

# Retiree Health Care



## A Cost Containment How-To Guide

September 2016



City Managers Department - OPEB Task Force

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## INTRODUCTION

Providing a safe, healthy, clean community for our residents to thrive is one of the most important duties of local government. Cities hold responsibility for the welfare of their residents and the hardworking public servants who choose a life of service. There is a growing realization that the promises of the past, made to now retired or soon to retire workers, are financially unsustainable. Cities are seeing once manageable costs for pensions and retiree health care programs grow much faster than revenues. Increasing post-employment costs are crowding out the provision of services to our communities.

Recognizing the increasing role of retiree health benefit programs in the deterioration of municipal finances, the League of California Cities City Manager's Department established a task force of city management and League staff. The charge of this task force is to assess the problem, educate member cities, and develop

strategies to address retiree health benefits also known as Other Post-Employment Benefits (OPEB).

This How-To Guide is intended to give an overview of strategies for addressing Retiree Health Care. It is not an exhaustive education in actuarial terms and methods. For more information on these topics consult with your actuary and refer to your periodic valuation report.

This How-To Guide presents the issue, describes problems with the current situation, suggests funding strategies, and offers cost containment methods. We recognize each city's unique circumstances inform the best mix of funding and cost containment strategies. This guide offers a variety of approaches in the hopes that communities wishing to address this growing problem may find their own blend of solutions.

## HEALTH BENEFITS FOR RETIRED EMPLOYEES

### ***Origins, Federal Health Care Reform, and California Law***

Many cities provide health benefits to retired employees; many do not. These benefits are usually, although not always, documented in labor agreements with employee bargaining units. In some cases, city council resolutions, ordinances, or charter provisions are the genesis of the benefits. Federal law requires cities to provide health benefits for active employees, however the Affordable Care Act does not mandate that cities provide health coverage to retired employees or their dependents. State law requires retiree medical only for cities using CalPERS as their employee medical benefit plan provider. These cities are required by the Public Employees' Medical & Hospital Care Act

(PEMHCA) to provide a minimum benefit for retired employees.

### ***Benefits Covered***

Cities vary in types of post-retirement benefits provided to retirees. These may include funding for retiree medical insurance, dental insurance, vision insurance, life insurance, retiree health savings accounts, or merely access to a city's group health insurance plan without a city financial contribution. These collectively are referred to as retiree health care or retiree health benefits. Bundled together they are often called Other Post-Employment Benefits (OPEB). The "Other" refers to benefits other than pensions.

### ***Contributions for Retiree Health Premiums***

Cities vary in amounts contributed to retiree

health benefits. Some cities vary their contributions by bargaining group, years of service, or Medicare enrollment/eligibility. Most cities require retirees to pay a portion of the medical premiums. PEMHCA cities incur minimum retiree health care premium contribution requirements. Establishing a cafeteria plan may increase flexibility within PEMHCA, although the requirements are complex.<sup>1</sup> Leaving CalPERS medical removes the PEMHCA requirements for minimum retiree medical contributions and thus increases flexibility for a city when dealing with retiree medical.

***Benefits Paid as Costs Incurred***

Until recently cities typically put aside little to no money to pay for future costs of retiree health care. The overwhelming majority of cities paid the cost of retiree health benefits on a pay-as-you-go basis along with employee medical benefits. This contrasts with the money cities set aside with CalPERS to fund pensions as those benefits were earned by employees.

***Pay-as-You-Go Costs Growing Significantly***

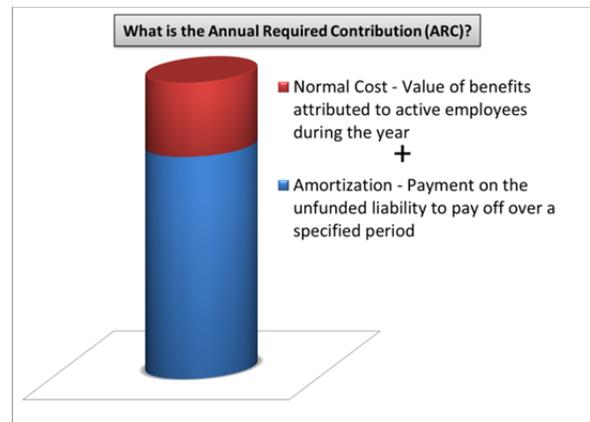
Because of rapidly rising medical costs, increases in longevity post-retirement, and the growing number of retirees receiving benefits, retiree health costs increased significantly over the last decade. For example, between 2001 and 2014, the California state government’s annual cost for retiree medical tripled from \$500 million to \$1.5 billion. Similar data for cities is not readily available as cities were not required to account separately for their retiree health costs until implementation of Governmental Accounting Standards Board Statement 45 (GASB 45)<sup>2</sup> in 2007.

<sup>1</sup> See [PEMHCA Retiree Health Rules, Bartel Associates, LLC, June 2015](#)

<sup>2</sup> GASB is the organization that sets standards for city financial reporting. Statement 45 required actuarial valuations of retiree health benefits and provided

***Prefunding Retiree Health Care Costs***

Upon receipt of GASB 45 mandated actuarial valuations of cities’ retiree health programs, cities began to realize the magnitude of program costs. This information, combined with projections of future cost growth, led some cities to begin prefunding retiree health care costs. The GASB 45 valuation reports generated a so-called “Annual Required Contribution” (ARC). Despite its name, the contribution is not required. However it does serve as a benchmark to help cities determine a prudent annual funding amount comprised of the benefits earned by employees in that year plus the amortization of the past benefit costs earned but not funded. Fully funding the ARC is a good goal for cities and some cities started funding their ARC or some portion of it.



***Are Retiree Health Benefits Guaranteed?***<sup>3</sup>

This is an evolving area of law and each city’s benefit structure is uniquely different. Cities should consult with their city attorney prior to making changes to retiree benefit programs. In some cases, retirement benefits are obligations protected under state and federal contract law. There is arguably some ambiguity as to whether retiree health benefits offered by cities are contractual obligations of this type and if so, the extent to which these benefits are protected from

guidance on the accounting of liabilities on financial statements.

<sup>3</sup> See [Inviolable—or Not, January 2016](#)

modifications. To the extent these benefits are guaranteed contractual obligations, a city’s ability to modify the benefit for current retirees is likely constrained. For existing employees—essentially future retirees—with benefits provided via a memorandum of understanding (MOU), those MOUs can be modified through the labor negotiation process. Subject to certain minimum benefit requirements of PEMHCA

cities, cities and bargaining groups can collectively modify retiree health benefits of current and future employees. Cities are advised that state law (Gov’t Code 7507) sets forth a pre-adoption process for any post employment benefit changes. The process includes holding a public meeting two weeks prior to adoption with an actuary providing a statement of future costs.

## PROBLEMS WITH STATUS QUO

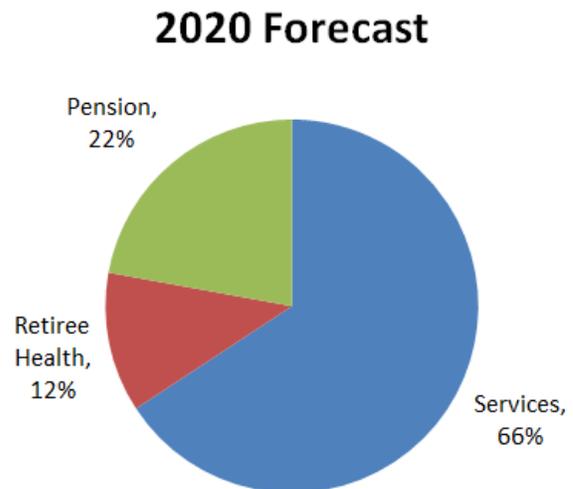
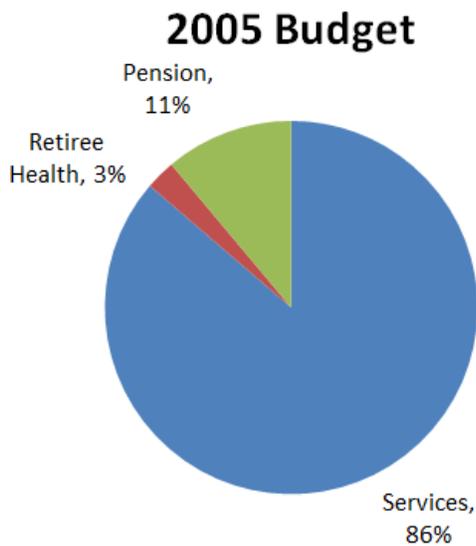
### *Retiree Costs Supplanting Basic Services*

Costs for pension and retiree health care benefits are growing much faster than monies received from taxes, fees, and other revenue. In a balanced budget, if some costs grow faster than revenues, then other costs must be reduced. “Crowd-out” is the term given to this condition. As a result of crowd-out, core services—police, fire, libraries, parks, building and street maintenance—are being reduced. In December 2014, local government staffing levels remained eight percent lower than they were prerecession in December 2007. By contrast, private sector jobs were up 2.4 percent.<sup>4</sup> This crowd-out condition suppresses local government salaries, restricts staffing possibilities and therefore limits

program and policy development and sustainability. Municipal infrastructure—buildings, streets, amenities—are particularly hard hit by the fiscal strains caused by rapidly increasing retiree costs. The charts below show one (non-PEMHCA) city’s experience with retiree costs crowding out services. They’ve gone from paying 14% of budget on post-retirement benefits to a forecasted 36% without reform. This means fewer officers on the streets, reduced service hours, poorly maintained infrastructure, and reduced program offerings.

### *Unfunded Liability is Significant*

A 2007 survey of 1,200 agencies in California indicated an unfunded liability for retiree health



<sup>4</sup> See [California Crowd-out](#)

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of at least \$118 billion.<sup>5</sup> At that time, the cumulative liability for the 231 cities responding to the survey was \$8.8 billion. California cities responding to a 2016 League survey showed an unfunded liability of \$10.8 billion for 312 responding cities.

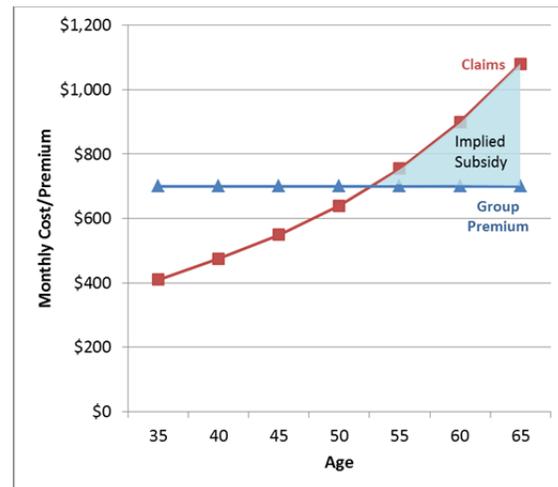
### *Situation Likely to Get Worse*

Baby Boomers are a very large cohort and they have or are reaching retirement. Many retired earlier than expected due to enhanced retirement formulas enacted by numerous cities. These recent retirees are expected to live longer than any prior generation. They are also accessing prescription benefits more than ever before. Medical costs, particularly prescriptions, are still increasing much faster than municipal revenues. CalPERS' pension costs are in the first year of a major ramp up period. Some cities will see 50% increases in pension costs by 2021. Now, in the sixth year of economic expansion, an economic slowdown in the next five years is a near certainty. Revenues will decline in the slowdown. These factors combine to create a very challenging fiscal period over the next five years for cities.

### *Actuarial Change Increases Unfunded Liability*

Each city is required by GASB to engage an actuary to value their retiree health benefit program periodically. The valuations include estimates of program costs attributed to retirees and employees. These valuations acknowledge that health care costs for active employees (statistically healthier than retirees) are much lower than health care costs for retirees. Some benefit programs, such as those established in PEMHCA cities, pool retirees and employees together for benefit premium determination. In these situations, the high cost of retirees results in higher premiums for employees than if they

were rated separately. This creates an active employee premium payment which subsidizes the costs for older retirees (called an implied subsidy). Recent changes to actuarial industry standard practices mean PEMHCA cities will see very significant increases to their implied subsidies on their next valuations resulting in an increase in unfunded liabilities and annual required contributions (ARC). This change does not require a cash contribution, yet it will impact the cities' perceived financial condition.



### *Accounting Change Puts Unfunded Liability on City Financials*

GASB 45 required cities to book the shortfall between their annual required contribution (ARC) and actual payments. For most cities this was a relatively small amount compared to the full unfunded liability. With the implementation of GASB 74 and 75 which replace GASB 45 (starting after 2017), cities will be required to book the full unfunded liability on the face of their financial statements. Because of this change, nearly every city with retiree medical benefits will see a significant reduction in their net position after 2017. In addition to affecting the public's perception of the financial condition of the city, this may negatively affect a city's ability to borrow funds. In addition you should expect the unfunded liability and, consequently, the impact on a City's net position will be volatile from one year to the next.

<sup>5</sup> See [Funding Pensions & Retiree Health Care for Public Employees](#)

## PREPARE FOR ACTION

### ***Educate Yourself About Your City's Situation***

While the fundamental nature of the problems facing cities are similar, each city's particular pattern of benefits, history, employee makeup and other contributing factors is unique. Fortunately, periodic actuarial valuations provide a wealth of information about existing circumstances. Take the time to fully understand your city's valuation and then endeavor to educate the city council, department managers, and city staff on your particular circumstances. This educational process should be embraced as ongoing—one that is never complete. Regular updates to city officials and key staff are imperative in the educational process.

### ***Commit to Solving the Problem***

Addressing rapidly growing retiree health care costs is not an easy undertaking. It will require resolve, commitment, time, energy and money. City leaders must commit to dedicating resources to address these problems before positive changes can occur.

### ***Take a Portfolio Approach***

Just as it makes sense to diversify investments, it makes sense to employ multiple methods to address retiree health care. Cities successfully addressing retiree health issues do so using a number of strategies that adjust over time to meet the needs of the organization. Use of carefully planned strategies early on in the process opens up doors to other strategies later on. Be open to adjusting your approach as circumstances change and evolve around you with the passage of time.

### ***Form Your Team***

Retiree health care is a complex and highly nuanced subject. There are legal implications for most actions and legal counsel with expertise

in employee relations and retiree health benefits is key to the successful implementation of your plan. Actuaries value historic earned benefits and forecast future benefit costs. They are critical to understanding and implementing changes to retiree health benefits. Some non-PEMHCA cities include a health benefit broker on the team. Finally, city management, human resources, and finance staff provide the local, organization-specific knowledge needed to guide strategy.

### ***Learn From Others***

A number of cities blazed a path for others to follow. Methods to reduce retiree health care costs by half, or eliminate them entirely, have already been developed. Creative solutions come from fellow cities; their case studies are attached as an appendix for your reference. Consulting with your own employees and retirees to garner information and suggestions can lead to possible solutions not yet anticipated. The League of California Cities is another resource available to cities. The League created an Other Post Employment Benefit Task Force which is comprised of city managers and is designed to work specifically on this issue. The Task Force developed a survey, compiled information, and created reference documents, including this one, for your use.

### ***Define Success for Your Organization***

Each city's unique circumstances inform the goals for the community. For some, the goal may be to eliminate retiree medical and put the savings toward community programs. For another community, success might be to fund retiree health care ahead of anything else. It is important for each city to make a conscious decision about how to allocate resources while understanding the tradeoffs between retiree health benefits and other community needs.

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Some suggested goals include:

- Provide a diversity of services to the community
- Maintain financial sustainability
- Maintain service levels for future generations
- Annually fully fund retiree medical normal cost plus amortization of accrued liability

### ***Recognize Solutions are Subjective***

We present cost containment strategies. While these do reduce cities' costs, from a beneficiary perspective, some of these may be viewed negatively. However, municipal finance is a zero sum game. A reduction in one area results in increases in another. Some employees value salary more than benefits. Benefit reductions can free up funds for salary increases or other compensation changes.

### ***Understand the Relationship between Employee Medical Benefits and Retiree Medical Benefits***

The interrelationship between active employee medical benefits and retiree medical benefits varies depending on a city's unique circumstances. For instance, whether a city pays a fixed amount for employee premiums, or a percentage of premiums for employees, can affect retiree medical benefit costs. Also, if retirees and employees are pooled (as with PEMHCA cities), there are increased employee premium costs and lower retiree medical costs and a cross subsidization occurs. Use of cafeteria benefit plans affect retiree medical contributions for PEMHCA agencies. These are just a few examples of the interplay between employee and retiree benefits.

## FUNDING STRATEGIES – TRUST FUNDS

In addition to cost containment strategies presented later in this guide, there are methods available to decrease unfunded liability through increased funding. While increased funding may not be an option for every city, it is a very effective intermediate to long-term strategy to lower overall costs.

### ***Establish an OPEB Trust Fund***

OPEB stands for Other Post-Employment Benefits and is commonly used to refer to retiree health care programs. An OPEB trust fund is an irrevocable trust where contributions and earnings may only be withdrawn to pay for retiree health care costs. Establishing a trust is a relatively simple matter. See the box at the end of this section for more information.

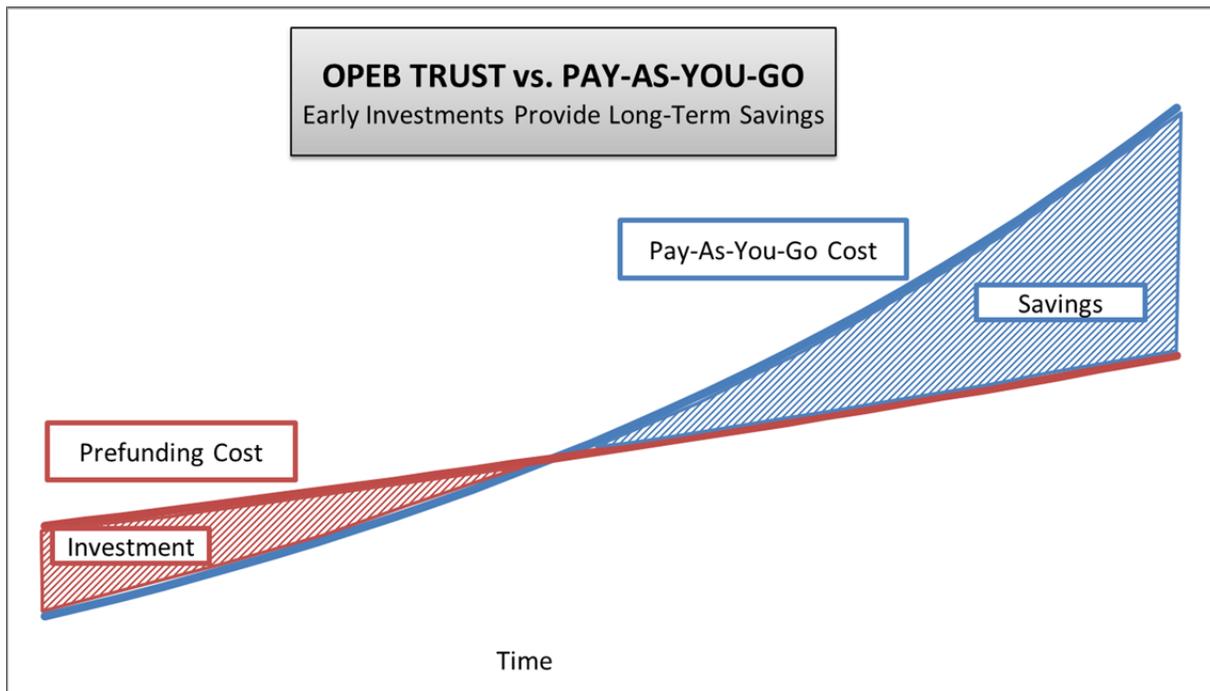
### ***Funding Plans Lower Future Costs***

Contributions placed in an OPEB trust fund grow at the rate of interest of the trust fund investments which is generally much higher than

a city's general fund investments. For example, OPEB trust funds expect a long-term rate of return in the range of 6.5%, compared to general fund long-term rates of return of 1 to 3%. This increased rate of return increases assets available to fund retiree health care. This can lower future costs as trust fund assets, instead of pay-as-you-go general fund payments, may be used to pay retiree medical premium contributions. Actuaries recognize this dynamic and adjust retiree medical valuations to account for the benefit of trust fund contributions, thereby lowering overall plan liability. See below for an example of the investment/savings dynamic.

### ***Trust Fund Use Growing Rapidly***

The California Employers' Retiree Benefit Trust (CERBT) managed by CalPERS, as of June 2015, had 474 agencies including 122 cities under contract for OPEB trust services. This increased fivefold over the last seven years. Another provider, PARS, contracts with over



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600 local agencies including at least 62 cities with OPEB trust funds.<sup>6</sup>

### ***Trust Funds Allow Greater Returns***

Municipal investing in California is governed by California law.<sup>7</sup> The law places a number of requirements on cities for reporting and investing. One of those restrictions is a maximum length of maturity for bond investments of five years. Post-retirement trust funds operate under different restrictions and are not subject to the five year maximum maturity. As a result, bonds with longer maturities are permitted in OPEB trust funds. Also, OPEB trust funds typically invest in private equities (usually through mutual funds). These two factors combine to offer much greater returns (and correspondingly greater risks) in OPEB trusts than in city treasuries or county investment pools. Typical municipal investing seeks to preserve capital and therefore tends to be conservative, achieving relatively low returns. Given the long-term nature of retiree health benefit programs investments may be optimized for each city. Early in the funding process when funding ratios are low, a city may seek greater capital appreciation. Later, when a city achieves significant trust fund balances it may transition to a capital preservation (lower

risk) investment approach. In the CERBT program, net contributions total \$3.44 billion while cumulative assets total \$4.49 billion. That means local government earned \$1.05 billion through the use of this particular OPEB trust fund program over the last seven years.

### ***Trust Fund Assets Grow Tax Free***

OPEB trust funds are sometimes referred to as Section 115 Trusts, a reference to Internal Revenue Service code permitting investments in such programs to be tax free. As long as contributions and withdrawals are managed in compliance with IRS requirements, the capital gains in the OPEB trust fund are not taxed, even though portfolios may include otherwise taxed investments like private equities.

### ***Trust Funds Lower Unfunded Liabilities***

Contributions placed in an OPEB trust fund lower a city's unfunded retiree health care liability. Trust fund assets directly offset retiree medical liability in actuarial valuations and on city financial statements. Funds held in general fund reserves, even if assigned to retiree health care, do not offset retiree health care unfunded liabilities for reporting purposes.

## **OPEB Trust Fund Implementation Steps**

- Step 1** Trust provider supplies sample resolution and staff report to adopt OPEB trust
- Step 2** City Council authorizes establishment of an OPEB Trust and appoints a Plan Administrator
- Step 3** Provider supplies legal documents for signature by Plan Administrator
- Step 4** Develop investment policy or select investment strategy
- Step 5** Develop policies and procedures for future contributions and/or disbursements
- Step 6** Communicate trust creation and contribution plan to actuary valuing retiree health plan
- Step 7** Annually review trust's investment performance

<sup>6</sup> Reference to these programs and their data is not an endorsement of these trust fund providers.

<sup>7</sup> Gov't Code Sections 16340, 16429, 53601, 53635, 53684. See [Local Agency Investment Guidelines](#).

***Trust Funds Allow Flexible Contributions***

Cities retain complete flexibility over whether and when to contribute to OPEB trust funds. Successful strategies often involve a number of the funding methods used in combination. Some cities adopt funding schedules where trust fund contributions increase on a schedule and ramp up to fully fund the actuarially determined recommended contribution. Others choose to

fund a percentage of the recommended contribution. Still others contribute a portion of excess year-end fund balance. Some send lump sum payments from reserves. The Government Finance Officers Association recommends cities do not issue OPEB bonds to prefund OPEB trust funds.<sup>8</sup>

## COST CONTAINMENT STRATEGIES – EMPLOYEES

Many cities provide no retirement health care benefit for their employees. It is in this context that these cost containment strategies are presented. Cities can generally change benefits for existing employees through the collective bargaining process. Each city’s situation is different and understanding whether the city has vested the benefit for any group of current employees or retired employees is a critical first step in understanding a city’s cost containment options. In some labor agreements, employees retire with a vested right to the benefits prescribed in their respective MOUs in effect when they retire.<sup>9</sup> This presents opportunities to modify benefits for both current and future employees. This section focuses on these bargained changes. The implementation of these strategies may require charter, resolution, ordinance, and MOU amendments in addition to the collective bargaining process. These require careful consideration from a legal, policy, and labor relations perspective. In addition, cities are advised that state law (Gov’t Code §7507) sets forth a pre-adoption process for any post employment benefit changes. The process includes holding a public meeting two weeks prior to adoption with an actuary providing a statement of future costs.

***Benefit Changes for Future Employees***

It is fairly common in labor relations to bargain reductions in benefits for future employees. This strategy is easy to implement. Because this strategy only addresses future employees it is only a very long-term strategy. Current employees with benefits and unaffected by this approach will take as long as 60 years to cycle through the system. Taking this type of action typically does not affect retention of existing employees. It is unlikely to affect recruitment of new employees as prospective employees rarely make employment decisions based on retiree medical benefits. This strategy has limited applicability to PEMCHA cities.

***Benefit Changes for Existing Employees***

This strategy can be effective in both the long to very long-term. Existing employees often number less than retired employees. Consequently, the majority of the accrued liability usually relates to already retired employees which limits the short-term effectiveness of this strategy. This can affect retention of existing employees, some of whom may be less mobile because they are approaching retirement and more highly value retiree health care benefits.

***Change Contributions to Fixed Amounts***

Some cities contribute a percentage of medical premium costs. When premium costs increase,

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<sup>8</sup> See [GFOA Advisory: OPEB Bonds, January 2016](#)

<sup>9</sup> Each city’s situation is different. Please consult legal counsel on your specific circumstances.

their contributions automatically increase. A cost control strategy is to move to a fixed contribution amount, say \$500 per month instead of 80% of monthly premium. This can greatly reduce unfunded liability and future costs provided there is no anticipation of future increases to the dollar cap.

### ***Limit Duration of Retiree Medical Benefit***

Some cities cover retirees only until age of Medicare eligibility. In this way, the retiree is covered for life, yet the city only pays for the time between retirement and Medicare eligibility. This can produce significant savings.

### ***Close the Benefit to New Employees***

This is a very effective long-term strategy. Depending on employee turnover rates, within about a decade, employees without the benefit can outnumber employees with retiree health benefits in some bargaining units. This dynamic opens up other benefit reduction possibilities through collective bargaining. This option (full elimination of benefit) is not available to PEMHCA cities because a minimum retiree medical contribution is required for all retirees.

### ***Adopt or Increase Vesting Requirements***

Most retiree health care programs include a requirement for employees to work a number of years before benefits vest. This is a very important component of controlling potential financial volatility. In organizations with no vesting requirement, employees can work one day and have a retiree health care benefit sometimes for life. There are cases of employees working only five years and collecting benefits for over 40 years. Vesting schedules vary—10, 15, 20, 25 or 30 years. However PEMHCA agencies should be careful about adopting the statutory vesting schedule (Gov't. Code §22893) as it might result in little savings and, perhaps, additional costs.

### ***Cover Only Retirees***

Covering medical expenses only for retirees is a possible plan adjustment worthy of consideration for most cities. Some cities' programs cover retirees and their dependents which drives up long-term health care costs. There are also cases of retirees remarrying and adopting children who are then added to the City's insurance. Another scenario involves surviving spouses of retirees who receive health benefits for decades following their spouse's death. Each city needs to decide what it believes is reasonable compensation for employees especially when considering the increasing financial burden created from escalating health care costs and long-term liability.

### ***Make City Insurance Secondary***

If retirees can access health insurance via a spouse, veterans program or other source, city insurance should be secondary and the other source used as primary. The effectiveness of this strategy depends on retiree access to other insurance.

### ***Eliminate Retiree Health Care<sup>10</sup>***

Many cities adopted retroactive pension enhancements. As a result, affected employees received significant increases in retirement benefits. For example, employees with a 2% at 55 pension formula that was enhanced to 2.7% at 55 received a 35% benefit increase. This more than covers the cost of medical premiums in retirement. There is a strong case to be made that paying for these retroactive pension increases eliminates a city's ability to pay for retiree medical benefits. Check your CalPERS unfunded liability – it very likely exceeds your retiree medical unfunded liability; before pension enhancement, it did not. This option is not available to PEMHCA cities because a minimum retiree medical contribution is required for all retirees.

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<sup>10</sup> See [The OPEB Off-Ramp, March 2016](#)

### ***Buy Down/Buy Out Benefits***

A handful of cities negotiated with employees to pay them a lump sum to reduce or eliminate their retiree health care benefit. This requires one-time, up front funding, but can yield future savings. Even if cities needed to borrow funds to effectuate this process, that would provide greater cost-certainty than the present system of unknown cost growth which is dependent on medical premium growth, demographic changes, etc. This is a complex strategy where consideration should be given to an employee's accrued benefit and years from retirement. This is to avoid negative selection—where employees very unlikely to retire from the city elect to be bought out at a high cost and others do not. A partial implementation of this strategy can be used alongside many of the benefit changes described in this section. Complete buyout is not available to PEMHCA cities.

### ***Adjust Health Care Plans***

Changing employee health care plans can affect current and future retiree medical costs, especially if retirees and employees are pooled for rating purposes. Also, depending on MOU language, changing health care plans to lower cost plans can positively impact employer contributions. This will not apply to PEMHCA cities, although cities can leave CalPERS medical and the PEMHCA restrictions.

### **League Health Benefits Marketplace (Exchange)**

A new OPEB liability and cost-reduction option now available to cities is participation in the League's Health Benefits Marketplace (HBM), a League-sponsored health insurance exchange in partnership with Connecture (for active employees) and Willis Towers Watson's One Exchange (for retirees). This new tool is a consumer-driven platform that gives options to active employees and retirees, letting them select the best coverage to meet their needs. Cities can choose from a variety of plan options from the best carriers in the state to offer their active employees, including HMO, PPO and consumer-directed plans. To reduce OPEB liabilities (along with implied subsidies to retirees), the HBM allows cities to transition their retirees to the individual market. The platform guides users through the process to select coverage that best suits their individual needs from more than 90 of the nation's leading health insurance carriers. Eligible retirees also are able to maximize their coverage under the federal Medicare program, helping lower costs for their former employer and themselves. For more information, go to: [www.cacities.org/HBM](http://www.cacities.org/HBM)

## COST CONTAINMENT STRATEGIES – RETIREES

Retirees do not collectively bargain so strategies for retirees are more limited than employees. The greatest short-term cost savings are derived from carefully administering retiree health care programs. Benefit reductions for retirees generate immediate pay-as-you-go savings, lower unfunded liability, and reduce future cost increases.

### ***Audit Retiree Medical Benefits***

Administering retiree medical can be simple (e.g. every retiree receives a fixed dollar amount) or complex (e.g. each retiree receives a different amount based on medical plan enrollment, MOU language at retirement, years of service, vesting, etc.) As with any complex program, periodic audits are necessary to ensure the benefit promised is administered correctly and only that benefit—not more. Through error,

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‘special deals,’ or other circumstances, contributions may be out of sync with enabling documents. A periodic audit is necessary to ensure compliance. During this audit, dependent status should be checked to ensure only covered persons are enrolled on health benefits. Questions related to other insurance (for example spouse’s) and if it can supplant city coverage are helpful.

### ***Enroll All Retirees in Medicare***

A very small number of retirees are ineligible for full Medicare coverage and must pay for Medicare Part A. In circumstances where cities promised to contribute a percentage of premiums, it may be more cost effective to pay for the retiree’s enrollment in Part A. Retirees over Medicare eligibility age but not enrolled are charged as much as \$1,500 per month for single coverage medical insurance premiums. If a city’s cost share is 80% of the premium, that far exceeds the \$226-441 per month for Medicare Part A.

### ***Utilize Federally Subsidized Prescription Plan for Medicare Retirees***

Some prescription plans for Medicare retirees includes federal subsidies as an offset to premiums. This can save about \$200 per month per retiree compared to plans without the federal subsidy.

### ***Buy Down/Buy Out Benefits***

It is possible to reach a negotiated agreement where a retiree waives their benefit or reduces their benefit in exchange for consideration paid by the city. Depending on individual circumstances (e.g. a relatively healthy retiree in need of funds more than medical insurance or a retiree who can access veterans’ benefits or spousal benefits) this may be an attractive option for certain retirees. This requires one-time up front funding, but can yield future savings. This is a complex strategy where consideration should be given to age and life expectancies of employees. A partial implementation of this strategy could be used to modify retiree benefits. Complete buyout is not available to PEMHCA cities.

## CONCLUSION

In order to meet the needs of the communities we serve, cities must account for both the current and long-term costs of benefits offered to the employees that provide those services. With increasing lifespans and rising healthcare costs, the magnitude of Other Post-Employment Benefits cannot be ignored.

The foregoing How-To Guide provides recommended strategies for addressing OPEB costs over time without hindering individual community choice.

Key recommendations include:

- Getting educated on the OPEB costs in your community;
- Prefunding future OPEB costs where appropriate; and
- Identifying potential solutions to lower OPEB costs through updated policies and labor relations strategies.

This guide offers a variety of approaches in the hopes that communities wishing to address this growing problem may find their own blend of solutions. For additional information, review the Resources links on the following page or contact the League of California Cities.

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# RESOURCES

1. [PEMHCA Retiree Health Rules, Bartel Associates, LLC, June 2015](#)
2. [The 2015-16 Budget: Health Benefits for Retired State Employees, Mac Taylor, Legislative Analyst, March 16, 2015](#)
3. [California Crowd-out: How Rising Retirement Benefit Costs Threaten Municipal Services, Stephen D. Eide, Civic Report No. 98, April 2015, Manhattan Institute](#)
4. [The Implied Subsidy and PEMHCA, Bartel Associates, LLC, June 2015](#)
5. [Local Agency Investment Guidelines, California Debt and Investment Advisory Commission, 2015](#)
6. [Reducing Unfunded Liabilities for Other Post-Employment Benefits, Nancy Kerry, Western City, May 2015](#)
7. [Funding Pensions & Retiree Health Care for Public Employees, A Report of the Public Employee Post-Employment Benefits Commission, California, 2007](#)
8. [Government Finance Officers Association \(GFOA\) Advisory: Other Postemployment Benefits \(OPEB\) Bonds, January 2016](#)
9. [Inviolable—or Not: The Legal Status of Retiree Medical Benefits for State and Local Employees, Amy B. Monahan, Manhattan Institute, March 31, 2016](#)
10. [The OPEB Off-Ramp: How to phase out State and Local Governments' Retiree Health Care Costs, Daniel DiSalvo & Stephen Eide, Manhattan Institute, March 2016](#)

# ACKNOWLEDGEMENTS

Cover Photo: Courtesy of 401(K) 2012 via Flickr from 401kcalculator.org

## APPENDIX A – CASE STUDIES

### **City of Rosemead Population 53,764**

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**With projected OPEB liability of over \$5.5 million, the City of Rosemead lowered their actuarial liability to \$2.6 million in one year by changing vesting options for retired employees and capping monthly premium payouts.**

In 2007, the City Council of the City of Rosemead started to consider enacting a program to reduce their actuarial liability of over \$5.5 million for retiree medical costs. The required Government Accounting Standards Board Statement 45, which took effect in the fiscal year 2007-2008, required Rosemead to report its unfunded liability. Consequently, the city was beginning to see a larger problem developing. The City of Rosemead is a fiscally conservative small city and with only 39 full-time employees and 14 retired participants and spouses in 2007, how could their other post-employment benefit costs be so high?

All former city employees and their dependents were given lifetime medical benefits, while active employees were provided full medical benefits at whichever CalPERS premium level they chose. The City of Rosemead was paying up to \$2,700 per month for medical, dental and vision plans for some active employees during their employment. Retirees were only offered medical care benefits but the city was still paying up to \$2,400 per month for their premiums. If an employee worked one year at the City of Rosemead, they were fully vested in their retirement medical benefits.

Something had to be done. The first step was to tier the system for existing and new hire employees of the city by changing the vesting options:

- Hired before July 1, 2007 and
  - Rosemead employee for 12-19 years - \$500/month/life.
  - Rosemead employee for 20+ years - \$1000/month/life.
  - Rosemead employee for less than 12 years – minimum amount mandated by CalPERS law (amount changes annually).
- Hired after July 1, 2007, they would receive no medical benefits during retirement.

However, cities that contract with CalPERS for medical care are required to provide a minimum mandated amount toward medical insurance for all retired employees so those hired after July 1, 2007 still receive the monthly mandated minimum. Every year this amount fluctuates depending on the Consumer Price Index and beginning in 2012 the monthly price is \$112. City Council has no plans to stop contracting with CalPERS for medical coverage

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A cafeteria medical benefits plan was offered to employees that included a \$1,600 per month medical stipend, regardless of the plan the employee chose. Many employees switched from the most expensive plan to a moderately priced plan and placed saved money in a deferred compensation account.

The City of Rosemead created an irrevocable trust that can only be used for medical benefit purposes. City Council acts as the trustees of that account, however the investment is held by a third party. Currently, Rosemead overfunds their liability into the irrevocable trust using reserve funds. The City has the intention of paying off the liability within five years of the initial date of the irrevocable trust.

Employees have expressed satisfaction with the new plan because of the medical benefit stipend. Even if the employee chooses the least expensive plan, that employee will still receive \$1,600 per month. Those with rich medical plans have reduced their coverage to a less expensive plan. The City of Rosemead still attracts talented employees to help build on the opportunities the city has created. Rosemead has saved money with this proactive initiative as the \$5.5 million liability was reduced to under \$2.6 million in 2008. For the 2011-2012 valuation, the liability is estimated at around \$3.4 million due to the anticipated decrease in the discount rate.

**City of San Luis Obispo  
Population: 45,119**

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**As the economic center of California’s Central Coast region, the City of San Luis Obispo employs over 500 city workers, most of whom are eligible for retiree medical benefits. The City is committed to providing employees a competitive benefits package while maintaining a fiscally responsible approach to budgeting.**

In 1993, the City of San Luis Obispo chose to join the CalPERS Health Benefit Program to provide employees with more plan options while reducing monthly insurance premiums. As the City had never contracted with CalPERS for medical insurance in the past, the amount the City contributed to retiree medical costs could be initially set at virtually any amount. In fact, the contributions started at \$1. The City of San Luis Obispo uses the unequal method of contribution for retiree medical care premiums and the contribution for retirees has increased from the initial \$1 to the current \$112 per month. The City’s OPEB liability therefore is relatively small; it is basically the minimum allowed under the CalPERS health program. Since 2008, San Luis Obispo has proactively budgeted for retiree medical health costs and as explained in more detail below, has taken steps which will help assure that costs in the future will be kept to a minimum.

In addition to the OPEB obligation arising from the City’s participation in CalPERS health, certain Department Heads that were appointed before August 2000 also receive a stipend that provides 50 percent of their retiree health insurance premiums, which can be used to provide coverage for the individual or family. Once that employee reaches the age of Medicare eligibility or dies, the contribution ends. While this has a fairly small OPEB liability associated with it, this program has since been eliminated from the Department Head compensation package and the associated liability will slowly disappear.

The 2007 Comprehensive Annual Financial Report reflected the use of the pay-as-you-go method but explained that in 2009, “pay-go” would no longer be the stand-alone way of funding the liability. As the City’s OPEB debt was certain to grow over time, the San Luis Obispo management recommended pre-funding the obligation through an irrevocable trust. A valuation determined that the effect of only paying the Annual Required Contribution (ARC) cost would be more expensive in the middle and long-term than if the city pre-funded the account because of the projected investment earnings. Because the “pay-go” system uses a lower discount rate, the higher rate of the chosen irrevocable trust aids the return on the investment and contributes more funds to cover the liability.

In order to pre-fund their OPEB liability of an estimated \$5.9 million in 2009, San Luis Obispo opted to contract with the California Employers’ Retiree Benefit Trust (CERBT) after requesting proposals for irrevocable trust and investment management services. San Luis Obispo

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has been able to decrease their liability from a 2009 valuation of \$5.9 million to \$4.2 million through the closed amortization process and pre-funding through CERBT. In fiscal year 2010-2011, the City fully funded their ARC of \$519,000 increasing the funded ratio of the accrued liability to 11.4 percent. In a time of budget cuts and service reductions, the San Luis Obispo City Council continues to prioritize this expenditure and commit to its funding as a means to achieving long-term fiscal sustainability.

In response to the relatively small employer contribution to retiree healthcare, in 2004, city employees that are members of the San Luis Obispo City Employees Association (SLOCEA) and the San Luis Obispo Management Group decided to initiate plans to form the San Luis Obispo Retirement Medical Trust (RMT). This trust is run independently of the City and a private third party administers the plan. Funds in the RMT are used on a pre-tax basis to pay for a retiree's medical expenses. The City of San Luis Obispo does not contribute funds to the RMT or pay any administrative costs, but does facilitate the transfer of money through payroll deductions. Recently, the Management Group decided to stop participating in the RMT due to changes in the economic climate and concerns about personal financial planning.

**City of Beverly Hills  
Population 34,658**

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**The City of Beverly Hills explored a new frontier in to manage OPEB liabilities. By effectively closing their unfunded liability gap through offering a second tier to new hires and providing cash Transition Amounts to employees in exchange for current and future retiree health care benefits, Beverly Hills significantly lowered their future financial risks and their unfunded liability.**

Nestled below the sunny slopes of the Santa Monica Mountains, the City of Beverly Hills is known more for luxury shopping than for expensive retiree medical benefits. However, recognizing the need for change, especially after a 2008-2009 actuarial valuation assessed the City's unfunded liability at around \$58 million, a team of finance, actuarial and legal professionals generated solutions to alleviate growing pension, current medical benefit and retiree medical expenses. Specifically, the voluntary employee retiree health payout option and the new employee second tier retiree program were designed to decrease OPEB costs without damaging relations with current and past employees. When presented to Beverly Hills City Council, the staff took extra precaution to explain the savings benefits over the long-term which would amount to approximately ten times the savings of a shorter term plan.

Several years earlier, the Beverly Hills' finance team noticed the significant liability the City was facing due to current health benefit levels, retiree medical benefits and current PERS retirement levels. They concentrated on a number of these areas to develop systemic changes in the benefits systems, and began to place money in a special fund to help fulfill the OPEB obligation. Over time, it became apparent the City would not be able to meet the annually growing OPEB of their large workforce with the "pay-as-you-go" system. With ten bargaining units, the retiree medical benefits varied from monthly cash payments for retiree medical to full two-party life coverage.

Two programs were designed to help lessen the unfunded and future liabilities. To begin with, all non-safety employees hired after January 1, 2010 were given defined contribution retiree health plans instead of the requisite defined benefit health plans, effectively closing their future liability cost risks except for CalPERS mandatory minimum payments (\$112 in 2012). The defined contribution plan the City developed offers employees portability so they are able to take their assets with them if they decide to separate from the city while eliminating OPEB liabilities for new hires. This program was also designed as a recruitment tool which helps younger employees in the first stage of their career feel free to explore new opportunities with the added security of medical retirement savings.

Next, Beverly Hills created the Alternative Retiree Medical Plan (ARMP), an entirely voluntary plan for non-safety employees. ARMP allowed current eligible employees to choose to receive an individualized Transition Amount (Cash) or keep their current defined benefit plan as

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outlined in the respective employee groups' Memorandums of Understanding. Each bargaining unit agreed to allow each individual to decide whether to take the program instead of bargaining collectively on behalf of their employees because ultimately it was an individual's choice to elect to participate in the program and the various employee associations' did not want to interfere in each member's financial decisions. As part of the ARMP Program, employees were sent individual letters outlining the specific amount they would receive under ARMP as calculated by an independent actuary. Since the City wanted as much participation as possible it opted to offer 100 percent of the present actuarial value of the employee's OPEB liability.

As part of the Program, the City put twenty percent of the individual employee's Transition Amount into an ICMA-RC health savings account while the remaining eighty percent was disbursed into cash, deferred compensation or a combination of both. An employee that chose the taxable cash amount, received cash, and had the option of an after-tax Roth contribution to their retirement savings account of up to \$15,600. Any deferred compensation could have been placed in a 457(b), 401(k) or 415(m) plan. Each employee was highly encouraged to discuss their decision with their own financial advisors in order to make the right individual choice. Several members of the Beverly Hills staff were also assigned to answer questions and make presentations regarding ARMP. However, no City staff member was allowed to give any financial advice.

Unfortunately, since Beverly Hills is contracted through CalPERS for medical benefits, the City will still have to pay the PEHMCA minimum amount even though the employee has received the cash equivalent of their full retirement benefit.

In order to fund the Transition Amounts, the City sold taxable municipal bonds. In total, \$20 million in taxable bonds were issued to the public. Beverly Hills considered different approaches to generating the cash flow needed for the ARMP including a line of credit and using reserves, however, in the end, by using municipal bonds it lowered the City's risks while still giving the City low annual payments. In total, over \$17 million was used in 2010 for the initial cash transition amounts. The remaining \$3 million dollars was set aside for future OPEB payments.

58 percent of non-safety workers volunteered to participate in ARMP which exceeded management's early estimate of 35 percent participation. The City of Beverly Hills held several educational workshops geared toward greater understanding of the ARMP because employee education was a key factor in the decision to accept the Program. So far, employees have been positive about ARMP and those who did not participate in the first round are eagerly hoping for a second offering, including public safety officers who were not offered the program the first round. The second tier retiree medical program and the ARMP reduced the City's unfunded liability by as much as \$20 million initially, with more expected over the next 20 years.