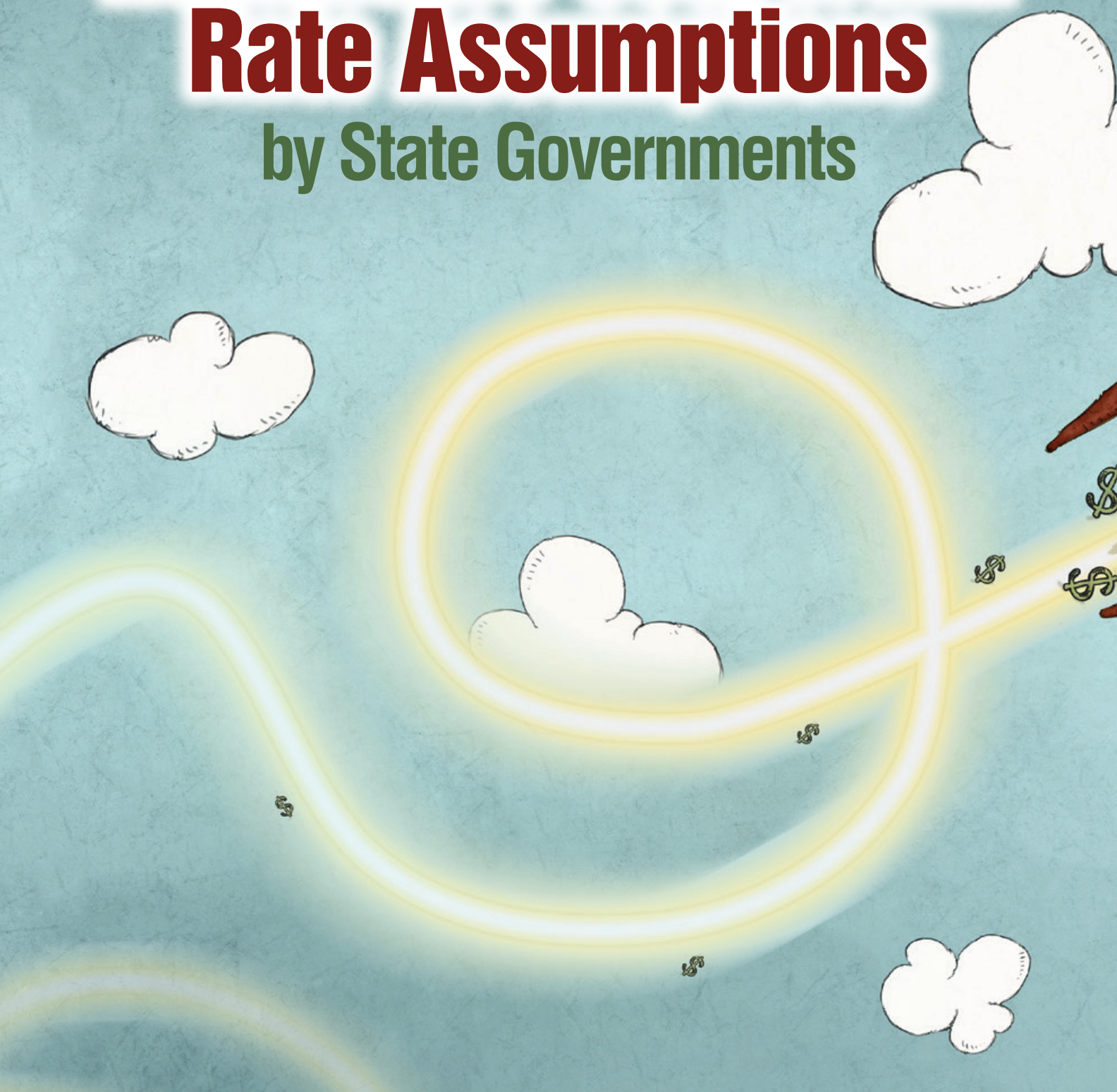


A Study of OPEB

Healthcare Cost Trend Rate Assumptions

by State Governments

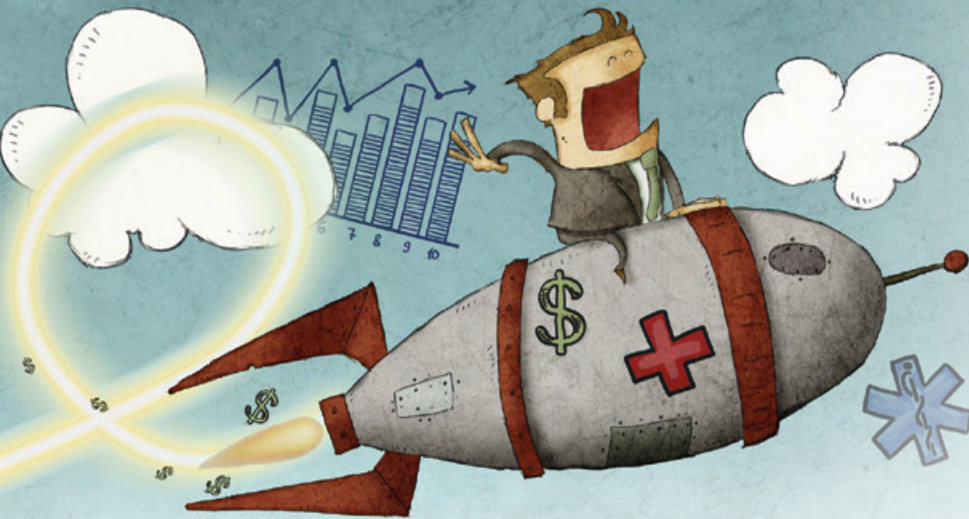




**By: Catherine Plante, Ph.D., CPA; and
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In the United States in 2010, the gap between the assets the 50 states had set aside for the payment of employee retirement benefits and the amount they actually owed was \$1.38 trillion dollars, 45 percent of which (\$627 billion) was related to retiree healthcare costs.¹ The promise made by the states to provide pension, health insurance, life insurance and other benefits to employees upon retirement is a form of deferred compensation. That is, for services rendered today, the government pays an employee a current salary, plus it promises to provide benefits upon the employee retiring. To the extent that the promise has not yet been fulfilled, the employer has a liability that must be disclosed in its financial statements.

The value of retirement benefit liabilities reported in a state government's financial statements is a function of many factors. Some of these factors, such as the mix or amount of retirement benefits promised, are under the control of the state (in conjunction with the employees). For example, some states may be more generous to employees with respect to the retirement benefits promised. Other factors, such as the demographics of the employee population are not as easily controlled by the state. Having an older or less-healthy workforce is not easily controlled. Other factors that impact the amount reported as a liability are the actuarial assumptions used by the individual state governments to determine the amount of liability



reported by the state. These assumptions are used to value the promises of tomorrow in today's dollars; thus, they influence the size of liability the state reports today.

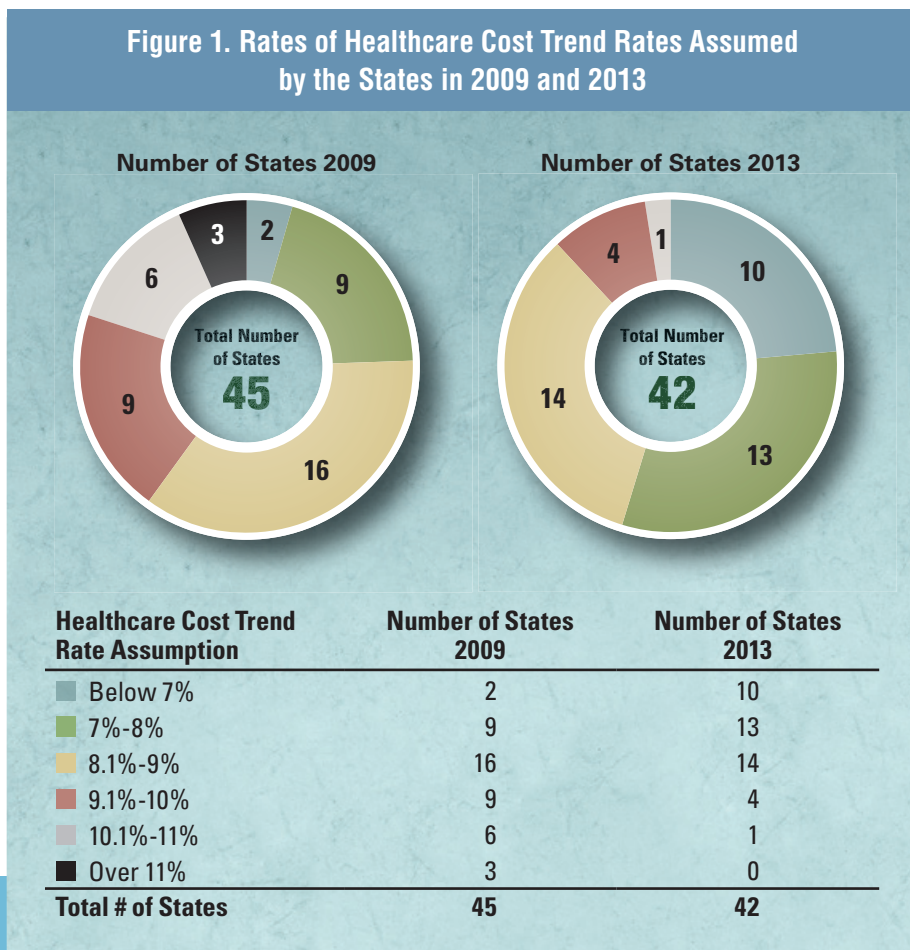
Actuarial assumptions used to determine pension liabilities have received a lot of attention in accounting literature. However, the actuarial assumptions related to non-pension retirement benefits — Other Post-Employment Benefits (OPEB) — have not received as much attention. OPEB may include health insurance, life insurance and legal fees, among others; but OPEB liabilities are dominated by the cost of providing health insurance to retirees. With over \$600 billion in OPEB liabilities, it is important to understand the actuarial assumptions used to determine the OPEB liabilities reported by the states.² There are a number of assumptions that impact the reported OPEB liability, however two assumptions are particularly important: the discount rate used to value future benefits at their present value and the healthcare cost trend rate. The healthcare cost trend rate (HCTR) is the “rate of change in per capita health claims costs over time as a result of factors such as medical inflation, utilization of healthcare services, plan design and technological developments.”³ A third assumption — rate of return on assets is important in determining pension liabilities, but is not as important in OPEB liability calculations because, relative to pensions, few states have set aside significant dollars to fund OPEB. As stated in the aforementioned Pew Report, only seven states have funded 25 percent or more of their current OPEB liabilities.

While the assumed rate-of-return on plan assets and the discount rate are important in calculating both pension and OPEB liabilities, the HCTR is unique to the calculation of OPEBs and is the focus of this study. Additionally, the HCTR is a ‘squishier’ number as it is harder to determine future healthcare costs. As the HCTR assumption used to calculate the OPEB liability increases, so does the size of the OPEB liability. Similarly, as the HCTR assumption

used to calculate the OPEB liability decreases, so does the size of the OPEB liability.

In a prior study, it was found that there was little variation in the return on plan assets and/or discount rates used by states to calculate their OPEB liability; however, there was a large variation in the HCTR assumptions utilized by the individual states in their financial statements.⁴ For example, in 2009, calculating a HCTR was a relatively new art. The Governmental Accounting Standards Board (GASB) Statement No. 45 was issued June 2004 with implementation required in three phases depending upon the government’s revenues. Since the 50 states are all large governments, their implementation date was for periods beginning after December 15, 2006. Typically, states have a June 30 year-end, so in this case, June 30, 2008 was their first reporting date. In 2009, there was a 7.6 percent range between the state with the highest HCTR (Idaho 13.6 percent) and the lowest (West Virginia 6 percent).⁵ The purpose of

Figure 1. Rates of Healthcare Cost Trend Rates Assumed by the States in 2009 and 2013



this study is to determine if the level and variation of the HCTR assumptions used by the states increased/decreased between 2009 and 2013. A small change in the HCTR has a large impact on the reported liability; therefore, examining trends in the HCTR assumption is important to understanding the OPEB liabilities being reported by the states.

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA) into law. The ACA is the first major reform to the U.S. healthcare system since Medicare and Medicaid were established by a 1965 amendment to the Social Security Act of 1935. The purpose of the ACA is to increase the quality and affordability of health insurance, reduce the number of uninsured people in the U.S., and to reduce the costs of healthcare for individuals and governments.⁶ The HCTR measures the states' estimates of future healthcare costs. If the states believe the increase in future healthcare costs will decrease (no matter if the cause is ACA or other-

wise), this belief will be reflected in their HCTR assumptions.⁷

Data and Analysis

We examined data from the 50 state's Comprehensive Annual Financial Reports (CAFRs) for fiscal year 2009 (pre-ACA) and 2013 (post-ACA). Not all States report their OPEB liabilities in their CAFRs. For example, in 2009, four states included their OPEB in separate trust accounts (Arizona, New Jersey, Oklahoma and South Carolina) and Nebraska did not have an OPEB liability. Therefore, for fiscal year 2009, HCTR assumptions are available from 45 states. For fiscal year 2013, HCTR data was available from 42 of the 45 states that had previously reported 2009 information (New Mexico had not filed its FY 2013 CAFR as of *Journal* publication; and both Nevada and West Virginia used separate trusts that don't require they report their assumptions in the state CAFRs). Therefore, HCTR assumptions are available for 42 states for both 2009

and 2013. **Figure 1** categorizes the HCTR assumptions used by the states in 2009 and 2013 respectively.

Figure 2 lists the states alphabetically along with their respective HCTRs for 2009 and 2013; it also lists the states by percentage-change in HCTR assumptions used in 2009 compared to 2013. Idaho shows the largest change from 13.6 percent in 2009 to 4.9 percent in 2013; five states show no change; and six states, used a higher HCTR assumption in 2013 than in 2009. Therefore, 31 of the 42 (74%) states included in this study are assuming healthcare inflation will be lower in the future when one compares the HCTR assumptions used in 2013 to those used in 2009, it is difficult to know exactly what caused this change. Potential explanations may include the notion that states are getting better at predicting future healthcare costs. This explanation would seem to be supported to some extent by the 'tightening-up' of the distribution of HCTR assumptions used in 2013 compared to

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Figure 2. Healthcare Cost Trend Rate Assumptions 2013 vs. 2009

| State | 2013 | 2009 | % Change | State | % Change |
|---------------------|--------------|---------------|---------------|----------------|---------------|
| Alabama | 10.50% | 12.00% | -1.50% | Idaho | -8.70% |
| Alaska | 9.00% | 8.00% | 1.00% | Ohio | -5.00% |
| Arkansas | 6.00% | 8.00% | -2.00% | Delaware | -4.75% |
| California | 9.00% | 9.00% | 0.00% | Pennsylvania | -3.80% |
| Colorado | 8.00% | 10.00% | -2.00% | Massachusetts | -3.50% |
| Connecticut | 7.00% | 9.00% | -2.00% | Kansas | -3.00% |
| Delaware | 4.25% | 9.00% | -4.75% | Mississippi | -3.00% |
| Florida | 7.40% | 9.60% | -2.20% | New Hampshire | -3.00% |
| Georgia | 8.00% | 9.25% | -1.25% | Rhode Island | -3.00% |
| Hawaii | 7.50% | 9.50% | -2.00% | Wisconsin | -2.38% |
| Idaho | 4.90% | 13.60% | -8.70% | Florida | -2.20% |
| Illinois | 8.50% | 9.00% | -0.50% | Minnesota | -2.17% |
| Indiana | 9.20% | 8.70% | 0.50% | Arkansas | -2.00% |
| Iowa | 8.40% | 8.10% | 0.30% | Colorado | -2.00% |
| Kansas | 7.00% | 10.00% | -3.00% | Hawaii | -2.00% |
| Kentucky | 8.50% | 10.50% | -2.00% | North Dakota | -2.00% |
| Louisiana | 8.00% | 9.00% | -1.00% | Wyoming | -2.00% |
| Maine | 8.00% | 8.00% | 0.00% | Connecticut | -2.00% |
| Maryland | 7.25% | 9.00% | -1.75% | Kentucky | -2.00% |
| Massachusetts | 7.00% | 10.50% | -3.50% | Maryland | -1.75% |
| Michigan | 9.00% | 9.00% | 0.00% | Tennessee | -1.75% |
| Minnesota | 6.80% | 8.97% | -2.17% | Vermont | -1.75% |
| Mississippi | 7.50% | 10.50% | -3.00% | Missouri | -1.60% |
| Missouri | 7.40% | 9.00% | -1.60% | Alabama | -1.50% |
| Montana | 10.00% | 8.00% | 2.00% | Utah | -1.50% |
| Nevada | N/A | 8.50% | N/A | Georgia | -1.25% |
| New Hampshire | 6.00% | 9.00% | -3.00% | New York | -1.00% |
| New Mexico | N/A | 8.00% | N/A | Louisiana | -1.00% |
| New York | 9.00% | 10.00% | -1.00% | North Carolina | -1.00% |
| North Carolina | 8.00% | 9.00% | -1.00% | Washington | -0.50% |
| North Dakota | 9.00% | 11.00% | -2.00% | Illinois | -0.50% |
| Ohio | 4.00% | 9.00% | -5.00% | California | 0.00% |
| Oregon | 8.00% | 7.00% | 1.00% | Maine | 0.00% |
| Pennsylvania | 6.20% | 10.00% | -3.80% | Michigan | 0.00% |
| Rhode Island | 9.00% | 12.00% | -3.00% | Texas | 0.00% |
| South Dakota | 8.00% | 7.67% | 0.33% | Virginia | 0.00% |
| Tennessee | 9.25% | 11.00% | -1.75% | Iowa | 0.30% |
| Texas | 8.00% | 8.00% | 0.00% | South Dakota | 0.33% |
| Utah | 8.50% | 10.00% | -1.50% | Indiana | 0.50% |
| Vermont | 6.25% | 8.00% | -1.75% | Alaska | 1.00% |
| Virginia | 10.00% | 10.00% | 0.00% | Oregon | 1.00% |
| Washington | 8.00% | 8.50% | -0.50% | Montana | 2.00% |
| West Virginia | N/A | 6.00% | N/A | Nevada | N/A |
| Wisconsin | 3.82% | 6.20% | -2.38% | New Mexico | N/A |
| Wyoming | 9.00% | 11.00% | -2.00% | West Virginia | N/A |
| Average HCTR | 7.72% | 9.35%* | -1.63% | | -1.63% |

* NOTE: The Average HCTR for 2009 is calculated using the same 42 states used to calculate Average HCTR for 2013.

those used in 2009. Another potential explanation is that the passage of the ACA provides states with a justification for reducing the HCTR assumption they use in calculating their OPEBs. Other potential explanations are also possible. However, only research methods capable of isolating potential explanatory and confounding factors can shed light on why lower HCTR assumptions were used in 2013 compared to 2009.

Conclusion

In 2010, the states reported over \$627 billion in total OPEB liabilities. The calculation of this figure is dependent upon a number of actuarial assumptions including estimates of future healthcare costs. In this paper, healthcare cost trend rate assumptions prior to passage of the ACA (2009) and after passage of the ACA (2013) were compared to determine if the healthcare cost rate assumptions used by the states to calculate their OPEB liabilities would be lower after the passage of the ACA.

The results indicate that the healthcare cost-rate assumptions used after passage of the ACA were lower and less dispersed than before. The lowering of the dispersal among the HCTR suggests that states may be converging in their beliefs about the future of healthcare costs. Whether this is because they are getting better at predicting costs or there are other factors causing the convergence is unclear (see endnote 6). The other finding of this study is that state governments are assuming that the rate of increase in healthcare going forward will be lower. This is not to assume the ACA will decrease future healthcare costs or is even related to the decrease in the assumptions about future healthcare costs, but it is interesting to note that, at least for now, states are assuming that healthcare cost rate increases will slow in the future. Whether the rate of healthcare cost inflation will go down, no matter the cause, remains an empirical question. █

Endnotes

1. The PEW Center on the States. 2011, April. "The Widening Gap: The Great Recession's Impact on State Pension and Retiree Health Care Costs." www.iaff.org/pensions/documents/Pew%20Pensions%20Retiree%20Brief%20Embargoed_May2011.pdf

2. While the focus of this article is on state governments, local governments that offer OPEB must also employ actuarial assumptions to determine OPEB liabilities. The issue of local government OPEB actuarial assumptions will be the focus of a future study.

3. Governmental Accounting Standards Board (GASB). 2004, June. "Statement No. 45 of the GASB Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions." Page 44 Glossary Definition.

4. Plante, Catherine. 2012, Summer. "Assumptions and States' OPEB Liabilities." *Journal of Government Financial Management.* Page 27.

5. Plante, Catherine. 2012, Summer. "Assumptions and States' OPEB Liabilities." *Journal of Government Financial Management.* Pages 28 and 30.

6. Patient Protection and Affordable Care Act. Accessed on August 31, 2014 at: http://en.wikipedia.org/wiki/Patient_Protection_and_Affordable_Care_Act

7. Usually, CAFRs do not include the discussion of or justification for any assumption made regarding pensions or OPEB.

One potential reason is that CAFR preparers simply accept the numbers provided by the actuaries.



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