

**Public Employee Post-Employment Benefits Commission**  
**DRAFT DISCUSSION DOCUMENT FOR SAN DIEGO HEARING**

Document Overview

In preparation for the San Diego hearing, this document provides background information on the following agenda items:

- Public Employee and Retiree Health Care
- Financial Economics
- OPEB Workgroup Issues

Note

This document summarizes key issues for each discussion item and is not intended to be an exhaustive review of a particular topic. Subject matter experts will be available at the hearing to provide additional detail and answer questions.

## **PUBLIC EMPLOYEE AND RETIREE HEALTH CARE**

### **Introduction**

Until the late 1990s, the cost of providing retiree health care was relatively low for public employers. In recent years, however, public employers in California have been confronted with increasing health care costs. This continuing escalation in premium costs places fiscal pressure on public agencies that maintain comprehensive health benefits. As heard in testimony before the Commission, some public agencies are re-evaluating their commitment to retiree health care contributions. Options such as capping and reducing financial contributions, placing retirees in separate risk pools, or shifting additional costs to employees and retirees have occurred in recent months.

Employers consider two key variables when determining their OPEB liabilities – expected cost trends for medical expenses and utilization of medical services. Actions that reduce these trends usually result in reduced liabilities. As a result, a growing number of public employers are evaluating and implementing proven cost containment methods. Not only do these strategies control or reduce OPEB liability, they can also ensure the continuation of any employer-provided health care benefit.

### **Factors Influencing Medical Cost Trends**

A recent analysis from the Congressional Budget Office (CBO) recognizes three major reasons for the continuing increase in medical cost trends. An aging population and an increase in disease prevalence account for a portion of the increasing cost trends, but the CBO concludes that the bulk of the cost increase results from the development and diffusion of new medical technologies and therapies.”

The CBO also concludes that another factor in increasing health care costs is the declining proportion paid by recipients of services. “Out-of-pocket payments accounted for 33% of personal health care expenditures in 1975, but by 2005, that share had fallen to 15%, and is projected to drop to 13% by 2015.”

### **Impact of Cost Containment Strategies**

Cost containment strategies can improve an employer’s ability to address an OPEB liability, potentially helping to ensure the continuation of any employer-provided health care benefit. At the same time, it is important to recognize that what an employer sees as cost containment may be viewed as a cost shift or a reduction in access to services to employees and retirees.

Despite this perception, evidence from the Health Insurance Experiment (HIE) conducted by the Rand Corporation in the 1970’s and 1980’s indicated that cost sharing reduced the use of health care services without significantly affecting the health of most participants.

Since the HIE, changes in benefit designs are more sophisticated and provide better opportunities for employers to expect employees to become better consumers of health benefits and make more appropriate choices about using services. Updates of the HIE type analysis indicate that the continuing development of consumer-directed health plans is an opportunity for employers to promote cost-consciousness and discourage the use of inappropriate care without deterring consumers from seeking needed care.

## **Employer and Employee Cost Containment Methods**

Cost containment can be accomplished by more effectively using services covered, including: reducing the amount or use of services covered, reducing the reimbursements to providers for services covered, shifting costs to another payor, or some combination of the previous options. For an employer, this can be accomplished by altering benefit designs, shifting costs to employees/retirees, limiting choices of providers, or moving responsibility for members/retirees to other payors (e.g. Medicare).

Following are some specific examples of cost containment methods:

- Benefit design changes (changes in co-pays, deductibles, coinsurance and a reduction in the number of covered benefits, etc.) generally result in lower premiums for both the employer and employees. For example:
  - Co-pays for generic drugs can be reduced while co-pays for brand name drugs can be increased as an incentive to use generics over brand name pharmaceuticals.
  - Co-pays for use of the emergency department can be increased while co-pays for urgent care services can be reduced to provide an incentive to avoid the emergency department.
  - Employers can offer health plans with choices of co-pays (higher or lower co-pays) with corresponding changes in premiums.
- Employers can cap their contributions for health care through either “hard caps” (a fixed dollar amount that does not increase) or “soft caps” (a dollar amount, such as percentage of premium, that changes as premium cost changes). Such caps reduce employer costs and shift some cost to employees/retirees as health premiums increase.
- Benefit designs that waive or reduce co-pays or deductibles for preventive services may provide incentives for employees/retirees to enroll in chronic disease management programs or other wellness initiatives. Employers can also adjust premiums to provide incentives for more efficiently and effectively using the benefits provided by the employer sponsored health plan.
  - For example, premiums can be reduced for members who participate in wellness programs that result in measurable improvements to individual health profiles that avoid chronic diseases (maintaining a specific BMI, smoking cessation, maintaining lower cholesterol levels, etc.).
  - Similar incentives can be adapted to reward successful participation in chronic disease management programs, after diagnosis of a chronic disease, in order to limit the costs and negative health outcomes associated with chronic conditions.
- Benefit designs can be aligned to provide incentives for “evidence based medicine” or preventive care. Evidence based medicine refers to a shift from management of health care utilization to care management that uses clinical research to determine the most appropriate treatment for a given disease.
  - This approach emphasizes adherence to guidelines linked to empirical clinical studies on diagnosis, treatment, and outcomes. It is believed that clinical based knowledge will assist physicians in making more accurate diagnosis and in coaching patients to remain compliant with treatment protocols.

- Financial incentives for both providers and patients need to be adjusted to avoid encouraging the use of more expensive treatments and procedures without evidence of relative effectiveness.
- Benefit designs can be adjusted to require employees/retirees to pay a greater portion of costs for more expensive treatments that are shown to be less effective or less cost effective, an emphasis on value-based insurance design.
- While empirical evidence is mixed, it is anticipated that such an emphasis will slow upward health care cost trends and improve quality of care.
- Employers can limit the choice of providers through selective provider networks. Premiums, co-pays, deductibles, and co-insurance can be increased when members use out-of-network providers. Empirical evidence is limited, in part because this approach is relatively recent. It is anticipated that narrower provider networks will be more efficient (and therefore less expensive) resulting in lower costs over time.
- Options that reduce premiums reduce costs for all plan participants, employers, employees and retirees. Employees and retirees are then in a position to better determine how their health care dollars are spent while providing employers with enhanced tools to control costs.
- Public employers can borrow a tool increasingly used by private employers to make certain that only eligible dependents are provided coverage under the employer's health plan.
  - Family dynamics, high divorce rates and blended families, can lead to ineligible dependents remaining on the employer's plan. Recent reports have suggested that Dependent Eligibility Audits can identify ineligible dependents (ex-spouses and over age or non-dependent children) and reduce costs for the health plan. Cases have been reported where 13-15% of dependents were found to be ineligible for coverage.
  - Under PEMHCA, information provided to members clearly identifies their responsibility to report health enrollment changes to their employer in a timely manner. Retroactive actions are limited to 6 months. Members who fail to report changes in health plan enrollments in a timely manner could be liable to reimburse premiums paid in excess of 6 months. State members must also reimburse the full amount of Medicare Part B subsidy that the State paid to the member based on inaccurate information. In addition, members may be liable to the health plans for costs incurred as a result of services provided to an ineligible dependent.
- Public agencies can also investigate participation in larger purchasing arrangements. These options include:
  - Evaluating the trade-offs of participating in the PERS purchasing pool under PEMHCA. A public agency in PEMHCA receives the benefits that comes from being part of a large purchasing pool (more stable rates, relatively low administrative costs, etc.), but largely delegates control of benefit design, premiums, and administrative structure to the PERS Board. Participation in PEMHCA also requires employers to agree to contribution levels for retirees that equal contribution levels for active employees.

- Joining with other local public agencies through the development of joint powers agreements (JPA). A number of JPAs already exist that address risk management and self-insurance issues for areas other than health care. The concept could be expanded to the provision of health care.
- Participating in joint purchasing arrangements with private sector employers in the same geographical area. Employers, whether public or private, typically use similar provider networks in a geographic area. They could combine their purchasing power to leverage more stable pricing and creative benefit designs. Employer contributions, risk across benefit designs, and out-of area coverage are examples of issues that would need to be addressed with this arrangement.

## **Medicare Coordination for Public Retirees**

### Summary

At the Fresno hearing, there was preliminary discussion about Medicare coordination, or the obligation for health plan members, once eligible for Medicare, to be shifted from a basic health plan to either Medicare or a Medicare supplement health plan. This coordination with Medicare reduces employer costs by shifting first payor responsibility to the federal Medicare program.

Such coordination seems to be the basic policy for local governments outside of PEMHCA, with their health plan partners or third party administrators aggressively transitioning individuals when appropriate.

During the Fresno hearing, it was indicated that under existing statutory and regulatory authority, CalPERS has a process in place to shift members to Medicare when they become eligible. However, additional information provided by CalPERS after the hearing indicates that:

- While such authority does exist, significant populations have been exempted from the requirement by Board policy.
- There are ongoing premium costs associated with individuals who are Medicare eligible but remain in basic health plans.
- Individuals who do not enroll in Medicare when eligible face life-long penalties for being late.

### Background

Under Government Code Section 22844, effective January 1, 1985 any employee, annuitant, or family member who became eligible to enroll in Medicare Part A and Part B may not enroll in a PEMHCA basic health plan, but must enroll in a Medicare health benefit plan. In effect, all such individuals must enroll in a Medicare supplemental plan or a Medicare Advantage (managed care) plan. California State University (CSU) members of PEMHCA were added to this requirement at a later date.

For a significant period of time, there did not seem to be much enforcement of this policy. In 1997, Section 599.517 was added to PEMHCA regulations. This CalPERS Board policy effectively says that:

- If you were retired, enrolled in a basic plan, and turned 65 before January 1, 1998, you could stay in your basic plan.
- The same applied to CSU retirees provided they turned 65 prior to January 1, 2001.

- If you did not meet this requirement and were otherwise retired and eligible for Parts A and B, you had to enroll in a supplemental plan or be subject to removal from a PEMHCA health plan.

Information provided by CalPERS indicates that for the 2006 year:

- Claims costs for individuals over the age of 65 for the Blue Shield HMO were \$12,449,348.
- Claims cost for individuals over age 65 in the self-funded PPO plans totaled \$7,668,807.
- Given the Board's exemption policy, not all of these claims would necessarily be covered by Medicare, but a substantial amount probably of these claims costs could have been avoided with corresponding reductions in premium costs.
- In addition, a surcharge was paid to Kaiser of \$15,465,175 for Medicare eligible members who remained in the basic plan. The Kaiser Medicare Advantage plan is an "at-risk" plan where the plan is responsible for first dollar costs and receives reimbursements from Medicare. With individuals who should be in Medicare remaining in the basic plan, Kaiser does not receive appropriate reimbursement from Medicare and the costs associated with the basic plan are higher than they should be; thus the need for the additional surcharge.

As of September 2007, there were almost 5,800 people over age 65 in the Blue Shield Basic plan, 5,562 in the PersChoice Basic plan, 2,577 in the PersCare Basic plan, and over 8,300 people over age 65 in the Kaiser Basic plan.

While some number of the individuals over the age of 65 will not be eligible for Medicare, this number should be declining since Medicare participation has been mandatory since 1986.

As noted above, individuals who do not register with Medicare when they are first eligible are required to pay a penalty if they join at a later date.

- For Part B, there is a 10% penalty for each year an individual waits beyond the initial eligibility enrollment period. In 2008, the Part B premium will be \$96.40 for a single individual with income up to \$80,000 or each member of a couple with income up to \$160,000. (For example, an individual who delayed enrollment by one year would pay an additional \$9.64 each month.)
- The penalty is an amount added to the monthly premium for Medicare Parts B and D.
- Late enrollees will have to pay the higher amount for as long as they continue to be covered by Medicare.
- Many of the people exempted by Board policy would have significant Medicare Part B penalties if they were shifted now since they would be many years late.

## FINANCIAL ECONOMICS: WHAT IS IT?

Financial economics is a branch of microeconomics focused on the study of capital markets and the allocation of resources over time. A central area of inquiry within financial economics is how markets determine current values or prices of items which involve future cash flows such as shares of stocks and bonds. Although pension benefit payments are not traded openly on markets (and thus, are difficult to value), the financial economics perspective suggests that their value should be based on openly traded fixed income investments (such as U.S. Treasury bills or high grade corporate bonds) which are argued as being close in nature to pension benefit payments.

Adherents to the financial economics perspective suggest that “much actuarial advice wrongly specifies value,” and that actuarial “guidelines and standards need radical revision.”<sup>1</sup> The crux of the debate between the financial economics perspective and the actuarial perspective is the question of whether public pension actuaries should evaluate the present value of expected cash flows from a pension plan in the same manner in which capital markets value other cash flows which are similar in nature to pension benefit payments.

An underlying difference between the two perspectives is that financial economics is focused on current values while actuaries are more concerned with future values.<sup>2</sup> Financial economics places an emphasis on shareholder value and the need for investors to understand current market value. Actuaries, in contrast, are focused on long-term objectives such as smoothing asset values to limit the volatility of short-term market swings. From a financial economics perspective, there is a concern that business pressures, rather than sound fund management principles, can lead “actuaries to depart from the true economic value of the liability.”<sup>3</sup>

### The Market Value of Liabilities (MVL)

A key issue in this discussion is related to the disclosure of pension liabilities. Proponents of the financial economics perspective are in favor of requiring pension plans to disclose the market value of liabilities (MVL). This measure of liability differs from the traditional actuarial liability in two ways. First, the liability is based only on current service and salaries, while the actuarial liability reflects expected future salary increases. The financial market perspective measures the liabilities as if they had to be paid immediately. Second, by measuring the liabilities using market values, the pension benefit payments owed to retirees in the future would be discounted back to the present in today’s dollars using interest rates reflecting fixed income investments, rather than the expected long-term earnings on plan assets. Although there are a variety of opinions as to what rate should be used, the U.S. Treasury bill rate is often suggested as an appropriate option.

Proponents believe that disclosing the liabilities using current market rates would provide useful information to taxpayers, investors and plan participants with respect to the financial position and risks of public pension plans. For example, Robert A. Kurtter, the senior vice president for state ratings at Moody’s Investors Service feels that this approach would be good for two

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<sup>1</sup> “Financial Economics and Actuarial Practice,” by Tony Day, North American Actuarial Journal, July, 2004, p.1. [http://findarticles.com/p/articles/mi\\_qa4030/is\\_200407/ai\\_n9435155](http://findarticles.com/p/articles/mi_qa4030/is_200407/ai_n9435155)

<sup>2</sup> “Financial Economics and Actuarial Practice,” by Tony Day, North American Actuarial Journal, July, 2004. [http://findarticles.com/p/articles/mi\\_qa4030/is\\_200407/ai\\_n9435155](http://findarticles.com/p/articles/mi_qa4030/is_200407/ai_n9435155)

<sup>3</sup> “Financial Economics and Actuarial Practice,” by Tony Day, North American Actuarial Journal, July, 2004, p. 7. [http://findarticles.com/p/articles/mi\\_qa4030/is\\_200407/ai\\_n9435155](http://findarticles.com/p/articles/mi_qa4030/is_200407/ai_n9435155)

reasons: it makes it easier to keep bond buyers informed of the likelihood that government entities which issue bonds will pay them off on schedule and, likewise, it would make it easier to value retirement systems across the country on a consistent basis.<sup>4</sup>

Opponents of this approach believe that the differences in the basic structure of public and private entities, differences in the type of benefit being promised, and differences in the ability of the entity to change that promise make the MVL method inappropriate because it is misleading. Those opposed to the application of the financial economic perspective to public pension accounting and reporting are also concerned that this additional information is unnecessary and may be used to mislead bond holders and taxpayers. Each of these areas is discussed below.

Based on research conducted by PEBC staff, it appears that New York City is the only government entity that has disclosed an additional funded ratio (based on MVL) for its pension plans. Since 1999, the City's pension plans have used a "frozen initial liability" actuarial valuation method that has made the plans appear to be fully funded. The City's chief actuary felt that the funded ratio produced by the City's actuarial method was "uninformative" and disclosed a separate funded ratio calculated in a conservative manner "similar to the way life insurance companies calculate the premiums for products that are comparable to pensions."<sup>5</sup> This alternative method revealed a \$49 billion funding gap in 2006. The City officially reported in its 2006 annual report that "the [pension] Plan is in the enviable position of having a fully funded ratio of 99.6%"<sup>6</sup>

### **Differences in Underlying Principles between Public and Private Accounting and Reporting**

Those who oppose reforms modeled on the financial economics perspective argue that the financial and accounting principles which relate to governmental bodies are different than those which apply to private sector corporations in the following ways:<sup>7</sup>

- Taxpayers and bond holders are not interested in the current value of the governmental unit, but need information to assess whether current taxes will be sufficient to fund future obligations.
- Taxpayers do not make a voluntary investment in the enterprise, but rather pay taxes which they only have an indirect role in determining.

Similarly, the National Association of State Retirement Administrators (NASRA) has taken the position that "the government financial reporting model should not be altered simply to appeal to the misguided perception of the need for public sector/private sector symmetry."<sup>8</sup> In a recent resolution, NASRA responded to recent reform proposals by stating, "the reported liability of a public pension fund must reflect: (1) the presumed infinite life of public employee retirement plans and governmental plan sponsors; (2) the guarantee of public pension benefits under State constitutional, statutory, contractual and/or case laws; and (3) the observable past and reasonable future return expectations for capital markets and common public fund portfolio construction."<sup>9</sup>

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<sup>4</sup> "Pension Fund Short or Full? Depends on the Evaluator," by Mary Williams Walsh and Michael Cooper, *The New York Times*, August 27, 2006.

<sup>5</sup> "City Gets a Sobering Look at Possible Pension Trouble," by Mary Williams Walsh and Michael Cooper, *The New York Times*, August 20, 2006.

<sup>6</sup> New York City Employees' Retirement System and New York City Public Employees' Group Life Insurance Plan, Annual Report 2006,

<sup>7</sup> See, for example, "Why Governmental Accounting and Financial Reporting is – and Should Be – Different," GASB White Paper, The Governmental Accounting Standards Board [http://www.gasb.org/white\\_paper\\_full.pdf](http://www.gasb.org/white_paper_full.pdf)

<sup>8</sup> National Association of State Retirement Administrators Resolution 2007-03.

<sup>9</sup> National Association of State Retirement Administrators Resolution 2007-03.

## **Appropriateness of MVL as a Measure of Future Cash Flows**

Actuaries generally take the position that the funded ratio which is disclosed for a public retirement plan should support the general principles of governmental finance. The role of the actuarial profession is to provide information that is consistent with these principles.

Pension actuaries suggest that:

- Although disclosing a MVL may be consistent with the current value of a business, it does not help to assess the adequacy of future cash flows.
- MVL is not an appropriate method to determine the liabilities of public sector plans. The majority of public sector retirement systems have state constitutions, or other protections, which guarantee the projected benefits of its members. The accrued benefit has no material significance from an employer or taxpayer perspective in public sector plans. Therefore the present value of accrued benefits (PVAB) measurement would be inappropriate.

There are a variety of opinions with respect to what interest rate should be used to calculate MVL.

- Proponents of financial economics suggest that the US Treasury bill rate (i.e. a “risk-free rate”) should be used. The argument is that using anything greater than that assumes a future equity-risk premium that may not occur and could leave the fund with an unanticipated shortfall.
- Actuaries counter, however, that in matching future obligations with future revenues, it is essential to make reasonable assumptions with regard to rates of return as well as other assumptions. Actuaries suggest that as long as the equity-risk premium is determined reasonably, the valuation will give a reasonable allocation of costs between current and future taxpayers. Most public sector plans are heavily invested in equities, and most prominent equity indices have produced annualized rates of return far in excess of those achieved by US Treasury rates or bonds over the past fifty years. The key, according to actuaries, is to use reasonable assumptions for future equity returns. And most would likely view the assumption that equity returns will exceed treasury rates as reasonable.

## **Potential Misuse and Misunderstanding of MVL**

Actuaries and others are concerned that the disclosure of a separate funded ratio which differs from another such ratio may be confusing or misleading to plan sponsors and the public, and may also give the impression that the actuaries are uncertain of the funded ratio. Actuaries feel that because they are trained and paid to provide expertise with respect to the determination of liabilities in pension plans, they and the retirement board should also determine the most appropriate figures to disclose.

Public sector plan governance is a delicate balancing act between state governors, legislatures, union representatives, community members, and trustees. Because these groups and individuals often have very different interests, the disclosure of additional funded ratios may allow each to select the numbers which best support their own particular interests. Additionally, because many of these groups and individuals have limited expertise related to pension fund management and actuarial practices, they may not read or understand the explanations and qualifications which accompany the disclosures of different funded ratios.

Opponents to the financial economics model also argue that public sector disclosure cannot be separated from funding since disclosure is designed to help determine whether current tax levels will support future obligations. The Governmental Accounting Standards Board (GASB) has removed disclosures that are not based on the funding method being used (see GASB Statement Number 25, paragraph 59). Their decision was based on responses received from the users of public sector financial statements indicating that such information was not useful because in practice it was “not used for any purpose”.

### **No Demand for Additional Disclosure**

The question has been raised whether there is a demand for additional disclosure. As evidenced by the recent NASRA resolution, public sector plan administrators and staff do not generally agree with the concept of MVL disclosure for public plans. Retirement systems have made disclosures in accordance with their different funding methods and assumptions since GASB 25 was issued in 1994. Actuaries and plan administrators opposed to additional disclosure requirements suggest that this information has been useful to financial analysts who specialize in governmental finance, and that unless there is a strong demand for MVL, no additional disclosure requirements should be mandated.

### **Disclosure not a Necessary Reform**

Those who are opposed to applying the financial economics perspective to public pension fund accounting point out that some of California’s retirement systems are over 70 years old, and that the vast majority are well-run, appropriately funded, prudently invested, and have paid monthly benefits to millions of retirees over many decades. Actuaries suggest that problems with public sector retirement plans are most often the result of required contributions not being made, a problem that MVL disclosure does not address.

## **OPEB WORKGROUP ISSUES**

### **Federal Payment of OPEB Bond Debt Service**

Federal block grant funds pay for a significant part of county and other California governmental payrolls related to health, human services, roads, education, child care, homeland security, etc. To receive reimbursement, the public agency performing the services which incur federal reimbursement must comply with standards established by the Federal Office of Management and Budget (OMB), including specific regulations regarding reimbursement of OPEB costs.

Currently, OMB guidelines provide for payment of public agency costs for OPEB benefits on a pay-as-you-go basis, in proportion to the reimbursement to those programs that receive federal funding for payroll costs. This cost reimbursement is particularly important for the state and counties, whose payroll costs are significantly offset by federal funds and, to a lesser extent, is important for schools, universities, cities and some special districts.

In addition, the Federal Government does not acknowledge any obligation to pay debt service on a bond used to prefund OPEB liabilities. Consequently, a public agency that currently receives federal funding for some or all of its OPEB obligations would be fiscally imprudent to consider an OPEB bond to prefund an OPEB trust account as a cost reduction strategy.

A similar problem presented itself two years ago when OMB officials raised objections to payment of debt service used to repay public agency pension obligation bonds. This issue was resolved when the OMB agreed to pay pension obligation bond debt service once it was demonstrated that such payments were less costly than direct payments to pension systems for Unfunded Actuarially Accrued Liability (UAAL).

### **Modification of GASB Irrevocable Trust**

The coalition of public agency employers and public retirement systems expressed concern at the Fresno meeting that some public agencies which would otherwise consider the use of bonded indebtedness as a cost-effective means to establish irrevocable OPEB trust accounts, will fail to do so due to the uncertainty regarding future health reform legislative changes that could make irrevocable OPEB trust accounts obsolete.

Specifically, concern was expressed that under state and federal law and GASB statements 43 and 45, an irrevocable OPEB trust can be used only for benefit payments. Consequently, should future legislative changes make payments from the OPEB trust unnecessary for its intended purpose, the remaining funds in the trust could not be used to retire remaining OPEB bonded indebtedness.