Spotlight *on*

Retiree Health Care Benefits for State and Local Employees in 2014

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December 2014

A 2013 report[1] from the National Association of State Retirement Administrators (NASRA) and the Center for State and Local Government Excellence (SLGE) examined the finances of health care benefits provided to general state employees for reporting periods 2011–2012.[2] This update offers finance data on other postemployment benefits (or *OPEB*) which is expanded to include additional state and local government employee cohorts including teachers, public safety officers, university employees, and legislators, among others. Data for most states are current as of fiscal year 2013, unless noted otherwise.

From an employee perspective, as of March 2014, 86 percent of state government employees and 66 percent of local government employees had access to retiree health care under the age of 65. Eighty-four percent of state workers and 59 percent of local employees had access to these benefits at age 65 and above.[3] From an employer perspective, as of 2012, 43 percent of state and local governments[4] offered insurance to employees under the age of 65 and 30 percent offered coverage to those 65 and older.[5] It is reasonable to assume that the asymmetry between employee access and employer offerings points to larger public employers, fewer in number, being more likely to continue to provide retiree health benefits relative to a larger number of smaller governments less likely to provide the benefit.[6]

For most employees who retire from state (or covered local) government service, this coverage continues into retirement. The style and size of coverage varies and state

1 Franzel, J. and A. Brown. *Spotlight on Retiree Health Care Benefits for State Employees in 2013*. Center for State and Local Government Excellence and National Association of State Retirement Administrators. http://slge.org/wp-content/uploads/2013/06/OPEB-Spotlight-06176.pdf.

2 Exceptions to this range are noted in the report

3 U.S. Bureau of Labor Statistics. *Table 42. Health-related benefits: Access, State and local government workers, National Compensation Survey, March 2014.* http://www.bls.gov/ncs/ebs/benefits/2014/ownership/govt/table42a.pdf.

4 Measured at the: "governmental unit level, which is defined as all sites under a single controlling governmental entity." See: U.S. HHS Agency for Healthcare Research and Quality. *MEPS-IC Sample Size*. 2014. http://meps.ahrq.gov/mepsweb/survey_comp/ic_sample_size.jsp.

5 U.S. HHS Agency for Healthcare Research and Quality. *Medical Expenditure Panel Survey*. 2014. http://meps.ahrq.gov/mepsweb/survey_comp/Insurance.jsp.

6 Related findings were noted in: Kearney, et al. *At a Crossroads: The Financing and Future of Health Benefits for State and Local Government Retirees*. 2009. Center for State and Local Government Excellence. (pg 62). http://slge.org/wp-content/uploads/2011/12/At_a_Crossroads.pdf.

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The authors would like to thank Mark Ossolinski for his assistance in collecting and verifying portions of the data offered and SLGE and NASRA staff for their review of this brief.

and local government retiree health programs do not have a uniform design. These plans have a range of benefit offerings and structures, employer to retiree subsidy levels, savings vehicles, financing arrangements, and eligibility requirements. Health plan options for retirees can be crafted as cost-sharing defined benefit arrangements in which public employers and (possibly) employees make contributions toward a plan with a defined level of coverage. Alternatively, defined contribution retiree health plans invest employee and employer contributions over the course of an employee's tenure and accumulate assets designed to offset health care expenses in retirement.

Different plan designs, coverage levels, and financing arrangements produce different costs for sponsoring state governments. States vary in how they approach financing retiree health benefits, with some prefunding future benefit obligations while others pay for the associated costs annually as part of the state operating budget. Many governments mitigate cost increases by scaling back the scope of coverage or the size of the subsidy or by increasing service requirements an employee must meet before becoming eligible for medical coverage as a retiree. In 2014, 61 percent of state and local government human resource executives responding to a national workforce survey answered that they had made changes to health benefits over the past year, up from 45 percent in 2011.[7] In 2014, 14 percent of respondents shifted health care costs from the employer to retirees, 8 percent set funds aside to cover future retiree health costs, while 1 percent eliminated retiree health care benefits altogether.

State OPEB Assets

Prior published reviews of state OPEB finances have identified a growing number of states who have elected to set aside assets to prefund retiree health benefits. For the reporting periods FY09–FY11, 18 states reported holding OPEB assets; for the period FY11–FY12, the number of states grew to 25. For the period FY13, 33 states held approximately $33 billion in OPEB assets.

The value of assets states hold in trust varies significantly. Nearly half of all reported OPEB assets are held by the State of Ohio, whose public employee retirement systems administer retiree health programs for their respective employee groups: general employees, teachers, school employees, and police officers and firefighters. With over $16 billion in assets, Ohio's retiree health plan cumulative funding ratio is just below 55 percent.

The size of plan assets alone, however, is not a determinant of a state's OPEB funding ratio. North Dakota holds $66 million in OPEB assets, an amount equal to less than one percent of the approximately $33 billion held by all states. Despite this, North Dakota's assets are enough to fund nearly 58 percent of the long-term OPEB liabilities in the state.

State OPEB Liabilities and Annual Required Contributions

The Governmental Accounting Standards Board (GASB) statement 45 establishes accounting and reporting requirements for state administered OPEB plans. The statement requires that states calculate the annual amount an employer is required to contribute to fund the normal cost of benefits accrued in the current year and an amount to amortize the unfunded liabilities over a specified timeframe (no more than 30 years).

State OPEB unfunded actuarial accrued liabilities (UAAL), in aggregate, remain relatively constant in the FY13 sample when compared to the data from FY10–FY12. When adjusted to include previously omitted employee groups, state OPEB liabilities for the period FY10–FY12 were nearly $495 billion, or 3.25 percent of national gross domestic product (GDP). For the FY13 sample (see Appendix), state OPEB UAAL was nearly $498 billion, or 3.21 percent of national GDP.[8] The size of a state's unfunded OPEB liability is a function of its funding strategy, the generosity of the benefit, and demographics. Figure 2 displays total unfunded OPEB liabilities by state and the data allow for the determination of a few broad, overarching characteristics.

The median average state OPEB UAAL is $2 billion, and the mean average is $10 billion. This positive skew, which indicates the effect of outliers with large amounts of unfunded liabilities imposing a disproportionate effect on the average state OPEB UAAL experience. Because of this effect, though the aggregate state OPEB UAAL is nearly half of one-trillion dollars, over 75 percent of the total is carried by the top ten states (see Figure 2).

7 Center for State and Local Government Excellence, International Public Management Association for Human Resources, and National Association of State Personnel Executives. State and Local Government Workforce Survey Series.

8 Author calculations using 2012 and 2013 national GDP data from the U.S. Bureau of Economic Analysis, http://www.bea.gov.

Figure 1: Relative distribution of state OPEB assets by their share of the total, FY13

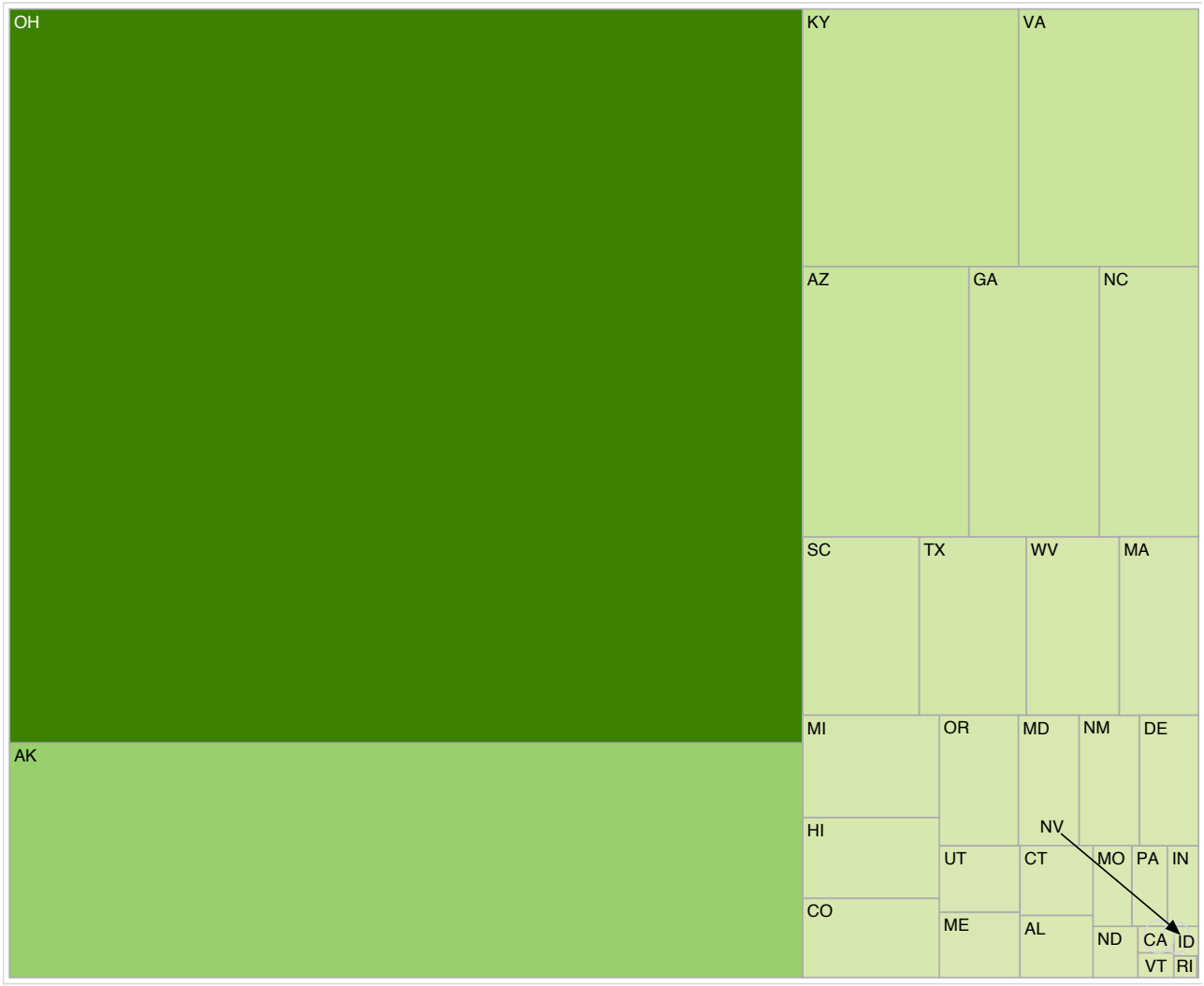
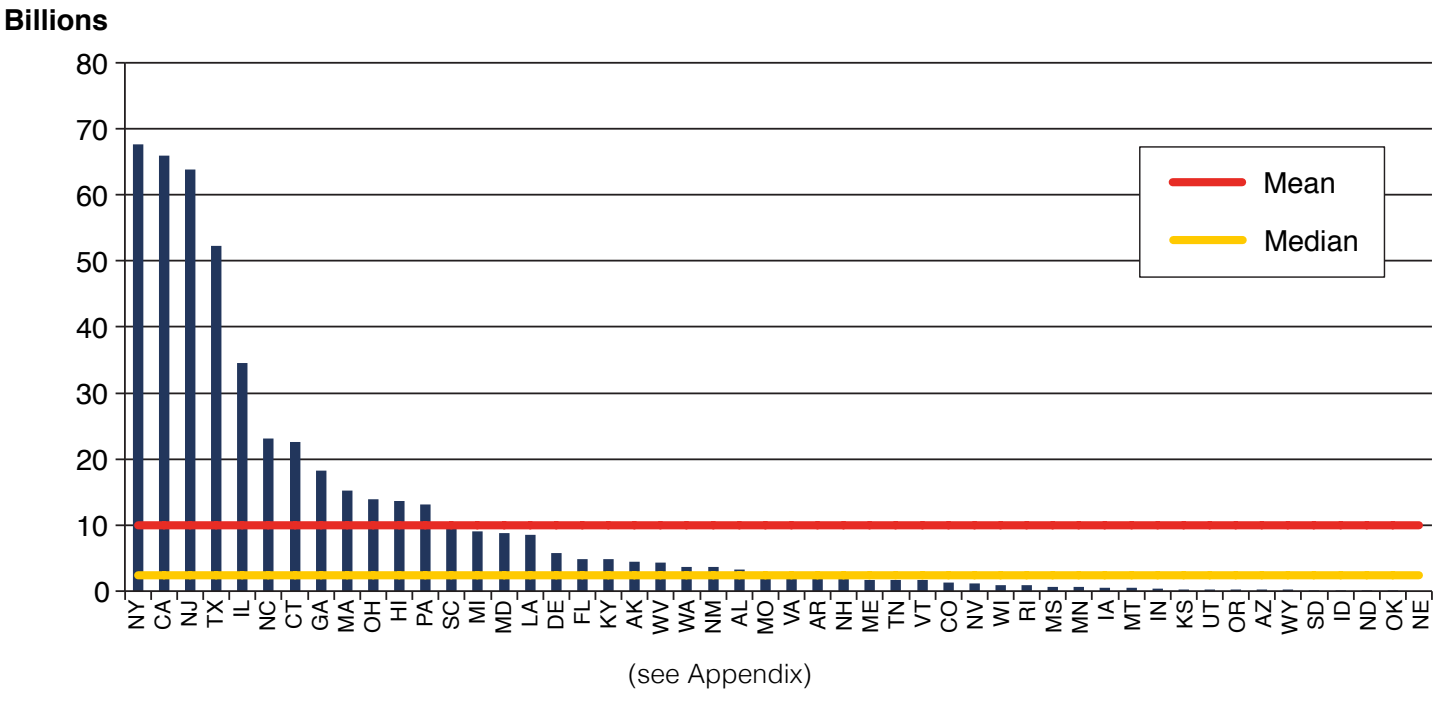


Figure 2: OPEB UAAL, by state, FY13

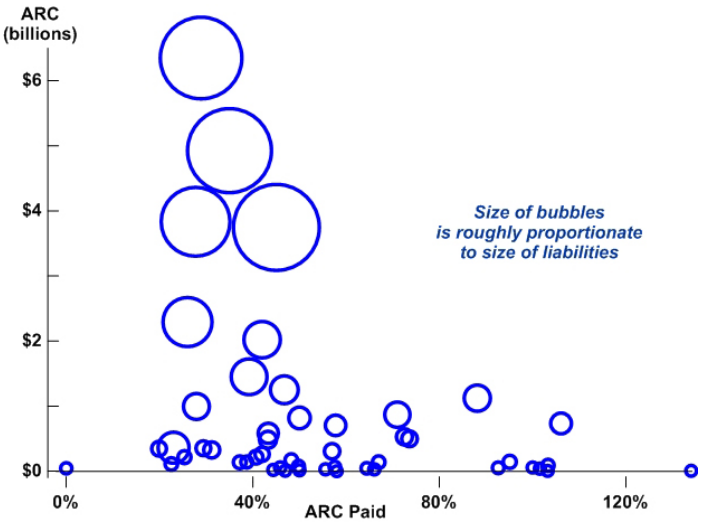


(see Appendix)

There is also disparity in the funding discipline for state OPEB benefits, as measured by the annual required contribution (ARC), which is the sum of the normal cost of OPEB benefits attributable to the current year and an amount determined to amortize unfunded OPEB liabilities over a specified timeframe (not to exceed 30 years). The average percentage of the OPEB ARC contributed by states for the FY13 period was 55 percent. However, the weighted average amount contributed was lower, at approximately 46 percent.[9] The states with larger UAALs and ARC requirements were among the lowest contributors.

Figure 3 highlights that states with higher OPEB UAAL contributed less than states with lower OPEB UAAL in FY13.

Figure 3: ARC and Percent Paid by States, FY13



Only one state (Montana) failed to contribute any amount towards its ARC for fiscal year 2013. Nine states (Arizona, Colorado, Idaho, Michigan, North Dakota, Ohio, Rhode Island, Utah, and Virginia) contributed 80 percent of their ARC or greater. The weighted average ARC experience is primarily influenced by the experience of five states (California, Illinois, New Jersey, New York, and Texas) represented by the five largest plots in Figure 3 in the upper-left most range, which was approximately 33 percent.

Key Assumptions

It is important to note some of the key assumptions used to derive retiree health liabilities and estimate asset growth: medical inflation rates, investment rates of return, and inflation assumptions. The mean average short-term (approximately the next 5–10 years) medical inflation rate assumption used by the plans in 2013 was 7.1 percent (median: 7.3 percent) and the mean average long-term (upper bounds for some plans being 70 to 80 years) assumption rate is 4.8 percent (median: 5 percent). These averages, which have been standardized at the state level, are relative to state and local government health expenditure annual growth benchmark estimates averaging 5.8 percent (mean)/6.0 percent (median) for the 2013–2024 timeframe.[10]

Similar to pension plans, if assets are being set aside, defined benefit retiree health plans also identify the rate of investment return assumptions which they use to determine the amount necessary to cover future health care costs. Standardized at the state level, the mean rate of return assumption used by state retiree health plans in FY13 was 4.9 percent (median: 4.5 percent). This is lower than the median assumptions used by state pension plans, which is currently 7.75 percent,[11] likely reflecting, among other factors, the difference in asset allocations between pension and retiree health plans and the level of pre-funding between the two types of trust categories.

Overall inflation underpins medical costs trends and investment returns. The retiree health plans analyzed use a mean and median average inflation assumption of 3.0 percent, relative to the average rate of inflation for the past 30-year period, 2.9 percent.[12] Longer term projections for inflation are around 2 percent, a projection that informs long-term assumptions for medical inflation.[13] The average inflation assumptions for the health plans are about the same as the average

9 The weighted average calculation represents the aggregate Annual Required Contribution (ARC) effort for all states.

10 U.S. HHS Centers for Medicare & Medicaid Services. *National Health Expenditure Data.* 2014. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html.

11 Brainard, K. and A. Brown. *NASRA Issue Brief: Public Pension Plan Investment Return Assumptions.* 2014. National Association of State Retirement Administrators. http://www.nasra.org/returnassumptionsbrief.

12 Author calculations based on CPI-U data published by the U.S. Bureau of Labor Statistics. http://www.bls.gov/cpi/; plan averages have been standardized at the state level.

13 Congressional Budget Office. *The Budget and Economic Outlook: 2014–2024.* 2014. http://www.cbo.gov/sites/default/files/45010-Outlook2014_Feb_0.pdf.

assumptions used by state and local pensions in 2013, which was 3.17 percent.[14] Medical cost trends are also supported by plan-specific factors such as the size and structure of the benefit, cost sharing, eligibility, and participation.

Outlook & Conclusion

Given the size of the unfunded OPEB liability in some states, it is likely that state governments will continue to address these issues by reforming benefits or taking other actions. Generally, legal protections for OPEB benefits are lower than protections for pension benefits, although this is not the case in every state. In 2012, the Illinois state legislature passed a law requiring retired workers to begin paying for health care insurance premiums, a cost many were not previously required to pay due to their length of service in covered employment. The law was challenged, and in July 2014, the Illinois Supreme Court ruled that the state constitution prevents the reduction of health care benefits for retired employees. This case illustrates that the scope of reforms aimed at reducing costs is dependent on the degree to which the benefit is constitutionally or otherwise protected in a given state.

States may have other means of cutting OPEB costs outside of the legislative process. Public health insurance exchanges, mandated as a part of the Affordable Care Act, took effect starting October 1, 2013, with coverage beginning January 1, 2014. While this practice has yet to be adopted by any state governments, some local governments, including Detroit, as of March 1, 2014,[15] and Chicago, as part of a phased approach which will conclude by 2016,[16] are taking advantage of the exchanges as an alternative means of providing health care to their pre-Medicare eligible retirees. Since the state-provided health insurance serves as the primary insurance for pre-Medicare retirees, moving this group to an exchange may produce significant cost savings.

It will also be important to track medical inflation, overall inflation, and rates of return on assets as these will, respectively, affect the overall costs of providing health benefits to retirees and the purchasing power of retiree health funding, as well as increase the level of funds available to cover future liabilities outside of a government's general budget.

In aggregate, states face a considerable unfunded OPEB liability, with just a few states carrying a significant portion of that liability. Additionally, more states are beginning to accumulate assets to prefund future retiree health benefits, which is a trend that is expected to continue. Finally, retiree health benefits are generally malleable and have a diminished standard of constitutional protection compared to pension benefits. These protections, however, are being challenged and some decisions have been rendered. This, in turn, will shape retiree health care policy moving forward, requiring states to consider other options for reducing OPEB costs.

14 Author estimate of 2013 data sets from Public Plans Database. http://slge.org/research/public-plans-database.

15 The city ceased providing health insurance to retirees as of this date. As part of a settlement with retirees, the city agreed to provide a monthly stipend to retirees which is based on income and Medicare eligibility. See settlement agreement between retired city employee organizations and City of Detroit, executed 2/18/14: http://bit.ly/1zKahAR

16 This change exempts those who retired prior to August 23, 1989. See City of Chicago 2014 retiree health care plan fact sheet, published 10/8/13: http://bit.ly/11Lg1PO

Appendix: State OPEB UAAL, FY13

State	Unfunded Liabilities (millions)	State	Unfunded Liabilities (millions)
Alabama	$3,216	Montana	$447
Alaska	$4,511	Nebraska	$0
Arizona	$220	Nevada	$1,181
Arkansas	$2,056	New Hampshire	$1,857
California	$66,000	New Jersey	$63,881
Colorado	$1,325	New Mexico	$3,687
Connecticut	$22,581	New York	$67,714
Delaware	$5,766	North Carolina	$23,117
Florida	$4,879	North Dakota	$48
Georgia	$18,239	Ohio	$13,959
Hawaii	$13,672	Oklahoma	$4
Idaho	$55	Oregon	$236
Illinois	$34,488	Pennsylvania	$13,151
Indiana	$315	Rhode Island	$858
Iowa	$526	South Carolina	$9,736
Kansas	$278	South Dakota	$68
Kentucky	$4,844	Tennessee	$1,694
Louisiana	$8,543	Texas	$52,314
Maine	$1,724	Utah	$267
Maryland	$8,792	Vermont	$1,644
Massachusetts	$15,377	Virginia	$2,128
Michigan	$9,103	Washington	$3,707
Minnesota	$652	West Virginia	$4,300
Mississippi	$690	Wisconsin	$953
Missouri	$2,671	Wyoming	$219

(1) *Sources:* comprehensive annual financial reports, valuation documents, and/or related documents;

(2) FY12 is offered for New Mexico

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