Mountain or Molehill?

Putting OPEB in Perspective for West Virginia

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Overview

Mention the words "OPEB liability" in West Virginia, and the likely response is that it is an $8 billion crisis that will cripple the state if serious action is not taken. The ensuing panic has led to budget paralysis. In short, the issue of other post-employment benefits (OPEB) has taken legislators' attention away from more pressing matters and could funnel state dollars away from much-needed programs and services that could benefit hundreds of thousands of West Virginians. Politicians have already indicated that the OPEB liability will be one of the main issues of the 2011 Legislative Session.

By placing the OPEB issue in context, this paper aims to demonstrate that the liability is not a crisis, but rather a manageable concern.

The OPEB liability is not new, just newly reported. It has existed since the 1970s when the Public Employees Insurance Agency (PEIA) began offering group health insurance to retired public employees at a subsidized price.

Access to affordable health care is of great importance to retirees who face large medical costs and high rates of economic insecurity.[1] Furthermore, West Virginia's average pay for public employees is one of the lowest in the nation and falls below all neighboring states. A benefit like subsidized health care for retirees, therefore, plays an important part in attracting and retaining quality employees.

The rising cost of health care over the past few decades has made this benefit more expensive, placing more pressure on state and local budgets. This growth is placed in perspective by examining historic, current, and future health care costs and comparing them to the funding streams that cover these costs.

Although revenue from active employees, employers, and retirees had been enough to pay for retiree health care, more rapid growth in the future may prompt the state to rethink its heavy reliance on this funding stream. Future growth will not be happening in a vacuum; state and local budgets also will grow during this same time period. The addition of other funding sources, not necessarily large ones, could prevent any large burden from falling on the shoulders of employees and retirees in the future.

The accounting rule, GASB 45, which first brought this liability to light for most states, is not a law. Nor does it require states to fully fund their liabilities. The OPEB liability is not a fixed dollar amount; rather, it is an estimate of costs depending on different assumptions, which can make the estimate vary widely.

A few points are worth bearing in mind when considering policy solutions for the complex issue of retiree health care for public employees.

- **Don't panic. The OPEB "crisis" is manageable.**
- **Find new revenue streams to supplement the revenue from premiums and employer contributions. These streams do not have to be large sums, but they should be used to slow the growth of revenue from employees and employers.**
- **Cap the overall revenue contribution from active employees to keep their premiums from becoming unaffordable. Exempt new hires from paying for a benefit that they will not receive.**
- **Control health care costs by implementing strategies like medical homes and increased use of information technology.**

Chapter One

Health Care Places Growing Pressure on Budgets

Over the last fifty years, the cost of health care has increased dramatically in the United States. In 1960, 5.2 percent of the nation's gross domestic product (GDP) went toward health expenditures, including both the private and public sectors.[2] By 2008, health expenditures comprised 16.2 percent of GDP.[3] Spending on health care is projected to grow to approximately 20 percent of GDP by 2019.[4] After including the impact of the 2010 Affordable Care Act, the Congressional Budget Office projected that total health care spending could reach 26 percent by 2035 and 41 percent by 2080.[5]

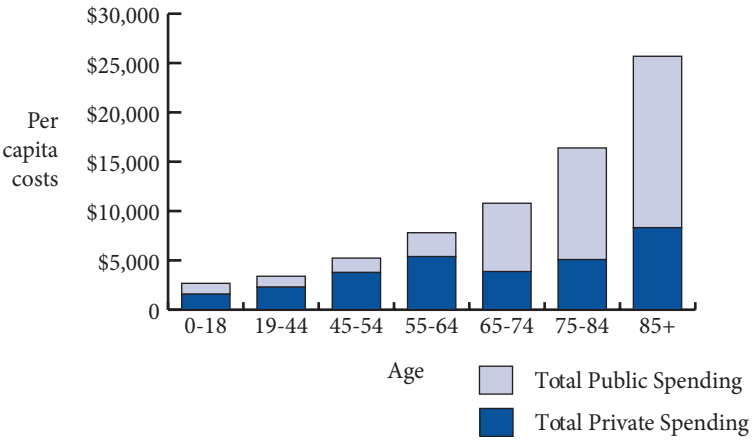
Similar growth has occurred at the state level. In 1973, the first full year that PEIA operated, medical claims for active employees and retirees accounted for approximately two percent of the General Revenue fund.[6] This item grew to just over 10 percent of General Revenue in 1990,[7] and 16 percent in 2009.[8]

Controlling spending on health care will remain a significant challenge over the next few decades. Care has become more expensive because of new medical technologies and innovations (drugs, equipment, skills), an increase in chronic illnesses and more long-term care, the expansion of coverage for those with insurance, and an aging population.[9]

Although medical technologies are expected to remain the largest driver of health care cost growth, the aging of the Baby Boom generation (born between 1946 and 1964) will also increase health care expenditures.[10] As people age, their per capita personal health care spending increases (Figure 1).

FIGURE 1

Health care spending increases with age



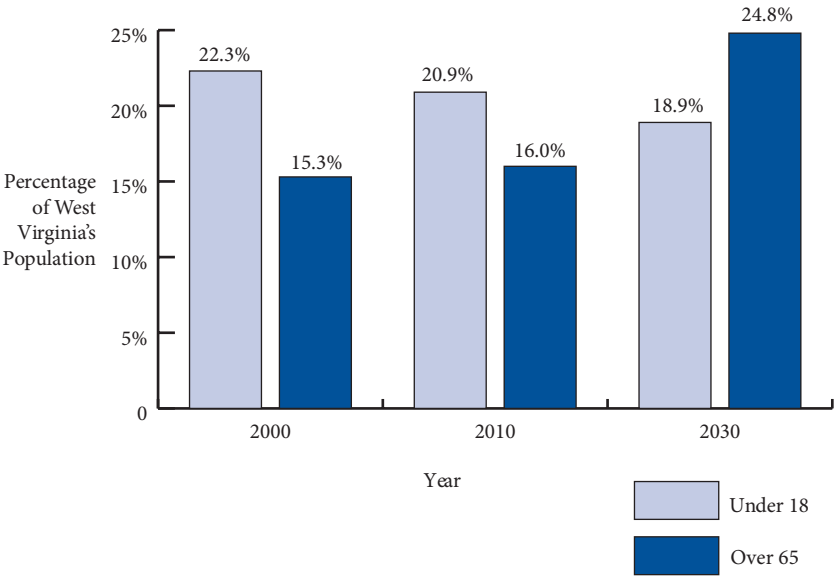
Source: Centers for Medicare & Medicaid Services, National Health Expenditure Data.

Whereas the average 30-year-old costs $3,370 a year to cover, the average cost for a 60-year-old is more than twice as much.[11] By the time someone reaches the age of 85, his or her average costs are nearly $26,000 a year.[12] Combining the growth in health care costs with an increasingly elderly demographic will result in a rapid rise in expenditures and will impact the budgets of individuals, states, and the country.[13]

The impact of this demographic shift will be acute in West Virginia. In 2000, 15 percent of the state's population was over 65 compared with 22 percent under 18 (Figure 2).[14] By 2030, when all members of the Baby Boom generation have reached retirement age, nearly a quarter of the population is projected to be over 65. In stark contrast, only 19 percent will be under 18.[15] As the overall population ages, the number of retirees in both the public and private sector will swell, meaning that there will be more people drawing benefits such as pensions and retiree health care.

FIGURE 2

West Virginia projected to become grayer by 2030



Source: U.S. Census Bureau. State Interim Population Projections by Age and Sex: 2004 – 2030.

Note: The figures for 2010 and 2030 are projections as of 2004.

Chapter Two

Retiree Health Care in West Virginia

Since the 1970s, retirees from West Virginia's state agencies, educational institutions, and other governmental bodies have been able to receive group health insurance from the Public Employees Insurance Agency (PEIA) at a subsidized price. Each of the seven retirement systems has its own eligibility rules that individuals must meet in order to receive full retirement benefits in West Virginia.

In the two systems that cover the majority of state and local employees, the Public Employees' Retirement System and the Teachers' Retirement System, a retiree must be 60 years old with at least five years of service.

The Public Employees' Retirement System also has the Rule of 80. This rule says that if a retiree's age (55 or older) plus the number of years of public service equals 80, he or she can receive full retirement benefits.[16] For example, a 60-year-old state employee who has worked in public service for 20 years would meet the eligibility requirements.

In addition, retired teachers of any age with 35 years of public service also can receive full benefits.[17] For example, a 57-year-old teacher who worked for 35 years could retire and receive full benefits.

Decisions about premium levels, benefits, and co-payments are made by the PEIA Finance Board, an eight-member board charged with bringing "fiscal stability to the Public Employees Insurance Agency through the development of annual financial plans and long-range plans designed to meet the agency's estimated total financial requirements."[18] This board consists of four at-large members and one representative each from education, labor, public employees, and retired public employees.[19]

The amount of a retiree's monthly premium that is subsidized depends on years of service to the state and is determined by the Finance Board. For example, in 2010 a non-Medicare retiree who had worked for the state for 25 years would have a monthly premium of $252. If the same person had only worked for 15 years, the monthly premium would be $436.[20]

Before 2008, retirees could choose either a PEIA Preferred Provider Benefit plan or a Managed Care plan through insurers like The Health Plan, depending on their Medicare eligibility, region of the state, and personal preference. All of these plans supplemented Medicare for those over age 65 or acted as the primary insurance for those under 65. In addition, these plans also provided prescription drug coverage. Since 2008, Medicare-eligible retirees have been covered by Medicare Advantage/Prescription Drug (MAPD) plans.

Funding retiree health care, pre-2007

Prior to July 1, 2007, West Virginia handled retiree health care as a pay-as-you-go system, meaning that the current year's retiree medical expenses (medical and prescription drug claims, managed care capitations) were paid directly as part of the state's annual operating expenses with revenue streams from the same year. The retirees paid some of these medical expenses with their monthly premiums, while a portion of active employees' premiums and money from state and local government agency employers covered the remainder (Table 1). The funding from active employees and employers was called the retiree subsidy and equaled the gap between the total retiree expenses and the total revenue contributed by retirees.

The retiree contribution in real dollars has increased somewhat since 1994,[a] but the percent of total expenses covered by retirees has fallen from 36.5 percent in 1994 to 33 percent in 2010 (Figure 3). By 2014, this figure is projected to fall to 29.7 percent. With retiree contributions growing more slowly than total retiree expenses, the gap that must be funded by the subsidy from active employees and employers has widened.

TABLE 1

Determining the retiree subsidy

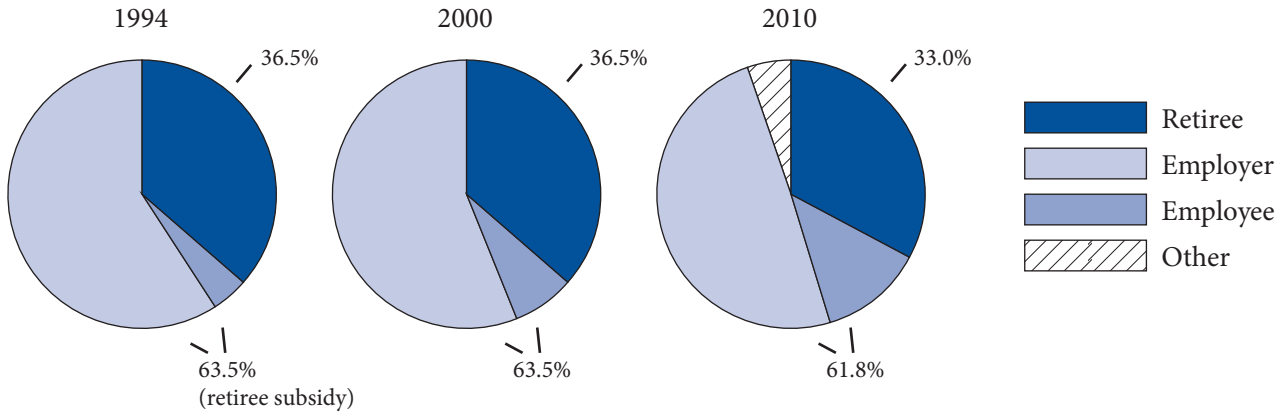
Total retiree expenses	$122,800,962
Total revenue from retirees	-$37,888,326
Retiree subsidy allocation	$84,912,636

Source: West Virginia Public Employee Insurance Agency, Financial Report, FY 2002.

In recent years, the retiree subsidy paid by employers and employees has accounted for 60 to 70 percent of the revenue that goes toward retiree health care. An increasing share of this revenue comes from active employees. For simplicity's sake, this paper assumes that local agencies (counties, cities, towns) divide the premium between employer and employee in the same way as the state. In reality, local agencies have wide discretion. Some may cover an employee's entire monthly premium, while others pay nothing toward the cost of coverage. In 1994, employees only accounted for 7 percent of the retiree subsidy. In 2010, that share grew to 20 percent with the remaining 80 percent coming from employers.[21]

FIGURE 3

Who pays for retiree health care?



Source: West Virginia Public Employees Insurance Agency, Financial Report, 1994 and 2000; Retiree Health Benefit Trust Fund, Quarterly Report, March 31, 2010.

[a] The starting point of 1994 was selected because the West Virginia Archives only had continuous PEIA data from 1994 to the present.

The move to a trust fund model

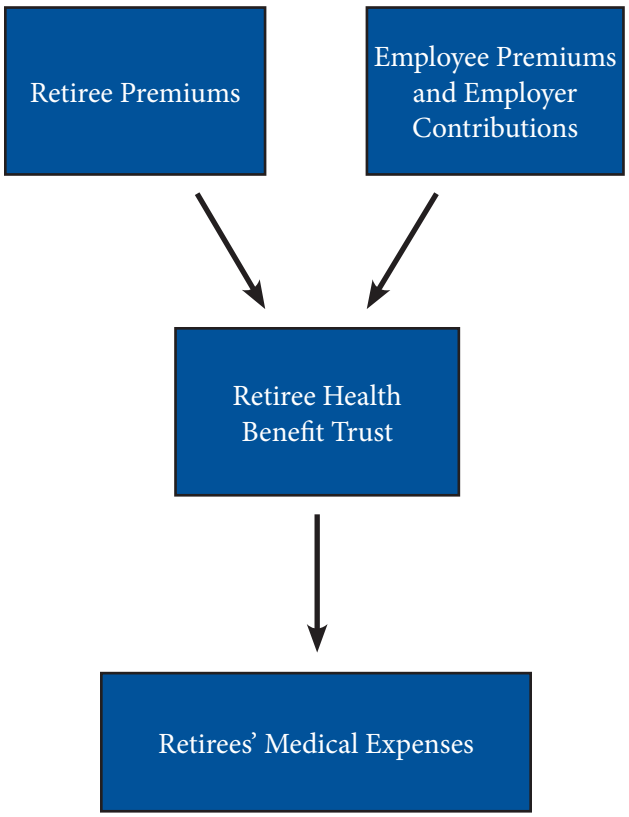
In 2006 the West Virginia Legislature enacted House Bill 4654, creating the Retiree Health Benefit Trust, an irrevocable Section 115 trust fund. As of 2007, West Virginia was one of only 11 states to establish an OPEB trust fund.[22] The Retiree Health Benefit Trust now allows the state to pre-fund its retiree benefits. Contributions made by or on behalf of current public employees go into the trust, gain interest, and, in theory, can be used to pay for benefits in the future.

Despite the creation of the new trust fund, West Virginia continues to fund retiree health care in nearly the same way as before 2007 (Figure 4). A portion of premium revenue from employees and employers goes into the trust, as does the revenue from retirees. Medical claims, administrative costs, and funding for the retiree assistance program are the main expenses flowing out of the fund. In addition to the traditional streams of revenue, the Retiree Health Benefit Trust also receives transfers from the PEIA Reserve Fund if that fund's balance is more than 15 percent larger than the recommended reserve.[23]

The main difference from the earlier pay-as-you-go structure is that if revenue is greater than expenditures in a given year, the remainder is carried into the plan reserve, a portion of which can then be invested by the West Virginia Investment Management Board. This helps to build the balance in the trust, which can be used in the future to pay for benefits. As of June 2010, the state had over $400 million in the Retiree Health Benefit Trust.

FIGURE 4

Premiums and contributions still main funding sources



Long-range projections

According to long-range projections published in June 2009, retiree health care for public employees will cost approximately $988 million in 2025 (Figure 5).[24] Although these long-range numbers seem staggering, they must be put in context.

It is important to remember that this growth in costs is not happening in a vacuum; state and local budgets and payroll also will be growing during this same time period. State and local spending grew from $5 billion in 1994 to $10 billion in 2008.[25] Assuming that the historic average growth remains constant into the future, state and local spending will be approximately $25 billion by 2025.

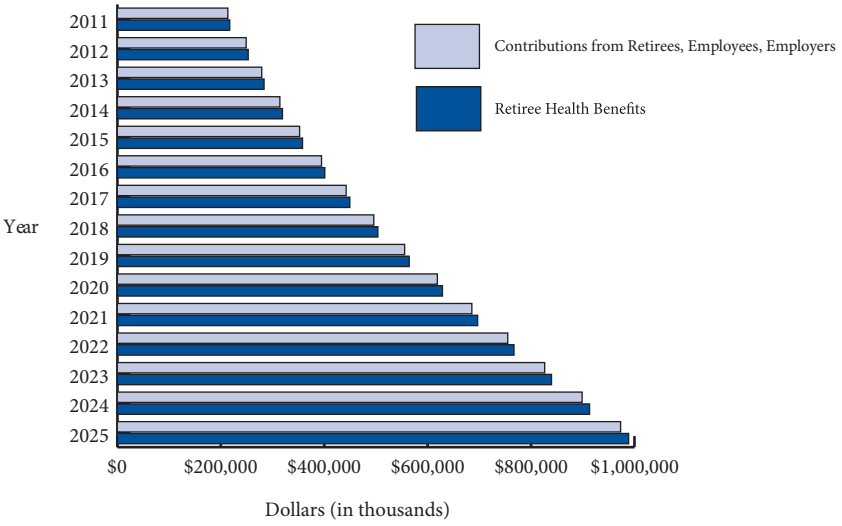
If revenue from active employees and employers remains the primary source of funding for the retiree health care benefit, then it will have to grow to keep pace with the cost of care. Again, this figure might seem staggering, but should be placed in some context.

Currently, contributions from employees and employers equal a small part of the state's economy or its gross domestic product (Figure 6). By 2025, the retiree subsidy could consume approximately 0.7 percent of the state's GDP. Despite the growth over the next fifteen years, this figure still pales in comparison with other state expenditures, such as education. It seems hard to call this a crisis.

By rethinking the existing funding structure of relying heavily on premium and employer contributions, West Virginia can prevent any large burden from falling on the shoulders of employees and retirees in the future.

FIGURE 5

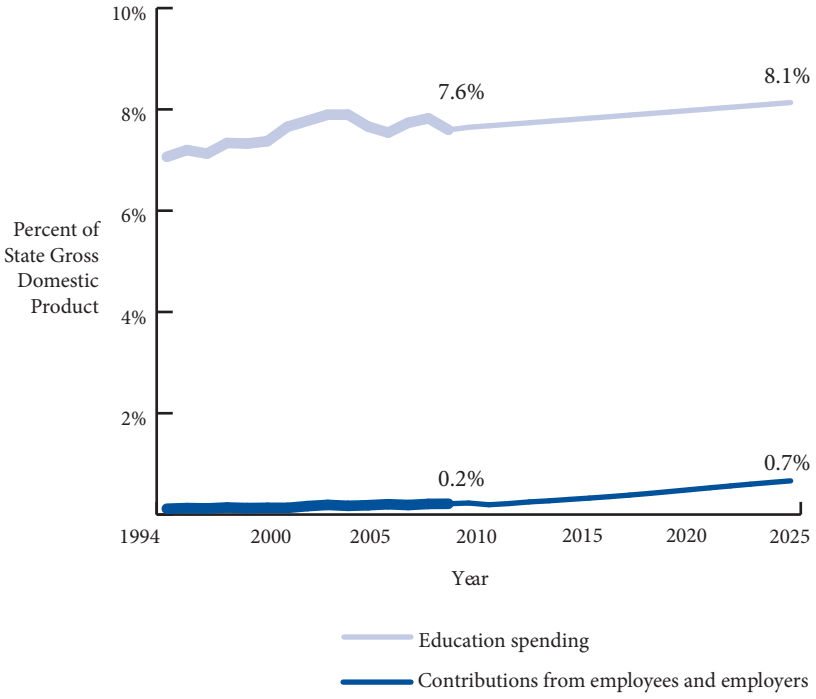
Revenue and costs projected to grow in future



Source: West Virginia Public Employees Insurance Agency, OPEB Baseline Projections from June 30, 2009.

FIGURE 6

Retiree subsidy only small part of state's economy



Source: U.S. Census Bureau, State and Local Government Finance, 2008; U.S. Department of Commerce, Bureau of Economic Analysis, Gross Domestic Product by State.
Note: Projections are authors' calculations.

Chapter Three

Accounting for Retiree Health Care

Prior to 2007, West Virginia handled retiree health care for public employees as a pay-as-you-go system. Similar to other states, West Virginia had not considered the long-term costs of the health care benefits that had been promised to public employees upon their retirement. This changed in June 2004 when the Governmental Accounting Standards Board (GASB) issued statement 45 requiring state and local governments to switch to an accrual basis for calculating the cost of these other post-employment benefits (OPEB). Instead of reporting the cost of retiree health care purchased during a specific year, states now are asked to account for the future costs of benefits earned by employees plus the liability of benefits already accrued and not yet paid (see Appendix for a more detailed look at how this liability is calculated). In short, GASB 45 called upon states to treat OPEB as a long-term liability when preparing budgets and financial statements. This parallels the treatment of pension costs.

Under West Virginia Code, PEIA is required to bill state and local employers for their portion of the Annual Required Contribution (ARC), or the amount needed to fully fund the liability over time.[26] Despite its name, the ARC is not actually required, largely because it is an estimate based on a number of assumptions and long-term projections, not an actual required dollar amount. PEIA is only required by law to collect what West Virginia calls the minimum annual employer payment. This payment includes premium contributions from the employer and active employees, plus additional dollars to partially cover the ARC.[27]

As Table 2 shows, paying the total ARC is an expensive proposition for state and local agencies. In 2010, the ARC was nearly 6.5 times larger than the payment made by most employers. If agencies began paying the ARC, then they might be unable to pay for other important services and programs or for payroll.

Most state and local agencies are not paying more than the minimum requirement from PEIA, in large part because there is no incentive for them to contribute anything more than that. If an agency decides to pay its full portion of the ARC, the money goes into the Retiree Health Benefit Trust but is not earmarked for the employees of that agency. Therefore, unless PEIA requires all agencies to pay the ARC for their employees, individual agencies have no incentive to contribute more than the minimum payment required by law.

TABLE 2

The ARC compared with the Minimum Payment

	Total	Per Policy	Per Policy, Per Month
Annual Required Contribution (ARC)	$795,199,000	$10,855.07	$904.59
Minimum Annual Employer Payment	$122,797,568	$1,676.28	$139.69
Unfunded ARC	$672,401,432	$9,178.79	$764.90

Source: West Virginia Public Employees Insurance Agency, Analysis of Defined Benefit Cost-Sharing Multiemployer Other Postemployment Benefit Plans, June 30, 2009; number of policies and minimum annual employer payment from the ARC document for 2010.

It is important to bear in mind that GASB 45 is not a law.[28] The Governmental Accounting Standards Board is a private, non-governmental organization that can only recommend generally accepted accounting principles – it cannot mandate their usage nor require any particular action from states or local governments. Also, GASB 45 does not require states to fully fund their liabilities. It would be better to think of this accounting rule as a tool that can remind the state of the potential cost of its promised benefits to public employees.

Finally, it is important to recognize that West Virginia's OPEB liability is not new, but rather newly reported. GASB 45 merely brings to light the liability that has existed since the state began offering the retiree health care subsidy.

Concerns with measuring long-term retiree health care costs

The primary concern with relying too heavily on the actuarial reports pursuant to GASB 45 is that estimating health care costs in the future is inherently difficult. Furthermore, changes stemming from the Affordable Care Act may impact future costs, rendering current estimates irrelevant. Even the analysts from CCRC Actuaries, LLC who prepare West Virginia's valuation each year state that: "the estimate of insurance program costs contains considerable uncertainty and variability and actual experience may not conform to the assumptions utilized in this analysis."[29]

An additional concern is that valuations are subjective.[30] States can choose to use a range of actuarial methods and assumptions to arrive at their liabilities,[31] which makes it difficult to compare West Virginia's estimated liability and funded ratio to that of other states. Also, different actuarial methods and assumptions could lead to a wide range of estimates within the same state or local area. This was the case in Travis County, Texas, where the chief auditor and different external actuaries arrived at estimated liabilities for the county ranging from $89 million to $380 million, depending on which assumptions they used.[32]

Changes in certain assumptions can lead to very large changes in the estimated liability. For example, between 2007 and 2008 West Virginia's liability nearly doubled in size due largely to two changes in assumptions made by the Finance Board. First, the discount rate (the investment return assumption) was lowered from 5.22 to 3.72 percent because of "recent bond returns and the percent of the plan that is funded."[33]

Second, new assumptions were made about payment rates and about medical and prescription drug trends.[34] The resulting increase demonstrates the great volatility of the liability based upon the underlying actuarial assumptions. It is important to remember that this number should not be seen as a fixed, definite cost for the state; rather, it is an estimate of costs based on actuarial assumptions about future trends.

These concerns should underscore the problems with focusing solely on the OPEB liability, rather than on the underlying problem of rising health care costs and a system of funding that may no longer be sufficient to cover the costs. By making decisions out of concern for the liability alone, West Virginia risks overreacting. If the state decided to pour hundreds of millions of dollars into the Retiree Health Benefit Trust, this would come at the expense of other government programs that provide important services to all residents.

West Virginia's liability

According to a 2010 report, states carried $587 billion in liabilities for post-employment benefits, but had only funded $32 billion as of 2008.[35] Like most states, West Virginia has been struggling to decide how to address this new liability on its books. Great emphasis has been placed on the state's funded ratio, which equals the unfunded portion of the liability divided by the total liability. The argument goes that by increasing the assets held in the trust fund, West Virginia would also increase the percent of its liability that is funded. As of June 30, 2010, West Virginia's funded ratio was 5.18 percent (Table 3). However, just as the liability is not an actual fixed number, so too is the funded ratio little more than an estimate based on actuarial assumptions.

It may be tempting to compare West Virginia's liability and funded ratio to other states, but such a comparison fails to account for the wide range of actuarial methods and assumptions used by states to calculate their OPEB liabilities. However, as of 2008, nearly half of the states had taken little or no action to prefund their OPEB liabilities, putting West Virginia ahead of the curve.

TABLE 3

How much of West Virginia's current liability is funded?

	2008	2009	2010
Actuarial Accrued Liability	$6,362,640,000	$7,410,241,000	$8,048,300,000
Assets in Trust Fund	$254,818,000	$397,414,000	$416,534,000
Unfunded Liability	$6,107,823,000	$7,012,826,000	$7,631,766,000
Funded Ratio	4.00%	5.36%	5.18%

Source: West Virginia Public Employees Insurance Agency, Analysis of Defined Benefit Cost-Sharing Multiemployer Other Postemployment Benefit Plans, June 30, 2009. (2010 figures are projections.)

Chapter Four

Setting the Record Straight

When the topic of OPEB arises, it is common to hear people draw comparisons with pensions. This conjures up painful associations, since West Virginia's pension systems historically have been funded at levels much lower than other states due to insufficient contributions and overly conservative investments.[36] In 2006, the average funding level for state pensions was 82 percent; West Virginia's pension systems lagged far behind at 55 percent.[37] In an effort to "catch up" and reach adequate funding levels, especially in the Teachers' Retirement System Plan A, West Virginia has been forced to allocate revenue well above the annual required contribution.

OPEB obligation not the same as pensions

Although states and local governments now account for their OPEB liabilities on financial statements using the same actuarial methods as for their pension plans, several key differences exist between pensions and other post-employment benefits like retiree health care. Pensions for public employees are legally protected in West Virginia,[b] while OPEB is not.[38]

The PEIA statute says, "Any contract or contracts entered hereunder may provide for group hospital and surgical, group major medical, group prescription drug and group life and accidental death insurance for retired employees on such terms as the director may deem appropriate."[39] Under West Virginia Code, the PEIA Finance Board has discretionary authority to choose to modify or eliminate subsidized retiree health care, although such a decision should not be taken lightly.[40]

West Virginia's pensions for its public employees are defined benefit plans, meaning that an individual's monthly annuity retirement benefit can be calculated accurately using a formula that includes his or her age, years of service as a public employee, final average salary, and the state retirement system in which he or she is enrolled.[41]

Although that same individual's retiree health care benefits could also be seen as a defined benefit, based as they are on a formula involving years of service, there is one glaring problem with this view. Since the PEIA Finance Board can modify or eliminate benefits as it sees fit, the state's commitment to pay for retiree health care is not 100 percent certain.[42] In addition, retiree health care benefits cannot be calculated easily. The growth in medical costs is volatile and far less predictable, making it hard to say how much an individual's premiums will be in retirement and how much the state will need to pay toward these premiums.

[b] In the 1988 case of Dadisman v. Moore (181 W.Va. 779, 384 S.E.2d 816), the West Virginia Supreme Court of Appeals held that "a public employee's rights under the State's statutorily-created pension system are contract rights," and as such are protected under W.Va. Const., art. III, §4. Public employees "have contractually vested property rights created by the pension statute, and such property rights are enforceable and cannot be impaired or diminished by the State." From http://caselaw.findlaw.com/wv-supreme-court-of-appeals/1395817.html

States differ from private sector companies

Although both the public and private sectors have accounting rules for estimating the liability of promised post-employment benefits (pensions and OPEB), there are fundamental distinctions between the sectors that should lead to differences in how the liability is handled. Since private sector employers cannot raise new revenue easily to cover their liabilities and can face the possibility of going out of business, some have turned to building an asset reserve and prefunding their obligations as a means of ensuring that any outstanding liabilities (or future costs) can be met. Despite the revenue limitations faced by private sector companies, the majority of large companies have still opted not to prefund their OPEB obligations.

Public sector entities are far more stable than the private sector and have the ability to raise new revenue through taxes in order to finance retirement benefits if the costs escalate. This does not imply that state governments should not set aside reserves for pensions and OPEB obligations; it simply means that legislators should evaluate a state's OPEB liability in a different manner than that of a private company, given the differences between the public and private sectors.

The impact of the OPEB liability on state credit ratings

Concerns have been expressed that credit rating companies will view a large unfunded OPEB liability as a negative and will downgrade West Virginia's rating for general obligation debt. Although companies such as Standard & Poor's do take OPEB liabilities into account when rating the creditworthiness of a state, they are clear that they simply want to see that states have plans for managing this liability.[43] Since states technically are not legally obligated to fund these benefits and can modify benefit plans if need be, Moody's calls OPEB a valid liability, but not debt-like.[44] As such, it does not "affect the debt-component of certain credit-relevant ratios."[45]

The OPEB liability is only one small determinant of a state's rating; therefore, a large unfunded OPEB liability might not adversely affect the rating. In 2008, seven of the 11 states rated AAA – "extremely strong capacity to meet financial commitments" – by Standard & Poor's had a funded ratio under one percent (Table 4).[46] Conversely, examining the ratings of the five states leading the way in terms of funding their OPEB liabilities reveals no glaring connection between the liability and rating. For example, while Virginia (33.86 percent funded) rates as AAA, Arizona (65.18 percent) rates as AA-.[47]

TABLE 4

More than half of AAA-rated states had funded ratio under one percent

State	Funded Ratio
Delaware	1.45%
Florida	0.00%
Georgia	4.07%
Indiana	0.00%
Iowa	0.00%
Maryland	0.80%
Minnesota	0.00%
Missouri	0.55%
North Carolina	2.12%
Utah	0.69%
Virginia	33.86%
West Virginia (AA)	**4.00%**

Source: The Pew Center on the States, "The Trillion Dollar Gap: Underfunded state retirement systems and the road to reform" (February 2010); Ben Schott, "U.S.A.A.A.," *The New York Times*, February 2, 2010.

Even states with credit ratings less than AAA are more reliable borrowers than most private sector companies. According to Moody's, if the public sector was evaluated in the same way as the private sector, all states except Louisiana would have an AAA rating.[48] Compared to corporate bonds, municipal bonds rarely default and have better odds of recovering in the event of default. In fact, the historical default rate on the lowest rated (A) municipal bonds is 80 times lower than the historical default rate on the highest rated (AAA) corporate bonds.[49]

The reality in West Virginia is that, despite the supposed "crisis" due to its large unfunded OPEB liability, the state has had its credit rating upgraded twice by Moody's over the past two years to Aa1, the second highest rating possible.[50] It also maintains a "very strong capacity to meet financial commitments" in the eyes of Standard and Poor's.[51]

Chapter Five

The State's Reaction to GASB 45

In FY 2008, Medicare-eligible retirees were moved out of a PEIA plan and into a Medicare Advantage Prescription Drug (MAPD) plan in an attempt to lower the state's retiree health care costs – something that other states have done as well.[c] Retirees receiving medical and prescription drug benefits through this plan no longer have coverage under either traditional Medicare (fee-for-service) or PEIA; rather, they fall under the domain of a private, for-profit insurance company, which contracts with PEIA. The insurance company receives payments from PEIA and the Centers for Medicare and Medicaid Services.

Whereas traditional Medicare and the former PEIA supplemental plan offered stable coverage, for-profit insurance companies offering MAPD plans can pull out of a market if they deem it not profitable enough. West Virginia experienced this firsthand when Coventry Health Care, the sole provider for PEIA's Medicare-eligible employees, announced in May 2009 that it was discontinuing its Medicare Advantage pay-for-fee-service plans due to federal reimbursement rate cuts.[52]

This decision came less than a year after the federal government mandated that plans like the one offered by Coventry for PEIA would be required to establish provider networks and report quality measures by 2011.[53] These requirements placed additional costs upon insurance companies, and some decided to simply get out of the business altogether. Although PEIA was able to enter into a contract with Humana to ensure ongoing access to care for retirees, this case highlights the risk of placing retiree health care in the hands of the private market.[54]

For low-income public retirees who qualify for Medicaid as well as Medicare, these new MAPD plans may present additional problems. There can be poor coordination between MAPD plans and State Medicaid agencies, and there is often confusion about coordination of benefits.[55] For example, the rules for cost-sharing with Medicaid differ between Medicare and Medicare Advantage. Medicaid does cover all out-of-pocket expenses under traditional Medicare, but only direct expenses under Medicare Advantage plans. There is also no requirement under MAPD plans for states to cover premiums through Medicaid.[56]

Elimination of retiree premium subsidies for new hires

In an attempt to reduce the long-term OPEB liability, the PEIA Finance Board decided in December 2009 to eliminate retiree premium subsidies for employees hired on or after July 1, 2010. This decision could greatly impact the ability of these new hires to afford health insurance upon their retirement, and may increase economic insecurity for retired public employees in West Virginia.

[c] For example: Pennsylvania's retired public employees receive coverage through Aetna (http://www.aetna.com/news/newsReleases/2009/0922_State_of_Pennsylvania.html), Oregon's through Providence (http://www.providence.org/healthplans/medicareplans/members/pers.aspx), Ohio's through Humana (https://www.opers.org/healthcare/) and Michigan's through Blue Cross Blue Shield (www.bcbsm.com/pdf/mpsers_medicare_advantage_summary.pdf).

Furthermore, these new hires still continue to pay a portion of their monthly premium toward the retiree subsidy for public employees hired before July 1, 2010, although they themselves will never receive subsidized retiree health care. Eliminating the subsidy for new hires while requiring them to continue contributing seems to violate the basic principle that "each generation of taxpayers should pay the full cost of the public services it receives."[57]

This decision will have the greatest impact on those who retire before they are eligible for Medicare. Adults age 55 to 64 years face medical expenditures 30 percent higher than adults age 45 to 54.[58] They also experience increased risk of incurring large medical expenses and are more likely to be in poorer health. Those without insurance have less access to medical care and utilize care less often than those with public or private health insurance. Affordable health insurance is clearly of great importance to retirees in this age range.

Currently, non-Medicare retirees receive a subsidy that enables them to afford the high cost of care for their age group (Table 5). An individual that had worked for 21 years and had purchased the Preferred Provider Benefit plan would pay less than one-third of the actual cost of his or her premium. The remaining $714 would be covered by the retiree subsidy. By eliminating the subsidy for new hires, the Finance Board effectively tripled the cost of insurance premiums that this individual would pay if he or she chose to (or had to) take early retirement. Although new hires will still be able to buy into the PEIA plan, the high monthly premiums might become prohibitive for some.

Considering that approximately one in three state and local government employees age 58 and older work in "physically–demanding jobs" and an additional one-fifth work in "difficult working conditions," many public employees physically cannot continue working until they qualify for Medicare at 65.[59] However, with the elimination of the retiree subsidy for new hires, the high cost of retiring before the age of 65 may encourage some public sector workers to stay in their jobs in order to keep the lower insurance premiums paid by active employees. If these workers are in poor health, then the workforce might experience a drop in productivity.

TABLE 5

Retired public employees receive subsidy for health care

Years of Public Service	Premiums for non-Medicare (Preferred Provider Benefit Plan)	Premiums for non-Medicare (Managed Care - The Health Plan)	Premiums for Medicare
Less than 5 years (no subsidy)	$1,051	$699	$397
5-9	$841	$466	$361
10-14	$647	$426	$265
15-19	$452	$402	$169
20-24	$337	$380	$112
25 or more	$260	$356	$73

Source: West Virginia Public Employees Insurance Agency, Shopper's Guide, Plan Year 2011.

New hires that still decide to retire early likely will pay a large portion of their pension toward their health insurance premium in the absence of state subsidies. For example, a teacher who retires at age 55 with 30 years of service and a final average salary of $50,000 would receive a monthly pension annuity of $2,500.[60] If this individual opted to buy into PEIA's Preferred Provider Benefit plan as an unsubsidized, non-Medicare policyholder, using Plan Year 2011's figures, he would pay 42 percent of his pension benefit toward health insurance.

The Finance Board's decision to eliminate the premium subsidy for new hires may also have implications for West Virginia's ability to recruit and retain public employees. According to a national survey conducted by the Center for State and Local Government Excellence, 62 percent of state human resource directors believe that retiree health care is helpful or very helpful for the state's ability to recruit employees. This post-employment benefit also is helpful or very helpful for retaining employees, according to 74 percent of human resource directors.[61]

West Virginia's average pay for public employees is one of the lowest in the nation and falls below that of all its neighboring states (Table 6).[62] Eliminating a key benefit like subsidized health care for retirees may further push potential workers to seek employment in another state or another industry.

TABLE 6

West Virginia's average pay for public employees falls below its neighbors

State	Average Pay for State and Local Employees (Rank)	Average Pay for Local Employees (Rank)	Average Pay for State Employees (Rank)
West Virginia	$35,218 (45)	$32,906 (44)	$39,531 (46)
Kentucky	$37,305 (37)	$35,322 (37)	$41,498 (39)
Virginia	$41,123 (25)	$40,168 (23)	$43,668 (34)
Ohio	$42,926 (21)	$41,157 (21)	$50,225 (17)
Pennsylvania	$44,761 (17)	$42,934 (16)	$51,080 (15)
Maryland	$49,856 (9)	$50,068 (8)	$49,338 (20)

Source: U.S. Bureau of Labor Statistics, Quarterly Census of Employment and Wages, 2009.

Legislative proposals

During the 2010 legislative interim sessions, the Joint Finance Subcommittee C was tasked with identifying possible solutions to reduce the OPEB liability. By August 2010, the subcommittee – co-chaired by Senator Brooks McCabe (D-Kanawha) and Delegate Steve Kominar (D-Mingo) – had created an extensive list of 47 solutions. These focused primarily on making changes to the subsidy and providing new sources of funding to the trust fund.[63]

Some of the possible solutions appear to have gained more traction than others. On the expenditure side of the equation, these options include changing the vesting requirements and raising the retirement age, reducing plan benefits and increasing co-pays, capping the contributions from active employees and employers, and making retiree premiums needs-based rather than based on years of service.[64]

Another proposal (DROP and CROP) would incentivize active employees to remain in the workforce until they were eligible for Medicare.[65] By postponing retirement until a later date, those public employees that chose one of these options theoretically would cost the state less to cover, since the PEIA insurance would become supplemental with Medicare bearing the brunt of costs. Missing from the list of solutions were proposals to contain medical costs through payment reform or other methods.

On the revenue side of the equation, the subcommittee proposed tapping into existing funds, such as Rainy Day B, and rededicating personal income tax proceeds ($95 million) and/or additional severance taxes ($85 million) from the Workers' Compensation Old Fund.[66] Another proposed solution is to increase the tobacco tax from $0.55 to at least $1.00, and to transfer this new revenue ($82 million) to the Retiree Health Benefit Trust.

Chapter Six

Recommendations

Although much attention has been given to finding solutions to "fix" the OPEB liability, it is important to remember that the true policy issue lies at a deeper level: health care costs for retirees are rising and premium revenue may no longer be sufficient to cover these costs. Due to the complex nature of the OPEB issue, no single policy response will solve the problem. Many possible solutions exist; however, the state should consider a few key points on both the revenue and expenditure side when determining its course of action.

Don't panic, respond judiciously

While the growing cost of retiree health care is a concern for state and local governments, West Virginia should not overreact by redirecting hundreds of millions of general revenue dollars into the Retiree Health Benefit Trust or by cutting essential services and programs in order to pay the full Annual Required Contribution (ARC). After all, the projected liability is not a fixed, actual dollar amount; rather, it is an estimate based on variables that can (and are likely to) change. Adjustments in actuarial methods and assumptions can lead to large increases or decreases in the liability without any real change occurring in the state. In addition, estimating long-term health care costs remains a difficult challenge.

As for the question of whether to fully prefund the OPEB liability, it is important to note that only a few states (Utah, Virginia) have chosen this option.[67] As of 2008, 21 states had done little or nothing toward prefunding. States that have taken action have adopted partial funding or hybrid models of funding, in which they make payments larger than pay-as-you-go but smaller than the full ARC. This increases the balance of the trust fund without taking too many dollars away from other state programs.

Make changes to contributions from active employees

Active employees and employers should continue to contribute revenue from premiums toward the retiree subsidy. However, West Virginia must stop shifting the burden of rising health care costs onto active employees and should consider capping their contribution at 20 percent of the retiree subsidy.

Furthermore, if the state decides not to reinstate the subsidized premiums for new hires, then these employees should be exempt from contributing toward the retiree subsidy since they will never receive the benefit themselves. Their monthly premiums should decrease, and the money that they formerly contributed to the subsidy should now be returned to them in the form of higher wages. The portion of the retiree subsidy that these new hires currently contribute would have to be covered by an alternative funding source.

Find new revenue to ease burden on employees and retirees

In order to slow the growth in contributions from active employees, employers, and retirees, West Virginia should identify new revenue streams to ensure that retirees' health care coverage remains affordable. The addition of other funding sources, not necessarily large ones, could ease the burden on employees and retirees by keeping their contributions at a more manageable level.

As identified by the Joint Finance Subcommittee C, several options exist on the revenue side. One option in particular, increasing the tobacco tax on cigarettes and smokeless tobacco and appropriating a portion of this revenue to the Retiree Health Benefit Trust, would serve the dual purpose of addressing health care and providing needed revenue. Regardless of what other sources of revenue the state chooses to appropriate (a higher tobacco tax, Rainy Day B), this additional revenue should be used explicitly to slow the growth of premiums.

Control health care costs

Although most proposals involving OPEB focus on increased cost-sharing and other options that shift more of the cost to the recipient of the care, the primary issue on the expenditure side of the equation is the high cost of health care. West Virginia could examine several ways of reducing the growth in these costs from year to year. A 2009 analysis by CCRC Actuaries demonstrated the potential cost-savings that some of these strategies might yield.

One potential option is the promotion of the medical home model:

> in which individuals use primary care practices as the basis for accessible, continuous, comprehensive and integrated care. … The premise of the medical home is to provide a broad spectrum of care to the patient, including preventive and curative and to provide coordination of all health care services.[68]

If the state chose to promote this health care model, then PEIA could see savings of $54.7 million in 2014 and $170 million in 2019, with more than half of these savings coming from Medicare-eligible retirees.[69]

A second option is to increase the use of information technology through e-prescribing and electronic medical records. With the adoption of both technologies, PEIA could see savings of $41.6 million in 2014 and $130.8 million in 2019.[70] Again, more than half of these savings would come from Medicare-eligible retirees.

Over the next several decades, West Virginia must reduce health care costs while ensuring high quality care. The options mentioned here are some of the possible ways that the state could work to contain the costs of health care for all of its residents, not just retired public employees.

Conclusion

The other post-employment benefits (OPEB) liability likely will be one of the main issues of the 2011 Legislative Session. This subsidized health care benefit is crucial for helping retired public employees afford care that otherwise would consume a large portion of their pensions and other retirement savings. In addition, considering that West Virginia's public employees have one of the lowest average pay rates in the nation, this retirement benefit plays an important part in attracting and retaining quality employees. Legislative decisions about the OPEB liability must be carefully considered, because each has a direct impact on active employees, employers, and retirees.

Future mention of the words "OPEB liability" in West Virginia will hopefully elicit an understanding that this is not a crisis, but rather a manageable concern. Solutions can be found that do not involve pouring hundreds of millions of dollars into a trust fund and freezing spending on other needed programs and services that benefit hundreds of thousands of West Virginians.

Appendix

A More Detailed Look at the OPEB Liability

Under GASB 45, states are asked to estimate the total cost of other post-employment benefits for eligible public employees, which in West Virginia primarily means retiree health care (Figure A). This estimated total cost of benefits is divided into a series of normal costs. The normal cost is the amount needed to pay for the future retirement benefits earned by active employees in a particular year. The normal costs then are summed to provide the total future normal costs (FNC).

Both the total cost of benefits and the future normal costs are converted into their present value. By subtracting the present value of future normal costs from the present value of the total cost of benefits, states arrive at their Actuarial Accrued Liability (AAL). The AAL reflects the value in today's dollars of benefits earned in the past by eligible public employees.

States then take the AAL and subtract any assets already set aside to pay for retiree health care. The result is the Unfunded Actuarial Accrued Liability (UAAL), which states are asked to include in their financial reports. This liability reflects future retirement benefits earned in the past for which money has not yet been set aside. The UAAL is then amortized over 30 years, and the resulting figure is added to the normal cost for a particular year to arrive at the Annual Required Contribution (Table A1).

Figure A

How to arrive at the Actuarial Accrued Liability

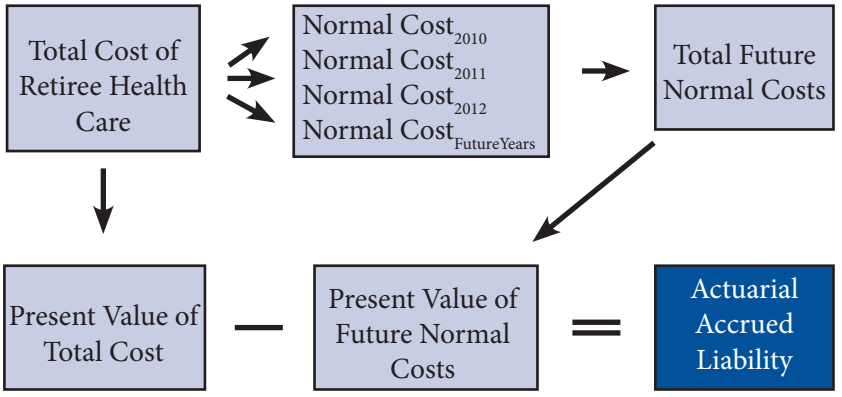


Table A1

Calculating the Annual Required Contribution

West Virginia's ARC, as of June 30, 2009	
Liability (AAL)	$7,410,241,000
Assets in Retiree Health Benefit Trust	-$397,414,000
Unfunded liability (UAAL)	$7,012,826,000
Unfunded liability, amortized over 30 years	$248,942,000
Normal Cost	+$495,082,000
Annual Required Contribution	$744,024,000

Source: West Virginia Public Employees Insurance Agency, "OPEB Addendum, June 30, 2010."

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