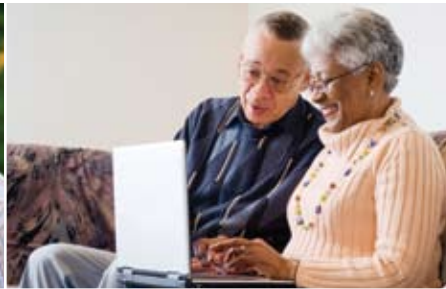




# Retiree Health Care in the American States



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**N**ow that state governments are aware of their other post employment benefit (OPEB) liabilities, are they making changes? Survey respondents from all 50 states are making incremental changes, focusing primarily on disease prevention, cost containment, and cost sharing strategies.

One reason state administrators are moving cautiously is because they see retiree health care benefits as central to their recruitment, retention, and retirement timing goals: 74 percent say that retiree health care benefits are helpful or very helpful in retaining employees and 62 percent say these benefits are helpful in recruiting employees.

Looking to the next five years, most states intend to keep financing retiree health care on a pay-as-you-go basis, with 30 percent planning partial funding to offset costs. Five states report that they have established a trust and 15 others say they are likely to adopt a trust.

On the cost side, 17 states expect to introduce a plan to limit the subsidy for future retirees; three states say it is likely they will terminate subsidies for current retirees. A large majority of states have introduced disease management programs, have precertification procedures in place for inpatient hospitalizations, and conduct claims payer audits. Sixteen states say they are likely to increase the years of service required for vesting in retiree health care.

The Center for State and Local Government Excellence was founded to explore issues that are important to attract and retain the talent needed for public service. With heightened emphasis on the economic security of future retirees and increasing fiscal pressures, government leaders will need authoritative data to understand the issues. They also will want to identify and adopt promising practices as quickly as practical.

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Elizabeth K. Kellar  
Executive Director  
Center for State and Local Government Excellence

# Retiree Health Care in the American States

DENNIS M. DALEY AND JERRELL D. COGGBURN\*

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This report examines how state administrators perceive the importance of retiree health care benefits to central human resources (HR) goals—namely, recruitment, retention, and retirement—how the states structure retiree health care programs, and which cost sharing and cost shedding measures have been adopted and/or are being considered.

Our findings suggest widespread recognition among state administrators of the importance of retiree health care to HR goals. These officials are also aware of OPEB liabilities, but they report that little has been achieved in the way of comprehensive strategies to deal with them. Relatively few states have adopted advance funding for OPEB liabilities and virtually none report a likelihood of taking unpopular action (e.g., raising taxes, shifting funds from programmatic areas to fund OPEB costs) to address their OPEB liabilities. Most states have adopted various cost containment strategies and cost sharing programs, and many have now begun to introduce preventive medicine and wellness efforts. A few states have even begun to contemplate major cost shedding options. The information presented in this chapter provides context for understanding how states arrived at their current situation regarding OPEB and how they intend to address it going forward.

## Survey Methods

The survey reported here includes three sections addressing, in order, the current structure of state retiree health care benefits, recent changes, and future directions. The format of individual survey items varied depending on the nature of the information sought and

included: dichotomous choice (Yes/No) response items, where respondents were asked to indicate whether a certain practice or feature was present in their state; Likert-type response items, where respondents were asked to indicate their level of agreement or disagreement with a series of statements related to retiree health care; and open-ended questions, where respondents were asked to provide factual information (e.g., the number of years of work required for employee vesting in retiree health care plans) and their opinions on other retiree health care matters (e.g., what other states they look to as innovators in retiree health care).<sup>1</sup>

Because administrative responsibility for retiree health care varies from state to state and opinions related to retiree health care issues vary depending upon one's role in state government, the survey targeted a number of top officials potentially knowledgeable about retiree health care in their respective states. In particular, five top state officials in each state were targeted, including the state: 1) human resources (HR) director, as identified by the National Association of State Personnel Executives (NASPE); 2) budget officer, as identified by the National Association of State Budget Officers (NASBO); 3) retirement system administrator, as identified by the National Association of State Retirement Administrators (NASRA); 4) treasurer, as identified by the National Association of State Treasurers; and 5) auditor or comptroller, as identified by the National Association of State Auditors, Comptrollers, and Treasurers (NASACT).

The mail survey followed a tailored design method and was administered between December 2007 and March 2008 (Dillman, 2000). The approach included: 1) a brief prenotice letter sent to respondents several days prior to the survey mailing; 2) a survey mailing, including a cover letter explaining the general purpose of the survey, how respondents were selected, and the voluntary nature of the survey; 3) a follow-up postcard sent approximately one week after the survey to thank those

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\*Dennis M. Daley is a professor of political science and public administration at North Carolina State University.

Jerrell D. Coggburn is chair of the Public Administration Department, School of Public and International Affairs, North Carolina State University.

who had already responded and to remind those who had not responded to do so; 4) a second mailing to nonrespondents containing a replacement survey, sent about four weeks after the initial survey mailing; 5) a final follow-up postcard reminder, about two weeks following the second survey mailing; and 6) personal telephone calls to key persons in nonresponding states. As suggested by Dillman (2000), all mailings were via first class mail, all correspondence was personalized (e.g., addressed to respondents by name, hand signed by the principal investigators, etc.), and respondents were provided postage-paid return envelopes.

Completed surveys were received from 121 officials from a total of 50 states (an additional 29 officials indicated their inability or unwillingness to complete the survey, bringing the total number of respondents to 150). For reporting purposes, the data are presented by state. In cases where multiple officials from a state responded, an overall “state response” was calculated by first averaging the responses to each survey item, then rounding up or down to the nearest whole number (i.e., up for scores of .5 or higher and down for .49 and lower).

## Results

### Importance of Retiree Health Care

There is a widely shared view that governments must continue to offer an attractive array of benefits, especially health care, in order to attract and retain employees (Keating and Berman, 2007). Previous research has shown almost universal agreement among state HR directors on the importance of health care benefits to meeting such staffing goals (Reddick and Cogburn, 2007). As reported in table 1, the same general view emerges from the current survey focusing on retiree health care: state administrators see the provision of retiree health care as a valuable tool for recruiting and retaining employees, and for workforce planning. On

the latter, the availability of retiree health care can facilitate early retirement, bridging the gap prior to Medicare eligibility. In the implementation of organizational strategic transformations, retiree health care (along with pensions) can be used as leverage to help avoid potential opposition to planned change. Generally, retiree health care is recognized as being important to key organizational HR goals. This general recognition foreshadows inevitable tension as governments attempt to balance their need to pursue strategic HR goals while simultaneously addressing unfunded OPEB costs.

### Availability of Retiree Health Care in the States

The Agency for Healthcare Research and Quality (AHRQ) notes that there has been a steady drop in the number of private sector organizations offering retiree health care benefits, from 22 percent in 1997 to 13 percent in 2002. Coverage for early retirees is more likely than for those who are Medicare-eligible. However, larger organizations (more than 1,000 employees) are more likely to provide retiree health coverage. Yet, a decline is noted here as well. Early retiree coverage has declined from 88 percent in 1991 to 68 percent in 2003, while Medicare-eligible coverage went from 80 percent in 1991 to 56 percent in 2003 (Fronstin, 2005). Similarly, from 1997 to 2002, local government retiree health care coverage declined from 62 percent to 55 percent for early retirees and from 47 percent to 35 percent for Medicare-eligible retirees (Fronstin, 2005).

This trend is not yet reflected among state governments. To the contrary, state government coverage actually rose between 1997 and 2002, from 76 percent to 92 percent for early retirees and from 69 percent to 86 percent for Medicare-eligible retirees (Fronstin, 2005). The most recent Kaiser Family Foundation survey of health benefits indicates that 98 percent of state and local governments surveyed offer retiree health care benefits to early retirees, and 81 percent offer these benefits to

**Table 1.** *Perceived Benefits of Retiree Health Care Benefits*

<i>How helpful is the availability of retiree health care with respect to the state's ability to:</i>	<b>Very Helpful</b>	<b>Helpful</b>	<b>Somewhat Helpful</b>	<b>Not Helpful</b>
Recruit employees	18% (9)	44% (22)	24% (12)	8% (4)
Retain employees	28% (14)	46% (23)	18% (9)	2% (1)
Influence the timing of retirement (i.e., early retirement) and help the state plan for employment transitions	18% (9)	44% (22)	26% (13)	6% (3)

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

**Table 2. Retiree Health Care**

<i>In regard to retiree health care:</i>	States Answering Affirmatively
Does your state offer retiree health care coverage?	92% (46)
Are newly hired employees eligible for future retiree health care benefits through the state?	90% (45)
Are Medicare-eligible retirees required to enroll in Medicare in order to continue to receive state retiree health care?	76% (38)

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

Medicare-eligible retirees—both figures are the highest among the government and industry groups identified (Kaiser/HRET, 2007).

The Kaiser Family Foundation survey figures from earlier data are reflected in the current survey results (see table 2). Specifically, 46 of the 50 responding states indicate that their state currently offers retiree health care coverage (Iowa, Kansas, Missouri, and Nebraska indicated no such coverage), and 45 states offer it to new employees (with the important caveat that cost-sharing and vesting periods may have changed). These programs are, more than ever, coordinated with Medicare. These results show that, despite growing concerns over retiree health care costs and in contrast to the private sector, retiree health care continues to be offered almost universally by state governments.

### Financing Retiree Health Care

The promise of retiree health care benefits and the costs of paying for them pose a serious obstacle for governments in the early 21st century. Escalating health care costs, in conjunction with a burgeoning number of projected retirements from the baby boom generation, add substantially to the seriousness and complexity of the issue. To address this, governments have a number of options, including doing nothing; raising taxes, cutting other spending or using surplus funds to begin prefunding existing liabilities; issuing bonds to pre-fund existing liabilities; or scaling back benefits (Boyd, 2006).

States traditionally have handled retiree health care expenses on a PAYGO basis, typically funding these

expenses as an annual operating expense. There are exceptions to the general approach, as some states have instituted a separate fund or have begun setting aside additional monies to cover the growing, anticipated liabilities. As shown in table 3, three-fifths of the states surveyed reported using the PAYGO approach, though one state reports fully funding this liability and another 15 states (30 percent) report partial prefunding. While GASB 45 only requires state and local governments to report their OPEB liabilities, it is likely that the reporting of substantial unfunded OPEB liabilities will serve as a catalyst for serious consideration of other, non-PAYGO funding.

Governments can choose to fulfill retiree health care promises by raising revenues. However, state responses quite clearly show that revenue-raising options are not presently under serious consideration (see table 4). Currently, 80–90 percent of the states indicate they are either “Unlikely” or “Very Unlikely” to adopt any extra means for paying these costs.

These results are striking since states’ actuarial valuations for OPEB liabilities often show unfunded liabilities reaching into the billions—and in some cases, tens of billions—of dollars. Viewed generously, one might surmise that, with recently completed actuarial valuations in hand, states are only now coming to understand the potentially daunting fiscal challenges they face. If true, then it might be understandable why states do not yet have a clear sense of how they are likely to try to finance their unfunded OPEB liabilities. Viewed less generously, one could argue that the states are unwilling, at present, to accept the reality of having

**Table 3. Current Financing of Retiree Health Care**

<i>How does your state currently finance retiree health care? (select one)</i>	States Indicating Approach
Pay as you go (all health care costs are paid out annually from the operating budget)	60% (30)
Partial funding (funds are set aside to offset the costs of retirees’ future health care)	30% (15)
Full funding (funds are set aside to prepay the full costs of retirees’ future health care)	2% (1)

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

**Table 4.** Future Financing Options for Retiree Health Care

<i>In the next five years, how likely do you think your state is to adopt the following strategies to finance its unfunded liabilities for non-pension/ other post employment benefits (OPEB) like retiree health care?</i>	<b>Already Adopted</b>	<b>Very Likely to Adopt</b>	<b>Likely to Adopt</b>	<b>Unlikely to Adopt</b>	<b>Very Unlikely to Adopt</b>
Issuing OPEB bonds	0% (0)	0% (0)	6% (3)	48% (23)	38% (19)
Issuing general obligation bonds	0% (0)	0% (0)	0% (0)	46% (23)	46% (23)
Cutting other state programs and using the savings to pay for the unfunded liability	0% (0)	0% (0)	4% (2)	48% (24)	40% (20)
Borrowing funds from the state's pension fund	0% (0)	0% (0)	4% (2)	28% (14)	60% (30)
Raising revenue through higher taxes and fees	0% (0)	6% (3)	6% (3)	40% (20)	40% (20)

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

to make difficult and politically unpopular choices. Marlowe (2007, 105–106) suggests that since most governments have not prefunded OPEB, such unwillingness should be short lived: governments will “be forced to meet new annual obligations by generating new revenues, diverting resources from programs and projects, or borrowing money in the public capital markets.”

Other than an annual PAYGO approach, retiree health care funding can also be addressed through a number of mechanisms such as medical subaccounts (Section 401(h) account), governmental trusts (Section 115 plan), and voluntary employee benefit associations (VEBA, or 501(c)(9)). Each of these approaches seeks to advance fund OPEB liabilities by creating a dedicated fund in which a portion of the actuarially determined costs of future benefits (known as the annual required contribution, or ARC) can be deposited and appreciate. GASB 45 does not *require* prefunding of OPEB, but “considerations of intergenerational equity, financial flexibility, and cost reduction favor advance funding” (Gauthier, 2005, xiii).

As table 5 shows, only a handful of states report having already adopted any of these advance funding vehicles: Ohio and Vermont for 401(h) plans; Alabama,

Alaska, Colorado, Maine, and Massachusetts for Section 155 trusts; and Montana, Ohio, and Washington for VEBAs.<sup>2</sup> These findings differ from research reported by Standard & Poor's (2007) showing that 11 states (Alabama, Delaware, Georgia, Kentucky, Maryland, Massachusetts, Ohio, South Carolina, Utah, Vermont, and West Virginia) have set up trust funds. This is intriguing in that the officials targeted for this survey should be among the most knowledgeable in the states about these issues: either they are unaware of the funds' existence or previous reports are in error. As for likely adoptions, with the possible exception of creating a governmental grantor trust (which 29 percent, or 14 states, indicate they are likely to adopt), the states report little current interest in adopting these OPEB prefunding mechanisms. As was the case with identifying revenue sources for funding retiree health care, the reported unlikelihood of states adopting these funding mechanisms suggests that either the states are only now contemplating what is feasible and preferable in light of their OPEB obligations, or they are failing to come to terms with the potentially daunting fiscal challenges facing them. As mentioned in chapter 2, governments that maintain PAYGO funding could see their

**Table 5.** Funding Mechanisms

<i>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?</i>	<b>Already Adopted</b>	<b>Very Likely to Adopt</b>	<b>Likely to Adopt</b>	<b>Unlikely to Adopt</b>	<b>Very Unlikely to Adopt</b>
A medical subaccount 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.

retiree health care costs increase dramatically by mid-century, from about 2 percent of payroll to 5 percent—a 150 percent increase—by 2050 (GAO, 2007).

**Structure and Generosity of Retiree Health Care Benefits**

In addition to the various funding strategies, governments may also focus efforts to rein in costs by altering the structure and generosity of their respective retiree health care benefits. In other words, governments might consider reducing or even terminating promised benefits. Legally, this may be possible, since retiree health care benefits often do not possess the status afforded pension programs as a recognized form of deferred compensation. Indeed, the lack of a contractual obligation to provide retiree health care has been the main argument advanced in Texas, where state officials argue that GASB 45 does not apply since such benefits could be scaled back at any time (Petersen, 2007; Marlowe, 2008). Recent case law also supports the states’ ability to curtail health care benefits for future hires and even for current employees (*AARP, et al., v. EEOC*, 2007; *Duncan v. Retired Public Employees of Alaska*, 2003; *Studer v. Michigan Public School Employees Retirement Board*, 2006; Norfus, 2008). This notwithstanding, it is important to note that many states do face constraints in the form of statutory or constitutional provisions requiring retiree health care or, in some states, collective bargaining agreements that limit unilateral alterations to benefit plans (GAO, 2007).

According to the survey results (table 6), within the past five years, five states have curtailed retiree health care benefits for *future* retirees and one has introduced a plan to terminate these benefits for future retirees. Not surprisingly, no state reported terminating benefits for *current* retirees.

When focus shifts from what the states have recently done to what they might do in the near future, the situation is to be expected to change. Facing newly reported and substantial unfunded liabilities, most states still see themselves as unlikely to undertake drastic action to curtail or eliminate retiree health care benefits (see table 7). Still, it is important to note that 34 percent intend to introduce plans to limit retiree health care subsidies. Three states are also “Somewhat Likely” to terminate the health care benefits of current retirees altogether. These findings suggest the strong possibility of states gradually shifting the burdens of retiree health care benefits to plan beneficiaries: it appears unlikely that many states will terminate the benefits entirely, but the states’ contributions are likely to diminish.

**Other Cost Control Strategies**

Governments could also introduce procedures designed to control costs (without sacrificing the quality of care), by monitoring health care treatments and expenses, sponsoring preventive and wellness programs that lead to healthier lifestyles (hence reduced costs), and introducing retiree health care savings accounts. Cost containment monitors the appropriateness of medi-

**Table 6.** Limitations on Future Retiree Health Care Benefits

<i>In the past five years has your state introduced a: (check all that apply)</i>	<b>States Indicating Approach</b>
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.

**Table 7.** Future Plans for Retiree Health Care Benefits

<i>In the next five years does your state intend to:</i>	<b>Very Likely</b>	<b>Somewhat Likely</b>	<b>Somewhat Unlikely</b>	<b>Very Unlikely</b>
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.

**Table 8. Cost Containment Programs**

<i>Which of the following programs does your state have? (check all that apply)</i>	<b>States Indicating Approach</b>
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.

**Table 9. Health Care Auditing**

<i>Does the state engage in:</i>	<b>States Indicating Approach</b>
Claims payer audits	74% (37)
Hospital bill audits	48% (24)
Utilization review vendor audit	58% (29)
Employee self audits	30% (15)

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

cal procedures and the efficiency with which they are provided. Cost containment is also obtained through gate-keeping efforts that require precertification or utilization reviews prior to an individual receiving treatment. These are designed to provide a second medical opinion on the appropriateness of procedures and tests. Since there may be a tendency for doctors to provide drugs that pharmaceutical companies heavily market and request various tests primarily as legal safeguards, an alternative, if not impartial, screening is appropriate. As shown in table 8, about 80 percent of the states have instituted cost containment on the more costly medical areas (e.g., hospitalization and long-term disease management programs); about 50 to 60 percent report monitoring secondary expenses.

Related to these types of a priori reviews are post hoc audits that can help control costs through recovery of unnecessary expenses. These audits are designed to verify the cost and appropriateness of care received by patients. As reported in table 9, a majority of states

have established claims payer, hospital bill, and vendor auditing programs.

To pay for uncovered aspects of health plans, the tax code allows states to establish individual health care accounts. Employee-funded options that derive their money entirely from contributions set aside by the employee have been adopted in a third of the states. A smaller group has created accounts in which they provide some kind of matching incentive. Employees can establish medical (as well as dependent care, elder care, and legal) accounts. The employees, according to a salary reduction agreement, deposit pre-tax dollars from their salary into these accounts. These personal “trust funds” are then used to pay the medical, dependent, or legal expenses incurred. Unexpended funds revert to the federal government at the end of the year. However, it is quite easy to budget for anticipated, on-going expenses or to plan some less serious medical procedures. A small number of states have set up employer-funded accounts and about a third offer employee-only funded accounts.

**Table 10. Tax-Exempt Savings Accounts**

<i>Does the state offer:</i>	<b>States Indicating Approach</b>
Employer-funded Retiree Medical Account (RMA), Health Reimbursement Account (HRA), Health Savings Account (HSA), or Medical Savings Account (MSA)	12% (6)
Employee/retiree-funded Health Savings Account (HSA) or Medical Savings Account (MSA)	34% (17)

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

**Table 11.** *Cost-Sharing Changes Recently Introduced*

<i>In the past five years has your state increased the: (check all that apply)</i>	<b>States Indicating Approach</b>
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.

**Cost Sharing**

Cost sharing programs establish a process that balances governmental subsidies with employee payments. From a governmental perspective, setting the balance of these various payments between employee/retiree and the governmental entity is a major cost containment factor. However, the more of the burden placed on retirees, the more likely it is that they will be priced out of obtaining services other than those involving catastrophic events.

Though the funding liability for retiree health care has begun to loom as a serious issue, states have not been inattentive or inactive with regard to other health care issues. Efforts at cost sharing have been ongoing (see table 11). Most states have increased the premiums/contributions that retirees pay towards their health care coverage. Deductible amounts and co-payment fees that must be paid entirely by the retiree prior to any state subsidy have been raised in over two-thirds of the states. Total out-of-pocket expenses for retirees have also been increased in a large number of states. In addition, nearly a third have increased the coinsurance proportion of each bill that retirees pay.

**Cost Shedding**

More drastic efforts can be seen in proposals for cost shedding. One may also note that four states report

having instituted Medical Savings Accounts coupled with catastrophic plans (see table 12). Now that there is a federal program that subsidizes the cost of prescription drugs, some states have eliminated the prescription drug benefit they used to offer. A few states have increased the age at which retiree health care is available, an appropriate strategy given that longer life spans are rendering traditional government retirement plans—which often allow retirement at relatively early ages—unsustainable (Miller, 2008). Finally, increasing the years required for vesting has gained some traction. For example, in 2006 North Carolina changed retirement (pension and health care) vesting for new hires from 100 percent after five years of employment to a tiered approach in which benefits are paid at the rate of 50 percent after 10 years of state service and 100 percent after 20.

**Wellness and Preventive Approaches**

Wellness programs focus on preventive health care. They attempt to encourage behaviors that lead to good health, ease stress, and discourage behaviors that are inimical to good health. Such programs encourage individuals to exercise, eat healthily, and give up poor habits. Many of these activities are geared to behaviors that are associated with the risk of cancer and heart

**Table 12.** *Major Changes Recently Introduced*

<i>In the past five years has your state introduced a: (check all that apply)</i>	<b>States Indicating Approach</b>
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.

**Table 13.** *Preventive Medicine and Wellness Programs*

<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 retiree's 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.

disease—two of the costliest insured illnesses (Erfurt, Foote, and Heirich, 1992). Wellness programs entail startup and maintenance costs but accrue substantial savings to the extent that they help reduce the more costly expenses associated with severe health problems. Governments may also address cost issues through incentive programs and by disseminating information on healthy life styles (see Carlson, 2005).

The results reported in table 13 show that certain aspects of preventive medicine and wellness programs have caught on in the states. A majority of states, for example, disseminate information on preventive medicine/wellness, encourage routine doctor visits by covering the full cost of physical exams and exempting those exams from annual deductibles, and offer smoking cessation and weight management programs. The

results also show some planned adoption of incentive programs to promote healthy life styles.

### **Future Action on Benefit Structure and Generosity**

To this point, research on OPEB suggests that states have not yet developed comprehensive strategies for addressing unfunded liabilities. Given that states are now aware of their unfunded liabilities, it is reasonable to assume that they are beginning to turn their attention to consideration of various alternatives.

As reported in tables 14 and 15, states appear poised to act incrementally to reduce future retiree health care costs by decreasing benefits through such measures as boosting retiree-paid contribution/premiums, deductible amounts, co-payments, and coinsur-

**Table 14.** *Future Cost Sharing Changes*

<i>In the next five years does your state intend to increase:</i>	<b>Very Likely</b>	<b>Somewhat Likely</b>	<b>Somewhat Unlikely</b>	<b>Very Unlikely</b>
Retiree contribution premiums	34% (17)	42% (21)	8% (4)	8% (4)
Dependent contribution premiums	26% (13)	46% (23)	12% (6)	8% (4)
Retiree deductible amounts	16% (8)	48% (24)	22% (11)	6% (3)
Family deductible amounts	18% (9)	44% (22)	22% (11)	8% (4)
Coinsurance rates	6% (3)	44% (22)	34% (17)	8% (4)
Co-payment amounts	18% (9)	50% (25)	16% (8)	6% (3)
Co-payments for prescription drugs	18% (9)	52% (26)	14% (7)	6% (3)
Cap on employee out-of-pocket expenses	8% (4)	30% (15)	42% (21)	12% (6)

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

**Table 15.** *Future Cost Shedding Changes*

<i>In the next five years does your state intend to:</i>	<b>Very Likely</b>	<b>Somewhat Likely</b>	<b>Somewhat Unlikely</b>	<b>Very Unlikely</b>
Offer catastrophic plan plus a retiree medical savings account	0% (0)	14% (7)	60% (30)	22% (11)
Eliminate prescription drug coverage	0% (0)	0% (0)	24% (12)	64% (32)
Decrease the total benefit cap amount that the state will pay	0% (0)	10% (5)	34% (17)	44% (22)
Increase the age at which retirement health care is available	4% (2)	16% (8)	38% (19)	34% (17)
Increase the years of service required for vesting in retiree health care	10% (5)	22% (11)	30% (15)	30% (15)

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

ance rates. The reported likelihood of adopting such tactics is not surprising given that they have been used previously (see table 11). Though these approaches may be categorized as incremental, such cost-shifting measures can generate substantial savings for the states.

Turning to table 15, it appears that more substantial cost shedding options may also be in the offing in coming years. A willingness to consider changes in age and/or years of service requirements is now becoming evident. When considered along with a willingness to reduce or eliminate retiree health care benefits for future and current retirees, we are seeing for the first time the introduction of proposals for major change. If adopted, these changes would truly transform the retiree health care system for state employees. The effect of such changes, if implemented, on state governments’ ability to attract and retain employees is unknown.

## Conclusion and Discussion

This chapter reports findings from a survey of retiree health care benefits in the American states. In addition to showing that state officials readily acknowledge the importance of retiree health care to HR recruitment and retention goals, findings suggest that comprehensive strategies for dealing with OPEB liabilities remain elusive. A few states have adopted advance funding for OPEB, and a number of others are contemplating doing so in the coming years. In general, state officials report little likelihood of adopting politically unpopular action like raising taxes or cutting existing government programs to fund OPEB.

How are states and state employees likely to respond? In the near term, survey findings indicate that most states will likely opt for incremental, piecemeal approaches, hoping to chip away at their current costs

by cost containment and cost sharing strategies and, by extension, reducing their longer-term obligations.

More broadly, it is important to consider the potential HR implications of the various strategies states are likely to employ in addressing OPEB liability. Relatively generous benefits packages have afforded governments a measure of competitive advantage in the market for human capital. The potential exists for cuts to OPEB generosity to have a negative impact on governments’ recruitment and retention efforts. When considered alongside other recent changes affecting public service—such as shifting pension risks to employees through defined contribution plans, scaling back or eliminating employee grievance rights, and eliminating job security—cutting government OPEB could exacerbate existing HR difficulties. Such prospects only underscore the importance of understanding the implications of proposed actions so that difficult, yet informed, choices can be made.

## Notes

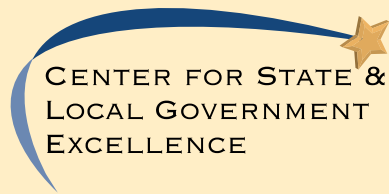
1. This survey was developed following a review of employee benefits literature and with input from officials in the North Carolina Treasurer’s Office and members of the Center for State and Local Government Excellence’s practitioner advisory board. These individuals reviewed early drafts of the survey, making suggested improvements in both clarity and coverage.
2. It should be noted that at least one respondent from several other states indicated the adoption of OPEB funding mechanisms: Arizona, Missouri, and New Hampshire for 401(h); and California, Delaware, Hawaii, Minnesota, Virginia, and West Virginia for Section 115 trusts. Given our conservative weighting of responses, these states are not reported as adopters in table 5.

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