Understanding Finances and Changes in Retiree Health Care

By Joshua Franzel and Alexander Brown

Governments need to understand what has been done so far to address OPEB liabilities, and assess whether these efforts are enough to put the provision of retiree health care on a more sustainable path.

As of March 2011, 87 percent of all state and local government workers had access to health care through their employer, with nearly three-quarters (72 percent) participating.[1] This employer-provided health coverage often continues once a public employee retires, should they meet tenure, age, and other related requirements. With overall state budgets continuing to feel the effects of the Great Recession, health-care cost trends continuing upward at more than 3 percent annually, annual premiums up 8-9 percent between 2010 and 2011,[2] relatively new accounting rules requiring states to report liabilities associated with retiree health care, and the continued use of pay-as-you-go funding approaches, governments need to understand what has been done so far so they can assess their own efforts and determine if their retiree health-care programs are sustainable.

RETIREE HEALTH CARE

All states offer some form of retiree health care to their employees, provided through public employer-provided health plans that are self-insured (funded by the state government) or purchased from a commercial insurer. Often, "states offer a relatively complex matrix of plans and premiums, varied by family size, type of plan (HMO, PPO, indemnity)."[3] The plans retirees participate in may be the same as those they had access to during active employment.[4]

The states vary in terms of when an employee is eligible for retiree health care and how much the public employer and employee or retiree pays for the health care. In some states, all employees are eligible for retiree health care, and in others, they must work for some specified period of time before being eligible, and sometimes the portion of the plan costs the state picks up increases over the course of the employee's tenure. Also, states vary in their approach to providing health care to retirees who are 65 and eligible for Medicare. Some states eliminate retiree health care at this point, and many states continue to provide the benefit, but as a secondary payer, behind Medicare.[5]

GASB STATEMENT NO. 43 AND STATEMENT NO. 45

In 2004, the Governmental Accounting Standard Board (GASB) issued Statement No. 43, *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans*, and Statement No. 45, *Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions*. The statements provide a set of standards for more completely valuing the costs of post employment benefits other than pensions (OPEB), a large portion of

Exhibit 1: Assets, Liabilities, and Annual Required Contributions for All States, 2009-2011*

State Name	Date of Report	Unfunded Liability (in millions)	UAAL Per Capita	ARC (in millions)	ARC per capita	Has Assets?
Alabama	2010	4,053	860.75	216	45.87	Y
Alaska	2010	8,637	12,365.55	275	393.72	Y
Arizona	2010	234	35.48	59	8.95	N
Arkansas	2010	1,684	582.81	172	59.53	N
California	2010	59,911	1,620.90	1849	50.02	N
Colorado	2009	1,503	299.12	78	15.52	N
Connecticut	2008	26,567	7,551.16	1,656	470.68	N
Delaware	2010	5,780	6,530.17	527	595.40	Y
Florida	2009	4,831	260.6	336	18.12	N
Georgia	2008	16,251	4,446.02	1,262	128.39	Y
Hawaii	2008	7,192	5,552.90	518	399.95	N
Idaho	2010	22	14.23	3	1.94	Y
Illinois	2009	27,124	2,100.94	1825	141.36	N
Indiana	2009	525	81.74	54	8.41	N
Iowa	2010	293	97.41	31	10.31	N
Kansas	2010	223	79.11	29	10.29	N
Kentucky	2010	3,973	920.93	362	83.91	Y
Louisiana	2010	10,915	2,429.83	852	189.67	N
Maine	2010	2,352	1,784.11	148	112.27	Y
Maryland	2010	16,099	2,824.64	1,185	207.91	Y
Massachusetts	2010	15,166	2,300.11	1,153	174.87	Y
Michigan	2009	12,618	1,265.63	870	87.26	N
Minnesota	2010	755	143.37	75	14.24	N
Mississippi	2010	727	246.27	56	19	N
Missouri	2010	1,231	205.59	94	15.70	Y
Montana	2010	358	367.18	34	34.87	N
Nevada	2010	1850	699.94	222	83.99	N
New Hampshire	2010	2,470	1,864.75	208	157.03	N
New Jersey	2010	56,782	6,520.87	4,668	536.07	N
New Mexico	2010	3,347	1,665.45	298	148.28	Y
New York	2010	46,316	2,370.14	2,681	137.2	N
North Carolina	2009	28,288	3,015.49	2,674	285.05	Y
North Dakota	2010	54	83.48	7	10.82	Y
Ohio	2008	18,875	1,635.24	1856	160.80	Y
Oklahoma	2008	359	97.37	148	40.14	N
Oregon	2009	297	77.63	30	7.84	Y
Pennsylvania	2009	15,273	1,211.68	1,002	79.49	Y
Rhode Island	2009	775	735.85	52	49.37	N
South Carolina	2009	9,203	2,017.65	727	159.39	N
South Dakota	2010	71	87.4	8	9.8	N
Tennessee	2011	1496	237.60	496	78.78	N
Texas	2011	21,502	867.64	1883	75.98	N
Utah	2010	393	141.13	44	15.8	N
Vermont	2010	917	1,474.85	58	93.28	Y
Virginia	2010	1,682	213.38	150	19.03	Y
Washington	2001	3492	523.99	321	48.17	N
West Virginia	2009	6,682	3,671.88	342	187.94	N
Wisconsin	2010	1,330	235.2	19	8.67	N
Wyoming	2010	239	439.12	19	34.91	N

**This table offers the latest available OPEB financial data (as of midyear 2011), updated from the 2005-2008 time period; in a few cases this update was offered in 2008. Data compiled by Alexander Brown.*

Note: Nebraska does not report OPEB liabilities.

which is retiree health care, but can also include dental, vision, and other benefits. The statements outline how state and local governments should report, through actuarial estimation, the costs of providing OPEB that have been and continue to be offered to employees and retirees. This estimation accounts for how many public workers are expected to receive OPEB; how long employees are likely to work before retiring, and then how long they're likely to live afterward; projected future health-care costs; and the expected investment rate of return on funds the government has set aside to pay for OPEB, if they have. The cost of providing OPEB is calculated to a present-day value that has been discounted based on projected long-term rates of return on investments. Some of the key data points that come out of the actuarial estimate are:

- The actuarial accrued liability (AAL), or the present value of benefits employees have earned in prior years and up through the current time.
- The actuarial value of assets (AVA), or the value of cash and investments that have been set aside to cover future OPEB costs, gains, and losses, which are smoothed over a 3-5 year period to reflect the long-term nature of OPEB provision.
- The unfunded actuarial accrued liability (UAAL), or the difference between the AAL and AVA.
- The annual required contribution (ARC), which represents the amount the public employer should set aside each year to cover the OPEB earned by employees during the current year, in addition to any UAAL, amortized.

By the end of 2008, all states had implemented the GASB OPEB standards, with valuations generally conducted every two years.

One useful way of comparing OPEB data and accounting for the size of the unfunded liability, relative to the size of the state, is to look at unfunded liabilities per capita.

STATE OPEB FINANCES

Exhibit 1 shows the OPEB financial data for all 50 states, compiled using state comprehensive annual financial reports (CAFR) and/or OPEB valuation reports. These data represent an update to the OPEB valuations reported during the 2005-2008 time frame, following the issuance of GASB Statement No. 43 and GASB Statement No. 45.[6] As the exhibit shows, state OPEB finances are quite varied. While some states hold assets in a trust to pay for OPEB benefits, most use a pay-as-you-go method of financing. During the 2005-2008 time frame, 10 states held assets to pay for OPEB benefits, while in the 2009-2011 time frame, the number had increased to 18 states. For example, at the end of 2008, Ohio had $10.7 billion in assets; as of June 30, 2009, Alaska reported $4.1 billion in assets; at the end of June 2009, Virginia had $294 million in assets; and at the end of June 2010, Oregon had $228 million in assets.

In data collected from the 2010 reports, some of the states that had the highest unfunded OPEB liabilities were California ($59.9 billion), New Jersey ($56.8 billion), and New York ($46.3 billion). Aside from Nebraska, which reports no liabilities, some of the states with the lowest OPEB unfunded liabilities in 2010 included North Dakota ($54 million), South Dakota ($71 million), and Idaho ($22 million).

One useful way of comparing OPEB data and accounting for the size of the unfunded liability, relative to the size of the state, is to look at unfunded liabilities per capita. Exhibit 2 shows the five states with the lowest UAAL

Exhibit 2: States with the Lowest UAAL Per Capita, 2009-2011

State	UAAL Per Capita (lowest)	State	UAAL Per Capita (highest)
Idaho	$14.23	Hawaii*	$5,552.90
Arizona	$35.48	New Jersey	$6,520.87
Oregon	$77.63	Delaware	$6,530.17
Kansas	$79.11	Connecticut*	$7,551.16
Indiana	$81.74	Alaska	$12,365.55

**OPEB financial update was offered in 2008*

per capita in the 2009-2011 time frame. Their range was between $14 and $82 per capita, averaging about $58. On the other end of the spectrum, Exhibit 2 also shows the five states with the highest UAAL per capita in 2009-2011. When averaged, these states have about $7,700 in unfunded liabilities per capita. (Exhibit 1 shows the unfunded liabilities per capita for all states.) Also, as one might expect, states follow a similar order when calculating their unfunded liabilities as a percentage of their state budgets. With little variation, the UAAL for states with the lowest UAAL per capita was proportionally small, compared to their budgets (as low as 1 percent), and the UAAL for states with the highest UAAL per capita was large, relative to their budgets (as high as 133 percent).

States also report their ARC for retiree health care, an amount that few actually fund. In 2010, New Jersey reported an ARC of $4.7 billion, which translates to $536 per capita, and New York had an ARC of $2.7 billion, or $137 per capita. In 2009, North Carolina reported an ARC of $2.7 billion, or $285 per capita. Conversely, North Dakota, South Dakota, and Idaho reported ARCs of less than $10 million in 2010, and all had ARCs around $10 per capita. (Exhibit 1 offers ARC data for all states.)

RETIREE HEALTH-CARE CHANGES

As the previous section shows, retiree health-care finances vary greatly among states, and the finances pose serious challenges for some states. Reports have estimated total state OPEB liabilities at anywhere from $400 billion[7] to more than $600 billion[8]. The unfunded liabilities collected from state CAFRs and OPEB valuations total $451 billion. That said, states have undertaken varied approaches to dealing with their OPEB liabilities, in addition to responding to increasing medical inflation rates and other costs that come with the aging state government workforce (approximately 35 percent of state workers are 50 years old or older, relative to 25 percent in the private sector).[9]

OPEB unfunded liabilities remain large, motivating many states to employ a range of prefunding, cost sharing, cost containment, and wellness policy and program responses.

In two surveys of state and local government human resource professionals, one conducted in November/December 2009 and the other in April/May 2011,[10] 50 percent and 53 percent of respondents, respectively, reported that their governments had made changes to the health benefits offered to employees and retirees. These changes include shifting more health-care costs from employer to employees and retirees; creating wellness programs, and creating chronic care management programs.

The survey information reinforces more detailed data collected for and offered in the 2009 Center for State and Local Government Excellence report, *At a Crossroads: The Financing and Future of Health Benefits for State and Local Government Retirees*. While other approaches exist, the policy and program responses state governments are implementing to address problematic retiree health-care finances can be categorized into four categories: prefunding, cost sharing, cost containment, and wellness initiatives.

OPEB received a lot of attention after GASB Statement No. 43 and GASB Statement No. 45 were issued, but in some cases, plans to prefund OPEB or expand funding were delayed because of the impact the recent recession had on state budgets. That said, during the 2005-2008 time frame, ten states, including Alaska, Delaware, and Kentucky, reported having funds set aside to pay for future retiree health costs.[11] By 2009-2011, 18 states reported OPEB assets.

By March 2008, 36 states had implemented some form of cost sharing, which translates to a state having increased one or more of the following components of its retiree health plans: retiree and/or dependent premium contributions; retiree and/or family deductibles; coinsurance rates; co-payments; and caps on out-of pocket expenses; among others. Also, by early 2008, 40 states had implemented one or more of the following cost containment programs for retirees enrolled in their health plans: inpatient and/or outpatient precertification; prescription drug prior authorization; prescription drug clinical intervention; the

use of health care/hospital centers of excellence; disease management programs; and health-care audits, among others. Finally, the implementation of wellness programs and policies had occurred in 35 states by early 2008. These approaches included one or a combination of the following wellness programs: wellness newsletters and websites; full or partial gym membership coverage by a public employer; full coverage for retiree annual exams by a public employer; on-site health clinics; smoking cessation programs; and weight management programs, among others.[12]

States that have employed a combination of cost sharing, cost containment, and wellness policies and programs include North Carolina, Rhode Island, and New Mexico, which increased retiree health-care vesting requirements.[13] North Carolina, among other states, authorized the increase of employee premiums, eliminated its most expensive health plan, and implemented wellness plans focused on participant weight and smoking reduction. In 2004, the California Public Employees' Retirement System adopted "new policies [which] included promoting hospital performance transparency and managing hospital costs, eliminating high cost hospitals from the Blue Shield network, adjusting premiums for regional markets, encouraging the use of generic drugs, adding new lower-cost health plans, and adopting a series of wellness programs."[14] Pennsylvania and New Jersey increased retiree contributions for those who retired after July 1, 2007. South Carolina has decreased the employer subsidy for the retiree health care of those hired after May 1, 2008.[15]

CONCLUSIONS

With American Recovery and Reinvestment Act funds winding down, sales and income tax revenues remaining relatively flat, and increasing citizen demand for services, states face many challenges, including state liabilities attached to their provision of retiree health-care. In some ways the retiree health care discussion has been eclipsed by increased attention on pension funding and related investment losses realized in 2008 and 2009, but OPEB unfunded liabilities remain large and remain the focus of decision makers at the state level, motivating many states to employ a range of prefunding, cost sharing, cost containment, and wellness policy and program responses. Many of these changes were made within the past 2-4 years, so time will tell if these measures are enough to curb states' OPEB liabilities and place the provision of retiree health care on a more sustainable path.

Notes

1. U.S.Department of Labor, *Employee Benefits in the United States — March 2011*.
2. U.S.Department of Labor, *CPI Detailed Report: Data for July 2011*, and Kaiser Family Foundation, Employer Health Benefits: 2011 Summary of Findings.
3. Richard Cauchi, *State Employee Health Benefits*, National Conference of State Legislatures, 2011.
4. Robert L. Clark and Melinda Sandler Morrill, *Retiree Health Plans in the Public Sector* (Northampton, Mass: Edward Elgar Publishing Limited, 2010).
5. Richard C. Kearney, Robert L. Clark, Jerrell D. Coggburn, et al., *At a Crossroads: The Financing and Future of Health Benefits for State and Local Government Retirees*, Center for State and Local Government Excellence, 2009.
6. The data collected and reported in this article were compiled using the data collection methodology previously used by R. Clark and M. Morrill of NCSU. See Clark and Morrill, and Robert L. Clark, *The Crisis in State and Local Government Retiree Health Benefit Plans: Myths and Realities*, Center for State and Local Government Excellence, 2009.
7. Robin Prunty, *U.S. States' OPEB Liabilities and Funding Strategies Vary Widely*, Standard & Poors, 2009.
8. *The Widening Gap: The Great Recession's Impact on State Pension and Retiree Health Care Costs*, Pew Center on the States, 2011.
9. Calculations based on Integrated Public Use Microdata Series, Current Population Survey Minnesota Population Center.
10. The Center for State and Local Government Excellence, *The Great Recession and the State and Local Government Workforce* and *State and Local Government Workforce: 2011 Realities*.
11. Jerrell D. Coggburn and Jamie McCall, *Prefunding Other Post Employment Benefits (OPEB) in State and Local Governments: Options and Early Evidence*, Center for State and Local Government Excellence.
12. *At a Crossroads*.
13. Robin Prunty.
14. Robert L. Clark and Melinda S. Morrill, *Health Insurance for Active and Retired State Employees: California, North Carolina, and Ohio*, Center for State and Local Government Excellence, 2011.
15. Robin Prunty; and *State and Local Government Retiree Health Benefits: Liabilities Are Largely Unfunded, but Some Governments Are Taking Action*, United States Government Accountability Office, 2009.

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