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journal homepage: www.elsevier.com/locate/econbaseThe fiscal stress arising from state and local retiree health obligations[☆]Byron Lutz^a, Louise Sheiner^{b,*}^a Federal Reserve Board of Governors, United States^b Brookings Institution, United States

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ABSTRACT

A major factor weighing down the long-term finances of state and local governments is the obligation to fund retiree benefits. While state and local government pension obligations have been analyzed in great detail, much less attention has been paid to the costs of the other major retiree benefit provided by these governments: retiree health insurance. The first portion of the paper uses the information contained in the annual actuarial reports for public retiree health plans to reverse engineer the cash flows underlying the liabilities given in the report. Obtaining the cash flows allows us to construct liability estimates which are consistent across governments in terms of the discount rate, actuarial method and assumptions concerning medical cost inflation and mortality. We find that the total unfunded accrued liability of state and local governments for the provision of retiree health care exceeds \$1 trillion, or about $\frac{1}{3}$ of total state and local government revenue. Relative to pension obligations discounted at the same rate, we find that unfunded retiree health care liabilities are $\frac{1}{2}$ the size of unfunded pension obligations. We also find that using assumptions concerning the growth in health care costs that are arguably more realistic than those employed by most states actually reduces the size of the liability in most cases. Pushing in the opposite direction, we find that using plausibly more realistic mortality assumptions increases the size of liability. The second portion of the paper places retiree health care obligations into context by examining the budget pressures associated with retiree health on a continuing, largely pay-as-you go basis. We find that much of the projected increase in retiree health obligations as a share of revenue is the result of health care cost growth. On average, states could put their retiree health obligations into long-run fiscal balance by contributing an additional $\frac{3}{4}$ percent of total revenue toward the benefit each year. There is, however, wide variation across the states, with the majority of states requiring little in the way of additional financing, but some states requiring a significantly larger increase.

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1. Introduction

Obligations for retiree benefits are among the most important factors behind the long-term fiscal imbalances of state and local governments (e.g. [State Budget Crisis Task Force, 2012](#)). Although state and local pension obligations have been analyzed in great detail, much less attention has been paid to the costs of retiree health insurance—the other major retiree benefit provided by these governments. Almost all state and local governments provide this benefit to their former employees and very few have put away funds with which to honor these obligations. Moreover, the ever escalating cost of medical care is expected to push up the cost of providing the benefit over time. This paper seeks to answer two fundamental questions surrounding state and local government retiree health care liabilities. First, how large are these obligations? Second, are these benefits fiscally sustainable over the long-term?

Retiree health insurance became prevalent in both the public and private labor markets following the 1965 introduction of

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Medicare, which significantly lowered the cost of providing the benefit. As with any fringe benefit, the coverage formed part of the employee compensation package and it was also used to encourage early retirement (Blau and Gilleskie, 2001; Fitzpatrick, 2014; Marton and Woodbury, 2006). Initially, both private firms and state and local governments accounted for the cost of the benefit on an annual, cash basis—i.e. they accounted for only the annual expenditures for current retirees. This situation changed for firms in 1989 when the Financial Accounting Standards Board (FASB) required employers to begin accounting for retiree health care on an accrual basis—i.e. the full expected future cost of promised benefits had to be acknowledged each year. The accounting statements which followed revealed extremely large liabilities. At least partially in response, firms began phasing the benefit out: In 1988, 66 percent of employers with 200 or more employees offered retiree health insurance; by 1993, only 36 percent of firms offered coverage (McArdle et al., 2014). The prevalence of retiree health insurance in the private sector has continued to decline since (Fronstin, 2010).¹

In sharp contrast, the significant majority of state and local governments continue to offer their retirees health coverage. Although there is immense heterogeneity in the provision of the benefit, full coverage is often provided until the retiree reaches Medicare eligibility at age 65, at which time the coverage either ends or converts to a supplemental plan.² The coverage is usually explicitly subsidized by the government offering it. In some cases, though, the subsidy is implicit: the retiree is offered access to an insurance pool which includes both current workers and retirees. The presence of the younger, current workers reduces the insurance premium for the retirees (and raises the cost to the government of providing insurance to their current workforce).

In 2004, the Government Accounting Standards Board (GASB) issued a statement requiring state and local governments to begin accounting for retiree health benefits on an accrual basis. The actuarial reports which followed revealed extremely large unfunded liabilities for many governments. Likely in response to both the acknowledgment of the size of the liabilities, as well as the escalating cost of the benefit, many state and local governments have begun to pare back the generosity of the benefit through actions such as increasing the percent of the premium that must be paid by the retiree and by tightening eligibility standards (e.g. Clark et al., 2014; Franzel and Brown, 2012). Some governments have even eliminated the benefit (Franzel and Brown, 2013). Going forward, the availability of potentially-subsidized health insurance through the health care exchanges operating under the Affordable Care Act (ACA) may lead more governments to curtail their retiree health coverage.³ Reducing and eliminating the benefit, though, comes at a cost to governments as it reduces the level of compensation being provided to its employees. In a competitive labor market, this will require boosting other forms of compensation or accepting employees of lower quality (Qin and Chernew, 2014).

In order to answer our first question—how large are state and local government liabilities for retiree health care?—we construct a comprehensive set of projections of these obligations. In doing so, we build on past work by Clark (2009, 2010), Clark and Morrill (2010), Clark and Morrill (2011), GAO (2009) and Pew (2012) that has carefully analyzed the stated liabilities in the retiree health care

actuarial reports mandated by GASB. In addition to being the logical starting point for an analysis of these liabilities, this approach benefits from being transparent (Pew, 2010). Moreover, it has clearly been successful in drawing considerable public policy attention to the issue (e.g. State Budget Crisis Task Force 2012).

We advance this existing literature in two ways. First, in reporting the present value of future liabilities, governments have significant latitude in setting the assumptions which underlie the stated obligation. For instance, they have discretion over the rate at which to discount future benefit payments, and also differ in their assumptions about underlying inflation and future health care cost growth. As a result, comparing the size of stated liabilities across governments is problematic as it is unclear if differences reflect fundamental budget issues, such as the generosity of the benefit, or merely reflect different actuarial and economic assumptions. We address this lack of comparability by harmonizing the assumptions upon which the liability estimates are based. Our estimates are therefore directly comparable to each other across governments. Second, much of the past literature relies on the state government actuarial reports. In some states, local government retirees receive their health insurance from the state and are therefore captured by the state report. In other cases, local retirees receive the benefit directly from their former local government employer and are not captured by the state report. Thus, despite the fact that most local government retirees are eligible for the benefit, there is significant variation across states in the percent of the local retirees captured by the state actuarial reports. The past work which has examined local government obligations has focused on subsets of local governments.⁴ Given that our aim is to assess the total fiscal burden of retiree health within each state, we need to fully account for all local government liabilities. We therefore develop a methodology and collect the data required to estimate the size of retiree health obligations for all local government retirees.

We produce our liability estimates by projecting the annual cash flows upon which the stated liabilities are based. (The stated liabilities are equal to the present discounted value of the projected future cash flows needed to fund the benefit.) While such cash flows have been constructed for retiree pension obligations (Novy-Marx and Rauh, 2011, 2014), we are the first to construct them for retiree health insurance. We reverse engineer the cash flows using the information provided in the retiree health care liability reports mandated by GASB. As discussed above, many of these reports cover only state employees and we therefore use supplemental information to gross up these cash flows so that they cover the entire state and local government sector. Once the statistical machinery is in place to produce the cash flows, we can alter the assumptions upon which they are based. Specifically, we produce liability estimates harmonized across three key factors: the discount rate, current and future life expectancy, and health care inflation. Moreover, we impose a common actuarial methodology.

We answer our second question—are retiree health benefits fiscally sustainable over the long-run—by performing a “current policy” projection. The projection assumes that state and local government continue to offer retiree health care under the set of policies (e.g. eligibility requirements) identified in the GASB

¹ This paragraph draws heavily from Clark and Morrill (2010).

² In most cases the receipt of retiree health care requires formal retirement from the system providing the benefit. It does not require exiting the labor force.

³ For example, in May of 2013, the city of Chicago announced its intention to terminate its retiree health care benefit. The city expects that retirees not yet eligible for Medicare will be able to find affordable coverage through the ACA exchanges being setup by the state of Illinois (Shields, 2013).

⁴ For example, Clark (2010) examines obligations for teachers and GAO (2009) examines obligations for the 39 largest local governments. We are unaware of any past work which has attempted to account for all retiree health obligations at the local level in a detailed fashion. There are, however, back-of-the-envelope calculations which attempt to account for the entirety of the local government sector (e.g. Zion and Varshney, 2007).

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