

Post-Employment Health Benefits in Public Schools and Colleges

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Many employees of California's schools and colleges have been willing to accept lower salaries during their working lives in exchange for the benefit of health insurance coverage in retirement. They paid for their retiree health benefits while working and expect the promise of healthcare coverage to be kept.

Now some are calling for a rejection of these contracted rights to post employment health coverage. These opponents of public employee benefits point to long-term actuarial reports showing huge "unfunded" obligations. While it is true that public schools and college districts are currently facing health care cost increases that are well above the rate of increase of the Consumer Price Index, the changes in the cost of post-retirement benefits represent a very small and easily manageable portion of district costs.

Some of these districts are moving to eliminate or reduce health care coverage to their current employees and to their retirees. One of the major drivers of the movement to deny employees of their hard-won health benefits is the newly established Governmental Accounting Standards Board 45 (GASB 45) reporting standard. **GASB-like standards are likely to increase the pressure to eliminate, for new employees, whatever retiree health care is left for current employees and retirees. If this is not the planned result, it certainly has acted as though it is In any case, GASB 45 has become an integral part of the attack on worker safety nets. Actuarial results are also being used by management to deflate faculty and staff salary and benefit increases.**

GASB - Not a Governmental Agency

The first thing one should understand about the Governmental Accounting Standards Board (GASB) is that it is not a federal agency. It has no ability to enforce its requirements on public employers. GASB is an independent, private-sector organization that provides national, state, and local governments with a view of what GASB believes should be considered as accepted accounting principles. It does not answer to either state or federal government. The self-stated goal of GASB is to help taxpayers and government officials determine the ability of their level of government to financially provide services and repay its debt. GASB believes, in its own words, that it is an *"independent body free from inappropriate political pressure or commercial influence"* and that it brings *"objectivity and integrity to the process of issuing neutral, unbiased accounting and financial reporting standards that are relevant in the government environment."* (www.gasb.org). There is no evidence to suggest that the claim of neutrality, unbiased accounting, or relevance is valid or invalid.

Even though GASB does not have enforcement authority, its standards do become part of what are called "generally accepted accounting principles." The Code of Professional Conduct of the American Institute of Certified Public Accountants requires that auditors follow the standards adopted by GASB. Audits will likely include information regarding compliance with the GASB standards.

Prior to GASB 45, public employers were only required to report the annual amount that they actually paid for benefits for current retirees. Most districts still pay their post-retirement benefits as they are due and have done so, without any problems, for many years. According to a report issued by Labor

Research Partners in 2005, 41 of the 72 California Community College Districts operated on the pay-as-you-go option. Many have had an actuarial study done. Thirteen districts reported that they have little or no liability. (The measuring period for revenue for this purpose is the first fiscal year ending after June 15, 1999).

Beginning in 2007-08, GASB 45 calls on public agencies to publicly provide periodic actuarial reports that disclose any long term retiree healthcare liabilities. Public agencies will be required to report on the cost of future benefits that current employees earn during the fiscal year as well as the value of benefits earned in prior academic years. Except for the cost of the accounting, no new costs for benefit coverage are created by GASB 45. The only new costs for benefit coverage would occur if an employer decided to put money aside in order to fund the long-term (30 year) liability in addition to its current pay-as-you-go obligations. These new set-aside costs could become a much bigger problem than any ongoing expense of benefits.

Shock and Awe

As public agencies began to follow the GASB 45 reporting guidelines they found that they have, at first glance, horrific obligations. The Los Angeles Community College District was quoted an Actuarial Accrued Liability of \$623.2 million. Currently the district is spending about \$26 million per year in retiree medical costs. The Los Angeles Unified School District had an estimated liability of \$4.9 billion. Currently the LAUSD spends approximately \$177 million per year for retiree health benefits. As one can easily see, the "unfunded liability" dwarfs the actual pay-as-you go cost.

Actuarial Projections

It must be noted that actuarial projections on retiree health benefit costs are highly speculative, especially over a thirty-year period of time. Very slight changes in the assumptions related to costs and return on investment result in huge differences in the level of projected liability. The factors that actuaries use to make their projected liability estimates (such as the predicted rate of return on investments, health care costs and the demographic makeup of the employees and retirees) can not be accurate over a thirty year span. Because of the speculative nature of assumptions, a good actuary should be asked to provide both a best-case and a worst-case scenario.

Los Angeles Community College Experience

Like most districts, the LACCD has been paying for their retiree health care on a "pay-as-you-go basis" (paying only the amount of actual benefit costs for retirees in any given year). The Los Angeles Community College District has had retiree health benefits for more than 30 years and has been operating on "pay-as-you go" system all of this time without any major problem. The percentage of General Fund Appropriations spent on benefits in 1989-90 was 18.1%. Since that time the percentage has varied from a low of 15.2% in 2001-02 to a high of 21.9% in 2003-04. Most fiscal years it has been in the 19% range. **It is clear that the percentage of expenditures on benefits compared to the total appropriation has not increased greatly over the period covered.** The increase in benefit costs is a problem, but not a disaster for districts - nor will it be in future years.

Pay-As-You-Go Comparison

The LACCD GASB 45 valuation report, prepared by Demsey, Filliger & Associates, LLC as of July 1, 2005, contained the following comparison of the cost of continuing to fund the retiree health benefits of current employees using a pay-as-you-go and several other methods (a level contribution for the next 20 years, a level percentage of the unfunded accrued liability, and a level percentage of payroll for the next 20 years). Note that for 2005, GASB would require a payment of almost \$55 million while pay as you go would only require about \$26 million. I have found that the doubling of cost by moving from pay-as-you-go is a common result.

It is important to note that even after ten years; the amount the LACCD would have to pay for the benefits of retirees is less than the amount required by GASB 45 in 2005. Meanwhile, all of the excess funding would have been available to provide service to students or salary increases to employees.

LACCD

	Pay as You Go	Level Contributed	Level % of Unfunded Liability	Level % Of Payroll	Annual Required By GASB 45
2005	\$25,969,881	\$65,460,000	\$56,446,082	\$51,099,000	\$54,989,936
2006	\$28,921,655	\$65,460,000	\$55,340,904	\$52,631,970	N/A
2007	\$31,507,093	\$65,460,000	\$54,328,776	\$54,210,929	N/A
2008	\$33,892,132	\$65,460,000	\$53,394,546	\$55,837,257	N/A
2009	\$36,108,400	\$65,460,000	\$52,526,490	\$57,512,375	N/A
2010	\$38,185,158	\$65,460,000	\$51,714,229	\$59,237,746	N/A
2011	\$39,860,247	\$65,460,000	\$50,948,524	\$61,014,878	N/A
2012	\$41,215,022	\$65,460,000	\$50,218,859	\$62,845,325	N/A
2013	\$42,519,060	\$65,460,000	\$49,517,075	\$64,730,684	N/A
2014	\$43,819,415	\$65,460,000	\$48,838,115	\$66,672,605	N/A
Total	\$361,998,063	\$654,600,000	\$523,273,600	\$585,792,769	

Increase over Pay-as-you go

\$292,601,937 \$161,275,537 \$223,794,706

Many pundits believe that the current pay-as-you-go method of paying retiree health benefits will lead to major problems in upcoming years as the mounting liability begins to come due. The fact that this has not occurred yet in districts (like the Los Angeles Community College District and the Los Angeles Unified School District) that have had such a benefit for more than thirty years seems to have had little effect on reducing any fears that they might have concerning the impropriety of using the pay-as-you go methodology. The probable emergence of a single-payer universal health care system (which would relieve districts of their retiree health care responsibilities since such a health care system would be responsible for the health care costs of retirees) in California or the United States over the next twenty years also has little impact on their fears.

Standards' Effect on Benefits

The large relative cost (as opposed to pay-as-you-go) of pre-funding retiree health benefits in the private sector has clearly led many private companies to abandon the welfare of their employees. The threat of future unsustainable liabilities is playing a part in the effort to eliminate defined benefit retiree health plans. As a result of a GASB-like requirement adopted by the Financial Accounting Standards Board (FASB) in the private sector, the Employee Benefit Research Institute (EBRI) found that *"some employers placed caps on what they were willing to spend on retiree health benefits. Some added age and service requirements, while others moved to some type of 'defined contribution' health benefit. Some completely dropped retiree health plans for future retirees."* (EBRI Issue Brief Number 236, August 2001). The Kaiser Foundation released a report (The State of Retiree Health Benefits: Historical Trends and Future Uncertainties, May 17, 2004) at a United States Senate Special Committee on Aging Hearing that found that *"In response to these cost increases and changes adopted in the early 1990s by the Financial Accounting Standards Board (FASB) that requires firms to account for their future retiree health obligations, employers have implemented a number of strategies to curb these costs. Of note, our survey found that roughly half of all large (1,000 + workers) private-sector employers that offer retiree health benefits to 65+ retirees have imposed caps on their future obligations, nearly half already hit the cap, and another third say they are likely to hit the cap in the next three years."*

Public agencies also have begun to cut back on retiree health care benefits. Not much has been said concerning whether GASB 45 makes sense for public agencies. Public institutions are very different from private companies because they do not go out of business. They have a regular stream of guaranteed income and huge assets in land and buildings. The need for public agencies to protect workers' benefits into retirement is different from that of private employers' since the income of the public institutions will continue. If a public institution ceases to exist, the assets can be sold off to pay for the ongoing health care requirements in a way that may not be available to a private sector business.

Drivers of Increased Health Care Costs

In the discussion revolving around GASB 45, not much emphasis has been placed on the real underlying reasons for the increased cost of health care. The *California Health Care Coalition* (CHCC) is one of several groups compiling data on the causes of high premium costs. The data that they have collected demonstrates the strong relationship between skyrocketing health costs, badly practiced medicine and hospital bills. The CHCC is active in adopting common standards for provider participation, collaborating with CalPERS and other purchasers to build local purchasing coalitions, negotiating collectively with providers, educating the public, and studying hospital and other costs in targeted areas of California. In the words of the CHCC: *"Three premises underlie our strategy. First, shifting health care costs to the users of care will do little to address the basic 'supply-side' problems of excessive charges and poor quality care. Second, health plans alone are unable to assure quality and stabilize costs. Third, the industry has consolidated and so must purchasers. We cannot be an effective force for health reform without first organizing ourselves in the healthcare marketplace."*

Research by the CHCC and the *California Education Committee for Health Care Reform* has made clear that the increased cost has come from the supply side, not the demand side of the equation. The usual explanations for increased costs (an aging population, the high cost of new technology, the

provider costs driven by trial lawyers, the development cost of new wonder drugs, and the irresponsible consumer) have not been found to be the dominant drivers of the inflation in medical insurance premiums.

In fact, although some industry-paid analysts say that health care costs are rising due to aging, technology, increased utilization, and increases in such diseases as diabetes, the major cost increase driver of the health care cost increases has been found to be on the supply side of the systems (the providers of health care) through a combination of excessive prices (and profits), pervasive medical error and quality deficiencies. High prices and high administrative costs are the critical causes of the substantial increases in health care spending that most districts have experienced. The often hidden truth is that the United States has the highest per-capita health care cost in the world but provides only a minimum of service and quality to those who can afford to participate. See "High Prices, Questionable Quality: A Program to Put Patients First in California Hospitals", The California Health Care Coalition, April 2005, for documentation on the drivers of cost. Also see "The Health Benefit Equation: A Joint Labor/Management Solution" by Ruben Ingram and Cindy Young in the August 2006 issue of the *California Public Employee Relations Journal*.

Poor care is also a major driver of cost. Various studies presented to the *Education Committee for Health Care Reform* by John J. Glynn and Alfredo Czerwinski, MD ("Benchmarks for Cost and Quality," September 12, 2006) and others using data from a RAND study JAMA 2003 and other sources, demonstrated that best medical practices are used only 50% of the time. 80% of diabetes patients are receiving the wrong treatment. 75% of coronary artery bypass graft surgeries are not effective and do not increase longevity. Quality experts have reported that between 20 and 30 percent of health care spending is attributable to poor quality care.

Health Plan Failures

The major health plans and insurance carriers have failed to address costly failures of the delivery system. Instead, they pass on rising costs to their customers, rationalizing increases by claiming that prices are up, utilization is up, and the users of health care are at fault because they don't take adequate care of themselves. At the same time, these health plans and insurance carriers keep secret the prices they negotiate with providers and are silent about their own failure to monitor and correct for physician-driven overuse of inappropriate services, pervasive provider failure to follow professional treatment standards, inefficient resource use, and high medical error rates.

No Hasty Decisions

Leaving the pay-as-you-go method of funding and adopting a more expansive method will deprive students of classes and employees of wage increases. I don't believe that it is fiscally responsible, at this time, to move away from pay-as-you-go into another way of funding retiree benefits. In any case, we don't need to make any hasty decisions. Even the worst doom-and-gloomers agree that any problems will not occur in the near future. Most experts agree the accrued liability is not, in the short run, a real debt. Others point out that any problems that may occur will not occur in the next five years but more likely over a 30 year span.

The first step that public agencies should be taking, rather than rushing into prefunding or eliminating retiree health care, is to address the real reasons for increasing costs. They should join *Health Access*

California, the *California Health Care Coalition*, and the *California Education Committee for Health Care Reform* in order to increase the influence of these organizations. Until purchasers organize to demand delivery system reform and performance accountability from health plans and providers alike, the problems with our health delivery system will continue and the cost pressures on public sector employers, unions, and workers will grow.

Public agencies should be spending more time on fixing the provider problems by identifying the best hospital for each type of treatment and informing or encouraging patients to go there, encouraging preventive primary care, and developing locally based coalitions (like those being formed under the umbrella of the *California Health Care Coalition*) to get the information needed to bargain effectively. Public agencies should also require doctors to write prescriptions through a computer system that checks for negatives and correct dosage.

Conclusion

Public agencies should take the time necessary to study the scope of any real problems posed by continuing their pay-as-you go coverage of retiree health benefits and should not be driven to rush precipitously to "solutions" which in the long run harm everyone: students employees, and retirees alike.