Health kicks

The US pension sector is having to cope not just with the increased cost of retirement provision but also the attendant healthcare obligations many schemes are under – liabilities that must now be accounted for upfront.

ANDREW SHEEN REPORTS

AS THE BABY boomer generation in the US hits retirement age over the next few years, stretched pension funds are going to be faced with the double whammy of generous promises for retiree benefits – studies show this generation will be the most dollar-rich generation of retirees in US history – and the costly burden of providing healthcare to millions.

With the attendant increases in longevity and rapid medical advances over the past few decades, these costs have risen dramatically, calling into question the long-term viability of the system. Many within the US pension industry now believe these cost increases to be both unsuitable and unsustainable.

Elizabeth Kellar, executive director at the Washington, DC-based Center for State and Local Government Excellence (SLGE), a research organisation that has worked extensively on the costs of public sector pensions and healthcare, says studies carried out by the organisation showed the total unfunded liability of healthcare obligations to be $558 billion (£338 billion).

"That's a significant piece of change – especially given the trend of funding healthcare obligations on a pay-as-you-go [PAYG] basis. But demographics are changing, meaning the PAYG system is not sustainable," she says.

These demographic shifts, which will see the total number of US workers aged 65 or over ballooning 84% from 38.8 million in 2005 to 71.1 million by 2030, according to a report co-authored by the World Economic Forum, the Organisation for Economic Co-operation and Development and consultancy firm Mercer, will place yet more pressure on a system struggling to cope.

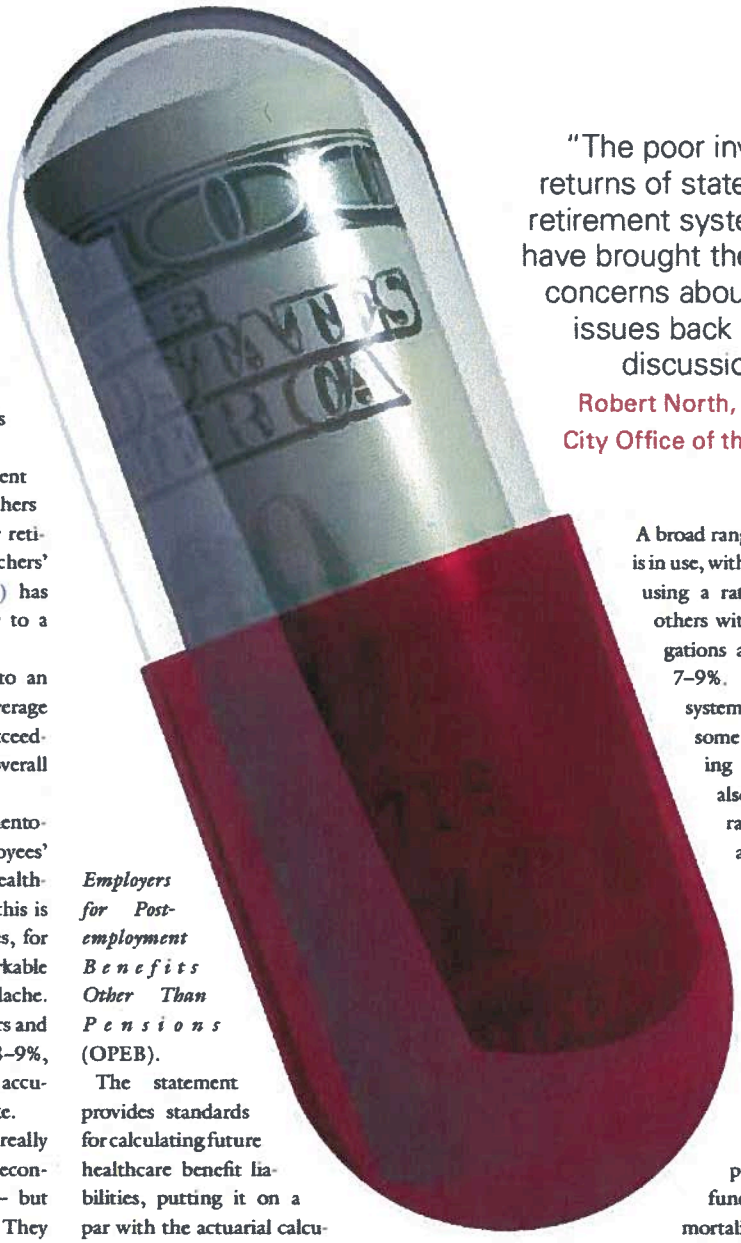
Robert North, chief actuary at the New York City Office of the Actuary, which oversees the actuarial requirements of the city's public pension funds, says the question of retirement benefits had come back with a vengeance, as many state and local government finances were focused on the short-term, immediate concerns of unbalanced budgets. As healthcare benefits are not guaranteed, unlike pension benefits, they are often seen as a way to reduce costs.

"The poor investment returns of state and local retirement systems of late have brought the long-term concerns about pension issues back into the discussions, including funding needs and possible benefit cuts, at least for new employees," he says.

Proof of North's observations comes from the governor of Ohio's proposals – later dropped – to cut more than $2.4 billion from the state budget, part of which would have been funded by reducing contributions to the $60 billion Ohio Public Employees' Retirement System from 14% to 8%. The scheme warned this would have led to severe cuts in healthcare benefits and the possible forced elimination of the programme within 10 years.

Likewise, data from SLGE shows 17 states have plans to limit future subsidies, three plan to eliminate subsidies altogether, while a further 16 are increasing the duration of service required to become vested in their healthcare programmes.

However, the fiscal constraints on many states and companies imposed by the economic crisis have only pushed the agenda forward, rather than causing new problems. Many funds were already looking at the issue, as rising costs make it increasingly difficult for schemes to honour their healthcare obligations.



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The issue of cost inflation has proven to be one of the most difficult aspects of healthcare provision for pension schemes and their sponsors to face up to, underpinning all attempts to rein in costs. Rises of 80–90% since the start of the decade are not uncommon, making it hard to come up with a workable model that is adequate over the long term.

An example of this is the predicament faced by the $23.4 billion Illinois Teachers Retirement System, where the cost per retiree of its externally managed Teachers' Retirement Insurance Program (Trip) has risen 82.3% since 2001, from $3,820 to a projected $6,963 in 2010.

The scheme is on course to run into an $81.3 million deficit in 2011, with average costs increasing 9.9% year-on-year, far exceeding the 5.4% projected growth in its overall funding for the programme.

Similarly, the $180 billion Sacramento-based California Public Employees' Retirement System has seen average healthcare costs rise 60% since 2003. While this is less of an issue for well-funded schemes, for many, coming up with accurate and workable projections is proving to be a major headache. While schemes can look ahead a few years and project healthcare inflation running at 8–9%, when it comes to longer-term forecasts, accurate predictions become difficult to make.

"Funds are saying [these costs] can't really go up too much more than the broader economy – assuming something like 5% – but that's an optimistic way of looking at it. They have to reset these assumptions every few years," says Derek Guyton, a partner with Mercer in Chicago.

The key issue facing schemes, however, is the actuarial recognition of these retirement healthcare liabilities, which has been a mandatory part of public sector pension scheme reporting since 2004, when the US Government Accounting Standards Board (GASB), which oversees public body accounting, introduced a measure known as Statement 45, *Accounting and Financial Reporting by Employers for Post-employment Benefits Other Than Pensions* (OPEB).

The statement provides standards for calculating future healthcare benefit liabilities, putting it on a par with the actuarial calculations used to project and discount pension benefit obligations.

While the full extent of these obligations as reported under Statement 45 is unknown, it is estimated they may surpass $1 trillion in present-value dollar terms. And although its use is mandatory for accounting purposes, funds are not obliged to make changes to their healthcare provisions or alter the basis of their funding. As a result, many schemes still operate their healthcare funds on a PAYG basis.

A broad range of discount rates is in use, with many PAYG funds using a rate of 4–5%, while others with pre-funded obligations are using a rate of 7–9%. Despite this, the system is open to abuse; some funds still operating PAYG systems are also using the higher rate, leading to a false and uneconomic view of the true liabilities.

The assumptions and techniques used to calculate the liabilities of healthcare funds are similar to those used by pensions, including fund population and mortality projections. But although improvements in longevity are being built into the assumptions and models, the effects of these increases remain a problem for many schemes to deal with.

"State and local governments are going through the process of making these calculations, but it is not quite as standardised as you might imagine," Kellar says.

Katie Kaufmanis, from the office of the executive director at the $30.7 billion Colorado Public Employees Retirement

Association (Copera) says the fund's Peracare retiree healthcare programme, established in 1985, a voluntary programme with a separate healthcare trust fund established to pay a set amount to offset the healthcare premiums for participants, funded by a 1.12% employer contribution.

At the end of 2008, the trust fund was a mere 17.7% funded, with a 39-year amortisation period, using a discount and investment return rate of 8.5%, in line with the main Copera fund.

Data provided by the fund showed the effects of a hypothetical half percentage-point move in the discount rate either way. If the discount rate fell to 8.0%, the solvency ratio of its healthcare fund would also fall to 17.9%, while a higher 9% discount rate would increase the coverage ratio to 19.5%. Although these were only indicative figures, they highlight the susceptibility of funding to market movements and actuarial whims.

Similarly, the $622 million Ohio State Highway Patrol Retirement System uses an 8% discount rate for its pension fund, while the healthcare fund uses a slightly lower 6.5% rate, due to the shorter investment period. While the main pension fund projects over a 30-year investment period, the healthcare fund is funded for about 17 years, partly due to the effects of Medicare (see box).

Despite this, the fund is invested in a broad range of assets, including an 8.6% allocation to hedge funds and a 10.2% allocation to private equity.

Richard Curtis, the fund's executive director and chief investment officer, says pre-funding the scheme removes some of the challenges, although costs are still an issue: "[The discount rate is] high because we invest it in a similar fashion as the main pension fund, and the scheme does not purchase medical coverage through a premium structure, it's self-funded. We hire claims administrators – they're paid a fee – and they're directly answerable to us. Those benefits come out of the healthcare pool of money held by the scheme."

Perhaps surprisingly, given the detailed assumptions used elsewhere, risk modelling techniques do not seem to be as complex as may be expected, with little or no emphasis on epidemiology. "It doesn't get down to that level [of looking at the risk factors and trends for individual diseases, such as heart disease and cancer]. We don't assume the risk profile will change that much, so there will be people with large claims, but that's offset by people with low claims," Guyton says.

Yet there is a debate within the industry as to the correct way to deal with the issue of setting discount rates and projecting inflation; it is thought many of the assumptions are not based on sound fundamentals. "They're saying we should set aside these assumptions that have no economic basis and come up with a better set of assumptions. But there's no defi-

The reform bill and Medicare

Although details of the contentious and highly ambitious US healthcare reform bill are unclear, it is evident any reform is likely to have far-reaching consequences for the provision of retiree healthcare benefits.

In his speech on September 9, President Obama said the US healthcare system placed an "unsustainable burden on taxpayers" and "skyrocketing" medical costs would eventually lead to the US spending more on Medicare and Medicaid than every other government programme combined.

At present, Medicare costs account for more than $500 billion of federal expenditure a year, which some have predicted to rise as employers 'wash their hands' of the situation and shift the burden of retiree medical costs to the government.

Michael Melbinger, a partner and chair of the employee benefits and executive compensation practice at law firm Winston & Strawn, says the reform bill, whatever form it takes, will have an effect. "Everyone who can get out of the retiree medical care business, will do. They'll shift that burden to the government. It should be obvious," he says.

Elizabeth Kellar, executive director at the Washington, DC-based Center for State and Local Government Excellence, says there have been cases where employers had shifted their retirees over to Medicare as soon as they were eligible at the age of 65.

She says that for many employers in physically demanding sectors, including steel and autoworkers, the police and fire service, where early retirees can be afflicted with poor health as a result of their work, effectively cutting off retirees after a certain age could deliver large healthcare savings.

"It's not a system-wide thing, but in one fell swoop you could remove a huge unfunded liability if you only fund early-retirees," Kellar says.

But Katie Kaufmanis, from the office of the executive director at the $30.7 billion Colorado Pubic Employees Retirement Association, says the bill is likely to have little effect on the actual benefits provided to retirees.

"In the past, when the federal government has passed healthcare-related legislation – such as Medicare Part D – Medicare Modernization, for example – the goal was to ensure that those who received healthcare-related services as a result of employment or former employment would not be left worse off than they were before. We anticipate that any legislation that is enacted would take that same approach."

Derek Guyton, a partner with consultancy Mercer in Chicago, also notes that Medicare actually helps employers: "Medicare dictates costs and helps to hold down cost inflation, so employers benefit from that."

nite opinion on this yet," Guyton says.

Part of the problem can be traced back to the relative lack of dynamism in the pension sector, with employers traditionally reluctant to move first unless others move as well. But it is becoming increasingly clear that employers will need to change their long-term assumptions at some point in the near future.

With the average cost of healthcare for retirees under 65 coming in at $13,296 a year, and slightly less for those over 65 because of the offsetting by Medicare, controlling costs is increasingly being seen as a key part of ensuring the long-term viability of healthcare plans, which many have seen as a ripe area for changes and efficiency gains.

One point of view sees the system as fundamentally flawed, with a greater emphasis on curing and treating and hospitals incentivised for contact with patients, rather than the prevention of illness and the promotion of wellness. "About five or six years ago, we decided to spend as much on wellness as we did on treating our members, with a lot of preventative-type services not [in other healthcare plans]," Curtis says.

By doing so, the Ohio State Highway Patrol Retirement System was able to reduce its healthcare costs from $10.5 million in 2007 to $8.5 million in 2008, although bringing pressure to bear on providers to discount their services and cutting waste also led to savings.

"We've cranked up the scrutiny of how healthcare providers 'pad' their bills. We review and dispute claims, for items such as excessive hospitalisations or use of radiography. We hold doctors and hospitals accountable for success, not just to pay them for what they've done," Curtis says.

Michael Melbinger, a partner and chair of the employee benefits and executive compensation practice at law firm Winston & Strawn says cutting costs for healthcare plans had been on the corporate agenda since the late '80s, "when they began to get out of hand", but current approaches did not completely resolve the problem, and instead just shifted the risk and costs to retirees.

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>
> **Michael Melbinger, Winston & Strawn**

Given the average cost for prescriptions of generic drugs is about $26, against $146 for brand name medication, simple measures, such as insisting on the use of generic drugs for treatments, could offer large savings. But this policing of the use of healthcare – making sure only those workers eligible for coverage get it and ensuring benefits were well co-ordinated with Medicare – should not be seen as a 'magic bullet' solution to the problem.

David Neikrug, chief executive officer of the Optimatum Group, which helps companies control their healthcare benefit costs, says there needed to be more accountability in the sector: "Nobody is talking about holding the vendors accountable for what they do. In any other job, we're all held accountable, but vendors in this case are not."

By doing so, companies could trim costs by a conservative 10–12% in the first year, and keep costs down by 5–7% in years after that.

"But it's a time-bomb – the older you get the more you need in terms of healthcare costs, and the numbers are getting even greater. A lot of businesses are getting out of this space as fast as they can. I don't think there's an employer today who, if given the option, wouldn't do that," he says.

One option has been to offload healthcare costs and risks through trusts or Voluntary Employee Benefit Associations (Vebas), such as the landmark deal signed between the 'New General Motors' and the United Auto Workers union (see *Life & Pensions*, June 2009, page 5) which saw the union take a 17.5% stake in the reformed company in the form of a Veba, although both GM and the UAW declined to comment for this article.

If a Veba, or its multi-employer equivalent, Multiple Employer Welfare Arrangements (Mewa), can be adequately pre-funded, as is thought to be the case with in the GM/UAW deal, the problem of onerous retiree healthcare benefits can be virtually eliminated. However, Melbinger says there is "an ongoing battle" with the government about limits imposed on vehicles for prefunding retiree benefits.

"Vebas used to be a very useful tool, but it's much less useful now because of the limits imposed on it. It would be the easiest thing in the world for Congress to relax Veba and Mewa rules to allow co-ops, and that would be highly beneficial for the industry, but they haven't, and I can't think of any reason why."

Elizabeth Kellar, Center for State and Local Government Excellence