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When Employers Fund Retiree Health Care

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One of the most challenging issues facing local government managers now and for the coming decade is retiree health care. A daunting challenge will exist whether the employer pays for benefits in whole, in part, or not at all.

The purpose of this article is to provide a framework for examining the retiree health care program to be offered by a governmental entity, compared with what is offered in other jurisdictions, and to point to the anticipated problems in covering the projected costs to the employer and to the employee/retiree.

Today's Costs for Retiree Health Care Premiums

The cost of retiree health care benefits has been increasing dramatically, and no consensus exists as to when double-digit inflation in health care costs and health insurance premiums may end. Particularly problematic is the rise in prescription drug costs and in employee health insurance programs that include such costs. Here are the current costs for two age groups:

Prior to age 65. Retirees who have employer-provided health care coverage before age 65 are either covered together with active employees or as a separate pool of retirees. Because of the cost of coverage for older workers who are covered separately, most localities providing coverage to retirees include them within their pool of active employees. While this pooling definitely lowers the cost for retiree health premiums, the premium for active employees is higher as a result.

Most employers have not focused on this implicit subsidy of retiree coverage to date but are more likely to do so in the future, as the Governmental Accounting Standards

Board (GASB) statement on “Other Post-Employment Benefits” becomes effective. Employers now covering retirees under age 65 will have ready access to the rates for those employees who retire before Medicare eligibility. Rates will vary depending on coverage, deductibles, region of the country, plan experience, and other factors. The employer, depending on its usual practice, may pay fully by the retiree, in part, or in full.

Retirees who do not have employer-provided coverage and who purchase coverage individually will pay substantial premiums, as much as \$1,000 per month or more, for coverage that includes preexisting conditions. This level of required expenditure by the individual is frequently the primary reason why an employee does not retire at the time he or she desires.

An individual retiring at age 55 with a generous pension benefit of \$60,000 per year will likely be paying as much as 20 percent of that amount (after taxes) for health coverage if none is provided through the employer. Individual coverage generally costs substantially more than group coverage, particularly when preexisting conditions are considered.

At age 65 and older. Most employers providing retiree health benefits to those over age 65 integrate their coverage with Medicare and treat Medicare as the primary payer for these benefits.

Most public sector employees will automatically be eligible for Medicare Part A (hospital insurance) at age 65. The exception is those employees hired prior to April 1, 1986, in jurisdictions not covered by FICA who are not eligible for Part A through a spouse. Medicare Part A coverage may be purchased for \$316 per month (2003 costs) if the retiree has up to 30 quarters of credit. If the retiree has 30 to 39 quarters of credit, the cost is reduced to \$174 per month. If this amount is paid by the individual without any subsidy for seven years, Medicare will then supply the coverage without further premium payment.

Medicare Part B (medical insurance) may be purchased by enrolling and paying a premium of \$58.70 per month (2003 cost). The combination of Medicare Part A and Medicare Part B may cover about 50 percent of the cost of retiree health care.

Individuals who do not have retiree health coverage from a former employer may elect to purchase Medigap insurance. Medigap insurance policies offer different coverage, and to make comparison among policies possible, policies are designated as Medigap A (the least coverage) through Medigap J (the highest level). Policies are

Figure 1. Local Governments’ Provision of Retiree Health Care

No coverage	40%
100% employer-paid	20%
100% employee-paid	20%
Costs shared between employer and employee	20%

available from insurance companies and other organizations providing health care and range in cost from about \$80 per month for Medigap A in the least expensive area to over \$200 for Medigap J in a more expensive location. The costs of Medigap policies in a given locale are listed on the Medicare Web site at www.medicare.gov.

As a rule of thumb for planning purposes, for those with several years to go before retirement, the cost of a Medigap policy plus out-of-pocket costs may range from \$350 to \$500 per month in today's dollars, with coverage that includes a spouse running to somewhat less than twice that amount.

Who Pays for Health Care?

Nationally, about 60 percent of local government employers provide coverage for retiree health care for those under age 65, with slightly fewer (57 percent) continuing coverage after age 65. Figure 1 summarizes local government provision of retiree health care. Many local governments have a length-of-service requirement that is tied to eligibility for benefits or to the percentage of premiums paid.

Authority for Providing Retiree Health Care Benefits

The authority for benefits may be as formal as a state statute or local ordinance or as informal as personnel policies or summary plan descriptions given to employees. Regardless of how they are authorized, retiree health care benefits do not enjoy the same protection under the law as pension plans. Benefits may be improved, decreased, or eliminated by revision of the establishing authority. When benefits are eliminated, current retirees are frequently "grandfathered in" at the existing benefit levels.

Types of Retiree Health Care Programs

Just as with public sector pension plans, retiree health care benefit programs come in two basic types: 1) defined-benefit (by far the more frequent form) and 2) defined-contribution.

With defined-benefit plans, the employer provides a benefit at retirement, normally either as a percentage of the employer's health care premium cost or as a flat dollar amount on a monthly basis.

Defined-contribution programs (also referred to as consumer-driven health care programs) provide individual retirees with accounts out of which an employee may pay for eligible medical expenses, which may include premium costs, deductibles, co-payments, prescription drugs, and so on. Employers may provide one or both of these types of plans to retirees.

Of increasing interest both to employers and to employees are hybrid plans that are basically designed as defined-benefit or defined-contribution but that include features of the other kind of plan. For example, a "target benefit" plan can be established, with individual accounts determining the assets available for retiree health care spending and

actuarial determinations of annual contributions designed to provide a given account balance at retirement. Thus, the plan is a defined-contribution plan with a funding formula that aims for but does not guarantee a given benefit level.

“Pay-as-You-Go” Employer Funding

The vast majority of government employers pay for retiree health care as a budgeted expenditure within the current year’s costs. This pay-as-you-go approach does not reflect the overall employer liability for promised defined benefits, as proposed by a new GASB accounting standard. This new standard will force employers to compute this liability and to report on funding progress toward reaching full funding for accruing costs. Relatively few employers have calculated these future costs, and fewer still have segregated funds dedicated to this obligation.

The Problem from an Employer’s Perspective (or, What Is GASB Doing Now?)

Currently, the rising cost of health insurance premiums is seen as a critical issue for employers. Double-digit premium increases are the norm in times when budgets are strained and enhanced revenue sources are dwindling. But this problem represents only the tip of the iceberg for public employers.

GASB has determined that post-employment benefits other than pensions—or “other post-employment benefits” (OPEB)—are an accruing cost, similar to pensions, that should be reflected in the governmental unit’s financial statements. A similar reporting requirement was added for private sector financial statements by the Financial Accounting Standards Board (FASB Statement 106, issued in 1990).

Early retirement incentives offered by employers seeking to trim their workforces may be enhanced if they can provide some level of continuing coverage.

The reporting requirement is in part responsible for the significant drop in the availability of employer-provided retiree health care in the private sector: from 66 percent of large firms (with more than 200 workers) in 1988, to 34 percent in 2002. Among small private firms (three to 199 workers), only 5 percent provided coverage for retirees in 2002.

The exposure draft for OPEB was issued by GASB in February 2003 and is slated to become effective for large governmental units (greater than \$100 million in revenue) with financial statements for years beginning after June 15, 2006. Medium-sized employers (between \$10 million and \$100 million in revenue) will be required to report

for the years beginning after June 15, 2007, and the following year the requirement will include the smallest employers. Employers will no longer be able to fund only the current year's cost for retiree coverage without causing a negative effect on the financial statements of the reporting entity.

Assets accumulated for funding future retiree health costs in both defined-benefit and defined-contribution plans will only be counted as OPEB assets if they are kept in a segregated trust fund available only for that purpose.

For defined-contribution plans, the reporting will be relatively straightforward; the employer will fund the annual required contribution, which is the annual OPEB cost. Additional information also will be required, including a description of the retiree health savings program.

Employers with defined-benefit retiree health plans covering more than 200 employees will be required to perform actuarial studies to determine liabilities every two years; employers with 100 to 200 employees, every three years; and employers with fewer than 100 employees are provided with a simplified approach. Financial statements for defined-benefit plans will be required to include each year the current year's actuarially calculated OPEB cost, consisting of:

1. The accrued cost earned by employees in the current year; plus
2. The cost for amortization of accrued liabilities.

The reporting entity also will have to report the net OPEB obligation (the sum of the required costs for all years starting with the first reporting year, less the contributions made to a trust reserved for retiree health expenses). Thus, for each year that the employer doesn't fully fund the current year's OPEB cost, including the amortized portion of the preenactment accrued liability, an increase will occur in the unfunded liability for OPEB benefits. Bond rating agencies have already indicated that attention will be paid to the mismatch between liabilities and assets. And this comes at a time when many local governments are experiencing difficulty in retaining their ratings.

For employers who are covering both active employees and retirees in the same insurance program, the true cost of the retiree premium is in part borne by the active employees and by the employer, even if the retiree pays 100 percent of his or her cost. This "implied subsidy" is considered part of the annual OPEB cost by GASB, and the final OPEB statement, due out late this year, will likely require the employer to recognize the implicit subsidy cost in its financial statements. Most employers have not yet calculated the actual value of this subsidy.

Few employers have calculated their OPEB costs, and the annual required contribution might be catastrophic for already-strained budgets. An employer with a payroll of \$60 million, for example, pays 75 percent of the cost of retiree health care. The current year's budget cost for retiree premiums is an "affordable" \$1.1 million. The first year's

required contribution (to fund the current year's accruing benefits and amortizing prior years' costs over 30 years) is estimated at \$11 million, almost 20 percent of current payroll costs.

Employers who do not provide any retiree health coverage may experience none of the financial difficulties outlined above, but frequently their employees will become job-locked and unable to retire because of the immediate necessity of covering the expenses of their retirement health care. Early retirement incentives offered by employers seeking to trim their workforces may be enhanced if they can provide some level of continuing coverage.

The Problem from the Employee Perspective

Those most fortunate retirees who have the most generous benefits often are still required to meet co-payments, deductibles, and possibly prescription drug costs, one of the most rapidly increasing components of medical care. Whether retirees share the cost of coverage with their employers or pay 100 percent of the cost, they will be hit by their portion of the rapidly increasing insurance premium, in addition to out-of-pocket costs. Finally, those early retirees who have no coverage through the employer will be at the mercy of the insurance industry until Medicare coverage starts at the age of 65.

To illustrate the problem, the following assumptions were used, together with the calculator available at www.choosetosave.org (see "Resources" list), to estimate the lump sum needed at retirement to cover retiree health costs.

Assumptions:	
Year of birth	1950
Retirement age	62
Annual cost of health insurance today	\$8,000
Today's cost of Medigap coverage at 65	\$3,600

Resources

Fronstin, Paul, and Dallas Salisbury. *Retiree Health Benefits: Savings Needed to Fund Health Care in Retirement*. Employee Benefit Research Institute, February 2003.

Harm, Kathleen Jenks. *Retiree Health Benefits*. International Personnel Management Association HR Resources Center, May 2001.

www.medicare.gov: Web site that is an invaluable source of information on the operation of the Medicare program; ability to research Medigap policies is available by zip code or state.

www.choosetosave.org: Web site with calculator for retiree health costs; also offers *Retiree Health Benefits* publication by EBRI.

"VantageCare Retirement Health Savings:" A folder for employers that reviews the structure and provisions of the prefunding vehicle offered by ICMA Retirement Corporation.

Rate of return on investments	7%
Life expectancy	87

The following total amounts were calculated to be required at age 62 in order to pay medical insurance premiums until age 65 and to cover Medigap (Medicare supplemental) insurance premiums from age 65:

With 4% inflation in premiums	\$256,300
With 6% inflation	\$366,800
With 8% inflation	\$535,800
With 10% inflation	\$796,700

Many public sector employees plan to use pension income or to withdraw assets from their deferred-compensation plans to pay for this expense in retirement. They should note, however, that the amount of assets calculated as necessary is somewhat misleading if the source of funds is taxable on payment to the individual. If the retiree is in a combined 33 percent tax bracket for federal and state income tax, the lump-sum amounts required would be 50 percent higher than those shown above.

Prefunding of Benefits

For both employers and employees, prefunding of retiree health benefits will become critical in the future. Employers will be forced by the GASB OPEB standard to prefund a dedicated trust if they provide any retiree health benefits and perhaps any implied subsidies. For their part, employees planning for retirement will need to consider seriously the level of assets required to cover their health care costs in retirement.

Among other vehicles, trusts for both employer and employee prefunding are now available through ICMA Retirement Corporation's VantageCare Retirement Health Savings (RHS) program. ICMA-RC's pioneering approach offers a defined-contribution (individual account) program that is flexible and customized to the employers' and employees' needs. Participation may be elective by individuals, and a number of different funding methods are possible.

Contributions are made on a pre-tax basis, earnings are tax-deferred, and reimbursements for eligible medical expenses are tax-free. The ICMA-RC VantageCare RHS program also gives employers the opportunity to segregate prefunding of the

employer's retiree health care liabilities in a trust that is invested in funds appropriate to the long-range nature of this obligation.

The Future of Retiree Health Care in the Public Sector

Costs will continue to go up at rates greater than general inflation rates for the foreseeable future. Medicare is unlikely to provide more of the solution; finding long-term fixes to the system may further tax the ability of employer and retiree alike to afford existing benefit structures.

Employee pressures will grow to establish, maintain, and improve benefits at the same time that OPEB disclosure and economic realities will dictate their reduction. Employees, particularly those who collectively bargain, are becoming more educated on the future cost of retiree health and are requesting retiree coverage where none now exists. The National Conference on Public Employee Retirement Systems (NCPERS) has made the establishment of these benefits a priority.

No consensus exists as to when double-digit inflation in health care costs and health insurance premiums may end.

Recently, five Ohio public-employee pension funds have taken action to boost the costs paid by retirees for previously low-cost or free retiree health benefits. For some retirees, these increases will consume most of their pension checks. One of the five union groups involved has already filed suit to block the price increase. The growing tension in the public sector over retiree health benefits will become more evident, and there will be substantial political risk for policymakers, as making decisions in this area will likely alienate either taxpayers or current and former employees, or both.

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