

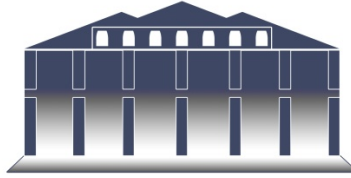
**Unfunded Actuarial Liability for Retiree Health is
Large, but State Could Save Up to
\$64 Million Annually by Shifting Costs to
Medicare Advantage Plans**



**Final Report to the Joint Legislative
Program Evaluation Oversight Committee**

Report Number 2015-05

July 27, 2015



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John W. Turcotte
Director

July 27, 2015

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Representative Craig Horn, Co-Chair, Joint Legislative Program Evaluation Oversight Committee

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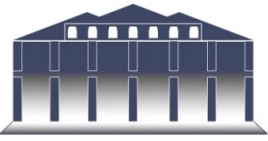
The 2013–15 Program Evaluation Division work plan directed the division to compare the funding status of North Carolina's Retiree Health Benefit Fund to other states' funds and explore options for improving its funding status.

I am pleased to report that the Department of State Treasurer, including the State Health Plan, cooperated with us fully and was at all times courteous to our evaluators during the evaluation.

Sincerely,

A handwritten signature in black ink, appearing to read "John W. Turcotte".

John W. Turcotte
Director



PROGRAM EVALUATION DIVISION

NORTH CAROLINA GENERAL ASSEMBLY

July 2015

Report No. 2015-05

Unfunded Actuarial Liability for Retiree Health is Large, but State Could Save Up to \$64 Million Annually by Shifting Costs to Medicare Advantage Plans

Summary

The Joint Legislative Program Evaluation Oversight Committee's 2013–15 Work Plan directed the Program Evaluation Division to examine the funding status of North Carolina's Retiree Health Benefit Fund. The fund contributes the State's share of retiree premiums to the State Health Plan, which provides several health plan options to non-Medicare-eligible (younger than 65) and Medicare-eligible (65 and older) retirees. In 2004, the Governmental Accounting Standards Board began including in its standards that state governments report liabilities for retiree health benefits on an accrual basis.

North Carolina's unfunded actuarial liability for the Retiree Health Benefit Fund is \$25.5 billion. Several factors explain the large unfunded liability: benefits are funded on a pay-as-you-go basis (meaning benefits are funded when they are provided rather than prefunded during an employee's active employment); retirees with sufficient contributory service are eligible for a non-contributory benefit (meaning the State pays 100% of their premium); and benefits are available to essentially all retirees with the requisite number of years of service.

North Carolina is not a strong performer on any of the measures used to compare the funded status of states. In Fiscal Year 2012–13, North Carolina ranked 41st in unfunded liability per state resident for retiree health benefits, with only eight states performing worse. It was one of 38 states with a funded ratio of 10% or less for its retiree health benefits and one of 26 states that paid less than 50% of its annual required contribution.

The General Assembly could consider the following options to reduce the unfunded liability of the Retiree Health Benefit Fund: (1) increase the appropriation to the fund, (2) shift more costs to the federal government, (3) transition to a defined contribution model, (4) reduce the number of individuals eligible for the benefit, (5) require active employees to contribute to the fund, and (6) increase the amount retirees pay for the benefit by increasing premiums and out-of-pocket costs.

To address the unfunded liability, the General Assembly

- should direct the State Treasurer and State Health Plan Board of Trustees to shift costs to the federal government by requiring eligible retirees to be on Medicare Advantage plans, generating an estimated savings of up to \$64 million annually, and
- could appoint a joint committee to determine which of the report's other options to pursue in light of the financial and legal implications discussed in this report.

Purpose and Scope

Through its 2013–15 Work Plan, the Joint Legislative Program Evaluation Oversight Committee directed the Program Evaluation Division to compare the funding status of North Carolina’s Retiree Health Benefit Fund to other states’ funds and explore options for improving its funding status.

This study addresses six research questions:

1. Who makes decisions about North Carolina’s retiree health benefits, and how are they funded?
2. What is the funding status of the Retiree Health Benefit Fund?
3. How does the funding status of the Retiree Health Benefit Fund compare to the funding status of other states’ funds?
4. What options exist for improving the funding status of the Retiree Health Benefit Fund?
5. What is the legal feasibility of making changes to improve the funding status of the Retiree Health Benefit Fund?
6. How should the General Assembly proceed in making changes to reduce the unfunded liability of the Retiree Health Benefit Fund?

The Program Evaluation Division collected data from several sources, including

- national data from the Center for State and Local Government Excellence, Medical Expenditure Panel Survey, National Association of State Retirement Administrators, and Pew;
- research on other states;
- interviews with and data from the Department of State Treasurer and State Health Plan; and
- interviews with the Retiree Health Benefit Fund’s actuary and experts at North Carolina State University.

Background

In addition to being eligible for pension benefits,¹ retirees from North Carolina state government are eligible for retiree health benefits in the form of comprehensive medical benefits received from the State Health Plan. The retiree health benefit is available to former employees of the State (including legislators), the University of North Carolina system, community colleges, Local Education Agencies, charter schools, the North Carolina Housing Finance Agency, and a limited number of local governments.² Based on an average salary of \$43,844 for state employees and teachers, the annual value of the retiree health benefit was approximately \$3,727 per active employee in 2013.³

History of Retiree Health Benefits

State governments across the country began offering health insurance to their retirees in the 1960s and 1970s, coinciding with the adoption of these plans by large, unionized firms in the private sector following the establishment of Medicare in 1966.⁴ Employers offer retiree health benefits to improve recruitment, retention, and transition to retirement. Exhibit 1 shows the timeline of how retiree health benefits in North Carolina evolved into what they are today.

The retiree health benefits discussed throughout this report are the benefits available under current law. The current eligibility criteria are established by the General Assembly, and the current benefits are set by the State Treasurer subject to the approval of the State Health Plan's Board of Trustees.⁵ N.C. Gen. Stat. § 135-48.3 states the General Assembly reserves the right to alter, amend, or repeal any section of state law regarding the State Health Plan. The legal ramifications of making changes to the current eligibility criteria or benefits are not clear because case law has not ruled whether there is a contractual obligation for retiree health benefits.

¹ See Program Evaluation Division. (2011, September). Compared to other states' retirement plans, TSERS is well funded and its plan features are typical or less generous. Report to the Joint Legislative Program Evaluation Oversight Committee. Raleigh, NC: General Assembly.

² Session laws allow 16 local governments to enroll their retirees in the State Health Plan; these retirees represent roughly 0.1% of the total State Health Plan membership.

³ Fiscal Research Division. (2015, March). Comparison of the value of state employee benefits. Fiscal brief.

⁴ Today, approximately 11% of private sector employers offer retiree health benefits according to the Medical Expenditure Panel Survey Insurance Component's (2013) "Percent of private-sector establishments that offer health insurance by health insurance offers to retirees by selected characteristics."

⁵ N.C. Gen. Stat. §§ 135-48.30, 135-48.22, 135-48.40.

Retiree Health Benefits for Individuals Younger than 65

Retirees younger than 65 have access to the same State Health Plan benefits as active employees. The State Health Plan offers three Preferred Provider Organization (PPO) plans to retirees younger than 65. PPO plans offer freedom of choice among in-network providers, lower out-of-pocket costs, and a strong emphasis on preventive health.⁶ All three plans include prescription drug coverage.

- **Traditional 70/30 Plan (70/30).** This plan is premium-free for retiree-only coverage when service time requirements are met, in exchange for higher deductibles, coinsurance, and copayments. Affordable Care Act preventive services and medications require copays under this plan.
- **Enhanced 80/20 Plan (80/20).** This plan has higher premiums in exchange for lower deductibles, coinsurance, and copayments. Affordable Care Act preventive services and medications are covered at no charge.
- **Consumer-Directed Health Plan (CDHP).** This plan is a high-deductible health plan that is accompanied by a Health Reimbursement Arrangement. Affordable Care Act preventive services and medications are covered at no charge.

When individuals younger than 65 retire, they are automatically enrolled in the health plan in which they were enrolled as active employees; changes to plan elections can be made during the next open enrollment period.⁷

⁶ Out-of-pocket costs are medical costs that are not reimbursed by insurance, which include deductibles, coinsurance, and copayments. A plan's deductible is the amount a plan participant owes for covered services before health insurance begins to pay for the services. Coinsurance is a plan participant's share of the costs of covered healthcare services after the deductible is met, calculated as a percentage of the allowed amount for the service. Copayments are a fixed amount a plan participant pays for a covered healthcare service, which varies by the type of covered healthcare service.

⁷ As of July 1, 2015, retirees were able to disenroll themselves and their dependents at any time during the plan year.

Exhibit 1: Timeline of Retiree Health Benefits for North Carolina State Employees

1970	1972 – General Assembly directs Board of Trustees for Teachers’ and State Employees’ Retirement System to establish fully-insured health benefits for active employees and appropriates employer contribution of up to \$10 per member per month.
1975	1974 – General Assembly grants health benefit to retirees who are vested in the Retirement System at the time of retirement on a fully contributory basis, meaning retirees pay the full premium cost of coverage. 1976 – General Assembly creates separate health benefit for Medicare-eligible retirees.
1980	1978 – General Assembly appropriates funds to fully cover retirees’ premiums for health benefit, making the benefit non-contributory. 1982 – General Assembly establishes self-funded State Health Plan, specifying non-contributory health benefit for active employees and retirees.
1985	1988 – General Assembly requires employees to have five years of state service to be eligible for retiree health benefit (previously, local service could count for some of this requirement).
1990	
1995	1995 – General Assembly changes minimum service time requirements for retiree health benefit, requiring employees to serve for 10 years to receive one-half contributory benefit and 20 years to receive non-contributory benefit.
2000	2000 – General Assembly undoes 1995 changes to service time requirements for retiree health benefit.
2005	2006 – General Assembly reinstates 1995 changes to service time requirements for retiree health benefit.
2010	2011 – General Assembly moves administration of State Health Plan to Department of State Treasurer and gives State Health Plan Board of Trustees more power to make benefit decisions.
2015	

Source: Program Evaluation Division based on general statutes and session laws.

Retiree Health Benefits for Individuals 65 and Older

When individuals turn 65, they become eligible for Medicare.⁸ Medicare has four parts:

- **Part A.** Part A covers most medically necessary hospital, skilled nursing facility, home health, and hospice care. It is provided directly by the federal government. There is no charge for those who have worked and paid Social Security taxes for 10 years; there is a monthly premium for those who have worked and paid taxes for less time.
- **Part B.** Part B covers most medically necessary doctors' services, preventive care, durable medical equipment, hospital outpatient services, laboratory tests, x-rays, mental healthcare, and some home health and ambulance services. It is provided directly by the federal government, and recipients pay a monthly premium.
- **Part C.** Part C is a policy that allows private health insurance companies to provide Medicare benefits. These private health plans are known as Medicare Advantage plans. Medicare Advantage plans must offer at least the same benefits as Parts A and B but can do so with different rules, costs, and coverage restrictions. Medicare Advantage plans also may include Part D coverage. These plans may charge a monthly premium. Medicare Advantage plans typically offer richer benefits than Medicare.
- **Part D.** Part D covers outpatient prescription drugs. It is provided by private insurance companies that have contracts with the federal government.

The State Health Plan mails a Medicare eligibility letter approximately 60 days prior to a member's 65th birthday to confirm the member's eligibility for Medicare benefits.⁹ If members are retired, Medicare is considered their primary insurer, and the State Health Plan becomes their secondary insurer.¹⁰ As the primary insurer, Medicare pays up to the limits of its coverage. The State Health Plan pays the remainder of the bill up to the limits of its coverage.¹¹ Some medical services are covered by the State Health Plan and are not covered by Medicare. For example, Medicare does not cover annual physicals and the shingles vaccination, but the State Health Plan's Traditional 70/30 plan does.

⁸ Individuals qualify for Medicare at age 65 or older if they are U.S. citizens or permanent legal residents and they or their spouse have worked long enough to be eligible for Social Security—usually having earned 40 credits from about 10 years of work—or they or their spouse are government employees or retirees who have not paid into Social Security but have paid Medicare payroll taxes while working. Individuals younger than 65 can qualify for Medicare if they were entitled to Social Security disability benefits for at least two years, have amyotrophic lateral sclerosis (ALS), or have end-stage renal disease.

⁹ If members are still actively employed, the State Health Plan sends them a Medicare eligibility election form. The State Health Plan remains their primary insurer, and Medicare becomes their secondary insurer.

¹⁰ The State Health Plan is a secondary insurer to Medicare and not a supplement to Medicare. Medicare Supplemental Insurance, often called Medigap, is sold by private companies and fills in coverage gaps in the standard Medicare policy, like copayments, coinsurance, and deductibles.

¹¹ If a member does not enroll in Medicare Part B, the State Health Plan reduces the member's claims by the amount that would have been covered under Medicare Part B and then pays any remaining amount that the member's State Health Plan option covers. As such, the member is responsible for the amount that would have been paid by Medicare Part B.

Retirees 65 and older can enroll in the State Health Plan's Traditional 70/30 Plan, which includes prescription drug coverage, as their secondary insurer.

- **Traditional 70/30 Plan (70/30).** This plan is premium-free for retiree-only coverage when service time requirements are met. Affordable Care Act preventive services and medications require copays under this plan.

Alternatively, retirees 65 and older can enroll in Medicare Advantage plans as their primary insurer. The State Health Plan contracts with Humana and UnitedHealthcare to offer two levels of Medicare Advantage plans. Both levels are open-network PPO plans that allow retirees to obtain services from any provider that accepts Medicare, and both include prescription drug coverage. The Medicare Advantage plans do not cover all services covered by the Traditional 70/30 plan (e.g., chiropractic care), but they do cover previously unavailable services (e.g., health and chronic disease management).

- **Medicare Advantage Base (MA Base).** This plan is premium-free for retiree-only coverage when service time requirements are met, in exchange for higher coinsurance and copayments. The plan is comparable in value to the 80/20 plan in place at the time the State Health Plan requested bids from contractors (i.e., the 80/20 plan in Fiscal Year 2011–12).
- **Medicare Advantage Enhanced (MA Enhanced).** This plan has higher premiums in exchange for lower coinsurance and copayments.

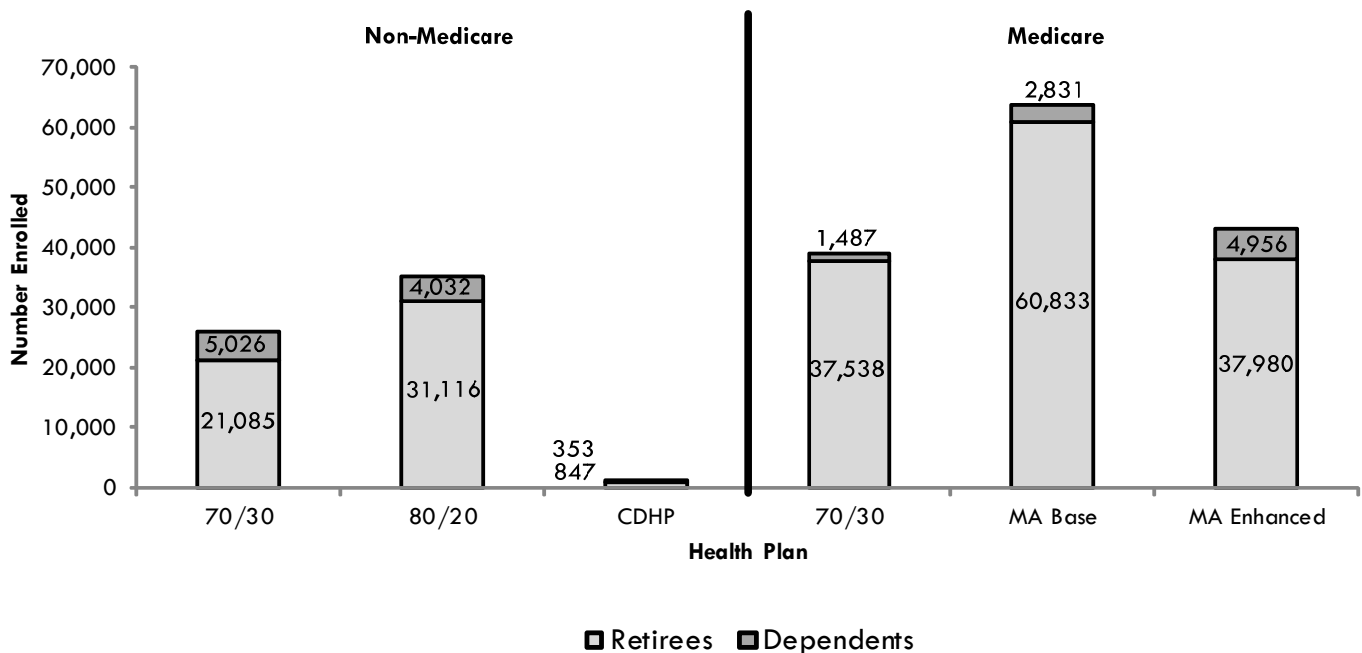
Employees who are 65 or older who submit their retirement paperwork fewer than 60 days prior to their retirement date are automatically enrolled in the Traditional 70/30 Plan. Employees who are 65 or older who submit their retirement paperwork 60 days or more prior to their retirement date are automatically enrolled in a Medicare Advantage base plan.¹² Changes to plan elections can be made during the next open enrollment period.¹³

Exhibit 2 depicts the number of retirees and their dependents enrolled in each of the plan options as of January 2015.

¹² Retirees are automatically enrolled in either Humana or UnitedHealthcare's plans. The base plans are identical. The difference between the enhanced plans is the Humana plan focuses on lower specialist copays, whereas the UnitedHealthcare plan focuses on lower drug copays and facility costs. Retirees have up to 30 days prior to their benefit effective date to change plans. If no action is taken, retirees remain in the Medicare Advantage plan in which they were randomly assigned.

¹³ As of July 1, 2015, retirees were able to disenroll themselves and their dependents at any time during the plan year.

Exhibit 2: North Carolina Retiree Membership by Plan, January 2015



Notes: CDHP stands for Consumer-Directed Health Plan; MA stands for Medicare Advantage.

Source: Program Evaluation Division based on data from the State Health Plan.

The cost to retirees for health benefits depends on their date of hire and years of service. N.C. Gen. Stat. § 135-48.40 defines eligibility for three levels of retiree health benefits based on the number of years served.¹⁴

- **Non-contributory coverage.** Retirees are eligible for a “non-contributory” health benefit—meaning the State pays their full premium cost—if they were hired before October 1, 2006 and have at least five years of service or they were hired on or after October 1, 2006 and have at least 20 years of service.
- **One-half contributory coverage.** Retirees are eligible for “one-half contributory” health benefits—meaning the State pays half of their premium cost—if they were hired on or after October 1, 2006 and have 10 but fewer than 20 years of service.
- **Fully contributory coverage.** Retirees are eligible for “fully contributory” health benefits—meaning the State pays none of their premium cost but they have access to State Health Plan coverage—if they were hired on or after October 1, 2006 and have fewer than 10 years of service.¹⁵

Retirees may enroll their eligible dependents, including their spouses, in the plan on a “fully contributory” basis, meaning the member is responsible for paying the full premium cost of dependent coverage. Exhibit 3 shows the 2015 monthly premium rates for retirees and spouses for each of the plans.

¹⁴ A description of how years of service is calculated can be found here: <https://www.nctreasurer.com/ret/Employers/GuidanceSHPChanges.pdf>.

¹⁵ The hiring date that determines the level of premium coverage for which legislators are eligible is February 1, 2007.

Exhibit 3: Monthly Premium Rates for Retirees and Spouses by Plan, 2015

	Retiree						Spouse	
	Non-Contributory Premium		One-half Contributory Premium		Fully Contributory Premium		Fully Contributory Premium	
Years of Service	Hired before 10/1/2006 with 5 years of service or hired on or after 10/1/2006 with 20 years of service		Hired on or after 10/1/2006 with 10 but fewer than 20 years of service		Hired on or after 10/1/2006 with fewer than 10 years of service		Legal spouse	
Medicare Eligibility	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare
70/30	\$ 0	\$ 0	\$ 224	\$ 174	\$ 448	\$ 348	\$ 529	\$ 384
80/20	\$ 14	Not offered	\$ 238	Not offered	\$ 462	Not offered	\$ 629	Not offered
CDHP	\$ 0	Not offered	\$ 224	Not offered	\$ 448	Not offered	\$ 476	Not offered
MA Base	Not eligible	\$ 0	Not eligible	\$ 115	Not eligible	\$ 115	Not eligible	\$ 115
MA Enhanced	Not eligible	\$ 33	Not eligible	\$ 148	Not eligible	\$ 148	Not eligible	\$ 148

Notes: CDHP stands for Consumer-Directed Health Plan; MA stands for Medicare Advantage. Rates are rounded up to the nearest dollar. The Enhanced 80/20 Plan and CDHP offer financial incentives for taking steps to improve one’s health. The rates shown presume members completed all three wellness activities—smoking attestation, primary care provider selection, and health assessment—to reduce their premiums as much as possible. The table does not include the premiums for coverage of children or families.

Source: Program Evaluation Division based on information from the State Health Plan.

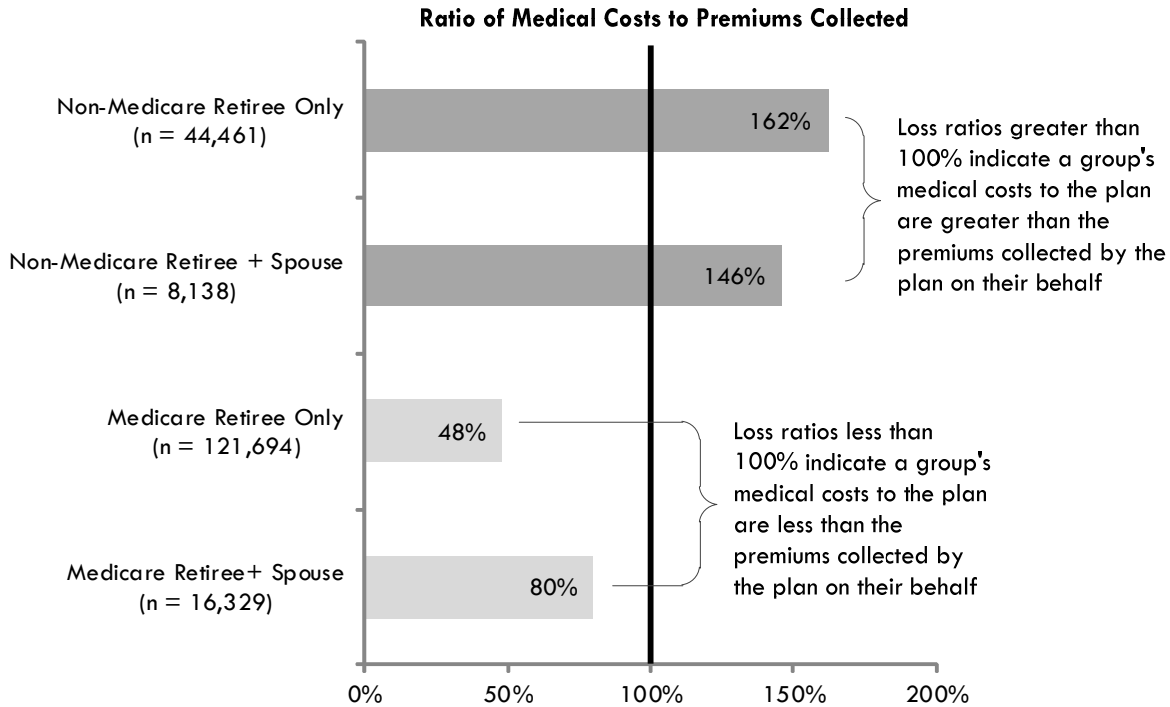
The cost to the State Health Plan to insure retirees differs based on whether retirees are eligible for Medicare. As shown in Exhibit 4, retirees not yet eligible for Medicare (younger than 65) are more expensive to the State Health Plan than retirees enrolled in Medicare (age 65 and older). Loss ratios compare the cost of providing health services to the income generated by premiums.¹⁶ A group with medical costs that exceed the premiums collected on its behalf has a loss ratio greater than 100%, whereas a group that has lower medical costs than the premiums collected on its behalf has a loss ratio less than 100%. As shown, non-Medicare retirees had a loss ratio of 162% in 2014, meaning the group’s actual costs exceeded premiums collected by 62%; for every \$1 in premiums collected, the State Health Plan paid \$1.62 in expenses. In contrast, Medicare retirees had a loss ratio of 48%.

Similarly, coverage for non-Medicare retirees plus their spouses is more expensive to the State Health Plan than coverage for Medicare retirees plus their spouses. Premium costs for non-Medicare spouses are based on the combined medical costs of active and retired employees’ spouses. Because retirees’ spouses tend to be older and need more medical attention, the non-Medicare spouse premium does not fully cover costs to the State Health Plan. As shown, non-Medicare retirees plus their spouses

¹⁶ Loss ratios incorporate State Health Plan administrative costs and subsidies received by the plan, but differences are primarily driven by claims experience in each group.

had a loss ratio of 146% in 2014, meaning the group's actual costs exceeded premiums collected by 46%; for every \$1 in premiums collected, the State Health Plan paid \$1.46 in expenses. In contrast, Medicare retirees plus their spouses had a loss ratio of 80%.

Exhibit 4: Loss Ratios Are Higher for Non-Medicare versus Medicare Retirees, 2014



Notes: "n" denotes the total number of individuals covered by the plan. The chart does not include the loss ratios for coverage of children or families.

Source: Program Evaluation Division based on data from the State Health Plan.

As more individuals retire and healthcare costs continue to rise, the importance of controlling retiree health benefit costs increases. In a 2012 report, the PEW Center on the States drew attention to the funding of retiree health benefits on a nationwide scale, reporting a \$627 billion gap between states' assets and their anticipated expenses for retiree health benefits in Fiscal Year 2009–10.¹⁷ National health expenditures are expected to grow, on average, 1.1% faster between 2012 and 2023 than the expected average annual growth rate for the Gross Domestic Product.¹⁸ These rising costs coincide with a forthcoming "retirement boom" among the U.S. population, as the percentage of U.S. residents who are 65 and older is expected to rise from 13.7% in 2012 to 20.3% by 2030.¹⁹ The combination of these factors has prompted states to examine how they fund, account for, and provide health benefits to their retirees. Accordingly, the Joint Legislative Program Evaluation Oversight Committee directed the Program Evaluation Division to examine how North Carolina's Retiree Health Benefit Fund is funded, how its funding status compares to other states, and what options exist for improving its funding status.

¹⁷ Pew Center on the States. (2012, June). The widening gap update.

¹⁸ Centers for Medicare & Medicaid Services, National Health Expenditure Data, 2013, NHE Fact Sheet.

¹⁹ U.S. Census Bureau, 2012 Population Estimates and 2012 National Projections. The Department of State Treasurer projects retirement among North Carolina state employees will increase 43% from 2012 to 2024.

Questions and Answers

1. Who makes decisions about North Carolina's retiree health benefits, and how are they funded?

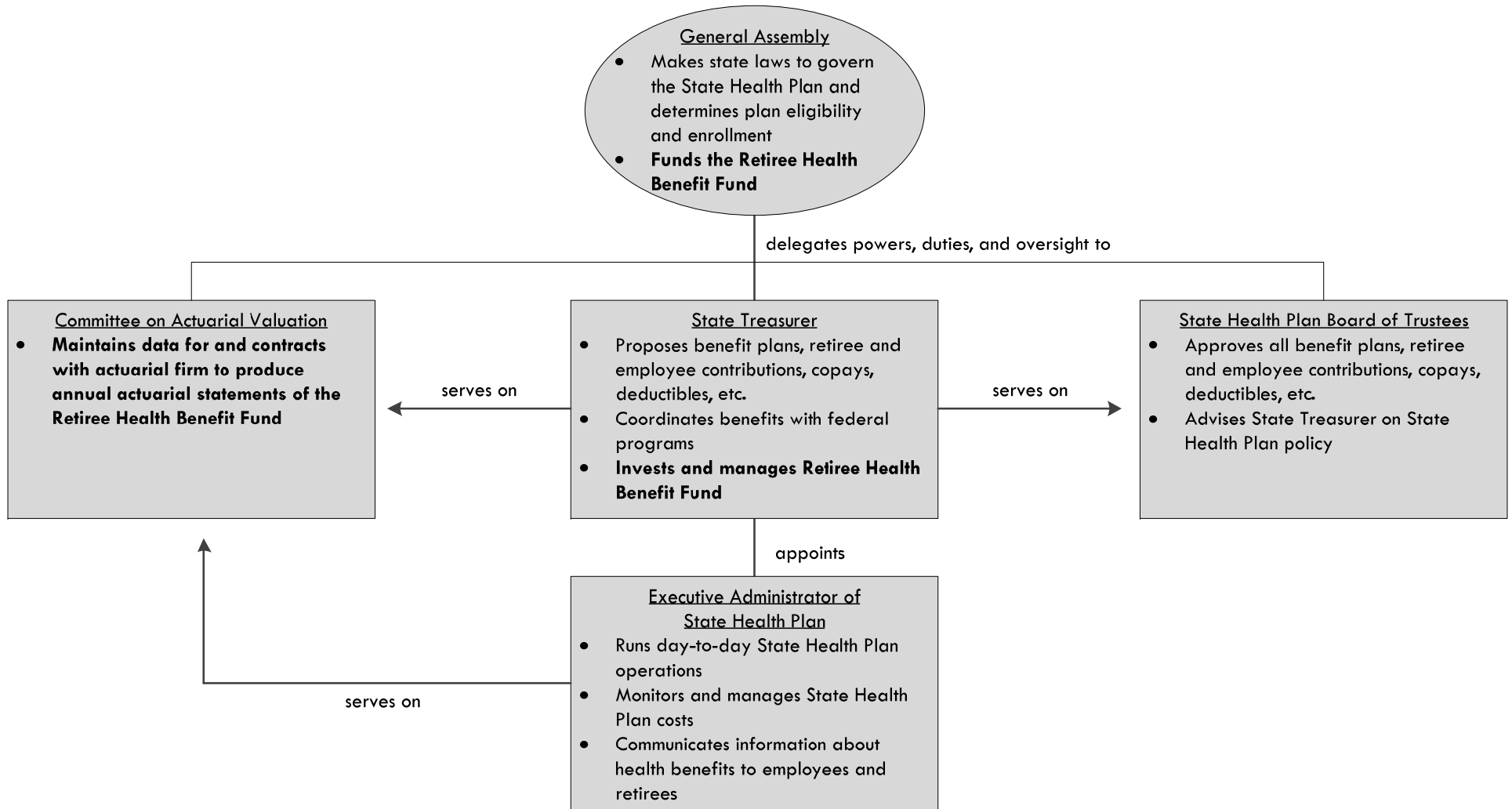
Five state entities make key decisions regarding retiree health benefits (see Exhibit 5). The General Assembly has legislative control regarding all aspects of the State Health Plan, including its administration of retiree health benefits. The General Assembly stipulates who is eligible to participate in the plan and reserves the right to alter, amend, or repeal any section of state law regarding the State Health Plan. The General Assembly delegates management of the State Health Plan to the State Treasurer and oversees the State Treasurer, the State Health Plan Board of Trustees, and the State Health Plan Executive Administrator. Through the Appropriations Act, the General Assembly funds the Retiree Health Benefit Fund, which is used to pay retiree premiums to the State Health Plan.

The State Treasurer establishes State Health Plan benefits, retiree and employee contributions, and out-of-pocket costs subject to approval by the State Health Plan Board of Trustees. The State Treasurer manages and invests the money in the Retiree Health Benefit Fund. Other responsibilities include setting the allowable charges for medical and prescription drug benefits, establishing and operating fraud detection and audit programs, and implementing and administering pharmacy and medical utilization management programs. The State Treasurer may enter into negotiations with the U.S. Department of Health and Human Services to coordinate the plan's benefits with those provided by Medicare.

The State Health Plan Board of Trustees performs strategic planning for the State Health Plan and approves contracts with a value greater than \$500,000. The board must approve benefit programs, retiree and employee contributions, and out-of-pocket costs proposed by the State Treasurer before implementation. The board provides consultation to the State Treasurer on the creation of administrative rules and the implementation of procedures regarding prior medical approval, utilization reviews, and internal grievances.

The State Health Plan's Executive Administrator is appointed by the State Treasurer and handles the day-to-day operations of the plan. The Executive Administrator's responsibilities include negotiating and executing contracts on behalf of the plan, managing staff, and submitting quarterly reports and recommendations to the President Pro Tempore of the Senate and the Speaker of the House of Representatives. The Executive Administrator and the Board of Trustees jointly decide which claim grievances are subject to external review and adjudicate internal grievances. The State Health Plan communicates information about benefits, plan changes, policies, and procedures to all current and retired employees.

Exhibit 5: Oversight, Management, and Administration of Retiree Health Benefits



Notes: According to N.C. Gen. Stat. § 135-48.12, the Committee on Actuarial Valuation of Retired Employees' Health Benefits has four members: the State Budget Officer, State Controller, State Treasurer, and Executive Administrator of the State Health Plan. According to N.C. Gen. Stat. § 135-48.20, the State Health Plan Board of Trustees has 10 members: the State Treasurer serves as chair and only votes to break ties, the Director of the Office of State Budget and Management is a non-voting member, two members are appointed by the Governor, two members are appointed by the State Treasurer, two members are appointed by the President Pro Tempore of the Senate, and two members are appointed by the Speaker of the House of Representatives. The appointees must include a current and retired state employee and a current and retired public school teacher.

Source: Program Evaluation Division based on general statutes.

The Committee on Actuarial Valuation of Retired Employees' Health Benefits, sometimes referred to as the OPEB Board, is charged with maintaining data for and contracting with an actuarial firm to produce annual actuarial statements of the Retiree Health Benefit Fund.

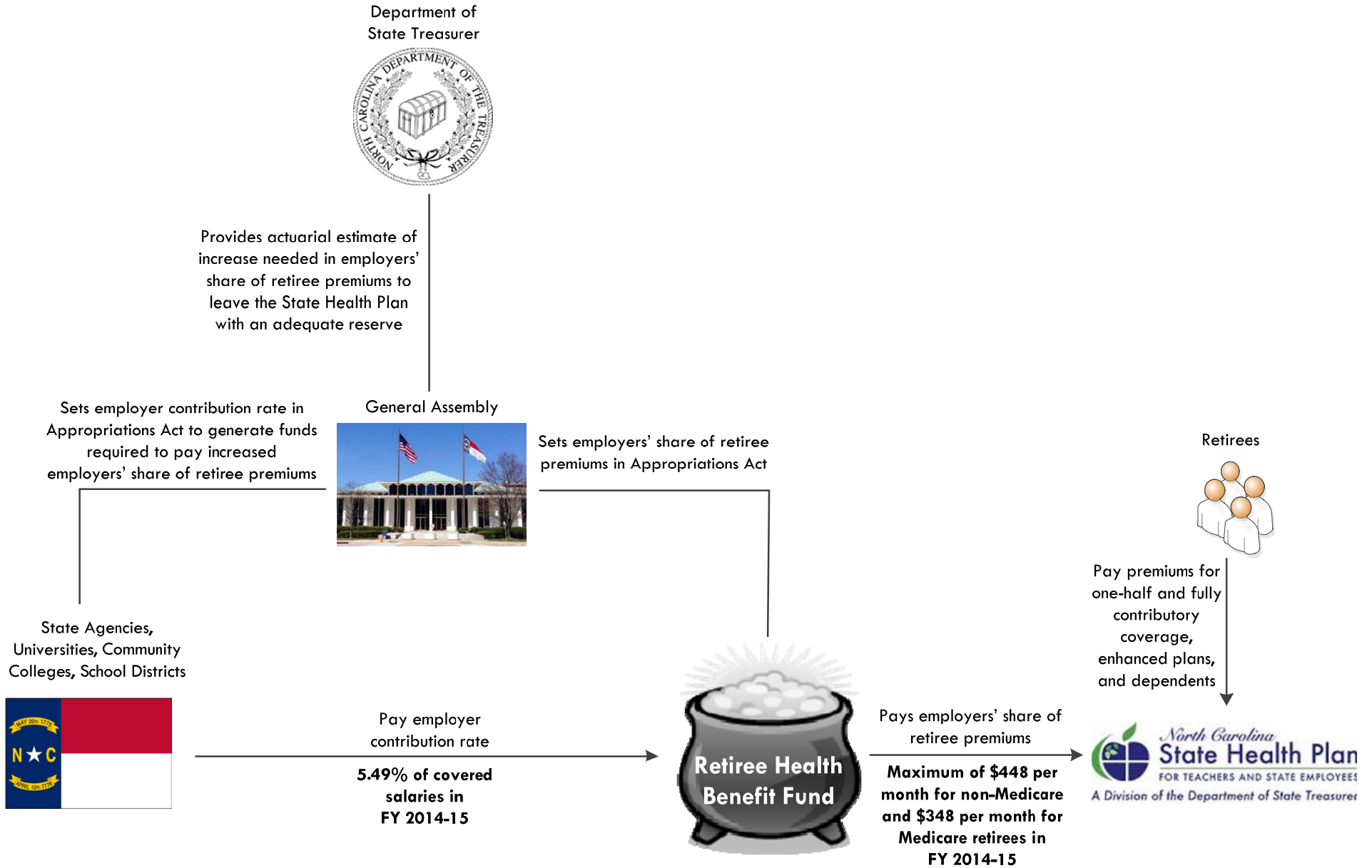
North Carolina funds its retiree health benefits on a pay-as-you-go basis. The Retiree Health Benefit Fund is a trust fund, the assets of which may be used only for payment of retiree health benefits and administrative costs.²⁰ The State funds the Retiree Health Benefit Fund on a pay-as-you-go basis, meaning the State funds the trust when the benefit is provided during retirement rather than prefunding the trust during an employee's active employment. In general, the amount of money the State designates for the fund each year is the amount needed to cover retiree health benefit costs for that same year. Since 2005, the General Assembly has appropriated enough for the fund to have an average annual increase of \$92 million in its reserve. However, because the State does not prefund the Retiree Health Benefit Fund in any meaningful way, the potential for the trust fund to accrue funds and earn interest is limited. Alternatively, the State could decide to make contributions during employees' working careers so that when employees retire those contributions along with investment income would pay for the entire cost of employees' benefits or a portion thereof.

As shown in Exhibit 6, the Department of State Treasurer provides the General Assembly with an annual actuarial estimate of the needed increase in the employers' share of retiree premiums. The actuarial estimate uses historical claims experience to estimate the amount needed to cover anticipated increases in cost and utilization and anticipated increases due to benefit changes.²¹ This estimate also assumes the build-up and maintenance of an adequate reserve, typically 9% of net annual claims costs, to cover fluctuating cash flows and fiscal year-end claims liability. Future premium rates are impacted by the State Health Plan's actual financial performance. If claims experience is less than projected, the plan's cash reserves increase during the year, and the required premium increase in the next year will be lower than originally projected. Conversely, if claims experience is higher than projected, the plan will use its reserve to cover the increased cost, and the required premium increase in the next year will be higher than originally projected. Based on the actuarial estimate, the General Assembly set the maximum employer share of retiree premiums at \$448 per month for non-Medicare retirees and \$348 per month for Medicare retirees in Fiscal Year 2014–15.

²⁰ In 1991, the General Assembly transferred \$47 million from the Retiree Health Benefit Fund to the General Fund. In 1999 and 2000, the General Assembly set the state contribution at 0% and 1.28% of payroll respectively, which meant the fund had to use reserves to cover expenses during those years. In the 2004 Appropriations Act, the General Assembly protected the fund from future raids by converting it to a trust fund, specifying employer contributions are irrevocable and fund assets are not subject to the claims of employers' creditors. However, the General Assembly could still raid the fund by not appropriating an adequate percentage of payroll in a given year.

²¹ The forecast model produces the projected premium increase required to cover the State Health Plan's expenses during the upcoming forecast period or fiscal biennium and that increase is applied to all rates across the board except Medicare Advantage premiums. If the model indicates a 5% increase is required, the General Assembly is asked to increase the employer contribution by 5%, and the employee-only, retiree-only, and dependent premium rates also are increased by 5%. Medicare Advantage premiums are increased by the amount needed to cover the agreed-upon premium and administrative costs.

Exhibit 6: Process for Funding the Retiree Health Benefit Fund



Source: Program Evaluation Division based on the 2014 Appropriations Act.

The General Assembly's Fiscal Research Division then determines what increase is needed in the employer contribution rate to generate the additional amount of funds projected to be paid out in premiums from the Retiree Health Benefit Fund. The employer contribution rate is meant to keep the inflow and outflow to and from the Retiree Health Benefit Fund in balance; the employer contribution rate is not meant to prefund benefits in any meaningful way or to generate investment income for that purpose.

The General Assembly does not appropriate funds directly to the Retiree Health Benefit Fund. Instead, it provides operational funds to state agencies, universities, community colleges, and school districts. In the Appropriations Bill, the General Assembly stipulates the state contribution will amount to a certain percentage of employees' salaries for the upcoming fiscal year. Each participating employer takes that percentage from each of its fund sources and contributes that amount to the Retiree Health Benefit Fund based on the salaries of its active employees. In Fiscal Year 2014–15, the General Assembly set the employer contribution rate to the Retiree Health Benefit Fund at 5.49% of covered salaries.

North Carolina's pay-as-you-go method of funding retiree health benefits does not promote intergenerational equity. Most states, including North Carolina, fund their share of the cost of retiree health benefits on a pay-as-you-go basis. State governments report they do not prefund retiree health benefits for several reasons:²²

- retiree health benefits typically began as an extension of active employee health benefits, which are usually funded from each year's available revenue;
- retiree health benefits were established at a time when healthcare costs were more affordable and hence paying for the benefits as a yearly expense was less burdensome;
- the inflation rate for healthcare is less predictable than for pensions, making it difficult to calculate the current funding status;
- specific retiree health benefits are generally not guaranteed by law (as compared to pension benefits) so employers are freer to modify retiree health benefits; and
- changes in national healthcare policy and health insurance markets can affect what benefits states cover.

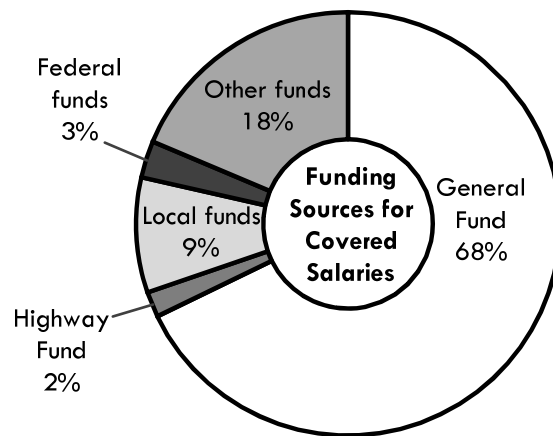
Nevertheless, failure to prefund retiree health benefits creates inequities between generations of taxpayers. Intergenerational equity refers to the concept that each generation pays the costs of the services it receives. Using a pay-as-you-go method to fund retiree health benefits means current taxpayers are paying for benefits for retirees who are no longer serving the State. In contrast, prefunding retirement benefits promotes intergenerational equity because taxpayers are paying for workers' benefits while those workers are providing services to them. Otherwise, the State is passing on the costs of retirement benefits for former employees to future taxpayers.

²² U.S. Government Accountability Office. (2008). State and Local Government Retiree Benefits: Current Funded Status of Pension and Health Benefits. Report to the U.S. Senate Committee on Finance.

The State's General Fund is the primary source (68%) of funding for covered salaries (see Exhibit 7) and thus the primary source of employer contributions to the Retiree Health Benefit Fund. As shown in Exhibit 8, the portion of General Fund revenue spent on the Retiree Health Benefit Fund is projected to grow during the next decade. As a result, taxpayers will pay an increased amount to fund health benefits for retirees not currently serving the State, and less money will be available for services directly affecting taxpayers, such as education and Medicaid. In 2014, North Carolina spent an estimated \$514.6 million dollars, or 2.6% of General Fund revenue, on retiree health benefits.²³ Projections indicate the General Fund will expend \$807.6 million dollars, or 3.1% of General Fund revenue, on retiree health benefits in 2020.

Exhibit 7

Funding Sources for Covered Salaries, 2014

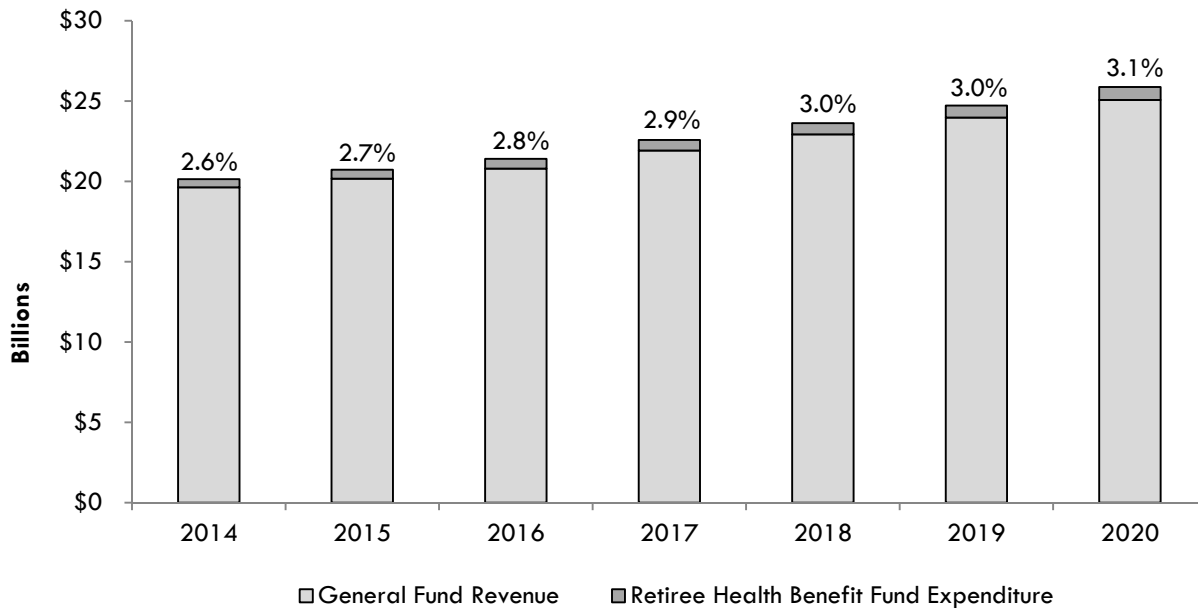


Notes: Federal and local funds are for school salaries. Other funds include revenue from enterprise funds, institutional funds, internal service funds, special funds, and trust funds.

Source: Program Evaluation Division based on data from the Fiscal Research Division and Office of State Budget and Management.

²³ The Program Evaluation Division reduced the projections of future total expenditures reported in the 12-31-2013 Actuarial Statement to report estimated expenditures from the General Fund only. To enable the Program Evaluation Division to estimate how much of total General Fund revenue would be spent on retiree health benefits, the Fiscal Research Division and Office of State Budget and Management provided estimates for how much total General Fund revenue would be available in future fiscal years.

Exhibit 8: Percentage of General Fund Revenue Spent on Retiree Health Benefit Fund Will Increase



Notes: General Fund Revenue is calculated on a fiscal year schedule and Retiree Health Benefit Fund Expenditure is calculated on a calendar year schedule, but the difference in timing does not materially affect results.

Source: Program Evaluation Division based on data from the 12-31-2013 Actuarial Statement, Fiscal Research Division, and Office of State Budget and Management.

2. What is the funding status of the Retiree Health Benefit Fund?

Ten years ago, accounting standards began including that state governments report unfunded liability for retiree health benefits on an accrual basis. State governments have been providing retiree health benefits since the 1960s and 1970s, but the long-term costs of these benefits received relatively little attention until 2004. At that time, the Governmental Accounting Standards Board (GASB), which establishes the standards of financial accounting and reporting for states’ Comprehensive Annual Financial Reports, approved Statement 45. Statement 45 directs governments to calculate the long-term actuarial liabilities for non-pension benefits, called “other post-employment benefits” (OPEB), using an approach similar to the one used for pension benefits. States’ largest OPEB is typically retiree health benefits, but states also may offer life insurance, dental, disability, and other non-pension benefits in retirement as OPEBs. North Carolina offers two OPEBs: the Disability Income Plan and the Retiree Health Benefit Fund.²⁴

Statement 45 directs state governments to report OPEB costs on an accrual basis, producing an actuarial statement that reports the present discounted value of the future liability of health insurance for current and future retirees. Under an accrual basis, the cost of retiree health benefits is recognized when an individual becomes eligible for the benefits, not when the benefits are paid. As shown in Exhibit 9, unfunded actuarial accrued liability (henceforth referred to as unfunded liability) is the difference

²⁴ In Fiscal Year 2013–14, the Disability Income Plan had an unfunded liability of \$80,518 and was 84.6% funded.

between the actuarial value of plan assets and the actuarial accrued liability of plan benefits.

Use of the terms “liability” and “accrued” throughout this report are not intended to imply any unalterable obligation. The General Assembly retains the right to alter, amend, or repeal the State Health Plan statutes.²⁵ However, so long as the State is offering a health benefit to its retirees, it is important to understand its projected costs, which this report terms “liability.”

Exhibit 9: North Carolina’s Retiree Health Benefit Had \$25.5 Billion in Unfunded Liability in 2013

Actuarial Accrued Liability	-	Actuarial Value of Assets	=	Unfunded Actuarial Accrued Liability
value of benefits for which employees are eligible		value of cash, investments, and other assets that are set aside to fund benefit		value of benefits for which employees are eligible for which no assets have been set aside
\$26,420,167,735		\$890,755,562		\$25,529,412,173

Source: Program Evaluation Division based on data from the 2014 Comprehensive Annual Financial Report.

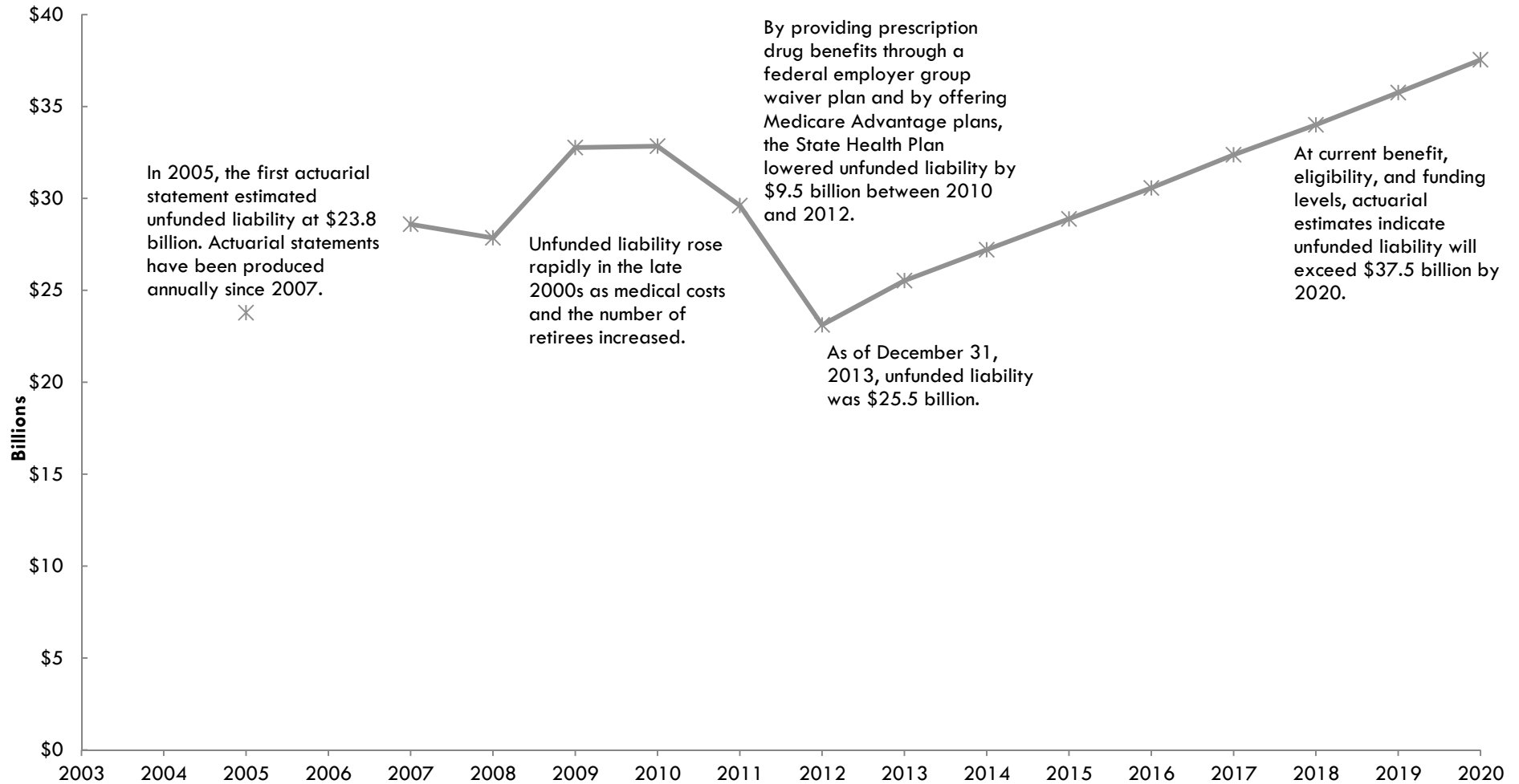
North Carolina’s most recent actuarial statement estimates the unfunded liability for the Retiree Health Benefit Fund is \$25.5 billion and projects this value could grow to \$37.5 billion by 2020. As shown in Exhibit 10, the first actuarial statement of the Retiree Health Benefit Fund was produced in 2005 and estimated the unfunded liability at \$23.8 billion. Unfunded liability rose rapidly in the late 2000s as medical costs and the number of retirees increased. The actuarial estimate for unfunded liability peaked at \$32.8 billion in 2010.

Subsequently, North Carolina reduced the unfunded liability by \$9.5 billion by leveraging federal dollars. In 2011, the State Health Plan decided to provide prescription drug benefits to Medicare-eligible retirees through an employer group waiver plan beginning in 2013. This change allowed the State to take advantage of federal reimbursement and decreased the unfunded liability by \$4.9 billion. Then, in 2012, the State Health Plan chose to start offering Medicare Advantage plans beginning in 2014, which decreased the unfunded liability by another \$4.6 billion.²⁶ Because the Medicare Advantage plans include prescription drug coverage, they replaced the employer group waiver plan. Even after these significant cost-saving measures were taken, the unfunded liability of the Retiree Health Benefit Fund stands at \$25.5 billion according to the most recent actuarial statement. The fund’s actuary estimates that at current benefit, eligibility, and funding levels, unfunded liability will exceed \$37.5 billion by 2020.

²⁵ N.C. Gen. Stat. § 135-48.3.

²⁶ The \$4.6 billion reduction is the result of offering both a Consumer-Directed Health Plan (CDHP) and Medicare Advantage plans. Because only 1,200 retirees and their dependents are enrolled in the CDHP, the Program Evaluation Division attributed the savings to the Medicare Advantage plans, in which 106,600 retirees and dependents are enrolled.

Exhibit 10: Current and Projected Unfunded Liability of Retiree Health Benefit Fund



Note: No actuarial statement was produced in 2006.

Source: Program Evaluation Division based on actuarial statements.

Experts caution against North Carolina increasing its discount rate to reduce its unfunded liability for the Retiree Health Benefit Fund. Some states have lowered their reported unfunded liability by increasing their discount rate, which is used to convert projected future costs and returns on investments into liabilities in today's dollars. GASB directs states to use a discount rate in their actuarial projections that is consistent with the return on funds used to pay retiree health benefits. Accordingly, most states that fund their plans on a pay-as-you-go basis use a discount rate between 4% and 5%. However, some states with trust funds use a higher discount rate to calculate their retiree health liabilities.

The Retiree Health Benefit Fund's actuary currently uses a discount rate of 4.25% in its projections. According to actuarial estimates, if North Carolina increased its discount rate from the current rate of 4.25% to 7.25%,²⁷ the unfunded liability of the Retiree Health Benefit Fund would decrease by \$7.2 billion.²⁸ However, North Carolina would violate GASB standards if it used a higher discount rate without prefunding the trust each year. At this time, sound fiscal policy suggests North Carolina should use the lower discount rate which is appropriate to the funding status of the retiree health fund and the yield on assets from which funds are drawn to pay health benefits for retirees.

Forthcoming changes in accounting standards for the discount rate and other variables will likely increase North Carolina's unfunded liability for the Retiree Health Benefit Fund. In June 2015, GASB approved new OPEB reporting requirements in Statement 75, which replaces Statement 45. GASB has specifically stated the new OPEB reporting requirements are for accounting purposes only and are not for the purpose of establishing funding standards. Instead, the new policies in Statement 75 are intended to increase transparency, consistency, and comparability.

Adherence to Statement 75 will require states to use a blended discount rate as follows.

- For projected benefit payments for which plan assets are projected to be sufficient, the discount rate will be based on the long-term expected rate of return.
- For projected benefit payments for which plan assets are projected to be insufficient, the discount rate will be based on bond rates.²⁹

According to preliminary actuarial estimates, this new requirement will substantially increase the unfunded liability of the Retiree Health Benefit Fund.

²⁷ Following the State Health Plan's move to the Department of State Treasurer in 2011, the General Assembly added the Retiree Health Benefit Fund to the Retirement Systems investment pool in 2012. Other plans in the investment pool, including the Teachers' and State Employees' Retirement System, use discount rates of 7.25%.

²⁸ This estimate also includes changing the funding method from the projected unit credit method to the entry age normal cost method used for the Teachers' and State Employees' Retirement System (see Footnote 30 for a definition of terms). Whereas increasing the discount rate reduces the unfunded liability of the Retiree Health Benefit Fund, transitioning to the entry age normal cost method offsets some of that reduction because it increases liabilities.

²⁹ GASB allows use of the yield on a tax-exempt, 20-year general obligation municipal bond or index as the discount rate. As of July 2, 2015, this yield rate was 3.85%, which is lower than the 4.25% currently being used for actuarial projections. Use of a lower discount rate makes the unfunded liability larger.

Other requirements of Statement 75 have implications for the funding status of the Retiree Health Benefit Fund.

- States will have to use the entry age normal cost method.³⁰
- States will have to factor several causes of change in liability (e.g., changes in benefit terms) into the calculation of expense immediately in the period in which the change occurs.

Other requirements of Statement 75 have implications for the financial status of the State.

- States will have to report retiree health benefit liabilities on their balance sheets rather than just in the notes section of their Comprehensive Annual Financial Reports, disclosing these liabilities at the same level they report long-term obligations.
- States will have to report the impact on liability of a one-percentage-point increase and decrease in the discount rate and healthcare cost trend rate.

Finally, a Statement 75 requirement has implications for the financial status of universities, community colleges, and school districts.

- Governments that participate in a cost-sharing OPEB plan that is administered through a trust will have to report a liability equal to their proportionate share of the collective OPEB liability for all entities participating in the cost-sharing plan.

This change will lower the State's unfunded liability for retiree health benefits in the Comprehensive Annual Financial Report. However, because universities, community colleges, and school districts participate in the Retiree Health Benefit Fund, they will have to disclose their share of the unfunded liability in their financial records. This change could negatively affect the financial status of these entities, which could ultimately be detrimental to the State because it provides a substantial portion of their funding.

North Carolina's unfunded liability for the Retiree Health Benefit Fund could affect the State's bond rating. Bond rating agencies use states' Comprehensive Annual Financial Reports to determine bond ratings. States aspire to have high bond ratings from the three rating agencies (Moody's Investor Services, Standard & Poor's Corporation, and Fitch Ratings). State bond ratings affect the interest rates paid when state governments issue general obligation bonds.³¹ North Carolina and nine other states received the highest rating from all three bond rating agencies in 2014.

OPEB liability is one of the factors that bond rating agencies use to assess states' long-term liabilities. However, at least one bond rating agency treats OPEB liability as less significant compared to debt and pensions.³² Nevertheless, more standardized estimation and reporting will make it

³⁰ The entry age normal cost method, which the majority of public pension systems use, distributes the present value of benefits—the total cost of benefits accrued throughout an employee's career, including benefits projected to be earned in the future, expressed in today's dollars—as a level percentage of the employee's pay across each year of an employee's career. The actuarial statement for the Retiree Health Benefit Fund currently uses a projected unit credit cost method, which allocates the present value of benefits proportionately to each year of service.

³¹ General obligation bonds are issued for funding permanent capital improvements such as buildings and roads. These bonds are repaid by levying taxes, which requires voter approval according to the North Carolina Constitution.

³² Porter et al. (2014). U.S. State OPEB Liabilities: Liability Limited for Most; Uncertain Assumptions Drive Calculations. Fitch Ratings.

easier for bond rating agencies to compare OPEB liabilities across states. As a result, North Carolina's unfunded liability for its retiree health benefits relative to other states is important to the State's overall financial status.

3. How does the funding status of the Retiree Health Benefit Fund compare to the funding status of other states' funds?

All states offer health coverage to at least some of their retirees.³³ However, the comparability of the financial status of states' funds for retiree health benefits is limited due to variations in how states structure their benefits and how actuaries estimate unfunded liability. For example, in states where retirees are required to pay a premium for coverage, the state's unfunded liability may only reflect a small implicit rate subsidy that results from allowing retirees (who are older and therefore more costly to cover) to participate in the plan with active employees. In states that cover school employees, including North Carolina, a portion of the reported unfunded liability for the state is actually attributable to employers other than the state, such as school districts. The comparability of different states' plans also is limited because actuaries may use different cost methods and assumptions to calculate liabilities. Furthermore, actuarial estimates must incorporate forecasts of healthcare costs well into the future, and minor forecasting differences can lead to variability in liability estimates.

Although comparability across states is limited, experts use three measures to compare the funding status of states' retiree health benefits. North Carolina is not a strong performer on any of these measures.

A common way to compare unfunded liability across states is to factor in population size, comparing unfunded liability per capita.³⁴ Unfunded liability per capita indicates how large of a burden it is for a state to pay off its liability relative to the size of its population. As shown in Exhibit 11, North Carolina ranked 41st in unfunded liability per capita for retiree health benefits in Fiscal Year 2012–13. Only eight states performed worse on this measure.

³³ Clark, R. L., and Morrill, M. S. (2011). The funding status of retiree health plans in the public sector. *Journal of Pension Economics and Finance*, 10(2), 291-314. Although data collected by the Medical Expenditure Panel Survey Insurance Component (MEPS-IC) shows, in 2013, 73% of state government units offered health benefits to retirees younger than 65 and 63% of state government units offered health benefits to retirees 65 and older, their data represents state government units, including parent and dependent agencies, not whole states themselves.

³⁴ "Per capita" means per state resident, not per state employee.

Exhibit 11

North Carolina Ranked
41st in Unfunded Liability
Per State Resident for
Retiree Health Benefits
in Fiscal Year 2012–13

Rank	State	Unfunded Liability per Capita	Rank	State	Unfunded Liability per Capita
1	Oklahoma	\$1	26	Michigan	\$920
2	Arizona	\$33	27	Pennsylvania	\$1,030
3	Idaho	\$34	28	Kentucky	\$1,102
4	Indiana	\$48	29	Ohio	\$1,206
5	Oregon	\$60	30	Maine	\$1,298
6	North Dakota	\$66	31	New Hampshire	\$1,403
7	South Dakota	\$80	32	Maryland	\$1,483
8	Utah	\$92	33	California	\$1,722
9	Kansas	\$96	34	New Mexico	\$1,768
10	Minnesota	\$120	35	Georgia	\$1,825
11	Wisconsin	\$166	36	Louisiana	\$1,847
12	Iowa	\$170	37	Texas	\$1,978
13	Mississippi	\$231	38	South Carolina	\$2,039
14	Florida	\$250	39	Massachusetts	\$2,298
15	Colorado	\$252	40	West Virginia	\$2,319
16	Virginia	\$258	41	North Carolina	\$2,347
17	Tennessee	\$261	42	Vermont	\$2,624
18	Wyoming	\$376	43	Illinois	\$2,677
19	Nevada	\$423	44	New York	\$3,446
20	Montana	\$440	45	Alaska	\$6,136
21	Missouri	\$442	46	Delaware	\$6,228
22	Washington	\$532	47	Connecticut	\$6,279
23	Alabama	\$665	48	New Jersey	\$7,178
24	Arkansas	\$695	49	Hawaii	\$9,738
25	Rhode Island	\$816			

Notes: Nebraska is not included because it carries an OPEB liability that is described as immaterial for purposes of reporting. The latest data available for New Mexico was from Fiscal Year 2011–12.

Source: Program Evaluation Division based on data from the National Association of State Retirement Administrators and the Center for State and Local Government Excellence.

Another way to compare state funding of retiree health benefits is by comparing funded ratios. As shown in Exhibit 12, the ratio between the actuarial value of assets and actuarial accrued liability indicates the extent to which a government has enough funds set aside to pay for benefits for which employees are eligible. In Fiscal Year 2013–14, only 3.4% of North Carolina's liability for retiree health benefits was funded.

Exhibit 12: North Carolina’s Retiree Health Benefit Fund Was Only 3.4% Funded in 2013

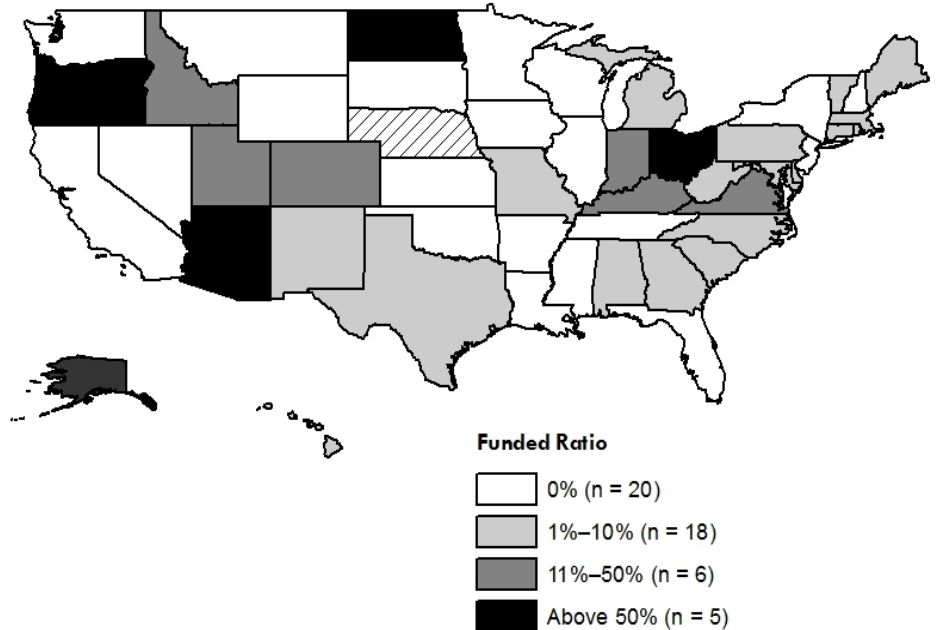
Funded Ratio	=	Actuarial Value of Assets	/	Actuarial Accrued Liability
extent to which enough funds are set aside to pay for benefits for which employees are eligible		value of cash, investments, and other assets that are set aside to fund benefit		value of benefits for which employees are eligible
3.4%		\$890,755,562		\$26,420,167,735

Source: Program Evaluation Division based on data from the 2014 Comprehensive Annual Financial Report.

Most states have a low funded ratio for their retiree health funds. As shown in Exhibit 13, 20 states had a funded ratio of 0%, and 18 states—including North Carolina—had a funded ratio between 1 and 10% in Fiscal Year 2012–13. The national average was 11%, and the median was 2%.

Exhibit 13

North Carolina Among 38 States With Funded Ratios of 10% or Less in Fiscal Year 2012–13



Notes: Nebraska is not included because it carries an OPEB liability that is described as immaterial for reporting purposes. The latest data available for New Mexico was from Fiscal Year 2011–12.

Source: Program Evaluation Division based on data from the National Association of State Retirement Administrators and the Center for State and Local Government Excellence.

A third method for comparing funding status between states is to examine how much of the annual required contribution they meet. The annual required contribution, or ARC, is the amount of money that an actuary calculates the government needs to contribute to the plan during the current year for benefits to be fully funded by the end of the amortization period (see Exhibit 14).³⁵ In most states, including North

³⁵ The amortization period is the span of time the plan has to fully pay its unfunded actuarial accrued liabilities.

Carolina, the legislature determines how much the State is going to contribute. Most states do not base their annual contributions for retiree health benefits on the ARC because they fund annual costs on a pay-as-you-go basis. If a state meets the ARC, the state contributed 100% of the ARC. If a state does not meet the ARC, the closer its percentage is to 100%, the closer its contribution is to meeting the plan’s actuarial recommendation. Percentage of ARC paid is one indication of which states are using funding as a way to reduce liabilities.

Exhibit 14: North Carolina Paid 36% of the Annual Required Contribution in Fiscal Year 2013–14

<p>Current Year Normal Cost costs of benefits for which employees became eligible in current year</p> <p>\$1,280,839,603</p>	+	<p>Amortized Portion of UAAL amount needed for benefits to be fully funded by end of amortization period</p> <p>\$943,060,734</p>	=	<p>Annual Required Contribution amount that, if paid in full each year, would fund currently accruing costs and a portion of unfunded liability</p> <p>\$2,223,900,337</p>
<p>State Contribution amount General Assembly appropriated</p> <p>\$798,401,569</p>	/	<p>Annual Required Contribution</p> <p>\$2,223,900,337</p>	=	<p>Percentage of Annual Required Contribution Paid extent to which government is using funding to reduce liabilities</p> <p>36%</p>

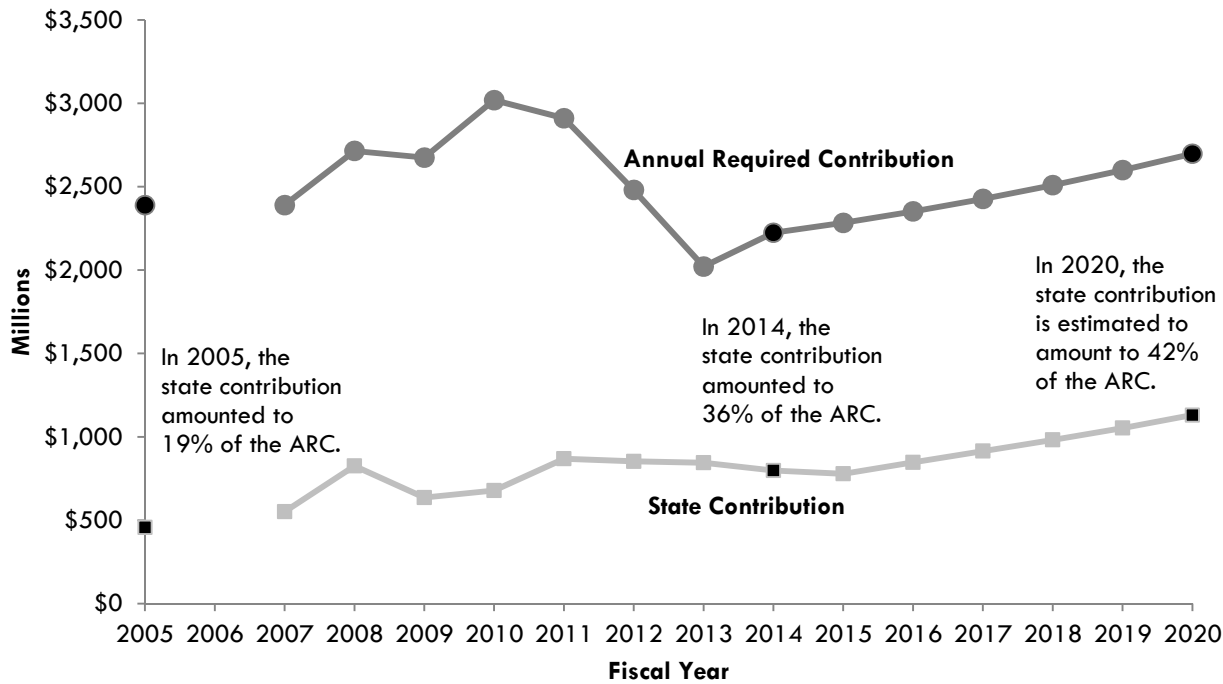
Notes: The amortization period is the span of time the plan has to fully pay its unfunded actuarial accrued liabilities. Similar to most other states, the amortization period for North Carolina’s Retiree Health Benefit Fund is 30 years.

Source: Program Evaluation Division based on data from the Comprehensive Annual Financial Report.

As shown in Exhibit 15, when the first actuarial statement of the Retiree Health Benefit Fund was produced in 2005, the state contribution amounted to 19% of the amount needed to fully fund the benefit. In Fiscal Year 2013–14, the General Assembly set the state contribution at \$798.4 million, which amounted to 36% of the ARC. The fund’s actuary estimates that at current funding levels, the state contribution will amount to 42% of the ARC in 2020. Although the percentage of ARC paid is going up, this increase is being driven by the cost of retiree health benefits in the current year relative to the future as opposed to a commitment to prefunding.

As shown in Exhibit 16, North Carolina was one of 26 states that paid less than 50% of its ARC in Fiscal Year 2012–13. The national average was 55%, and the median was 47%.

Exhibit 15: On Average, North Carolina Has Paid a Third of its Annual Required Contribution

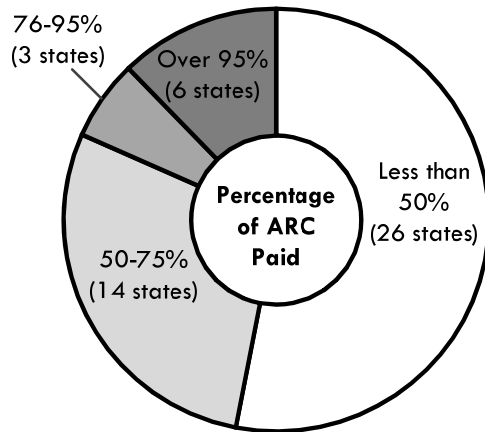


Notes: No actuarial statement was produced in 2006. The dip in the State Contribution in 2009 and 2010 was due to the Retiree Health Benefit Fund’s actuary using a different method for calculating the contribution.

Source: Program Evaluation Division based on data from actuarial statements.

Exhibit 16

North Carolina Among 26 States that Paid Less than 50% of Annual Required Contribution in Fiscal Year 2012–13



Percentage of ARC Paid	States
Less than 50%	AL, AR, CA, CT, DE, FL, GA, HI, IA, IL, LA, MA, MO, MT, NC , NH, NJ, NM, NV, NY, OR, SD, TN, TX, VT, WA
50-75%	AK, IN, KS, KY, MD, ME, MN, MS, OK, PA, SC, WI, WV, WY
76-95%	OH, RI, VA
Over 95%	AZ, CO, ID, MI, ND, UT

Notes: Nebraska is not included because it carries an OPEB liability that is described as immaterial for purposes of reporting. The latest data available for New Mexico was from Fiscal Year 2011–12.

Source: Program Evaluation Division based on data from the National Association of State Retirement Administrators and the Center for State and Local Government Excellence.

4. What options exist for improving the funding status of the Retiree Health Benefit Fund?

Several factors explain why North Carolina's unfunded liability for retiree health benefits is large.

- The benefits have always been funded on a pay-as-you-go basis.
- Retirees with sufficient contributory service are eligible for a non-contributory benefit, meaning the State pays 100% of their premium.
- The benefits are available to essentially all retirees with the requisite number of years of service, regardless of whether they retire before age 65 or retire directly from state employment.

The General Assembly could take actions to change some of the factors contributing to the large unfunded liability of the Retiree Health Benefit Fund. As shown in Exhibit 17, several options exist to either increase the amount of funding for the retiree health benefit or reduce the value of the benefit. Some of these changes require action by the General Assembly, and some can be made by the State Health Plan with or without a directive from the General Assembly. More details about each option are presented below.

1. The General Assembly could increase the amount of assets in the Retiree Health Benefit Fund through appropriation. Although North Carolina has a trust fund, retiree health benefits are still funded on a pay-as-you-go basis. The low funded ratio of North Carolina's trust is similar to other states' retiree health trusts. Although 32 states had trusts in 2014, most states still funded annual costs on a pay-as-you-go basis.

Currently, the annual required contribution for the Retiree Benefit Health Fund amounts to 15% of payroll, but the General Assembly appropriated 5.49% of payroll in Fiscal Year 2014–15. According to the fund's actuary, the General Assembly would need to appropriate 10% of payroll to be considered to be prefunding the trust. Although an increased appropriation would not eliminate North Carolina's unfunded liability, it could incrementally build the trust fund and generate more investment income.

Exhibit 17: Ways to Decrease North Carolina’s Unfunded Liability for Retiree Health Benefits

Option	Impact			Decision Maker	
	Increase funding		Reduce value of benefit to employees	General Assembly	State Health Plan
	State	Federal			
1. Increase appropriation	✓			✓	
2. Increase the costs borne by the federal government					
2a. Shift all Medicare-eligible retirees to Medicare Advantage plans		✓			✓
2b. Encourage retirees to opt for coverage from the health insurance exchange or TRICARE		✓		✓	
3. Transition to a defined contribution model	Depends on state’s contribution rate		Depends on individual circumstances	✓	
4. Reduce the number of individuals eligible					
4a. Increase service time requirements for the benefit			✓	✓	
4b. Eliminate benefit for eligible employees			✓	✓	
4c. Eliminate benefit for employees not yet eligible			✓	✓	
4d. Eliminate benefit for new hires			✓	✓	
4e. Eliminate benefit for individuals not directly retiring			✓	✓	
4f. Eliminate benefit for individuals younger than 65			✓	✓	
4g. Eliminate benefit for individuals 65 and older			✓	✓	
4h. Eliminate the benefit for spouses			✓	✓	
5. Require active employees to make contributions			✓	✓	
6. Increase the amount retirees pay					
6a. Increase premiums			✓		✓
6b. Increase out-of-pocket costs			✓		✓

Notes: Possible legal ramifications for exercising these options are discussed in Question 5. The value employees place on defined contribution plans depends on their individual circumstances, such as age at retirement and health status.

Source: Program Evaluation Division.

2. The State Health Plan could increase the amount of retiree health benefit costs borne by the federal government, potentially saving up to \$64 million annually. One of the easiest ways to reduce the unfunded liability of the Retiree Health Benefit Fund would be for the State Health Plan to require all Medicare-eligible retirees to enroll in the Medicare Advantage plans. In 2015, 27% of Medicare-eligible retirees were enrolled in the Traditional 70/30 Plan. The State Health Plan could shift these individuals to Medicare Advantage plans, under which they would pay either the same or lower premiums and receive benefits comparable in value to an 80/20 plan. Retirees could opt out of the plan through an appeal process if individual circumstances warranted a different plan. The Georgia State Health Benefit Plan takes this approach, allowing Medicare-eligible retirees to choose among plan options but only subsidizing the Medicare Advantage option.

Based on estimates of past savings, the State could save between \$44 and \$50 million annually if the remaining 35,000 to 40,000 Medicare retirees on the Traditional 70/30 Plan were enrolled in Medicare Advantage plans.³⁶ A comparison of per capita medical costs borne by the State for Medicare and Medicare Advantage plans presented in the most recent actuarial valuation indicates this savings may be as high as \$64 million.³⁷ The shift toward requiring participation in Medicare Advantage plans could produce a 10-year savings of approximately \$515 million and reduce the State's unfunded liability for the Retiree Health Benefit Fund by up to \$3 billion.³⁸

In addition, the State could consider offering financial incentives to encourage early retirees to obtain insurance through the health insurance exchange created by the Affordable Care Act.³⁹ The State Health Plan could provide a supplement to retirees younger than 65 to offset the additional costs of obtaining their health insurance through the exchange relative to the cost of premiums for coverage through the State Health Plan.

According to preliminary analyses, shifting retirees and their households to health insurance purchased on the exchanges would save every state money, approximately \$18 billion to state and local governments collectively over 10 years.⁴⁰ Other states are exploring the option of selective divestment. For example, when retiree health rates increased in South Dakota in 2015, State Human Resources sent a letter to state retirees encouraging them to compare their state rates to rates on the health insurance exchange.

³⁶ Recent analyses estimate the State saved approximately \$1,248 per member per year when more than 100,000 Medicare retirees enrolled in Medicare Advantage plans. Multiplying 35,000 and 40,000 members by \$1,248 would lead to future savings of \$44 to \$50 million annually.

³⁷ The following assumptions were used to generate this estimate: participants and dependents were evenly split between men and women and the population using the 70/30 Traditional Plan had an age distribution that was 35% age 65, 35% age 70, 20% age 75, and 10% age 80.

³⁸ The 10-year savings amount is expressed in present value, which was calculated by adjusting the annual savings for each of the next 10 years by a 4.25% discount rate.

³⁹ Employers do not face a penalty for shifting retirees younger than 65 to the exchanges.

⁴⁰ Goldhaber-Fiebert, J. D., Studdert, D. M., Farid, M. S., & Bhattacharya, J. (2014). Will Divestment from Employment-Based Health Insurance Save Employers Money? The Case of State and Local Governments (No. w20222). National Bureau of Economic Research.

During the 2013 Session, the Speaker of the North Carolina House of Representatives established an interim House Select Committee on Legacy Costs for the State's Obligations for Pensions, Retiree Health Benefits, State Health Plan, and Unemployment Benefits. The committee recommended the State explore the possibility of encouraging non-Medicare-eligible retirees to transition from State Health Plan coverage to private coverage provided on the health insurance exchange. Although the North Carolina Senate considered a bill during the 2013 Session to allow the State Treasurer to pay premiums for retirees for alternative coverage outside of the State Health Plan, the bill was never heard by committee. The 2015 Appropriations Act had not passed at the time of this report's release, but the Senate's version of the budget authorized the State Treasurer to offer to pay or reimburse premiums for retirees with alternative health benefit plan coverage in lieu of coverage under the State Health Plan.

The committee also recommended the State explore the possibility of encouraging eligible retirees to utilize TRICARE coverage in lieu of State Health Plan coverage. TRICARE is the U.S. Department of Defense's military healthcare program for active duty service members, National Guard and Reserve members, retirees, and their families. It offers several different health plans that all meet the coverage requirements of the Affordable Care Act. Georgia and South Carolina offer access to TRICARE supplemental insurance plans to retirees on TRICARE that pay up to 100% of the participants' balance of covered medical expenses after TRICARE pays.

3. The General Assembly could reduce the State's future liability by transitioning to a defined contribution model. North Carolina's retiree health benefit is a "defined benefit" in the sense that the State as the employer specifies a determinable benefit—doctor visits, hospitalization, pharmacy and so on, but the level of benefits provided may change from year to year.⁴¹ Defined benefit plans cover determinable benefits often at uncertain annual costs to states.

By contrast, in a defined contribution plan, the employer provides its employees a health insurance allowance, and the employee takes on the risks of rising healthcare costs, poor investment returns, and outliving account assets. Providing a fixed subsidy through a defined contribution plan can help reduce a state's unfunded liability by defining the limits of its costs. Two types of defined contribution models that can be used to fund retiree health benefits are Health Reimbursement Arrangements and Health Savings Accounts.

- **Health Reimbursement Arrangements (HRAs).** Through an HRA, employers can set up a fund to reimburse employees and/or retirees for a set amount of annual medical costs. Unused funds can be carried forward to the next period. Employees and retirees are not allowed to make contributions to HRAs. In general, an HRA can be used in conjunction with active employee health benefits and/or established for retiree benefits.

⁴¹ The health plan offered to both active employees and retirees is a defined benefit plan. Current retirees are offered the same defined benefit health plan as current active employees. Future retirees may be offered the same benefit as future active employees.

North Carolina already uses an HRA as part of its Consumer-Directed Health Plan (CDHP) available to employees and non-Medicare-eligible retirees, which can be viewed as a precursor to a defined contribution approach. Although it offers the same medical services as the Enhanced 80/20 and Traditional 70/30 plans, the CDHP is a high-deductible health plan with an HRA. The State Health Plan funds each employee or retiree's HRA at the beginning of the calendar year with \$500. If the employee or retiree does not spend all of the HRA, the money is carried forward to the next period. If the employee or retiree spends all of the HRA, he or she has to pay healthcare expenses until the deductible is met, after which point co-insurance costs are applied.

- **Health Savings Accounts (HSAs).** An HSA is a tax-favored savings account established to accumulate funds on a tax-deferred basis, similar to a 401(k) retirement plan, and it must be established with a high-deductible plan. An HSA can be funded by both employer and employee contributions, which must remain within limits established by the Internal Revenue Service. Under these limits, it may be difficult for an employee or retiree to accumulate funds if they are needed to pay for current-year healthcare costs.

The Minnesota State Retirement System began an HSA in 2001. Retirees are reimbursed from the plan for eligible medical expenses. For example, the plan can be used to pay for premiums, which are fully contributory for Minnesota retirees. The employer elects to contribute either a specified dollar amount or a percentage of employees' salaries into employees' plans. These contributions are funded by additional employer contributions beyond salary and other employee benefits, mandated employee contributions through reduced salaries, and/or severance pay such as unused vacation or sick leave. Assets in a participant's savings plan accumulate on a tax-free basis, and participants choose from a variety of investment options.

4. The General Assembly could reduce the number of individuals eligible for retiree health benefits by increasing the service time requirements for the benefit or eliminating the benefit for certain groups. The General Assembly reduced the number of individuals eligible for retiree health benefits in 2006 by increasing the requisite years of service to 20 for the non-contributory health benefit and to 10 for the one-half contributory health benefit for employees hired on or after October 1, 2006. This increase in service time requirements reduced the unfunded liability by \$78 million in 2006. The General Assembly could further reduce the unfunded liability by increasing service time requirements from 20 years to 25 or 30 years. At least three states require retirees hired after a certain date to have 25 years of service to receive premium-free health benefits.⁴² Ohio requires retirees to have 30 years of service to receive premium-free health benefits.⁴³

⁴² The three states are Alabama, Hawaii, and New Jersey.

⁴³ Retirees with at least 10 years of service prior to or on January 1, 2007, receive an allowance equal to 100% of the cost of coverage in 2007.

Another way for the General Assembly to reduce the number of individuals eligible for retiree health benefits is to eliminate it for certain groups. Exhibit 18 shows the rationale for and against eliminating the retiree health benefit for a certain group, examples of states that do not offer the benefit to that group, and the percentage of the unfunded liability that could be reduced by eliminating the benefit to that group. The 2015 Appropriations Act had not passed at the time of this report's release, but the Senate's version of the budget eliminated retiree health benefits for employees hired on or after January 1, 2016.

5. The General Assembly could require employees to contribute to the Retiree Health Benefit Fund. Currently, active employees are not required to contribute toward prefunding their retiree health benefits. In contrast, state employees have been contributing to the Teachers' and State Employees' Retirement System (TSERS) for pension benefits since its inception in 1941; currently, employees pay 6% of their compensation for the duration of their employment with the State.⁴⁴ These employee contributions along with employer contributions and investment earnings pay the cost of providing retirement benefits to members of TSERS, which had a funded ratio of 98% in 2013.

In Fiscal Year 2013–14, the cost of retiree health benefits was \$1.3 billion or 8.49% of payroll, but the General Assembly appropriated 5.49% of payroll in Fiscal Year 2014–15. The General Assembly could require employees to contribute a certain percentage of their pay (e.g., 3%) to the Retiree Health Benefit Fund to help prefund their retiree health benefits.

Several states require their employees to contribute to their state's retiree health funds.

- **Connecticut.** Connecticut state employees hired after June 30, 2009 and eligible for state-paid health insurance are required to contribute 3% of their compensation to offset the cost of providing retiree health benefits.
- **Kentucky.** In 2008, Kentucky passed a law to require state and county employees, state police members, and teachers participating in the retirement system hired after September 1, 2008 to make a 1% employee contribution to its trust fund for retiree health benefits.
- **New Mexico.** In New Mexico, employees participating in the retirement system have been required to contribute to the retiree health fund since 2002, with contributions incrementally increasing to up to 1.25% of employees' salaries in 2012.
- **Michigan.** The Michigan legislature required state employees enrolled in the retirement system to contribute an amount equal to 3% of compensation to the fund beginning with the first pay date after November 1, 2010 and ending September 30, 2013.

⁴⁴ N.C. Gen. Stat. 135-8(b)(1).

Exhibit 18: Potential Groups for Which to Eliminate Retiree Health Benefits

Group of Employees	Rationale for Eliminating	Rationale for Not Eliminating	Examples of States Not Providing Benefit	Percentage Reduction in Unfunded Liability in 2026
Eligible employees and retirees	<ul style="list-style-type: none"> Employees do not place a high enough value on retiree health benefits to affect their behavior 	<ul style="list-style-type: none"> High probability of lawsuit Eliminating benefit without increasing compensation may hurt retention 	--	78%
Employees not yet eligible	<ul style="list-style-type: none"> Employees do not place a high enough value on retiree health benefits to affect their behavior 	<ul style="list-style-type: none"> Potential lawsuit Eliminating benefit without increasing compensation may hurt retention 	--	22%
New hires	<ul style="list-style-type: none"> Employees do not place a high enough value on retiree health benefits to affect their behavior 	<ul style="list-style-type: none"> Eliminating the benefit without increasing compensation may hurt recruitment 	--	10%
Those who do not retire directly from state service	<ul style="list-style-type: none"> Individuals who go to work for other employers following their state service could get health insurance from their new employers or through the new health insurance exchange under the Affordable Care Act 	<ul style="list-style-type: none"> May discourage retirees younger than 65 from seeking subsequent employment Potential lawsuit Eliminating the benefit without increasing compensation may hurt transition to retirement 	CA, FL, LA, MD, RI, VA, VT, WV	Eligible: 13% Not yet eligible: 8% New hires: 4%
Younger than 65	<ul style="list-style-type: none"> Individuals who retire from state government before they reach age 65 could find employment elsewhere or could get health insurance from the new health insurance exchange under the Affordable Care Act Costs of non-Medicare retirees exceed the premiums collected 	<ul style="list-style-type: none"> May discourage employees from retiring before age 65 Potential lawsuit Eliminating the benefit without increasing compensation may hurt transition to retirement 	--	Eligible: 16% Not yet eligible: 7% New hires: 3%
65 and older	<ul style="list-style-type: none"> Medicare coverage is sufficient for retirees 	<ul style="list-style-type: none"> Costs of Medicare retirees are less than the premiums collected May discourage employees from retiring Potential lawsuit Eliminating the benefit without increasing compensation may hurt transition to retirement 	ID, IN, NE	Eligible: 62% Not yet eligible: 15% New hires: 7%
Spouses	<ul style="list-style-type: none"> Spouses did not work for state government and thus should not be eligible for a benefit offered to former employees Costs of non-Medicare retirees plus their spouses exceed the premiums collected 	<ul style="list-style-type: none"> Retirees enroll their spouses on a fully contributory basis, meaning the member pays the full premium cost of dependent coverage Costs of Medicare retirees plus spouses are less than premiums collected Potential lawsuit Eliminating the benefit without increasing compensation may hurt recruitment and retention 	--	Data not available

Notes: The Program Evaluation Division verified the inclusion of states that appear as examples but did not verify the exclusion of states that do not appear. Percentage reduction in unfunded liability for eligible and not-yet-eligible employees is based on 2011 estimates provided by Aon Consulting, the State Health Plan actuary at the time. The Program Evaluation Division estimated reductions in unfunded liability for new hires by estimating the percentage of not-yet-eligible employees who were new hires and would make it to retirement and multiplying this number by Aon Consulting’s estimates for not-yet-eligible employees.

Source: Program Evaluation Division.

Another possibility is for the General Assembly to enact legislation that offers employees a choice between contributing or giving up their retiree health benefit. The legislation could stipulate that employees can keep their retiree health benefit as long as they contribute a certain percentage of their pay for the remainder of their employment with the State, but they can choose to stop contributing at any time if they sign an agreement to forfeit all future retiree health benefits. If employees do not value the retiree health benefit, they would choose to forfeit the benefit, which would significantly reduce the unfunded liability of the Retiree Health Benefit Fund.

6. The State Health Plan could increase the amount retirees pay for their health benefits by increasing premiums or out-of-pocket costs. Although the State Health Plan's ability to change provider reimbursement and utilization rates is limited,⁴⁵ there are actions it could take to reduce the amount the plan spends on healthcare. The State Health Plan could reduce the value of the health benefit by requiring retirees to pay a higher percentage of premium costs.

Scholars have found that a state's subsidization of retiree premiums is the most robust determinant of a state's unfunded liability.⁴⁶ States, like North Carolina, that subsidize between 50 to 100% of retiree premiums tend to have higher unfunded liabilities than states that pay less than 50% of premiums. In 2006, North Carolina was one of 14 states offering retirees younger than 65 a non-contributory health plan option.⁴⁷

In some cases, states offer retirees health insurance but do so on a fully contributory basis. In 2006, 14 states required retirees younger than 65 to pay 100% of the premium cost. For example, Iowa and Idaho allow retirees to enroll in a state employee health plan but do not subsidize any of the premium cost. Although Virginia requires its retirees to pay 100% of the health plan premium cost, it contributes a fixed subsidy of \$4 per month for every year of service for retirees who have at least 15 years of service. According to the National Association of State Retirement Administrators (NASRA), 25% of state governments surveyed increased retiree premium amounts from 2008 to 2013.

Although the State Health Plan currently spreads any premium increases needed to cover its expenses evenly amongst active employees, retirees, and dependents, it could choose to uncouple these premium rates. Currently, if a 5% increase is required, the General Assembly is asked to increase the employer contribution by 5%, and the premium rates for plan participants are increased by 5%. Accordingly, the employee-only, retiree-only, and dependent premium rates are increased equally even though loss

⁴⁵ The State Health Plan pursues programs to improve the health of plan participants and thereby reduce their utilization of healthcare services. In 2012, the State Health Plan began offering wellness incentives for participant engagement as part of its Enhanced 80/20 Plan and Consumer-Directed Health Plan. In 2014, the State Health Plan offered health and chronic disease management programs as part of its Medicare Advantage plans. In addition, SilverSneakers—a national fitness program designed exclusively for older adults to help them manage their health and increase their strength, balance, and endurance through fitness classes taught by certified trainers—is part of the Medicare Advantage plans.

⁴⁶ Clark, R. L., & Morrill, M. S. (2011). The funding status of retiree health plans in the public sector. *Journal of Pension Economics and Finance*, 10(02), 291-314.

⁴⁷ Government Accountability Office. (2007). *State and local government retiree benefits: Current status of benefit structures, protections, and fiscal outlook for funding future costs*. A more recent compilation of 50-state data is not available.

ratios indicate certain groups cost the State Health Plan more. For example, active employees had a loss ratio of 89% as compared to 162% for non-Medicare retirees and 48% for Medicare retirees. Although uncoupling premium increases would place the burden of higher premiums on the populations that cost more to cover, creating a separate risk pool for retirees could increase their premium costs substantially.

When pricing the different retiree health plans, the State Health Plan must decide how to encourage retirees to enroll in the best plan for them while acting in a cost-effective manner for the State. Retirees with sufficient contributory service are eligible for a premium-free benefit. However, the State Health Plan could shift some costs to retirees if retirees chose to enroll in health plans with a premium. The State Health Plan could analyze enrollment information to determine what type of plan would incentivize retirees to choose a premium option over a premium-free option.

Another way the State Health Plan could decrease the share of medical costs borne by the State is increasing out-of-pocket costs (deductibles, coinsurance, and copayments) for its different health plan options. According to the NASRA survey, more than 20% of state governments surveyed increased retirees' copayments from 2008 to 2013, and more than 15% of state governments increased retirees' deductibles.

Although the State Health Plan could shift medical costs to retirees by increasing out-of-pocket costs, North Carolina already does not have a rich plan compared to other states. Plan richness reflects the relative cost sharing between a health plan and enrollees based on the required deductibles, coinsurance, and copayments. The richness of a plan depends on its actuarial value, which represents the proportion of overall cost a plan pays for an employee. Health plans in the federal health insurance exchange are categorized as follows:

- platinum plans cover 90% of medical costs;
- gold plans cover 80% of medical costs;
- silver plans cover 70% of medical costs; and
- bronze plans cover 60% of medical costs.

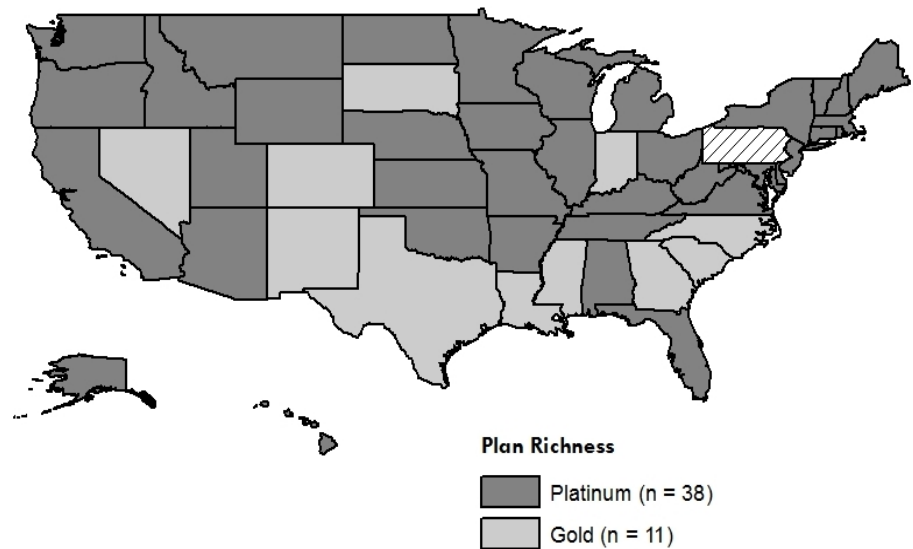
The Program Evaluation Division applied these federal categorizations to the average actuarial value of state health plans (see Exhibit 19).⁴⁸ In 2013, North Carolina's State Health Plan had an average actuarial value of 82%, which made it a gold plan. Of the 49 states considered, 38 states had platinum plans.⁴⁹ Of the 11 states with a gold plan, only Georgia had a lower average actuarial value than North Carolina.

Moreover, increasing out-of-pocket expenses would impact coverage costs for active employees because they participate in the same plan as retirees.

⁴⁸ States' average actuarial values for health plans for active employees were presented in the Pew Charitable Trusts and John D. and Catherine T. MacArthur Foundation's 2014 report, "State employee health plan spending: An examination of premiums, cost drivers, and policy approaches."

⁴⁹ No data was available for Pennsylvania.

Exhibit 19

North Carolina Among
11 States With Gold
Plans in 2013

Notes: Platinum plans cover 90% of medical costs, and gold plans cover 80% of medical costs. No data was available for Pennsylvania.

Source: Program Evaluation Division based on data from the Pew Charitable Trusts and John D. and Catherine T. MacArthur Foundation.

5. What is the legal feasibility of making changes to improve the funding status of the Retiree Health Benefit Fund?

There could be legal ramifications if the General Assembly transitions to a defined contribution model, makes changes to retiree health benefit eligibility, or requires employee contributions. To date, no legal precedent exists regarding the State's obligation, if any, to maintain certain levels of retiree health benefits. The issue of whether retiree health benefits are entitled to the same protections as have been found to exist with regard to state pension benefits is the subject of a pending lawsuit.

Lake v. State Health Plan for Teachers and State Employees. In 2012, a lawsuit was filed by a group of retirees with at least five years of contributory service.⁵⁰ The plaintiffs allege breach of contract by the State based on the

- elimination of a non-contributory 80/20 health insurance plan in 2011;
- forced election of a significantly reduced 70/30 health insurance plan to receive a non-contributory benefit in 2011; and
- elimination of a contributory 90/10 health insurance plan in 2009.⁵¹

⁵⁰ The lawsuit is a potential class action suit, but as of July 2015 the class had not been certified by the court.

⁵¹ The State's motion to dismiss was denied by Superior Court in 2013, and the Court of Appeals upheld the denial in 2014. The Court of Appeals held the plaintiffs sufficiently pled a valid contract to waive the State's defense of sovereign immunity but did not determine whether any contractual relationship actually existed. In addition, the State's petition to transfer the case to the Supreme Court, bypassing its determination first by the Court of Appeals, was denied by the Supreme Court in December 2014. The parties are in the discovery phase of litigation, which is expected to continue into early 2016.

The plaintiffs allege that because they had amassed at least five years of service before 2011, they are “vested” and eligible to receive health insurance benefits from the State Health Plan on a non-contributory basis for an 80/20 plan as well as access to a 90/10 plan.

The State’s main defense for the case is N.C. Gen. Stat. § 135-48.3, which stipulates the General Assembly reserves the right to alter, amend, or repeal any section of state law regarding the State Health Plan.

If the plaintiffs are successful, the damages may exceed \$100 million, which does not include the cost to the State Health Plan of complying with the plaintiffs’ demands going forward. Settlement of the case is unlikely, inasmuch as any potential settlement of present claims—even if such damages could be compromised and agree upon—would leave unresolved the underlying issue of whether the State Health Plan could make adjustments to cost-share levels and plan premiums for retiree health benefits in the future.

The issue of whether the State could make other alterations to retiree health benefits, such as the options discussed in Question 4 (i.e., changing to a defined contribution model, increasing service time requirements, eliminating the benefit, requiring employee contributions) is not under consideration in the pending lawsuit. These changes could be made for new hires without the threat of a lawsuit, but it is unclear what the legal ramifications would be if the General Assembly made these changes to retiree health benefits for eligible or not-yet-eligible employees. The fact that one of the premises of the plaintiffs’ allegations is they have the requisite number of years of service to be eligible for benefits suggests the plaintiffs may expect the court to treat employees eligible for benefits differently than employees not yet eligible for benefits.

6. How should the General Assembly proceed in making changes to reduce the unfunded liability of the Retiree Health Benefit Fund?

The General Assembly should take action immediately to save the State up to \$64 million dollars annually by directing the State Treasurer and State Health Plan Board of Trustees to shift all Medicare-eligible retirees to Medicare Advantage plans. Transitioning the 27% of Medicare-eligible retirees who are in the Traditional 70/30 plan to the Medicare Advantage plans would increase the cost borne by the federal government and reduce the cost to the State Health Plan. Retirees would not be adversely affected because their premiums would be the same or lower and their benefits would be comparable in value to an 80/20 plan.

The State Health Plan would have to make the administrative change of automatically enrolling all retirees who are 65 or older in the Medicare

Advantage base plan.⁵² The State Health Plan would need to develop and implement an appeal process for retirees who do not qualify for the Medicare Advantage plans because of Medicare eligibility requirements.⁵³

The General Assembly could establish a joint committee to determine other ways North Carolina could best address the \$25.5 billion unfunded liability of the Retiree Health Benefit Fund. The joint committee could consist of 13 members:

- five members of the Senate appointed by the President Pro Tempore of the Senate, with one serving as co-chair;
- five members of the House of Representatives appointed by the Speaker of the House of Representatives, with one serving as co-chair;
- the State Treasurer as an ex officio, nonvoting member;
- the Executive Administrator of the State Health Plan as an ex officio, nonvoting member; and
- a representative of the State Health Plan Board of Trustees, other than the State Treasurer, as an ex officio, nonvoting member.

The purpose of the joint committee could be to examine options—including the six options presented in this report and any other options the committee develops—for reducing the unfunded liability of the Retiree Health Benefit Fund. The joint committee could start by requesting that the State Health Plan report on the feasibility and impact of increasing the amount retirees pay by increasing premiums and out-of-pocket costs. The joint committee could meet for six months and then make a final report to the General Assembly. The report could contain any legislation needed to implement any recommendations of the committee. The committee could be dissolved after it issues its report.

Agency Response

A draft of this report was submitted to the Department of State Treasurer to review. Its response is provided following the report.

Program Evaluation Division Contact and Acknowledgments

For more information on this report, please contact the lead evaluator, Kiernan McGorty, at kiernan.mcgorty@ncleg.net.

Staff members who made key contributions to this report include Meg Kunde and Sara Nienow. Fiscal Research staff member David Vanderweide also contributed. John W. Turcotte is the director of the Program Evaluation Division.

⁵² Currently, only employees who are 65 or older who submit their retirement paperwork 60 days or more prior to their retirement date are automatically enrolled in the Medicare Advantage base plan. Retirees who are 65 or older who submit their paperwork fewer than 60 days prior to their retirement date are automatically enrolled in the Traditional 70/30 plan.

⁵³ Medicare requires that individuals be U.S. citizens or permanent legal residents and that they or their spouse have worked long enough to be eligible for Social Security or that they or their spouse are government employees or retirees who have not paid into Social Security but have paid Medicare payroll taxes while working.



NORTH CAROLINA

OFFICE OF THE TREASURER

JANET COWELL, TREASURER

July 10, 2015

John Turcotte, Director
Program Evaluation Division
300 N. Salisbury Street, Suite 100
Raleigh, NC 27603-5925


Dear Mr. Turcotte:

Thank you for the opportunity to review your division's report on the state's Retiree Health Benefit Fund titled, "*Unfunded Actuarial Liability for Retiree Health is Large, but State Could Save Up to \$64 Million Annually by Shifting Costs to Medicare Advantage Plans.*" The stated purpose of the report – to compare the Retiree Health Benefit Fund's status to that of other states and to explore options for improving its funding status – is important and has the potential to objectively inform the General Assembly's deliberations in a manner conducive to effective decision making.

The report includes valuable information regarding North Carolina's actuarial funding gap for retiree health benefits and makes recommendations for improving that funding. Your agency was very responsive to the 13-page technical response to your draft report prepared by staff of the Retirement Systems Division and the State Health Plan.

Further, we appreciate the Program Evaluation Division's indefatigable efforts to provide policy research to members of the General Assembly. We thank you for understanding that our agency is committed to administering the State Health Plan benefits in a cost-efficient manner for the members of the Plan and taxpayers of our state.

Again, we appreciate being asked to comment on the report.

Sincerely,

Melissa Waller
Chief of Staff