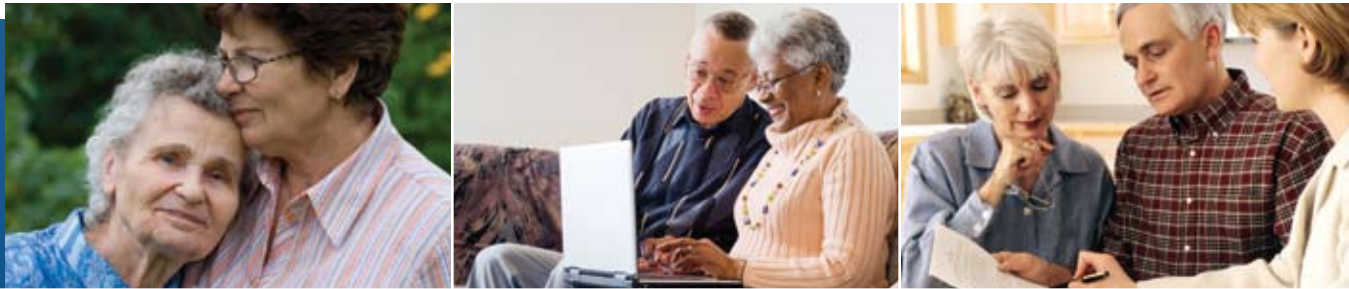




# ISSUE BRIEF

## **After GASB 45: Solving the Unfunded Liability Problem in Retiree Health Care**



September 2008



There are no easy or quick answers to address the unfunded retiree health liabilities facing state and local governments. After analyzing new survey data from the 50 states and a large sample of local governments, Dr. Richard Kearney concludes that an incremental approach to managing retiree health care costs has certain advantages. They stress the importance of examining the complex legal, accounting, and tax questions that are involved with some alternatives.

This issue brief examines the major policy alternatives state and local governments are exploring: cost containment, cost sharing, efficiencies, future cost shedding, pre-funding mechanisms, selling assets, and wellness and preventive illness programs.

- Nearly all states have created a state-wide health care pool, providing uniform benefit levels for the active workforce and to all retirees residing in the state.
- Many state plans include teachers and provide a local option for local governments and special districts to participate.
- In the last five years, 10 percent of states have established a plan that limits the state subsidy for future retirees; 34 percent say they are likely to introduce such a plan in the next five years.
- Most states have implemented a variety of cost containment programs: 84 percent have a disease management program and 80 percent require hospital inpatient precertification.
- The most popular preventive medicine programs in states are (1) coverage for a retiree's annual physical exam (72 percent); (2) smoking cessation (70 percent); and wellness newsletters or websites (66 percent).

The Center for State and Local Government Excellence and researchers from North Carolina State University's School of Public and International Affairs and College of Management have established a partnership to focus on state and local government retiree health care. Future Center publications will examine intergenerational issues, benchmarking, lessons learned, balancing priorities, and case studies of individual state and local government strategies.

The Center gratefully acknowledges the financial support from the ICMA Retirement Corporation to undertake this research project.

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# After GASB 45: Solving the Unfunded Liability Problem in Retiree Health Care

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## **State and local governments take an incremental approach to address rising costs of retiree health care.**

The Government Accounting Standards Board (GASB) adopted Statement No. 45 to give investors and stakeholders a better assessment of the cost associated with providing retiree health benefit plans to employees in the public sector. GASB 45 requires public employers to produce an actuarial statement, using generally accepted accounting standards, that presents the projected actuarial accrued liabilities and the annual required contributions for retiree health plans.<sup>i</sup>

The goal of GASB 45 is to provide a transparent assessment of the liabilities associated with health care promises to public employees. In general, GASB 45 requires state and local governments to report the present value of the future liability of health care promises to current workers as these benefits are being accrued, along with the present value of these promises to current retirees. In addition, the actuarial report must indicate the annual required contribution that is needed to pay current health care costs and to amortize current unfunded liabilities.

From surveys of the fifty states and a large sample of local governments, we determined that the majority of these jurisdictions continue to manage retiree health care obligations on a pay-as-you-go basis, giving little or no attention to the potential impacts of mounting unfunded obligations<sup>ii</sup>. Most states and some local governments have adopted incremental policies to contain, shed, and or share costs. In general, our surveys tell us that states have been more responsive to the health care dilemma than municipalities and counties.

Most states report substantial levels of unfunded retiree health care liabilities. These benefits are consuming increasing proportions of annual payroll costs. Baby boomer demographics, including an aging public labor force, increased longevity, and the inevitable health afflictions of old age, portend greater demand for health care services at higher costs. Persistently high rates of inflation for health services and prescription drugs appear to be endemic. Pressures are increasing on those governments confronting significant retiree health care liabilities to take appropriate actions. The alternative appears to be a growing overhang of billions of dollars in retiree health care liabilities that could endanger bond ratings, lead to other pressing spending priorities being shortchanged, and foist a heavy financial burden on future generations.

This issue brief categorizes and examines the wide range of policy alternatives for addressing retiree health care liabilities under GASB 45. Advantages and disadvantages are discussed within the context of an uncertain economic and policy environment. A cautious, multifaceted approach to ameliorating the unfunded liability problem is suggested.

## **Policy Alternatives**

There is no one best way—no silver bullet—to alleviate future retiree health care liabilities. Each local and state government exists within a complex and distinctive economic, political, and policy environment. Health care benefits may be subject to determination by collective bargaining (Kearney, 2009) and therefore embodied in a legally enforceable contract. (Even here there is diversity; however, in some jurisdictions, health care benefits are excluded from the scope of bargaining.) Alterations in health care provisions are possible through contract negotiations, but unions are nearly certain to resist any reductions in health care benefits for present and future retirees.

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For states and localities that bear no significant retiree health care liabilities because such benefits are not provided at all or not meaningfully subsidized, no future policy actions appear to be necessary<sup>iii</sup>. Those that do report significant GASB 45 liabilities vary in what actions, if any, they are taking or considering to address them. In some, governors, mayors, key legislators and legislative staff, treasurers, controllers, human resource directors, finance directors, or other official actors are engaged in active debate and policy proposals. In most, however, officials appear reluctant to engage the problem.

There is certainly no paucity of possible policy paths for those governments setting out to manage retiree health care costs. The real challenge is for each to select an option, or a package of options, that is appropriate for its unique circumstances, and continually assess results in the context of economic conditions and new policy developments at the federal level to inform any necessary adjustments.

Retirement health care policy alternatives may be classified as follows: cost containment, cost sharing, efficiencies, future cost shedding, pre-funding mechanisms, selling assets, and wellness and preventive illness programs.

### **Cost containment**

**Cost containment** strategies are both common and commonsensical. These include hospital inpatient pre-certification, prescription drug prior authorization, and disease management programs that are designed to reduce costs for the chronically or terminally ill. A second opinion of physicians may be required to ensure that, for example, a specific medical procedure or prescription drug is needed. Plan design can specify or subsidize the use of formulary drugs and/or generics to hold down prescription pharmaceutical costs. Finally, retirees may be required to use health care and hospital “centers of excellence.” Such centers are recognized for their established reputations in such areas as cancer, heart, or kidney treatment and their use of evidence-based medicine. None of the options mentioned above imposes significant additional costs on retirees.

Post treatment reviews and audits can also reduce costs. These usually entail audits of claims filed by clinics, hospital and physician bills, and bills for various procedures ordered by physicians such as MRI or CT scans. A majority of states and about one-quarter of local governments indicated in our surveys that they engage in such practices.

### **Cost sharing**

**Cost sharing** arrangements allocate health care costs between the insured and the government provider. Like cost containment, health care cost sharing is widely practiced and our surveys find that additional employee cost sharing is planned. Higher premiums, co-payments, and deductibles for retirees and their dependents help discourage needless or casual physician visits and medical procedures and encourage generic drugs, while immediately reducing overall government health care expenses. Some plans assess the cost-share in percentage terms, and others in absolute dollar amounts. In the latter case, if the pronounced growth in health care inflation continues, as seems likely, this may necessitate hiking the dollar contributions by retirees.

Cost-shifting may price retirees out of obtaining services, procedures, or prescription drugs that could help prevent debilitating and costly ailments down the road. It can also press retirees to drop their health care plan. In essence, cost-sharing provisions reduce the value of retiree health care coverage by increasing out-of-pocket costs. As such, they will usually be opposed by unions.

### **Efficiency improvements**

**Efficiency improvements** present a promising area for cutting costs. There are economies of scale to be gained from expanding the retiree health care pool, such as additional purchasing power for negotiating lower prices with providers of the full range of health care services and products (Marlowe, 2008: 222).

Nearly all states have created a statewide health care pool, providing uniform benefit levels for the active workforce and all retirees residing in state. Many also include teachers and local option to participate for municipalities, counties, and special purpose governments. There is some debate about what constitutes an optimal size purchasing pool. According to one source (NASPE, 2006: 7), maximum economy of scale is attained at 20,000 participants.

The astounding inefficiencies of health care record keeping and information management are well known. According to one study, administrative costs account for some 11 percent of total health care premiums (IPPSR, 2008: Matrix 4, p. 2). Improvements in electronic data bases for information access and storage could result in faster, more accurate, and less expensive record keeping. Perhaps a promising program like South Carolina’s Health Information Exchange

(SCHIEx) could be extended to government plan providers. SCHIEx is a protected Web portal than can access Medicaid patient medical histories to prevent dangerous drug interactions and unnecessary tests and procedures, and generally improve patient treatment.

### Shedding and shifting of future costs

**Shedding and shifting of future costs** incorporates a variety of options, including terminating health care or prescription drug coverage entirely for present or future retirees and raising the minimum retirement age and/or years in service (vesting) period to qualify for, or begin to receive, health care coverage. Some states cut costs by eliminating classes or categories of individuals from coverage. For example, states providing coverage for dependent care can eliminate this entire category of recipients.

Extending vesting requirements for future employees saves costs, but has no immediate impact of liabilities. This option creates a new, somewhat less privileged, tier of future retirees that is based on employment start date. California, Michigan, and North Carolina are counted among the states that have opted for longer vesting periods.

Health plan coordination with Medicare or other available coverage to serve as first payer for health care and prescription drug costs is the norm. (This option is limited or nonexistent for employees who have not participated sufficiently in the Social Security system to become eligible for Medicare because their employers did not participate). At age 65, retirees are helped to declare Medicare as their primary provider in many of the states. In some jurisdictions, retirees are dropped completely from government-assisted health care upon turning 65. Michigan estimates cost savings of transition into Medicare at \$12,000 annually per retiree (IPPSR, 2008: 13). States can also offer financial inducements for retirees to opt into a spouse's health insurance plan or to change primary payer status to a plan from a former employer. For instance, Illinois pays individuals \$150 to drop state health care coverage for alternative coverage (IPPSR, 2008: Matrix 4, p. 5).

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### Prefunding mechanisms

**Prefunding mechanisms** set aside monies today for funding future health care liabilities. Among the most commonly mentioned are the Health Care Benefits Account, Voluntary Employee Beneficiary Association (VEBA), Health Care Trust Fund, Health Reimbursement Arrangement (HRA), Health Savings Account (HSA) and High Deductible Health Plan (HDHP), OPEB Bonds, and asset sales. Some of these mechanisms are rather exotic, making expert—and objective—financial, tax, and legal advice very important.

**Health Care Benefits Sub-Account:** This arrangement, allowable under Internal Revenue Service section 401(h), is a defined benefit pension trust sub-account that allows the employer to dedicate up to 25 percent of the total pension fund contribution for allocation to retiree health care benefits (U.S. GAO, 2007: 37). This is a separate sub-account within a pension trust that is dedicated exclusively to paying retiree health care benefits. Investment income of the sub-account accumulates tax free and benefits paid to retirees and their eligible dependents are not taxed. The plan is

said to be fundable using assets residing in a qualified pension plan (“Funding for Retiree Health Care, 2006). There are limitations on the amounts that can be placed in the 401(h) account.<sup>iv</sup> Because complicated IRS regulations apply, governments are urged to take due diligence.

**Voluntary Employee Beneficiary Association (VEBA):** This is also a tax-exempt, non-taxable distribution account (usually a trust) that can be voluntarily established for and accessed by retirees<sup>v</sup> and administered by an employee association or other organization (U.S. GAO, 2007:37). Employer and pre-tax employee contributions fund the VEBA “much like a 401(k)” (Miller, 2007a: 1) and are reserved for paying health care costs. Essentially, the VEBA represents a defined contribution approach to retiree health care funding.

<sup>vi</sup> We could find only two examples of existing VEBA-type arrangements in the states: Alaska, which in 2005 began automatically enrolling all new employees in a defined contribution retiree health plan, and Montana,

which established a VEBA in 2005 for present employees, retirees, and dependents.

The concept commands consideration. Advantages of this approach include plan portability if a retiree changes employers, employees' ability to make additional after-tax contributions to the account, and institutionalization of the principle that the employer and the employee/retiree will share future health care expenditure risk. Disadvantages include the risk of the VEBA failing, thereby imposing a significant financial burden on retirees if suitable alternative arrangements are not made

Health Care Trust Fund (Governmental Trust). This irrevocable trust arrangement permits unlimited contributions for tax-free pre-funding of future retiree health care benefits. Employer contributions, investment income, and payouts to retirees are not taxed if the plan is approved as such by the IRS under Section 115. California established the California Employers' Retiree Benefit Trust Fund in March 2007 for pre-funding of CalPERS OPEB liabilities (U.S. GAO, 2007: 37). In 2006 West Virginia enacted a bill to create the Retiree Health Benefit Trust Fund and adopted a schedule for transferring reserves into the fund (CCRC, 2007). As in the case of the pre-funding vehicles described above, setting up the Health Care Trust Fund is complex. It does, however, transfer risk from the employer to employees, provide a highly flexible means for paying down future OPEB obligations, as well as offer great latitude in determining employee eligibility and the amount and type of benefits.

Health Reimbursement Arrangement (HRA). The HRA establishes an individual employee account whose balance can be carried over into retirement without a "use it or lose it" penalty. The HRA can be pre-funded during the employee's work years. Benefits paid are not taxable. The employee cannot personally contribute to the HRA and usage is only for qualified expenses ("Funding for Retiree Health Care, 2006: 16).

A similar pair of programs is the Health Savings Account (HSA) and the High Deductible Health Plan (HDHP), which may benefit those who have retired but not yet reached Medicare eligibility. Such plans, which function similar to a 401k, are in use in at least 10 states for various categories of state and local workers.

They have minimum deductibles and maximum out-of-pocket expenses for participants. Both individual and employer contributions are permitted. The accounts are "owned" by the employee/retiree and savings can be rolled over to subsequent years. By shifting the burden of health care spending to the employee/retiree, the plans encourage informed, intelligent consumer choices on health-related expenditures. The IRS rules, as expected, are complex. Individual recipients require professional help as well in interpreting and utilizing the HSA and HDHP.

According to our survey results, several states and a handful of local governments have recently taken actions to pre-fund retiree health care using one of the mechanisms described above. Alabama has created a defined contribution scheme for future retirees. Hawaii is planning to do the same. Connecticut reports that it is establishing an irrevocable trust fund for OPEB liabilities.

OPEB Bonds. This option involves the jurisdiction selling bonds to raise cash to pay all or part of its unfunded liabilities for retiree health care. The premise is similar to that underlying Pension Obligation Bonds (POBS). The objective is to alleviate future liabilities through investing OPEB bond proceeds in equities. OPEB, then, represents a form of risk arbitrage. The assumption is that the return on equities will exceed debt service on the bonds. As with any arbitrage practice, significant risks are involved.<sup>vii</sup>

However, OPEB bonds do present attractive advantages. True costs of OPEB liabilities are recognized and paid, impacts on the operating budget are reduced, and a trust fund composed of bond proceeds lowers the future discount rate.

As public fund investment experts and several investment firms have pointed out, results depend on fortuitous market timing and prudent investment decisions (Miller, 2007b, 2008)<sup>viii</sup>. It is important to recognize that not only are equity markets mercurial, but also that the retiree health care liability is inherently volatile because of medical inflation and the unstable health policy environment. Certainly, a state or locality interested in the OPEB bond option should retain knowledgeable consultants and ensure that the bonding strategy is authorized under state law and regulatory policy. Among the states that currently authorize POBS,

*Several states and a handful of local governments have recently taken actions to pre-fund retiree health care.*

and plausibly OPEB Bonds as well, are California, Florida, Indiana, Massachusetts, New Jersey, New York, Ohio, Oregon, Pennsylvania, and Wisconsin. According to a recent report (Miller, 2008b), Minnesota and Virginia have provided state and local officials with authorization to establish an OPEB trust fund and issue bonds to fund it.

Finally, a “one shot” approach to eliminating OPEB liabilities is to sell or privatize government assets, then eliminate or reduce liabilities with the proceeds. Targets might include the state lottery, toll roads and bridges, a water or sewer system, or capital goods and equipment. Obviously, this is an approach that demands a great deal of preparation and due diligence.

### Preventive measures

**Wellness, preventive illness, and disease management programs.** It is said that 10 percent of the sickest patients consume 70 percent of total health care costs. Often discussed but seldom adopted and executed in a substantive way are programs aimed at discouraging unhealthy habits and behaviors, instilling more healthy activities, behaviors, and lifestyles, and identifying potentially costly health problems in early stages. Such programs can range from the banal (newsletters and websites on wellness), to the physically-oriented (coverage or subsidization of gym or health club membership, encouragement of individual and team athletic activities), to disease management (containing health care costs while also improving patient care for chronic conditions such as asthma, diabetes, hypertension, or HIV/AIDS), to behavior modification (smoking cessation, weight management, health coaching), to early detection programs (on-site medical clinics or medical personnel, full coverage or subsidization of annual physical examinations, prostate screening). Disease management and chronic care programs help avoid costly side effects of illness, as Medicaid programs in Florida and Wyoming have shown (Goodman, 2008).

There is skepticism in the research community about the monetary value of wellness and preventive care programs (Cohen, Joshua T., Neumann, Peter J., Weinstein, Milton C., 2008). Much of the investment in preventive care and wellness is misdirected, but some programs have been shown to pare health care costs. Of course, preventive care today may simply delay future costs, but if the retiree is passed to Medicare the jurisdiction should reap benefits.

Though these programs are primarily, if not entirely, for in-service employees, the assumption is that healthy

behavior changes will carry over into retirement, thereby reducing demand for health care services and products. Disease management programs and preventive health screenings are available for non-Medicaid retirees in South Carolina and Utah.

The success of wellness and preventive illness programs ultimately depends upon their ability to motivate individuals to make changes in their lifestyle in order to improve their health. Research is needed on what incentives—and disincentives—are effective in stimulating healthy changes

## GASB 45 and the Politics of Uncertainty

State and local governments are challenged by many unknowns that lurk in the GASB 45 decision making environment. First, and most fundamentally, the issues raised by GASB 45 touch many different actors and offices in governments, with great variance among them as to who the salient actors and offices are. Primary decision making responsibility for unfunded retiree health care liabilities typically rests with the legislative body. This presents the inherent problem of short, election-driven time horizons. Addressing large unfunded liabilities requires long-term, intergenerational thinking. Spending operating funds today to ameliorate future obligations may not be politically popular if existing programs are cut, taxes are raised, or assets are sold. There is a natural inclination to put off addressing the implications of GASB 45. Other actors with a stake in health care policy issues include chief executives, treasurers, auditors/controllers, budget officers, personnel executives, and retirement system administrators. The important point is that fragmented authority and a predilection for incremental decision making do not make a good recipe for fast and decisive action.

Second, as noted above, there are a myriad of strategies, choices, and options that may be chosen to address GASB 45 liabilities. Many of these alternatives present exceedingly complex legal, accounting, and tax questions that primary decision makers are not schooled in. And each action, once implemented, sets into motion new forces that are not entirely predictable. Significant changes in retiree health care can push some current employees into retirement, encourage others to take jobs elsewhere, or motivate some to stay on the job well past their productive years. Meanwhile,

decision makers must fend off consulting firms eager to lead the state into favored (and lucrative) program designs. All of this argues for caution, diligence, and study before any substantive action is taken.

Third, many jurisdictions have collective bargaining contracts with one or more employee groups. Unilateral management action to change the terms and conditions of the current contract or to impose new rules and restrictions in a subsequent contract is ill-advised, if not illegal. As protectors of the welfare of employees in the bargaining unit and, in many cases, of retirees as well, unions demand to be equal partners in making such decisions. Change—if agreed to by the union at all—is not likely to be far-reaching.

Finally, there is a creature under the bed and the state and local governments do not know when it will crawl out, what it will look like, or the dangers (or opportunities) it will bring. That creature would be the federal government. There are active discussions and debates in the Congress, among presidential candidates, and in the media about health care reform. Most agree that the present health care system is in fact a “non-system” that is “broken”, with too many working Americans without any health insurance at all and costs for doctor and hospital visits, procedures, and prescription drugs rising rapidly for many years now with no relief in sight. Alternatives under discussion include a universal national single-payer system like Canada’s, mandatory employer coverage of workers, federally funded health care for all children through age 18, and modest market-based adjustments. No one can say with any certainty how the debate will be resolved, if it indeed can be resolved. Meanwhile, Massachusetts, Maine, Vermont, and other states have enacted comprehensive state-wide health care policies for their residents that approach universal coverage, and several others are developing comprehensive reform plans.

Implications for states and localities and their retirees could be major (e.g., national health care), minor (changes that affect only the private sector), negative (cuts to Medicare, pushing more costs to states and localities), or positive (financial relief). A critical question is how any new federal health care policy will affect existing state and local health care plans. One

should not blame state and local officials for treading water or swimming slowly when the policy sea is roiled with uncertainty. Indeed, a cautionary path today facilitates future policy adjustments as federal health care policy evolves.

What might a cautionary path look like? For one thing, employers are well advised not to rush into comprehensive actions on retiree health care. Even in those jurisdictions with the highest relative levels of unfunded liabilities, relatively modest changes now can have substantial effects years hence. An attractive policy entry point might be to make slight course changes through cost containment, cost shifting and sharing, and preventive illness programs, while seriously investigating a pre-funding option. While the economy is weak and interest rates low, OPEB bonds

are attractive, but again, careful research and prudent advice are important. As a general principle, a multi-pronged, incremental approach to managing OPEB liabilities is the safest course of action while uncertainties settle. And where possible, a “value-based medicine” approach is advised to tie together pricing, cost-sharing,

and effectiveness in the chosen course of action (Adams, et.al., n.d.).

States and localities should look to innovators for promising approaches and policy advice. According to our state survey respondents, regional peers, AAA-rated jurisdictions, actuarial firms, and associations (e.g., GFOA, National Association of Auditors, NASBO) are useful resources. Local governments most frequently identify their sources of best practices as leagues of municipalities, municipal associations, GFOA, their respective states, other (or benchmark) local governments, foundations<sup>ix</sup>, and consultants.

In gaining control of future retiree health care costs, employers must be careful not to enact such Draconian benefit reductions that their ability to attract and retain desirable workers suffers. And they should understand that retraction or significant reduction of current retiree benefits will provoke strong negative reactions and claims that the government employer is acting immorally and possibly illegally by breaking a contract. Future retirees are owed less fealty by employers and unions and are better positioned to make necessary financial

*Employers must be careful not to enact such Draconian benefit reductions that their ability to attract and retain desirable workers suffers.*

adjustments to contend with reduced future benefits.

In charting their course for managing the unfunded liabilities of retiree health care, states and localities should also be attentive to the need to educate and assist recipients in making the transition to new arrangements. The transition should be as seamless

and transparent as possible to mitigate the concern and confusion that many retirees and their families might experience. It bears repeating that, in the case of retiree health care, incremental change at a measured pace has significant advantages over comprehensive, disruptive change.

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## Endnotes

- i GASB Statement 45, *Accounting and Financial Reporting by Employers for Post-employment Benefits Other Than Pensions (OPEB)* was issued by the Governmental Accounting Standards Board in 2004. Basically, GASB 45 requires public employers to account for the cost of retiree health plans using the same methods used to estimate the liabilities associated with pensions. The complete standard can be seen at <http://www.gasb.org/st/summary/gstsm45.html>. Earlier in 2004, GASB issued Statement No. 43, *Financial Reporting for Post-employment Benefit Plans Other than Pension Plans*. GASB 43 sought to establish uniform reporting standards for retiree health plans.
- ii The Center for State and Local Government Excellence, in collaboration with N.C. State University’s School of Public and International Affairs and Department of Economics, commissioned surveys of state and local governments on retiree health care. See earlier issue briefs for additional information.
- iii Our data show that 10 states have liabilities of less than \$1 billion and five more have liabilities of \$1 to \$2 billion.
- iv It has been suggested that states blessed with a strong pension fund balance that exceeds estimated future liabilities might consider using excess assets to “seed” a pre-funded OPEB trust fund (Miller, 2007c). More than one consulting firm are currently promoting this approach.
- v See IRS Section 125 501(c)(9).
- vi It does not differ significantly from the 457 deferred compensation plans already offered by many states (Miller, 2007a: 2).
- vii Specifically, if investment returns do not meet expectations over time, the financing could go “underwater,” lose money, and actually add to the UAL. Several states experienced this problem with POBS in 1998 (Miller, 2007b), most notably New Jersey, which lost an estimated \$10.3 billion (Guillory, 2006). Municipal and state OPEB bonds issued in 2007-2008 are likely underwater at the time of this issue brief.
- viii One must sell bonds when interest rates are low, purchase equities at reasonable prices, and hope that they appreciate over the life of the bonds. GFOA’s (2005) *Evaluating the Use of Pension Obligation Bonds* provides advice and recommended practices.
- ix Best practice foundations include The Kaiser Family Foundation ([www.kff.org/about/index2.cfm](http://www.kff.org/about/index2.cfm)) and The Commonwealth Fund (<http://www.commonwealthfund.org/aboutus/>).

## Appendix

This section reports the findings of (1) the data collection for a national assessment on retiree health plans and (2) a 2007/2008 nationwide survey of state administrators focused on the current structure of state retiree health care benefits, recent changes, and future directions. The state administrators surveyed included the state human resources (HR) director, budget officer, retirement system administrator, treasurer, and auditor or comptroller. The findings reflect the responses of 150 officials from a total of 50 states.

Payment Responsibility of State Retiree Health Insurance Premiums		
State Pays for Total Premium*	Premium is Subsidized	Retiree Pays for Total Premium
Alabama	Arizona	Florida
Alaska	Arkansas	Kansas
California	Colorado	Minnesota
Delaware	Connecticut	Mississippi
Hawaii	Georgia	Wisconsin
Illinois	Idaho	
Iowa	Indiana	
Maine	Kentucky	
Maryland	Louisiana	
Nebraska	Massachusetts	
New Hampshire	Michigan	
Ohio	Missouri	
Pennsylvania	Montana	
Rhode Island	Nevada	
Texas	New Jersey	
	New Mexico	
	New York	
	North Carolina	
	North Dakota	
	Oklahoma	
	Oregon	
	South Carolina	
	South Dakota	
	Utah	
	Vermont	
	Virginia	
	Washington	
	West Virginia	
	Wyoming	

\*Total payment of premium cost by the state is conditional in most cases

Specific Conditions of 100% Contribution of States toward Health Insurance Premiums by State		
	Condition(s)	Contribution toward Premium by State with 20 Years of Service
Alabama	Must have at least 25 years of service	90%
Alaska	Must have at least 10 years of service and at least 60 years old	100% (if at least 60 years old)
California	Must have at least 20 years of service or hired before January 1, 1985	100%
Delaware	Must have at least 20 years of service	100%
Hawaii	Must have at least 25 years of service and hired after July 1, 1996, or 10 years and hired before July 1, 1996	75%
Illinois	Must have at least 20 years of service	100%
Indiana	Enrollment in High Deductible Health Plan 1	N/A
Iowa	Must have a positive balance in sick leave account	100% (if retiree has a positive balance in sick leave account)
Maine	Must have at least 10 years of service or hired before July 1, 1991	100%
Maryland	Must have at least 16 years of service or hired before July 1, 1984	100%
Nebraska	Must have at least 28 years of service if over 65 years old or at least 35 years of service at any age	70% if 60-65 years old, 90% if over 65 years old
New Hampshire	State pays premium of retiree regardless of years of service	100%
Ohio	Must have at least 30 years of service or hired before to January 1, 2007, with at least 10 years	100% if eligible to retire after January 1, 2007; 66.67% if hired before January 1, 2003, and eligible to retire after January 1, 2007; or 50% if hired after January 1, 2003
Pennsylvania	Must retire before July 1, 2005	N/A
Rhode Island	Must have at least 35 years of service or at least 60 years old with 28 years of service	70% if 60-65 years old; 90% of 65 or older
Texas	Must have been working full-time at the time of retirement	N/A

Funding Mechanisms					
States have several options for funding retiree health care obligations. In your opinion, how likely is your state to adopt the following options in the next five years?	Already Adopted	Very Likely to Adopt	Likely to Adopt	Unlikely to Adopt	Very Unlikely to Adopt
A medical sub-account from a qualified pension plan (Section 401(h) account)	4% (2)	2% (1)	6% (3)	48% (24)	32% (16)
A governmental (i.e., "grantor") trust (Section 115 Plan)	10% (5)	2% (1)	28% (14)	32% (16)	20% (10)
Voluntary Employee Benefit Association (VEBA)	6% (3)	0% (0)	2% (1)	48% (24)	36% (18)

Note: Figures are percentage (number) of states responding in each category. Remaining percentages (states) are missing values: rows may not sum to 100 percent.

Limitations on Future Retiree Health Care Benefits	
<i>In the past five years has your state introduced a: (check all that apply)</i>	States Indicating Approach
Plan that limits the state subsidy for <i>future</i> retirees	10% (5)
Plan that terminates health care for <i>future</i> retirees	2% (1)
Plan that terminates all state subsidies for <i>current</i> retirees	0% (0)

Note: Figures are percentage (number) of states responding affirmatively. Missing values included with “No” responses.

Future Plans for Retiree Health Care Benefits				
<i>In the next five years does your state intend to:</i>	Very Likely	Somewhat Likely	Somewhat Unlikely	Very Unlikely
Introduce a plan that will limit subsidy for future retirees	4% (2)	30% (15)	34% (17)	26% (13)
Introduce a plan that will terminate health care for <i>future</i> retirees	0% (0)	2% (1)	18% (9)	72% (36)
Terminate all subsidies for <i>current</i> retirees	0% (0)	6% (3)	8% (4)	76% (38)

Note: Figures are percentage (number) of states responding in each category. Remaining percentages (states) are missing values: rows may not sum to 100 percent.

Cost Containment Programs	
<i>Which of the following programs does your state have? (check all that apply)</i>	States Indicating Approach
Hospital inpatient precertification	80% (40)
Outpatient precertification	50% (25)
Prescription drug prior authorization	62% (31)
Prescription drug clinical intervention	58% (29)
Utilization of health care and hospital centers of excellence	50% (25)
Disease Management Program	84% (42)

Note: Figures are percentage (number) of states responding affirmatively. Missing values included with “No” responses.

Cost-Sharing Changes Recently Introduced	
<i>In the past five years has your state increased the: (check all that apply)</i>	States Indicating Approach
Retiree contribution premiums	66% (33)
Dependent contribution premiums	68% (34)
Retiree deductible amounts	46% (23)
Family deductible amount	50% (25)
Coinsurance rates	26% (13)
Co-payment amounts	56% (28)
Co-payments for prescription drugs	66% (36)
Cap on employee out-of-pocket expenses	34% (17)

Note: Figures are percentage (number) of states responding affirmatively. Missing values included with “No” responses.

Major Changes Recently Introduced	
<i>In the past five years has your state introduced a: (check all that apply)</i>	States Indicating Approach
Catastrophic plan plus a retiree medical savings account	8% (4)
Plan that eliminates prescription drug coverage	4% (2)
Plan to increase the age at which retirement health care is available	6% (3)
Plan to increase the years of service required for vesting	14% (7)

Note: Figures are percentage (number) of states responding affirmatively. Missing values included with “No” responses.

<b>Preventive Medicine and Wellness Programs</b>		
<i>Which of the following preventive medicine and wellness programs does the state currently provide or plan to provide to retirees?</i>	<b>Currently Provided</b>	<b>Plan to Provide</b>
Preventive medicine-wellness newsletter/website	66% (33)	8% (4)
Full coverage of gym/spa membership	12% (6)	6% (3)
Subsidized/partial coverage of gym/spa membership	16% (8)	12% (6)
Full coverage of retirees' annual physical exam	72% (36)	6% (3)
Physical exams are exempt from deductible charges	54% (27)	2% (1)
On-site clinic	14% (7)	4% (2)
Weight management program	54% (27)	4% (2)
Smoking cessation program	70% (35)	4% (2)
Incentive programs for healthy living (e.g., monetary or other material incentives for participating in health/wellness programs)	24% (12)	20% (10)

Note: Figures are percentage (number) of states responding in each category. Remaining percentages (states) are missing values.



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## Helping state and local governments become knowledgeable and competitive employers

### About the Center for State and Local Government Excellence

The Center for State and Local Government Excellence helps state and local governments become knowledgeable and competitive employers so they can attract and retain a talented and committed workforce. The Center identifies best practices and conducts research on competitive employment practices, workforce development, pensions, retiree health security, and financial planning. The Center also brings state and local leaders together with respected researchers and features the latest demographic data on the aging work force, research studies, and news on health care, recruitment, and succession planning on its web site, [www.slge.org](http://www.slge.org).

The Center's five research priorities are:

- Retirement plans and savings
- Retiree health care
- Financial education for employees
- Talent strategies and innovative employment practices
- Workforce development