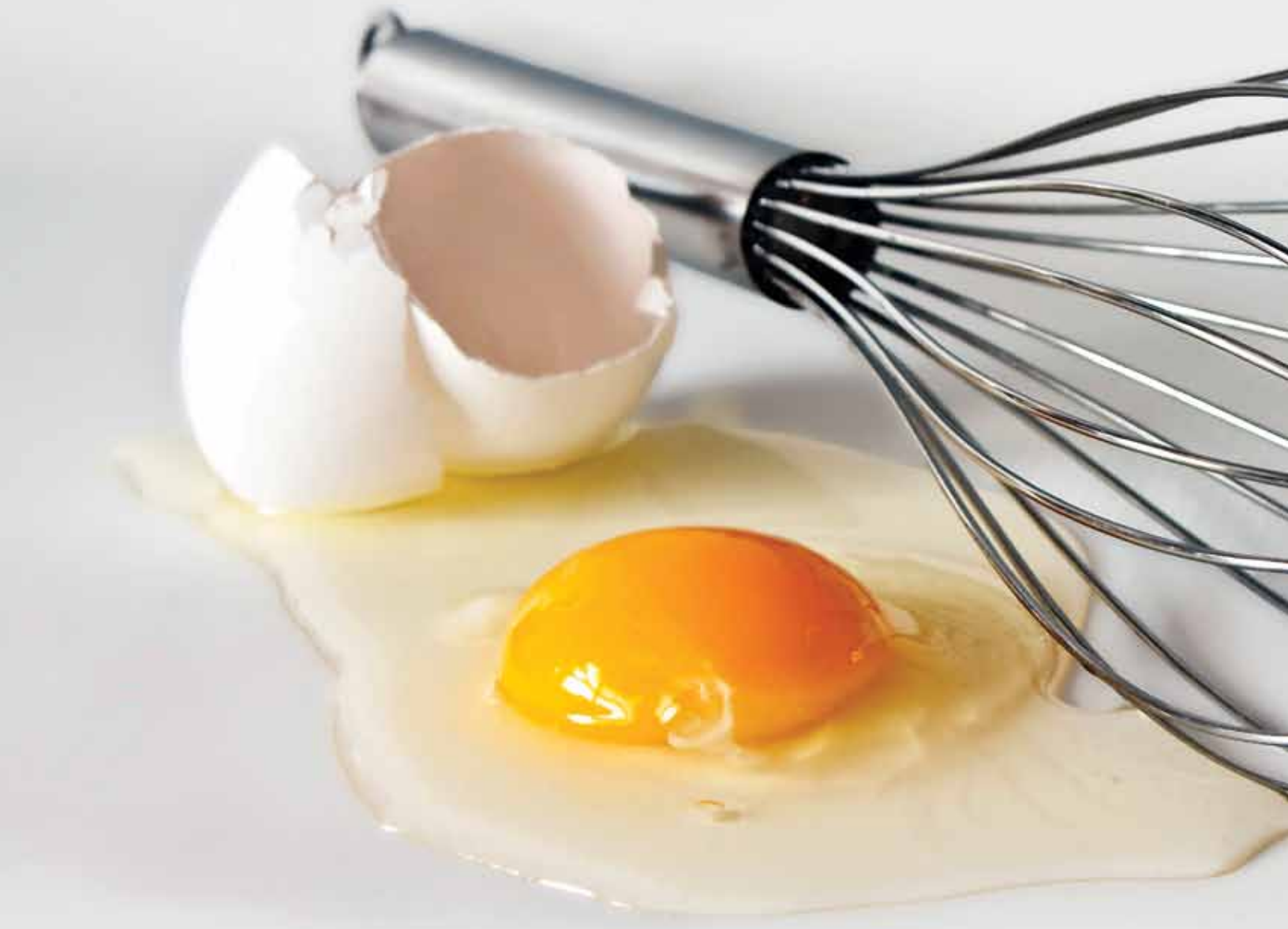
OPEB Liability— Does It Matter?



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An underused strategy for reducing the cost of retiree drugs, the employee group waiver plan (EGWP), can legitimately lower other postemployment benefits (OPEB) liability. This article focuses on public employee retiree health plans, particularly those of municipalities.

Other postemployment benefits (OPEB) liability refers to an employer's financial obligation to provide retiree health care and other benefits besides pensions. Across the country, the OPEB funding shortfall is estimated to be in the trillions of dollars, and how municipalities and other public employers control the liability is the topic of much discussion.

Most public employers fund the cost of health care benefits for current retirees from their annual operating budget. However, many fail to set aside money to pay for the benefits promised retirees in the past or for the future benefits promised to current employees when they retire. As a result, unfunded OPEB liabilities grow over time.

The Governmental Accounting Standards Board (GASB) brought the issue to the forefront with Statement 45 forcing municipalities and other public employers to measure and put a number on their balance sheets for this long-term obligation. But the financial reporting of OPEB liability has had some negative, unintended consequences.

takeaways >>

- OPEB liabilities continue to grow when employers fail to set aside money to pay for promised retiree health benefits.
- An actuary makes assumptions about medical cost trends, cash-flow valuations and interest rates to put a present value on OPEB liabilities.
- The EGWP subsidy pushes a higher share of pharmacy costs onto the federal government, lowering the plan sponsor's liability.
- Two advantages EGWPs have over the more commonly used RDS are a higher base subsidy and catastrophic reinsurance.
- ACA has eliminated the tax-free status of RDS payments received by federal tax-paying employers, increasing interest in EGWPs. Public employers are tax-exempt but can save money by using EGWPs.

Taxpayer groups, the media, bond-rating agencies and, to a lesser extent, the public have focused on the unfunded liability, and public employers have used accounting assumptions to bring down OPEB liability. However, this strategy has no meaningful impact on the underlying cost of retiree health care.

To reverse this trend, it is essential to understand how an OPEB valuation is calculated and the shortcomings of focusing not on underlying costs, but on the assumptions that drive the magnitude of OPEB liability.

This article discusses an underused strategy that legitimately lowers OPEB liability—the employee group waiver plan (EGWP—pronounced "egg whip").

Assumptions That Generate OPEB Liability

The OPEB liability on a public sector employer's balance sheet is an attempt by the accounting and actuarial professions to turn the continuing liability for retiree health care into a reliable present value. While there clearly is a liability for future health care costs, the amount calculated by the actuarial analysis appears divorced from reality in many ways. That is not to say that the number is not valuable. However, if public plan officials don't understand how the value of the OPEB liability is generated and what its limitations are, the number can be misleading and misused.

For this article, we will focus on municipalities, but it is important to remember that OPEB liabilities pertain to all public and private sector employers. In calculating the OPEB liability, an actuary looks at how many people work for the municipality, how many have retired and the benefits promised. Other critical inputs include the age of workers, when they are likely to retire and how long benefits are likely to continue after retirement.

The actuary then reviews the various health plans that the municipality offers retirees, the costs of those plans and the retiree cost share. At this point, the actuary must make some big assumptions in order to calculate the present value of the OPEB liability.

Big Assumption Number 1: Medical Cost Trends

The actuary needs to estimate how much the cost of retiree health care coverage will rise or fall in the future. To do so, the actuary typically starts with a growth rate, say 8% or 9%, and then reduces it by 0.5% each year until it reaches a final growth rate of 5% some number of years later.

However, when the actuary returns two years later to conduct the biannual OPEB valuation and the municipality has not seen the rate of growth drop by even 1%, more often than not the actuary just resets the schedule at 8% or 9% and pushes back the terminal date.

Big Assumption Number 2: Cash-Flow Valuations

The calculation of current cost, cost trends, the number of people receiving benefits and the timing of those benefits is designed to generate a set of future cash flows required to pay for retiree health benefits.

If a municipality does not fully fund benefits earned by retirees in the past, currently and in the future, the liability will continue to rise. Moreover, even if the municipality does fund the past, present and future obligations to retirees, but health care costs outstrip the actuary's estimates or the fund's investment returns are below projections, the unfunded liability will only continue growing.

Big Assumption Number 3: Interest Rates

Another critical element is the interest rate assumptions made by the actuary. An actuary can choose from two interest rates in order to calculate the present value of OPEB—the funded rate and the nonfunded rate. The *funded rate* is the interest a municipality earns from the value of its retiree benefits fund assets (e.g., cash, stocks,

bonds, etc.) if it has put aside money to cover the OPEB liability. Typically, that rate of return is around 8%. If the municipality has not formed an OPEB trust or started to fund it, the actuary is forced to use a much lower rate of return, say around 4%. For this reason, forming an OPEB trust and depositing a minimal amount of assets into it can significantly lower the OPEB liability.

While funding an OPEB trust is a step in the right direction, it has inherent limitations as well. The most obvious limitation is the likelihood that in the current economic climate, an OPEB trust fund will achieve a return of 8% over the next 30 years. Currently, yields on ten-year government bonds are under 2% and the earnings yield on U.S. stocks is under 6%. Assuming a 70/30 stock/bond mix, this would suggest prospective OPEB trust returns of around 4.8%. So the likelihood of achieving an 8% return from those assets is currently pretty slim.

Another significant flaw in the GASB 45 regulation is the triggers under which a municipality can change from a nonfunded to a funded rate assumption. All that is required to form an OPEB trust is to put a funding "plan" in place and deposit some money in the trust. The amount can be significantly less than the total OPEB obligation. However, a municipality does not have to fund the trust every year in order to apply the higher assumed rate of return. Going from a 4% to 8% return/discount rate assumption can drop the OPEB liability as much as 50%.

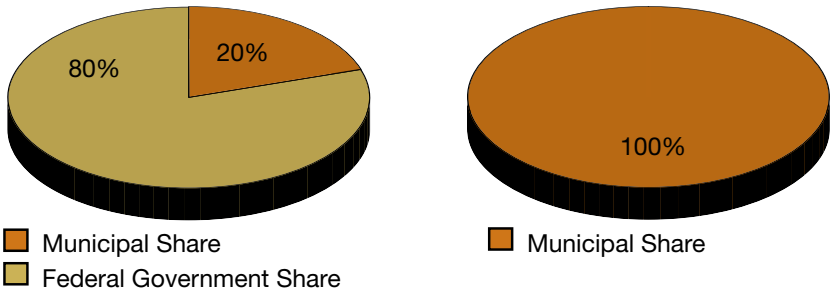
OPEB liability is supposed to accurately reflect the cost of retiree health benefits. Creating a trust with a nominal dollar balance does nothing to affect the cost of providing the benefits, but it can reduce the OPEB liability on paper by tens of millions to hundreds of millions of dollars for larger cities.

What lessons can be learned from this process for generating the OPEB valuation?

The OPEB valuation itself is generated through a complex process with a number of critical assumptions, which can have a significant impact on the size of the liability. None of these assumptions deals directly with the actual cost of providing health care benefits to retirees. If municipal managers are focusing only on the accounting value of the OPEB liability, they are not tackling the real problem—why the costs are rising and how best to contain them. Addressing those issues, rather than manipulating interest rates or health care cost growth assumptions, will help reduce the real drivers of municipal and retiree health care costs.

FIGURE

Employer Group Waiver Plan vs. the Retiree Drug Subsidy



Example: If retiree has drug expenditure of $20,000, the EGWP pays ($20,000−6,773) × 80% = $10,581.60 in extra subsidy. The RDS would pay $0 in extra subsidy.

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Linda Cahn. International Foundation Webcast. 2010.
For more information, visit *www.ifebp.org/books.asp?DL1007.*

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Pharmacy Benefits: Plan Design and Management
F. Randy Vogenberg. International Foundation. 2011.
For more details, visit *www.ifebp.org/books.asp?6962.*

TABLE

Maximum Subsidy Comparison for Selected Specialty Drugs Under the EGWP and the RDS

Drug Name	Most Common Indication	Days' Supply	Plan Cost*	Course of Therapy (or) Annual Cost	Maximum RDS Subsidy **	EGWP Subsidy ***	EGWP Savings Over RDS
Incivek	Hepatitis	28	$16,796.41	$50,389.23	$1,757.00	$35,574.38	$33,817.38
Revlimid	Cancer	21	$8,101.07	$97,212.84	$1,757.00	$73,033.27	$71,276.27
Sutent	Cancer	30	$7,906.13	$94,873.56	$1,757.00	$71,161.85	$69,404.85
Gleevec	Cancer	30	$6,010.14	$72,121.68	$1,757.00	$52,960.34	$51,203.34
Humira	Inflammatory Conditions	28	$5,937.62	$71,251.44	$1,757.00	$52,264.15	$50,507.15
Zytiga	Cancer	30	$5,673.81	$68,085.72	$1,757.00	$49,731.58	$47,974.58
Tobi	Infections	28	$5,353.17	$32,119.02	$1,757.00	$20,958.22	$19,201.22
Tarceva	Cancer	30	$4,890.07	$58,680.84	$1,757.00	$42,207.67	$40,450.67
Victrelis	Hepatitis	28	$4,537.20	$49,909.20	$1,757.00	$35,190.36	$33,433.36
Xyrem	Misc. Specialty Conditions	27	$4,499.27	$53,991.24	$1,757.00	$38,455.99	$36,698.99
Gilenya	Multiple Sclerosis	28	$4,139.45	$49,673.40	$1,757.00	$35,001.72	$33,244.72
Copaxone	Multiple Sclerosis	30	$4,115.77	$49,389.24	$1,757.00	$34,774.39	$33,017,39
Sprycel	Cancer	30	$4,060.63	$48,727.56	$1,757.00	$34,245.05	$32,488.05
Enbrel	Inflammatory Conditions	28	$3,727.06	$44,724.72	$1,757.00	$31,042.78	$29,285.78
Rebif	Multiple Sclerosis	28	$3,483.27	$41,799.24	$1,757.00	$28,702.39	$26,945.39
Avonex	Multiple Sclerosis	28	$3,359.82	$40,317.84	$1,757.00	$27,517.27	$25,760.27
Pegasys	Hepatitis	28	$2,531.33	$30,375.96	$1,757.00	$19,563.77	$17,806.77
Pulmozyme	Respiratory Conditions	30	$2,323.81	$27,885.72	$1,757.00	$17,571.58	$15,814.58

* Actual cost of individual prescription based on number of days' supply.

** Maximum RDS is 28% of the per retiree prescription costs between $325 and $6,600; this example assumes one retiree takes only this drug.

*** $650 base subsidy plus 80% of per retiree prescription costs in excess of $6,733.75.

EGWP Can Legitimately Lower OPEB Liability

One solution overlooked by many public and private sector employers is to structure Medicare prescription drug benefits to take advantage of the EGWP subsidy instead of the more commonly used retiree drug subsidy (RDS). These are federal subsidy programs available to plan sponsors (i.e., municipalities, in this case). This one shift can save an average of $480-$840 per Medicare retiree per year and dramatically lower the OPEB liability.

Retiree health insurance generally is funded by municipalities as the benefit payments come due (i.e., "pay as you go"), in which current costs are funded annually from the operating budget. Because the EGWP subsidy pushes more of the cost of providing benefits onto the federal government, it can significantly lower a municipality's annual pay-as-you-go costs, leaving more money in the operating budget to fund the OPEB trust without cutting retiree benefits or shifting a greater share of the costs onto retirees.

The EGWP subsidy has two distinct advantages over the RDS—a higher base subsidy and catastrophic reinsurance.

A Higher Base Subsidy

The RDS program rebates to plan sponsors 28% of each retiree's pharmacy expenditures between $325 and $6,600. The maximum rebate for a plan sponsor for any covered individual is $1,757 ($6,600−$325 × .28 = $1,757). It is important to note that the amount of the RDS payment depends on the level of the retiree's spending. According to Medpac data, the average subsidy for plan sponsors is approximately $510 for each retiree per calendar year.

The EGWP subsidy is not deter-

mined by a retiree's pharmaceutical spending. Instead, the federal government applies a formula for risk rating the plan's members. On average, the EGWP subsidy is approximately $650 per participant per calendar year.

Catastrophic Reinsurance

A significant benefit of the EGWP is its catastrophic reinsurance, which is not offered by the RDS program. In the EGWP, once an individual's drug spending exceeds $6,773.75, the program pays 80% of the cost (see the figure). Given the increasing prevalence of very expensive specialty pharmaceuticals, the value of this catastrophic reinsurance, compared to the maximum $1,757 RDS program subsidy, can't be understated. *Specialty pharmaceuticals* are a category of drugs for very specific disease states. They typically have only a very small potential target population but can cost tens of thousands of dollars per year. The table provides a comparison of the EGWP subsidy and RDS for a sampling of specialty pharmaceuticals.

Other EGWP Benefits

Beyond simply reducing costs, the EGWP provides other key benefits. GASB has determined that because RDS receipts are considered general revenues to the municipality, they do not count as a cost reduction when calculating the OPEB liability. In contrast, because the EGWP subsidy and reinsurance directly lower the cost of retiree health care benefits, this cost reduction can be factored into calculating the OPEB liability.

Health Care Reform and Subsidy Programs

For plan sponsors that benefit from federal subsidies to help pay for retirees' drugs under Medicare Part D, it is currently unknown how much future health care reform will impact these subsidy programs. What is known, however, is that the Affordable Care Act (ACA) has eliminated the tax-free status of RDS payments received by federal tax-paying employers. Plan sponsors that pay no federal income tax, such as state governments, municipalities and other not-for-profit organizations, are not affected.

This change meant that businesses that received the 28% RDS reimbursement had to treat it as taxable income on their financial statements when the law was enacted in 2010. This one change can mean a sizable hit to a company's financial condition. AT&T, for example, reported a write-down of $1 billion against income when the tax advantage was eliminated.

As expected, the new tax status of RDS payments dramatically increased interest in EGWPs from tax-paying plan sponsors. This, in turn, has led to greater awareness of the EGWP advantages by tax-exempt organizations as well. The state of Connecticut switched from the RDS program to the EGWP in 2011 and, according to the state's actuary, reduced its OPEB liability by $4.5 billion.

Until ACA takes full effect in 2014, the best thing for subsidy beneficiaries to do is stay informed. Additionally, plan sponsors may want to take advantage immediately of the EGWP, run a competitive bidding process for retiree health benefits and focus on lowering the OPEB liability by actually lowering the cost of health care.

<< bios

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