

GASB 45 White Paper
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GASB 45, Health Care, and Public Schools and Colleges

*By Mr. Martin Hittelman
President, Community College Council (California Federation of Teachers)*

Many employees of California's schools and colleges have been willing to accept lower salaries during their working lives in exchange for the benefit of health insurance coverage in retirement. The gain from that trade-off is now in jeopardy. Most public schools and college districts are currently facing health cost increases that are well above the rate of increase of the Consumer Price Index. Some of these districts are moving to eliminate or reduce health care coverage to their current employees and to their retirees. One of the major drivers of the movement to deny employees of their hard-won health benefits is the newly established Governmental Accounting Standards Board 45 (GASB 45) reporting standard.

GASB – Not a Governmental Agency

The first thing one should understand about the Governmental Accounting Standards Board (GASB) is that it is not a federal agency. It has no ability to enforce its requirements on public employers. GASB is an independent, private-sector organization that provides national, state, and local governments with a view of what GASB believes should be considered as accepted accounting principles. It does not answer to either state or federal government. The self-stated goal of GASB is to help taxpayers and government officials determine the ability of their level of government to financially provide services and repay its debt. GASB believes, in its own words, that it is an “*independent body free from inappropriate political pressure or commercial influence*” and that it brings “*objectivity and integrity to the process of issuing neutral, unbiased accounting and financial reporting standards that are relevant in the government environment.*” (www.gasb.org). There is no evidence to suggest that the claim of neutrality, unbiased accounting, or relevance is valid or invalid.

Even though GASB does not have enforcement authority, its standards do become part of what are called “generally accepted accounting principles.” The Code of Professional Conduct of the American Institute of Certified Public Accountants requires that auditors follow the standards adopted by GASB. Audits will likely include information regarding compliance with the GASB standards.

GASB 45

GASB 45 establishes guidelines for how public employers should report the costs of employer-provided retiree health plans. Prior to GASB 45, public employers were only required to report the annual amount that they actually paid for benefits for current retirees. Beginning in 2007-08, GASB 45 calls on districts to publicly provide periodic actuarial reports that disclose any long term retiree healthcare liabilities. The standard allows for up to 30 years to spread the liability of retiree health benefits. The reported liabilities are to be included in the district's financial statement. Districts will continue to report on how much the medical coverage of their current retirees costs.

They will now also have to report on the cost of future benefits that current employees earn during the fiscal year as well as the value of benefits earned in prior academic years. Except for the cost of the accounting, no new costs for benefit coverage are created by GASB 45. The only new costs for benefit coverage would occur if an employer decided to put money aside in order to fund the liability in addition to its current pay-as-you-go obligations.

Shock and Awe

As districts begin to follow the GASB 45 reporting guidelines they will find that they have what, at first glance, are horrific obligations. The Los Angeles Community College District was quoted an Actuarial Accrued Liability of \$623.2 million. Currently the district is spending about \$26 million per year in retiree medical costs. The Los Angeles Unified School District had an estimated liability of \$4.9 billion. Currently the LAUSD spends approximately \$177 million per year for retiree health benefits.

There is no requirement to actually fund the liability, only to report it. District budgets will only be affected by GASB 45 if a district decides to fund retiree benefits in a new way. Most districts have traditionally paid for retiree benefits as the employees retired. Some have done so without any financial problem for more than fifty years.

Actuarial Projections

It must be noted that actuarial projections on retiree health benefit costs are highly speculative – especially over a thirty-year period of time. Very slight changes in the assumptions related to costs and return on investment result in huge changes in the projected liability. The factors that actuaries use, such as rate of return on investments, health care costs and the demographic makeup of the employees and retirees, change from year to year. A good actuary should have the ability to provide either a best-case and a worst-case scenario or both. Districts should ask for both.

GASB 45 Timeline

The new accounting standard takes effect in 2007-08 for districts with total annual revenue of \$100 million or more*. For districts with revenues from \$10 million to \$100 million, the effective date is 2008-09 and for districts with revenue less than \$10 million the date is 2009-10.

According to a report issued by Labor Research Partners in 2005, 41 of the 72 California Community College Districts operated on the pay-as-you-go option. Many have had an actuarial study done. Thirteen districts reported that they have little or no liability.

*The measuring period for revenue for this purpose is the first fiscal year ending after June 15, 1999.

Los Angeles Community College Experience

Most districts currently pay for their retiree health care on a “pay-as-you-go basis” (paying only the amount of actual benefit costs for retirees in any given year). The Los Angeles Community College District has had retiree health benefits for more than 30 years and has been operating on a “pay-as-you go” system all of this time without any major problem. Here is the cost to the district of benefits (including health benefits for retirees) over the last 15 years:

LACCD
Unrestricted General Fund
Appropriations (in millions)

	Certificated Salaries	Classified Salaries	Benefits	Unrestricted Total	% of benefit. increase over previous year
1989-90	107.649	48.861	41.185	227.585	
Percentage	47.3%	21.5%	18.1%		
1990-91	103.281	48.788	43.038	231.351	4.5%
Percentage	44.6%	21.1%	18.6%		
1991-92	102.199	51.466	44.208	228.335	2.7%
Percentage	44.8%	22.5%	19.4%		
1992-93	101.519	51.932	47.718	234.902	7.9%
Percentage	43.2%	22.1%	20.3%		
1993-94	99.679	52.573	50.255	239.006	5.3%
Percentage	41.7%	22.0%	21.0%		
1994-95	101.167	54.714	47.317	238.471	-5.8%
Percentage	42.4%	22.9%	19.8%		
1995-96	99.747	58.759	50.848	244.159	7.5%
Percentage	40.9%	24.1%	20.8%		
1996-97	114.067	62.480	52.664	274.626	3.6%
Percentage	41.5%	22.8%	19.2%		
1997-98	119.803	66.723	53.662	277.310	12.5%
Percentage	43.2%	24.1%	19.4%		
1998-99	122.854	66.846	50.955	281.537	-5.0%
Percentage	43.6%	23.7%	18.1%		
1999-00	134.288	71.930	54.875	290.480	7.7%
Percentage	46.2%	24.8%	18.9%		
2000-01	155.157	79.121	61.552	367.517	12.2%
Percentage	42.2%	21.5%	16.7%		
2001-02	185.100	88.970	62.541	411.692	1.6%
Percentage	45.0%	21.6%	15.2%		
2002-03	181.983	87.187	76.787	409.281	22.8%
Percentage	44.5%	21.3%	18.8%		
2003-04	173.731	79.972	85.429	390.547	11.3%
Percentage	44.5%	20.5%	21.9%		

It is clear that the percentage of expenditures on benefits compared to the total appropriation has not increased greatly over the period covered.

The Los Angeles Community College District 2005 actuarial valuation reported that Actuarial Accrued Liability was found to be \$623.2 million. As noted above, actuarial results can vary widely based on the assumptions made concerning the increase in the cost of health care, return on investments, effects of Medicare coverage for retirees, and likely life expectancy.

Pay-As-You-Go Comparison

The LACCD GASB 45 valuation report, prepared by Demsey, Filliger & Associates, LLC as of July 1, 2005, contained the following comparison of the cost of continuing to fund the retiree health benefits of current employees using a pay-as-you-go and several other methods (a level contribution for the next 20 years, a level percentage of the unfunded accrued liability, and a level percentage of payroll for the next 20 years). Note that for 2005, GASB would require a payment of almost \$55 million while pay as you go would only require about \$26 million. I have found that the doubling of cost by moving from pay-as-you-go is a common result.

It is important to note that even after ten years, the amount the LACCD would have to pay for the benefits of retirees is less than the amount required by GASB 45 in 2005. Meanwhile, all of the excess funding has not been available to provide service to students or salary increases to employees.

LACCD	Level % of				Annual Required By GASB 45
	Pay as You Go	Level Contribution	Unfunded Liability	Level % Of Payroll	
2005	\$25,969,881	\$65,460,000	\$56,446,082	\$51,099,000	\$54,989,936
2006	\$28,921,655	\$65,460,000	\$55,340,904	\$52,631,970	N/A
2007	\$31,507,093	\$65,460,000	\$54,328,776	\$54,210,929	N/A
2008	\$33,892,132	\$65,460,000	\$53,394,546	\$55,837,257	N/A
2009	\$36,108,400	\$65,460,000	\$52,526,490	\$57,512,375	N/A
2010	\$38,185,158	\$65,460,000	\$51,714,229	\$59,237,746	N/A
2011	\$39,860,247	\$65,460,000	\$50,948,524	\$61,014,878	N/A
2012	\$41,215,022	\$65,460,000	\$50,218,859	\$62,845,325	N/A
2013	\$42,519,060	\$65,460,000	\$49,517,075	\$64,730,684	N/A
2014	\$43,819,415	\$65,460,000	\$48,838,115	\$66,672,605	N/A
Total	\$361,998,063	\$654,600,000	\$523,273,600	\$585,792,769	N/A
Increase over pay as you go		\$292,601,937	\$161,275,537	\$223,794,706	

Many pundits believe that the current pay-as-you-go method of paying retiree health benefits will lead to major problems in upcoming years as the mounting liability begins to come due. The fact that this has not occurred yet in districts (like the Los Angeles Community College District and the Los Angeles Unified School District) that have had such a benefit for more than thirty years seems to have had little effect on reducing any fears that they might have concerning

the impropriety of using the pay-as-you go methodology. The probable emergence of a single-payer universal health care system (which would relieve districts of their retiree health care responsibilities since such a health care system would be responsible for the health care costs of retirees) in California or the United States over the next twenty years also has little impact on their fears.

Standards' Effect on Benefits

The large relative cost (as opposed to pay-as-you-go) of pre-funding retiree health benefits in the private sector has clearly led many private companies to abandon the welfare of their employees. The threat of future unsustainable liabilities is playing a part in the effort to eliminate defined benefit retiree health plans. As a result of a GASB-like requirement adopted by the Financial Accounting Standards Board (FASB) in the private sector, the Employee Benefit Research Institute (EBRI) found that *“some employers placed caps on what they were willing to spend on retiree health benefits. Some added age and service requirements, while others moved to some type of ‘defined contribution’ health benefit. Some completely dropped retiree health plans for future retirees.”*(EBRI Issue Brief Number 236, August 2001). The Kaiser Foundation released a report (The State of Retiree Health Benefits: Historical Trends and Future Uncertainties, May 17, 2004) at a United States Senate Special Committee on Aging Hearing that found that *“In response to these cost increases and changes adopted in the early 1990s by the Financial Accounting Standards Board (FASB) that requires firms to account for their future retiree health obligations, employers have implemented a number of strategies to curb these costs. Of note, our survey found that roughly half of all large (1,000 + workers) private-sector employers that offer retiree health benefits to 65+ retirees have imposed caps on their future obligations, nearly half already hit the cap, and another third say they are likely to hit the cap in the next three years.”*

Public agencies also have begun to cut back on retiree health care benefits. For example, a few years ago the Los Angeles Community College District (LACCD) negotiated increased requirements for new employees to be eligible for retiree health benefits. In addition, retirees now get the same benefits as those active members even if they have been reduced since the employee retired.

Some in the LACCD are now suggesting that new employees not be eligible for retiree health plans. They propose that the District negotiate a two-tier system of retiree benefits with one set of benefits for current employees and retirees, and another for new employees. Others have suggested that a percentage of the state funded cost-of-living adjustment be used to begin to build a fund to pay for future retiree health benefits. These proposals are being driven by the increased pressure caused by the threat of GASB 45, the recent escalation of the cost of health care, and the drive by some to eliminate all social net provisions.

GASB 45 and Public Agencies

Not much has been said concerning whether GASB 45 makes sense for public agencies. Public institutions are very different from private companies because they do not go out of business. They have a regular stream of guaranteed income and huge assets in land and buildings. The need for public agencies to protect workers benefits into retirement is different from that of private employers since the income of the public institutions will continue. If a public institution ceases to exist, the assets can be sold off to pay for the ongoing health care requirements in a way that may not be available to a private sector business.

Drivers of Increased Health Care Costs

In the discussion revolving around GASB 45, not much emphasis has been placed on the real underlying reasons for the increased cost of health care. The *California Health Care Coalition* (CHCC) is one of several groups compiling data on the causes of high premium costs. The data that they have collected demonstrates the strong relationship between skyrocketing health costs, badly practiced medicine and hospital bills. The CHCC is active in adopting common standards for provider participation, collaborating with CalPERS and other purchasers to build local purchasing coalitions, negotiating collectively with providers, educating the public, and studying hospital and other costs in targeted areas of California. In the words of the CHCC: *“Three premises underlie our strategy. First, shifting health care costs to the users of care will do little to address the basic ‘supply-side’ problems of excessive charges and poor quality care. Second, health plans alone are unable to assure quality and stabilize costs. Third, the industry has consolidated and so must purchasers. We cannot be an effective force for health reform without first organizing ourselves in the healthcare marketplace.”*

Research by the CHCC and the *California Education Committee for Health Care Reform* has made clear that the increased cost has come from the supply side, not the demand side of the equation. The usual explanations for increased costs (an aging population, the high cost of new technology, the provider costs driven by trial lawyers, the development cost of new wonder drugs, and the irresponsible consumer) have not been found to be the dominant drivers of the inflation in medical insurance premiums.

In fact, although some industry-paid analysts say that health care costs are rising due to aging, technology, increased utilization, and increases in such diseases as diabetes, the major cost increase driver of the health care cost increases has been found to be on the supply side of the systems (the providers of health care) through a combination of excessive prices (and profits), pervasive medical error and quality deficiencies. High prices and high administrative costs are the critical causes of the substantial increases in health care spending that most districts have experienced. The often hidden truth is that the United States has the highest per-capita health care cost in the world but provides only a minimum of service and quality to those who can afford to participate. See “High Prices, Questionable Quality: A Program to Put Patients First in California Hospitals”, The California Health Care Coalition, April 2005, for documentation on the drivers of cost. Also see “The Health Benefit Equation: A Joint Labor/Management Solution” by Ruben Ingram and Cindy Young in the August 2006 issue of the *California Public Employee Relations Journal*.

There has been a tendency to blame the consumer of health care and efforts have been made to change patient behavior through higher co-pays and the like. This has been shown to just shift the cost of care from the employer to the employee but it also seems to drive up the total cost of care when routine care is replaced by emergency care. *“The RAND Health Insurance Experiment showed that cost sharing (requiring out of pocket expenditures by the patient) reduces costs by lowering health care utilization - but that it has some undesirable consequences. As compared with the provision of free care, cost sharing reduced the percentage of low income adults who sought ‘highly effective care for acute conditions’ by 39 percent and was associated with worse blood-pressure control and less reliable use of preventive care measures such as Pap smears.”* (“Do High-Deductible Health Plans Threaten Quality of Care?”, *New England Journal of Medicine*, September 20, 2005).

Others are beginning to realize some of the problems with high co-payments. In a report prepared for the California Healthcare Foundation (“Managing the Costs of Health Care Coverage: Emerging Practices Among Public-Sector Employers”, September 2006) the value of employee incentives to change health practices for the better is described: “.. employers have learned that it may be advantageous or even necessary to reduce employee cost sharing.”

Poor care is also a major driver of cost. Various studies presented to the *Education Committee for Health Care Reform* by John J. Glynn and Alfredo Czerwinski, MD (“Benchmarks for Cost and Quality”, September 12, 2006) and others using data from a RAND study JAMA 2003 and other sources, demonstrated that best medical practices are used only 50% of the time. 80% of diabetes patients are receiving the wrong treatment. 75% of coronary artery bypass graft surgeries are not effective and do not increase longevity. Quality experts have reported that between 20 and 30 percent of health care spending is attributable to poor quality care.

Health Plan Failures

The major health plans and insurance carriers have failed to address costly failures of the delivery system. Instead, they pass on rising costs to their customers, rationalizing increases by claiming that prices are up, utilization is up, and the users of health care is at fault because they don't take adequate care of themselves. At the same time, these health plans and insurance carriers keep secret the prices they negotiate with providers and are silent about their own failure to monitor and correct for physician-driven overuse of inappropriate services, pervasive provider failure to follow professional treatment standards, inefficient resource use, and high medical error rates.

Large Regional Variations

Research by the CHCC and others has shown very large regional variations in rates of use of diagnostic tests and procedures, mortality rates and infections and complications that are unrelated to the severity of the medical conditions. In addition, costs vary greatly from hospital to hospital in the same region and in the state. Heart surgery in Sacramento costs three times what it does in San Diego. The CHCC reports that the average hysterectomy in Sacramento ranges from \$13,921 to \$43,931 depending on the hospital. The average cost of paid claims at Sutter Health hospitals was 73% greater than the average cost of all other CalPERS paid claims in the state. Operation margins vary greatly from the statewide average for the non-profit (non-Sutter) hospitals at 2.5% to Memorial Hospital in Modesto at 21.1%.

It has been shown in a number of studies presented to the *Education Committee for Health Care Reform* and the CHCC (see the 2005 Dartmouth Medical School study as an example) that there are more elective surgeries in areas where there is a high concentration of surgeons. Greater use of diagnostic tests occur where heavy investments have been made in expensive technologies. Admissions to hospitals depend on the number of beds available. The *California HealthCare Foundation* (“Evaluating the Efficiency of California Providers in Caring for Patients with Chronic Illness”, November 2005) reporting on the Dartmouth study: “*The study found that the higher use in California reflected a delivery system in which services were driven not only by patient need, but by the supply of medical resources. In regions that have more hospitals, more ICU beds, more physicians, and more specialists, patients receive significantly more service at greater cost, but with no improvement in outcomes.*”

In a June 2, 2005 report by Tom Moore, Jr. entitled “Was this surgery necessary? Our hidden epidemic,” Mr. Moore illustrated his point by quoting Daryl Cordoza’s (CFO of Hill Physicians) remark before the Health Benefits Committee of CalPERS: “*if there is a woman on the streets of Redding over the age of 21 with an intact uterus, she must be a tourist.*”

Consolidation of Health Care Providers

The ability of health care providers and insurers to sharply escalate costs has arisen as a result of the elimination of competition. Only 50 hospital systems now exist in California and these are part of six national chains. All of these have been found to have billing frauds and irregularities. Some hospitals have up to 90% of local market share.

And it is not just the hospitals and the doctors. Two large pharmacy benefit managers (Caremark and Express Scripts) control 50% of the nation’s supply. Pharmaceutical companies are absorbing competitors, achieving monopolies in some types of drugs, and driving up the cost to United States users. Prescription drug sales are now advertising driven, with consumers requesting certain highly advertised drugs and doctors prescribing heavily promoted drugs. People in the United States pay 80% more for drugs than do the rest of the world.

In summary, there are widespread and medically unjustified variations in hospital admissions, elective surgery rates, provider charges, average cost per case, and patient outcomes.

California Health Care Coalition

CHCC is attempting to “*establish and apply performance standards for hospitals and physicians. The burden of proof must shift to high cost institutions to demonstrate that their higher charges or premiums are justified by special circumstances or better patient results.*”

“*Negotiate directly with health care providers, plans and intermediaries on cost, quality and transparency issues. Contracts should establish full financial transparency and performance accountability, with providers required to provide detailed cost, utilization and outcome data. These data are needed to determine whether rates are justified and treatments are appropriate and effective.*”

“*Restructure networks to include only those who are able and willing to meet our cost, quality and reporting standards. Providers who are unable or unwilling to meet CHCC performance standards will risk elimination from our networks. We can no longer tolerate inappropriate, ineffective and inefficient care.*”

“*Promote competition in local health care markets and eliminate the anti-competitive business practices of consolidated provider systems. Hospital conglomerates and other provider systems should not be allowed to require inclusion of all facilities in their network as a condition for accessing any one of them*”

“*Support and promote industry-wide performance reporting and information disclosure standards. Purchasers and patients need timely, reliable data comparing hospitals and physicians on quality and cost-efficiency. We cannot reliably compare hospitals on cost and quality unless the comparisons are based on a common set of performance measures that are fully and freely disclosed from a reliable third party entity.*”

How to Cut Benefit Costs and Increase Quality

The first step that districts should be taking, rather than rushing into prefunding or eliminating retiree health care, is to address the real reasons for increasing costs. They should join *Health Access California*, the *California Health Care Coalition*, and the *California Education Committee for Health Care Reform* in order to increase the influence of these organizations. Until purchasers organize to demand delivery system reform and performance accountability from health plans and providers alike, the problems with our health delivery system will continue and the cost pressures on public sector employers, unions, and workers will grow.

Districts should be spending more time on fixing the provider problems by identifying the best hospital for each type of operation and inform or encourage patients to go there, encouraging preventive primary care, developing locally based coalitions (like those being formed under the umbrella of the *California Health Care Coalition*) to get the information needed to bargain effectively, require doctors to write prescriptions through a computer system that checks for negatives and correct dosage (see the Leapfrog research on the issue at www.leapfroggroup.org), and eliminate high cost, low quality doctors and hospitals from participation in health plans.

Health Access California is another organization working in California, primarily at the legislative level, to address health care issues. They begin by focusing on the uninsured. “*Over six million Californians are uninsured, out of 35 million. These are families that work hard, play by the rules, and pay their taxes, yet don't get basic health coverage. Over 80% of the uninsured are in working families, with the uninsured person either a worker, or the dependent of a worker.*”

The uninsured are not uninsured by choice. Over 85% of the uninsured are either not offered or not eligible for health insurance from their employer. (UCLA Center for Health Policy Research). Buying health insurance as an individual is often not an option, as coverage is too expensive for the low- and middle-income families that are the vast majority of the uninsured. Coverage simply is not available for many, because of "pre-existing conditions." (Families USA)"

Health Access California has also found that “uninsured families live sicker and die younger. The uninsured often delay or avoid getting needed care, including screenings and preventive care, ongoing treatments for chronic conditions, and emergency care, resulting in severe health impacts. (*American College of Physicians*). The uninsured are more likely to die prematurely than insured patients with similar problems, for every type of ailment or problem, from emergency trauma to cancer. (*Institute of Medicine*).”

In fact, nearly half of all personal bankruptcies are the result of health problems or large medical bills. (National Health Care for the Homeless Council, www.nhchc.org/singlepayer.htm).

Health Access California has worked through legislation, the budget, and the ballot box to improve the health care conditions of the uninsured, the underinsured, and all health care consumers in California. Their goal is to have access to health care for all without financial barriers or consequences.

Fiscal Sense?

GASB-like standards are likely to increase the pressure to eliminate, for new employees, whatever retiree health care is left for current employees and retirees. If this is not the planned result, it is certainly a likely result. GASB 45 has become an integral part of the attack on worker safety nets. Actuarial results are also being used by management to deflate faculty and staff salary and benefit increases.

Since using any of the alternatives to pay-as-you-go is much more expensive, why would a district move to pre-fund its obligation? The Community College League of California (CCLC) has provided a number of reasons for advance-funding - none of which demonstrate that it is the most responsible and least costly method. I have yet to see anyone say that pre-funding is either the best or the least costly way to go. Some believe that is a good political way to go in under to resist the attack from the right on public employee health coverage into retirement. The CCLC has listed a number of possible consequences of not fully funding retiree health benefits in future years. The CCLC stated that “*District auditors will be required, beginning in the years listed above, to report on the status of funding of post-employment benefits, including any liability.*” This is true, but not a problem, unless there is a public outcry that the district has a huge debt and a Board of Trustees buckles under the pressure. It is incumbent on a district to explain why the actuarially derived debt is not a real problem any more than a mortgage on a home is a real problem.

A second finding is that “*Not funding the actuarially determined liability could result in substantially higher expenses in future years.*” This MAY be true but past experience does not so indicate. In the LACCD (as shown in an earlier table), even with the huge increases in health care costs over the last few years, the percentage of the district’s Unrestricted General Fund Appropriations spent on benefits, of which retiree health benefits is a part, has remained fairly constant since 1989-90 - mostly in the 18% - 21% range.

It has ranged from a low of 15.2% (due to no PERS contribution) in 2001-02 to a high of 21.9% in 2003-4. It was 21% in 1993-94 and 20.8% in 1995-96. The huge increase expected has just not occurred in the past. The cost would go down if universal single payer health care is provided in California or in the United States.

CCLC also notes that *“Negative audit reports could impact on the ability of districts to borrow funds or issue bonds at advantageous rates.”* To my knowledge, this has not happened either in the private sector since the FASB standards were adopted or in the public sector since GASB was adopted. It might happen, but there is no evidence that it will. In fact, those that do bond rating look at a variety of factors to determine the credit worthiness of a district. Over reacting to the sticker shock of GASB 45 may cause districts to make bad economic decisions which will likely have more impact on their bond rating than any perceived retiree benefit liability. To date, the level of the unfunded liability for retirement benefits has not played a major role in the rating that employers receive.

Accreditation has been cited as reason to pre-fund retiree benefits. The Accrediting Commission for Community and Junior Colleges, Western Association of Schools and Colleges (WASC) looks to see whether *“When making short-range financial plans, the institution considers its long-range financial priorities to assure financial stability. The institution clearly identifies and plans for payment of liabilities and future obligations.”* Depending on how this is interpreted, WASC may go after colleges in districts which have not pre-funded retiree health benefits in accordance with GASB 45 based actuarial studies. This may become a real issue since WASC has not been averse to attacking colleges for other than their academic program and their service to students (as they did in 2006 in removing the accreditation of Compton College). The California Community College Academic Senate, the CFT, and other faculty and classified groups have been in the forefront in opposing many of the new requirements (such as measurable student learning outcomes) that have been implemented by WASC. We will need to continue to fight these accreditation “standards” that represent current fads rather than proven drivers of quality improvement. We will carry on this fight whether or not the GASB 45 standard is added to the WASC agenda.

No Hasty Decisions

Leaving the pay-as-you-go method of funding and adopting a more expansive method will deprive students of classes and employees of wage increases. I don't believe that it is fiscally responsible, at this time, to move away from pay-as-you-go into another way of funding retiree benefits. In any case, we don't need to make any hasty decisions. Even the worst doom-and-gloomers agree that any problems will not occur in the near future. Most experts agree the accrued liability is not, in the short run, a real debt. Others point out that any problems that may occur will not occur in the next five years but more likely over a 30 year span.

Districts should take the time necessary to study the scope of any real problems posed by continuing their pay-as-you go coverage of retiree health benefits and should not be driven to rush precipitously to “solutions” which in the long run harm everyone – students employees, and retirees alike.

An Actuary's Perspective

Mr. Geoffrey Kischuk, FSA, MAAA, FCA, Consultant, Total Compensation Systems, Inc.

INTRODUCTION

Having specialized for almost 20 years in health actuarial services for California public employers, I hope to be able to shed light on actuarial issues related to GASB 43 and 45. Before embarking on a discussion of actuarial issues, it's important to establish the context in which actuarial valuation services are provided. While the actuary has a well-defined, limited role in the measurement of OPEB expenses and liabilities, the actuary's perspective is indispensable in the management of OPEB benefits, generally.

Many professionals will be involved in the management of OPEB benefit plans – actuaries, benefit consultants, auditors, attorneys, financial consultants, bond underwriters, and many others. This is in addition to the involvement of various stakeholders – public employer administrators, employee groups, governing boards, and the public. Understanding the role and point of view of the various involved parties is essential to providing effective actuarial services. This paper will, therefore, touch on relevant issues that affect the actuary's work. Non-actuarial issues will be subject to general discussion without getting involved in details that are the purview of other professionals' expertise.

I. CURRENT ENVIRONMENT

GASB 43 and 45 will have far-reaching consequences for governmental entities, employees, governing Boards, taxpayers, insurers, investment managers, and many others – not to mention actuaries! The full magnitude of the fiscal impact will not be known until 2010 or later. Estimates of \$1 trillion in actuarial accrued liabilities (AAL) nationwide are likely to be low. Based on my own analysis, in California the total AAL for all governmental entities is likely to exceed \$200 billion. Little of this liability has been funded.

Some observers believe that the private sector response to SFAS 106 can serve as a predictor of what will happen in the public sector. In the private sector, the number of large employers offering retiree health benefits has dropped substantially. The number is still declining and those still offering retiree health benefits are modifying their plans to limit their liability. Few small employers have provided retiree health benefits for other than a few key employees. Most small employers that extended benefits to rank and file employees have ceased doing so.

While GASB 43/45 is likely to cause public sector employers to do a cost/benefit analysis of their retiree health plans, I don't think the public sector will track the private sector response to accruing retiree health benefit costs for several reasons:

- 1) A much greater proportion of retiree health coverage for public sector employees is provided under collective bargaining agreements and cannot be unilaterally changed or eliminated.
- 2) Employee benefits – and retirement benefits in particular – have historically been a much more important part of compensation for public sector employees than for private sector.

- 3) Public sector employers are not constrained by deductibility of retiree health funding contributions or taxation of investment income on accumulated retiree health funds.
- 4) Public sector compensation is not directly affected by global competition to the extent that private sector manufacturing and, increasingly, service sector compensation is.
- 5) Public sector health coverage is often provided through statewide systems, joint powers authorities, multiple employer trusts, association plans, and other multiple-employer arrangements. Retiree benefits are much more easily provided, and risks more effectively shared, making it easier to provide retiree health benefits.
- 6) Retiree health coverage may be provided by statute which cannot be changed except through legislative processes.
- 7) Certain types of employees – particularly firefighting and law enforcement – are viewed favorably by the public and are perceived to be in high-risk jobs. The public is likely to support providing for these employees' retirement years.

While there are many reasons why public sector employers are more likely to retain retiree health benefits than private sector employers, there are also considerations which make providing retiree health benefits more problematic in the public sector:

- 1) Public sector revenue is not as controllable as is private sector revenue. Private sector employers can recover cost increases through increased prices, subject to competitive considerations.
- 2) Many private sector employers can absorb large one-time liability increases due to substantial owners' equity. Public sector employers usually don't have substantial surpluses over and above a reasonable contingency reserve.
- 3) Public sector employee benefits can be affected by political factors. This can either help or hurt retiree health benefit programs depending on voter perceptions.
- 4) Public sector employees typically have lower turnover, earlier retirement and – for some employees – lower mortality than private sector employees. These factors make it more expensive to provide retiree health benefits than in the private sector.

FUTURE PROSPECTS

While the number of public employers providing retiree health benefits may not shrink as much as the private sector, there will inevitably be a drop in the number of retirees and dependents covered. In addition, the extent and terms of coverage will be changed. This is already happening. However, coincident with negotiated reductions in coverage, there are still many cases where bargaining is taking place to establish new OPEB plans or to enhance existing ones. From now on, bargaining involving establishing or changing OPEB plans will take into consideration GASB 45 expenses and liabilities.

Unfortunately, the manner in which expense and liability issues affect benefits is not clear-cut. There are two main reasons for this: First, valuation of OPEB expenses and liabilities involves considerable subjectivity. The fiscal impact can vary considerably depending on expectations of economic factors (e.g. medical care inflation). Parties to collective bargaining may have very different expectations with respect to these economic factors.

Second, many public employers budget and manage their finances using modified accrual basis accounting. Unless there is legislation mandating funding of OPEB liabilities, GASB 45 will not necessarily have an effect on modified accrual basis accounting. Additional expenses attributable to GASB 45 may be reflected only in conversion entries used to produce full accrual basis government-wide statements.

While government-wide financial statements might not be used directly for financial management, they are not irrelevant. Bond rating agencies will use these statements. Public employers that use bond financing will need to pay attention to GASB 45 expenses and liabilities. Educational institutions seeking accreditation are likely to have their long-term debt reviewed to include OPEB liabilities. Auditors can opine about whether OPEB liabilities that cause government-wide statement liabilities to exceed assets will create a going-concern issue.

The subjective nature of the actuarial calculation and the implications of dual accounting practices are already leading to disagreement between parties in collective bargaining. Greater understanding of the actuarial valuation process may actually exacerbate rather than mitigate this situation.

Assuming that a consensus emerges about the need to reduce OPEB benefit costs and, even, the amount of the needed cost reduction, the question is: “How?” OPEB expenses and liabilities can be affected in many ways; for example:

Restricting eligibility

- Delaying commencement of benefits
- Reducing duration of benefits
- Reducing the annual benefit amount
- Increasing investment income on plan assets

If the needed cost reduction is relatively modest, the reduction can be achieved by chipping around the edges of the existing OPEB plan. Another common action is to eliminate OPEB benefits for future hires. This action has virtually no immediate effect but will, gradually over time, reduce and then eliminate the cost (unless benefits are later implemented).

If the needed cost reduction is substantial, it is advisable to take a more studied approach to modifying the plan to assure the plan design reflects shared priorities. There is no universal plan design that best reflects the priorities of employers and employees generally. Each OPEB plan should reflect the unique priorities of the employer and its employees. In arriving at this unique plan, it can be helpful to consider several questions, including the following:

- 1) To what extent should the value of OPEB benefits reflect length of service?
- 2) To what extent are OPEB benefits intended to serve as a “bridge” to Medicare?
- 3) To what extent should OPEB benefits be provided to dependents as well as retirees?
- 4) To what extent are OPEB benefits used to encourage early retirement in support of human resources goals?

Most current OPEB plans are very regressive in the senses that the value of benefits, on average, is inversely proportional to length of service. For example, a common OPEB plan pays retiree medical benefits to age 65 for an employee who retires at age 55 or older with ten or more years of service. An employee with ten years of service who retires at age 55 can receive benefits for as long as they worked for that employer. On the other hand, an employee retiring at age 65 with 40 years of service receives nothing.

I believe that, as the years pass, OPEB plans will evolve so that the value of plan benefits is more directly related to service. For example, we have developed a plan where the benefit is defined in terms of a lifetime cap that is a function of length of service. Defined contribution (DC) plans can provide a direct relationship of benefit value to service, but vesting of DC plan contributions results in far lower OPEB benefits for a given contribution level than the lifetime cap concept mentioned above.

GASB 43/45 is likely to accelerate this process. First, of course, because GASB 43/45 will require employers to acknowledge the true cost of OPEB benefits. Second, because I believe most employers will elect to reflect the normal cost, UAAL amortization or both as a level percentage of payroll. This will, in turn, cause employers and employees to relate OPEB costs to COLA. Consequently, employees are likely to compare their personal expectation of OPEB benefits to the amount of foregone salary. This comparison may expose the regressive nature of most OPEB plans and create pressure to realign OPEB benefit structures. Of course, one possible result of this would be a move to a defined contribution or similar plan.

II. ACTUARIAL ROLE AND RESPONSIBILITIES

Actuarial expertise will be absolutely crucial for public employers to manage OPEB costs and liabilities. This may seem obvious in light of the actuary’s pivotal role in determining the Annual Required Contributions (ARC) for public employers with 100 or more participants.

However, it is important to remember that GASB 43 and 45 are accounting standards and are under the purview of the accounting profession. It is also important to note that the application of GASB 43/45 – including prudent selection of actuarial methods and assumptions – is an employer responsibility. Finally, GASB has provided “simplified” measurement procedures which, though actuarially based, do not require an actuary to be involved in the process at all for small public employers.

While the actuary has a crucial but not primary role in the measurement of OPEB costs and liabilities, the actuary's role looms larger in implementation of GASB 43/45 than in implementation of the *private sector* OPEB accounting standards. There are several reasons for this.

- 1) OPEB valuation concepts are closely related to valuation of defined benefit pension plans. At the time the SFAS 106 was implemented, most employers with retiree health plans also had defined benefit pension plans. As a result, most or all stakeholders (e.g. employer management, governing Boards, employee groups, outside auditors, etc.) had knowledge of and experience with the conceptual issues. While most public employers have defined benefit pension plans, most are covered under multiple employer plans. As a result, stakeholders have little direct involvement with pension issues. Actuaries are the best and, perhaps, only resource the vast majority of public employers will have to help educate stakeholders in the new standards, their implications, etc.
- 2) GASB 43/45 provide far more flexibility in determining expenses and liabilities than SFAS 106. Helping public employers focus on the most viable options requires actuarial guidance.

Thus, the responsibility of educating stakeholders and the various professionals affected by GASB 43/45 will fall disproportionately on the actuary – and not just any actuary. There is a relatively small number of actuaries with extensive experience performing retiree health valuations for public agencies in each state. Without highly specific experience, an actuary will be unfamiliar with many crucial areas necessary to provide the best actuarial service and advice.

For example, in California, an actuary must be familiar with many issues specific to California public agencies to provide adequate services:

A. California Law

The legal environment is extremely important for assessing investment returns, assessing special legal requirements and understanding mandated financial reporting processes.

1. The California Constitution includes some constraints on investment.
2. The Government Code includes rules related to investments, operation of the CalPERS health plan (i.e. PEMHCA), formation and operation of JPAs; establishment of LAIF (the Local Agency Investment Fund); etc.
3. The Education Code contains important rules regarding the budgeting process, which are likely to include provisions specific to OPEB liabilities if and when legislation is passed to do so.
4. The Probate Code includes the implementation of the Prudent Investor Act.
5. Various regulatory and oversight bodies (e.g. Department of Education, Community Colleges Chancellors Office, County Offices of Education, etc.) issue regulations specific to OPEB.

B. California Healthcare Market

It is extremely important to understand the healthcare market in order to assess “implicit rate subsidies” and healthcare trend. An actuary should understand the extent to which rates are experience-rated; whether individual employer accounts are maintained; whether individual

employer claim experience is available; the approximate proportion of a pooled program the employer's enrollment represents, etc.

1. A very large number of public employers have benefits provided through large, pooled programs such as CalPERS, SISC (Self-Insured Schools of California, a JPA), CVT (Central Valley Trust, a multiple employer trust), local JPAs, association plans (e.g. ACWA – the Association of California Water Agencies), etc. In addition brokers and carriers have set up products or pools exclusively for public employer groups.
2. Because the vast majority of public employers are situated in very limited geographical areas, knowledge of local healthcare markets is crucial to rendering effective services. For example, California includes large metropolitan areas with high HMO penetration as well as vast rural areas with no HMO presence.
3. California is a progressive state in the sense of providing social programs to take care of basic needs. Individual cities such as San Francisco are exploring initiatives to fundamentally alter the financing and delivery of healthcare services.

C. Accounting Environment

1. While the GASB accounting standards, themselves, are national, their implementation is local. Public agencies use standardized accounting structures. Understanding OPEB-related asset, liability, expense and income accounts can greatly facilitate communication between the actuary and a public agency's financial managers.
2. The manner in which State and Federal categorical program expenses are charged is of great concern to many public employers. This can vary from state to state.

D. Collective Bargaining

It's a given that collective bargaining involves specific, local issues. However local unions typically receive support and guidance from the union organization to which they belong. Most school employees in California belong to unions that are part of state-wide organizations (e.g. CSEA and CTA). Understanding the position these organizations take and programs they initiate that affect OPEB benefits is important in helping stakeholders respond to GASB 43/45.

E. Pension Plans

Although eligibility provisions for most OPEB plans differ from pension eligibility rules, the availability and amount of pension benefits is a key consideration for employees' retirement decisions. These pension benefits are provided through statewide pension plans (e.g. CalPERS, CalSTRS) or a relatively small number of local plans (e.g. 1937 Act County plans). Understanding key provisions of these plans and the legal environment in which they operate is important to assessing the combined impact of an OPEB plan and pension plan on retirement incidence.

All told, the above considerations and others make it impossible to provide high quality actuarial services without extensive knowledge of and experience with California public employer OPEB plans. This is not to say that an out-of-state actuarial consultant would be unable to provide excellent service. However, employers should be aware of the extreme importance of specific California public employer knowledge and expertise.

The actuary's role in the education process begins early and continues throughout the initial valuation and beyond through the early years of reacting and responding to GASB 43/45. As OPEB plans and budgets are modified, and as public agency stakeholders become familiar with GASB 43/45 issues, concepts, models, effects, etc., the actuary's role will shrink back to more of a technical role – for example, calculating the ARC which is a key building block for determining OPEB costs and liabilities.

This intensive actuarial involvement in the education process comes at a time when actuarial resources are already stretched to the limit responding to the needs of public employers who are planning for future implementation. As of this writing (August/September, 2006), our impression is that actuaries in California with extensive public agency OPEB experience are working either at or near capacity. This is despite the fact that there are still perhaps thousands of California public agencies that have yet to have an OPEB valuation, and others who are not yet on the two or three year cycle mandated by GASB 43/45.

The actuary's technical role is inextricably intertwined with the education role. Particularly for valuations that are not intended to be used for compliance, the actuary is likely to play a much greater role in selecting actuarial assumptions and methods. As stakeholders become comfortable with the dynamics of the actuarial model, establishing assumptions and methods will become a much more collaborative process.

For example, in the current environment, if an actuary asks a public agency financial manager what interest rate to use in a valuation, the answer is likely to be something close to the rate currently earned on surplus funds by the County Treasurer following the Government Code. However, to make an informed decision requires an understanding of several things:

- The different basis of the interest assumption depending on whether a GASB qualifying OPEB plan is established or not;
- The different mechanisms for reflecting actuarial gains and losses from investment depending on whether a GASB qualifying OPEB plan is established;
- The impact of Actuarial Standard of Practice 27 on establishing an appropriate rate;
- The importance of a written Investment Policy to establish an appropriate rate for a GASB qualified OPEB plan.

Each of the above can involve an in-depth discussion of many factors, even if the financial manager has a thorough understanding of the impact of the interest assumption on OPEB valuations, in general, and the impact on the valuation of that agency's OPEB plan, in particular.

My experience has been that, for expediency's sake, most managers prefer to let the actuary set an appropriate interest rate for the first valuation; use that valuation as an educational tool; and then rerun the valuation (if necessary) after a discussion of key assumptions. This approach works quite well, but takes much more time than simply running a valuation using historically consistent assumptions modified as appropriate after a brief discussion.

APPLICATION OF THE ACTUARIAL MODEL

I have spent a lot of time discussing education, as this is an aspect of actuarial services that will be most visible on an ongoing basis. The other visible aspect of the actuary's service is the consulting report. The consulting report is the output resulting from application of the actuarial model.

Essentially, the actuarial valuation involves:

- The “Substantive Plan”
- Economic Assumptions
- Non-Economic Assumptions
- An Actuarial Cost Method
- Employer Elections

Each of these has one or more sources of authority.

The goal should be to conduct the valuation on a “best estimate” basis, i.e., neither too optimistic nor too conservative. An overly conservative valuation will over-estimate costs and liabilities. Inasmuch as the new standard will increase expenses for the vast majority of public employers under any circumstances, a conservative valuation will exacerbate this situation. Implementation of GASB 43/45 will trigger difficult decisions for many stakeholders on whether and how to change their OPEB plans. A conservative valuation suggests more dramatic plan changes than may be necessary. The fact that conservatism will be adjusted in later valuations by cost reductions due to actuarial gains will not replace OPEB benefits lost unnecessarily as a result of the conservative valuation.

An optimistic valuation, on the other hand, can understate long term costs which will ultimately lead to the need to adjust the plan one or more additional times before costs are brought into line. As a practical matter, this may not have much of an impact, inasmuch as many employers will need “several bites of the apple” to migrate their OPEB plan to where it needs to be.

Another factor to consider is the impact of the “Substantive Plan” rules. Under GASB 45, plan changes cannot be reflected until they are agreed to and communicated. This is in light of the fact that rapidly increasing healthcare costs cause consistent, regular plan changes to reduce costs. For example, employers with nominal deductibles and coinsurance payments increase them from time to time. The inability to anticipate these plan changes may embolden some employers to take a more aggressive position on certain assumptions (e.g. medical trend).

Of course, deciding whether an assumption is “conservative” or “optimistic” is, for the most part, a subjective matter. For example, statistical models do not exist to determine probable future medical trend increases. The very construction of such a model would introduce bias.

Despite this subjectivity, actuaries must be prepared to provide guidance on what reasonable assumptions may be. In many cases, a reasonable assumption may be any point in a range of reasonable assumptions. This is particularly true of the economic assumptions (interest, medical trend, salary increase). Where this is true, the actuary's best guess assumption would typically fall near the middle of the range.

At this point, it may be helpful to reinforce a statistical point. Let's say that there are 6 independent variables, for each of which an actuary specifies a reasonable range. Let's further imagine that, contrary to practical reality, it's possible to assign a probability of 40% that any one assumption will fall outside the range – i.e. 20% above and 20% below. If 2 valuations are performed – one with all assumptions set at the conservative end of the range; and the other with all set at the optimistic end, what is the result? The result is that there is only about a 4% chance that actual results could fall outside the range. For most purposes, this is too wide a range to be of value, even if it were possible to determine such probabilities.

The message here is that alternative valuations to explore variability of results should either explore variability of one key assumption (e.g. medical trend) or look at relatively modest changes for several assumptions.

CalPERS is in the process of developing its response to GASB 43/45. For employers that participate in CalPERS' GASB 43/45 program (eligibility and conditions yet to be determined), CalPERS expects to establish certain mandated actuarial assumptions and/or methods.

Entities that choose (or are required?) to participate in the CalPERS program will be limited in their ability to choose actuarial assumptions and methods. The remainder of this paper may therefore be of limited use in helping those employers participate in the valuation process. However, it's still important for these employers to understand key assumptions and relevant issues surrounding their selection.

On a personal note, it is interesting that CalPERS is apparently setting their standards using only input from three actuarial firms approved by CalPERS for doing pension calculations. While these firms are undoubtedly expert in the CalPERS pension plan, they have done relatively little in the area of California OPEB valuations. There are several actuarial consulting firms with extensive experience and expertise in this area. I am not aware of any of these who have been asked for input. I believe that CalPERS is doing a disservice to its members by not involving the actuarial consulting firms with the most expertise in this area.

With the end of the above general discussion, we now move to a discussion of actuarial assumptions and methods.

ECONOMIC ASSUMPTIONS

Economic assumptions include healthcare trend, interest and salary increase. The role of healthcare trend and interest is fairly clear. However, very few defined benefit OPEB plans include a benefit that depends in any way on salary. Salary projections are necessary for those employers who elect to express either the normal cost, the UAAL amortization, or both as a level percentage of payroll. I'm sometimes asked why GASB would allow expressing these items as a level percentage of payroll when the benefits are not payroll related. I don't know the answer, but the effect is to allow allocation based on level "real dollars" (i.e. inflation adjusted).

In addition to GASB 45, selecting appropriate economic assumptions is also guided by Actuarial Standard of Practice (ASOP) 27 published by the Actuarial Standards Board (ASB). ASOP 27 provides that, since economic assumptions are affected by inflation, it is essential to make an assumption of the long-term inflation rate in order to set meaningful assumptions for other variables.

1. Inflation

Setting an appropriate long-term inflation rate is important for comparing the other economic assumptions. Many people feel that the Federal Reserve Board (Fed) is much better at controlling inflation than many years ago. While the Fed wants to keep inflation in check, it has a secondary goal of avoiding deflationary periods, resulting in a middle course of a small, positive level of inflation as a way of balancing the two conflicting goals. I feel that 2½% to 3½% is a reasonable range and typically recommend 3%.

For most plans, the choice of an appropriate inflation rate is not crucial. This is the case when benefit costs will be affected by inflation. Benefit costs are affected by inflation if either the employer's contribution is indexed; or if the employer pays a fixed percentage of costs. Over the long run for these plans, over- or understatement of inflation is likely to result in offsetting actuarial gains/losses attributable to investment and healthcare trend.

For plans where the employer's commitment is limited to a specified dollar amount (a "cap"); and where past practice does not justify assuming future increases; and where most or all retirees' health costs are at or near the "cap", the inflation assumption and resulting interest rate will have a more direct impact on OPEB expenses and liabilities. However, in these cases, the expenses and liabilities are likely to be manageable. (This is particularly true if the employer elects the level percentage of payroll method for one or both ARC components.) As a result, any inflation assumption in a reasonable range should suffice.

2. Interest

Under GASB 43/45, the interest rate assumption depends on the following factors:

- Whether or not a GASB qualifying "plan" is established;
- The extent to which the "plan" is expected to be funded; and
- The "plan's" investment policy with respect to asset allocation.

Under ASOP 27, economic assumptions can be expressed as "select and ultimate," i.e. short-term rates that differ from the assumed "ultimate" long-term rate. I'll first address ultimate rates.

To the extent that OPEB liabilities are not funded through a "plan" (i.e. they are not funded at all or they are funded but not through a qualifying "plan"), the ultimate interest rate should reflect the long-term return expected for employer assets, generally. In California, general employer assets are subject to Government Code Sections 53601 et seq. These rules govern the investing process. As they relate to

the OPEB interest assumption, these “surplus” funds rules specify permissible investments. Permissible investments are generally high quality, short-term, fixed income investments. We typically assume, over the long run, that short-term, high quality, fixed income investments will yield about a 2% real rate of return (i.e. after inflation).

To the extent OPEB liabilities are funded through a plan, the interest rate should be based on “plan assets”. Ideally, plan assets should be invested in accordance with a written investment policy document. Among other things, this document should specify (or provide for) an allocation of permissible investments among asset classes. Typically, this allocation is expressed as allowable ranges.

Particularly, in light of the fact that most OPEB plans are not substantially funded, I favor the “building block” approach to determining a reasonable interest rate for plan assets. Under this approach, a percentage is determined for each asset class that is at or near the midpoint of the allowable range for that class. These percentages must sum to 100%. For each asset class, a reasonable benchmark index is established. This index should be averaged over a long period of time (e.g. 15 to 20 years) to determine the historical real rate of return. I’ll call this weighted average the “benchmark rate”. If the plan’s investment manager(s) have a long history, the managers’ historical performance can be averaged over a similar period, and a weighted average developed to reflect historical performance of the plan’s investment managers. Typically, at the plan’s outset, a plan’s investment managers will show performance in excess of the benchmark rate. This happens because the investment manager selection process explicitly chooses the best-performing managers.

The interest rate should, then, reflect the historical benchmark; adjusted to reflect any opinions about whether the future will differ from the past with respect to real rates of return; adjusted to reflect any investment manager performance premium; and finally adjusted to reflect plan expenses that aren’t already reflected in the other components.

Because different employers have different attitudes toward risk, there can be a wide variation in investment policy asset allocations. Consequently, there’s no standard interest assumption that can be used for plan assets. There are some public employers who have not yet established a plan but expect to do so and want their valuation to reflect higher investment returns than surplus funds. Where this is the case, I usually express reluctance in using an interest assumption that’s higher than CalPERS’s assumption. CalPERS returns are helped to some degree by types of investments (e.g. venture capital) that are likely to be unavailable to the investment pools used for OPEB plan assets – at least for the next several years.

3. Healthcare Trend

For most current OPEB plans, the trend factor has a huge impact on the magnitude of expenses and liabilities. For example, many plans pay a percentage of retiree health costs. For these, employer costs will increase directly with overall OPEB costs.

Other OPEB plans have nominal caps on employer contributions, but the cap has been periodically increased. Under “substantive plan” rules, historical cost-sharing practices must be projected into the future. While these historical practices may not result in the employer bearing the entire brunt of healthcare cost increases, usually the historical pattern reveals cap increases exceeding the underlying inflation rate.

Finally, some OPEB plans with unchanging caps may involve an “implicit rate subsidy”. The amount of the subsidy is typically subject to health care trend.

To illustrate the importance of the healthcare trend assumption, it is not unusual to find that future healthcare cost increases are responsible for two-thirds or more of an employer’s costs and liabilities. In other words, going from 0% trend to a reasonable trend assumption can triple or quadruple expenses and liabilities.

There is no consensus on reasonable trend factors. ASOP 27 allows use of “select and ultimate” rates. Under this protocol, short-term rates are typically higher, transitioning over some number of years to an ultimate rate. The questions are:

- What is an appropriate first year rate?
- What is a reasonable step-down period and step-down decrement?
- What is an appropriate ultimate rate?

My interest here is not to suggest an appropriate assumption or range of assumptions; but to provide some food for thought in discussing and selecting an appropriate rate.

a. Trend Cycles

Healthcare trend rates have long been observed to be cyclical. The reasons and mechanics can vary somewhat. However, my experience tells me that trend cycles result from market forces. Certainly, overall trend levels respond to and reflect inflation. However, there is considerable fluctuation around the inflation rate. I believe this is the result of market forces operating between providers and payers; as well as market forces operating between insurers/HMO’s and customers.

In drawing conclusions about the effects of these different forces, we have observed different types of healthcare plans for California public employers. The pure inflation effect is best illustrated by large, self-funded health plans in rural areas of California where no significant provider networks exist.

Market forces operating between providers and payers are best illustrated by self-funded plans with strong provider networks. Because provider networks can involve local and regional provider alliances (i.e. hospital chains, group practices, etc.), these market forces can vary considerably from area to area.

Insurer vs. customer market forces are best isolated in fully insured plans in rural areas with no significant provider networks.

GASB 45 provides that OPEB expenses and liabilities are based on actual costs or, in the absence of reliable cost information, age-adjusted rates (if feasible). In this context, cost increases due to insurer vs. customer market forces should not be reflected, except possibly for community rated plans. (Under GASB 43/45, community-rated plans are interpreted under ASOP 6 which differs from common conceptions of what constitute community-rated plans.)

Insurer vs. customer market forces exacerbate underlying trend cycles. During the uptrend of a cycle, insurers are normally projecting recent trends conservatively and increasing premiums to recover recent losses and/or restore target profit margins. Depending on how steep the uptrend is, these steps may or may not be sufficient. If so, the insurer will continue its conservative rating but remove the provision to recover profitability. If not, the insurer will become more conservative in its rating.

Sooner or later, the trend cycle reaches its peak. At this point, insurers have excess margin in their rates and profits increase. As trends decline, insurers are unlikely to project decreasing trends. As a result, trends continue to be overstated and profits increase as the downtrend accelerates. Insurers rarely project trend decreases. Instead, there is an increasing recognition by the sales force that rates are higher than they need to be. This results in formal or informal premium reductions to maintain or increase market share. For a time, premium reductions may not adversely affect profit margins, which encourage insurers to maintain or expand premium reductions.

Eventually, trends level out and turn up. At this point, sales-driven premium reductions combine with under-estimated trend to dramatically reduce profits. The cycle begins again.

Understanding the impact of insurer vs. customer market forces on the trend cycles is important in setting appropriate trend rates. Usually, employer trend expectations are related to current trend rates. Current trend rates are based on insurer rating practices which, as discussed above, exacerbate the magnitude of actual claim trends. Insurer expectations are based on their assessment of current trends. Unfortunately it takes several months to get reliable data about what trend is doing. The end result is that insurer trend expectations tend to lag actual claim experience and be conservative at every point of the trend cycle except for the transition from the downcycle to the upcycle. Premium rates include additional adjustments (e.g. profit recovery) which make premium increases an even worse indicator of true, underlying trend rates.

On the other hand, provider vs. payer market forces translate directly into healthcare costs. In the early days of managed care, payers had a lot of leverage. Providers were desperate to join networks, often at low contracted rates. For a number of years, payers pitted providers against each other to obtain larger discounts. These actions reduced trend from what it otherwise would have been.

Eventually, providers merged, associated, organized and coordinated to provide more of a unified front in negotiating with payers. In addition, providers modified systems, procedures and practices to thwart some of the effects of managed care processes. These actions allowed providers to regain part of what was lost in the early days of managed care.

Since then, there has been a constant tug-of-war with payers and providers alternately making inroads. However, in my opinion, it's unlikely that we'll see provider vs. payer market forces have as dramatic an effect on trends in the future – as long as the current finance and delivery system remains intact. My sense is that provider vs. payer market forces will generate modest swings around the basic trend line without, over the long run, adding to or subtracting from it. This is not to say that there won't be dramatic trend effects caused by provider vs. payer market forces in certain areas.

One area that may be worth further comment is prescription drugs. In recent years, prescription drug prices have been a primary contributor to healthcare trend – particularly for Medicare Supplement coverage. What is the nature of this price swing? Essentially, drug companies take the role of provider more so than medical supplier. Drug companies have been successful in gaining market clout through such measures as direct-to-consumer (DTC) marketing; lobbying to prohibit price discounts for Medicare Part D; resisting purchase of drugs from Canadian pharmacies; and other actions. Payers, on the other hand, attempt to counter these actions through plan design (e.g. generic substitution), promotion of moving drugs to over-the-counter (OTC) status, etc.

The drug companies seem to be prevailing in the short run, but sooner or later market forces should become more balanced. This could be through legislation or other measures. In the meantime, while drug companies may be able to continue to increase prices at a rapid rate, it is increasingly difficult for drug companies to increase utilization at the same rate as before. This is for two reasons. First, the “low-hanging fruit” has already been picked. Second, as prescription drugs take a greater proportion of the healthcare dollar, it requires far more dollars to generate the same percentage increase. Absent new blockbuster drugs for pervasive health conditions, such large utilization increases seem unlikely. Should such blockbuster drugs become available, the added cost would presumably be offset by lower treatment costs for the condition.

For reasons discussed earlier, insurer trend projections are not reliable. Are broker/consultant projections more reliable? In my experience, the answer is only marginally so. Why? First and foremost, consultants tend not to have access to enough data on a timely basis. Second, the data they have is not in a format that facilitates cross-sectional analysis on a regular basis. Third, most consultants started their careers and received their training from insurers. For this reason, they're more likely to adopt the insurer's analytical framework. Fourth, consultants are usually not privy to cost increases associated with renewing provider contracts. Finally, consultants have some incentive to be conservative inasmuch as they learn through experience that clients are more unhappy if costs are underestimated than overestimated

As a result, consultants often rely on insurer surveys and recent year-to-year increases for self-funded clients. Neither of these approaches is optimal. The former suffers from the aforementioned problems, while the latter involves a sizeable time lag vs. analyzing the most current claim data monthly.

In projecting year-to-year healthcare cost increases, the above limitations related to trend projections are problematic but not debilitating. For OPEB benefits, however, systematically overstating trend by several percentage points can cause huge expense and liability overstatements. Such overstatements can end up costing jobs, benefits, educational programs, etc. For this reason, I don't believe that the trend assumption should be approached cavalierly. The issue needs to be completely rethought rather than relying on current approaches to trend projection.

b. Initial Trend Rate

If asked to specify an initial trend rate, most employers will rely on the last rate increase (or increases) and or what their insurer consultant is telling them about currently used trend rates.

The first point to make is that a valuation will usually reflect current rates and, if the next renewal has been received, upcoming rates. This means that the first assumed trend will apply anywhere from 3 to 18 months in advance! (e.g. CalPERS rates are set more than six months in advance of their effective date). If actual trends are increasing or decreasing, and if the current upside or downside of the cycle is not too old, the initial trend rate might anticipate further increases or decreases.

Second, as mentioned earlier, the initial trend should reflect actual claim increases only. Consumer trend is usually conservative and may reflect loads to restore target profitability.

c. Ultimate Trend

After setting the initial trend rate, it is important to set an ultimate trend rate. Only with the ultimate trend assumption established is it possible to set transitional rates.

In setting an ultimate trend rate, it is important to consider economic realities. In the past 20 to 30 years, healthcare trends have exceeded general inflation by a considerable margin. There is a temptation to extrapolate this relationship indefinitely into the future. However, both logic and theory argue against this. First, the logical component.

The fact that healthcare costs have outstripped inflation has not been without consequences. First, the number of uninsured Americans has grown dramatically – both in absolute and percentage terms – as health benefits have become too expensive for an increasing number of individuals and employers. Recent estimates put the number of uninsured at close to 50 million, approaching 16% of the population. These figures do not include a rapidly increasing number of “underinsured”.

Second, the United States spends nearly twice as much on healthcare than other industrialized nations. The additional expense does not translate into better health outcomes. Dozens of countries are rated higher than the U.S. in health quality using a composite of health measures. As a result of higher healthcare costs, U.S. companies are at a severe disadvantage relative to other countries. This results in the loss of hundreds of thousands of manufacturing and service jobs to other countries. If this trend continues, U.S. employers will be increasingly disadvantaged unless they eliminate or cut healthcare benefits, thereby exacerbating the uninsured/underinsured problem.

It is only a matter of time before a tipping point is reached where state, local, and/or federal governments establish much tighter control over the finance and/or delivery system. How long this will take is unknown but it is unlikely that the existing situation will continue for 30, 40, 50 years or more – which is the horizon for OPEB actuarial calculations.

As a theoretical matter, healthcare trend is often viewed in relation to overall inflation. However the inflation component of healthcare trend is part of overall inflation. As healthcare makes up more and more of the economy, healthcare trends must be higher and higher to maintain the same relationship to general inflation. Projecting a constant difference between overall inflation and healthcare trend eventually results in impossible conclusions.

The more correct way to project trend differences is to project a difference between trend in the healthcare sector and inflation in the non-healthcare economy. If one does this using a constant percentage difference, the spread between healthcare trend and overall inflation decreases over time.

d. Transitional Trend

Having settled on the initial and ultimate trend assumptions, it is then necessary to determine the length and progression of the transition from one to the other. To do this, it is helpful to consider historical trend cycles.

Unfortunately, there is no uniformity with respect to the duration and magnitude of trend cycles. While the duration has varied from cycle to cycle, the average duration is, perhaps, seven years. This means that uptrends and downtrends last from 2 to 4 years each.

Typical peaks are likely to exceed inflation by 10% or so. Some may dispute this, pointing to rate increases that are higher than the mid-teens. However, it is important to keep in mind that – in the middle of the uptrend – rate increases must also make up for the prior year's trend underestimate and may also include the effect of adverse claim fluctuation. Actual claims for a large population will show much less severe fluctuations than premium increases for individual employers.

The bottom of the trend cycle tends to be at or near the general inflation rate. It can fall below if market forces push it too far down. However, sub-inflation trend is not likely to be significant absent dramatic changes in our healthcare finance/delivery system.

If one accepts that higher magnitude trend swings are likely to be accompanied by longer duration cycles, a reasonable conclusion would be that year-to-year trends would step down perhaps 2% to 3% per year.

I believe that select and ultimate rates should reflect reasonable trend cycle duration and acknowledge how long the current down or upcycle has been in progress. This is certainly not an exact science. Even the most up-to-date trend studies using large databases will be a little behind in assessing the magnitude and direction of healthcare trend. However, I still think it's important to reasonably reflect what we do know.

e. Other Trend Issues

There are a few other trend-related issues that can be important to consider. First is whether Medicare Supplement trend should be a separate assumption. Certainly, Medicare Supplement costs have historically been subject to different trends. This has been due to several factors.

Services not covered by Medicare may have a different trend than those that are. This is most apparent by looking at prescription drug costs in the last several years.

Another factor was the introduction of Medicare Risk plans. It took several years for the Federal Government to adjust the rates it used to compensate HMOs for providing Medicare-equivalent care. For a time, HMOs in California were offering Medicare Supplement plans for free. This situation has worked itself out and Medicare Supplement premiums for Medicare Risk plans are more reasonable in relation to premiums for Medicare Supplement over standard Medicare.

While there are likely to be differences – even large ones – over time between trend rates for Medicare Supplement and comprehensive health plans, over the long run it is difficult to argue for an ongoing substantial difference. For example, the new Congress seated in 2007 may make one of their first actions to allow the Federal Government to negotiate discounts with drug companies under Medicare Part D. No matter how such action were to be implemented, it would translate into significant or substantial savings in providing what is now Medicare Supplement coverage for many employers.

While there are certainly scenarios under which Medicare Supplement costs could continue to increase, there are scenarios where costs could substantially decrease. It's impossible to assign reliable probabilities to any of these scenarios. My own preference is to reflect a general trend for Medicare Supplement. Any differences in actual trend can be reflected in future actuarial gains or losses.

Another issue is whether to break apart healthcare claims and project components individually. For example, a typical claims process involves several intermediate steps between claim submission and claim payment. Assuming that the claimant is eligible, the following steps are typical:

- Evaluate claim to determine if services are eligible.
- Evaluate claim to assure required procedures have been followed.
- Determine if there is any Coordination of Benefits (COB).
- Apply deductibles, co-payments, co-insurance, etc.
- Determine if claim exceeds any inside or overall limits.

Some projection models attempt to project components of these intermediate steps. While this approach is more elaborate and intellectually pleasing, I think it suggests far more accuracy than is, in fact, the case. An actuary that understands the dynamics of how plan provisions affect trend can make a reasonable trend adjustment without all this complication. There are very few plans – particularly for public employers – where plan provisions are going to have an appreciable effect on trend.

f. Applying Trend

In the previous section, it was mentioned that the effect of trend can vary based on OPEB benefit design. While this is certainly an area that an actuary should consider, it has a far less impact than “substantive plan” rules.

GASB borrowed the concept of the “substantive plan” from the private sector accounting standard – SFAS 106. The substantive plan is the plan “as understood” by the employer and participants and includes not only written plan description materials but past practice patterns.

A plan that includes a cap on what the employer will pay toward coverage may have had the cap increased from time to time. Substantive plan rules require the actuary to determine the average annual increase in the cap in the past and to apply that in the future unless there is something to suggest that the cap will never be changed again.

OPEB PLAN COSTS

Healthcare trend rates are crucially important in determining OPEB plan expenses and liabilities. However these trend rates are applied to estimates of current plan costs. Establishing valid base rates for assessing costs is also crucial.

On the surface, it may appear that determining base rates for establishing OPEB costs is straightforward. After all, if premium rates do not apply (e.g. for self-funded plans), there are certainly cost rates used for budgeting purposes.

Unfortunately, there are two issues that can create problems in this regard. The first is the concept of the “substantive plan”. The second is the directive to use age adjusted rates in determining OPEB costs.

The “substantive plan” may have more of an impact on the application of healthcare trend than on base costs. The first issue is that the substantive plan includes not only contractual benefits and benefits under a written plan document but also on historical practices. A second issue is that any OPEB plan changes cannot be reflected in the valuation until they are agreed to and communicated to plan participants.

Once the appropriate benefits are identified based on the substantive plan, their costs must be determined. As mentioned in the section on healthcare trend, costs should be based on underlying claims costs rather than premiums.

The use of age-adjusted premiums is perhaps the most difficult aspect of determining costs. Age adjusted rates are intended to be used for plans that are not “community rated”. However, determining whether a plan is community rated is, itself, problematic. GASB 45 defers to ASOP 6 for a determination of what a community-rated plan is. ASOP 6 contains a convoluted definition of a community-rated plan that is nearly impossible to apply in practice. Without having claims and demographic data for the plan as a whole as well as the employer’s data, it is not possible to apply ASOP 6’s criteria. Furthermore, ASOP 6 does not have a “materiality” threshold.

The issue of what constitutes an community-rated plan is important as many public employers provide health benefits through JPA or trust plans that are operated as “blind pools” – i.e. no participating employer has access to its own claim experience. Having performed Education Code Section 17566/17567 certifications for many JPA plans, I know that the premium rate paid by a particular employer can consistently be higher or lower than actual costs.

ASOP 6 provides an “out” for situations like these. The actuary can use actual premium rates subject to making a disclosure that these rates may not reflect true, underlying costs. Using this provision can solve the immediate problem, but can create problems should an employer move from a blind pool to a “participating” plan (where the employer has access to claim experience). Such a move could result in a substantial increase in OPEB expenses and liabilities. Unfortunately, there’s no way to confidently predict the effect of a change.

A similar but not insurmountable problem occurs when an employer is not able to obtain claims experience separately for active employees and retirees, or any claims experience at all. In these circumstances, given sufficiently detailed enrollment data, an actuary can infer a relationship between active and retiree rates. However, for Kaiser plans, their unique healthcare delivery model may render commonly used age factors inapplicable. Kaiser is in the process of changing its rating and funding practices and options, so it may become easier to resolve this situation in the future.

Even with reliable claim experience in hand, the actuary is not out of the woods. The actuary may determine age-adjusted rates based on age/sex factors and assumed or actual dependent content. A crucially important part of this process is normalizing base claims to make sure that application of age-adjusted claim costs will reproduce overall claims. Of course, health plan costs other than claims must also be considered in setting appropriate age-adjusted premium rates.

VII. NON-ECONOMIC ASSUMPTIONS

Non-economic assumptions relate to demographics. Non-economic assumptions are directed by GASB standards and by ASOP 35. These assumptions typically include:

- Employment termination prior to retirement
- Retirement rates
- Mortality
- Disability rates
- Participation rates
- Dependent prevalence
- Dependent age distribution
- “Vesting” schedule

1. Employment Termination

The assumption regarding employment termination prior to retirement can have a substantial impact on OPEB expenses and liabilities. A relatively small difference in year-to-year termination rates can accumulate to have a large impact on the ARC. Unfortunately, projecting employment termination can be difficult for several reasons

First, employment termination rates can vary substantially from public employer to public employer – even for neighboring employers of the same type. The best source of data is the employer’s own termination experience over the most recent two or three years. Unlike the private sector, this information is rarely available in an easily accessible format. We have been encouraging employers to begin maintaining employment termination data. This would involve running an annual report to count, for each employee class, the number of benefit-eligible employees terminating for reasons other than death, disability or retirement.

Two to three years is usually sufficient because factors affecting turnover can change significantly over time. Turnover data tends to be cyclical. It’s important to keep in mind that the actuarial valuation is concerned with the long term. A turnover scale should be selected that can be expected to reproduce actual turnover (adjusted for any cyclical or temporary effects).

While most employers can be expected to eventually accumulate relevant turnover data, some employers will be too small to have reliable data, while others will require time to accumulate sufficient data. In these cases, an average assumption must be used. The best source may appear to be CalPERS and CalSTRS data. However, CalPERS and CalSTRS data have a limitation in that they are concerned with terminations from the system rather than terminations from an employer. Particularly for teachers, this limitation can understate terminations for OPEB purposes.

Another issue has to do with separation of results by employee classification. Valuation results are usually separated by employee classification for a variety of reasons:

The actuary must separate results to correctly apply actuarial assumptions or due to plan differences.

Separate results are requested to support an employer's internal accounting needs.

Separate results are needed for collective bargaining.

It's this last item that may create difficulty. We expect that, over time, unions will negotiate separate funding for their own OPEB plans. To the extent plan assets will be restricted to providing benefits only for union retirees, employment termination rates will have to be adjusted. This is because the promotion of a member to a non-represented position will have the effect of a termination for the union plan.

For an employer that has had valuations performed with results separated by employee classification, it may come as a surprise that establishing a separate union plan carries a lower cost than what is shown in an actuarial valuation covering the employer as a whole for that employee group. There is no easy solution to this problem, and accumulating data to accurately assess this form of "termination" will be difficult.

The use of the employment termination assumption is also affected by whether terminated employees who have a vested pension benefit can claim an OPEB benefit at retirement. It is not unusual for employers covered under 1937 Act County plans to provide OPEB benefits for vested, terminated employees. In addition to affecting the application of the termination assumption, this raises an issue of obtaining data on vested, terminated employees. Such data should be easily available, as it is needed to conduct the pension valuation.

2. Retirement Rates

Retirement rates are not subject to as many problems as termination rates. An employee's decision to retire is affected mostly by the terms of the retirement plan, which doesn't vary from employer to employer for employees of the same type. Given the same circumstances with respect to age and length of service, retirement rates don't vary substantially from employer to employer.

However, as healthcare costs have increased rapidly, the availability and cost of retiree healthcare coverage are having an increasing impact on the retirement decision. We have observed a definite correlation between retirement rates and the richness of OPEB plans.

While retirement rates may not vary substantially between employers, the retirement scale can still have a significant impact on OPEB expenses and liabilities – especially for plans providing benefits to age 65 (i.e. a "bridge plan"). For example, a retirement scale resulting in an average retirement age of 60 rather than 61 could increase costs by 20% or so for a "bridge plan". For lifetime benefits, the impact might be less than 5%.

Again, the best source of data for the retirement assumption is an employer's own data. Maintaining information of retirement dates for all OPEB-eligible retirees can be helpful.

3. Mortality and Disability

We have not observed significant, predictable, sustained differences in mortality and disability from employer to employer for employees of the same type. CalPERS and CalSTRS conduct periodic experience studies for these assumptions. The risks for OPEB plans are similar enough to let CalPERS and CalSTRS take the lead.

4. Participation Rates

Participation rates are an important determinant of OPEB costs and liabilities. Many times an employer will assert that all retirees take medical coverage, only for us to find in the course of a valuation that an occasional retiree does not. If as few as 2% or 3 % of retirees decline coverage, OPEB costs and liabilities will be similarly reduced.

Employers should maintain, as part of their retiree database, information about OPEB-eligible retirees who have declined coverage, even if these retirees cannot re-enroll in the plan at a later date.

A related problem has to do with situations where retirees not currently enrolled can enroll at a later date. This is an issue for all employers with coverage through the CalPERS health plan. Retirees covered for at least a month after retirement can enroll at any open enrollment, subjecting the employer to the minimum CalPERS contribution rate. Obtaining data for these eligible but uncovered retirees can be problematic. (A similar issue can arise for plans that allow retirees to defer their OPEB benefit.)

5. Dependent Prevalence and Age Distribution

Again, actual data is better than assumed. Dependent prevalence should depend on age and gender, but this refinement may not be deemed worthwhile. Dependent prevalence is also heavily affected by the terms of the plan (i.e. by dependent participation).

6. Vesting Schedule

The vesting schedule is typically a straightforward application of plan provisions. Difficulties can arise when vesting depends on length of employment with public employers, generally. This can occur, for example, when a plan simply requires CalPERS or CalSTRS retirement. Other plans may explicitly require, for example, “15 years of public school teaching experience with the most recent 10 years with the XYZ School District.” It is unusual for an employer to have data about prior employment that can be used to apply such a provision. The actuary usually must rely solely on employees’ employment history only with their current employer.

VIII. SUMMARY

OPEB valuations under GASB 43 and 45 involve complex calculations using many assumptions applied subjectively. This paper has been an attempt to discuss some of the more important aspects of the actuarial calculations and provide a context for considering their application and effects. There are bound to be important omissions and issues that will benefit from more study. For example, time and space do not permit a discussion of allowable actuarial cost methods or employer elections.

However, I hope this adds to the development and understanding of key issues by those interested in this subject. I appreciate the opportunity to make this contribution.

A Practical Approach to the New GASB Standards

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I. Introduction

Whether you agree or disagree with its premises, GASB Statement 45 deserves careful consideration and a deliberate response. Accountants, actuaries, and finance officials must play a crucial role in preparing for and implementing the new standards, of course. But everyone, experts and non-experts alike, has a stake in ensuring that active and retired workers and their union representatives are well informed and able to participate effectively in discussions and debates surrounding the accounting rules. Broad and well-informed participation will lead to better options and outcomes, less political manipulation of the standards-implementation process, and greater buy-in from employees, unions, and the public.

On any issue that involves the eye-catching financial figures associated with unfunded liabilities for non-pension retirement benefits, there is ample room to substitute ideological interest for reasoned discussion, as California's recent fight over defined benefit pension plans demonstrated. Opponents of defined benefit plans appeared intent upon eliminating a system whose structure they found objectionable, by fanning outsized public outrage decoupled from reasonable concerns about the state's pension systems. And if arcane pension structures and funding rules lent themselves to manipulation during that struggle, the combination of health care issues and accounting standards stands to provide even greater opportunity for ideological exploitation. It is relatively easy—and clearly wrong—to misrepresent the standards to suggest that the only possible outcomes are bankrupting the government, a drastic reduction in benefits, or a shift to consumer-driven health structures. Unfortunately, we see just such an approach in many places around the country.

Press coverage of the GASB issue and opinion pieces on the subject sometimes get the facts wrong, but perhaps more insidious is the use of value-laden words that wrongly suggest that public employees are somehow taking advantage of taxpayers. The new accounting rules are variously said to lift the “veil” behind which employers and unions have hidden the practice of “political give-aways” that are “handed out” or “bestowed” upon public employees and create a “fiscal hole.” Although rhetorical posturing may make for good reading, it makes for bad public policy, given that the truth lies elsewhere.

Much is at stake in the debate about implementation of the GASB standards, beyond the hard-earned retirement benefits that public employees were promised when hired. The ability to attract and retain qualified and experienced firefighters, nurses, teachers, bus drivers, and other public employees hangs in the balance. Retiree health care and other retirement benefits play a very important, consciously determined role with teachers in California, for example. The California Teachers Association (CTA) has over 900 chapters, but less than half offer some form of benefit covered by the new GASB standards—including retiree medical, dental, and vision benefits, referred to as other postemployment benefits (OPEB).

Less than 10 percent offer lifetime health benefits to retirees, and, of these, most are urban districts with constrained budgets that would not be able to attract or retain high-quality teachers without offering OPEB. In fact, both management and labor agreed to the benefits precisely to ensure the retention of top-notch employees.

It is also easy to exaggerate the scope of benefits offered, underplay employee contributions, and dismiss pay-as-you go options. Where OPEB are included within CTA contracts, the association estimates that more than half provide for premium costs to be shared by the employer and employee. What's more, health care benefits are typically offered for a maximum of five years to employees who retire before age 65. The average retirement age is now over 63, meaning that retirees who use employer-sponsored health care benefits typically do so for about two years before becoming eligible for Medicare. For such a short period of time, savings from the replacement cost of retirees—the difference between the salary and benefits of a retirement-ready teacher and a new hire—cover the cost of health care benefits. Put a different way: If teachers decide to stay on the job because they cannot afford to pay for increased health care costs in retirement, eliminating retiree health care benefits for teachers who would otherwise retire, or shifting more financial responsibility to them, could actually cost districts more in salaries and benefits than they would save in retiree health care payments.

Another canard consists of comparing the public sector to the private sector, where retiree health care benefits have been eroding for years. Proponents of cutting or eliminating benefits sometimes argue that employer-sponsored retiree health care benefits in the public sector are anachronistic. However, the analogy between the public and private sectors does not hold. The labor force dynamics are distinct, as are the public policy interests and financial issues involved. In addition, the salary, benefits, and working conditions of most public employees are negotiated, and it is inappropriate to second guess the decisions reached—gains achieved, cuts taken, or trade-offs made—by labor and management in past negotiations. And even if private sector workers are suffering through an unfortunate benefit-cutting trend, that makes it neither acceptable on its own terms nor good policy for public employees.

GASB Statement 45 has unquestionably brought scrutiny to the postemployment benefit promises of public sector employers, but it has also increased the realization, at least in labor circles, that the real, underlying problem has more to do with the health care system in the United States than with the level of retiree health care benefits received by public employees. The longer-term solution rests with the development of a national, single-payer health care system that provides quality, affordable care, and with state initiatives like California's SB 840, the California Health Insurance Reliability Act, which would have provided comprehensive and affordable health care coverage to more than 6.5 million Californians who cannot afford it. California Governor Arnold Schwarzenegger vetoed the bill in September, 2006.

Reality dictates that we not wait for national or statewide health reform programs before developing a response to the short-term situation created by the new GASB standards. At the same time, however, reality also demands that whatever approach we develop be informed by the desire to maintain benefits without shifting risk and uncertainty to working women and men, and without creating new benefit tiers. That does not mean that no GASB implementation plan should ever carry with it a carefully considered and negotiated change in benefits, just that implementation plans and the work underlying them should not be developed with the goal of forcing a benefit-cutting resolution. It also means that creative solutions to funding should be sought, not impeded.

No single solution can be applied to every county, city, and school district in a particular state, let alone to all states in the country. Careful and considered work by the unions representing public sector workers should go into determining what approach makes sense in which particular place—maintaining benefits, altering the approach to funding, improving health care arrangements, or cutting benefits. What we can say, however, is that the best possible outcomes will be reached when labor unions are well informed and engaged in the process—whatever that process may be.

“A Practical Approach to the New GASB Standards” begins with a description of the types of standards-related problems we have seen around the country, including the myths that have set unfavorable conditions for discussing or acting on the new standards. Some states, like Utah, seem to have experienced a disproportionate share of inaccurate, even alarmist, work on GASB.¹ Other states, like California, appear in broad terms to be moving forward without wholesale manipulation of the process.

In the spirit of promoting effective dialogue and interaction on the GASB issue, and after looking at myths and facts related to the standards, this paper lays out possible strategies for non-experts to engage in GASB issues. Experience has shown that when non-experts feel comfortable with the actuarial issues that arise in the GASB valuation process, they are much better prepared to participate. For that reason, this paper ends with an explanation of the role and work of actuaries, including an annotated financial statement from a valuation for a teachers’ retirement system.²

There is no doubt that GASB Statement 45 is serious business, but not just because governments’ financial statements, bond ratings, and fiscal integrity deserve our considered attention. The new accounting rules are serious business because misstating, misunderstanding, or misusing them to attempt to wrest benefit concessions from public employees will have considerable negative impact on both public employees’ lives and the invaluable work they perform.

II. Myths and Facts about the New Standards

Some employers will seek to take advantage of the new accounting standards to wrest benefit changes from employees, while others will work to preserve benefits. In too many cases, however, we have seen approaches to implementing the standards that begin with the preconceived

¹ The Utah State Legislative Auditor General, for example, issued a report on GASB liabilities in the public education sector that suggested a clear ideological interest in eliminating defined benefit retiree health care benefits. Rather than dispassionately review the standards and possible approaches, and using wording that falsely suggested a legal mandate, the auditor made assertions throughout the report like the following: “Public education must modify or eliminate offered benefits and develop a plan to fund the remaining liability without compromising educational services or required additional taxpayer assistance.” (Office of the Utah Legislative Auditor General, “A Review of the Public Education Retirement Benefits,” July 2005, p. i.). To bolster its argument, the auditor’s office produced an overall GASB liability figure for 40 school districts by extrapolating from valuations done in four of those districts. The earlier work done by the Auditor General’s office had already set the stage for “inevitable” benefit cuts, which have taken place in some cases.

² Much of the material in this paper is drawn from a series of publications produced by the National Education Association to empower its state and local affiliates to effectively engage on the GASB issue: *Defending Retiree Health Care Benefits: An NEA Guide to Understanding and Preparing for the New GASB Standards*; “Myths and Facts about New Accounting Standards for Education Employers;” “Steps for Defending Retiree Health Care Benefits (When You’re Not a Technical Expert);” “A Non-Expert’s Guide to Actuarial Valuations;” and “Plain Talk about New Accounting Standards for Education Employers.”

notion that benefits must be cut, with possible solutions following from that presupposition. Around the country, we have begun to identify harmful myths related to the new GASB standards. When countered early on, NEA members have found far more productive engagement with management over the standards; unfortunately, too many have moved forward to implement plans based on the myths.

MYTH ONE: The new accounting standards require that benefits be funded

Fact: The new standards only say that employers should account for their non-pension retiree benefits, not that they must fund them. The new rules also say that employers can have up to 30 years to amortize the liabilities.

Implication: Employers certainly do not have to rush to change their approach to providing retiree health care benefits. In some cases, when employers falsely say that funding is a requirement, they do so to suggest that the only options available are to siphon money from the budget or eliminate retiree health care benefits. In reality, employers have a variety of options for dealing with the new accounting standards.

MYTH TWO: The new accounting standards are law

Fact: Except in the limited number of jurisdictions that mandate compliance, the standards do not carry the force of law, and state and local government employers cannot be obligated to use them. Nonetheless, the standards become part of “generally accepted accounting principles,” which auditors use when examining employers’ financial statements. As a result, compliance is very important, and most governments and school districts will probably adopt the standards.

Implication: Experience suggests that employers who say the new accounting standards are law usually do so to make their demands for cutting benefits read like a legal requirement or, at least, an inevitability.

MYTH THREE: To protect their bond rating, governments must fund or eliminate benefits

Fact: Public employers want to have good bond ratings, and that makes sense. However, with respect to the issues covered by the new accounting standards, the companies that rate the creditworthiness of governments will look at many factors to draw their conclusions about bond ratings and creditworthiness.

Implication: Blanket statements about the negative impact of unfunded retiree health care benefits can lead to an exaggerated sense of urgency to deal with liabilities and a harmful impulse to cut or eliminate benefits. In some instances—and based on specific information and analyses—concerns about bond ratings might be legitimate, but generalized concerns about bond ratings should not set the context for discussions and actions related to the new standards.

MYTH FOUR: The accounting standards create new expenditures that will bust the budget

Fact: There is no causal link between an employer's budget and the value of promised retiree health care benefits to be reported on financial statements. That is because the standards do not require funding, and budgets only include the items expected to be paid during the year. If a government or school district decides to put money aside to pay for retiree health care benefits promised to active workers, only then would the cost appear in the budget.

Implication: Watch out for tough talk on benefits based on the myth that the new standards will bust the budget. Engaging with employers over options for implementing the new accounting standards could include discussions about pre-funding, but the budget impact should be a *result*, not a *cause*, of decisions.

MYTH FIVE: The results of actuarial valuations are set in stone

Fact: Actuaries use a series of facts and assumptions to determine the value of the retiree health care benefits that employers have promised. Assumptions often rely on judgment calls on factors that are very sensitive to the slightest variation, including investment rates of return. By changing the assumptions, or by using outdated facts, the total value of promised retiree health care benefits can change significantly. The factors that actuaries use, like the demographic makeup of plan participants, can change over time.

Implication: Actuarial valuations are crucial to the process created by the new standards, because they provide governments with information on the scope of the costs the employer will face in the future. So, know which actuarial assumptions have the biggest impact on the valuation, and make sure those assumptions make sense. Smaller districts can opt to calculate the value of promised benefits without using an actuary, although the calculations will still be quite complicated. In either case, do not accept figures on projected costs without making sure the underlying facts and assumptions are reasonable.

MYTH SIX: We must prepare for the worst

Fact: Actuarial valuations sometimes include different sets of conclusions based on alternative but equally realistic scenarios. If you have not reviewed the actuarial valuation itself or talked about this with your employer, you cannot be sure that you have received all of the relevant information in the valuation. Perhaps an employer only gave you the worst-case-scenario numbers that highlight liabilities instead of providing other realistic conclusions that the valuations make. If the valuation contains conclusions drawn from a single scenario, whether or not it's the "worst case," your discussion about retiree health care benefits might be unnecessarily limited by that fact.

Implication: Know what is in the valuation before you talk about it. If only one set of assumptions was used, determine if other assumptions might have been equally reasonable and whether you need further information before discussing the future of public employees' retiree health care benefits.

III. Responding to the New Standards

This paper began with the suggestion that a careful and deliberate GASB Statement 45-related process would lead to better outcomes. An effective strategy might consist of letting employers know that protecting retiree health care benefits will be a priority for the union, or of accurately defining benefits in a way that excludes them from the statement's requirements. However, reality is likely to be more complicated than that, and some give and take may be necessary. If it is, begin by using information-based resources first, examining actuarial assumptions and other data, for example, to make sure that liabilities and trends are realistically reported.

For unions dealing with challenges to retiree health care benefits, it will be important to avoid a dynamic in which the only options are portrayed as extreme: bankruptcy for the employer, the elimination of benefits for current or new workers, or shifting to consumer-based health plans. At the same time, unions should be gathering and examining information from nearby jurisdictions and other relevant sources, educating members, and strategically countering exaggerated statements made in public forums, in the press, at GASB task force gatherings, or in other settings. They might consider conducting polls and other work to aid in crafting public responses. Make sure funding options are examined on the front end, because it may take time to develop appropriate funding options and structures, and the discussion of how to address benefits may vary depending on how funding questions are answered.

Before considering benefit reductions or switching to an individual account-based funding arrangement, if that is what you are forced to do, attempt to find other ways to reduce health care costs, including through administrative changes to the plan and competitive bidding. In addition, explore funding-related responses that could lessen or obviate the need for changes to the plan. Of course, adopting such cost-saving and funding-related responses could make sense even absent a fight over health care benefits, and they could be implemented before or along with the information-related responses described above.

RESPONSE ONE: Be Prepared to Counter Harmful Myths about the New Standards

Misinformation about the standards can be used to justify cutting retiree health care benefits. Among the common myths: the new standards require the funding of benefits (they don't); the bond rating of government entities that don't fund or slash benefits will surely suffer (the bond rating process is a more subtle process); and the standards create new mandatory expenditures that will bust school budgets (the standards deal with financial statements, not budgets). Those working on GASB issues must be prepared to counter myths, misperceptions, and falsehoods. Incorrect information could unnecessarily put the union on the defensive, rile workers, and undercut a serious approach to implementing the new standards.

RESPONSE TWO: Determine When Your Employer Will Implement the Standards

Statement 45 establishes different implementation dates for government entities, depending on the size of their annual revenues. Preparing for the new standards can be time-consuming, however, and many governments and school districts are already focusing on the standards. Also, employers can adopt the rules earlier than called for by GASB. Even if you have heard nothing about the new standards, chances are that preparations to implement them are under way in your local government and school district, so consider actively exploring where things stand so you can determine the steps you need to take.

RESPONSE THREE: Learn How Employers Are Preparing to Meet the Requirements

Regardless of their different implementation dates, employers may have already hired outside experts to determine the amount of retiree health care liabilities, and they may have developed options for funding or cutting benefits. The subject may already have been discussed at board of education meetings, city council hearings, or other venues that deal with financial concerns.

Figure out who is heading up the employer's efforts to develop a response to the new standards. Understand what the process will be for making decisions. At a minimum, this will help you determine what to watch out for. These steps could also be invaluable in assuring your input in the process. Determine whether you have the right to bargain over any proposed benefit changes. If not, figure out how best to have a say in decisions on the subject. Check meeting minutes, financial reports, and annual reports of the school district, board of education, county, or other jurisdictions with a stake in your employer's financial issues. You could find valuable information about discussions and actions that have already taken place. In addition, talk to public employee unions to see what they have heard and what they know.

RESPONSE FOUR: Strategically Educate Plan Participants

Both active and retired members will be hearing a lot more about the costs of retiree health care benefits. Expect questions. No matter what positions you ultimately take, ensuring that members understand and appreciate the retiree health care-related situation could make it easier to deal with the issue. Californians for Health and Retirement Security, a coalition of groups, including CTA, has engaged in polling and message development to help guide the public response.

RESPONSE FIVE: Understand the Impact of Plan Participant Demographics

The demographic makeup of health plan participants has a big impact on the projected costs of retiree health care benefits—in part because, as workers and retirees grow older, their health care costs generally increase. Knowing the demographic trends for members in the plan might help you to understand whether cost estimates for retiree health care are reasonable or exaggerated.

RESPONSE SIX: Understand the Impact of Key Actuarial Assumptions

Actuaries' calculations are very sensitive to even slight changes. Key assumptions include the rate of return they assume employers will make on their investments and the rate at which health care costs will increase. An actuary's report will sometimes contain different sets of projections based on different assumptions.

Be prepared to ask about the assumptions used to calculate projected retiree health care costs, and know whether the valuation contained multiple projections based on different sets of assumptions. You may need to slow discussions down in order to evaluate the reasonableness of the assumptions. If an actuarial valuation has not already been commissioned or completed, you may be able to help shape the assumptions used. For further detail, see "The Work of Actuaries," in section IV-A, below.

RESPONSE SEVEN: Consider the Relevance of Bond Markets and Credit Rating Agencies

Companies that rate the credit of government agencies will examine the funding status and strategies of school districts and state and local governments dealing with liabilities reported under GASB Statement 45. Chances are good that employers will raise issues related to bond markets and credit ratings—whether or not they think cutting retiree benefits is a good idea. For jurisdictions that raise money through bonds, as many do, factoring in the way rating agencies and investors view unfunded liabilities can pose a very real challenge. But that does not mean that benefits must be cut or eliminated to please bond buyers. In fact, credit-rating agencies have said that the size of unfunded liabilities is not, on its own, the key piece of information they will look to when determining the creditworthiness of a school district or government.

In Maryland, for example, an October 2005 actuarial valuation pegged the state’s unfunded accrued actuarial liability for public employees at \$20 billion.³ Yet when the state floated \$300 million in general obligation bonds in March 2006, the credit-rating agencies did not take issue with the liability. Standard & Poor’s, Moody’s, and Fitch all gave the state its highest rating, even though Maryland had yet to announce a plan for addressing the issue.⁴

RESPONSE EIGHT: Determine Which, If Any, Pre-funding Mechanisms Make Sense

Although GASB does not require employers to pre-fund their retiree health care liabilities, discussion of pre-funding options is likely to be widespread, as public attention to unfunded liabilities pushes politicians to take steps to address them and credit-rating agencies increasingly review how school districts and other government entities are dealing with liabilities. In addition, the unfunded liabilities of employers who pre-fund using an irrevocable trust will be smaller than those of employers who do not pre-fund in this way.

Whether or not it makes sense to pre-fund, and which pre-funding options are best, will depend on many factors specific to the district, city, or other jurisdiction in question. Pre-funding could provide a secure basis for paying for retiree health care benefits in the future, but the financial drain that could be caused by funding a plan could create bargaining or political difficulties. Structurally, several pre-funding arrangements might be available, including setting up a separate irrevocable trust or having a retirement system take on the responsibility of handling the assets. In some areas, legal or tax restrictions could make some possible funding structures impossible or too costly to adopt.

Some pre-funding options may make sense for some jurisdictions but not others: floating bonds, diverting part of pension COLA increases to retiree health care trusts, increasing a government’s contribution from general revenues, or other possible solutions.

RESPONSE NINE: Identify Sources of Administrative or Investment Assistance

Employers looking to cut costs may quickly try to impose on plan participants more of the health care tab, or they may seek to change the way the plan is structured. Knowing how the

³ Aon Consulting, “State of Maryland Postemployment Benefits Other Than Pensions,” October 2005.

⁴ Moody’s Investors Service, “Moody’s Assigns Aaa Rating to State of Maryland’s \$300 million General Obligation Bonds; Rating Outlook is Stable,” February 24, 2006; Fitch Ratings, “Fitch Ratings Assigns an ‘AAA’ Rating to \$300 Million State of Maryland General Obligation Bonds,” February 23, 2006; Standard and Poor’s, “Maryland; Tax Secured, General Obligation,” February 27, 2006.

current retiree health care benefit plan evolved and understanding what cost-saving options have already been explored, taken, or rejected will help. By identifying cost-saving measures that do not change benefits, you may be able to steer discussions away from benefits cuts and ensure that the process for making decisions about retiree health care benefits is as well informed as possible.

Plans and employers can sometimes save money by seeking competitive bids from health care providers asked to meet or exceed the type and level of benefits currently offered. Although doing so could result in the opportunity to switch to a better or comparable plan that costs less, it could also lead a current health care provider to cut its own costs in order to be more competitive. Another way that employers could potentially decrease their costs is by merging plans that are small, which could eliminate duplicative administrative costs and broaden the risk pool upon which health care premiums are based. Employers might also be able to move into a state-administered plan, if such a plan exists that permits smaller employers to join.

In the realm of prescription drugs, plans can sometimes save money by switching to more efficient programs that include incentives for using generic drugs when available. Employers can also seek to eliminate ineffective plan management and fraud.

To the extent that employers provide health insurance based on a local pool of participants, they may pay more for insurance than they would if the pool of participants was larger. In general, the larger the pool of participants, the more the risk is spread among individuals and the less expensive the premiums. However, the mandatory creation of pools could be highly controversial. Pooling could potentially decrease costs through risk-sharing and the lowering of administrative costs, but benefits design and risk-sharing strategies could also increase costs and lead to a loss of local autonomy and control. Multiple options for risk-sharing and pooling exist.

RESPONSE TEN: Monitor Legislative Activity that Needs Support or Opposition

Legislatures are increasingly focusing on health care and other non-pension retirement benefits, holding hearings, establishing commissions, and passing legislation. In some cases, legislation will facilitate effective responses to the standards. In Maryland in 2006, for example, the state legislature lifted restrictions on the way municipalities could invest, making it possible for them to put funds into viable trusts for OPEB liabilities. In California, the legislature discussed allowing CalPERS to invest the OPEB funds of entities that do not participate in CalPERS and to develop common actuarial assumptions that would be used to for health care trend and rate of return; the governor vetoed the bill in September 2006. Legislative initiatives, however, could also be negative.

RESPONSE ELEVEN: Identify Possible Legal Strategies

The appropriate legal response to proposals to modify or eliminate retiree health care benefits will vary from jurisdiction to jurisdiction, and the development of a responsive strategy will likely include a consideration of multiple factors. Working with legal counsel to identify appropriate strategies is important, and several avenues are potentially available.

Identify constitutional, statutory, and/or contractual provisions that expressly or by implication deal with the rights of retirees and active employees to receive retiree health care benefits. If such provisions exist, determine if they have been the subject of any decisions by judicial or administrative agencies. Determine under what circumstances, if any, a retired or active employee's right to receive retiree health care benefits vests (becomes nonforfeitable).

Vesting could take place in several ways, including after a fixed term of employment, after reaching a certain age, or upon actual retirement. Verify the precise nature of the commitment that was made with regard to retiree health care benefits. A commitment could have been made for retirees to receive the same coverage they had at the time of retirement, regardless of cost. Or, a promise could have been made that retirees would receive the same benefits as may from time to time be received by active employees. Multiple other possibilities exist. Determine how substantially—in financial and other terms—the proposed modification will affect retiree health care benefits and whether all similarly situated retirees and active employees will be affected in the same way.

IV. Understanding What Actuaries Do

One key to effectively facilitating effective union participation in GASB-related processes is building understanding of actuarial issues. Unions have an interest in making sure all parties are able to effectively participate in actuarial discussions.

A. The Work of Actuaries

Actuaries use multiple facts and assumptions to determine how much benefits will cost in the future. Then, they work backward, figuring out how much money would have to be set aside now for the fund to grow large enough to pay for those benefits in the future (technically, that's the present value of benefits). The money grows by gathering interest or through other investment returns (or it shrinks due to investment losses). If the facts and assumptions used in an actuarial valuation are not good, the outcome won't be either.

B. What to Look for in a Retiree Health Care Actuarial Valuation

When looking at an actuarial valuation, it's important to analyze various facts and assumptions regarding the benefits structure, plan participant demographics, and economic assumptions, among other things. It's also important to review the projected benefit costs based on those facts and assumptions. Even the calculation method used by actuaries can affect the way costs are reported.

C. Key Facts and Assumptions in a Retiree Health Care Valuation

For a retiree health care valuation, actuaries consider a long list of factors. The specifics of your plan and plan participants help to dictate which have the biggest impact on the outcome of the valuation, but some of the most consistently important facts and assumptions are listed here.

- **The benefits structure.** Logically, a comprehensive plan that pays 100 percent of all medical costs will cost more than one that pays and covers far less. So, actuaries have to know what the plan offers. And they need to know what the “substantive plan” is—as described in writing but also as understood by the employer (or employers) and plan members.

This means that one of the simplest ways to change the outcome of an actuarial valuation is to weaken the terms of the plan, and many employers will try to start a conversation by doing just that. Also, as employers create task forces or other groups to study retiree health care benefits, they frequently ask for detailed recommendations on how specific benefit changes would affect the value of the benefits promised by the employer.

- **The demographic makeup of plan participants.** Here, we're talking about the number, age, and sex of plan participants, information about spousal coverage, and retirement rates, among other factors. Health care costs tend to rise dramatically as people age, but even without age-related cost considerations, demographics are important. For example, the new standards don't ask employers to account for the benefits that actives have yet to earn, so the younger your actives are, the lower your overall unfunded liability is likely to be—because they won't have earned as much toward their retiree health care benefits.

The current age and other demographic characteristics of your members are fact-based inputs, but don't take for granted that an actuary received the right facts. Plus, the actuary is going to project costs many decades into the future, so a variety of assumptions will be utilized, including future staff turnover. Make sure the actuary receives the most correct and up-to-date information. If it's too late for that, determine whether incorrect information affected the valuation's output.

- **The rate of return that investments are likely to get** (sometimes referred to as the **discount rate**). If you set aside money to pay for benefits in the future, but you receive only a 1 percent investment return, it's going to take you a lot longer to reach your savings goal than if you're receiving 12 percent on your investments. The example at the end of this paper illustrates the importance of the investment rate of return, showing the difference in liabilities under 2 percent and 8 percent interest assumptions. Valuations can be produced using just one rate, or actuaries can create multiple scenarios with different rates. Actuaries also have leeway in suggesting assumed rates of return. The new accounting rules point out that if you are going to pre-fund the benefits using a trust dedicated to that purpose, you can use a higher rate than if you keep the money in a general account.

Understand that retiree health care liability figures are easily inflated or deflated depending on the investment return assumption, so, if your valuation is not yet completed, you may want to insist that any actuarial valuation take into account a higher and a lower investment rate of return. Learn what kind of rate was used to calculate the figure, and if that rate was reasonable. While you're at it, determine if the actuarial valuation you're discussing included different scenarios.

- **The rate of health care cost increases (health care trend).** No one really knows for sure what health care costs are going to be 30 years from now. However, an actuary can give you the best guess possible.

Check the health care cost rate of increase assumptions used, and make sure they make sense for your plan participants. If assumptions about the future cost of benefits are too optimistic (for example, expecting lower increases than reasonable), the actuarial valuation will underestimate the cost of benefits in the years ahead, resulting in the future in an unfunded liability that will be larger than expected.

D. Key Figures in Retiree Health Care Valuations

- **Accrued actuarial liability.** This is the amount the actuary determines it would take to pay for the already promised benefits over the period of the valuation—if money we're set aside now in order to grow through interest and other investment returns. Subtracting money already set aside to pre-fund benefits provides the “unfunded accrued actuarial liability,” as described

below. (By the way, the liabilities are usually amortized over 30 years, and the entire period covered by a valuation—including an analysis of the lifetime benefits of young workers—can be many decades beyond that.)

This number may be much, much bigger than the amount the employer pays every year to cover current retirees' health care benefits. Try not to let this figure set the tone for your discussions, because employers are not going to put aside this money all at once and, in fact, are not required to put aside any money at all.

- **Unfunded accrued actuarial liability.** This figure tells you the overall liability after subtracting out any money already set aside to pre-fund the benefits. This number is likely to catch the attention of employers, lawmakers, and journalists. It will be the same as the accrued actuarial liability if the employer has no money set aside to pre-fund benefits. It will be smaller if money has been set aside, but it is still likely to be quite large.

Don't let the number set the tone for your discussions. Here's why: The figure can be amortized (spread out) over a period of 30 years.

- **Unfunded liabilities sliced and diced.** In addition to the unfunded liability figure, two new pieces of information in an employer's financial statement are going to jump out at you. The first one is the **annual service cost (or normal cost)**; that's the value of the retiree health care benefits that actives earn during the year. If an employer paid only this and interest on the unfunded liability every year, the unfunded liability would stop growing (although it wouldn't get any smaller). The other figure to look for is the **amortized portion of the unfunded accrued actuarial liability**. For purposes of producing the year's financial statement, an employer can break up the unfunded liability into pieces and show it little by little over 30 years.

This is where the rubber meets the road. These are the numbers that are likely to be the focus of serious discussions, because they bring the liability figure into year-to-year perspective. So, determine the key assumptions and learn whether you are discussing the correct, up-to-date figures.

- **Annual required contributions.** This term refers to the amount that an employer would contribute if the employer wanted to set money aside to cover the year's portion of the amortized unfunded liability and the annual service cost.

Don't let the name fool you; the new accounting rules don't actually "require" contributions.

**E. Annotated Actuarial Valuation for a Teachers' Retirement System
Actuarial Analysis Conducted June 2004
Costs for Year 2005
(Annotations by NEA)**

a) Assumed investment return	8%	2%
b) Actuarial value of assets	\$0	\$0
c) Actuarial accrued liability		
Active Participants	\$303,854,640	\$1,231,692,833
Retired Participants	<u>\$131,369,424</u>	<u>\$254,076,087</u>
Total	\$435,224,064	\$1,485,768,920
d) Unfunded actuarial liability (c.-b.)	\$435,224,064	\$1,485,768,920
e) Funded ratio (c./b.)	0%	0%
f) Annual covered payroll	\$453,517,000	\$ 453,517,000
g) Unfunded actuarial liability as percentage of covered payroll	96.0%	327.6%
h) Normal cost for the 2005 fiscal year	\$18,343,569	\$98,864,637
i) Amortization of unfunded actuarial liability for the 2005 fiscal year (30-year)	<u>\$22,886,578</u>	<u>\$32,159,070</u>
j) Annual required contribution (ARC) for the 2005 fiscal year (h.+i.)	\$41,230,147	\$131,023,707
k) Expected benefit payments	\$10,160,530	\$10,160,530
l) Increase in annual cost to fund the plan (j.-k.)	\$31,069,617	\$120,863,177

The new accounting standards allow employers to assume a higher rate of return on assets placed in an irrevocable trust. The difference in the resulting liability calculations can be huge. Using the higher rate of return shaves more than \$1 billion off the unfunded liability of this plan.

The cost of retiree health care benefits already earned by active employees during 2005 is expected to be \$18 million if the fund sets aside the money in an irrevocable trust but almost \$100 million if addressed through general revenues.

In order to pre-fund the future health care benefits accrued during 2005 and pay off a portion of the unfunded liability that built up in prior years (together, the "annual required contribution"), it would take over \$41 million if the amount were calculated using the higher assumed return. The tab increases by almost \$100 million if the lower rate is used. Notice that the big contributor to the different figures is the annual service cost (normal cost).

The accrued actuarial liability and the unfunded actuarial liability are the same because the plan has not been pre-funded. For the same reason, the actuarial value of assets is \$0 and the funded ratio (the relationship of pre-funded assets to the liability) is also \$0.

This is the year's allocated portion of the liability from prior years.

This is the amount of new money it would take in 2005 to pre-fund this year's portion of the benefits – above and beyond the payments planned for current retirees' benefits.

The cost of the retiree health care benefits that current retirees will use during 2005 does not change with the assumed rate of return on investments (neither does the cost of the annual payroll).

California Schools and the Role of the Joint Powers Authority (JPA)

Mr. Russ Bigler, CEO, Self-Insured Schools of California

I think it tells us something when employees mention they don't want their benefits touched before they talk about a Cost of Living Adjustment (COLA) increase on their salary schedule. It certainly has told the Federal Government something, and they have responded with Governmental Accounting Standards Board Statement No. 45, or more commonly called GASB 45.

As we are all aware, GASB 45 requires that Other Postemployment Benefits (OPEB) be recognized as an expense and obligation on the agency's financial statements reported on the full accrual basis of accounting. The GASB 45 compliance effective date will be contingent upon the 1998-99 annual revenues of the district or county office as shown below:

Revenues of \$100 million or more:	Effective 2007-08 fiscal year
Revenues > \$10 million but < \$100 million:	Effective 2008-09 fiscal year
Revenues < \$10 million:	Effective 2009-10 fiscal year

For school agencies, the most common OPEB is health benefits provided to employees after retirement. For many districts, the financial impact of GASB 45 compliance will be substantial. In the past, the obligation to pay retiree benefits has typically been funded on a "pay-as-you-go" basis. Because of this, once the accrual accounting standards of GASB 45 take effect, retiree benefits will increasingly compete for today's dollars, immediately impacting the amount available for active employees.

GASB 45 does not require the district to fund the liability. This determination is still in the hands of the local district, although the growing retiree health benefit liability is causing legislative attention to the problem. A number of measures have been introduced this year which attempt to set new state policy in the area. In the meantime, a district that chooses not to begin funding the unfunded liability once it is required to recognize the liability on its financial statements will see, over a period of a few short years, that the district's net assets will significantly decline or even become negative. This will cause bond rating agencies to downgrade the credit rating, making it difficult and expensive for the agency to issue debt or voter-approved measures, such as bonds, Tax and Revenue Anticipation Notes (TRANs), and Certificates of Participation (COPs). The bond rating agencies will not only be looking at the impact on net assets, they will pay close attention to the plan the district has developed to finance the unfunded liability.

In developing a plan for financing OPEB, the plan, the following information should be collected:

- An actuarial valuation
- The fiscal year the district must implement GASB 45
- A substantive plan that includes:
 - Plan document
 - Level of benefits provided to retirees, as evidenced by collective bargaining agreements, MOUs, etc.
 - What eligibility criteria must be met
 - Communication method between employer and plan members
 - A review of historical practice patterns
 - A decision as to whether or not to fund the unfunded liability, and what the funding plan will look like (i.e., over 50, 75, or 100 years, etc.)
(Note: GASB 45 requires that the OPEB liability be recognized over a period not to exceed 30 years. However, there is no requirement on the number of years over which the liability is funded.)
 - A method regarding how the plan will be updated as changes occur, and at what intervals (i.e., annually, biennially, etc.).
- How the plan will be managed regarding the liability, the funding, and investments for the liability.

There are several options being used by agencies to pre-fund the liability, which vary in terms of the accounting transactions required, the agency's access to the funds after transfer, the ability to allocate the cost of the OPEB funding to all programs and funds of the agency, and the ability to count the funding amount as an offset to the liability. These options pertain specifically to California school districts although some of them may be generalizable to other types of agencies or agencies of other states:

1. **Designate funds within the ending balance of the General Fund.** This option would require an entry to designate a portion of the agency's unrestricted ending balance to the OPEB liability. Using this option, the board can take action to increase the designation over time, or to reduce or eliminate the designation. This option would not allow the agency to allocate the cost of funding the liability to all of its unrestricted and restricted programs and funds, and would not be recognized under GASB 45 as a legal contribution to offset the liability.
2. **Transfer funds to the Special Reserve Fund for Postemployment Benefits (Fund 20).** This option would require an accounting entry that is a transfer from the General Fund to the Special Reserve Fund for accumulation. Then, as the funds are needed to pay premiums, there would be accounting entries to transfer the funds back to the General Fund and then to pay the premiums. The board can take action to continue the transfers to this Special Reserve Fund, increase the transfers, reduce or eliminate the transfers, or to transfer the funds back to the General Fund for other uses. The ability to allocate the cost across all programs is currently under review by

the U.S. Department of Education (USDE). The hope is that this guidance will not change, but a prudent effort is being made to ensure this is an allowable activity. As funds are transferred into the Special Reserve Fund, they would not comprise a legal contribution to offset the liability on the financial statements.

3. **Contribute funds to formal trust.** The use of this fund requires the agency to set up an irrevocable trust in which to accumulate the funds for the purpose of retiree benefits (i.e., health benefits). Once the funds are transferred into the trust fund, the board cannot take action to transfer any of the funds back to the originating fund. This option would be recognized under GASB 45 as a “legally qualified” contribution to offset the liability on the financial statements as funds are transferred into the trust fund. As mentioned above, the allocation of these expenditures across all programs is currently under review by the USDE.
4. **Contribute funds to an external third party provider of an irrevocable trust.** Similar to the use of the formal trust described in option 3, once funds are transferred into the irrevocable trust, the agency’s board cannot take action to transfer the funds back to the agency for any purpose. This option would also be recognized as a “legally qualified” contribution to offset the liability. Again, the allocation of these expenditures across all programs is currently under review by the USDE.
5. **Issue an OPEB bond.** This option may be beneficial for some agencies that have a large OPEB liability, can’t fund the annual required contributions (ARC), and have capped benefits to control costs. Additionally, this may allow the agency to better manage retiree health care costs since bond payments could be less than or equal to pay-as-you-go payments. It is likely this alternative will utilize a revocable/restricted trust, in which case funds can only be used to pay retiree benefits or retire bond debt. This funding choice will not offset the liability on the financial statements, but can be disclosed in the notes to the financial statements. Also, the OPEB bond debt service is considered a General Fund obligation of the agency.

No matter which option is utilized, I believe it is fiscally prudent and strongly advisable for a District to pre-fund its OPEB liability. Having said this, I haven’t seen any product on the market that will enable a district to have its GASB 45 obligations met nearly as cost effectively as does the SISC GASB 45 Trust program. SISC is a large non-profit Joint Powers Authority (JPA) operating out of the Kern County Superintendent of Schools' office in Bakersfield, California. This non-profit structure, combined with a strong existing relationship with hundreds of school districts throughout California, provides us with many unique advantages in the form of hands-on service, a wide array of products, group buying power, and lower administrative costs that we constantly pass on to our members.

I would like to thank School Services of California, and Cindy Sproles, Self-Insured Schools of California, for letting me use some of their material. For those readers not familiar with the goals and objectives of a JPA, I have attached the following excerpt from SISC's charter.

**Excerpt from the Charter of
The Self-Insured Schools of California
Article II - Purposes**

The purpose of this Agency shall be to:

1. Administer the Joint Powers Agreement pursuant to the provisions of the California Government Code, Title I, Division 7, Chapter 5, Article 1, Sections 6500 ff;
2. Provide services necessary and appropriate for the establishment, operation and maintenance of a self-funded program for Medical, Dental and Vision insurance claims by employees and eligible dependents of member public educational agencies;
3. Provide a forum for discussion, study, development and implementation of recommendations of mutual interest regarding self-insurance for Medical, Dental and Vision protection;
4. Provide a forum for discussion, study, development and implementation of other self-funded programs for different kinds of risk management.

Article III - Powers

This Agency shall have the power to:

1. Exercise any power common to the public educational agencies which are parties to this Joint Powers Agreement, provided that such powers are exercised in the furtherance of the purposes and functions of this System, and in a manner expressly provided in law;
2. Provide member agencies with a plan and system of self-funding for Medical, Dental and Vision losses;
3. Provide districts with protection within the scope of the law;
4. Pursue subrogation or third party liability when, in the judgment of the Board of Directors, such subrogation rights or third party claims shall result to the benefit of the self-insured program and parties;
5. Establish and maintain a fund to pay self-insured losses;
6. Acquire, hold and dispose of property, real and personal, all for the purpose of providing the membership with the necessary education, study, development and implementation of a self-funded insurance program or programs;
7. To contract with third party administrators and/or administrative agent to administer the day-to-day operations of the program;
8. Perform such other functions as may be necessary or appropriate to carry out the purposes and programs of this system.

Raising Retirement Age Key to Reducing OPEB Costs

*By Ms. Marcia Fritz, CPA
Treasurer, California Foundation for Fiscal Responsibility
and Mr. Jon Coupal
President, Howard Jarvis Taxpayers Association*

For too many years, union leaders, politicians and public agency budget managers have favored retirement benefits with low current-year costs and larger long-term costs, such as pay-as-you go retiree health coverage. Deferring retirement costs in this way opaquely shifts part of the budget pain to future leaders and taxpayers who will not benefit from the employees' work performed in prior years.

In recent years throughout California, pensions and retiree health care benefit levels have increased, along with costs to pay for them. Many state and local government employees now retire at 55 years old on generous benefits, which will be paid by future taxpayers. The unsustainable benefit packages often include full medical coverage before retirees become eligible for Medicare and a very generous supplement package once Medicare takes over. These years of comfortable leisure are not enjoyed by private sector employees and come at a very high cost. Indeed, the California Legislative Analyst estimates unfunded retiree healthcare obligations for state and local government agencies may exceed \$140 billion. Unfunded pension obligations may also exceed \$100 billion.

Fortunately, the Governmental Accounting Standards Board (GASB) recognizes the fiscal consequence of these unfunded liabilities and now requires government financial reports to reflect the full cost of these benefits while services are *provided*. Regulations taking effect this fiscal year require a calculation of past service liabilities and require future costs be fully recognized as they are earned by active workers. Full disclosure of these liabilities, and any offsetting assets, provide bond investors a better of government agencies' creditworthiness.

Although GASB requires only that the full expense be *disclosed*—they don't have authority to require the future obligation to be *funded*—bond-rating agencies will frown on governments who don't adopt a plan to cover existing unfunded liabilities and set aside sufficient money for the future benefits being earned by current employees. The days of using easy "pay as you go" payment plans for retiree health care costs are numbered. The new GASB rules will shine a bright light on the too common practice of deferring retiree health benefit costs to future budgets.

So instead of starting the hard work of designing and negotiating a more fiscally responsible retiree health care benefit for new employees— one that should include raising state and local government retirement ages to those found in Social Security and Medicare – public employee union leaders advocate establishing a statewide, single payer healthcare system that would conveniently take unfunded retiree health care obligations off the wage negotiation table and place them on the back of every other citizen and business in California.

This strategy for avoiding the fiscal consequences of unsustainable benefits by establishing a government run, single-payer health care system is both audacious and predictable. Audacious because it seeks to transfer hundreds of billions of dollars in health care obligations to other taxpayers and predictable because it would both eliminate accountability for state and local government leaders who find themselves in a huge financial hole and also allow union leaders to press for even better wage packages in the years ahead.

While health care experts work hard to reduce the rising costs of California's health care system, state and local government officials should focus on a key retirement benefit design decision entirely within their power – increasing the eligibility age for public employee retirement benefits. Any cost savings achieved in broader health care reform measures will add to the substantial savings available through increased retirement ages. Yet a responsible plan to pay down growing public OPEB liabilities cannot wait until uncertain state and federal health care reform efforts are complete.

Experts estimate conforming state and local government retirement ages to the normal retirement age for Social Security retirement benefits -- 65 for those born before 1938 and increasing to 67 for those born after 1960 – would reduce pension costs by at least 60% (12 more years of payments into the pension fund per employee, 12 less years of payments out and 12 more years of interest) and retiree health care costs by about one third (providing only Medicare supplement coverage).

While increasing the public employee retirement age to 65 or more is appropriate for most government workers, the physical demands of police and firefighter jobs make 55 years old a responsible age for public safety employees to retire. Indeed, 55 years old was the prevalent retirement age until California public retiree benefit levels were unsustainably enhanced in 1999 and continues at that age for most of the nation.

Although key court decisions have limited the ability to change benefit levels for existing public employees, there is no responsible reason why new employees should continue to be offered the same unsustainable benefits packages that are threatening local governments with insolvency and taking away the money needed to fund existing education, health, public safety and infrastructure programs. Indeed, reducing benefit levels for new employees will reduce future benefit obligations and provide the cash flow needed to help pay for the current unfunded retiree liabilities.

Many weak union leaders, politicians and public agency budget managers want to avoid the painful fiscal consequences of making unsustainable retirement promises to public employees, but establishing a government run, single payer health care system for all California is not the answer. The cheap and easy solution rarely makes good public policy.

The right answer is establishing lower cost retirement benefit levels for new employees and using those savings to pay for current employees and to help cover unfunded retiree health care liabilities. Requiring non-safety public sector employees to work as long as private sector employees do is a good starting point on the long, painful road to state and local government fiscal responsibility.

The California Foundation for Fiscal Responsibility is a new 501(c)4 organization committed to educating the public and key decision makers about California public employee retirement benefit issues and developing fiscally responsible solutions that are fair to employees, employers and taxpayers. The Howard Jarvis Taxpayers Association, founded in 1978, has fought a continuing battle in the California State Legislature, in local governments statewide, and in the courts — including the United States Supreme Court — to defend Proposition 13 and taxpayer rights.

No Easy Way to be Free (of our OPEB obligations)

by Mr. Lou Filliger, FSA, Demsey, Filliger & Associates

There you have it - 5 viewpoints, each from people with a great deal at stake in the outcome of the next few years, each knowledgeable and experienced in their particular area of the healthcare field, and each with a substantially different perspective.

How can these views be reconciled? There may not be a way to do it immediately. A cynic would say we're bound to end up with the worst of all worlds - a "solution" in which OPEBs still weigh down the bottom line of government financial statements, doctors, hospitals and insurance companies are still vilified, a substantial proportion of the population remains uninsured, and the taxpayer gets handed the bill for the pleasure of financing the whole debacle. Well, a cynic is saying it ... me!

One time-tested technique to end worrying is to imagine the worst that could happen, plan for it, and then try to imagine how you can steer the outcome to be slightly better than the worst, in increments. I think that principle is well applied to the current health care situation in the United States in general, and in California in particular. People have repeated over and over that there is a crisis, until now, by golly, there is one. So let's just repeat over and over that we can solve it, and who knows? maybe we can.

It is perhaps fortunate that GASB 45 implementation comes at a time of decreasing newspaper readership. In our experience, the press has been more likely to overstate the severity of a problem than to understate it. The author has submitted a number of letters and commentaries to various news outlets, and has found that our message of moderation has frequently been edited out prior to publication. We don't understand why it benefits the press to intentionally alarm its readership; perhaps the chronic doomsaying is one reason the readership is turning to other more reliable sources of information as the new century unfolds. Some of the articles we've seen on the unfunded liabilities of public agencies seem more apropos for the National Enquirer than for any other venue.

Given this backdrop, it is to the credit of public agencies throughout California as well as the United States in general, that the reaction to GASB 45 has been, for the most part, sober and measured. The city-manager style of government has worked well, so far, to shield agencies from the political vicissitudes which could threaten their independent decision-making ability at this critical juncture in history. There are some notable exceptions to the general rule, though.

For example, Los Angeles Mayor Anthony Villaraigosa's attempted takeover of LAUSD: He has recently achieved limited authority in the district's operations, including veto power of incoming district superintendents. This was neatly circumvented by the school board quickly hiring its new superintendent before the effective date of the new arrangement, and notably, while Villaraigosa was out of the country. Given the splashiness of the politics involved, it seems extremely unlikely that the "takeover" will have much of an impact on the district's GASB 45 implementation. Nevertheless, it's an ominous development. Having an elected official making decisions for the district during the implementation phase of GASB 45 is like bringing a witch-doctor into the operating room during a critical moment of open-heart surgery and passing him the scalpel. The timing could not be worse.

In Spring of 2006, The California School Employees' Association sent a letter to district superintendents throughout California urging their support of the proposed single-payer health insurance bill for California, the recently vetoed SB 840. This in and of itself may not be so unusual, but the letter implied that SB 840's government-run health insurance would be a way to avoid compliance with GASB 45. In the first place, this conclusion may be erroneous - nobody knows how SB 840 would affect promises made to retirees before its effective date.

But in a broader sense, the implications of this message are extremely worrisome. If individual districts have unmanageably large unfunded obligations, then what the CSEA is championing amounts to a pooling of these into one colossal unfunded obligation and handing the bill to the taxpayer, of course.

Note that the obligation to provide healthcare benefits to retirees can only be avoided by breaking the promises made at the bargaining table. Those promises, for the most part, state that the district will provide some sort of health insurance to the retiree, but they are typically vague as to the specific plan of insurance. Presumably retirees in a private HMO or PPO would be moved over en masse to the SB 840 single payer system (given that SB 840's preamble states that it would actually be *illegal* to provide healthcare in California other than through the single-payer system, this seems an inescapable conclusion.) Many of the retirees might initially be happy about the move, in fact. But the bill for healthcare services for these retirees isn't going away. It's just being spread differently.

Initially, SB 840 would mean a combined employer-employee payroll tax of 11% of pay. This would fall on districts that have not historically granted retiree benefits, as well as those that have. So, 30 years of individual district negotiations will be erased with the stroke of a pen. School employees who have foregone past pay increases in order to retain richer retiree health benefits will now be thrown into the same pool with employees and retirees from districts that have given away the store year after year. Districts that have been carefully diligent about not promising benefits they can't afford, will be thrown into the same pool as districts with unfunded promises to pay full life-time medical, dental and vision benefits to retirees, spouses, dependent children, and survivors.

Perhaps the CSEA letter should have gone out to only the districts with benefits richer than the State average; with a separate letter with slightly different wording sent to districts below the mean, as follows: "We urge you to support SB 840 because you will be able to help fund, through your payroll taxes, the GASB 45 liabilities of all the other districts in the state (since our records show that you don't have any of your own.)"

The topic of universal and/or single-payer health care is just outside the scope of this White Paper, but it certainly has at least one nexus with GASB 45: the idea that single-payer healthcare is a knight on a white horse coming to rescue the damsel government agencies from the evil GASB 45 dragon. The proponents of single-payer healthcare believe that cutting out insurance company profits and administrative waste will result in significant savings.... and it might, at first. But after the initial savings, how do you keep costs at 2007 levels in subsequent years? By freezing the quality of healthcare at 2007 levels and rationing expensive procedures. By letting the aged and infirm die (even if they can afford treatment) because it shall be *illegal* to provide services through any means other than the State.

That may be what the American consumer wants - and if so, that's what the American consumer will probably end up with. But make no mistake: it's not what has been promised to government employees and retirees all these years. DF&A strongly believes that promises made to government employees and retirees should not be breached under any circumstances. And a change to a single-payer system could well constitute the biggest potential breach of all.

Periodic labor negotiations allow for constant adjustments and tweaks in benefits. If an employer and its unions bargain for a set of benefits and it turns out that it's not what everybody wanted, they go back to the table and hammer out a better deal for next time. That luxury will go away under the single-payer system. It's possible that everyone will be happy with a State-run system.

But what if they're not happy? What if they realize too late that they were given a promise that could not be delivered? There will be no tweaking, no negotiating. There will only be reluctant acceptance, because it shall then be *illegal* to provide benefits other than those prescribed by the State. Can the State of California (or the Federal Government, for that matter) be absolutely trusted to deliver 100% of what they promise?

It's absolutely amazing to the author to hear people who already enjoy Cadillac benefits clamoring for a broken-down VW bus as a solution to their healthcare problems. Rather than fearing the disease, California's public employees and retirees should be fearing the proposed cure, and GASB 45, unfortunately, is being used as a scare tactic by the very groups who should be protecting those employees' interests.

A free lunch is being promised that, if consumed, is guaranteed to cause financial and societal indigestion for many, many years to come.

Discussion of Other Submitters' Articles

Martin Hittelman

GASB 45 - A Threat to Retiree Benefits

I attempted to make several major points in my viewpoint piece. Many of these points were also addressed by other participants. One of the most important of these points is the threat that GASB 45 represents to the medical coverage of retirees.

I began by stating that “One of the major drivers of the movement to deny employees of their hard-won health benefits is the newly established Government Accounting Standards Board 45 reporting standard.” Geoffrey Kischuk supports this contention in his contribution to this White Paper. He points out that under the similar SFAS 106, “In the private sector, the number of large employers offering retiree health benefits has dropped substantially.” Although he isn’t sure how much the public sector will follow this example, he does state a list of reasons why public employers will find the GASB 45 standards “problematic.” He then concludes that “there will inevitably be a drop in the number of retirees and dependents covered.” This is one of my greatest fears.

Beware of Hasty Overreactions

My contribution to this White Paper cautions against moving too quickly to address the long-term liabilities that arise out of retiree health care benefits. Those who care about employee benefits into retirement should deal carefully with the new GASB requirements so as not to undermine the benefits that were earned over long employment careers. Mr. Solomon (from the *National Education Association*) and I both point out in this White Paper that those who care about public service must be on the alert to the way that GASB 45 will be used by those who seek to eliminate it. Or as Mr. Solomon states “Those working on GASB issues must be prepared to counter myths, misperceptions, and falsehoods. Incorrect information could unnecessarily put the union on the defensive, rile workers, and undercut a serious approach to implementing the new standards.” The threat of myths, misperceptions, and falsehoods is real. Lou Filliger, in his concluding remarks, notes, “In our experience, the press has been likely to overstate the severity of a problem than to understate it.” He goes on to state that, “We don’t understand why it benefits the press to intentionally alarm its readership...” Mr. Solomon rightly cautions that due to the “eye-catching financial figures associated with unfunded liabilities for non-pension retirement benefits, there is ample room to substitute ideological interest for reasoned discussion.” We must not let that happen. Mr. Solomon provides a list of things that unions should do to protect their “hard-earned retirement benefits.” His advice should be taken seriously.

Ms. Fritz and Mr. Coupal make clear, in their contribution to this White Paper, their organizations' desire to downgrade health care plans for public employees. Their answer to the current alarm regarding retiree health benefits is to establish “lower cost retirement benefit levels for new employees and using these savings to pay for current employees and to help cover unfunded retiree health care liabilities.” In other words, develop a have and have-not split between current and new employees and in the long run reduce retiree health benefits. This is something that I hope no union will agree to.

Ms. Fritz and Mr. Coupal claim that the current benefit packages are “unsustainable” but provides no evidence to back up that claim. My example of the costs for retiree health plans as a fraction of the LACCD’s budget illustrates the falseness of her statement. The LACCD continues to provide retiree benefits for life without a substantial proportional draw from the district budget. As I and many others have shown, the current pay-as-you-go method of payment of retiree health plans is the least expensive approach to their funding and has not, after more than fifty years of experience, shown any tendency to significantly impact budgets. Nevertheless, GASB 45 still exists and must be taken into consideration.

Getting Health Care Off of the Negotiations Table

Ms. Fritz and Mr. Coupal claim that “These years of comfortable leisure are not enjoyed by private sector employees and come at a very high cost” is also not backed by any data. The years of “comfortable leisure” have not been felt by any school employees that I know. The drive to the bottom ideology embedded in their statement does not help create an atmosphere favoring quality healthcare for all. It helps neither public nor private employees seeking to have protection in their retirement years.

Ms. Fritz and Mr. Coupal agree that the cost of health care is making it difficult for public employees to negotiate reasonable salary schedules. Predictably, Ms. Fritz and Mr. Coupal decry the effort to take medical costs off the table by substituting a health care system that provides quality care for all. Even while arguing against a statewide, single-payer health care system, they recognizes that its enactment will eliminate concerns regarding unfunded health care liability. They instead focus attention on unions: “public employee union leaders advocate establishing a statewide, single-payer healthcare system that would conveniently take unfunded retiree health care obligations off the wage negotiation table and place them on the back of every other citizen and business in California.”

It is not only union leaders who wish to take negotiations over health care off the table - it is one of the main goals of the joint labor/management *Education Committee for Health Care Reform*. Many large corporations in the United States would also like to take health care off the bargaining table so that they can better compete with companies from countries that have a civilized system of providing health care to all of their citizens.

Persons against a single-payer system for public employees speak of the burden on taxpayers without reflecting on the fact that not only are current public employee health care and salaries paid for through taxes, but that these costs would be reduced in a single-payer system. One need only go to Senator Kuehl’s background papers on SB 840 to see how much is saved by a universal system. The fact that fewer taxes would be required to provide health care benefits for public employees under a single-payer system do not alter the ideologically based critics of such system from opposing their implementation. It needs to be pointed out that the cost of private insurance for health care would also be reduced under a universal system.

Those of us that support a single-payer universal health care system would like to see the total cost of health care reduced while quality is increased. We would like to see the cost of health care off the bargaining table. We would like to see a system where quality healthcare is guaranteed for all. We believe that bills like SB 840 would lead to such a system - not just for public employees but for everyone. I will return to that point later in this response.

Bond Ratings as a Threat

There are several mentions concerning the effect of failure to pre-fund the retiree health benefits on bond ratings. Russ Bigler, Self-Insured Schools of California, makes the statement that “This will cause bond rating agencies to downgrade the credit rating, making it difficult and expensive for the agency to issue debt or voter-approved measures, such as bonds.” Ms. Fritz and Mr. Coupal state, without providing any evidence, that “bond-rating agencies will frown on governments who don’t adopt a plan to cover existing unfunded liabilities and set aside sufficient money for the future benefits being earned by current employees.” To my knowledge, this has not occurred. As Mr. Solomon noted “the companies that rate the creditworthiness of governments will look at many factors to draw their conclusions about bond ratings and creditworthiness.” He advises that “generalized concerns about bond ratings should not set the context for discussions and actions related to the new standards.” I agree.

Actuarial Variability

It is clear, based on the contributions to this White Paper, that the actuarial projections on retiree benefit costs are highly speculative over a 30-year period. Employers and Unions should follow the advice Joel Solomon from NEA gives. His advice that they should “know which actuarial assumptions have the biggest impact on the valuation, and make sure these assumptions make sense.” The important variables that he mentions include the benefit structure, the demographic makeup of plan participants, the rate of return on investments, and the rate of health care cost increases or decreases. Mr. Kischuk notes that “the goal should be to conduct the valuation on a ‘best estimate’ basis, i.e., neither too optimistic nor too conservative.” In making the predictions, I would suggest an optimistic approach.

Mr. Kischuk notes that an “optimistic” estimate, “as a practical matter”, “may not have much of an impact inasmuch as many employers will need ‘several bites of the apple’ to migrate their OPEB plan to where it needs to be.” A conservative valuation, on the other hand, may lead to large unnecessary expenses. For these reasons, I would think that most employers and Unions would begin with more optimistic assumptions and later adjust them if needed. In any case, given the complexity outlined by Mr. Kischuk regarding the assumptions, districts and unions should go slow in doing anything precipitous around the new GASB 45 requirements.

The Politics of Premium Increases

The rate of health care increases or decreases is a big wildcard and has a large impact on the calculation of liability. Given the heavy emphasis this year, at both the national and state level, on the unnecessarily high cost of health care in the United States, I would expect health care costs to level off over the next few years. One should recall that when Bill Clinton came into the White House and proposed health care reform, health care premiums dropped. This is likely to happen again.

It is not yet clear what state and national approaches to reducing health care premiums will occur this year. The enactment of a single payer health care system would eliminate much of the duplicative paperwork now required and result in substantial dollar savings. The effect of reforms such as single payer should be considered in calculating costs over the near and short run. The *California Health Care Coalition* work should also drive down costs in California as purchasers receive detailed information on costs and quality. Their efforts should drive down costs for pharmaceuticals. Their increased spotlight on quality should also reduce costs as infection rates and the number of other preventable incidents are reduced. The passage and signature on Senator Sheila Kuehl's single-payer plan would also reduce employer costs considerably. Laws directed at correlating premiums and cost and halting the increasingly monopolistic industry practices of the health care industry can also lead to a lowering of unfunded liability.

SB 840 - A Civilized Approach to the Provision of Health Care

One of the points I attempted to make was also made by Joel Solomon of NEA. I stated my belief that districts should spend time trying to solve the real problem of health care costs and quality. Mr. Solomon agrees, "GASB Statement 45 ... has also increased the realization, at least in labor circles, that the real underlying problem has more to do with the health care system in the United States, than with the level of retiree benefits received by public employees." He then goes on to support the "development of a national, single-payer health care system that provides quality, affordable care, and with state initiatives like California's SB 840, the California Health Insurance Reliability Act."

Lou Filliger, in his conclusion, takes on the California School Employees' Association for urging support "of the proposed single-payer health insurance bill for California - the recently vetoed SB 840." As I mentioned earlier, the California Federation of Teachers was also in strong support of SB 840 and continues to support its passage in the current session on the legislature.

It is unfortunate that Mr. Filliger puts forward a series of negative (and false) claims regarding SB 840. In fact, in contrast to the claims of Mr. Filliger, SB 840 contained robust coverage which would cost public employers much less than their current employee and retiree health care premiums do. In SB 840, individuals would still be able to choose their doctors and hospitals. SB 840 is very much like Medicare in that respect.

Mr. Filliger mentions that SB 840 "would mean a combined employer-employee payroll tax of 11% of pay." Most public employers pay much more than this currently and would save substantially under SB 840 even if they picked up the full 11%. Mr. Filliger cautions that under an SB 840 type bill, "presumably retirees in a private HMO or PPO would be moved en masse to the SB 840 single payer system." Ms. Fritz and Mr. Coupal calls single payer healthcare systems "government run." Both of these claims are very misleading. Under SB 840, the doctors and the hospitals would continue to determine and provide the services needed, the "government" is only the mechanism for payment. Under SB 840, patients would continue to choose their doctors and hospitals but they would receive better health coverage at less cost.

The combined "11%" payroll tax to fund SB 840 is an estimate by a consulting firm as to what would be required. SB 840 was not the budget part of the bill. In any case, the 11% contribution would reduce the benefit costs for all the districts that we have looked at. The *Education Committee for Health Care Reform* has developed a spreadsheet that can be used to estimate the savings a district would achieve under SB 840.

Mr. Filliger concludes with the statement that, “the proponents of single-payer healthcare believe that cutting out insurance company profits and administrative waste will result in significant savings” might be right in the short run. I predict that the savings will continue as the current high cost of duplicative paper work is replaced by a single-payer. This is certainly what has happened when other countries enacted their single payer universal coverage systems. This has also proven to be true in Medicare. Great saving will also be achieved by having a community rating with one statewide purchasing pool that spreads the liability of health care costs. Certainly, the elimination of profit by the insurance companies will reduce the cost of the health care system as funds are used for quality service and not advertising and profits.

In the long run, Mr. Filliger offers concern regarding the possible freezing of the quality of care at 2007 levels. If that happened it would be tragic. Given the relatively low quality and very high price of medical care in the United States, when compared to the provision of universal medical care in most other industrial nations, it could only be improved under a plan like that in SB 840. Covering everyone should lower costs as people seek medical care when needed, not just when an emergency finally occurs. Having an agency that will see that quality outcomes are achieved would also be a big step forward.

SB 840 called for a robust level of coverage, including coverage for hospital, medical, surgical, mental health, dental, vision, prescription drugs, podiatric, chiropractic, acupuncture, immunizations, dialysis, immunization, preventive, durable medical equipment, diagnostic, laboratory services, emergency care and transportation, skilled nursing care, rehabilitative care, substance abuse recovery programs, health education, home health care, and hospice for all at a total reduced cost. It is what Mr. Filliger calls a “Cadillac” plan. I would call it a plan that provides quality medical care to all California residents.

Conclusion

Make no hasty decisions. Invest your dollars wisely. Carefully look at the actuarial assumptions and ask for the effects of different assumptions. Watch out for those who would use GASB 45 as a means to eliminate health coverage. Support real solutions to our health care crisis.

Geoffrey Kischuk

First, I would like to thank Demsey, Filliger & Associates for allowing me to participate in this important discussion. I hope these papers will further understanding and discussion of OPEB benefits.

In my discussion of the articles, I will address them in the order in which they occur.

Mr. Hittelman has done an excellent job outlining important issues leading to higher healthcare costs. However, GASB's intent is not to solve the healthcare financing problem, but to provide better financial reporting. Having performed valuations for nearly 300 public employers (including 80% of California community college districts), I have seen substantial differences between district liabilities for OPEB benefits. GASB's concern is that users of financial statements will be better served knowing the magnitude of OPEB liabilities. Mr. Hittelman does not address this issue directly.

I sympathize with Mr. Solomon's concern about how OPEB benefits are or will be handled by the media. Unfortunately, the first public employers to comply will be the largest employers, many of which provide substantial OPEB benefits. The expense and liability figures for these Phase I employers are likely to garner a lot of press and may lead some to conclude the issue is much bigger than, in reality, it is (although it is certainly important).

I also agree with Mr. Solomon that education – including exploding OPEB myths and “urban legends” – will be an important prerequisite to effective dialogue on the issue. Mr. Solomon's paper is an important tool in the education process.

Mr. Bigler's paper addressed the role of the JPA in addressing OPEB. It would have been interesting if Mr. Bigler had compared and contrasted using a JPA to qualify as a GASB 43 “plan” as opposed to a trust (e.g. 501(c)(9), 115, etc.)

Ms. Fritz's and Mr. Coupal's paper focuses largely on raising retirement age as a means of reducing OPEB costs. It should be noted that eligibility requirements of many (if not most) OPEB plans are much more restrictive than pension plan requirements. Furthermore, OPEB are rarely vested for employees terminating employment prior to retirement. While increasing the qualifying age for OPEB will, in fact, reduce costs, OPEB should be viewed and managed as a different benefit from pensions.

One has to admire Mr. Filliger's restraint in his conclusion section inasmuch as he is an expert in this area and surely has much more to contribute. Mr. Filliger scratches the surface of how OPEB might affect public policy and vice versa. We certainly will be hearing much more about changing the healthcare delivery and financing system. These changes – whatever they are – will have a substantial impact on OPEB expenses and liabilities.

One again, I'd like to express my appreciation to Demsey, Filliger & Associates as well as to all the contributors.

Joel Solomon

Protecting retiree health care benefits has become an increasingly important part of the work of public sector unions. The representatives of public employees have had to respond to a variety of new technical issues, but they have also had to confront growing media and political pressure focused on other postemployment benefits. Given the stakes—the maintenance of decent health benefits for hardworking school employees, police officers, fire fighters, and other public employees—developing a serious approach to Governmental Accounting Standards Board Statement 43 and Statement 45 is crucial for those most affected by the new standards. In this regard, well informed dialogue and debate are to be welcomed, and this collection of papers should help to move us in that direction.

It is important to recognize that divergent viewpoints on OPEB exist, even when we disagree with some of them. Looked at from school district to school district, we engage with some employers motivated by a desire to preserve the retiree health care benefits of California Teachers Association members, while others seem intent upon attempting to use the new GASB standards as a tool with which to wrest concessions. The successful effort in 2005 to protect the defined benefit pensions of California's public employees taught us many things, including that a serious treatment of a complicated subject with big numbers attached can prevail over the overheated rhetoric of those who, for ideological reasons, would do away with public employees' retirement benefits. The new accounting standards have opened the door to renewed attacks on public employees' retirement benefits, and serious dialogue on the subject of OPEB provides a welcome opportunity. CTA and NEA are pleased to be able to contribute to that process.

Marcia Fritz and Jon Coupal

First we want to commend *Lou Filliger* for compiling these timely papers on government accounting for OPEB expenses. They present thought provoking perspectives that are likely to evolve in the months ahead as public awareness builds and solutions are proposed. The actuarial and joint powers information will be useful for non-financial professionals who are trying to understand the issue and potential solutions for GASB 45 implementation.

Everyone agrees that GASB 45 does not itself require pre-funding or modification of retiree health care benefits. Yet, based upon everyone's reactions, the new requirement to disclose the total costs of public employee retirement benefits will prompt a vigorous discussion about how to control long term costs. *Geoffrey Kischuk* said it best, "Implementation of GASB 43/45 will trigger difficult decisions for many stakeholders on whether and how to change their OPEB plans."

Labor representatives *Martin Hittelman* and *Joel Solomon* are the only ones to disagree about the importance of prepayment and adopting less costly benefits packages. Mr. Hittelman tries to argue that large unfunded liabilities are "not a real problem" and "not, in the short run, a real debt." Mr. Solomon cautions us that "Blanket statements about the negative impact of unfunded retiree health care benefits can lead to an exaggerated sense of urgency to deal with liabilities and a harmful impulse to cut or eliminate benefits."

These positions echo those of other labor representatives who try to divert attention from the magnitude of unfunded liabilities for pension and retiree health programs by practically endorsing Ponzi accounting principles ("We are still sending out checks, so what is the problem?"). Although living paycheck-to-paycheck may be an all-too-common practice for private individuals, government agencies responsible for keeping decades-old promises made on behalf of taxpayers must back those promises up with adequate assets. As Mr. Kischuk tells us, following this fiscally responsible practice is important enough to be included in the academic accreditation process and *Russ Bigler* clearly states the obvious "I believe it is fiscally prudent and strongly advisable for a District to pre-fund its OPEB liability." I am sure they would also agree that labor costs should be fully paid in the year they are incurred.

The union officials also decry the growing political pressure to hold government leaders accountable for the benefits packages provided to public employees. Mr. Hittelman urges Boards of Trustees not to "buckle under" "public outcries" and to explain away unfunded liabilities as a mere "home mortgage." Yet unlike a home mortgage where payments are made to own a valuable asset, paying the unfunded liabilities for public employee retirement benefits is like making payments for a car that is no longer running. The value has been consumed, but some of the expenses remain.

California Foundation for Fiscal Responsibility does not fault employees for accepting the generous benefits offered by their employers. Nor does CFFR fault union leaders for negotiating the best possible deal from public employers. Our economic system is built upon self-interest and labor organizations should not be criticized for pursuing theirs. Indeed, they have successfully maximized the employees' self-interest at the expense of other programs and taxpayers.

CFFR's focus is exclusively on establishing a public employee retirement package that is fair to employees, employers and taxpayers. During the past decade, many public officials have proven unable to find that package that fairly balances the interests of employees, employers and

taxpayers. Our call for raising the retirement age for new, non-safety public employees to 65 establishes an outer bound for public generosity. There is simply no defensible reason why clerks, diesel mechanics, cooks and middle managers working for public agencies should retire 10 years earlier than their private sector counterparts.

Actuarial analysis shows eliminating retiree health benefits before age 65 saves about one third of total retiree health care costs. Establishing a 65 year retirement age for new non safety employees saves about 60 percent on pension costs. These savings could be used to reduce the large unfunded liabilities threatening many retirement systems and to provide additional resources for important education, health care, transportation and public safety needs.

CFFR does not expect unions to compromise their fiduciary duties to get the best available benefits for their members. We believe in limiting the retirement benefits government officials can offer, especially when their full costs are not known when granted and are often pushed onto future budgets. Any additional compensation needed to attract and retain employees should come from transparent salaries which do not extend beyond the period in which services are provided.

As for using single payer health care as a way to avoid paying the full cost of public retiree health care, our host Mr. Filliger said it best, “A free lunch is being promised that, if consumed, is guaranteed to cause financial and societal indigestion for many, many years to come.”

Let us start the process of restoring fiscal health to California’s government agencies and school districts by establishing a uniform 65 year retirement age for all new, non-safety government employees. Waiting for the elusive free lunch of single payer health care will only make matters worse.

Conclusion - Lou Filliger

This concludes the first edition of DF&A's GASB 45 White Paper. We will encourage other responsible viewpoints for future discussions of this nature. The selection of participants was intended to get as broad a cross-section of viewpoints as possible. When we first conceptualized this White Paper we hoped to have several other viewpoints represented (for example, representatives of the bond market), but we found numerous people/organizations unable or unwilling to go on record. Perhaps only an actuary would complain that a 70+ page document was too short.

We congratulate those of you who made the commitment to say what you believe. As to Mr. Kischuk's comment about my restraint, there is nothing that William Wallace, Adam Smith and Milton Friedman (among others) haven't already said that I could hope to say any better. I would like to add, however, that I went back and checked the Lewin report on SB 840 and the "11%" Mr. Hittelman and I both make repeated reference to is actually 11.95%. One arrow shot into the blue is pretty much as good as the next, I suppose.

I'd like to close with the words of Teddy Roosevelt (who, I hasten to point out, probably never intended them for so dry a topic as an accounting standard):

"It is not the critic who counts: not the man who points out how the strong man stumbles or where the doer of deeds could have done better. The credit belongs to the man who is actually in the arena, whose face is marred by dust and sweat and blood, who strives valiantly, who errs and comes up short again and again, because there is no effort without error or shortcoming, but who knows the great enthusiasms, the great devotions, who spends himself for a worthy cause; who, at the best, knows, in the end, the triumph of high achievement, and who, at the worst, if he fails, at least he fails while daring greatly, so that his place shall never be with those cold and timid souls who knew neither victory nor defeat."

"Citizenship in a Republic,"
Speech at the Sorbonne, Paris, April 23, 1910

DF&A would like to thank all participants in the GASB 45 White Paper, including those we haven't met yet. Questions or comments may be directed to Lou Filliger, FSA, at lfilliger@demseyfilliger.com. The Glossary of Acronyms begins on the following page.

Glossary of Acronyms Used in the GASB 45 White Paper

AAL – Actuarial Accrued Liability (AAL) represents the total dollars needed as of the valuation date to fund all benefits earned in the past for current members. It is the portion of the actuarial present value attributable to service rendered as of the valuation date.

ACWA – The Association of California Water Agencies (ACWA) is the largest coalition of public water agencies in the country. Its nearly 450 public agency members collectively are responsible for 90% of the water delivered to cities, farms and businesses in California. ACWA has been a leader in California water issues since 1910. Its primary mission is to assist its members in promoting the development, management and reasonable beneficial use of water in an environmentally balanced manner.

AFT – The American Federation of Teachers was founded to represent the economic, social and professional interests of classroom teachers. It is an affiliated international union of the AFL-CIO. The AFT has been a staunch advocate of delaying the implementation of GASB 43/45 regulations until Congress investigates the impact of these changes on public employees. The AFT also has been advocating counting the full value of any prescription drug subsidy payment received from Medicare as a revenue offset against their OPEB liability.

ARC – The Annual Required Contributions (ARC) is the amount that an employer would contribute to a defined benefit OPEB plan. There is no requirement under GASB 43 or GASB 45 to actually contribute the ARC. The ARC is comprised of two components: (a) cost associated with service rendered during the year by the active members and (b) an amortization of any unfunded actuarial accrued liability (UAAL).

ASOP – An Actuarial Standard of Practice (ASOP) are a principles-based framework for actuaries when they perform their assignments. ASOPs are designed to offer guidance on relevant issues, recommended practices, documentation, and disclosure. ASOPs are written to reflect practices that are broadly accepted by qualified actuaries. ASOPs are not intended to shift the burden of proof or production in litigation, and failure to satisfy one or more provisions of an ASOP should not, in and of itself, be presumed to be malpractice.

ASOP 6 - Actuarial Standard of Practice #6 (ASOP 6) provides guidance to actuaries when measuring obligations under a retiree group benefits plan.

ASOP 27 - Actuarial Standard of Practice #27 (ASOP 27) provides guidance to actuaries economic assumptions – primarily investment return, discount rate, and compensation scale – for measuring obligations under defined benefit pension plans. ASOP 27 applies to GASB 43/45 in that since economic assumptions are affected by inflation, it is essential to make an assumption of the long-term inflation rate in order to set meaningful assumptions for other variables. ASOP 27 allows an actuary the use of “select and ultimate” medical trend rates for use in GASB 43/45 valuations.

ASOP 35 - Actuarial Standard of Practice #35 (ASOP 35) provides guidance to actuaries in selecting demographic and other noneconomic assumptions for measuring obligations under defined benefit pension plans.

CCLC – The Community College League of California (CCLC) is a non-profit organization whose voluntary membership consists of the 72 local community college districts in California. CCLC serves its constituency in six areas: education programs, research and policy analysis, fiscal services programs, governmental relations, communications, and governance of athletics

CDE – The California Department of Education (CDE) is a California agency that oversees the state's diverse and public dynamic public school system. The Department oversees funding, testing, and holds local educational agencies accountable for student achievement.

CHCC - The California Health Care Coalition (CHCC) is a membership organization of employers, unions and health and welfare funds, representing 2 million Californians. Members of the Coalition seek to reduce health costs and improve quality without degrading benefits. The CHCC seeks working partnerships with accountable, high value providers and health plans. CHCC's goal is to raise performance at the hospital and physician level so that California families and communities have timely access to medical care that is appropriate, evidence-based, patient-centered, prevention-oriented, efficiently delivered, and fairly priced.

CFT – The California Federation of Teachers (CFT) is the California affiliate of the American Federation of Teachers (AFT). The CFT is composed of 135 local unions chartered by the AFT. The CFT represents over 120,000 educational employees working at every level of the education system in California, from Head Start to the University of California. CFT was founded to provide a labor union alternative to the California Teachers Association, which was then dominated by school administrators. The CFT spoke for classroom teachers during a long period when California's teachers worked in near-feudal conditions.

COLA – A Cost-of-living adjustment (COLA) is an increase of a monthly annuity amount based on a rate of inflation which is typically measured by the Consumer Price Index (CPI). The COLA is intended to protect an annuity's purchasing power.

COPs – Certificates of Participation (COP) assists school districts, county offices of education and community college districts in their efforts to raise funds for real property acquisitions and capital improvements. A COP program allows districts to finance capital projects or refinance existing lease obligations without voter approval. The California School Boards Association (CSBA) Finance Corporation assists school districts with the issuance of COPs.

CSEA – The California State Education Association (CSEA) began in 1927 when a group of Oakland school custodians set out to secure retirement benefits. Today, CSEA represents nearly 220,000 workers, making it the largest classified school employee union in the nation. CSEA pursues the interests of California's classified employees, transforming non-certificated, "support staff" into classified professionals and respected partners in the education community.

CTA – California Teachers Association (CTA) is California's largest professional employee organization, representing more than 340,000 public school teachers, counselors, psychologists, librarians and other non-supervisory, certificated personnel. It is affiliated with the 2.8 million-member National Education Association.

CVT – California’s Valued Trust (CVT) is the former Central Valley Trust. The Trust was formed through a combined effort of District Superintendents and labor representatives of the CTA and CSEA. The purpose of the Trust is to pool the resources of smaller school districts to achieve health care benefits similar to those available to larger districts. The Trust provides health, dental, vision and life benefits. Benefits, other than life, are self-funded, and are paid out of the assets of the trust.

DC – A Defined Contribution (DC) pension or OPEB plan having terms that (a) provide an individual account for each plan member and (b) specify *how contributions to an active plan member’s account are to be determined*, rather than the income or other benefits the member or his beneficiaries are to receive at or after separation from employment. Those benefits will depend *only* on the amounts contributed to the member’s account, earnings on investments of those contributions, and forfeitures of contributions made for other members that may be allocated to the member’s account. At or after separation from employment, the balance of the account may be used by the member or on the member’s behalf for the purchase of health insurance or other healthcare benefits.

DTC – Direct to consumer marketing (DTC) of prescription drugs began in the early 1980’s. The Food and Drug Administration imposed a moratorium on this marketing strategy in 1983, then lifted it in 1985. Since then the industry has devoted increasing resources to this strategy. Direct to consumer marketing of prescription drugs is seen as beneficial and also leading to an increase in the demand for prescription drugs.

EBRI – The mission of the Employee Benefit Research Institute (EBRI) is to contribute to, encourage, and enhance the development of sound employee benefit programs and sound public policy through objective research and education. EBRI is a unique organization. It is dedicated to undertaking research in order to provide objective, unbiased information on employee benefits, so that decisions may be based on verifiable facts. EBRI lets the facts tell the story. EBRI functions in an objective and unbiased manner and not as an advocate. EBRI has been the most relied upon source for the annual publication of summary census data on health care coverage and the uninsured, turned into consumable form.

FASB - Financial Accounting Standards Board (FASB) is a private, not-for-profit organization whose primary purpose is to develop generally accepted accounting principles in the United States. The Securities and Exchange Commission designated the FASB as the organization responsible for setting accounting standards for public companies in the U.S. The FASB is in the middle of a convergence project with the International Accounting Standards Board to make it easier for companies to prepare financial statements, US and international business.

GASB – The Governmental Accounting Standards Board (GASB) is currently the source of generally accepted accounting principles (GAAP) used by state and local governments in the United States. The GASB is subject to oversight by the Financial Accounting Foundation (FAF), which selects the members of the GASB and also FASB and funds both organizations. The mission of the Governmental Accounting Standards Board is to establish and improve standards of state and local governmental accounting and financial reporting that will result in useful information for users of financial reports and guide and educate the public, including issuers, auditors, and users of those financial reports.

GASB 43 – Governmental Accounting Standards Board Statement Number 43 (GASB 43) sets accounting standards for retiree healthcare plans, if the plans are pre-funded. GASB 43 requires the accrual of liabilities of other postemployment benefits (OPEB) generally over the working career of plan members rather than on a pay-as-you-go basis which is the current practice for most government sponsored plans. It is analogous to GASB 25 for defined benefit plans of public employers.

GASB 45 – Governmental Accounting Standards Board Statement Number 45 (GASB 45) establishes guidelines for how public employers should report the costs of employer provided retiree healthcare benefits. GASB 45 introduces accrual accounting for these benefits rather than pay-as-you-go accounting. No new costs for benefit coverage are created by GASB 45. It is analogous to GASB 27 for defined benefit plans of public employers.

HMO – A Health Maintenance Organization (HMO) is a type of managed care organization. Unlike traditional indemnity insurance, care provided in an HMO generally follows a set of care guidelines provided through the HMOs network of providers. Under this model, providers contract with an HMO to receive more patients and in return usually agree to provide services at a discount. This arrangement allows the HMO to charge a lower monthly premium provided that its members are willing to abide by the additional restrictions.

Most HMOs require members to select a primary care physician (PCP), a doctor who acts as a “gatekeeper” to medical services. HMOs often shift some financial risk to providers through a system called capitation, where certain providers (usually PCPs) receive a fixed payment per member per month and in return provide certain services for free. Under this arrangement, the provider does not have the incentive to provide unnecessary care, as he will not receive any additional payment for the care. Some plans offer a bonus to providers whose care meets a predetermined level of quality.

JAMA – The Journal of the American Medical Association (JAMA) is an international peer-reviewed general medical journal, published 48 times per year by the American Medical Association. Its official name is now JAMA and it is referred to by this name in reference lists. JAMA is the most widely circulated medical journal in the world. Founded in 1883 and published continuously since then, JAMA publishes original research, reviews, commentaries, editorials, essays, medical news, correspondence, and ancillary content. JAMA’s objective is to promote the science and art of medicine and the betterment of the public health.

JMT – A Jointly Managed Trust (JMT) is a Voluntary Employees’ Beneficiary Association (VEBA) described in IRS Code Section 501(c) (9). A Board of Trustees, including teacher representatives, contract with various health care providers, govern a trust and design health care plans to best meet the needs of your members. Through this joint effort, benefit costs may be lower, new benefit ideas can be explored, and problems that arise can be dealt with immediately.

JPA – Joint Powers Authority (JPA) refers to an act in the mid 1970’s of the California Legislature that amended the Government Code to add the ability for two or more public agencies to join together to provide more effective or efficient government services or to solve a service delivery problem. JPAs were needed since private insurance companies were unwilling or very reluctant to provide insurance products to public agencies. The JPAs being referred to in this white paper are risk management JPAs. These risk-management JPAs pool their assets to provide

medical, prescription drug, behavioral health, dental, and vision benefits for California school districts.

LACCD – The Los Angeles Community College District (LACCD) serves Los Angeles and some of its neighboring cities. The Los Angeles Community College District is the largest community college district in the United States and is one of the largest in the world.

LAIF – The Local Agency Investment Fund (LAIF), is a voluntary program created by statute. LAIF began in 1977 as an investment alternative for California's local governments and special districts. The enabling legislation for the LAIF is Section 16429.1 et seq. of the California Government Code. This program offers local agencies the opportunity to participate in a major portfolio, which invests hundreds of millions of dollars, using the investment expertise of the Treasurer's Office investment staff at no additional cost to the taxpayer. The funds deposited with LAIF are protected from default in an analogous manner to separate accounts held by insurance companies.

LAUSD – The Los Angeles Unified School District (LAUSD) is the largest (in terms of number of students) public school system in California and the second-largest in the United States.

MOU – A Memorandum of Understanding (MOU) is a legal document describing a bilateral agreement between parties. It expresses a convergence of will between the parties, indicating an intended common line of action, rather than a legal commitment. It is a more formal alternative to a gentlemen's agreement, but generally lacks the binding power of a contract.

NEA – The National Education Association (NEA) is the largest labor union in the United States representing many of the country's teachers along with other school personnel. Traditionally a professional organization, it is not a member of the AFL-CIO unlike its smaller rival the American Federation of Teachers. The NEA has opposed measures such as merit pay, school vouchers, reforms to teacher tenure, curriculum reform, the No Child Left Behind law, and many accountability reforms. Critics note that in general, the NEA opposes any measure which distinguishes between bad and good teachers, makes bad teachers easier to fire, or increases competition.

OPEB – Other postemployment benefits (OPEB) are addressed under GASB 43 and GASB 45. OPEB refers to postemployment benefits other than pension benefits and includes (a) postemployment healthcare benefits and (b) other types of postemployment benefits (for example, life insurance), if provided separately from a pension plan. Like pension, OPEB arises from an exchange of salaries and benefits for employee services rendered and constitutes part of the compensation for those services.

PEMHCA – Public Employees' Medical and Hospital Care Act (PEMHCA) directs the administration of the CalPERS Health Program. It is part of the California Government Code, starting at Section 22751. CALPERS recently filed for approval that would allow PEMHCA employers to prefund their retiree health care unfunded liabilities through CalPERS.

PERS (CalPERS) – The California Public Employees' Retirement System (CalPERS) provides pension fund, healthcare and other retirement services for approximately 1.5 million California public employees. It is the largest pension fund in the United States. CalPERS provides benefits to all state government employees and, by contract, to local agency and school employees. Being

one of the largest pension funds in the world (and the third largest purchaser of employee health benefits in the nation), CalPERS has attempted to use this power to change the way certain things are done in business.

OTC – Over-the-counter (OTC) drugs do not require a prescription for their use. As a general rule, over the counter drugs are used to treat conditions not necessarily requiring a doctor's care and will have been proven to meet higher safety standards for self-medication by patients. Often a lower dosage of a drug will be approved for OTC use.

PPO – A Preferred Provider Organization (PPO) is a managed care organization who has covenanted with an insurer or a third-party administrator to provide healthcare at reduced rates to the insurer's or administrator's clients. The providers will provide the insured members of the group a substantial discount below their regularly-charged rates. Preferred provider organizations themselves earn money by charging an access fee to the insurance company for the use of their network. They negotiate with providers to set fee schedules, and handle disputes between insurers and providers. PPOs can also contract with one another to strengthen their position in certain geographic areas without forming new relationships directly with providers. The rise of PPOs was credited by some with a reduction in the rate of medical inflation in the 1990's. However, as most providers have become members of most of the major preferred provider organizations sponsored by major insurers and administrators, the competitive advantages outlined above have largely been reduced or almost entirely eliminated.

SFAS 106 - The Statement of Financial Accounting Standards #106 established accounting standards for employers' accounting for postretirement benefits other than pensions (hereinafter referred to as postretirement benefits). Although it applies to all forms of postretirement benefits, this Statement focused principally on postretirement health care benefits. It significantly changed the prevalent current practice of accounting for postretirement benefits on a pay-as-you-go (cash) basis by requiring accrual, during the years that the employee renders the necessary service, of the expected cost of providing those benefits to an employee and the employee's beneficiaries and covered dependents. It is the private sector's accounting standard similar to GASB 43/45. (One sentence)

SISC – Self Insured Schools of California (SISC) is a Joint Powers Agreement administered by the Kern County Superintendent of Schools Office. SISC is not-for-profit. SISC's purpose is to pool the resources of smaller school districts to achieve health care benefits similar to those available to larger districts. SISC has developed its own GASB 45 compliance program called SISC GASB 45 TRUST. The SISC GASB 45 Trust is a tax-exempt governmental trust established under Internal Revenue Code Section 115, and an irrevocable trust under applicable law of the State of California. By adopting an irrevocable trust, districts will greatly reduce the audit disclosures required by GASB 43/45.

SB 840 – Senate Bill 840 (SB 840), the California Health Insurance Reliability Act, would have established a single-payer health insurance system for California. A new government-administered system would have replaced all private health insurers and existing government insurance programs, including Medicare. An elected Health Insurance Commissioner would oversee all aspects of the new system, including contracts with health care providers, the allocation of health care workforce and capital equipment, and the introduction of new technologies. All residents of California—defined as those with a physical presence in the state with intent to reside—would

have automatically been covered under the system. The benefit package would have been very comprehensive. Governor Arnold Schwarzenegger vetoed the bill in September 2006. It is being introduced in a revised version for the 2007 legislative session.

STRS (CalSTRS) – The California State Teachers’ Retirement System (CalSTRS) is the second largest public pension plan and the largest teachers’ retirement fund in the United States... CalSTRS’ primary responsibility is to provide retirement related benefits and services to teachers in public schools from kindergarten through community college. The three basic benefits provided by CalSTRS are service retirement, survivor and disability benefits.

TRANS – Tax and Revenue Anticipation Notes (TRANS) are short-term debt instruments issued by school district and other agencies to create additional cash reserves. These cash reserves act as a cushion to the general fund in the event that school districts experience temporary cash flow needs. These cash flow needs may occur as a result of the timing mismatch between the receipt of revenues (property taxes) and payments to staff and vendors. The California School Boards Association (CSBA) Finance Corporation assists school district with the issuance of TRANS.

UAAL – The Unfunded Accrued Actuarial Liability (UAAL) represents the difference between the total dollars needed as of the valuation date to fund all benefits earned in the past for current members and the actual assets on the valuation date.

USDE – The United States Department of Education (USDE) was created in 1980 by combining offices from several federal agencies. The USDE is a Cabinet-level department of the United States government. The primary function of the United States Department of Education is to formulate federal funding programs involving education and to enforce federal educational laws involved with privacy and civil rights. The elevation of the Department to cabinet status was controversial. President Reagan sought to eliminate it as a cabinet post but did not go through with the threat. Under President George W. Bush, the Department has primarily focused on elementary and secondary education through its focus on the No Child Left Behind law.

WASC –The Western Association of Schools and Colleges (WASC) is one of six regional associations that accredit public and private schools, colleges, and universities in the United States. California is part of this region. WASC looks to see whether “*When making short-range financial plans, the institution considers its long-range financial priorities to assure financial stability. The institution clearly identifies and plans for payment of liabilities and future obligations.*” WASC may pursue colleges in districts which have not pre-funded retiree health benefits in accordance with GASB 45 based actuarial studies. WASC has not been averse to challenging colleges for other than academic programs and services to students.