

Living With GASB 45:

How to Manage Liabilities Associated With Retiree Medical Benefits

by Frank Thoen and Daniel Wade

The Governmental Accounting Standards Board Statement 45 (GASB 45) obliges public employers to disclose liabilities related to postretirement medical benefits. Most state and local government entities are beginning to analyze and quantify how GASB 45 liabilities will affect their balance sheets and credit ratings. This article describes the many ways to reduce those liabilities without eliminating retiree medical plan benefits altogether. Now is the time for employees and employers to work together and make difficult choices for keeping retiree medical costs and GASB 45 liabilities manageable.

INTRODUCTION

GASB 45 obliges public employers to disclose liabilities related to postretirement medical benefits. By now, it is probably familiar to every state and local government entity. Most are beginning to analyze and quantify the problem. Many already understand how GASB 45 liabilities will affect their balance sheets and credit ratings. Few, however, have taken action to reduce those liabilities.

The options for cost reductions are many, and several of the changes entail shifting risk and cost to the employee. This is particularly difficult in the public sector, where collective bargaining and state and municipal laws may influence any discussion of benefits. Few public sector employers can act unilaterally. And, of course, nobody wants to break promises made to loyal employees. Nevertheless, many employers will need to cut costs or increase taxes in order to meet the obligations brought to light by GASB 45. Obviously, the accounting statement did not create the gaps between current funding levels and the future benefit payments implied by the existing retiree medical programs, but those gaps are now much more apparent.

In order to begin this challenging but necessary dialogue, the authors present a number of strategies for

managing and reducing GASB 45 liabilities. They discuss the likely effect of each strategy—the cost impacts and the potential controversies—so that public employers and employees can start talking about ways to address the situation.

REDUCE BENEFIT COSTS

Probably the least painful way to reduce an employer's retiree medical costs is to cut the total cost of the actual care provided. If there are ways to reduce those costs without negatively affecting the standard of care, stakeholders will support them.

One way to reduce the expense of treating a disease is to prevent its occurrence in the first place. To that end, prevention has become a watchword of the health care industry. Health costs are concentrated among the sickest in our society, since approximately half of all health care costs are incurred by 5% of the U.S. population.¹ Much of that cost is for the elderly. Obviously, employers cannot fully eliminate disease; but modest expenditures on programs that make it more likely that employees and retirees can avoid joining that most-expensive 5% would be worth the cost. Wellness programs seek to prevent many of the diseases that are so costly to treat by providing every-

thing from printed health information, to reduced-cost annual checkups, to diet and exercise regimens. They are well established in the health care industry and have shown some promise in reducing the incidence of preventable conditions like obesity, heart disease and certain kinds of cancer. In addition to the potential health care cost reduction, these programs can save employers by reducing absenteeism, workers' compensation costs and disability claims.

While managing the cost of care doesn't have the immediate and dramatic effects on GASB 45 liability that shifting costs to recipients or simply reducing benefits does, it is the first place to look for savings because these changes require less sacrifice. ◀

Disease management (DM) programs are similar to wellness programs. The idea is to prevent chronic diseases like asthma and congestive heart failure from degenerating and incurring ever-higher costs. As with wellness and prevention programs, the costs and benefits of DM in the context of GASB 45 liability need to be weighed carefully. Employers may need to wait years before seeing a return on their investment in DM.

Approximately 70% of all health care expenditures are related to chronic disease.² Carefully controlled clinical trials prove that healthy lifestyle and behavior improve health. Both wellness and DM advocates claim to reproduce the proven results of clinical trials, but without the intensity, control and expense that usually accompanies clinical trials. The extent to which these programs can truly impact behavior isn't well understood, and the cost impact even less so.

Most attempts to quantify the cost-savings potential of DM programs have produced inconclusive results. For example, an issue paper by the Kaiser Commission on Medicaid and the Uninsured³ found that standalone DM programs showed promising initial savings and quality results and also are viewed as a relatively low-cost means of improving health care for those with chronic conditions. However, the com-

mission determined that because DM program outcomes varied from state to state and because the collected data was so preliminary, a conclusive evaluation of the impact of DM programs was not yet possible. Likewise, a Congressional Budget Office (CBO) review of DM program literature⁴ concluded that there was insufficient evidence to support claims that DM programs can reduce overall health spending. Although small studies conducted under controlled settings have pointed to DM cost savings, the CBO said that the savings were likely to disappear if the programs were applied to a broader group, and especially an older and sicker Medicare population. However, the CBO did note that DM programs may still be considered useful, regardless of whether they can pay for themselves.

Both wellness and DM initiatives are more likely to be effective in low-turnover groups; retirees are an excellent example of such a group—who tend to stay in one place and with one set of providers for a long time, so these programs may be more beneficial to the retired population than they are to current employees. The investment is only worth making in situations where employees will be around long enough for the employer to reap rewards from the program.

The management of care delivery can also make a difference. Managed care integrates the payer and provider roles in order to deliver health services with an emphasis on cost containment. It tends to be less expensive than the alternatives, but most public agencies already use it. A managed care approach can be integrated with Medicare Parts A, B and D; this is discussed later in the article.

Aggressively managing prescription drug cost is less common and can produce significant returns. Promoting the use of generics by making retirees pay more for name-brand drugs, using a mail-order prescription program and auditing the prescription drug plan to look for savings can all bring significant cost reductions with little pain for plan recipients.

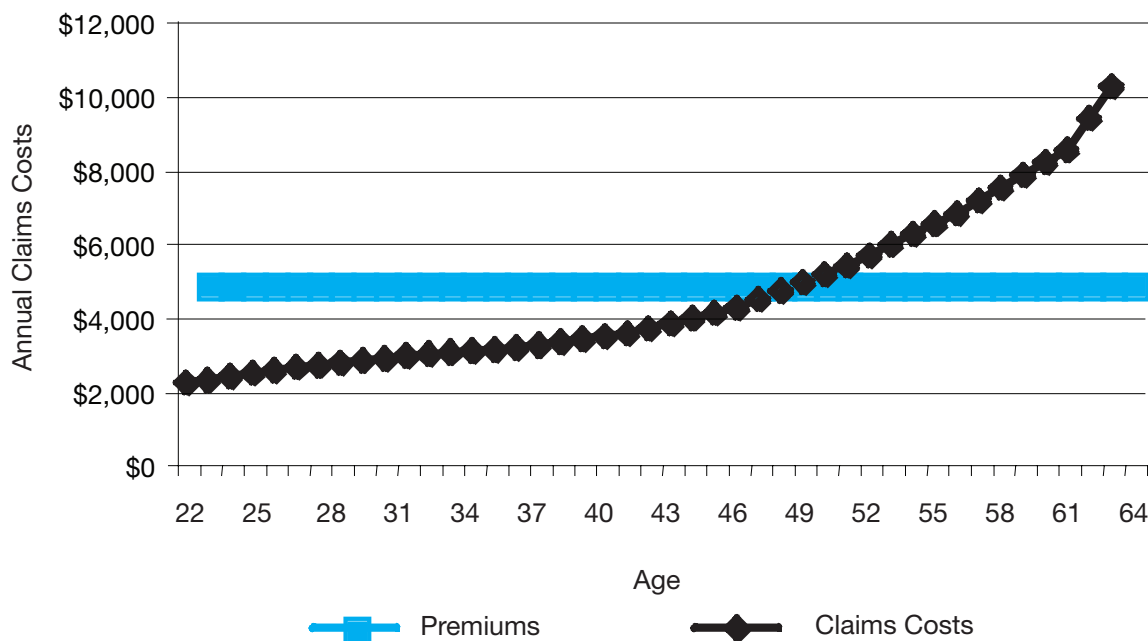
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SHARE COST INCREASES

If the employer takes on the entire responsibility for health care cost increases, its costs (and GASB 45 liability) may become unmanageable, particularly in maturing systems that are experiencing increases in retirees as a percentage of the covered population. It's not a secret that health care costs usually go in

FIGURE 1

MEDICAL BENEFITS—PREMIUM LEVEL VS. CLAIMS COST, BY AGE



one direction—up. It may be reasonable for employers to ask retirees to share some of the responsibility for the cost of health care inflation, reducing the employer’s share of the financial risk involved. Employers may choose to shift some or all of the cost of inflation to retirees by capping or restricting the growth of the dollar amount paid by the employer at current premium levels at a certain future date or future amount, or above a specified percentage growth. For example, the employer might agree to pay annual increases in health costs up to 5% per year and have the retiree pay the remainder, or pay up to 150% of the current retiree premium with the retiree paying anything above that amount.

ELIMINATE OR DECREASE SUBSIDIES FOR RETIREES

Many group health insurance programs use a blended-rate premium for both active and retired employees. Retirees often pay a rate based upon this blended rate. They may pay either a portion of the blended rate or the full blended rate.

Under such an arrangement, an employer may think of its share of the cost as simply the difference between the blended rate and the rate paid by the retirees (zero in the case where the retiree pays the en-

tire blended rate). However, GASB states that this does not reflect the true retiree cost for the employer, because an implicit rate subsidy exists between active employees and retirees. The subsidy exists because the cost of health care increases with age; and because retirees tend to be older than the active population, the true costs for retirees is generally higher than those of blended claims experience. GASB statements require that an employer include this implicit rate subsidy when measuring its other postemployment benefits (OPEB) liability.

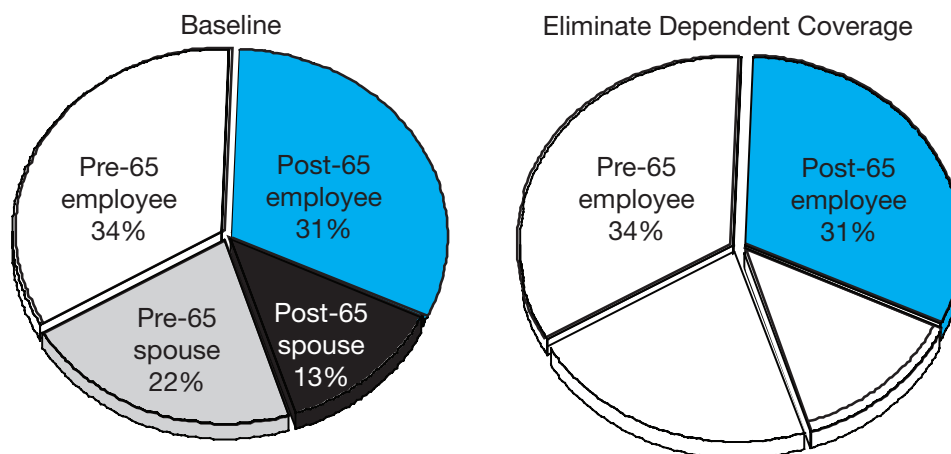
The implicit rate subsidy may be best explained with a picture; see Figure 1.

Note the flat line indicating the premium level, which serves as an average per person cost for medical benefits. As you can see—and no doubt expect—The true cost of benefits rises as participants grow older. The implicit rate subsidy is the true cost of benefits above and beyond the average cost (in other words, the costs that fall above the [blue] line). The closer the retiree gets to the age of 65, the greater the disparity between claims costs and retiree-paid premiums.

By rating retirees separately from actives, the employer can remove the implicit rate subsidy. Rather than charging active employees and retirees the same amount, benefits can be priced with the implicit rate subsidy in mind. This will usually result in higher rates

FIGURE 2

RETIREE MEDICAL BENEFITS—RELATIVE MAGNITUDE OF COST BY GROUP



for retirees than for active employees. If the retiree is charged the full rate based upon the expected retiree claims experience, the employer will eliminate its implicit rate subsidy OPEB obligation. Even if the employer chooses to provide a direct subsidy for retirees, the use of a separate premium for retirees will help the employer control and measure costs.

CHANGE ELIGIBILITY REQUIREMENTS OR IMPLEMENT SERVICE-RELATED BENEFITS

Changing who becomes eligible for a plan—and when they are eligible—can have a big impact on GASB 45 liability by removing certain groups from coverage altogether. The most obvious strategy is to reduce—or even eliminate—benefits for early retirements or spouses.

For example, a typical plan may include both pre- and post-65 coverage to both retirees and their spouses. The relative magnitude of these benefits is shown in Figure 2.

By providing benefits only up to the age of 65, an employer can eliminate 44% of its liability; likewise, by not providing spousal coverage an employer can eliminate 35% of the liability.

The total elimination of early retirement benefits would save the most money (56% in our example), but unions and employees may balk at such radical measures. It may be possible to reach a compromise by tying the percentage of retiree medical premiums paid to the length of service at retirement. Employers and unions should be very familiar with the concept of tying the level of benefits to length of service, since

that is standard practice for pension benefits. Some employers pay full retiree medical benefits for life for anyone who retires with ten or more years of service. These same employers usually provide pension benefits with full retirement income only for those who have a full career with the employer; they provide significantly less to those with shorter service.

To illustrate this concept, consider California's retiree medical plan, which uses a tiered approach to benefit levels (Table I). For workers with ten to 20 years of service, the state pays 5% of total premiums for each year served. It pays 100% of premiums for those who work for more than 20 years and 0% for those with fewer than ten years of service.

It should be noted that while California's plan is less generous than a plan that provides full coverage for everyone with more than ten years of service, it is still a very generous plan. By agreeing to pay 100% of retiree medical premiums for all members with 20 or more years of service, the state becomes responsible for 100% of the effect of future health cost increases for those employees. An employer could lower the 5% multiplier to 3% and cap the employer-paid portion at 90%, leaving even employees with long service responsible for some portion of current cost and future increases. The result might look something like the plan in Table II. This plan still provides attractive incentives, but at reduced cost and risk to the employer.

Reductions in the current percentage paid by the employer could be combined with limits on future increases described above.

There are several other coverage changes that can significantly affect the cost structure of retiree medical

TABLE I**CALIFORNIA'S TIERED APPROACH TO RETIREE MEDICAL COST SHARING**

Years of Service	Percentage of Retiree Medical Premiums Paid by Employer
<10 years	0%
10-11 years	50
11-12 years	55
12-13 years	60
13-14 years	65
14-15 years	70
15-16 years	75
16-17 years	80
17-18 years	85
18-19 years	90
19-20 years	95
20+ years	100

TABLE II**A MORE CONSERVATIVE TIERED APPROACH TO COST SHARING**

Years of Service	Percentage of Retiree Medical Premiums Paid by Employer
<10 years	0%
10-11 years	30
11-12 years	33
...	
29-30 years	87
30+ years	90

plans. One is to limit the postretirement coverage period. A generous plan might limit it to 20 years; a more conservative plan, ten years.

If there are changes to an existing plan, it is important to consider to whom the changes will apply. Making the change effective for current retirees or all future retirees, rather than new hires, will save the most money in the least amount of time but could be perceived as a “broken promise.” Any reduction in employer costs at the expense of current employees or retirees will involve political, human resource and potentially legal risk. Within a collective bargaining agreement, it may be difficult to negotiate changes.

Of course, if it's a choice between a reduced plan or no plan at all—which may be the case in the GASB 45

environment—Unions may be willing to compromise. Even if benefits are not collectively bargained, employees and retirees might bring legal challenges based upon contract law.

Making changes effective only for new hires will tend to be less controversial and risky. While actual cost reductions might not be seen for years or even decades, there will still be some effect within the next few years on GASB 45 calculations, which by their nature anticipate future costs.

CHANGE MEDICAL COVERAGE

Altering the details of what the plan covers can reduce plan costs, although not usually as dra-

matically as eligibility changes. Up for consideration here are plan elements familiar to anyone who deals with health insurance—deductibles, copayments and drug tiers, for example. Additionally, if an employer already provides higher-deductible rather than comprehensive coverage, it might save some money by moving its plan down a notch to catastrophic coverage.

Integration with Medicare Part A and Medicare Part B also offers cost savings. For retirees, Medicare-integrated plans are secondary to Medicare, covering the costs beyond what Medicare pays. The plan-provided benefit can still be subject to a deductible to further reduce employer cost. With Medicare Part D now in effect, it is also possible to coordinate employer-paid prescription drug coverage with government-paid coverage. And the Medicare reimbursement options have improved since Part D's inception in 2006.

For example, at the outset of Medicare Part D, employers might have received a retiree drug subsidy of \$500 per person annually. Now, Medicare has something better called the Employer Group Waiver Program (EGWP). The employer can bow out of Medicare Part D and set up a plan that coordinates with Medicare up front, so that Medicare pays a per capita reimbursement to the plan to subsidize the plan. The plan then pays those prescription benefits. The annual amount paid by Medicare is generally more than \$500 per person, meaning that the employer's share of the premium is reduced. Employers should talk to their carriers about this option the next time their plans come up for renewal.

Another option is the Medicare Advantage Plan (MAP). MAPs now have integrated drug coverage and can pay all costs associated with Medicare Parts A, B and D. MAPs get a per capita reimbursement from Medicare to subsidize these costs. Between the EGWP and MAPs, employers have several options for reducing their GASB liability.

MOVE FROM DEFINED BENEFIT TO DEFINED CONTRIBUTION PLANS

Most employers provide defined benefit retiree medical coverage. The plan describes which procedures will be covered and pays a defined percentage of the cost. The cost may be negotiated between the insurer and the employer, but the plan still pays. This approach provides stability for employees but exposes the employer to a multitude of risks. These risks include trend and utilization risk, longevity/mortality risk and investment risk. There

are different methods of structuring and sharing these risks.

- **Trend and utilization risk.** Employers can reduce trend and utilization risk by requiring retirees to pay all or a share of premium increases after they retire. Doing this places some of the burden of any increases in medical costs on the retiree.
- **Mortality risk.** Employers can reduce mortality risk by setting up their benefits one of two ways: (1) Employers pay for benefits through the retiree's life expectancy instead of until the retiree's death; or (2) the employer establishes a fund calculated to provide for premiums over the lifetime of the retiree; the employer guarantees the return on that fund (so that the employer holds onto the investment risk).
- **Investment risk.** There are two periods of investment risk: preretirement and postretirement. The preretirement risk can be transferred to the employee by accumulating an account for each employee while he or she is working; the balance is then used to provide retiree medical benefits. If the balance at retirement is converted to fixed benefit levels, the postretirement investment return risk is then kept by the employer. On the other hand, to transfer postretirement risk to the retiree, the employer might stipulate that retiree benefits will be provided by a fund (established by the employer at retirement if the employer is keeping the preretirement investment risk, or equal to the preretirement accumulation if the employee is bearing the preretirement investment risk). This postretirement fund will grow with market returns, which transfers the investment risk to the retiree.

There are a number of nuances that can help determine what risk belongs to the employer and what risk belongs to the retiree. Defined contribution plans remove many traditional insurance risks from the employer and put them on the employee. Health savings accounts (HSAs) are an example of defined contribution plans that have received a lot of press in recent years. In defined contribution plans, the employer pays a fixed amount toward employees' medical costs each month, which the employees can use or save as they see fit. The amount can be fixed or it can grow over time. In defined contribution plans, the plan provides the retiree with an account from which to pay for medical expenses or premiums.

In general, new plans—referred to as consumer-driven health insurance—usually include a defined contribution account coupled with a high-deductible insurance program. By giving consumers financial responsibility for their decisions, these plans encourage

consumers to reduce utilization and costs. Consumer-driven health plans are becoming more common in the insurance market overall, although their adoption has been slower than anticipated.

HSA's are particularly attractive to employees who plan to switch employers prior to retirement. When these employees leave an organization, they can take their accounts with them, which is better than what they would get under a defined medical cost plan that would pay them nothing. Few public sector retiree medical plans currently use defined contribution plans, pointing to untapped potential for reducing GASB 45 liability.

CONCLUSION

Private sector accounting standards similar to GASB 45 have led to the drastic reduction or elimination of retiree medical benefits in some cases. That is unfortunate, because retiree medical benefit coverage can help fill the holes in the health care safety net for retired individuals and is a valuable incentive for loyal employees. So far, GASB 45 has not had the same effect in the public sector. According to a recent survey, 66% of public sector employers are not considering making any changes to their plan designs to reduce OPEB costs.

There are many ways to reduce plan costs without eliminating retiree medical plan benefits altogether. Getting there requires employees and employers to work together and make difficult choices—And those choices will not get easier as time passes. Now is the time to begin analyzing and discussing how to

keep retiree medical costs and GASB 45 liabilities manageable. ◀

Endnotes

1. *Characteristics of Persons with High Medical Expenditures in the U.S. Civilian Noninstitutionalized Population, 2002*, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, March 2005, www.meps.ahrq.gov/mepsweb/data_files/publications/st73/stat73.pdf.
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