

GASB Update for State and Local Leaders

Joel Solomon, Senior Policy Analyst at the National Education Association, opened the meeting and offered an overview of the issues. In 2004, the Governmental Accounting Standards Board (GASB) established new rules related to accounting and reporting for state and local government “other postemployment benefits” (OPEB). These are benefits, other than pension benefits, that are paid after an employee leaves employment. Retiree health care benefits are, by far, the largest component of OPEB.

The GASB rules require OPEB costs and liabilities to be actuarially determined and reported in a government’s annual financial report. While the rules do not require OPEB benefits to be prefunded, there are certain advantages for doing so, including the use of a more favorable interest rate for discounting plan liabilities. Moreover, if OPEB costs and liabilities are not managed, the credit rating agencies may downgrade the government’s credit quality.

The disclosure of OPEB costs and liabilities under the GASB’s new rules have led many state and local governments to begin renegotiating retiree health care benefits. The purpose of the GASB Update conference was to review the OPEB challenges facing labor leaders and to discuss what labor organizations are doing to meet the challenges.

Session 1: Health and OPEB Funding Survey

Paul Zorn, Director of Governmental Research at the benefit consulting firm of Gabriel, Roeder, Smith & Company (GRS), presented results from the 2009 Health and OPEB Funding Strategies survey of approximately 1,500 local governments across the U.S. The study was conducted by Cobalt Community Research and sponsored by the National Conference on Public Employee Retirement Systems (NCPERS), the International Foundation of Employee Benefit Plans (IFEBP) and others. Key findings include:

- The economic downturn is affecting local government revenues and employment expectations. Almost half of the survey respondents expect revenues to decline in the coming year and 21% expect a decrease in the number of local government employees, partly due to downsizing.
- Over three-quarters of the respondents provide health care benefits for active employees. Of these, two-thirds pay at least 80% of the premiums. Generally small governments (those with populations of 5,000 or less) are less likely to provide health care benefits for active employees than larger governments.
- Less than a one-third of the respondents provide health care benefits to retirees. Generally governments serving larger populations are more likely to provide retiree health care. Of governments providing retiree health care, one-third pay at least 80% of the premium and another third pay none of the premium, with the rest paying some amount in between. For half of the respondents that provided retiree health care, retirees paid the same premium as active employees.
- Most (81%) of the respondent governments providing retiree health care are aware of the GASB requirements to measure and report their OPEB costs and liabilities. Of these, two-thirds report having calculated their OPEB liabilities or that the calculation is in progress. Of the governments

that have completed their OPEB valuations, 40% plan to fully or partially prefund their liabilities, while the rest plan to continue the pay-as-you-go approach.

- With regard to strategies for managing health care costs, in the past most respondents have done so by increasing deductibles and co-pays, increasing the employees' share of the premiums, implementing wellness programs, expanding the use of generic drugs, negotiating costs with carriers, and educating participants to make better health care decisions.
- With regard to strategies for managing OPEB costs in the future, Mr. Zorn suggested additional efforts were needed to better understand the best methods for managing health care costs and establishing OPEB trusts.

Session 2: Case Study – Statewide Plan

Marianne Steger, Director of Health Care and Public Policy at AFSCME's Ohio Council 8 (AFL-CIO), presented a case study related to preserving retiree health care benefits for public employees in Ohio. Key aspects of her talk include:

- As a result of concerns about likely reductions in health care benefits for active members and retirees, the unions representing employees covered by the Ohio Public Employees Retirement System (OPERS), established a coalition to examine pension and health care issues. The coalition included union members elected to serve on the OPERS board, as well as union staff with responsibility for health care, pensions, and communications.
- After the OPERS coalition was established, other coalitions of Ohio public employees also formed and eventually grew into the Ohio Retiree Health Care Coalition (ORHCC). ORHCC's goals include: (1) exploring policies to provide affordable retiree health care; (2) reducing retiree health care cost trends through creativity and collaboration; (3) working to shape national health care policy; (4) providing education, best practices, and practical solutions; and (5) seeking consensus around policy recommendations.
- To address the health care issues, OPERS established a Health Care Workgroup. Although the unions were first skeptical about whether the process could work, both OPERS and the unions committed significant time and resources to the project. An important first step was to develop a set of guiding principles, which served as the cornerstone for fostering cooperation during the negotiation process and helped to shape the final outcome. As adopted by the Health Care Workgroup, these guiding principles include:
 1. Preserving access to quality health care for all eligible members and dependents;
 2. Committing to a long-term solvency period;
 3. Balancing health care changes between current and future retirees;
 4. Considering career services, membership status, and affordability in setting health care premiums;
 5. Balancing OPERS responsibilities with personal accountability and consumerism to preserve benefits for the long-term;

6. Managing the program using sound business practices consistent with industry norms and marketplace developments;
 7. Reviewing annual program adjustments to keep pace with increasing health care and pharmacy cost trends, which allow for a phased-in approach to benefit changes;
 8. Supporting health and disease management activities that assist benefit recipients and hold vendors accountable for results;
 9. Pursuing health care public policy changes and related advocacy activities;
 10. Maintaining affordability of health care through multiple plan designs while maximizing group purchasing power; and
 11. Educating and communicating with all interested parties as early as possible and on an ongoing basis regarding all aspects of the health care program.
- While there was agreement that enrollees needed to have “skin in the game,” the unions were opposed to major cost-shifting, especially if other avenues of cost reduction had not been pursued. In addition, the unions felt that the real solution would come as a result of working on more global issues, including: (1) using the large purchasing power of all the Ohio pension systems to demand the best price and practices for members; and (2) working at the national level to unite all public pension systems to work on meaningful health care reform.
 - As a result of these efforts, OPERS increased its solvency period to 27 years. One key to success was that OPERS was committed to working on global issues, and not simply cost shifting. OPERS actively pursued vendor negotiations and collaboration with other Ohio public pension systems. Another key to success was the unions’ commitment to understanding the issues and communicating the related tradeoffs to their members.
 - Among the lessons learned: (1) get into the nuts and bolts and understand solvency periods, health care benefit design, and legal rights; (2) make use your experts; (3) communicate with you members before, during, and after negotiations; (4) know what your options are; and (5) continue to work with coalitions.
 - While OPERS initially increased its solvency period, the subsequent decline in the financial markets erased much of these gains. However, collaboration on managing the benefits continues.

Session 3: Case Study – Public Safety

Greg Beasley, President of the Chesterfield Professional Firefighters Association (IAFF Local 2803) presented a case study of how the implementation of GASB 45 has affected public employees in Chesterfield County, Virginia.

- Chesterfield County is located in central Virginia, and is the fourth largest county. It has a population of 306,000, with a median household income of about \$69,400, the highest in the region. The County employs a total of 4,500 full-time and part-time employees (not counting school employees). The County holds a triple-A bond rating, which County officials are proud of.

Virginia has “right-to-work” laws. The County also reserves the right to modify or eliminate retiree health benefits at any time.

- Prior to July 1, 2006, if an employee retired from Chesterfield County, and met the eligibility requirements of the Virginia Retirement System (VRS), the County would continue to pay the retiree’s portion of medical insurance premiums. However, for people retiring on or after July 1, 2006, the County has changed the health care benefit promise. These changes can be grouped into three major categories: (1) grandfathered benefit; (2) capped benefit; and (3) access benefits.
- **Grandfathered Benefit:** Employees whose combined age and service total at least 60 years as of July 1, 2007, (including at least 10 consecutive years) will be grandfathered into the earlier health care plan and see only slight benefit changes. However, as this was originally proposed, no breaks in service were allowed. Later, this change was amended to allow employees with a break in service before July 1, 2006 to receive credit for all County service before and after the break. As a result, more employees were eligible for the grandfathered benefit.
- **Capped Benefit:** The capped benefit sets County contributions for retiree health care premiums based on years of service with the County, using the following scale:
 - \$0/month for employees with less than 14 years of service;
 - \$154/month for 15-19 years of service;
 - \$232/month for 20-24 years of service; and
 - \$309/month for 25+ years of service (with all amounts increased 3% annually).
- Under the capped benefit as originally proposed, non-grandfathered employees would receive retiree health care benefits only if they retired at age 55 or later, with at least 15 years of service. This was a big problem for public safety employees, who generally retire at age 50. The County’s public safety employees worked together to change this provision. As amended, non-grandfathered employees can receive the capped benefits if they are eligible for full VRS retirement before age 55. Once they turn 55, they are eligible to receive \$300/month, increased 3% annually for inflation.
- **Access Benefits:** For employees hired, rehired, or reinstated after an absence of more than 30 days on or after July 1, 2006, and who retire at age 55 or more with 15 or more years of service, the County allows them to purchase retiree health care benefits for themselves and their dependants at the County group rate, but without a County contribution toward the premium.

Other related issues addressed by IAFF Local 2803 include:

- For years County employees have been paid less than other workers in the region. The Local has worked hard with the County Board of Supervisors to address pay issues and, prior to the economic downturn, the Board had begun to implement pay improvements. However, as a result of the downturn, both pay and benefits are being cut.
- However, Local members have become more involved and have a better understanding of what can be accomplished politically. As a result, 4 of the 5 candidates endorsed by the Local were elected to the County Board of Supervisors. Consequently, the County Board is more willing to work with the Local on its issues, including pay, benefits, fire apparatus, and fire stations.

Session 4: Education

Julie Washington, Elementary Vice President of United Teachers Los Angeles (UTLA), discussed the activities of the Health and Benefits Committee (HBC) and the agreement entered into by the HBC and the Los Angeles Unified School Districts (the District).

- Recent efforts to significantly reduce or eliminate health care have prompted Los Angeles teachers and other employees to become more active in protecting their benefits. As a result, the unions and other associations representing the District's employees formed the Health and Benefits Committee (HBC). This in turn, led to an agreement between the District and the HBC regarding health care financing and management.
- The agreement covers calendar years 2009 through 2011. It preserves lifetime benefits for new employees, but changes the eligibility requirements. It also increases the role and accountability of the HBC, and commits the unions and associations to participating in the HBC until Jan. 1 2012.
- The agreement caps the District's health care contribution per participant to specific amounts for active members and retirees, adjusted annually (increasing about 3.5% in 2010 and 3.4% in 2011). If actual costs are less than the District's contributions, the excess is carried over into the next year (essentially offsetting participant's costs). If actual costs exceed the District's contributions, they are deducted from the District's contributions in the next year. This approach helps the District manage GASB OPEB liabilities by putting a cap on District contributions for health care costs tied to changes in the number of participants and a predictable rate of health care cost increases.
- In return, HBC must present the District with an annual Health Care Plan that does not exceed the District's projected contributions. The HBC is also responsible for plan design changes, negotiations with health care providers, and communicating plan design changes to members.
- If the HBC does not submit the plan by the annual deadline (August 1), then dispute resolution procedures are followed. There are three basic circumstances that would trigger dispute resolution procedures: (1) if there is disagreement about projected costs and if the plan will fall within the projected district contribution; (2) if the district claims that a planned change is illegal; and (3) if the district claims that a planned change is inequitable or would have an adverse impact.
- As noted above, the agreement preserves lifetime benefits for new employees, but changes the eligibility requirements. Effective for employees hired on or after April 1, 2009, to be eligible for retiree health care a member must have a minimum of 25 years of consecutive service and the sum of age and service must equal 85. However, breaks in service do not include authorized leave (e.g., for illness, industrial injury, pregnancy, family care, etc.)
- There is also an opt-out option for employees who can obtain health care benefits through their spouse. Active District employees who opt-out receive payments of \$3,000 annually.

Session 5: Strategy Session

Chick Steinberg, Senior Vice President at Aon Consulting, presented a number of issues to consider in negotiating OPEB liabilities. Highlights of his presentation include:

- Although GASB doesn't obligate employers to fund OPEB benefits, it does require them to report the OPEB costs and liabilities. However, a lack of funding will eventually lead to ratings downgrades for employers, making it more difficult for them to fund the liabilities.
- Getting an early start on funding has several advantages. If the OPEB plan is funded and the monies are held in trust, a higher discount rate can be used, thus lowering the liabilities. Funding will also help employers maintain their credit ratings.
- If the health care problem isn't addressed now, it will need to be addressed in the future. However, if labor makes concessions related to benefit changes or cost shifting, they should get something in return, such as an agreement from the employer to fund the OPEB plan.
- Funding doesn't have to be an all or nothing proposition. While funding the annual required contribution (ARC) is the ultimate goal, any funding above the pay-as-you-go amount is helpful. Funding can also be done using a scaled approach, with contributions increasing annually as allowed by General Fund revenue growth.
- It's important to understand the OPEB valuation and the reasonableness of the assumptions, including: projected health care cost trends, wage increases, and expected investment returns. For example, a large Northeastern school district had an OPEB valuation done that estimated a large annual required contribution. Subsequent review of the valuation found flaws in several assumptions, which, when corrected lowered contributions. The union and the district reached a compromise to split the contribution 50/50. The union also agreed to a higher deductible in return for the district's cash contributions to an OPEB trust.
- In addition, understanding needs and establishing guidelines can lead to improved negotiations. For example, a Midwestern county had an initial OPEB liability of \$369 million. In negotiations, certain guidelines were established related to initial needs, due diligence, and mutual oversight. Negotiations lead to benefit concessions in exchange for OPEB funding. Ultimately, the OPEB liability was reduced to \$225 million.
- Public sector entities are currently making or contemplating major changes to plan benefits in an effort to reduce the government's expenses, including: increasing employee premiums and co-pays; eliminating or reducing spousal or dependent coverage; and capping employer contributions or establishing defined contribution health care plans. If such concessions are negotiated, they should come with firm commitments.