipment.
- Think of it as **insurance for everyday medical care.**

 Part C – Medicare Advantage

- An alternative to Original Medicare offered by private insurance companies.
- Enhanced plan that includes Parts A and B coverage, and often includes Part D plus extra benefits like dental, vision, or hearing.

 Part D – Prescription Drug Coverage

- Helps pay for prescription medications.
- Available as a standalone plan or included with many Medicare Advantage plans.

How Does a Retiree Get Medicare?

Medicare Part A (Hospital Insurance)

- Retirees are **automatically enrolled** at age 65 if they're already receiving Social Security.
- Retirees **pay no premium** because they paid Medicare taxes while working.

Medicare Part B (Medical Insurance)

- If you're receiving Social Security, you're **automatically enrolled** at age 65.
- If not, you must **sign up yourself** through Social Security.
- Part B requires a **monthly premium**.

Simple Takeaway

- **Part A:** Usually automatic and usually free.
- **Part B:** Automatic only if you're already on Social Security; otherwise, you must enroll and pay a monthly premium.

What It Means for the Retiree

Many retirees assume triple coverage = triple protection

In reality, they often end up with:

- **Higher premiums** for benefits they rarely use
- More claim complexity
- Coverage that has little left to pay after **Medicare and Medicare Part B pay first**.

Often, they’re paying for reassurance – not meaningful additional coverage.

Medicare Coverage

In nearly all cases, Medicare + the Council's Medicare Advantage provides:

- More comprehensive coverage
- Lower monthly premiums

Today:

- An average Council retiree who qualifies under Article 35.5 pays about **$378/month** for non-Medicare single coverage vs. about **$104/month** for Medicare Advantage
- That's over **$270 in month savings** – for better coverage.
- Some current retirees could save as much as **$860 per month** to cover themselves and their dependents.

When You Delay Enrolling in Medicare

About **65%** of ATU retirees that are enrolled in a non-Medicare plan who are Medicare eligible already pay for Medicare Part B.

Delaying enrollment in Medicare Part B coverage can result in a lifetime late **enrollment penalty**.

- The **premium increases by 10%** for every full 12-month period the individual could have had Part B but didn't enroll.
- Waiting **two full years generally means paying 20%** more for Part B.

How Medicare Advantage Compares to Open Access

More benefits. More support. More value.

Enhanced Benefits

Medicare Advantage includes more.

- Dental coverage
- Vision coverage
- Hearing coverage
- Gym membership
- Transportation to medical appointments
- Meals after hospitalization
- In-home support services
- Nationwide provider access
- $0 copay for hospital stays

Comparable Benefits

Similar coverage you can count on.

Doctor visits	Low copays
Specialist visits	No referral required
Prescription drug coverage	Comprehensive coverage included
Emergency & urgent care	Covered

Medicare Advantage builds on Medicare by adding benefits that Open Access does not include.

Features of the Council's Medicare Advantage Plans

Financial Protection You Can Count On

- **$0** medical deductible – Coverage begins immediately.
- $3,000 annual out-of-pocket maximum – Once you reach this limit, the plan pays **100%** of covered Medicare medical costs for the rest of the year.
- $10 doctor visits – **Flat copay** for both primary care and specialists.

Comprehensive Medical Coverage

- **$0** inpatient hospital stays (unlimited days)
- **$0** outpatient surgeries
- **$0** laboratory services, X-rays, MRIs, CT scans, and other diagnostic imaging

Strong Prescription Drug Coverage

- **$0** prescription drug deductible
- $2,100 annual Part D out-of-pocket maximum – After you pay $2,100 for covered prescription drugs, you pay **$0** for covered Part D medications for the remainder of the year.
- $35 **maximum** for a one-month supply of covered insulin.

Healthy at Home Recovery Benefit

- After an inpatient hospital or skilled nursing facility stay, members automatically receive up to 30 days of recovery support at **$0** cost:
- 28 home-delivered meals
- 12 rides to medical appointments or the pharmacy
- 6 hours of in-home personal care assistance

Wellness & Preventive Benefits

Included at **$0** cost:

- Preventive dental care
  - 2 exams
  - 2 cleanings
  - Bitewing X-rays
- Annual hearing exam
  - Plus a **$500** hearing aid allowance every 3 years
- SilverSneakers® fitness membership
  - Gym access plus online fitness classes
- Optum HouseCalls®
  - Annual in-home wellness visit from a licensed healthcare professional

Until age 65, eligible retirees keep the same health plans.

AGE 55

AGES 55 – 64
Retired but not yet on Medicare

AGE 65
Medicare begins

YOU CAN STAY ON THE SAME HEALTH PLANS

Open Access · Distinctions · HRA

The same plans you know and use as an active employee.

THE EMPLOYER CONTINUES PAYING ITS SHARE

Employer → Pays its share

The Employer share will continue as outlined in the contract.

AT AGE 65, MEDICARE BEGINS

You will move to Medicare coverage at that time.

Nothing changes before age 65.
Same plans.

Examples:

Example 1 – Retiring After Age 65

 **Mike retires at age 68.**

- Mike is eligible for the Medicare Advantage plan at retirement.
- The Employer share is determined as outlined in the contract.

✓ **Impact:** He moves to Medicare Advantage Plan upon retirement.

Example 2 – Turning 65 After Retirement

 **Sarah retires at age 61.**

- She keeps her active employee health plan until age 65.
- At age 65, she enrolls in the Council's Medicare Advantage plan.
- If eligible, she receives Employer contributions as determined in the contract.

✓ **Impact:** She moves to Medicare Advantage instead of staying on the active employee plan. The employer contributions, if eligible, continue under the Medicare Advantage plan as outlined under the contract.

Example 3 – Already Over Age 65

 **Tom retired four years ago and is already 68.**

- Tom is already retired.
- The proposal does not change his coverage.
- He can continue his current coverage.

✓ **Impact: No change.**

Example 4 – Retiree With a Younger Spouse

 **Lisa retires at age 65. Her husband is 59.**

- Lisa enrolls in the Council's Medicare Advantage plan.
- Her husband stays on the active employee health plan until he becomes eligible for Medicare.
- The Employer share is determined as outlined in the contract.

✓ **Impact:** Each person stays on the coverage that fits their age and eligibility.

Actual Impact to Current Employees & Retirees

- There are currently **26** ATU retirees or their dependents over age 65 and participating in the active employee health plan
- All current retirees can stay on their current plan– no plan changes for them
- Dependents under age 65 stay on the active plan until the reach Medicare eligibility – They don't have to transition until they are Medicare eligible.
- Nearly **65%** of ATU retirees who are enrolled in a Non-Medicare plan, already have both Medicare Part A and Medicare Part B.

What It Means for Employees

- Health insurance is a shared pool – When the plan pays for coverage that adds little value, premiums increase for everyone.
- To help keep costs down for everyone, enrolling in Medicare when eligible helps ensure our plans stay healthy.

The Proposal & What it Does

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"Upon reaching age 65, the medical plan option available is limited to an Employer-sponsored Medicare plan only. This requirement does not change a retiree's eligibility for health benefits or applicable Employer contributions."

What the Proposal Does:

- Preserves all current retirees
- Protects dependents under 65
- Reduces retiree premium costs
- Moves retirees to richer benefit after age 65 with the Medicare Advantage
- Helps control plan costs, including for active employees
- Aligns retirees with coverage most already choose

The Proposal

Article 35. Group Insurance – Active Employees, Plan C – HRA/VEBA Trust – Active Employees

"This is an optional plan made available to employees of the Metropolitan Council. The Employer will preserve the **total** value of the optional HRA plan for the duration of this Agreement, unless changes are negotiated by the parties. ~~Attached to this contract are the current plan provisions of Plan C. These benefits will remain unchanged for the duration of this contract. Should the Council, following discussions with all unions, choose to make changes to the plan which the union finds unacceptable, the union may opt out of Plan C."~~

Why Total Value Matters More Than Plan Design

People often focus on specific copays or deductibles.

But total value answers the real question: **“How much of a benefit am I actually getting?”**

If total value stays the same, the plan remains just as generous – even if individual pieces shift.

DIFFERENT TOOLBOXES. SAME VALUE.

Different tools.
Different organization.
Same ability to get the job done.

ACTUARIAL VALUE PROTECTED.

Plan design can change.
Overall value does not.

What is “Total Value”?

Total value isn't about one doctor's visit or one prescription.

It answers one question: **On average, how much of members' healthcare costs does the plan pay, and how much do members pay?**

For example, if a plan has a 90% total value, that means that across thousands of people using the plan –

- The plan pays roughly 90% of covered healthcare costs
- Members pay roughly 10%.

Changes in Total Value

What Would Reduce “Total Value”?

These are the kinds of changes that actually make the coverage less valuable:

- Making employees pay substantially more overall.
- Eliminating major covered benefits.
- Increasing deductibles without providing anything to offset them.
- Raising out-of-pocket costs across the board.
- Shifting a much larger share of medical costs onto employees.

Those changes reduce the overall value of the insurance.

Under a guarantee that total value cannot decrease, those types of changes wouldn't be allowed.

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What it Does

Healthcare changes constantly.

Plans need the flexibility to adapt to those changes.

The total value guarantee provides a safeguard – The overall value of the health plan cannot decrease without negotiating the change.

Protects the value of the health plan while helping manage future premium increases.

The Proposals Changed Through Bargaining

Original Proposal

- Allowed flexibility to make changes across all employer-sponsored health plans.

Concerns Raised During Bargaining

- Maintain health insurance benefits and find ways to address costs.

Current Proposal

- The Open Access plan remains outlined in the contract.

Bargaining made a difference – The bargaining process resulted in a meaningful change to the proposal by preserving the Open Access plan as currently designed while maintaining flexibility to respond to future changes in healthcare.