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State Government Retiree Health Benefits: Current Status and Potential Impact of New Accounting Standards

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The AARP Public Policy Institute, formed in 1985, is part of the Policy and Strategy group at AARP. One of the missions of the Institute is to foster research and analysis on public issues of importance to older Americans. This publication represents part of that effort. The views expressed herein are for information, debate, and discussion, and do not necessarily represent formal policies of AARP.

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Foreword

The likelihood that an employer offers retiree health benefits varies by size of employer, region, and industry. State and local governments continue to offer retirees health coverage at a higher rate than any other industry. While there are some common factors that influence health benefit decisions of employers in both the public and private sectors, there are also factors that distinguish public and private sector employers.

One such distinction is that state and local governments follow accounting standards for financial reporting different from those followed by private companies. State and local governments follow standards set out by the Governmental Accounting Standards Board (GASB), whereas private companies follow those of the Financial Accounting Standards Board (FASB). In the early 1990s, FASB implemented accounting standards for retiree health benefits that changed how a company's costs for retiree health benefits have to be reported. The standards required a change from reporting the expense of retiree health benefits on the basis of the cost of benefits in the period in which they are paid to reporting the cost of benefits as they are earned, which involves estimating and accruing both the future cost of these commitments and current spending for these commitments. This change has been widely cited as one factor, along with rising cost of these benefits, that has led companies to revise their retiree health benefit programs. Although GASB did not implement similar standards at the same time, it is now issuing new standards for state and local governments to report the costs of their Other Postemployment Benefits (OPEB), i.e., benefits other than pensions. The new standards raise the question of how their implementation will affect retiree health benefits in the future.

The AARP Public Policy Institute commissioned Workplace Economics, Inc. to conduct this research on retiree health benefits in state governments. In addition to providing a snapshot of state government retiree health benefits under existing accounting rules, the report gives an overview of current accounting practices for these benefits and of the changes that the new standards require. Based on this information, the report discusses potential issues that the new standards may raise for governments, taxpayers, and retirees. For example, reports based on the new accounting standards will make information on the long-term costs of retiree health benefits to state and local governments more readily available. Such information may focus attention on the challenge of honoring past and future commitments for retiree health benefits.

We hope this report will help inform debates that implementation of the new GASB standards may stimulate.

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Executive Summary

Purpose

The Governmental Accounting Standards Board (GASB) issued an Exposure Draft[1] early in 2003, and a revision to the draft in early 2004, detailing proposed new accounting standards for state and local government retiree health care and other non-pension benefits. The Board adopted Statement No. 43, *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans,* in May 2004 and a related Statement, *Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions,* in June 2004. The earliest these will go into effect is for fiscal years starting in December 2006. To the extent that the new GASB standards require changes in assumptions or methods currently used by public sector entities to account for and report the costs of retiree health care, decision-makers' consideration of the more comprehensive information developed may result in changes in behavior and practices by both providers and users of retiree health benefits. To assess the potential impact of the new GASB standards on public policy, this paper examines retiree health care benefits currently provided in state government employment by the 50 states excluding the District of Columbia and practices employed by state governments to account for and finance their retiree health benefit obligations. The results can be used as a baseline against which to gauge the implications of the changes in accounting standards.

Background

Current practices used by state governments to account for and report their retiree health benefit obligations diverge from private sector practice and are shaped by existing accounting standards such as GASB 12, 25, 26, and 27. The new standards for governmental employer reporting of OPEB are broadly similar to standards applicable to the private sector issued by the Financial Accounting Standards Board (FASB) in 1990; they understand that OPEB is deferred compensation and their objective is to achieve accrual of benefit costs and liabilities during periods when employees render services. However, the new GASB standards are modeled after previous GASB standards on employers' reporting of pension benefits and include differences from FASB requirements designed to address the accounting and reporting practices of the public sector. For many states, the new OPEB standards will require accrual accounting for such benefits for the first time.

Methodology

To provide a current snapshot of health benefits for retired employees, Workplace Economics, Inc. analyzed information in its proprietary database on benefits provided to state government employees in all 50 states (the District of Columbia is not part of the state government database). To provide the overview of current state financial reporting practices, Workplace Economics analyzed state governments' annual financial reports.

[1] Standards for "Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions" and "Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans" can be ordered from GASB at its internet website (www.gasb.org).

Findings

1. Many states play a substantial role in the provision of retiree health benefits. Current retiree health care programs available to state government retirees vary significantly by key plan characteristics such as number and type of plans offered; premium costs; cost-sharing features such as copayments, coinsurance, and deductibles; and prescription drug plan features. For example, total monthly premiums for individual coverage for pre-Medicare retirees range from $159.92 for the lowest-cost plan offering available among the 50 states to $925.42 for the highest-cost plan offered in any state. For Medicare-eligible retirees, total monthly premiums for single coverage range from $46.40 for the lowest-cost available plan to $448.52 for the highest-cost plan offered in any state.

2. State financial statement reports provide some insight into the dimensions of retiree health insurance programs and their aggregate cost. Significantly, 41 states report providing some contribution towards defraying the cost of state retiree health insurance through programs covering more than 1.7 million retirees. Of the 41 states that reported providing some contribution towards retiree health insurance, 30 finance the state costs on a pay-as-you-go basis, while only 11 reported a prefunding arrangement. In the aggregate, state spending on OPEB approximated $4.4 billion in FY2001. About $3.8 billion was financed on a pay-as-you-go basis.

3. There are currently four GASB standards that provide guidance for existing state government accounting and reporting for postemployment health insurance benefits. GASB 12, *Disclosure of Information on Postemployment Benefits Other Than Pension Benefits by State and Local Government Employers*, became effective June 15, 1990 and requires that all employers who finance all or some portion of their retiree health insurance should provide: (1) a description of the benefits provided, employee groups covered, and the employer and participant obligations to contribute; (2) a description of the statutory, contractual, or other authority under which the benefit provisions and obligations to contribute are established; (3) a description of the accounting and financing or funding policies followed for those benefits; and (4) the expenditures/expenses for those benefits recognized for the period. These disclosures are typically accomplished through a note to the governmental entity's financial statement. However, unlike the new OPEB standards, GASB 12 does not require that particular practices be employed in recognizing and measuring retiree health insurance benefits. Subsequently, three additional GASB standards were implemented which affected the treatment of retiree health care benefits when provided through a public employee retirement system. First, GASB 27, *Accounting for Pensions by State and Local Governmental Employers*, issued in late 1994 but not effective until mid-1997, provides guidance to employers that elect to apply their pension accounting standards to retiree health care. In June 1996, GASB 25, *Financial Reporting for Defined Benefit Pension Plans and Note Disclosures for Defined Contribution Plans*, and GASB 26, *Financial Reporting for Postemployment Health care Plans Administered by Defined Benefit Pension Plans*, became effective. GASB 25 and GASB 26 have delineated the applicable standards, not only for retiree health care plans that are advance funded through a public employee retirement system, but, more broadly, for any retiree health care plan administered by a governmental defined benefit pension plan, regardless of whether the health care plan is funded on an actuarially determined basis or by some other mechanism. In its OPEB project, the Board decided to apply the same overall approach adopted in GASB 25 and GASB 27 to the reporting of OPEB by employers and plans, with such modifications as the Board considered necessary to reflect differences between pension benefits and OPEB.

4. While GASB's new OPEB standards are similar to FAS 106 in requiring those government employers to accrue the costs of postretirement health insurance during the years of service of their employees just as private sector employers are required to accrue the costs of such benefits, it appears likely there will be some significant differences in the standards as well as differences in the impact of the standards.

Impact and Implications

Employer-sponsored retiree health care provided by public employers is an important component of our nation's system of health care insurance for retirees. Therefore, any significant changes to state government employer retiree health care insurance resulting from the new OPEB standards or from the impact of underlying cost drivers necessarily will call for a response from policymakers if insurance gaps arise.

1. The private sector experience with FAS 106 provides mixed lessons for trying to anticipate the outcome of the new OPEB standards as formulated by GASB.

2. State government employers are typically large employers, and large employers generally provide postemployment benefit programs that remain relatively stable over time.

3. The financial information produced by the application of the new OPEB standards may encourage state governments to think about reducing retiree health benefit programs in the future in order to avoid liabilities. Yet, while the new OPEB standards may result in the consideration of changes that would minimize adverse accounting effects on public budgets, health benefit program changes seem more likely to be prompted by the availability of a drug benefit through Medicare and the underlying cost drivers, e.g., health care inflation, an expanding retiree population relative to active employees.

4. The new OPEB standards may encourage greater prefunding of retiree health care benefits. Because prefunding typically produces higher short-term costs as compared to pay-as-you-go financing, it may add to state government financial obligations at an inopportune time for those states and may, therefore, prompt a reconsideration of the level of state commitments for future retirees. At the same time, states which do begin prefunding (and those already prefunding) may find that their direct employer costs will be lower in the long run and that their credit rating may be bolstered.

5. To the extent the new OPEB standards may encourage greater prefunding of retiree health care benefits, they may produce greater intergenerational equity for taxpayers. This is because each generation, at least in theory, can assure itself that it is paying only for the personnel costs associated with the services provided by employees active during the taxpayer's lifetime, not previous lifetimes.

Conclusion

Economic and demographic factors are putting upward pressure on the cost of retiree health insurance provided by state public employers and, unless adequately prefunded, increasing

retiree health insurance costs may result in mounting deferred liabilities for state employers with the potential for an adverse impact on credit ratings. The concern over the future potential effect of such liabilities has prompted an examination of current governmental accounting standards for financial reporting to determine if such reporting achieves a sufficient consideration of the impact of providing retiree health care benefits on overall government operations. However, the implementation of new governmental accounting standards concerning retiree health insurance and other postemployment benefits, while adding to short-term pressures on government employees, appears unlikely to change what are typically the stable benefit provision patterns of large state employers, unless coupled with significant health care cost inflation for the foreseeable future and a continued deterioration of the active-to-retiree workforce ratio.

Introduction

It is the widespread practice of state governments to provide health benefits to former employees when they retire. In fact, the share of public sector employers offering retiree health benefits remains high in comparison to private employers.

The Governmental Accounting Standards Board (GASB) issued an Exposure Draft early in 2003 detailing proposed new accounting standards for state and local government retiree health care and other non-pension benefits; the Board adopted Statement No. 43, *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans*, and a related statement, *Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions*, in June 2004. The new standards for employer reporting of Other Postemployment Benefits (OPEB) are broadly similar to standards applicable to the private sector issued by the Financial Accounting Standards Board (FASB) in 1990; they understand that OPEB is deferred compensation and their objective is to achieve accrual of benefit costs and liabilities during periods when employees render services. However, the new GASB standards are modeled after previous GASB standards on employers' reporting of pension benefits and include differences from FASB requirements designed to address the accounting and reporting practices of the public sector. Some additional differences from private sector requirements are associated with GASB's simplified alternative measurement method for small plans, e.g., single employer OPEB plans with fewer than 100 members.

To the extent that the new GASB standards require changes in assumptions or methods currently used by public sector entities to account for and report the costs of retiree health care, the introduction of these new standards may result in changes in behavior and practices by both providers and users of retiree health benefits. Faced with more comprehensive financial information and revised expectations regarding current and future health care costs, it is generally assumed that public employers, retiree health care plans, plan participants (including both retiree participants and actively employed future participants) and policymakers may alter their decision-making regarding the structure and level of postretirement health benefits.

Organization of Paper. This paper begins with a description of how retiree health care benefits are provided in state government employment in fiscal year 2003. This "current" state of retiree health care benefits provided by state government employers then can be used as a baseline against which the impact of any policy changes can be assessed. Next, this paper reviews the current practices used by state governments to account for and finance their retiree health benefit obligations. This involves a review of existing accounting standards, such as GASB 12, 25, 26, and 27, where relevant, and a delineation of how these standards have set the stage for movement to new OPEB standards. Then, this paper examines the potential impact of the new OPEB standards on accounting practices and contrasts the standards' likely effect with the impact of the adoption of FASB 106, highlighting the major similarities and differences between the standards. Finally, this paper concludes with an assessment of the potential impact of the new OPEB

standards on current and future state government retirees, public employers, taxpayers, and policymakers.

Methodology. In order to provide an overview of current state government retiree health insurance benefits, Workplace Economics, Inc. analyzed information in its proprietary database, developed over 15 years, on benefits provided to state government employees in all 50 states (the District of Columbia is not part of the state government database). The database is the product of an annual survey of state governments on their employee benefits as well as an analysis of state employee health insurance plan documents; the database includes information on health benefits for retired employees. The information in Appendix A comes from this database. To provide the overview of current state financial reporting practices and the information in Appendix B, Workplace Economics analyzed state governments' annual financial reports.

The discussions of the current and new standards are based on the authors' knowledge of the two sets of standards, and the section on the impact reflects the authors' own assessment of some of the potential effects of the implementation of new GASB accounting standards.

Overview of Current State Government Retiree Health Benefits

In order to properly assess the impact of any new OPEB standard, both the depth and breadth of retiree health care benefits received by state government retirees needs to be determined. That is, it is important to identify the scope of such state programs and to understand the share of the financial burden borne by each state government for such benefits. To shed light on these issues, Workplace Economics, Inc. undertook two data analyses in this paper: (1) an examination of the key plan characteristics of state retiree health care programs and (2) a review of state government annual financial reports on the scope and aggregate annual cost of state OPEB spending.

Key Characteristics of State Retiree Health Care Plans

Fiscal year 2003 data for each state were examined in order to determine: (1) the actual dollar amount of premiums paid for retiree health care coverage by the state and by the retiree, respectively; (2) the deductibles, coinsurance, physician co-payments, and out-of-pocket maximums associated with the plans reviewed; and (3) the key characteristics of any prescription drug plans offered as part of the retiree health care program. When more than two plans were offered, the lowest-cost and the highest-cost plans were included in the analysis.[1] As summarized below, retiree health care programs available to state government retirees varied significantly in design.

Plan Offerings. In fiscal year 2003, all 50 state government employers surveyed offered health care benefits for retirees under the age of 65, and 48 states—all but Indiana and Nebraska—offered health care benefits to retirees age 65 and older. (See Appendix Table A1.) Roughly one in five states offered a single plan statewide, while some others offered as many as 10 or more plans. However, in states with multiple options, generally no more than three or four plans were available statewide, while additional offerings—usually HMOs—were available only in limited service areas. A retiree therefore typically had no more than three or four options available, based on the location of his or her residence.

In a number of cases, health coverage options offered to pre-Medicare retirees were the same as or similar to those available to active employees. In some cases, pre-Medicare and/or Medicare-eligible retirees selected from either additional or different options offered by the state and the retirement system. In Arizona, for example, retirees could

[1] Because some states offer a large number of pre-Medicare and Medicare retiree health care plans that would make a complete inventory of the key characteristics of all such plans unwieldy, this analysis was limited to providing information on the key plan characteristics of the lowest-cost and highest-cost plans offered to retirees, where "lowest-cost" and "highest-cost" refers to the retiree premium cost in dollars for retiree-only coverage. These plans were selected for analysis because they set the lower and upper bounds for the premium costs for all available plans and because such plans often attracted the largest enrollments among available plans. For example, a survey of state plan sponsors revealed that, for 72% of the responding states, the retiree health plan with the largest enrollment was either the "lowest-cost" plan or the "highest-cost" plan that was described for that state in Appendix A.

select from separate sets of plans offered by the retirement system and by the state Department of Administration.

Upon reaching age 65, when retirees become eligible for Medicare, plan payment and/or coverage changed. Retirees of the states of Indiana and Nebraska were no longer covered under the state's health plan after age 65 and had to seek individual coverage elsewhere to supplement Medicare. In the remaining 48 states, many retirees were able to continue coverage in the same health plan that they had while working or as an early retiree, but in 20 states they were also offered options for Medicare supplement plans.[2] A few states offered only Medicare supplement plans to retirees over the age of 65. In either case, Medicare was the primary payer for retirees age 65 and over, so individuals had to sign up for Medicare as soon as they became eligible. Comprehensive plans were not explicitly designed to complement Medicare as were the supplement plans, but they all coordinated coverage with Medicare to avoid duplicate payment for services covered by both plans.[3]

The majority of states offered the two groups of retirees—pre-Medicare and Medicare eligible—the same number of plan options. Nevertheless, 14 states offered fewer options, and seven states offered more options to retirees age 65 and over than their younger counterparts.

Eligibility for Retiree Health Benefits. In most states, individuals eligible for pensions based on their years of service could opt for continued health care coverage, although 17 states had additional requirements such as some minimum number of years of active service with the state or prior coverage in the health plan as an active employee. (See Appendix Tables A2 and B1.) States also differed as to when the retiree could opt for coverage. A dozen states required the individual to enroll within a limited time period — usually 30 to 90 days — surrounding the retirement date. A few allowed the retiree to defer enrollment in specific situations, such as when the retiree was already covered as a dependent under a state-sponsored plan but later lost that coverage upon the spouse's death, or when an employee terminated employment prior to retirement but with specified service credit.

Premium Contribution. Eligibility requirements for state subsidization of the premium frequently differed from requirements for participation in the plan, i.e., a retiree who was eligible to participate in the health plan may not have been eligible for a premium

[2] The Centers for Medicare and Medicaid Services (CMS) and the National Association of Insurance Commissioners (NAIC) have defined 10 standardized "Medicare supplement" or "Medigap" plans that may be offered to Medicare-eligible retirees. Employers that offer Medicare supplement plans to retirees over age 65 conform to one of these types. The plans (designated "A" through "J") are designed to complement Medicare coverage by paying for varying degrees of deductibles, coinsurance, prescription drugs and other services not covered by Medicare.

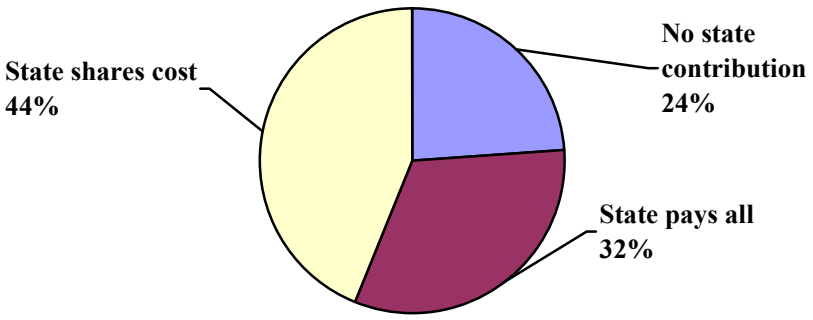
[3] Retirees who do not enroll in Medicare are effectively treated by state government health plans "as if" they were enrolled. Some plans make allowances for individuals not eligible for Medicare because their employer did not pay taxes into the program to retain some level of coverage. See Appendix Table A2.

subsidy. (See Appendix Tables A2 and B1 for details about eligibility for subsidies from health plan documents and financial reports, respectively, and also the notes to Tables A3 and A4 on premium costs for early retirees and Medicare-eligible retirees.) Almost one-third of states varied the portion of the subsidy based on the individual's years of credited service at retirement, with long-service employees (typically with 20 to 30 years) eligible for the maximum subsidy.

Figure 1 summarizes how states shared premium costs with pre-Medicare retirees for single coverage assuming the individual was eligible for the maximum subsidy.[4] For pre-Medicare retirees, 16 states (32%) paid the full amount of the premium for at least the lowest-cost plan offered and, in 12 states (24%), the retiree paid 100 percent of the premium.

Figure 2 summarizes premium cost-sharing requirements for Medicare-eligible retirees for single coverage assuming the individual was eligible for the maximum subsidy. Seventeen states (34%) paid the full premium for at least the lowest-cost plan offered to eligible retirees over the age of 65, while Medicare-eligible retirees in 11 states (22%) paid the full amount of the premium themselves. Of the remaining states, 20 states (40%) shared premium costs for individual coverage between the state and the retiree (shown in Appendix Tables A3 and A4), and two states (4%) had no plan.

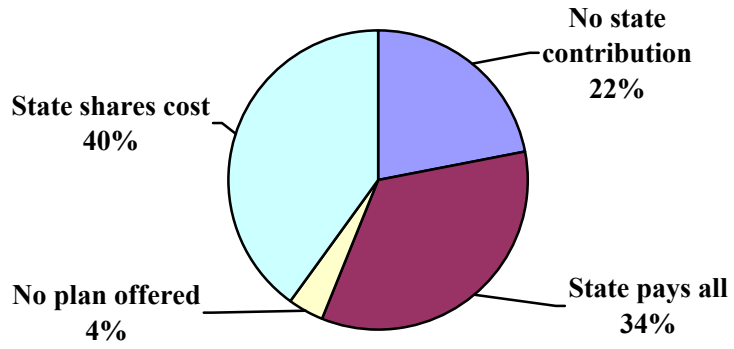
Figure 1. Premium Cost Sharing For Pre-Medicare Retirees, FY 2003



Note: Data are for single coverage and assumes maximum subsidy. Other conditions may apply, e.g., enrollment in the lowest-cost plan.
Source: Workplace Economics

[4] The information cited and provided in the Appendix tables applies to individual coverage for the retiree only. States vary in their practices regarding coverage and the extension of subsidies to dependents.

Figure 2. Premium Cost Sharing For Medicare-Eligible Retirees, FY 2003



Note: Data are for single coverage and assumes maximum subsidy. Other conditions may apply, e.g., enrollment in the lowest cost plan.
Source: Workplace Economics

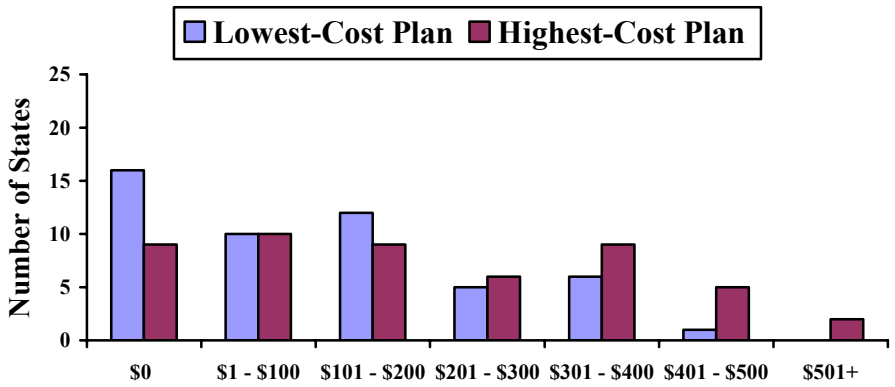
Across all 50 states, total monthly premiums for individual coverage for pre-Medicare retirees ranged from $159.92 in South Dakota for the state's low-option preferred provider plan (PPO) to a high of $925.42 for a PPO plan in Arizona. Among the 34 states where the pre-Medicare retiree paid either all or some portion of the premium costs, the monthly payment varied from $5.01 in Utah for an HMO to $795.40 for an indemnity plan in Wisconsin, assuming the retiree qualifies for the maximum subsidy. Figure 3 shows the distribution of pre-Medicare retiree premium contributions in $100 increments. The figure includes the highest-cost plan and the lowest-cost plan for each of the 50 states.

For Medicare-eligible retirees, total monthly premiums for single coverage ranged from $46.40 for an HMO in New Mexico to $464.23 for a regional HMO in New York. Among plans requiring retirees to pay all or a portion of premium costs, the monthly premium share for individual coverage paid by Medicare-eligible retirees varied from $10.00 in Georgia for a Medicare HMO to $448.52 for Iowa's open access plan, assuming the retiree qualifies for the maximum subsidy. Figure 4 shows the Medicare-eligible retiree premium contribution within $100 increments. The figure includes the highest-cost plan and the lowest-cost plan for each of the 50 states.

These findings clearly show the substantial role played by many states in the provision of retiree health care benefits in terms of the dollar amount of premium contributions that they made. It should also be noted that, in many cases, the health insurance premium applicable to pre-Medicare retirees might have been the same premium applicable to active employees. This may have been the case particularly where pre-Medicare retirees continued to be pooled for health insurance together with active employees. As a result, the premiums reported in such cases may have understated the actual claims costs incurred on behalf of the pre-Medicare participants. While such pooling of individuals

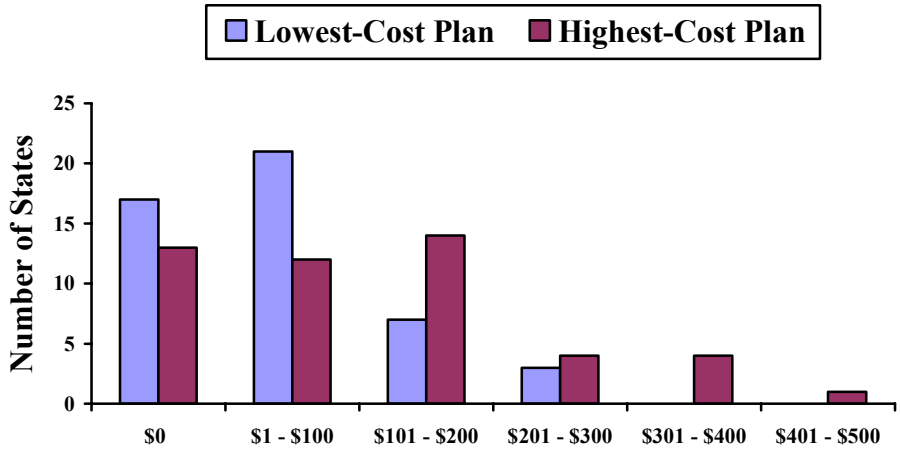
who are offered the same benefits (even though they may have different health or age characteristics) is at the heart of the insurance principle of spreading the risk, a few states took the position in their plan reporting that they were providing an implicit premium subsidy to their pre-Medicare retirees.

Figure 3. Premium Contributions Paid by Pre-Medicare Retirees by State, FY 2003



Note: Data are for single coverage and assumes maximum subsidy.
Source: Workplace Economics

Figure 4. Premium Amounts Paid by Medicare-Eligible Retirees by State, FY 2003



Note: Data are for single coverage and assumes maximum subsidy.
Source: Workplace Economics

Types of Plans and Cost-sharing Features. Key features of the lowest-cost and highest-cost plans available to retirees in each state are detailed in Appendix Tables A5 (pre-Medicare retirees) and A6 (Medicare-eligible retirees). Note that plan types in the tables — for example, HMO, PPO, and point-of-service (POS) — reflect the terminology of the particular state, i.e., the terms are not uniformly defined from state to state. Furthermore, the traditional distinctions between plan types have blurred as providers, plan administrators, and the state employers or retirement systems that offer the plans have altered plan features and added options to both minimize costs and provide alternatives.

Most common among the plans offered to pre-Medicare state retirees were plans that offer a different level of coverage and out-of-pocket payment depending on whether the member chooses to obtain care from in-network providers or out-of-network providers. Deductibles were common in most plans, except plans that only offer benefits when network providers were used. Many plans required copays that vary by the type of service obtained (e.g., specialty physicians, mental health, laboratory, physical therapy). Though not widespread, some plans (such as those that do not have deductibles) required hospital copays, typically from about $100 to $300 per admission, after which the plan paid all or most covered charges. A majority of plans reviewed had out-of-pocket maximums to limit the annual expenses paid by members. The per person maximums (using in-plan services where provider networks are part of the plan design) varied from $400 to $10,000 per year, but typical maximums were $1,000 or $2,000. Nonetheless, nearly a third of plans reviewed had no out-of-pocket maximum. Deductibles, copays, coinsurance and out-of-pocket maximums could vary considerably within a plan depending on whether the individual has obtained care from in-network or out-of-network providers.

Plan options available to Medicare-eligible retirees either were the same or similar in structure and characteristics to the options offered to pre-Medicare retirees, or were Medicare supplement plans (see Appendix Table A6). Yet plans without an out-of-pocket maximum were more likely in offerings to Medicare-eligible retirees. Plans that were not Medicare supplements differed from those described in the preceding paragraph only in how the benefit payment was calculated. Because Medicare was the primary payer, remaining charges were submitted to the insurance plan, which paid in accordance with the features of the plan. Copayments and out-of-pocket limits still applied (and, where applicable, continued to vary depending on whether the provider was part of the plan network). Medicare supplement plans, as noted previously, were explicitly designed to pay certain covered charges that are not paid by Medicare, such as all or part of the deductibles required under Medicare, or the retiree's 20 percent share of coinsurance for physician services.

In general, the lowest-cost plans were those requiring the retiree to pay the greatest share of covered benefits in the form of higher deductibles, copays or out-of-pocket maximums. In addition, plans with the greatest restrictions on where and how a member receives care tended to have lower premium costs.

Prescription Drug Benefits. Almost all of the highest- and lowest-cost state plans reviewed included some level of prescription drug coverage (see Appendix Tables A7 (pre-Medicare) and A8 (Medicare-eligible)). Since Medicare currently does not cover prescription drugs, this benefit was of particular importance to retirees over the age of 65. The majority of states offered the same drug benefit to early retirees and retirees on Medicare. However, in one state (South Dakota), both the lowest-cost and highest-cost Medicare-eligible plans did not include a drug benefit, although this benefit was available for early retirees. In a few other states, a drug benefit may have been available in one, but not both, of the plans examined in this study.

Many states offered a single prescription drug benefit as part of all (or most) of the health plans. Generally, under these plans, the retiree made a payment when purchasing the drug at a participating retail pharmacy. The vast majority of plans required copayments of a certain dollar amount, but a dozen or so plans required retirees to pay coinsurance of a certain percent of the drug price; the plan paid the balance. Some of these plans had a minimum or maximum coinsurance amount. Plans may have had different levels of copayments or coinsurance. The levels typically differed depending on whether the drug was classified as generic, brand name/formulary, or nonformulary. Of state government drug benefits reviewed, a small share had a single copayment level and a slightly larger share had two copayment levels. The majority had three levels of copayment. Among the plans reviewed, typical copayments were $5 or $10 for the lowest level; $15, $20, or $25 for the second level; and $30, $35, or $40 for a third level. The copays typically applied to a 30-34 day supply, and many plans offered further discounts for retirees who purchased maintenance or other medications by mail order (e.g., a requirement of two copays for a 90-day supply is typical). In addition, a few plans required a drug deductible or limit out-of-pocket payments for drugs. Limits on out-of-pocket payments be limited to generic and preferred drugs and drugs purchased in the plan's network. While benefits commonly included a mail order pharmacy option, this option was not included in at least one plan in about a dozen states.

State Retiree Health Care Program Financial Report Data

The analysis of health plan documents in the previous section provides information on the availability of, premiums for, and nature of benefits offered to state retirees. While that is an important part of the picture of current state retiree health benefits, it does not describe the current size, funding, or costs of these benefits to the state. To develop a picture of these aspects of state retiree health benefit plans and because, ultimately, any change in the OPEB accounting standards is most likely to be reflected in the comprehensive annual financial report (CAFR) of the state or the entity through which the benefit is provided (e.g., state retirement plan), each state's most recently available CAFR was reviewed with respect to OPEB reporting.

Each state's relevant annual reports were examined for the following categories of information: (1) the number of eligible retirees reported (generally as of mid-year

2001);[5] (2) the scope or nature of the retiree health care benefit program, particularly in terms of eligibility; (3) the reported percentage of employer contributions; (4) whether the state finances its retiree health care insurance obligations on a pay-as-you-go or prefunded basis; and (5) the most recent annual total cost reported by the state in connection with providing retiree health care insurance (details for items 1-3 and 4-5 are presented in Appendices B1 and B2, respectively).

Generally, the information of interest for each state was included in its CAFR in a note disclosure as required by applicable GASB reporting standards.[6] Some states did not include an OPEB disclosure note, usually indicating —as borne out by the absence of state contributions to retiree health insurance premiums— that the state determined that it had no OPEB impact to report. Of the 50 states, only six states (Arkansas, Indiana, Iowa, Nebraska, South Dakota, and Wyoming) did not include an OPEB disclosure; only one of these states (Arkansas) in fact provided some retiree health care insurance subsidy. On the other hand, Mississippi included an OPEB disclosure note in the CAFR, notwithstanding the fact that the state incurred no expense for retiree health care benefits. Vermont included a note disclosing a retiree health benefit obligation, but not the number of retirees, funding, or cost.

Wisconsin —– whose "contribution" to the financing of retiree health care benefits consisted solely of a program that converts accumulated sick leave to retiree health insurance credits[7]— reported these programs in an OPEB disclosure note. This last reporting approach arguably may have overstated Wisconsin's retiree health care contribution relative to other states that provided accumulated sick leave cash-out programs[8] inasmuch as these states' retirees receiving such lump sum payments at retirement could use the payments to finance some portion of their health insurance costs.[9]

Excluding the nonreporting states and the other exceptions noted above (Mississippi, Vermont, and Wisconsin), 41 states reported providing some contribution towards

[5] Data reported in state CAFRs typically follow a fiscal year format; not every state or relevant reporting entity follows the same fiscal year.

[6] See *infra* at pp. 13 to 16 for a discussion of currently applicable GASB reporting standards for state postemployment health benefit obligations.

[7] Upon retirement, all or some portion of accumulated sick leave, instead of being paid as cash termination benefit, is converted to credits to pay the retiree's own group health insurance premiums.

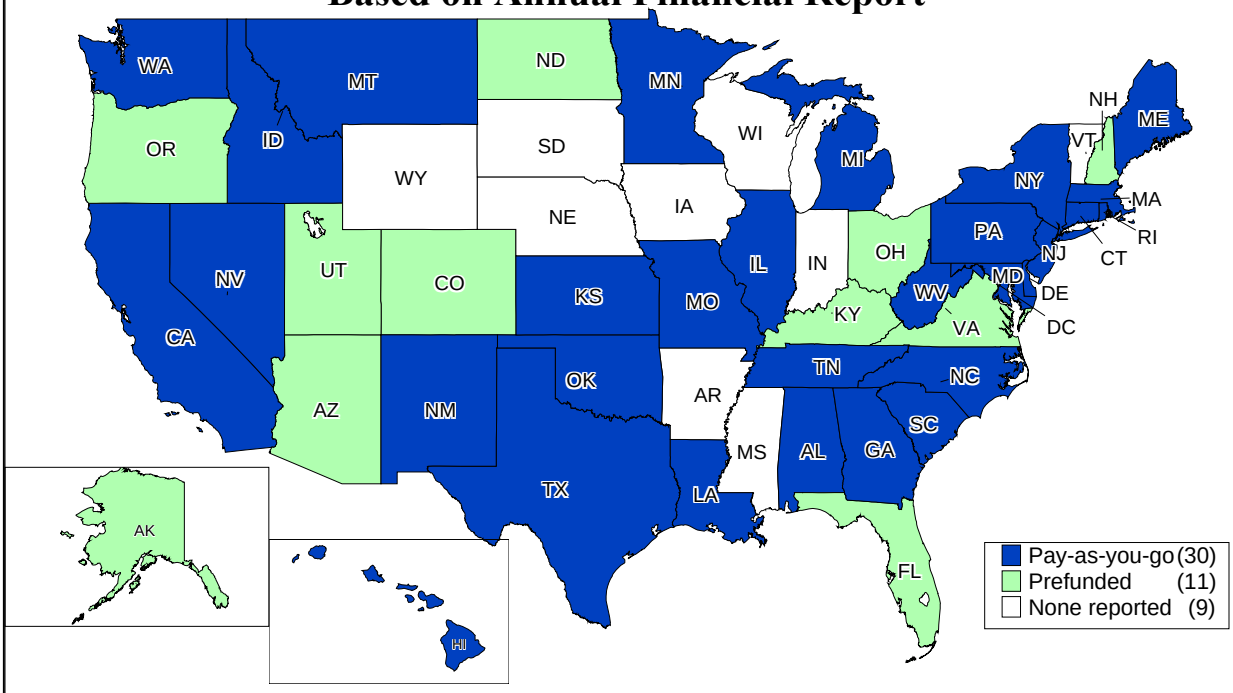
[8] In such programs, upon retirement, accumulated unused sick leave is converted at some rate to cash and paid to the retiring employee in a lump sum (typically, conversion is at a 25% rate, rather than a one-for-one or 100% rate).

[9] More consistent comparisons across states would appear possible in part if the dollar value of such sick leave conversion programs were reported only in the "compensated absences" disclosure note found in most state CAFRs along with lump sum sick leave and annual leave cash out programs. For a discussion of the governmental accounting treatment of sick leave conversion programs, see Governmental Accounting Standards Board Statement No. 16, *Accounting for Compensated Absences*.

defraying the cost of state retiree health insurance through programs covering more than 1.7 million retirees (see Figure 5). The OPEB disclosure note in the state CAFR provided some information about the dimensions of their postretirement health care programs.[10] In some cases, when the benefit was provided through a separate retirement system, the information was augmented by additional information presented in the state retirement system's CAFR.

Of the states that reported providing some contribution towards retiree health insurance (other than expenditures for sick leave conversion credits), 30 states financed these costs on a pay-as-you-go basis, while only 11 states percent reported a prefunding arrangement.

Figure 5. State Financing of Retiree Health Benefits, 2001
Based on Annual Financial Report



Source: Workplace Economics

Moreover, in states where retiree health benefits were prefunded separately from pension benefits, the funded levels reported for retiree health benefits often were lower than the funded levels reported for pension benefits. In short, both the predominance of pay-as-you-go financing among state retiree health care programs, as well as the low funded levels of many of those state retiree health care plans which are prefunded, could presage larger future cash outflows for such programs. This may be especially the case if the ratio of retired to active state employees continues to increase and retiree medical cost inflation continues to rise faster than the general rate of inflation.

[10] While providing some information about their programs, three states did not indicate the total fiscal year costs of the benefits provided in their OPEB disclosure notes.

Total annual spending on retiree health care benefits was reported by most of the 41 states that reported OPEB benefits.[11] In the aggregate, state spending on OPEB retiree health benefits approximated $4.4 billion in FY2001.[12] About $3.8 billion was financed on a pay-as-you-go basis. It should be noted that the remainder – roughly $600 million – that was financed on a prefunded basis represented the actual state contributions made to plan assets, rather than total expenditures made by those plans for the current provision of postemployment benefits.

Given the current prevalence of retirement health care benefits provided by state public employers, the substantial cost involved, and the relatively small number of states prefunding to meet their potential liabilities, it is not surprising that OPEB transactions have received GASB attention.

[11] Three states (Tennessee, Vermont and Washington) included an OPEB disclosure note in their 2001 comprehensive annual financial report but did not report an annual cost expense or total dollar amount of annual contribution in their OPEB disclosure notes.

[12] It should also be noted that not every state segregated retiree health care expenses from expenditures on other postemployment benefits provided such as life insurance. Such other expenditures are typically very modest relative to the cost of retiree health insurance. At the same time, some state reporting also included state expenditures for retiree health insurance subsidies provided to public employees other than state employees (e.g., teachers); usually such expenditures were reported as separate amounts from the amounts spent on state employee retirees.

Current Standards Applicable to Accounting for State Retiree Health Insurance Obligations and the Implications of the New OPEB Standards for Accounting Practices

Four GASB standards currently provide guidance regarding existing state government accounting and reporting for postemployment[13] health insurance benefits: GASB No. 12, 27, 25, and 26. This section describes the evolution of these standards which govern the current practices of state governmental entities that provide postemployment health benefits to retirees of various state government agencies. Since 1990, GASB standards have progressed from requiring financial disclosure by entities that finance some portion of retiree health benefits to providing guidance about how different types of entities might adapt pension accounting standards for the purposes of reporting on health benefits for all categories of retirees. Much of the content in the current standards is reflected in the new standards which will be implemented over the several years beginning in fiscal years starting in December 2006.

Not all of the standards apply to all governmental entities providing retiree health benefits. Retiree health benefits are provided through a number of different organizational/administrative arrangements (e.g., as part of the state employee benefit system, through a separate public employees retirement system, under the auspices of a defined benefit pension plan), and some of the standards are particular to the type of organizational arrangement responsible for the plan. Other standards are particular to the methods used to finance the health benefits, e.g., pay-as-you-go vs. prefunded basis.

Governmental Accounting Standards Board Statement No. 12, *Disclosure of Information on Postemployment Benefits Other Than Pension Benefits by State and Local Government Employers*, became effective June 15, 1990 and requires that all governmental employers who finance all or some portion of their retiree health benefit costs should provide: (1) a description of the benefits provided, employee groups covered, and the employer and participant obligations to contribute; (2) a description of the statutory, contractual, or other authority under which the benefit provisions and obligations to contribute are established; (3) a description of the accounting and financing or funding policies followed for those benefits; and (4) the expenditures/expenses for those benefits recognized for the period.[14]

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[13] While the focus of this paper is retiree health insurance benefits, it should be noted that the term postemployment as used by GASB is not synonymous with retirement. Rather, the term postemployment has a broader meaning that embraces not only retirement but also any period after termination but before retirement during which benefits may be provided.

[14] GASB 12 permits state government employers to simply state that OPEB expenditures/expenses "cannot be reasonably estimated" if a reasonable approximation of OPEB expenditures/expenses is not possible because OPEB expenditures cannot be separated from similar expenditures for active employees, e.g., where pre-Medicare retirees participate in the same health insurance plans offered to active employees.

These required disclosures are accomplished through a note to the governmental entity's financial statement. A GASB 12 footnote disclosure for OPEB financed on a pay-as-you-go basis might read as follows:

> "In addition to the pension benefits described in NOTE X, the State provides postretirement health care benefits, in accordance with State statutes, to all employees who retire from the State on or after attaining age 60 with at least 15 years of service. Currently, 25,000 retirees meet those eligibility requirements. The State reimburses 75 percent of the amount of validated claims for medical, dental, and hospitalization costs incurred by pre-Medicare retirees and their dependents. The State also reimburses a fixed amount of $25 per month for a Medicare supplement for each retiree eligible for Medicare. Expenditures for postretirement health care benefits are recognized as retirees report claims and include a provision for estimated claims incurred but not yet reported to the State. During the year, expenditures of $30 million were recognized for post-retirement health care. Approximately $500,000 of the $3 million increase in expenditures over the previous year was caused by the addition of dental benefits, effective July 1, 19XX" (Governmental Accounting Standards Board Statement No. 12, 1990, Appendix B).

If the retiree health program is prefunded, a GASB 12 footnote disclosure would include the employer's actuarially required contributions, the amount of net assets available for OPEB, and the actuarial accrued liability and unfunded accrued liability for OPEB according to the actuarial cost method in use.

GASB 12 is an interim standard pending the new OPEB standards. However, unlike the new OPEB standards, GASB 12 does not require that particular practices be employed when recognizing and measuring retiree health insurance benefits; therefore, when GASB 12 became effective in 1990, state and local government employers were not required to change their accounting for those benefits. In short, GASB 12 addresses only the disclosure of the nature and extent of retiree health insurance benefits, but does not establish recognition and measurement standards applicable to those benefits.

Moreover, GASB 12 permits employers that advance fund their retiree health insurance benefits on an actuarially determined basis through a public employee retirement system to elect to apply alternative disclosure standards applicable to public employee pension plans. Those alternative standards are part of **Governmental Accounting Standards Board Statement No. 5, *Disclosure of Pension Information by Public Employee Retirement Systems and State and Local Government Employers***. The impact of electing this alternative is that: (1) the employer has to disclose its health care cost inflation assumption along with the other actuarial assumptions it is already disclosing for pension purposes; and (2) the employer has to calculate the funded status and funding progress of retiree health care benefits in a manner consistent with the requirements already applicable to pension benefits. While the disclosure of the funded status and

funding progress of retiree health care benefits separate from that of pension benefits is encouraged, such disclosure is not required.

Subsequently, three additional GASB standards were implemented which both move beyond disclosure requirements and affect how retiree health care benefits are to be treated for accounting purposes when provided through a public employee retirement system. First, **Governmental Accounting Standards Board Statement No. 27, *Accounting for Pensions by State and Local Governmental Employers***, issued in late 1994 but not effective until mid-1997, supersedes that part of GASB 12 that permits employers the option of reporting under GASB 5 standards if they prefund their retiree health care benefits through a public employee retirement system. GASB 27 provides guidance to employers that elect[15] to apply their pension accounting standards to retiree health care benefits on an interim basis pending the issuance of the OPEB standards. Essentially, employers who elect to apply GASB 27 to retiree health care benefits, are instructed to: (1) apply not only the measurement and recognition requirements of GASB 27 to those retiree health care benefits but also to provide notes to the financial statements required by GASB 27 instead of the note disclosures required by GASB 12; (2) to measure required supplementary information in the same manner as the pension plans if the retiree health benefits are administered through a defined benefit pension plan;[16] (3) to disclose the health care cost inflation assumption used in the valuation; and (4) to provide information on retiree health care benefits separately from information on pension benefits. While this elective standard governs *employer* reporting, other GASB standards address financial reporting by government defined benefit pension plans when such pension plans administer a retiree health care plan.

In June 1996, **Governmental Accounting Standards Board Statement No. 25, *Financial Reporting for Defined Benefit Pension Plans and Note Disclosures for Defined Contribution Plans***, and **Governmental Accounting Standards Board Statement No. 26, *Financial Reporting for Postemployment Health Care Plans Administered by Defined Benefit Pension Plans***, became effective. GASB 25 and GASB 26 delineate the applicable standards, not only for retiree health care plans that are prefunded through a public employee retirement system but also for any retiree health care plan administered by a governmental defined benefit pension plan, regardless of how the health care plan is funded, e.g., on a prefunded, pay-as-you-go, or partially prefunded basis. GASB 26 is an interim standard meant to apply until the new OPEB standards become effective; it basically requires that retiree health care benefit plans administered by defined benefit pension plans apply the reporting standards of GASB 25 which are also applicable to pension plans. Essentially, under GASB 26, retiree health care benefit plans are required to present a statement of plan net assets, a statement of changes in net assets, and note disclosures similar to those required of pension plans (providing for a brief description of benefit eligibility requirements and the required employer

[15] Employers are not required to apply GASB 27 pension accounting rules to retiree health benefits; the application remains an election.

[16] Required supplementary information under GASB 27 includes, among other information, such disclosures as the plan's funded ratio, the unfunded actuarial liability or funding excess as a percentage of covered payroll, and the actuarial methods and assumptions used in the plan valuation.

contribution rates). However, GASB 26 does not require that these retiree health plans provide the "required supplementary information" applicable to pension plans, i.e., a schedule of funding progress, a schedule of employer contributions, and related note disclosures such as valuation methodology and key assumptions employed in the valuation. GASB 26 simply says that, if such disclosures are elected for the retiree health care plan, they should mirror the disclosures required for the pension plan and such information should be presented separately for the retiree health care plan and for the pension plan.

GASB 26 applies to only retiree health insurance plans administered by retirement systems (rather than state and local government employers) and does not require the disclosure of the "required supplementary information" applicable to pension plans. Nevertheless, the reporting guidance it provides to such retiree health benefit plans that choose to report this information is a precursor of the GASB standards for reporting of OPEB plans generally.

In its **OPEB project**, charged with developing the standards, the Government Accounting Standards Board decided to apply the same overall approach adopted in GASB 27 and GASB 25 to the reporting of OPEB by employers and plans, with such modifications as the Board considered necessary to reflect differences between pension benefits and OPEB. For example, in early 2001, the Board decided to allow the use of the same six actuarial cost methods used for pension financial reporting, although it added the requirement that employers using the aggregate cost method for financial purposes should prepare the required supplementary schedule of funding progress using, as a surrogate, the entry age normal cost method.[17] Similarly, in 2002, the Board decided to require valuations of the largest OPEBs at least biennially, unless significant changes had occurred in benefit provisions or the population covered by the plan which would precipitate a more frequent valuation. Other GASB 27 and GASB 25 approaches have also been approved.

With regard to disclosures, staff's recommendations to the Board generally were that OPEB disclosure requirements track GASB 27 and GASB 25 disclosure requirements fairly closely. Although a number of disclosure modifications to the GASB 27 and 25 approach were considered by the Board, few were adopted. Those few adopted include: (1) disclosure of the health care cost trend rate; (2) the use of the entry age normal actuarial cost method as a surrogate for the aggregate cost method in presenting the schedule of funding progress; and (3) an indication that financial reporting is based on the current substantive plan as well as on an assumption of continuation of benefit coverage and historical patterns of cost sharing with employees. In short, the new OPEB regime may not so much produce new retiree health care disclosure or reporting standards as require the application of standards that are now elective, but which the authors' analysis of states' financial reports indicate are seldom applied.

[17] Unlike alternative cost methods such as the entry age normal cost method, the aggregate cost method does not separately measure or amortize an unfunded actuarial liability.

The Board adopted **Statement No. 43,** ***Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans***, in May 2004 and a related Statement, ***Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions***, in June 2004. The new standards will be phased in over a three-year period with the effective date dependent upon the size of the governmental unit sponsoring the plan. The standards will become effective for the largest governmental units first; the earliest effective date under the proposal would be in 2006.[18]

GASB's new OPEB standards appear likely to impact current governmental accounting practice in some important ways. Those government employers who are currently recording the costs of postretirement health insurance on a pay-as-you-go basis will be required to accrue the future costs during the years of active service of their employees for financial reporting purposes, just as private sector employers were required to accrue the cost of postretirement health care benefits by the Financial Accounting Standards Board's Statement 106, *Employers' Accounting for Postretirement Benefits Other Than Pensions*. However, to the extent that state governments are advance funding OPEB plans[19] or providing them through state retirement systems, they may already be meeting what new OPEB standards require.

In addition, the discount rate used in such valuations (i.e., the investment return assumption) is identified in current GASB 27 as being "based on an estimated long-term investment yield for the plan, with consideration given to the nature and mix of current and expected plan investments." This discount rate sharply contrasts with the FAS 106 discount rate. The latter standard calls for use of the current low-risk investment rate of return and may change substantially from year to year, whereas the GASB 27 discount rate is less volatile and produces more level employer contribution rates.

The FAS 106 paradigm of a "substantive plan" has been adopted by the Board for the new OPEB standards rather than the GASB 27 approach to determining the nature of the retiree health care benefit plan. The former requires actuaries to consider evidence other than just written plan documentation when determining the benefits provided by the plan. The GASB has determined that this approach will be employed in the OPEB standards so that actuaries will be required to consider not only the written plan document (as they are today), but also other communications between the employer and employees and the employer's historical pattern of sharing costs with the employees. Such an approach may well capture costs that a consideration of only written documents might minimize.

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[18] GASB is phasing in the implementation of the new OPEB standards. Public employers would be required to implement the standards for fiscal years beginning after either December 15, 2006, December 15, 2007, or December 15, 2008. The magnitude of a government's revenues determines in which year the standard will apply. The governments with the largest revenues will implement the standard first.

[19] As noted *supra* at p.11, of the 41 states that reported providing some contribution towards retiree health insurance (other than expenditures for sick leave conversion credits) in FY2001, 11 states reported a prefunding arrangement.

Given such similarities and differences of the new OPEB standards with FAS 106, can the impact of that standard in the private sector translate directly to the public sector? The answer is obviously mixed. For most large state employers, shifting to the notion of a "substantive plan" does not seem likely to produce a very large difference in the value of retiree health insurance benefit liabilities inasmuch as most statewide benefits programs are well documented, rather than based on historical cost-sharing patterns. Indeed, many retiree health care benefit programs have been statutorily amended to specifically change benefit levels for groups of state employees hired at different times.[20] On the other hand, as shown earlier, the overwhelming majority of states offering retiree health care benefits currently are funding such benefits on a pay-as-you-go basis. Shifting to an accrual basis will certainly raise the amount of long-term obligations reported by the states.[21] Further, assuming that the current level of benefits remains unchanged and the number of state government retirees grows faster than the state's active employee workforce, then shifting to accrual reporting will accelerate the relative proportion of state funds reported annually to finance retiree health care benefits.

[20] Moreover, guided particularly by developments in private sector litigation in recent years (e.g., courts in public plan litigation may recognize ERISA decisions as persuasive authority), public employers no doubt have noted the significance of defining, by statute or other formal action taken by the plan's governing body, what benefits are being promised and how and by whom those promises may be limited. In the private sector, courts have been reluctant to find that a lifetime benefits commitment has been made by an employer absent clear and express language in a contract, summary plan description, or formal plan document; nevertheless, courts have upheld obligations to employees based on alternative theories such as the breach of a fiduciary duty to accurately disclose the level of obligations assumed by the employer. The latter theory can be traced to the Supreme Court decision in *Verity v. Howe*, 516 U.S. 489, 116 S. Ct. 1065 (1996) which held that an employer acted as a fiduciary when it communicated about benefits to its employees and thus had a fiduciary duty not to misrepresent plan benefits. In short, even absent any OPEB reporting requirements, state government employers have had greater incentive in recent years to formally define their retiree health benefit programs. By contrast, private employers did not have quite the same amount of litigation experience on which to draw when FAS 106 was implemented.

[21] Once the new standard is implemented, all states with such programs will start reporting as a liability the cumulative difference between the amounts accrued as expense and the amounts actually paid or contributed each year. They also would disclose the full actuarial accrued liability (the portion of the present value of projected benefits attributed by an actuarial cost method to services already rendered) and the unfunded actuarial accrued liability in a note to the financial statements and in a required multi-year trend schedule of funding progress.

Potential Impact of the New GASB OPEB Standards on Current and Future Retirees, Public Employers, Taxpayers and Policymakers

Employer-sponsored retiree health benefits provided by public employers are an important component of our nation's system of health insurance for retirees. Therefore, any significant changes to such benefit programs may consequentially impact current and future retirees, public employers, taxpayers and public policy. The relevant question is in what way and to what degree might the new OPEB standards have an impact.

1. The private sector experience with FAS 106 provides mixed lessons for trying to anticipate the outcome of the new OPEB standards as formulated by GASB.

In December 1990, the Financial Accounting Standards Board (FASB) approved Statement 106 (FAS 106), which required employers, who previously merely recorded the existence of a postretirement medical benefit and the cost for the current period, to report unfunded retiree health benefit liabilities on their financial statements beginning with the fiscal years after December 15, 1992. In other words, firms which largely reported retiree health insurance on a pay-as-you-go basis prior to 1991 were required to report their postretirement benefit liabilities on an accrual basis, often resulting in reported liabilities far in excess of those costs reported prior to the implementation of FAS 106.

As Fronstin notes, FAS 106 "caused many employers to reexamine their role in providing health benefits for current and future retirees" (Fronstin, 1995). Yet, while fewer private sector employees received employer-financed retiree coverage as a benefit after 1993, the role that FAS 106 implementation played in this trend is not clear. For example, the U.S. Bureau of Labor Statistics (BLS) surveys of retiree health benefit incidence among employees of medium and large establishments showed that, for plans covering retirees under age 65, employer-related coverage dropped from 45 percent in 1988 to 35 percent in 1997; between 1991 and 1993 (the period between the approval of FAS 106 and its required implementation date), coverage actually increased from 43 percent to 44 percent (U.S. Department of Labor, BLS, 1989, 1990, 1993, 1995, 1997, 1999). Employer-sponsored coverage of retirees age 65 and over reached its highest level during 1991 and 1993 as compared to the rest of the 1988-97 period. For both retirees under age 65 and age 65 and over, BLS reported that the percentage of employees participating in retiree health plans for whom the employer paid the full cost fell between 1991 and 1993 (from 16 percent to 13 percent and from 17 percent to 14 percent, respectively), but this downward trend appears to represent a continuation of a pattern largely evident throughout the 1988-97 period (U.S. Department of Labor, BLS, 1989, 1990, 1993, 1995, 1997, 1999). Using a different data source, Fronstin reports that between 1994 and 2000, the percentage of retirees ages 55 through 64 covered by health benefits through a former employer or union was largely unchanged (Fronstin; August 2001 and August 2002).

Kalman and Anderson describe the aftermath of FAS 106 as follows:

> ". . . once the transition obligation was recognized (and the significant pain it inflicted on some income statements), the furor over FASB Statement 106 subsided. Plan designs did change, but the seeds for that came from annual double-digit increases in health care costs and the possibility that the federal government would step in to take a far larger role in ensuring that all Americans had access to health care" (Kalman and Anderson, 1997).

In short, it is difficult to pinpoint the extent to which the change in the FASB standard was responsible for employer decisions on benefit reductions.[22] In part, that difficulty lay in putting a value on the informational consequences of the new accounting standard, rather than any increase in real costs generated by the standard. After all, the standard simply requires reporting estimates of full liability based on promises already made to employees; assuming such promises are intended to be honored, the standard imposes no "new" benefit costs on the employer that were not already envisioned.

Nevertheless, private employers were concerned that, as the FAS 106 accounting changes were implemented, there would be large changes in reported corporate income and net worth, with negative implications for stockholder values. Some research has shown that retiree health benefit liabilities impact stock prices, but the same research suggests that, if such liabilities have already reduced share prices in a manner similar to other liabilities, then the introduction of new, even more revealing, accounting standards for these benefits would not lead to great financial pressure to reduce or cancel the benefits (Warshawsky and Mittelstaedt, 1993). One study of the impact of FAS 106 found that near the time of the issuance of the exposure draft for the new standard in February 1989, a group of 143 firms offering retiree benefits suffered a decline in equity values of about 3 percent, while a control group of 100 firms not offering the benefits did not experience similar losses (Espahbodi, Strock, and Tehranian, 1991). Other research conducted after implementation of FAS 106 failed to show any significant negative impact on stock prices and led the authors to conclude that "in efficient markets, adoption of an accounting rule should not affect stock prices since cash flows and other investor relevant factors would not be influenced" (Haddad, et al., 1995).

2. State government employers are typically large employers and large employers generally provide postemployment benefit programs that remain relatively stable over

[22] It is not clear how many employers changed their existing plans versus how many new or growing employers did not offer a plan. For example, based on Current Population Survey (CPS) data reviewed for the period 1994-99, Paul Fronstein reported that "(o)verall, there have been no statistically significant changes in sources of health insurance for early retirees since 1994. In addition, the likelihood of their being uninsured remains statistically unchanged since 1994." The percentage of early retirees with retiree health benefits largely fluctuated in a narrow band ranging from 36 percent to 39 percent. This apparent stability may be explained by the movement of workers from smaller firms without such benefits to larger firms that more typically have such programs. See Paul Fronstin, "Employment-Based health Benefits: Trends and Outlook," *EBRI Issue Brief*, May 2001, pp. 1-23 at pp.14-15.

time. More than an OPEB accounting standard effect would appear to be necessary to prompt major changes to the patterns of benefits provided by large state employers.

One important measure of employment health insurance program stability is premium sharing over time. State employee retiree health insurance programs have been fairly stable over the past decade with respect to the share of premium contributed by the sponsor. In 1992, 17 states reported contributing as much as 100 percent of the premium costs for pre-Medicare state government retirees and 20 states reported contributing as much as 100 percent of the premium costs of Medicare-eligible state retirees.[23] A decade later, 17 states reported contributing 100 percent of the premium costs of pre-Medicare state retirees, while 21 states reported contributing 100 percent of the premium costs of Medicare-eligible state retirees. In other words, the number of states paying 100 percent of the premium costs of retiree health insurance was virtually unchanged.[24] Similarly, in 1992, some 12 states reported making no contribution toward pre-Medicare retiree premium costs and 15 states reported making no contribution toward Medicare-eligible premium costs. As of 2002, the number of states reporting no contribution toward pre-Medicare premiums remained unchanged at 12, and the number of states reporting no contribution toward Medicare eligible premiums fell by one to 14. The remaining states share premium costs with their retirees in varying amounts, but overall pre-Medicare and Medicare-eligible premium sharing patterns for these states as a group also appear relatively stable over the past ten years (Workplace Economics, Inc., 1992, 1997, and 2002).

This relative stability in premium sharing patterns is not surprising as state employers are more typically large employers, which are more likely to offer retiree health insurance benefits (Bokemaier, et al., 1990; Kohler and Sutch, 1994) and to not change premium cost-sharing dramatically from year to year. Nor do large employers tend to totally abandon such programs completely, even when faced with challenges. For example, notwithstanding the implementation of FAS 106, the number of retirees covered by large private employers has changed very slowly.[25]

3. The financial information produced by the application of the new OPEB standards may encourage state governments to think about reducing retiree health benefit programs (and their associated liabilities) in the future. Yet, while the new OPEB standards may lead to the consideration of changes that would minimize adverse accounting effects, health benefit program changes seem more likely to be prompted by the availability of a

[23] In some states, the contribution rate varies by plan selected and/or retiree length of service so that, while a retiree has the potential to receive fully paid health insurance at retirement, the choice of plan selected and service at retirement may result in an employer contribution of less than 100% of the premium.

[24] It should be noted that while premium shares are a broad measure of cost-sharing stability, premiums alone do not capture all relevant costs. For example, other aspects of plan costs such as participant copays, deductibles and out-of-pocket maximums and plan sponsor administrative costs are also relevant. Moreover, stable premium sharing may have been preserved by substituting managed care plan designs for traditional indemnity plan designs.

[25] See *infra* at p.19.

drug benefit through Medicare and the underlying cost drivers, e.g., health care inflation, an expanding retiree population relative to active employees.

The potential impact of new OPEB standards should not be evaluated in a vacuum, given that other important factors may more fundamentally influence the provision of retiree health care benefits by state employers. The cost of these benefits is a critical factor and cost, in turn, depends on factors such as health care cost inflation and demographic trends and how the state responds to the addition of a drug benefit in Medicare. Indeed, the interest in establishing new OPEB reporting standards may well have been prompted, in part, by concern over these same factors.

A recent Kaiser Family Foundation survey of public and private employee health insurance costs showed that the premium costs of private and public employer-based health insurance programs rose 13.9 percent in 2003, following a 12.9 percent increase in 2002, and a 10.9 percent increase in 2001(Kaiser Family Foundation, 2003). Double-digit medical care inflation rate, which characterized the late 1980s and early 1990s but had been quiescent during the spread of managed care plans in the mid 1990s, has apparently returned, as the rate of medical inflation has accelerated from its nadir in 1996. Costs have increased due to a combination of factors such as an aging population, pharmaceutical prices, utilization (generally higher with age, particularly with respect to prescription drugs), and new technology (Miller, 2001).

In addition, like the U.S. population generally, the public sector has a growing retiree population that is living longer. As a result, the ratio of active employees to retirees has become less favorable in recent years. For example, in 1996, the ratio of active employees to retirees in large public pension plans covering state employees was 2.8 to 1. By 2002, that ratio had declined to 2.4 to 1 (National Education Association, 1996 and 2002).

In short, both recent trends in medical inflation and long-term declines in the number of active employees to retired employees represent a significant challenge for state governments that help finance their retirees' health insurance costs.

Adding the new OPEB standards into this mix may encourage state governments to reduce retiree health benefit programs in the future in order to reduce liabilities. Yet it seems unlikely that the adoption of the new accounting standards alone will produce a wholesale abandonment of these programs. It seems more likely that other factors that impinge on whether retiree health benefits are offered and the level at which they are offered will ultimately prove more important to the continuation of benefit programs. For example, if health care insurance costs were to continue to climb at current double-digit levels for the foreseeable future, this alone will prompt public employers to reexamine the levels of continued commitment that they can afford. In such an inflationary environment, the new OPEB standards may bring added pressure but, even without the new OPEB standards, employers will feel considerable pressure to contain health insurance expenditures. To the extent that employers respond to this pressure by reducing

their retiree health insurance commitments, policymakers may become increasingly concerned with how to address these gaps.

4. The new OPEB standards may encourage greater prefunding of retiree health care benefits. Because prefunding typically produces higher short-term costs as compared to pay-as-you-go financing, it may add to state government financial obligations at an inopportune time for those states and may, therefore, prompt a reconsideration of the level of state commitments for future retirees. At the same time, states that do begin prefunding (and those already prefunding) may find that their direct employer costs will be lower in the long run and that their credit rating may be bolstered.

Generally, if state employers begin to prefund the cost of postretirement health insurance benefits that were previously financed on a pay-as-you-go basis, then their short-term contributions will likely be higher because part of future cash flow requirements for retiree benefits will be financed by current period contributions. For states already faced with fiscal crises — and many currently are[26] — a higher outlay in the short-term may not be attractive and may prompt these states to look at curbing benefits rather than prefunding existing levels of benefits.[27]

On the other hand, states that do begin prefunding retiree health benefits, in time may see investment income from the fund paying for a significant portion of the benefits cost that they otherwise would have shouldered. This long-term result coupled with the stability of an annual prepayment and the more accurately disclosed long-term obligation may also have a salutary, rather than a negative, effect on the state's bond rating. Harris, Raymond and Zorn describe the benefits of prefunding as follows:

> "Advance funding reduces direct employer costs over time, increases security for employees, and stabilizes the cash flow commitment for benefits. By recognizing these costs and implementing a plan to prefund them, a jurisdiction can increase its long-term financial strength, possibly improving its credit rating" (Harris, Raymond, and Zorn, 1998).

As previously noted, of 41 states that reported contributing to the cost of state retiree health insurance costs, 11 already prefund their retiree health insurance programs. It is

[26] For example, the Wall Street Journal reported that at least 46 states struggled to close a combined budget gap of $37 billion in a recently completed fiscal year and that the subsequent year's gap was an even wider $58 billion, as the economy continues to maintain a sluggish pace and state revenues feel the consequences. See Russell Gold and Robert Gavin, "Fiscal Crises Force States To Endure Painful Choices," *The Wall Street Journal*, October 7, 2002 at pp. A1, A14. Similarly, the National Conference of State Legislatures reported that two-thirds of the states indicated declining revenues and that more than half of the states face budget deficits. See National Conference of State Legislatures, *State Budget Update*, November 2002.

[27] At the same time, state employers who choose to reduce retiree health benefits may prompt affected active and retired employees to seek stronger guarantees of security such as mandatory prefunding and vesting through collective bargaining or the legislative process. In other words, the ultimate outcome of a state's consideration of reducing such benefits is not necessarily determined unilaterally by the employer.

the remaining 30 that will be faced with determining whether they can manage these costs in the short-run.

Yet it should be noted that the current fiscal difficulties faced by many states, to the extent they are cyclical rather than structural in nature, may be alleviated if the general state of the economy improves over the next several years. Because large governments probably will have until their fiscal year 2007 to implement the new OPEB standards, the economic environment in which they make their consequent decisions regarding their retiree health care programs may be improved over current conditions.

5. To the extent the new OPEB standards may encourage greater prefunding of retiree health care benefits, it may produce greater intergenerational equity for taxpayers. This is because each generation, at least in theory, can assure itself that it is paying only for the personnel costs associated with the services provided by employees active during the taxpayer's lifetime, not previous lifetimes.

Employer-financed retiree health care benefits, like employer-financed pension benefits, represent deferred compensation for services provided by state employees while active. To the extent that employers currently finance deferred compensation benefits on a pay-as-you-go basis, they are paying for the deferred compensation costs of past employees. That is, current generations of taxpayers are paying for services rendered to previous generations of taxpayers. At the same time, current taxpayers are shifting to future taxpayers the burden of paying for the benefits costs associated with services currently received. This arrangement might advantage or disadvantage current taxpayers, depending upon the relative level of services previously provided as compared to the level of services currently provided.[28]

By encouraging more prefunding of retiree health care benefits, the new OPEB standards could result in taxpayers paying for the deferred compensation of state government employees who provide the public services that these taxpayers receive. Better intergenerational tax equity would result. Of course, while some may argue strongly in favor of intergenerational equity, others would argue that allocating the burden of retiree health care costs accurately across generations may be difficult in practice, i.e., who should pay for what service and when raise thorny issues. Arriving at accurate assumptions about the trends in retiree health care costs and state government employment growth over several generations may prove to be challenging. Moreover, even if current and future costs can be satisfactorily allocated across generations of taxpayers, there remains the question of which generation will be burdened with the cost of transitioning to the new system. Should the cost of past services currently being paid for be fully assumed by the current generation together with the cost of current services or should it be spread over all future generations to some degree? Then too, the effects of

[28] Only the initial generation of taxpayers clearly gains from a pay-as-you-go approach that postpones full payment for current benefits because only that generation of taxpayers has inherited no bills to pay from a prior generation. Each successive generation is either a winner or loser depending on whether the bills it creates are higher or lower than the bills it has inherited.

decisions to prefund are unlikely to be incurred instantaneously. Because the contribution the new OPEB standards might make toward achieving intergenerational equity may be difficult to assess practically and may never fully be achieved, this potentially worthwhile impact should not be overstated.

Conclusion

Economic and demographic factors are putting upward pressure on the cost of retiree health insurance provided by state public employers and, unless adequately prefunded, increasing retiree health insurance costs may result in mounting deferred liabilities for state employers with the potential for an adverse impact on credit ratings. The concern over the future potential effect of such liabilities has prompted GASB's examination of current governmental accounting standards for financial reporting and adoption of new reporting standards that achieve sufficient consideration of the impact of providing retiree health care benefits on overall government operations. However, the implementation of that new governmental accounting standards for retiree health insurance and other postemployment benefits, while adding to short-term pressures on government employers, appears unlikely to change what are typically the stable benefit provision patterns of large state employers, unless coupled with significant health care cost inflation for the foreseeable future and a further deterioration of the active-to-retiree workforce ratio. In short, the continued prevalence of retiree health benefits among large employers will be based on the strength of real economic pressures. To the extent that employers respond to economic pressures by reducing their retiree health insurance commitments, policymakers will need to determine how to meet these gaps, inasmuch as the benefits now provided by these employers are an important component of the nation's system of health insurance for retirees.

References

Bokemaier, L. Charles, Van Daniker, Relmond P. and Parish, Sharon, *Other Postemployment Benefits in State and Local Governmental Units,* (Norwalk, CT: GASB, 1990).

Espahbodi, H., Strock, E. and Tehranian, H., "Impact on Equity Prices of Pronouncements Related to Nonpension Postretirement Benefits," *Journal of Accounting and Economics*, Volume 14 (December 1991), pp. 323-346.

Financial Accounting Standards Board's Statement 106, *Employers' Accounting for Postretirement Benefits Other Than Pensions,* (Norwalk, CT: FASB, December 1990).

Fronstin, Paul, "The Availability of Retiree Health Insurance," *Employee Benefit Research Institute Notes,* Vol.16, Number 1 (January, 1995), pp. 3-6.

Fronstin, Paul, "Employment-Based Health Benefits: Trends and Outlook," *EBRI Issue Brief*, May 2001, pp. 1-23.

Fronstin, Paul, "Health Insurance Coverage and the Near Elderly, 2000," *Employee Benefit Research Institute Notes,* Vol.23, Number 8 (August 2002), pp. 5-9.

Fronstin, Paul, "Retiree Health Benefits: Trends and Outlook," *EBRI Issue Brief* (August 2001), pp. 1-27.

Governmental Accounting Standards Board Statement No. 12, *Disclosure of Information on Postemployment Benefits Other Than Pension Benefits by State and Local Government Employers*, (Norwalk, CT: GASB, May 1990).

Governmental Accounting Standards Board Statement No. 16, *Accounting for Compensated Absences,* (Norwalk, CT: GASB, November 1992).

Governmental Accounting Standards Board Statement No. 25, *Financial Reporting for Defined Benefit Pension Plans and Note Disclosures for Defined Contribution Plans,* (Norwalk, CT: GASB, November 1994).

Governmental Accounting Standards Board Statement No. 26, *Financial Reporting for Postemployment Health care Plans Administered by Defined Benefit Pension Plans,* (Norwalk, CT: GASB, November 1994).

Governmental Accounting Standards Board Statement No. 27, *Accounting for Pensions by State and Local Governmental Employers*, (Norwalk, CT: GASB, November 1994).

Gold, Russell and Gavin, Robert, "Fiscal Crises Force States To Endure Painful Choices," *The Wall Street Journal*, October 7, 2002, pp. A1, A14.

Haddad, Mahmoud M., Bar, Saul Z., Redman, Arnold L., and Cowan, Arnold, "Adoption of FASB 106 and Stock Prices," *International Advances in Economic Research*, Volume 1, Issue 2 (May, 1995), pp. 156-164.

Harris, Jennifer D., Raymond, Jeannine Markoe, and Zorn, Paul, *Prefunding Retiree Health Benefits*, (Chicago: Government Finance Officers Association, 1998).

Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2003 Annual Survey*, (Menlo Park, CA, KFF/HRET, September 2003 p. 21).

Kalman, Robert, and Anderson, Thomas R., *Post-Retirement Health Care Benefits: Key Issues For Decision Makers In The Public Sector* (Chicago: Government Finance Officers Association, 1997).

Kohler, Dan, and Sutch, Michelle, "Retiree Health Care: GFOA Members' Perspectives," *Government Finance Review* (December 1994), pp. 45-47.

Labor, U.S. Department of, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms, 1988* (Washington, D.C., U.S. Government Printing Office, 1989).

Labor, U.S. Department of, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms, 1989* (Washington, D.C., U.S. Government Printing Office, 1990).

Labor, U.S. Department of, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Private Establishments, 1991* (Washington, D.C.: U.S. Government Printing Office, 1993).

Labor, U.S. Department of, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Private Establishments, 1993* (Washington, D.C.: U.S. Government Printing Office, 1995).

Labor, U.S. Department of, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Private Establishments, 1995* (Washington, D.C.: U.S. Government Printing Office, 1997).

Labor, U.S. Department of, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Private Establishments, 1997* (Washington, D.C.: U.S. Government Printing Office, 1999).

Miller, Joel E., *Déjà Vu All Over Again: The Soaring Cost of Private Health Insurance and Its Impact on Consumers and Employers* (Washington, D.C.: National Coalition on Health Care, May 2000).

National Conference of State Legislatures, *State Budget Update*, (Denver, CO: NCSL, November 2002).

National Education Association, *1996 Characteristics of 100 Large Pension Plans*, (Washington, D.C.: NEA, August 1996).

National Education Association, *2002 Characteristics of 100 Large Pension Plans*, (Washington, D.C.: NEA, September 2002).

U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms, 1988*, (Washington, D.C., U.S. Government Printing Office, 1989).

U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms, 1989* (Washington, D.C., U.S. Government Printing Office, 1990).

U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Private Establishments, 1991*, (Washington, D.C.: U.S. Government Printing Office, 1993).

U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Private Establishments, 1993*, (Washington, D.C.: U.S. Government Printing Office, 1995).

U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Private Establishments, 1995*, (Washington, D.C.: U.S. Government Printing Office, 1997).

U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Private Establishments, 1997*, (Washington, D.C.: U.S. Government Printing Office, 1999).

Verity v. Howe, 516 U.S. 489, 116 S. Ct. 1065 (1996).

Warshawsky, Mark J., and Mittelstaedt, H. Fred, "The Impact of Liabilities for Retiree Health Benefits on Share Prices," *The Journal of Risk and Insurance*, Vol. 60, No.1 (1993), pp. 13-35.

Workplace Economics, Inc., *1992 State Employee Benefit Survey*, (Washington, D.C., 1992).

Workplace Economics, Inc., *1997 State Employee Benefit Survey*, (Washington, D.C., 1997).

Workplace Economics, Inc., 2002 *State Employee Benefit Survey*, (Washington, D.C., 2002).