Spotlight *on*

Retiree Health Care Benefits for State Employees in 2013

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Most state government employees in the United States have a portion of their compensation deferred until they retire. Types of this compensation typically include annuity payments, more commonly known as defined benefit pension plans. Some public workers also participate in primary or supplemental defined contribution retirement savings plans, and many workers have access to an assortment of other retirement-related benefits, including public employer provided health care.

The term "other post-employment benefits" (OPEB) refers to a range of employer-provided benefits, other than pensions, that are available to public employees once they retire. Usually the largest portion of OPEB benefits is retiree health insurance, which most states provide to retired employees, should the employees meet certain criteria.[1] Although a sizable majority of state workers have access to retiree health insurance,[2] similar to pensions,[3] the two benefit categories differ significantly in regard to their protected status, costs, short and long term financing, and benefits offered.

This brief uses recent data samples to highlight characteristics of health benefits states offer to their retired workforce while exploring how the health benefit differs from pension benefits available to this same group. In addition to these distinctions, this brief considers the underlying OPEB finances, approaches states take to paying for retiree health care, and the range of policy and program changes made to retiree health benefits by states since the recent 18-month recession ended in 2009.[4]

Our review reveals that 1) state government units offering retiree health care benefits have declined in number during the past decade; 2) retiree health care obligations are concentrated in a minority of states; specifically, of all state retiree health care unfunded liabilities, 80 percent are attributable to 12 states; 3) on a per capita basis, retiree health care obligations vary widely among states; and 4) states are utilizing a variety of methods designed to shift a greater portion of the cost of providing retiree health care to employees and retirees.

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[1] Given that the predominant OPEB benefit is retiree health care, this brief will treat the terms "OPEB" and "retiree health care" interchangeably.
[2] Table 42. Health-related benefits: Access, State and local government workers, National Compensation Survey, March 2012. Bureau of Labor Statistics. U.S. Department of Labor. <http://www.bls.gov/ncs/ebs/benefits/2012/ownership/govt/table39a.pdf>
[3] Table 2. Retirement benefits: Access, participation, and take-up rates, State and local government workers, National Compensation Survey, March 2012. Bureau of Labor Statistics. U.S. Department of Labor. <http://www.bls.gov/ncs/ebs/benefits/2012/ownership/govt/table02a.pdf>
[4] Business Cycle Dating Committee. National Bureau of Economic Research. <http://www.nber.org/cycles/sept2010.pdf>

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Overarching Legal Issues

Pensions for state employees are protected, to varying degrees, by state constitutions, statutes, or other edicts.[5] To the extent that health insurance for state retirees has the same standard of protection, it is usually due to being an element of a negotiated labor agreement. Some cities and counties have contractual agreements for medical benefits with their employees, but generally no such statewide guarantees exist.[6] This lesser legal protection means that health insurance benefits can often be modified to a greater degree than pension benefits.

Health Insurance Costs, Overall

The overall U.S. health insurance market saw annual cost increases of about 5 percent between 2008 and 2011.[7] These increases were lower than the four years prior (2004-2007) when yearly cost increases averaged 7.2 percent.[8] Also, in recent years, 2008-2012, consumer prices for medical care have annually increased at a lower rate, 3.4 percent, than they did between 2003 and 2007, when they experienced annual increases of 4.2 percent.[9]

For public employers, health care as a portion of overall employee wage and benefit compensation has increased from 10 percent in 2004 to 12 percent of total compensation in 2012.

For the four years 2008 to 2011, wage and salary earners of all sectors saw their costs for health insurance increase from the previous year by an average of 7.4 percent, relative to average annual increases of 4.8 percent from 2004 to 2007. Retirees of all sectors experienced average annual cost increases of 7.5 percent between 2004 and 2007 and 2.6 percent between 2008 and 2011.[10]

State and local government employers have seen their costs for providing employee health care increase annually by an average of 4.4 percent from 2004 to 2012, with rates increases generally lowering from 8.7 percent in 2005 to 2.4 percent in 2012.[11] These increases are similar to those found for employers of all sectors. Also, for public employers, health care as a portion of overall employee wage and benefit compensation has increased from 10 percent in 2004 to 12 percent of total compensation in 2012 (by comparison, the percentage of wages and salaries as a portion of public employee wage and benefit compensation fell from 69 percent to 65 percent over the same time period).[12]

State Retiree Health Insurance: Provision and Access

Eligibility for a pension benefit in most states is based on age and/or length of service and a minimum amount of creditable service known as a vesting period.

Eligibility requirements for government-provided retiree health insurance are much more diverse and usually more stringent. Some states simply tie eligibility for health insurance to eligibility for a pension benefit. Other states require employees to vest in order to be eligible for health insurance, and some in this category provide benefits on a tiered system calculated based on an employee's length of tenure in the system.[13]

An additional characteristic of state-provided retiree health care is that the benefit is linked to the age of the plan participant, with benefit levels typically changing once a retiree reaches the age of eligibility for Medicare (currently age 65). While pension benefits generally provide a guaranteed, level benefit for an individual's entire retirement, state-provided retiree health benefits usually become secondary to Medicare, once the retiree has reached the age of eligibility for the program.

Eligibility and access to retiree health care differ significantly from that of pensions due to the differences in legal protections discussed earlier.

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[5] Klausner, Robert D. State Constitutional Protections for Public Sector Retirement Benefits. Presented at the 2013 NASRA NCTR Joint Legislative Conference, February 25, 2013, Washington, D.C.

[6] Klausner, Robert D. State and Local Government Retirement Law: A Guide for Lawyers, Trustees and Plan Administrators 2012 ed. Thomson West; pg 488.

[7] Table 3 National Health Expenditures; Levels and Annual Percent Change, by Source of Funds: Selected Calendar Years 1960-2011. Centers for Medicare & Medicaid Services. U.S. Department of Health & Human Services. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf>

[8] Ibid.

[9] Author calculations of: Bureau of Labor Statistics. U.S. Department of Labor. Consumer Price Indexes (All Urban Consumers). <http://www.bls.gov/cpi/home.htm>

[10] Author calculations of: Bureau of Labor Statistics. U.S. Department of Labor. Consumer Expenditure Survey. <http://www.bls.gov/cex/>

[11] Author calculations of: Bureau of Labor Statistics. U.S. Department of Labor. Employer Cost for Employee Compensation. <http://www.bls.gov/data/#wages>

[12] Ibid.

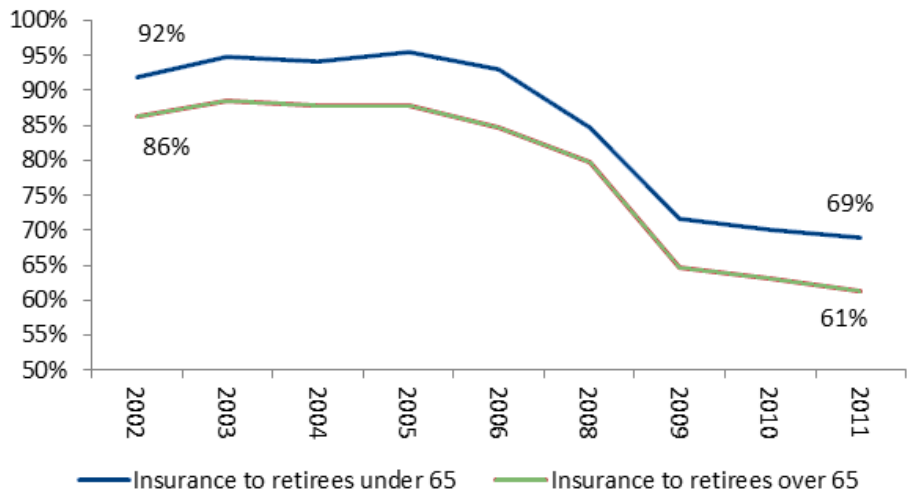
[13] Kearney, C., et al. At a Crossroads: The Financing and Future of Health Benefits for State and Local Government Retirees. Center for State and Local Government Excellence. <http://slge.org/wp-content/uploads/2011/12/At_a_Crossroads.pdf>

As can be seen in Figure 1, 2006 marked the beginning of a recent shift in state government units[14] offering health care to retirees, both under and over the age of 65.

Between 2002 and 2006, the percentage of state government units offering health care to retirees under age 65 ranged between 92 percent in 2002 and 96 percent in 2005; but in recent years (2011) the rate dipped to 69 percent.

For retirees over 65, the percentage of state government units offering health care was between 86 percent in 2002 and 88 percent in 2005, dipping to 61 percent in 2011.[15]

Figure 1: Percent of State Government Units Offering Insurance to Retirees (Medical Expenditure Panel Survey – US HHS)



Meanwhile, the level of access to health insurance for retirees of all ages has remained relatively stable and, in fact, has actually increased. In 2009,[16] 82 percent of 82 percent of state workers had access to retiree health benefits before turning 65, with 79 percent having access when they were 65 or older. In 2012,[17] the percentages were 86 percent and 83 percent, respectively.

State Retiree Health Insurance: Finances

Unlike retiree health care, pensions for state employees are generally financed in a manner similar to one another, with little variation among states. Retirement systems collect contributions from both employees and employers, which are invested to grow the fund, pay the plan's administrative costs, and provide formulaic benefits for the remaining life of an individual retiree or their survivor.

Retiree health insurance coverage varies significantly in financing from state-to-state and calculations of benefits are not typically formulaic like they are for pensions. Many states fund retiree health benefits on a pay-as-you-go basis, meaning benefits are paid from the annual operating budget. Other states choose to prefund benefits, setting up trusts or other fiscal arrangements for retiree health care whose assets may be invested and grown to pay future benefits.[18] The number of states setting assets aside has grown in recent years, as has the overall value of retiree health care assets themselves.

In a review of state-administered OPEB plan finances reported between 2009-2011, 18 states had set aside assets to prefund retiree health benefits. In a similar review of finances reported between 2011-2012, the number of states that had set aside assets grew to 25.[19]

State government retirees receiving health care coverage often contribute towards the cost of their benefits. In most cases, beneficiaries are responsible for paying a portion of plan premiums, making copayments for medical services, and

[14] "sample is drawn at the governmental unit level, which is defined as all sites under a single controlling governmental entity:" Quote comes from MEPS-IC Sample Size web page. <http://meps.ahrq.gov/mepsweb/survey_comp/ic_sample_size.jsp>
[15] From Medical Expenditure Panel Survey. Agency for Healthcare Research and Quality. U.S. Department of Health & Human Services. <http://meps.ahrq.gov/mepsweb/data_stats/MEPSnetIC.jsp>
[16] Table 37. Health-related benefits: Access, State and local government workers, National Compensation Survey, March 2009. Bureau of Labor Statistics. U.S. Department of Labor. <http://www.bls.gov/ncs/ebs/benefits/2009/ownership/govt/table39a.pdf>
[17] Table 42. Health-related benefits: Access, State and local government workers, National Compensation Survey, March 2012. Bureau of Labor Statistics. U.S. Department of Labor. <http://www.bls.gov/ncs/ebs/benefits/2012/ownership/govt/table39a.pdf>
[18] Kearney, C., et al. At a Crossroads: The Financing and Future of Health Benefits for State and Local Government Retirees. Center for State and Local Government Excellence. <http://slge.org/wp-content/uploads/2011/12/At_a_Crossroads.pdf>
[19] 2009-2011 data was collected from state comprehensive annual financial reports for use in the article "Understanding Finances and Changes in Retiree Health Care" by Franzel and Brown (published by the Government Finance Review, 2012)." Data reported in this article was collected in early 2013 following the same data collection methodology as an update.

paying a deductible. Similar to pension benefits, which often require employee contributions to the pension system during service years, some states are requiring individuals employed by a state government to make contributions towards their health benefits as periodic in-service payroll deductions.[20]

Previous reports have offered and discussed unfunded liabilities, annual required contributions (ARC), and other measures, collected from state comprehensive annual financial reports (CAFR), associated with state retiree healthcare programs, both in the aggregate and by individual state.[21]

Table 1 offers recent data on liabilities for retiree health care by state. There is wide variation in unfunded liabilities across the states. "The substantial variation in unfunded liabilities is a function of the size of the state workforce, the generosity of the retiree health plan, the portion of the total cost of the health program paid for by the state, and what type of employees are included in the plan."[22] In the aggregate, unfunded liabilities for the states is about $425 billion, or approximately 2.7 percent of combined state GDP.[23]

Using the data provided in Table 1 we can draw some conclusions about the range among states with regard to OPEB liabilities. Figure 2 breaks out OPEB liability by state and shows some of the variation in total liabilities carried. In fact, the data show that a large portion of overall OPEB obligations are held by a handful of states. The median state OPEB liability is $2.1 billion. Values above the median represent approximately 96 percent of all state OPEB liability, with values below the median representing approximately 4 percent of the total.[24]

Table 1: Retiree health care liabilities by state, 2010-2012[25]

State	Unfunded Liabilities (millions)	Unfunded Actuarial Accrued Liability - Per Capita[26]	Date of Report	State	Unfunded Liabilities (millions)	Unfunded Actuarial Accrued Liability - Per Capita	Date of Report
AL	$3,261	$676	2012	MT	$337	$335	2012
AK	$4,039	$5,522	2012	NE*	$0	$0	2012
AZ	$257	$39	2012	NV	$947	$343	2011
AR	$1,953	$662	2012	NH	$2,258	$1,710	2012
CA	$63,840	$1,678	2012	NJ	$18,078	$2,039	2012
CO	$1,429	$275	2011	NM	$3,347	$1,605	2011
CT	$17,905	$4,987	2012	NY	$59,668	$3,049	2012
DE	$5,641	$6,151	2012	NC	$29,610	$3,036	2012
FL	$4,903	$254	2012	ND	$54	$77	2012
GA	$4,312	$435	2012	OH	$18,211	$1,577	2011
HI	$11,706	$8,408	2012	OK	$359	$94	2008**
ID	$24	$15	2012	OR	$161	$41	2011
IL	$33,295	$2,586	2011	PA	$12,907	$1,011	2012
IN	$(7)	$(1)	2012	RI	$775	$738	2012
IA	$378	$123	2012	SC	$9,145	$1,936	2011
KS	$283	$98	2012	SD	$66	$79	2012
KY	$2,679	$612	2012	TN	$1,476	$229	2012
LA	$4,862	$1,057	2012	TX	$20,823	$799	2012
ME	$1,180	$888	2012	UT	$375	$131	2012
MD	$9,371	$1,592	2012	VT	$998	$1,594	2012
MA	$16,299	$2,452	2012	VA	$1,849	$226	2012
MI	$14,251	$1,442	2012	WA	$3,492	$506	2012
MN	$799	$149	2012	WV	$6,987	$3,766	2011
MS	$665	$223	2012	WI	$953	$166	2012
MO	$1,511	$251	2012	WY	$219	$380	2012

*Note: NE carries an OPEB liability that is described as immaterial for purposes of reporting [27]

**2008 is the latest year that published data is available for Oklahoma OPEB liabilities[28]

[20] National Conference of State Legislatures researchers tracking changes to public employee retirement benefits have noted that certain states have passed recent legislation requiring some employee groups to begin making contributions, while employed, to offset the costs of health care for retirees (see NCSL Enacted State Pension Legislation, http://www.ncsl.org/issues-research/labor/pension-and-retirement-legislative-summaries-and-r.aspx).

[21] See: Clark and Morrill - The Crisis in State and Local Government Retiree Health Benefit Plans: Myths and Realities (published by the Center for State and Local Government Excellence, 2009); Prunty - U.S. States' OPEB Liabilities and Funding Strategies Vary Widely (published by Standard & Poors, 2009); The Widening Gap: The Great Recession's Impact on State Pension and Retiree Health Care Costs (published by Pew Center on the States, 2011); Franzel and Brown - Understanding Finances and Changes in Retiree Health Care (published by the Government Finance Review, 2012).

[22] Clark, R and M. Morrill. The Crisis in State and Local Government Retiree Health Benefit Plans: Myths and Realities. Center for State and Local Government Excellence; pg. 5. < http://slge.org/wp-content/uploads/2012/01/NC-State-Brief1-UPDATED_The-Crisis_Nov-09.pdf>

[23] Author calculations using latest available state GDP data from the U.S. Bureau of Economic Analysis. <http://www.bea.gov/iTable/iTable.cfm?ReqID=99&step=1#reqid=99&step=4&isuri=1&9901=1200&9902=1&9903=200&9990=99>

[24] Author calculations using data provided in Table 1.

[25] The data offered in this table reflects the most recent comprehensive annual financial report OPEB figures available at the time this piece was drafted. For most of the states, the amounts offered are associated with the retiree health care of general state employees (the focus of this brief). Some states offer amounts that may include other state employees. To compile the data of this table the authors used the data collection methodology previously used by R. Clark and M. Morrill of NCSU (see: 'The Crisis in State and Local Government Retiree Health Benefit Plans: Myths and Realities', Center for State and Local Government Excellence, 2009) and later used during for the research and writing of *'Understanding Finances and Changes in Retiree Health Care,'* Government Finance Review, 2012 by J. Franzel and A. Brown.

[26] Per capita calculations use 2012 population estimates from the U.S. Census Bureau. <http://quickfacts.census.gov/qfd/index.html>

[27] Standard & Poor's, "U.S. States' OPEB Liabilities and Funding Strategies Vary Widely," June 3, 2009. <http://www.naic.org/documents/committees_e_rating_agency_101118_hearing_doc4.pdf>

[28] There is no separate OPEB trust for retirees in Oklahoma; the assets of the health plans for active employees and retirees are combined.

Another way to compare OPEB liability by state is to compare the relative size of liabilities by measuring them on a per capita basis. When population is factored in, as it is in Figure 3, we find that the chart reinforces the data presented in Figure 2. The values above the $1,000 per capita indicator represent 51 percent of the population, with 49 percent residing below the $1,000 line.[29]

Figure 2: UAAL By State[30]

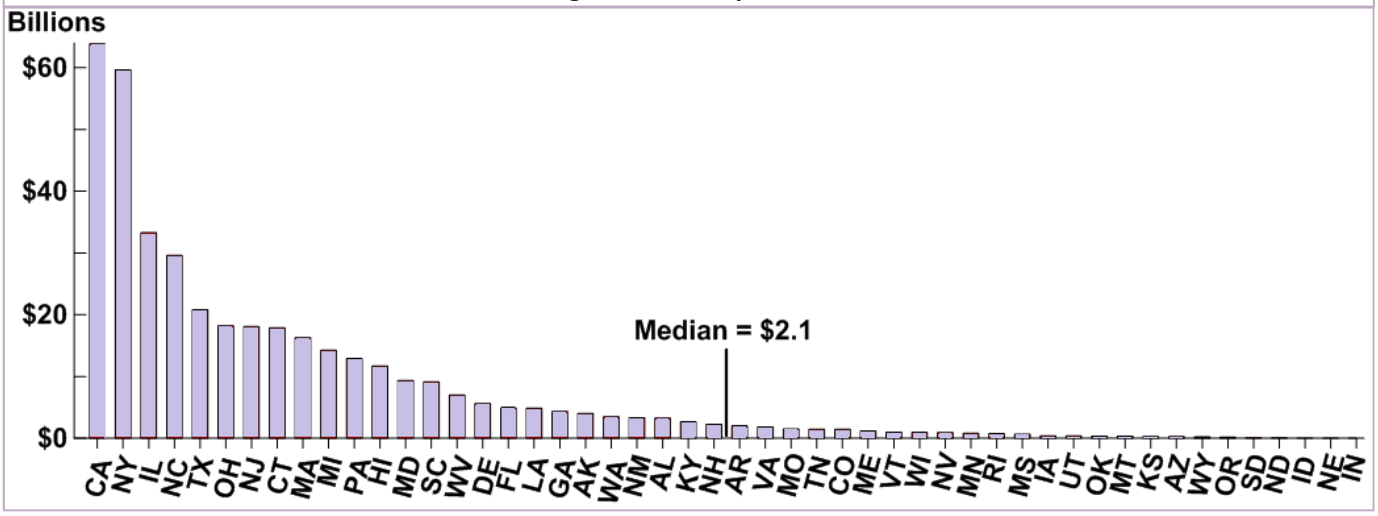
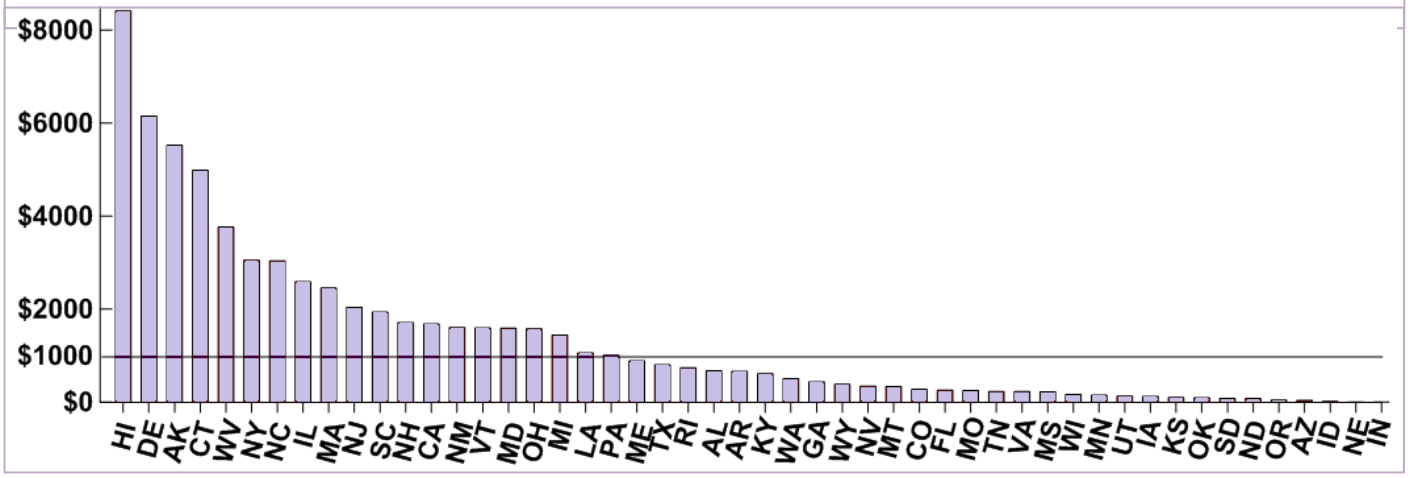


Figure 3: UAAL Per Capita By State[30]



[29] Author calculations using data provided in Table 1.

[30] For a 2006-2008 data chart see Kearney, C., et al. At a Crossroads: The Financing and Future of Health Benefits for State and Local Government Retirees. Center for State and Local Government Excellence. <http://slge.org/wp-content/uploads/2011/12/At_a_Crossroads.pdf>

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State Governments Making Changes to Retiree Health Care Coverage

Given overall continued increases in health insurance costs, liabilities (Table 1) related to the past and current offering of retiree health insurance by state governments, and improving, yet still vulnerable, underlying state revenues,[31] changes have and continue to be made to retiree health insurance benefits.

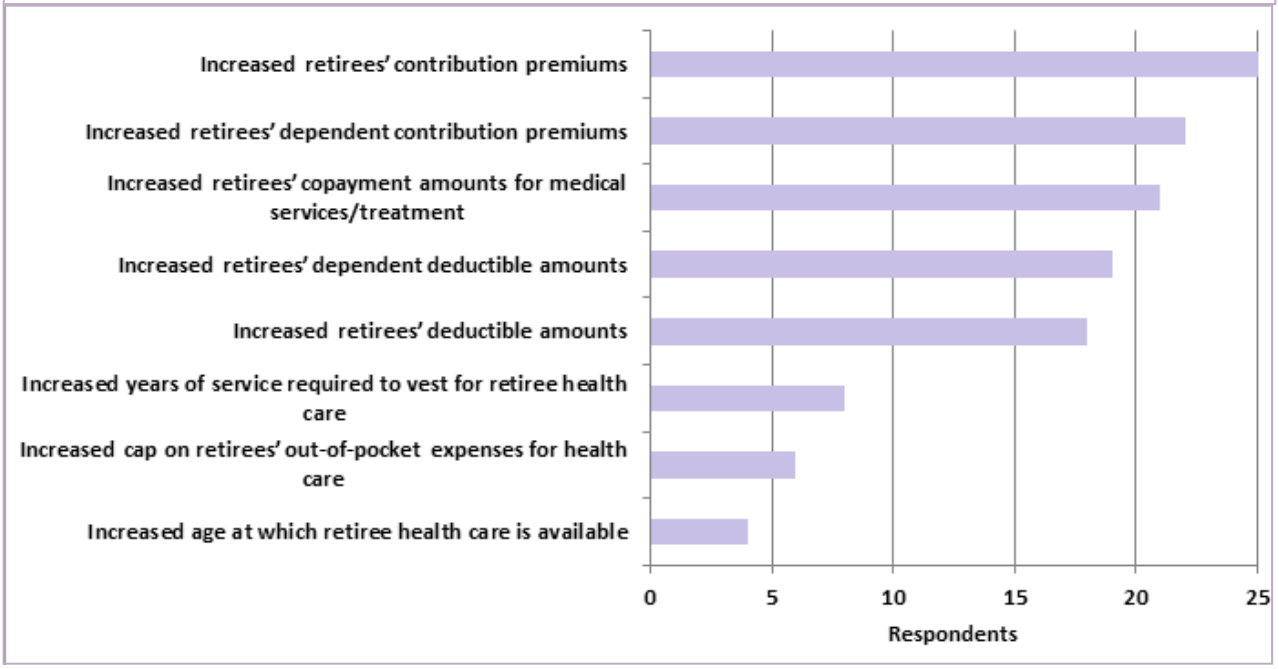
Since 2011,[32] the Center for State and Local Government Excellence, National Association of State Personnel Executives, and International Public Management Association for Human Resources have surveyed state and local human resource executives across the United States asking about a range of topics related to the public workforce, including changes to retiree health care coverage.[33]

In 2011, 65 percent of state government respondents reported that over the past year, their government had made changes to the health benefits offered to employees and retirees. In 2012, 61 percent, and in 2013, 66 percent, of state respondents indicated that their governments had made such changes.

More specifically, in 2011, 31 percent of state government respondents answered that more health care costs were shifted from the employer to retirees in the form of higher premiums, copayments, and/or deductibles, among other approaches. Since 2011, fewer respondents have noted this type of change: 12 percent in 2012 and 13 percent in 2013.

A 2013 National Association of State Retirement Administrators (NASRA) survey[34] provides a further breakdown of the types of changes to retiree health care being pursued by state governments. According to the survey findings (see Figure 4), altering the cost-sharing arrangement by increasing premiums or deductible amounts for beneficiaries and/or their dependents, and increasing copayment amounts have been the most common methods of reform.[35] Other changes implemented by some states include increasing the age of eligibility and/or years of service required to vest in the health care plan, and increasing the cap on retirees' out-of-pocket expenses.

Figure 4: Changes made to retiree health benefits in the past five years



[31] The Fiscal Survey of States. National Governors Association and National Association of State Budget Officers. <http://www.nasbo.org/sites/default/files/Fall percent202012 percent20Fiscal percent20Survey.pdf>

[32] 2011 was the first year the three organizations included questions about retiree health care. SLGE, NASPE, IPMA-HR. State and Local Government Workforce: 2011 Realities. <http://slge.org/wp-content/uploads/2011/12/S-L-Govt-Workforce_2011-Realities_11-220.pdf>; SLGE, NASPE, IPMA-HR. State and Local Government Workforce: 2012 Trends. <http://slge.org/wp-content/uploads/2012/04/S-L-Govt-Workforce-2012_12-195_web.pdf>; SLGE, IPMA-HR. State and Local Government Workforce: 2013 Trends. <http://slge.org/wp-content/uploads/2013/05/Workforce-Trends-2013_13-3541.pdf>

[33] Note the 2013 survey was administered by SLGE and IPMA-HR.

[34] The survey was conducted in March 2013, with questions sent to 51 directors (50 states and one university system) of public employee retirement systems whose members are primarily employees of state government. The questions were based on an earlier surveys conducted by The Center for State and Local Government Excellence (City/County Government Retiree Health Care Survey, 2008) and International City/County Management Association (Local Government Employee Health Insurance Programs, 2011); 38 responses were received from 37 states.

[35] Respondents were allowed to cite more than one change made to their retiree health care benefit.

Conclusion

Pensions and retiree health care differ in the way they are financed and the benefits provided. Where they share similarities is in the unprecedented levels of attention both are receiving from policymakers, media, and the general public, and the changes that are being implemented to manage and lessen their costs.

As discussions continue and proposed policy and program changes are advanced it is important to recognize the unique ways in which these two different benefits are structured, financed, and administered.

The data points identified in this brief show that health benefits for public retirees are being offered by fewer state government units with participating retired public employees likely receiving less and/or paying a larger portion of the cost of the benefit. These two trends will likely continue to change the landscape of state employee retiree health care moving forward.

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