

**M A N A G I N G
Public-Sector Retiree Health-Care Benefits
under the Affordable Care Act**

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The news surrounding the often contentious launch of the Patient Protection and Affordable Care Act has been full of stories about website failures, mandated switches in health plans, and ongoing policy divides. Underneath the debates and the headlines, however, a new landscape is taking shape, providing access to health-care benefits through the ACA's state exchanges. Government finance officers, who are charged with both maximizing scarce budgetary resources and sustaining quality and competitive benefits for public employees, are facing uncertainty and confusion, but also — potentially — opportunities.

This article assesses the emerging terrain of the ACA and some of the early initiatives for navigating it — with a focus on the possibilities for shaping more affordable and sustainable retiree benefit programs within the public sector.

NEW, BUT NOT UNPRECEDENTED

Many state and local governments that offer retiree health-care programs have long aligned these benefits with federal coverage, as provided under Medicare. Approaches vary by employer, but many require Medicare enrollment upon eligibility (typically age 65) and offer a lower-cost supplemental plan or an integrated Medicare Advantage plan. In other cases, employer coverage ceases altogether when retirees become eligible for Medicare. In general, the approach is to avoid having the employer pay for benefits that are available through Medicare, to which both the employer and employee have contributed via payroll taxes over the employee's active career.

With the ACA, one key question is whether further realignment of existing retiree benefit structures through state-sponsored health exchanges — particularly for younger retirees who are not yet eligible for Medicare — is a viable option for reducing the employer's cost while still providing quality coverage in sync with what is now available elsewhere.

This dynamic is particularly relevant for public employers because some large groups of government employees routinely retire before they are eligible for Medicare. For example, public safety workers such as police officers and firefighters often have benefits designed to encourage retire-

ment well before age 65 because of the physical demands of their positions. The continued prevalence of defined benefit pensions in the public sector (which provide for retirement after many years of service, but, in some cases, before age 65), can also contribute to this circumstance. Governments that provide pension plans that allow for "25 and out" (full retirement after 25 years of service, or some other fixed period) with no minimum retirement age, or have a minimum age requirement of 62, 60, or younger, can wind up paying postemployment health care for pre-Medicare eligible employees for years, sometimes for more than a decade.

From a fiscal perspective, this issue is chiefly important because these earlier retirees who are not yet eligible for Medicare have still reached a point in life when their health-care needs and costs tend to be greater than the needs and costs for their active-workforce colleagues. Furthermore, managing other postemployment benefit (OPEB) costs and liabilities has become more important than ever before, from

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a balance sheet perspective, since the implementation of Governmental Accounting Standards Board Statement No. 43, *Financial Reporting for Postemployment Benefit Plans Other than Pension Plans*, and Statement No. 45, *Accounting and Financial Reporting by Employers for Postemployment Benefits Other than Pensions*, which require actuarial accounting for such

benefits. Future OPEB accounting changes now under consideration, potentially parallel to recent changes for pensions under GASB Statement No. 67, *Financial Reporting for Pension Plans — an Amendment of GASB Statement No. 25*, and Statement No. 68, *Accounting and Financial Reporting for Pensions — an Amendment of GASB Statement No. 27*, are likely to be adopted within a few years and will bring additional focus on these financial pressures.

NO ONE-SIZE-FITS-ALL APPROACH

Because employer approaches to retiree health-care benefits vary significantly, it is difficult to generalize about strategies for addressing these costs that will be applicable to all employers. There is no one-size-fits-all approach.

For example, the legal protections surrounding retiree benefits for employees can vary greatly by jurisdiction. In many

states, a variety of constitutional, contractual, and/or property rights protections can greatly restrict a state or local government from impairing an existing pension benefit for current employees.¹ In contrast, public employers in many communities are generally thought to have more flexibility for enacting retiree health-care reforms — so much so that in some states, retiree health-care benefits may be considered a gratuity rather than a right. Collective bargaining laws, which also vary by jurisdiction, often add yet another dimension to an employer's prospects for reform. Sound legal guidance is critical to developing any strategy for changing benefits.

In addition, each government's level of exposure to retiree health-care costs will also vary. Most cities, and many counties, have public safety employees such as police officers and firefighters. These employees, again, typically retire earlier than civilian workers because of the nature of their work, generating strong OPEB cost pressures. Among state governments and certain public authorities, however, the budget impact of early retirees can be less significant, as public safety workers generally represent a smaller percentage of their overall workforce.

Furthermore, different public employers may offer very different health-care programs for retirees, with much more variation in the level of benefits than is typically found among plans for active employees. For example, the level of employer subsidy, coverage for dependents, duration of coverage, and many other plan characteristics can all vary widely in retiree programs.

Nevertheless, aggregate retiree health-care costs remain a major financial challenge across the public sector. In a January 2013 review of 61 U.S. cities (the largest city in each state, plus those with populations of 500,000 or more), the Pew Center on the States reported that these local governments had funded just 6 percent, or \$8 billion, of the total \$126.2 billion actuarial liability associated with OPEB benefits earned by active workers and retirees, leaving a funding gap of \$118.2 billion.² Across the states, Pew reported an even larger unfunded liability for retiree health care, \$627 billion — almost as big as the \$757

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billion unfunded liability reported for state pensions.³

Health-care costs continue to grow faster than either general consumer prices or revenues for many government employers. From 2003 to 2013, premiums for medical coverage across both private and public employers grew by more than 80 percent⁴ — nearly triple the rate of general inflation, far outpacing revenue growth for almost every state and local government. At the same

time, with increasing longevity and the aging of the baby boomer generation, there are also more public-sector retirees receiving postemployment benefits than those still in active service. According to the most recent Public Fund Survey of major retirement systems (which represents approximately 85 percent of the state and local government retirement community),⁵ the number of pension annuitants has increased faster than the number of active employees in every year of the past decade, growing by 4.2 percent in fiscal 2012 alone. In the same year, the number of active state and local government workers declined.

In 1990, when private corporations became subject to Financial Accounting Standard No. 106, *Employers' Accounting for Postretirement Benefits Other than Pensions* — new accounting rules for retiree health care that were similar to GASB Statement No. 45 — many companies simply phased out retiree health-care benefits altogether. Across the public and private sectors, the number of large employers offering retiree health-care benefits fell from 66 percent in 1988 to just 36 percent by 1993, and was down to just 28 percent by 2013. Many of the remaining corporate plans are capped at an annual limit. In contrast, 78 percent of state and local governments still provided some form of retiree health benefits as of 2013.⁶

Most state and local governments have yet to make meaningful headway toward funding their OPEB liabilities. While many municipalities have begun to establish OPEB trusts to prefund these benefits, many are not able to meet their full actuarially determined annual required contribution, commonly referred to as the ARC. Instead, these employers are funding retiree health care on a “pay-go” basis, or just slightly

more than that minimal amount. At the outset of the Great Recession, many public employers that planned to establish trusts and set aside funds for OPEB were forced to cannibalize that money for other purposes. At the same time, in an effort to manage these liabilities downward, many local governments enacted retiree health-care benefit reforms such as moving from a defined benefit plan to a defined contribution plan, increasing the employees' share of the premium, or changing the vesting schedule.

With economic indicators showing modest improvement, local governments in general are beginning to refocus on establishing OPEB trusts in order to reduce unfunded liabilities and maximize investment earnings, while providing employees with a secure and sustainable benefit. Specific circumstances and options to achieving these objectives vary widely, however. With the adoption of the ACA, additional opportunities for liability management may be emerging.

OPPORTUNITIES UNDER THE ACA: HEALTH-CARE COVERAGE

Before the ACA, public-sector retirees who were not yet eligible for Medicare kept up their health-care coverage through three primary methods: 1) continued coverage through their employer-sponsored retiree health-care program, if available; 2) participation in the health-care program offered by a subsequent employer as an active employee; or 3) seeking health-care coverage in the individual marketplace.

It is not uncommon for public-sector retirees to have a second career after retiring from their jurisdictions, particularly public safety workers and other early retirees. Before the ACA, a second career was sometimes the way retirees provided health-care for themselves and their dependents. But there have been many disincentives for retirees to do that, and incentives for them to remain in their government-sponsored retiree health-care program. New employers tend to offer less generous health-care offerings and/or greater premium cost-sharing (and the same problem exists with self-employment). There is also the risk of losing coverage altogether if a new job is terminated after the worker has waived retiree coverage from the prior governmental employer.

As a result, many retirees opted to continue their coverage through their public employer, at least until attaining Medicare eligibility. Retirees who did not have access to an employer-sponsored retiree health-care program, and who

did not work a second career after retirement, often had little choice in obtaining health-care coverage. Prior to the ACA, the individual marketplace for some pre-Medicare eligible retirees was limited due to insurer underwriting practices that denied coverage based on pre-existing conditions. For those who could obtain coverage, the cost was often prohibitive because of pricing practices that based premiums on health condition and age.

In this longstanding context, many public employers adopted — or negotiated through collective bargaining — policies to continue providing health-care benefits for retirees until they reached Medicare eligibility. Many employers further grouped their active and pre-Medicare populations into the same cost structure, essentially creating an “implied subsidy” for retirees (since active workers paid higher premiums because the retiree population was included in their claim cost). It is anticipated that many employers will begin splitting active and retiree groups to avoid ACA rules and regulations, as the ACA applies only to active employees and not to retiree health care, if the retiree plan is maintained separately. While employers face a federal penalty if they send their active employees to the state exchanges, there is no such penalty for directing retirees to the exchanges.

The ACA may provide employers with an opportunity to develop affordable alternatives to providing employer-spon-



sored retiree health-care programs, while still ensuring that retirees have access to a quality health-care benefit. The ACA ensures two critical components for pre-Medicare eligible retirees that did not exist previously, both of which are highly relevant for public employers: accessibility and affordability. State exchanges ensure access for everyone, regardless of health status. Age is still a factor in determining cost, but there are restrictions on how much older age groups will pay relative to younger age groups. And there are federal subsidies (paid as a tax credit) for qualifying pre-Medicare retirees. These subsidies may make coverage more affordable, even without employer contributions. The amount of the subsidy is based on the level of income (tied to the federal poverty level) and the size of the household.

Many factors and details of the ACA are still developing, particularly regarding the detailed response from the health-care marketplace. Nonetheless, a growing number of private employers report expectations that the exchanges will be a viable option for retirees.⁷ Similarly, the ACA and state health-care exchanges will likely also create opportunities worth exploring for many public employers, some of which are already taking steps to shift retirees who are not yet 65 into the state exchanges.

In January 2014, for example, the City of Chicago, Illinois, began phasing out retiree health benefits for employees hired after August 1989 (when the city started participating in Medicare). The phase-out did not apply to employees hired before the city started participating in Medicare or to retired police officers and firefighters because of their collective bargaining agreements.

Since the late 1980s, the issue of whether Chicago was obligated to subsidize retiree health care, and to what extent, was the subject of extended litigation (*City of Chicago v. Korshak*). The Korshak case resulted in a series of settlement agreements requiring the city to contribute toward the cost of retiree health-care benefits through June 30, 2013. More specifically, the agreement required the city to contribute 55 percent of the cost of coverage for retirees who retired before June 30, 2005, and an amount ranging from 40 to 50 percent of the cost of coverage for post-June 30, 2005 retirees, based

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on their completed years of service (with a minimum of 10 years).⁸

The Korshak agreement also required the city to establish a commission, known as the Retiree Health Benefits Commission, to study and make recommendations about the future of Chicago's retiree health-care benefits program after June 30, 2013. Upon completion of the study, the RHBC rec-

ommended that the city explore options to take advantage of reforms under the ACA.

The commission's analysis indicated that married employees with dependents would see their 2014 annual health-care contributions decline from \$9,159 under the city's plan (if continued) to \$4,862 under the state's exchange, assuming no additional outside sources of income (policyholders' income is assumed to equal their pension payment). Using the same assumptions, only single annuitants without dependents were projected to see an increase in the cost of their coverage under the exchange, versus the status quo. In the aggregate, 58 percent of annuitants were expected to pay less under the state's exchange than they would if the city plan were to continue under these income assumptions (although the number of annuitants paying less under the state's exchange would be smaller, to the extent that they have other household income available).⁹

Chicago's strategy for phasing out locally funded retiree health-care benefit coverage was targeted at reducing city spending on existing retiree health-care costs, reducing unfunded liabilities, avoiding projected future cost increases, and making use of the ACA exchanges in a way that allows retirees to have continued access to care.

POTENTIAL COMPLEMENTARY TOOLS

In tandem with the new exchanges, greater use of fixed stipend and defined contribution approaches may emerge as ways to increase the certainty and sustainability of retiree health-care costs, and as methods of reducing unfunded OPEB liabilities. At the same time, employers could use such strategies to help ensure that retirees can more affordably obtain coverage through exchanges or through their subsequent employer, without the inefficiencies manifest in the current approach. For public employers, fixed payments can provide a more predictable and manageable expense.

Public employers have begun to explore defined contribution approaches to retiree health care. In the State of Michigan, for example, employees hired after January 1, 2012, are no longer eligible for premium subsidies. Instead, employees are eligible for a 2 percent matching contribution into a qualified savings vehicle such as a 401(k) or 457 account, plus a \$2,000 credit to a health reimbursement arrangement upon termination of employment (with at least 10 years of service; the credit is \$1,000 for employees who are not yet 60).

In developing such defined contribution approaches with an eye toward alignment with ACA benefits, however, it is important to seek expert legal and benefits advice. Pre-retirement health reimbursement arrangements, for example, may need to be integrated with an employer-sponsored health plan to comply with ACA annual limit provisions and preventative care restrictions. And retiree-only health reimbursement arrangements may benefit from inclusion of an opt-out feature (allowing for permanent opt out and waiver on at least an annual basis of future reimbursements from amounts already accumulated) because the availability of HRA benefits could potentially prevent a retiree from qualifying for an ACA tax credit. Given the complexity of the new and still-evolving benefits landscape, sound counsel is essential for developing an optimal defined contribution health-care program.

Alternatively, other local governments have maintained a defined benefit approach to postretirement health care for their employees, but they have significantly curtailed costs by moving from guaranteed coverage levels to a fixed stipend. Under this approach, a retiree would receive an annual dollar amount that they could use to purchase health benefits. This approach helps mitigate the employer’s exposure to the medical inflation rate inherent in traditional defined benefit OPEB programs.

OTHER OPPORTUNITIES: PRESCRIPTION DRUG COVERAGE

In addition to creating health-care exchanges and other new options for coverage prior to Medicare eligibility, the ACA also closes the coverage gap, popularly known as the “donut hole,” for Medicare Part D prescription drug costs. In turn, again depending on a public employer’s existing retiree benefit structure, this may create significant opportunity to realign plan design for cost savings.

Before this program was expanded under the ACA, the original Medicare Part D plan required beneficiaries to pay 100 percent of prescription drug costs between the initial coverage limit and the catastrophic coverage threshold — a major cost, if it wasn’t separately covered by the employer. With the passage of the ACA, however, cost sharing for covering the gap is being reduced over time from 100 percent to 25 percent. This reduction is being phased in gradually from 2011 and 2020, as shown in Exhibit 1. As of 2014, Medicare Part D covers 28 percent of the cost of generic drugs, with further increases ramping up to 75 percent by 2020. In addition, pharmaceutical manufacturers are providing a discount on the ingredient cost for “applicable” drug costs (brand name prescriptions for the companies in the program) in the donut hole, which will also increasingly moderate costs for beneficiaries.

With the Medicare Part D donut hole gradually closing, public employers that now provide pharmacy benefits for Medicare-eligible retirees can reevaluate the alignment of such coverage with the improved federal program. Given the substantially lower 25 percent cost-sharing for beneficiaries, significant protection for retirees with high prescription drug usage, and further federal subsidies for low-income retirees, some state and local governments may find that continuing to provide an employer-designed and -administered pharmacy plan for Medicare-eligible retirees and beneficiaries is no longer the best use of their health-care dollars.

In 2011, for example, the Commission on Public Employees’ and Retirees’ Benefit Sustainability for the State of Maryland

Exhibit 1: Maximum Medicare Part D (Rx) Member Coinsurance

Year	Non-Applicable Drugs	Applicable Drugs
Pre-ACA	100%	100%
2011	93%	50%
2012	86%	50%
2013	79%	47.5%
2014	72%	47.5%
2015	65%	45%
2016	58%	45%
2017	51%	40%
2018	44%	35%
2019	37%	30%
2020 and beyond	25%	25%

recommended that “the state establish in statute a requirement that, by the year 2020, all Medicare-eligible state retirees must join Medicare Part D for prescription drug coverage,” with no continued eligibility for the state prescription drug plan. Largely based on the assumption that the Part D coverage gap will be eliminated by 2020 under the ACA, the commission estimated that such action would reduce Maryland’s OPEB liability by \$5.5 billion and the state’s annual required contribution for retiree medical liabilities by more than \$420 million. As part of a broader package of benefit reforms, this commitment was enacted later that year.

In evaluating this option and related opportunities, governmental employers will face differing degrees of change, depending on factors such as the existing plan design, cost-sharing requirements, and the availability of dependent coverage. As the market develops, alternative approaches such as “wrap around” Medicare plans that coordinate supplemental benefits with the improved Part D coverage may provide further options for some public employers.

CONCLUSIONS

Given the recent and ongoing rollout of the ACA, significant issues and uncertainties remain about the new health-care landscape that is taking shape. Further, these issues extend well beyond the ones that have been the focus of this article. Other large, complex, and possibly more costly issues for governmental employers are also on the horizon. The “Cadillac” tax, for example — which is scheduled to go into effect in 2018 and will establish a 40 percent excise tax on high-value health-care plans — will be particularly challenging for many public employers.

In many communities, the current health-care landscape may present an opportunity for municipalities to establish interdisciplinary working groups to explore local options and possibilities for reform. These groups, which should draw from financial, human resources, and legal professionals within each public employer, might also benefit from expert assistance. In 2011, the GFOA adopted a best practice, *Developing a Review Process for Implementing National Health-Care Reform*, that provides useful guidance on the issues and approach to this important process.

The ACA ensures two critical components for pre-Medicare eligible retirees that did not exist previously: accessibility and affordability.

In addition, governments should consider establishing working groups that provide a joint, open forum for representatives of both labor and management to gain a common understanding of the full set of issues, opportunities, and challenges posed by the ACA within the unique context of each jurisdiction. The legal landscape and collective bargaining framework (or lack thereof) in each commu-

nity will affect the design of any such labor-management approach. For many communities, however, this type of collaboration can begin to build the level of trust and shared understanding that is important for any eventual changes to move forward with input — and ideally support — from all stakeholders.

The sooner key ACA issues and opportunities can be identified, the sooner successful and sustainable strategies can be implemented. ■

Notes

1. Alicia H. Munnell and Laura Quinby, *Legal Constraints on Changes in State and Local Pensions*, Center for Retirement Research at Boston College, August 2012.
2. *A Widening Gap in Cities: Shortfalls in Funding for Pension and Retiree Healthcare*, the Pew Charitable Trusts, January 2013.
3. *The Widening Gap Update*, the Pew Charitable Trusts, June 2012.
4. *Employer-Sponsored Health Benefits, 2013 Annual Survey*, the Kaiser Family Foundation and the Health Research and Educational Trust, 2013.
5. *Public Fund Survey, Summary of Findings for fiscal 2012*, December 2013.
6. Kaiser/HRET.
7. Paul Fronstin and Nevin Adams, *Employee Benefit Research Institute Issue Brief No. 377*, October 2012.
8. City of Chicago, “Report to the Mayor’s Office on the State of Retiree Healthcare,” Retiree Healthcare Benefits Commission, January 11, 2013.
9. City of Chicago.

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