

LOCAL GOVERNMENT RETIREE HEALTH CARE: CURRENT OFFERINGS AND FUTURE DIRECTION

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In 2007, the U.S. Government Accountability Office wrote:

In addition to supporting a secure retirement for state and local government employees and their families, such [retiree health care and pension] benefits constitute an important component of the total compensation package state and local governments offer to attract and retain the skilled workers needed to protect lives and health, and to promote the general welfare. These workers include highway patrol officers, local police, firefighters, school teachers, and judges, as well as general state and local government employees who staff the broad array of state and local agencies.¹

In a recent nationwide local government survey, 40% of local governments identified re-

tree health care benefits as being helpful in recruiting employees, 61% of governments believed the benefits were helpful in retaining employees, and 54% felt the provision of retiree health care influenced the timing of employee retirements.²

In light of the importance of these benefits, this article will outline the health care plans local governments are currently offering to their retirees, highlight new accounting rules that relate to retiree health care and other post employment benefits (OPEB), and offer details on what municipalities are doing (or are considering doing) given the current and future costs of providing retiree health care benefits.

LOCAL GOVERNMENT RETIREE HEALTH CARE

In 2003 and 2006/2007 respectively, the International City/County Management Association completed two surveys, *Local Government Health Care Plans: Customers, Costs, and Options for the Future* and *Local Government Employee Health Insur-*

ance Programs. Both surveys were mailed to about 8,000 city and county governments with populations of 2,500 persons or more that had a council-administrator or council-elected-executive form of government. Both asked a wide range of questions, including those on types of employee and retiree health insurance plans offered and plan costs.³

As of 2003, the main vehicles local governments used for providing current employee health care were:

- **Preferred Provider Organizations (PPO)**, which offer health coverage at a discounted cost to members when they use providers who have contracts with the PPO [68% of local governments offered this option];
- **Health Maintenance Organizations (HMO)**, which contract or employ health care providers that HMO members must select and use for all health care services

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[41% of local governments offered this option];

■ **Point of Service Plans (POS)**, which offer coverage from providers who contract with the plans, but also allow for participants to go out of this network of providers in return for higher cost sharing rates with the consumer [17% of local governments offered this option];

■ **Indemnity Plans**, in which members go to any health care provider, who is then reimbursed directly based on a pre-determined percentage of the medical procedure's expense, after the expense has been incurred [13% of local governments offered this option].⁴

These percentages remained about the same in 2006/2007 for active employees. In both 2003 and 2006/2007, about 60% of governments offered some form of health insurance to retirees (although larger local governments were more likely to offer retiree health care than their smaller counterparts). In 2006/2007, for retirees younger than age 65, about 49% of governments offered PPO plans; 28% offered HMO plans; 14% offered POS plans; and 6% offered indemnity plans. For retirees 65 and older, 36% of local governments offered PPO plans; 24% offered HMO plans; 11% offered POS plans; 16% offered Medicare Supplement plans; 5% offered indemnity plans; and 3% offered Medicare Advantage plans.⁵

The financing of health care plans, both for current and retired employees, is an increasing challenge for local govern-

ments. Overall increases of health care spending are projected to be about 6.9% annually until the year 2016.⁶ While governments typically require employees to pay a portion of their health care premiums, "[Local Governments] often do not have the flexibility that the private sector has to increase the level of cost sharing with employees.... One issue affecting these costs is that they are often negotiated in union contracts.... The local government may not be able to make adjustments in out-of-pocket expenses paid by the employees; this significantly increases the costs to the local government when the insurer increases premiums."⁷

A local government may use one or more of a variety of plans. Unlike the private sector though, while employees do have to pay a portion of their premiums, usually employee contributions are not proportionately linked to one's salary. In 2003, 77% of local governments required retired employees to pay a premium, with 40% of these governments charging higher premiums (and 3% charging lower premiums) to retirees, relative to current employees. In 2006/2007, 25% of governments fully paid for retiree health care benefits, 41% partially paid for these benefits, and 54% offered health care benefits to retirees at cost.⁸

According to the U.S. Government Accountability Office (2007 report), in 2006, the retiree health care expenses of state and local governments amounted to 2% of salary costs. This percentage is projected to rise by 150% to 5% of salaries by 2050. The report also stated:

State and local government officials we spoke with said that the

rising cost of health care was one of the biggest fiscal challenges confronting them in the near term. They said the drivers of their health care costs mirror those of the nation as a whole: rapidly escalating costs for prescription drugs, medical care, and hospital care. Further, they noted that the health care industry's practice of shifting costs not paid by the Medicare and Medicaid programs to employers is causing employers' costs for health insurance premiums to rise even faster.

NEW LOCAL GOVERNMENT OPEB REPORTING REQUIREMENTS

The Governmental Accounting Standards Board (GASB) issued, in April and June 2004, respectively, Statement No. 43—*Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans* and Statement No. 45—*Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions*. GASB, "the private, nonpartisan, non-profit organization that works to create and improve the rules U.S. state and local governments follow when accounting for their finances and reporting them to the public," issued the statements to establish standards with which state and local governments are to account for their current and past employees' non-pension, other post employment benefits (OPEB), such as health insurance, and, when applicable, related vision, dental, prescription, and other benefits.⁹

When an employee completes a year of work, his or her salary usually has been paid over the course of the year, the costs of which are recorded by municipalities in their annual financial reporting documents. The same is usually true for

the cost to the employer for providing them with health care benefits during the year of employment, other in-service benefits, and, if applicable, the necessary contributions toward their pensions (as required by previous 1994 GASB statements).

An impetus for establishing accounting standards (GASB Statement 43 and Statement 45) is that most governments traditionally have not accounted for the true, full costs of the retirement health-care benefits and other OPEB earned by their current and past employees. Most governments currently use a “pay-as-you-go” method for retiree health care costs that simply accounts for the funding level distributed or claimed for OPEB during a specific year.¹⁰ This approach does not factor in how much of a financial liability OPEB will be in the future, given changes to the environment within which governments operate.

The new GASB statements require governments to record the actuarial valuations of future OPEB liabilities in their financial reporting, taking into account factors such as how many employees receive or will receive OPEB, when these employees are expected to retire, how long they are expected to receive the OPEB, what the expectations are for future costs (such as health care), what the expected performance of investments is (if any) that governments plan to use to fund OPEB, etc. With the factors above, among others, along with one of a set of six acceptable actuarial cost methods, the new GASB statements should help governments determine how much funding will be needed to pay for all

current and future OPEB. They can then work backwards, given rates of return on investments and present dollar value, to determine how much current funding should be set aside to pay for tomorrow’s employee OPEB.¹¹

INITIAL ESTIMATES OF OPEB LIABILITIES

Under GASB Statement 45, all local governments are expected to report their future OPEB liabilities for fiscal years beginning after December 15, 2008, with larger cities (>\$100 million annual revenues) for fiscal years beginning after December 15, 2006 and cities with annual revenues between \$10 and \$100 million for fiscal years beginning after December 15, 2007.

When the 2006/2007 ICMA survey *Local Government Employee Health Insurance Programs* asked cities and counties what they estimate to be their level of OPEB liabilities, 44.1% answered less than \$10 million, 15% answered between \$10 and \$100 million, about 3% answered more than \$100 million, and 26% were not sure.¹² In 2008, 290 municipalities reported unfunded liabilities for their retiree health care ranging from \$25,000 to over \$10 billion, with a median average of \$13.7 million.¹³

Research analysts at Credit Suisse Securities estimate that as of March 2007, the 25 largest cities in the U.S. had OPEB plans that were under-funded by more than \$90 billion, including New York City (\$50.5 billion), Memphis (\$2.7 billion), Dallas (\$1.5 billion), Seattle (\$1 billion), and Indianapolis (\$46 million). Aside from the budgeting decisions that have led to these liabilities, varia-

tions among the 25 largest cities (along with smaller municipalities) can be attributed to which personnel positions and associated benefits packages fall under the specific city’s jurisdiction. The analysts extrapolate that the OPEB under-funding total for all local governments in the U.S. could be as high as \$1 trillion.¹⁴

WHAT MIGHT LOCAL GOVERNMENT DO IN LIGHT OF CURRENT AND FUTURE OPEB COSTS?

Many local governments have promised retirement health care to current and past employees, using these and similar benefits to attract and retain public employees, and thus amassing large future liabilities by offering the benefits without putting money aside to cover these obligations. The health care benefits, for the most part, do not have the same level of legal protections against changes as do other retiree benefits, such as pensions.¹⁵

While it is projected that these liabilities can be measured in the billions of dollars, there are various steps governments could take to reduce such liabilities. Because many local governments are reluctant to raise taxes and fees (50% of municipalities say it is unlikely they will do so over the next 5 years) or cut spending in other programs (55% of municipalities say this is unlikely in the next 5 years, as well), they are adopting other strategies to reduce their current and future OPEB liabilities.¹⁶

Make changes in benefit offerings, such as raising eligibility requirements for retirees to receive the health care benefit. For example, changes can be made to the number of years one must

work for the local government before s/he is eligible to receive all or a portion of retiree health benefits. Also, governments may modify the number of years former employees have access to the benefit once they retire. Employee tiers have been established based on employment start date or similar criteria, which dictate the level and type of health benefits after retirement. Dependent coverage may be altered.¹⁷ Also, required employee contribution levels can be adjusted to increase the level of deductibles, co-payments, and co-insurance employees are required to pay for health insurance. This could be done in combination with redefining the level and extent of the benefit. While some municipalities are considering this approach, 50%-64% of municipalities say that it is unlikely that they will introduce a plan to limit (or terminate) subsidies for current and/or future retirees' health care, while less than 10% have already done so.¹⁸

Establish a trust to set aside funds to pay for current and future health care costs. For example, a Voluntary Employees' Beneficiary Association (VEBA) could be created that is "a tax advantaged exempt entity, usually a trust, for the benefit of a voluntary membership of active and retired employees, and from which tax-free distributions may be made for qualifying health care expenses of retirees." A second trust option is a health benefits subaccount [401(h)]. This is "a separate subaccount of a defined benefit pension trust that allows up to 25 percent of the total employer contribution to the pension fund to be allocated to retiree health benefits. Investment in-

come on assets in the subaccount accumulates tax free, and retiree health benefit payments made from the subaccount are not taxable to retirees." Another option is a Governmental Trust (115), which is "a trust established by a governmental employer to fund an essential government function, which may include providing retiree health benefits. Contributions to the trust are not limited, unlike contributions to a VEBA or health benefits subaccount. The investment income on the trust is not taxed, and the benefits ought to be tax free to the retiree when received, with confirmation from the Internal Revenue Service".¹⁹ Between 2% and 15% of municipalities say they have or will adopt one of the above funding mechanisms in the next 5 years.²⁰

Issue OPEB Obligation Bonds. The proceeds from the sale of these bonds are deposited into a trust fund and invested in equities, bonds, and other investment vehicles. The trust fund increases in value and ultimately can be used for OPEB costs, should the trust's investments experience a higher rate of return than the interest costs of the bonds.²¹ This option does not seem to be a preferred option of municipalities, as 70% of municipalities report that they are unlikely to issue OPEB bonds to address their liabilities over the next five years.

Emphasize the use of consumer-directed coverage. Examples of consumer-directed coverage are Health Reimbursement Arrangements (HRA) and Health Savings Accounts (HSA). HRAs allow employers to contribute funds to individual accounts that their employees can use to cover qualifying health expenses. The

employer is the only contributor to the account, decides how much will be deposited into each employee's account, and determines what happens to any remaining balance at the end of the year or when the employee leaves his or her job.²² HSAs allow employees to save before-tax money in an account that can be used to pay for current and future health care expenses. The employer may establish an account and/or make contributions on behalf of their employees as well. These accounts can earn interest, allow funds to be accumulated from year to year, and can be used by employees both while they are working and after they have retired. Although these arrangements provide an avenue to address OPEB underfunding situations, less than 20% of municipalities currently offer these employer-funded medical or employee/retiree-funded health savings accounts.²³

Keep employees healthy and manage chronic disease more effectively. Wellness programs, for example, have been put in place to promote fitness and healthy life styles. The early evidence is that such strategies can work, especially if the programs include incentives and have accountability measures built into them. The more popular preventative medicine and wellness programs currently being provided by local governments include preventive medicine-wellness newsletters / websites (36% of municipalities currently provide); full coverage of retirees' annual physical exams (29% of municipalities currently provide); smoking cessation programs (21% of municipalities currently provide).²⁴

The above are some of a range of options local governments may consider as they look to address their OPEB liabilities. It is not likely that one option over others is a silver bullet for addressing the liabilities many local governments face. It is more likely that a combination of several approaches will be required to fund the retiree health care already earned and to continue to provide a sustainable level of benefits to employees expecting health care when they retire.

CONCLUSION

Local governments are faced with a complex management and financial challenge. They have begun to tally how much the current and future provision of retiree health and other post employment benefits will likely cost. Of those that offer retiree health care, many, if not most governments are likely to find very large obligations, relative to their budgets, that will be difficult to fund. While governments have a variety of options to address their unfunded liabilities, there are no simple or easy answers. Localities continue to use retiree and similar benefits as portions of their overall employee recruitment and retention strategy. Making wise choices about the structure of health care benefits will make it more likely that the public will continue to have competent public administrators in place who can ensure that drinking water is safe, bridges are soundly built and inspected, and there is a rapid and competent response to emergencies.

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NOTES

1. United States Government Accountability Office (GAO). 2007. State and Local Government Retiree Benefits: Current Status of Benefit Structures, Protections, and Fiscal Outlook for Funding Future Costs. Washington, DC.
2. Kearney, Richard and Jerrell Cogburn. 2008. *City/County Government Retiree Health Care Survey*. International City/County Management Association, Center for State and Local Government Excellence, and North Carolina State University. Washington, DC and Raleigh, NC: SLGE. Responses were received from 2,136 out of 8,044 municipalities (cities/counties).
3. Moulder, Evelina R. 2004. Local Government Health Care Plans: Customers, Costs, and Options for the Future. *The Municipal Year Book*. Washington, DC: ICMA; International City/County Management Association. 2006/2007. *Local Government Employee Health Insurance Programs, 2006*. Washington, DC.
4. Moulder, Evelina R. 2004. Local Government Health Care Plans: Customers, Costs, and Options for the Future. *The Municipal Year Book*. Washington, DC: ICMA; International City/County Management Association. 2006/2007. *Local Government Employee Health Insurance Programs, 2006*. Washington, DC.
5. Moulder, Evelina R. 2004. Local Government Health Care Plans: Customers, Costs, and Options for the Future. *The Municipal Year Book*. Washington, DC: ICMA; International City/County Management Association. 2006/2007. *Local Government Employee Health Insurance Programs, 2006*. Washington, DC.
6. United States Department of Health and Human Services. 2005. *National Health Expenditure Projections 2006-2016*. Baltimore, MD.
7. Moulder, Evelina R. 2004. Local Government Health Care Plans: Customers, Costs, and Options for the Future. *The Municipal Year Book*. Washington, DC: ICMA; International City/County Management Association. 2006/2007. *Local Government Employee Health Insurance Programs, 2006*. Washington, DC.
8. Moulder, Evelina R. 2004. Local Government Health Care Plans: Customers, Costs, and Options for the Future. *The Municipal Year Book*. Washington, DC: ICMA; International City/County Management Association. 2006/2007. *Local Government Employee Health Insurance Programs, 2006*. Washington, DC.
9. Governmental Accounting Standards Board (GASB). 2005. Other Postemployment Benefits: A Plain-Language Summary of GASB Statements No. 43 and No. 45. Norwalk, CT.
10. The 2008 *City/County Government Retiree Health Care Survey* found that 61% of local governments paid for all health care costs out of their annual operating budgets while only 16% set aside some or all funds needed to fund future retiree health care costs.
11. Governmental Accounting Standards Board (GASB). 2005. Other Postemployment Benefits: A Plain-Language Summary of GASB Statements No. 43 and No. 45. Norwalk, CT.
12. Moulder, Evelina R. 2004. Local Government Health Care Plans: Customers, Costs, and Options for the Future. *The Municipal Year Book*. Washington, DC: ICMA; International City/County Management Association. 2006/2007. *Local Government Employee Health Insurance Programs, 2006*. Washington, DC.
13. Kearney, Richard and Jerrell Cogburn. 2008. *City/County Government Retiree Health Care Survey*. International City/County Management Association, Center for State and Local Government Excellence, and North Carolina State University. Washington, DC and Raleigh, NC: SLGE. Responses were received from 2,136 out of 8,044 municipalities (cities/counties).
14. Zion, David and Amit Varshney. 2007. *You Dropped a Bomb on Me*, GASB. Credit Suisse.
15. United States Government Accountability Office (GAO). 2007. State and Local Government Retiree Benefits: Current Status of Benefit Structures, Protections,

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| <p>and Fiscal Outlook for Funding Future Costs. Washington, DC.</p> <p>16. Kearney, Richard and Jerrell Coggburn. 2008. <i>City/County Government Retiree Health Care Survey</i>. International City/County Management Association, Center for State and Local Government Excellence, and North Carolina State University. Washington, DC and Raleigh, NC: SLGE. Responses were received from 2,136 out of 8,044 municipalities (cities/counties).</p> <p>17. Brown, Patrice. 2007. <i>Funding Retiree Health Care: The Impact of GASB 43-45</i>. Presented at the 2007 ICMA Annual Conference, Pittsburgh, PA, October 8, 2007. Young, Parry. 2005. Funding OPEB Liabilities: What are your options? <i>Government Finance Review</i>, December 2005.</p> <p>18. Kearney, Richard and Jerrell Coggburn. 2008. <i>City/County Government Retiree Health Care Survey</i>. International City/County Management Association, Center for State and Local Government Excellence, and North Carolina State University. Washington, DC and Raleigh, NC: SLGE.</p> | <p>Responses were received from 2,136 out of 8,044 municipalities (cities/counties).</p> <p>19. United States Government Accountability Office (GAO). 2007. State and Local Government Retiree Benefits: Current Status of Benefit Structures, Protections, and Fiscal Outlook for Funding Future Costs. Washington, DC.</p> <p>20. Kearney, Richard and Jerrell Coggburn. 2008. <i>City/County Government Retiree Health Care Survey</i>. International City/County Management Association, Center for State and Local Government Excellence, and North Carolina State University. Washington, DC and Raleigh, NC: SLGE. Responses were received from 2,136 out of 8,044 municipalities (cities/counties).</p> <p>21. Brown, Patrice. 2007. <i>Funding Retiree Health Care: The Impact of GASB 43-45</i>. Presented at the 2007 ICMA Annual Conference, Pittsburgh, PA, October 8, 2007. Young, Parry. 2005. Funding OPEB Liabilities: What are your options? <i>Government Finance Review</i>, December 2005.</p> <p>22. United States Department of Health and Human Services. 2007. <i>Questions and</i></p> | <p><i>Answers About Health Insurance: A Consumer Guide</i>. Rockville, MD.; Saleem, Haneefa T. 2003. <i>Health Spending Accounts</i>. Washington, DC: United States Department of Labor, Bureau of Labor Statistics.</p> <p>23. Kearney, Richard and Jerrell Coggburn. 2008. <i>City/County Government Retiree Health Care Survey</i>. International City/County Management Association, Center for State and Local Government Excellence, and North Carolina State University. Washington, DC and Raleigh, NC: SLGE. Responses were received from 2,136 out of 8,044 municipalities (cities/counties).</p> <p>24. Kearney, Richard and Jerrell Coggburn. 2008. <i>City/County Government Retiree Health Care Survey</i>. International City/County Management Association, Center for State and Local Government Excellence, and North Carolina State University. Washington, DC and Raleigh, NC: SLGE. Responses were received from 2,136 out of 8,044 municipalities (cities/counties).</p> |
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