Prefunding retiree health benefits

Vehicles for Prefunding and Case Study Experiences

by Jennifer D. Harris
Jeannine Markoe Raymond
Paul Zorn

Government Finance Officers Association

Funding Provided by the ICMA Retirement Corporation
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By
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Government Finance Officers Association
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Foreword

With life expectancy increasing, government employers are becoming increasingly concerned about the health care costs they will face for tomorrow’s retirees. Some governments are planning ahead and considering prefunded retiree health care programs.

Prefunding future retirees’ health costs over the term of their career provides a rational relationship between current and future compensation and benefits. This publication discusses pay-as-you-go funding versus prefunding and examines some of the vehicles that have been used to prefund retiree health care. The experiences of five jurisdictions and one multiple-employer system are presented in case studies.

The Government Finance Officers Association and the authors are indebted to the individuals in each of the case study sites for their assistance in supplying information, answering questions, and reviewing the summaries:

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Jeffrey L. Esser
Executive Director
Government Finance Officers Association
1998
Introduction

Retiree health benefits have become a topic of substantial and growing concern to public- and private-sector employers. The aging of the population combined with escalating health care costs raises serious concerns about how these benefits can be financed. Between 1970 and 1995, the medical cost index increased 549 percent, compared with a 293 percent increase in the general consumer price index (CPI). In 1995 alone, medical costs rose by 4.5 percent, compared to a 2.8 percent CPI increase. Governments are reevaluating the retiree health benefits they offer and their methods of funding those benefits.

Government employers must also plan for future costs of retiree health care. In the private sector, the Financial Accounting Standards Board’s (FASB’s) Statement No. 106, Employers’ Accounting for Postretirement Benefits Other than Pensions, requires employers providing retiree health care benefits to accrue the expense of those benefits as they are earned by employees. While there is no similar requirement for public-sector employers, the Governmental Accounting Standards Board (GASB) is currently reevaluating existing accounting and financial reporting for postemployment benefits in the public sector and may require such an accrual in the future. If GASB decides to mandate the accrual of retiree health care costs as benefits are earned by employees, many governments will undoubtedly reconsider their retiree health care benefits and prefunding options. Many jurisdictions have yet to quantify retiree health care costs.

As state and local governments take on the additional burdens of financing social services previously handled by the federal government, legal and political constraints hamper their ability to raise taxes and generate revenues. In such an environment, it is crucial that state and local officials carefully consider both the type of health benefits offered to retirees and the mechanisms for funding this significant expense.

The experiences of several jurisdictions striving to fund retiree health care are described in this report. After a brief overview of how retiree health care can be prefunded, six case studies illustrate a range of efforts in prefunding these benefits. Two case studies show the use of voluntary employees’ beneficiary associations (VEBAs), a vehicle designed specifically to prefund benefits such as retiree health. Three case studies show the use of a separate trust or insurance fund structured specifically for prefunding retiree health benefits. The final case study demonstrates the experience of a large, multiple-employer pension trust, illustrating the cost-containment efforts of and funding challenges faced by a large system.

The case study information included here is based on written documents from the plans and telephone interviews. The summaries were reviewed by the case study participants. While every effort has been made to present complete information, readers are encouraged to seek outside counsel before implementing any of these prefunding vehicles in their plan.
STATE AND LOCAL RETIREE HEALTH BENEFITS

The majority of governmental entities in the United States provide some form of retiree health care benefits. According to ICMA Retirement Corporation tabulations of U.S. Bureau of Labor Statistics data, 74 percent of state governments and 57 percent of local governments provide health benefits to retirees over age 65. In addition, 75 percent of state governments and 59 percent of local governments provide health benefits to retirees under age 65.\(^1\)

Private firms are less likely to provide retiree health care benefits than public-sector employers. A 1992 survey showed that 52 percent of all employers provided coverage to retirees under age 65, although the average for government employers was 79 percent. Among private firms, larger businesses are more likely to provide retiree health coverage than smaller companies.\(^2\)

The employer bears most of the cost of retiree health care benefits. For state and local plans that offer retiree health benefits, an average 80 percent of plan costs for retirees are covered by employer contributions. Many plans, however, do require contributions from retirees. Over one-half of the state plans and one-third of local plans providing retiree health benefits require retirees to pay for part of the coverage.\(^3\)

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THE ROLE OF MEDICARE

For most individuals 65 years of age or older, Medicare is the major source of funding for retiree health benefits. While Social Security and Medicare benefits are universal for private-sector employees and most public employees are covered by Medicare, some public employees do not have this coverage. The cost of providing and managing retiree health care for these employees is much greater than for other employees. These differences present special challenges in dealing with government retiree benefits.

Medicare covers most in-hospital costs through its Part A coverage and a significant part of physician and miscellaneous costs through Part B. Medicare has deductibles and copayments, however, and does not cover certain important medical costs, such as prescription drugs, private-duty nursing, and some other services.

Often the employer's health plan will turn into "Medigap" coverage for retirees age 65. This employer-provided coverage is a critical supplement to ensure adequate health care benefits in the post-65 retirement years. The way in which an employer coordinates, or integrates, its retiree health benefits with Medicare can substantially affect the distribution of costs between the employer and retirees. An integration method specifies the proportion of costs paid by the retiree and the employer.⁴

Employees who retire before age 65 must rely solely on employer-based benefits or pay health care premiums from their own financial resources until Medicare coverage begins. In a 1992 survey, public employers reported the highest percentage of retirees under the age of 65 (41 percent) among all industries studied.⁵ Since many public employees frequently retire before age 65, such as police and fire personnel, this situation is not expected to change in the near future.

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Managing Retiree Health Care Costs

Employers look to various methods for managing their future costs of retiree health care within two broad categories: limiting liability or prefunding future costs.

Future liabilities can be limited by
- curbing benefits,
- capping employer contributions,
- converting to a defined contribution plan, or
- increasing vesting requirements.

These efforts can limit an employer's retiree health care liabilities for its entire workforce.

The other method of managing costs is to prefund them. Prefunding allows investment income on contributions to grow over time. Taking advantage of investment returns reduces an employer's contributions (i.e., costs) to maintain full funding. If an employer chooses not to prefund, it is called pay-as-you-go funding. (See sidebar below.)

Several vehicles can be used to prefund retiree health benefits, including voluntary employees' beneficiary associations (VEBAs), Section 115 trusts, rabbi trusts, and Section 401(h) accounts. The six case studies that follow do not address all of these types of prefunding vehicles; rather, they are intended to illustrate the concerns and issues officials faced as they decided whether and how to prefund their retiree health benefits. Although the focus is on prefunding efforts, there are examples of employer efforts to limit liabilities as well. In implementing these limits, the employers fully evaluated the benefits they want to and can provide their retirees.

Two Methods of Funding Retiree Health Care Costs

Pay as You Go
This method of paying for retiree health costs typically uses general funds to pay for current retiree health care costs. Although the pay-as-you-go method may result in lower annual payments in the short term, this method leads to higher direct employer costs in the long run because there is no investment income to supplement the employer's contributions.

Prefunding
Some state and local government employers have begun to prefund retiree health care liabilities, usually after completing an actuarial valuation. The valuation focuses on the value of the retiree benefits being earned by current employees, as well as the value of benefits already earned by current retirees. While this information may have adverse short-term impacts by exposing a large liability, it is essential to the advance funding of retiree health care costs. Advance funding reduces direct employer costs over time, increases security for employees, and stabilizes the cash flow commitment for benefits. By recognizing these costs and implementing a plan to prefund them, a jurisdiction can increase its long-term financial strength, possibly improving its credit rating.
**Voluntary Employees’ Beneficiary Associations (VEBAs)**

A Veba is a tax-exempt trust, established under Section 501(c)(9) of the Internal Revenue Code (IRC), to which the employer contributes a certain amount during a worker’s employment. Depending on the structure of the plan, employees also may contribute. Within the Veba, an account is generally established for each employee for the employer’s (and possibly employee’s) contributions.

Retired employees have a right to the money in their Veba account to pay for eligible benefits if they meet vesting requirements. Vesting requirements are usually based on age and/or years of service. Vested retirees can use the money to help pay whatever portion of their health insurance premiums is not covered by the employer. If the funds in the Veba are not sufficient to cover the retiree’s health premiums, the retiree must make up the difference from personal resources.

Federal regulations exist to make VEBAs nondiscriminatory and to ensure that the assets are held solely for the benefit of participants and beneficiaries. If retiree health benefits are discriminatory, the employer is subject to a 100 percent excise tax on the discriminatory amount. An exemption letter should be obtained from the Internal Revenue Service (IRS) to qualify the Veba.

Two case studies focus on VEBAs: the City of Moreno Valley, California, and Monroe County, Michigan.

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**Trusts and Insurance Funds**

Another way employers can prefund retiree health care benefits is to establish trusts and insurance funds to hold monies set aside for future expenses. These trusts are usually established under IRC Section 115 as a tax-exempt trust. These trusts do not have the same nondiscrimination rules as VEBAs, and the 100 percent excise tax for discrimination does not apply. Further, these are pooled vehicles, unlike the separate employee accounts under a Veba.

Insurance funds are most likely self-insurance funds in which the jurisdiction sets aside monies for future obligations within a trust or other vehicle without the benefit of specific IRC protection. In other words, the employer designates that the money will be used for future retiree health benefits but is not obligated by federal law or regulation to use the funds for that purpose. The structure of these self-insurance funds varies.

The case study of Saginaw County, Michigan, examines its trust fund approach. Two case studies examine insurance funds: an insurance fund in Multnomah County, Oregon, and a self-insurance fund in the City of Winston-Salem, North Carolina.

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**Multiple-Employer Issues**

Multiple-employer funds attempting to prefund retiree health liabilities are likely to encounter special issues when coordinating with several jurisdictions. The multiple-employer case study focuses on the issues faced by the School Employees Retirement System of Ohio.
VEBA Case Study

City of Moreno Valley, California

The City of Moreno Valley instituted a VEBA in 1993 and received final IRS approval in 1995.

Moreno Valley, located 60 miles east of Los Angeles with a population of 135,000, has about 270 full-time equivalent employees, and tax revenues total $35 million annually. Police and fire services are provided under contract with Riverside County.

History of Plan

Until 1993, the City of Moreno Valley paid all of its retiree insurance premiums, exposing the city to significant and unknown future costs. When Moreno Valley converted to a defined contribution medical plan, it significantly lowered its contribution levels for retiree health and provided funding for most of the future retirement liabilities. Converting the defined benefit arrangement to a defined contribution plan did not require the city to enact new legislation, but it did require the city to negotiate a new labor agreement with employees. This conversion was accompanied by a new plan for paying retiree premiums. For new retirees, the city now contributes a small amount toward a retiree’s yearly premium, and the retiree pays the difference.

Moreno Valley started a VEBA to allow employees to accumulate funds to pay their share of the premium. The city contributes a set amount into a VEBA account for each active employee, and the employee directs how it is invested. Retirees can draw on their account to purchase health insurance coverage arranged by their employer. The city’s contribution to the VEBA and payment of insurance premiums is considered a tax-exempt employee benefit. The city has reserved the right to amend or terminate the plan at any time by action of the city council.

Retiree Health Benefits

The Retiree Medical Insurance Plan, administered by the California Public Employees Retirement System (CalPERS), provides medical benefits to Moreno Valley retirees. Retirees are required to participate in Medicare Part B, and there is coordination with Medicare benefits. When an employee retires, the VEBA account can be used to pay a significant portion of the insurance premiums to CalPERS.

The city’s plan imposes a vesting requirement and a limitation on spousal and dependent coverage. Employees must be employed full time with the city for two years to be vested in the VEBA. Retirement can occur at age 50 or

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6 In a defined contribution plan, the employer’s annual contribution to the plan is determined in advance. In retirement, the retiree can use these funds to purchase retiree health insurance. Any shortfall, however, must be made up by the retiree. This contrasts with a defined benefit plan, where the employer arranges to provide health insurance throughout retirement.

7 Coordination of benefits is a method by which the plan’s benefits are merged with those of Medicare so that duplicate payments are not made.
later after five years of service with the city or another entity that participates in CalPERS. Spouses and dependents of retirees can be covered as long as the total number of spouses and dependents participating in the plan does not exceed 10 percent of all retirees receiving medical benefits.

The city is reducing its share of the CalPERS retiree insurance premiums on a decreasing scale over a 10-year period. For those employees who retired in 1996, the city is paying $3,372 of the insurance premium each year, while the retiree makes up any shortfall. The city premium payment decreases for each year’s new retirees until for those employees retiring in 2003 and after, the city will pay $192 per year of the insurance premium. Retirees must pay the difference, but those vested in the VEBA can use that money to pay the remainder of the insurance premium.

Contributions

For each employee eligible to participate in the retiree medical plan, Moreno Valley contributes $50 per month for up to 10 years to a VEBA account. This contribution is subject to change in the future. It is likely that subsequent labor negotiations will lead to lengthening of the 10-year period.

Vested employees who retire from the city may withdraw their VEBA money to pay CalPERS their share of the retiree medical insurance premium. Retirees choose a set amount to receive from the VEBA each month for those insurance premiums, although every August they have the opportunity to change that amount. If the insurance premium is larger than the sum of the city’s contribution and the amount from the VEBA, the retiree must make up the shortfall from personal resources.

How Contributions Are Invested

The IRS approved the Moreno Valley VEBA as a bona fide tax-exempt trust. The city will invest employee contributions into the VEBA fund. The trustee of the VEBA invests the contributions primarily in conservative mutual funds of the trustee’s choosing. Each employee will have “shares” in the VEBA fund; these will increase or decrease in value depending on the performance of the investments. Assets will be distributed proportionally based on the number of shares an employee has in the plan when the money is withdrawn.
VEBA Case Study

Monroe County, Michigan

Monroe County (population 136,000), located in Michigan’s southeast corner, employs nearly 750 people and currently provides retiree health insurance to approximately 250 retirees. The county has adopted a VEBA. A trust agreement has been drafted that includes the appointment of an administrative board and trustee to administer the VEBA; the trust document and the health care plan for retirees were approved by the county board of commissioners.

History of the Plan

As in other jurisdictions, Monroe County sought to limit its overall exposure to health insurance inflation. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers to provide qualified beneficiaries with the option to continue in a group health plan upon separation of employment for 18 months, and usually the former employee pays the group premium. The county had been paying the entire cost for retiree health insurance during these 18 months, but now it requires employee contributions to pay for and to begin prefunding these benefits. The county does not provide health insurance past the COBRA period.

Newly hired employees are required to contribute 1.5 percent of annual pretax base compensation on an after-tax basis to the VEBA, which averages $425 per employee. County costs for current retirees are approximately $600 per month per retiree family, and this coverage drops to $200 when the retiree becomes eligible for Medicare.

Monroe County uses the VEBA, which includes both employer and employee contributions, to pay 100 percent of the COBRA premium for retirees. For retirees’ spouses and dependents, the county pays 50 percent of the COBRA premium plus 2.27 percent of the premium for each year of service over eight years. (The county would pay the entire spouse/dependents premium if the employee had worked for 30 years.)

Retiree Health Care Benefits

The benefits provided to retirees are the same as for active employees. Retirees must enroll in Medicare Part B upon reaching age 65, and county benefits are considered supplemental to Medicare benefits. Retiree spouses covered by their own past or present employer’s group health plan are not eligible to participate in the plan.

Employees are eligible to receive retiree health care benefits if (1) they receive pension benefits from the retirement plan and (2) they were contributing to the plan immediately before retiring. The vesting for retiree health care benefits is currently the same as for the retirement plan: age 60 with eight years of service. Early retirees are eligible for health benefits if they are 55 years old with at least 30 years of service. Sheriff’s department employees are eligible at age 50 with 25 years of service.
Contributions

Employer contributions are considered supplemental to the 1.5 percent employee contribution described above. If employee contributions are sufficient to pay benefits and begin prefunding, then the county would not make any contribution. Because employee contributions are constant, however, the county still bears the risk of future health insurance inflation, and it is likely that county contributions will always be necessary. The county expects to contribute 6.35 percent of payroll into the VEBA.

The VEBA trustee is required to maintain a separate account for each employee and to account for the county and employee contributions separately. Monroe County documents specifically state that: contributions made by current employees are held in a trust and continue to be subject to the general creditors of the county. In the event that the county declared bankruptcy, employees could lose the money they contributed to the retiree health trust.

An employee who terminates employment before becoming eligible to receive benefits under the plan, or is covered under another insurance plan, is entitled to all of their personal contributions to the trust plus earnings. County contributions to the employee’s trust would be distributed among the remaining employees or used to reduce the county’s contribution.

How Contributions Are Invested

All employer and employee contributions are invested. Contributions currently are placed in a separate retiree health care fund. Money is invested in low-risk investments, such as certificates of deposit and other eligible investment vehicles as determined by the VEBA trustee. More active management is planned soon.
Trust Fund Case Study

Saginaw County, Michigan

Saginaw County, in central Michigan, provides pension and health care benefits to county retirees who are vested members of the county's pension plan at the time of retirement. Approximately 260 county retirees receive health care benefits, which cost approximately $920,000 in 1996.

History of the Plan

Saginaw County has achieved significant cost savings as a result of its efforts to identify and control its retiree health care liability. Identification of this liability has enabled the county to improve its bargaining position during labor contract negotiations. For example, since 1993, county-paid retiree health care coverage for newly hired employees is limited to the employee and is not extended to beneficiaries. In addition, newly hired part-time employees must pay a graduated portion of the group retiree health premium (e.g., 50 percent for those working 20 hours per week, and 25 percent for those working 30 hours, etc.).

The county uses a national insurance company as a third-party administrator—partly to contain costs and partly to ensure that retirees moving to other states receive quality care under the county's plan. Using a third-party administrator has allowed the county to institute stringent cost-control measures, including mandatory second opinions and designated pharmacies for prescription drugs. These measures have kept health care cost increases down to 0 percent in 1993, 9 percent in 1994, 0 percent in 1995, 5 percent in 1996, and 0 percent in 1997.

Although these changes have been difficult to implement, county officials emphasize that the changes are important to ensure that funds are available to pay promised benefits.

Retiree Health Care Benefits

Saginaw County self-funds hospitalization, surgical and medical insurance, and semiprivate rooms for regular full-time and part-time employees. Employees who retire from Saginaw County are eligible to continue receiving these benefits.

Retirees and their dependents are converted to Medicare and receive supplemental coverage from the county upon reaching age 65. Those who retired before May 1, 1984, are also eligible for partial reimbursement of Medicare Part B costs on an annual basis, provided that satisfactory proof of payment is presented to the county controller's office. Retired employees may elect to receive $75 per month for life in lieu of health coverage, except under limited circumstances.

Retirees are eligible to receive retiree health care benefits if they

- are eligible according to the county's personnel policy or labor agreement,
- are vested in the county's retirement plan,
- are members of the plan at the date of retirement, and
- have made proper application for health care coverage.

A vested employee who leaves county employment before meeting the age and service
requirements to receive a pension is not eligible for health insurance coverage, unless the employee is 55 or older and has 10 or more years of service at the time of termination. In such a case, the deferred retiree is reenrolled in the plan at the time the pension benefit begins.

The county pays 100 percent of the retiree health care cost for employees who retired before 1990. Employees who retired after January 1, 1991, pay a graduated percentage of the cost, depending on the number of years of county employment.

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<th>Years of Service</th>
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<td>10</td>
<td>60 - 75%</td>
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<tr>
<td>10 to 15</td>
<td>35 - 55%</td>
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<tr>
<td>15 to 20</td>
<td>10 - 30%</td>
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<tr>
<td>20 or more</td>
<td>5%</td>
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**Contributions**

In 1991, the county hired an actuarial firm to calculate its future retiree health care liability and establish reimbursement rates needed to fund the liability. The consultant’s report estimated that the county’s total retiree health liability for 1,040 employees and 220 retirees ranged from $22.1 million to $28.4 million, depending on the assumptions used. Under the more optimistic assumptions, a contribution rate of 6.71 percent of payroll was calculated, amounting to $1.6 million in 1993. The 1992 budgeted retiree health care cost had been $704,000, or 2.97 percent of payroll.

In August 1992, the county board of commissioners approved the 6.71 percent contribution rate starting with calendar year 1993. This rate was incorporated into budgets for 1994 through 1996 and was intended to cover normal costs along with the required prefunding of retiree health benefits. In approving the contribution rate, the county board agreed that prefunding retiree health benefits would stabilize future budgets and assure employees that future benefits would be funded.

In August 1996, the county had its actuarial report updated. The new report estimated that, for the year ended December 31, 1995, the county’s total retiree health liability ranged between $18.2 million and $24 million, principally due to changes in the benefit plan. Under the more optimistic assumptions, the report calculated a contribution rate of 6.19 percent of payroll for FY1997, which reduced the 1992-established rate by 0.52 percentage points.

**How Contributions Are Invested**

Saginaw County budgets for and pays the actuarially determined contribution rate to a separate trust to fund postemployment health benefits. The cash and investments held to fund retiree health care costs are invested by a retirement commission in no-load mutual funds with a maximum of 60 percent invested in stocks and 40 percent in bonds.

As of September 30, 1996, the trust held assets of $4.9 million at cost and $5.5 million at market value. Considering the assets on hand during the 1996 actuarial valuation, the county’s unfunded accrued liability for retiree health benefits was calculated to be $15.2 million. County officials expect that the unfunded accrued liability will be eliminated within 10 years or less given the positive cash flow and anticipated nominal increases in retiree health care costs.
Insurance Fund Case Study

Multnomah County, Oregon

Multnomah County, Oregon (population 636,000) has 3,900 permanent employees. The county maintains one insurance fund for all insurance purposes, and the retiree health fund is a "subset" of that fund.

History of the Plan

The retiree medical insurance prefunding program was started in Multnomah County in 1988 after the passage of FASB Statement 106. As of June 1996, the program is 89 percent funded, and it is expected to be fully funded in three to four years.

Through labor agreements, the county provides certain medical, dental, and life insurance benefits for retired county employees, disabled retirees, early retirees, and their eligible dependents. The county also extends limited benefits to "exempt" (i.e., nonunion) employees.

Retiree Health Care Benefits

Through collective bargaining agreements, the county pays between 50 percent and 100 percent of retiree health insurance premiums based on age and service requirements. Exceptions are made for disabled retirees and early retirees.

For members of nurses’ and crafts’ (i.e., electricians, painters, and engineers) unions hired before 1992, the county pays 100 percent of the monthly health insurance premiums for retirees (and their dependents) who (1) have 10 years of service, (2) are between the ages of 60 and 65, and (3) are not eligible for Medicare. These benefits are provided until the retiree turns 65, dies, or becomes eligible for Medicare. Employees of these unions hired after 1992 will have only 50 percent of their retiree health premiums paid when they are eligible for their benefit.

For other retirees and their eligible dependents, the county pays 50 percent of the monthly health insurance premium until the person reaches age 65, becomes Medicare eligible, or dies. Retirees are eligible to receive these benefits if they have

- 5 years of continuous service immediately preceding retirement at or after reaching age 58,
- 10 years of continuous service immediately preceding retirement prior to reaching age 58,
- 10 years of continuous service immediately preceding retirement due to disability, or
- 30 years of participation as a member of the Oregon Public Employee Retirement System and 30 years of county service immediately preceding early retirement at or after age 55.

The county does not supplement Medicare benefits. At age 65 or Medicare eligibility, the employee may continue coverage by paying 100 percent of premiums. Eligible retirees also can participate in the county’s dental plans by paying the full dental premium.
Contributions

The cost of retiree health care and insurance benefits (i.e., current expenses) are charged to the Insurance Fund. The Retiree Health Fund is a subset of the Insurance Fund, and excess balances from other components of the fund are transferred to it to reduce the unfunded liability. The county's contributions to pay for future retiree medical benefits are actuarially determined. The funding method used for the calculations is the projected unit credit fund-to-decrement method, which decreases the accrued liability and costs more rapidly than some other projected unit credit methods. The county considers this more appropriate for determining a contribution rate.

The unfunded actuarial liability is amortized as a level percentage of salary over a 30-year period. Actuarial assumptions include (1) a 6 percent rate of return on the investment of present and future assets, (2) annual 6 percent salary increases, and (3) trend rate increases starting at 10 percent in Year 1 and gradually declining to 5 percent. As of 1997, the funding rate is 0.86 percent of payroll, and the county's annual contribution has met the actuarial requirements. Once the retiree health insurance fund is fully funded, the funding rate charged to each department is expected to be significantly reduced. It is anticipated that future interest earnings will be sufficient to cover departmental contribution amounts.

How Contributions Are Invested

The retiree health care funds are pooled with all other county assets and invested in short-term investment vehicles (i.e., Treasury bills, agencies, commercial paper, banker's acceptances, and repurchase agreements). The yield of the pool is currently in the range of a three-year Treasury note.
History of the Plan

The City of Winston-Salem had been sponsoring a retiree health benefit program that provided the same coverage for retirees and active employees. This plan used a cost-sharing arrangement: The city paid 50 percent of retiree premiums and 50 percent of premiums for eligible retirees’ spouses and dependents. The vesting rights required five years of full-time service by retirement or age 62, and the program was a defined benefit plan.

Although this program had been actuarially determined to be sound, future costs would rise quickly if the actuarial study recognized future health care costs using 15 percent growth rates for five years and 7.5 percent thereafter, consistent with FASB Statement No. 106.® As a defined benefit program where there was no limit on future costs of the stated benefits, Winston-Salem’s plan became unaffordable.

In 1991 and 1992, the city’s board of aldermen approved several modifications to bring the program back within reasonable cost levels.

• The program was changed to a defined contribution plan in order to limit the city’s future liabilities. The maximum program cost for an individual member to be paid by the city was set at $2,400. January 1993 estimates indicated, however, that program costs were only $1,620 per member, approximately two-thirds of the city’s defined contribution maximum. This left room for future cost increases. The city believes that actuarial gains may allow the future maximum cost to be raised without increasing the actuarial liability costs to the city.

• The vesting requirement was increased from 5 to 15 years of full-time employment, although those employed full-time prior to the effective date were grandfathered. Full-time employees who retire due to a disability are automatically vested in the program.

• The cost-sharing system was changed. Rather than paying 50 percent for retirees under 65 and their spouses/dependents, the city now pays the full cost (within the maximum) for individual retirees only. The city does not make contributions for retirees’ spouses/dependents, although they are allowed to pay the full cost and participate.

Retiree Health Care Benefits

The City of Winston-Salem offers its retirees under age 65 the same medical coverage that active employees receive. Retirees and active employees can choose from among two point-of-service (POS) plans and a health maintenance organization (HMO). All three plans have the same premium structure, thus employees choose the plan that best meets their financial, medical, and geographic circumstances. For example, the POS plans offer an out-of-network/plan benefit level so that retirees who move from the area may still receive coverage.

® Winston-Salem used FASB Statement No. 106 as a surrogate measure of the cost of postretirement health care should GASB elect to require the accrual of such costs in the future.
Employees are eligible to participate in the retiree health insurance program at retirement or at age 62 if they have 15 years’ full-time employment with the city. The program pays 100 percent of a retiree’s premiums with an annual benefit limit initially set at $2,400. Eligible retirees can choose spouse/dependent coverage but must pay the additional monthly cost. Retirees over age 65 can elect Medicare supplementary insurance (Part B). The city pays 100 percent of the premiums for the Medicare supplementary program. Spouses and dependents of eligible retirees must pay their own premium cost for Medicare Part B.

**Contributions**

With the recent changes in the program, the unfunded accrued liability computed according to FASB Statement No. 106 was revised to $13.1 million. In November 1992, the North Carolina Municipal Leasing Corporation issued $25 million in certificates of participation (COPs), of which $13.1 million of the proceeds was used to fully fund the retiree health and life plan.\(^9\)

Low investment returns in 1993 and 1994 prompted the city to continue funding the plan on a pay-as-you-go basis for those years. The city determined its funding portion for those years by totaling (1) the health premiums for retirees under 65, (2) the estimated cost of the Medicare supplement for older retirees, and (3) the actuarially determined normal cost of the plan. This total was then divided by the estimated payroll to determine the benefit percentage; the benefit percentage is charged monthly against current city department salaries.

In the first eight months of 1995, the investment return for the city was over 28 percent. Now that the plan is substantially funded, the city will only incorporate the normal cost (which includes fiscal agent fees for making the market) to determine the benefit percentage.

Annual actuarial reports help recalculate the funding requirements. The money for the retirement health insurance program is accounted for and tracked as an independent self-insurance fund for internal purposes, although its results are combined with all self-insurance activities for the comprehensive annual financial report.

**How Contributions Are Invested**

The ability to invest in corporate stocks and bonds and the percentage of assets that can be allocated to these types of assets is limited by North Carolina statute; however, local legislation was passed that allows the city to invest up to 60 percent of pension and pension-related assets in high-quality corporate equities—the same limit that applies to the state retirement system’s investments. Because the instruments are traded as short-term investments that pay short-term interest rates (roughly 3.5 percent) while the funds are invested in traditionally longer term instruments such as high-quality corporate stocks and bonds (interest equaling roughly 10 percent), the spread on the difference is expected to be more than enough to pay off the principal and interest on the COPs over the 20 years. Should a prolonged period of extremely high interest rates ensue, the city can sell off its equity and bond holdings and call in the COPs early.

Currently, the investments are doing better than what is needed to pay off the principal and interest on the COPs over the 20 years. Although there is no commitment on behalf of the city to keep this program fully funded in the future, the city plans to do so.

\(^{9}\) The city retains fiscal agents that maintain liquidity by buying and selling the COPs, although the COPs do not mature for 20 years—when a balloon payment is due.
History of the Plan

Recognizing the problems related to the rapid growth of health care costs, the SERS board has sought to control costs over the past decade through a variety of legislative and managerial actions. Starting in 1986, a 10-year service requirement for eligibility for retiree health care benefits was instituted. Graduated premium payments based on years of service were adopted in 1989. Also in 1989, SERS reduced its dependent health care benefits from 50 percent to 30 percent of premiums, froze its Medicare Part B reimbursement to retirees at $24.80 per month, and established an employer health care surcharge. In 1993, SERS started phasing in a managed care network for retirees and dependents not covered by Medicare. As of January 1, 1997, SERS added four Medicare-risk HMOs to its health care program. In 1992, SERS added a retail prescription network program, which saved the system $2 million per year in prescription and administrative costs. In 1994, the retail program was integrated with the existing mail order program.

Retiree Health Care Benefits

SERS offers qualified retirees and their dependents a comprehensive health care plan, including major medical coverage and prescription drugs. SERS also reimburses eligible enrolled retirees $24.80 per month toward the basic Medicare Part B premium. Benefits are provided to eligible retirees and beneficiaries through one of several providers. In FY1996, retirees and beneficiaries received health care benefits totaling $90.2 million, up from $88.3 million in FY1995.

To qualify for benefits, retirees must have at least 10 years of service at the time of their retirement. Employees hired after June 30, 1993, must pay the full premium for health care until they are eligible for Medicare. Those hired before then pay a percentage of their premium based on years of service.

<table>
<thead>
<tr>
<th>Years of Service</th>
<th>% Paid by Retiree</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 to 15</td>
<td>75%</td>
</tr>
<tr>
<td>15 to 20</td>
<td>50%</td>
</tr>
<tr>
<td>20 to 25</td>
<td>25%</td>
</tr>
</tbody>
</table>

Members who retire with 25 or more years of service, as well as those who retired before August 1989, do not pay a premium. If a retiree elects to cover dependents, the monthly retirement allowance is reduced by 70 percent of the insurance premium for the dependents.
Contributions

SERS receives contributions to its health care reserve from 765 local government employers, including city, county, and local school districts as well as some colleges and technical and vocational schools. Employer contributions for retiree health care are assessed on the employing jurisdictions at the same time as pension contributions. The maximum statutory employer contribution rate for pensions and retiree health care benefits combined is 14 percent of active employee payroll. Pension benefits are determined first, and the remainder is allocated for health care benefits. For example, in FY1996, the actuarially required employer contribution rate for pension benefits was 10.5 percent of payroll, leaving 3.5 percent for retiree health care benefits.

In addition, a retiree health care surcharge was instituted in 1989 to recognize that the percent-of-payroll costs for health care benefits are significantly higher for SERS than for other major Ohio retirement systems, because the salaries of employees covered by SERS are, on average, significantly lower than for other government employees. The surcharge is assessed on each participating employer and is equal to 14 percent of the difference between the employees’ actual pay (subject to prorating for partial service credit) and the actuarially determined “minimum pay” ($11,800 in 1996 and adjusted annually for inflation). During 1996, employer contributions totaling $77 million were made.

Although not required by statute, health care cost expenses on an annual as well as an actuarial cost basis were reported by SERS beginning in the early 1980s. Using the entry-age normal methodology (as is used for pensions), the actuarial accrued liability for retiree health care benefits grew from approximately $1.0 billion in 1987 to $1.8 billion in 1994. At the same time, the health care reserve grew modestly to $141 million, resulting in a considerable unfunded accrued health care liability. After consulting with its actuary, SERS determined as of July 1, 1995, to discontinue level-cost funding and to institute pay-as-you-go financing with the target level of the health care fund to be maintained at or above 125 percent of annual health care expenses in the fund. For 1996, this 125 percent target was determined to be $112.8 million; however, the actual balance in the health care reserve was $135.8 million.

How Contributions Are Invested

The SERS health care reserve is invested along with the SERS pension trust fund. Approximately 45 percent of the total fund is invested in domestic stocks, 27 percent in fixed-income securities, 15 percent in international equities, 10 percent in real estate, 3 percent in short-term securities, and less than 1 percent in venture capital.
CONCLUSION

These six case studies demonstrate several prefunding options and the issues and concerns some jurisdictions have had in implementing those arrangements. While there does not appear to be an ideal method for prefunding ever-growing retiree health care liabilities, jurisdictions that acknowledge the liabilities and have begun to funding those liabilities are to be commended. The issues will certainly not disappear: As Congress contemplates limitations to federal health entitlement programs, the importance of employer-provided benefits can only continue to grow.