

# NORTH CAROLINA'S OPEB EXPERIMENT: Defusing the State Debt Bomb

**Daniel DiSalvo**  
Senior Fellow



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## About the Author



**Daniel DiSalvo** is a senior fellow at the Manhattan Institute and an associate professor of political science in the Colin Powell School at the City College of New York–CUNY.

DiSalvo's scholarship focuses on American political parties, elections, labor unions, state government, and public policy. He is the author of *Engines of Change: Party Factions in American Politics, 1868–2010* (2012) and *Government Against Itself: Public Union Power and Its Consequences* (2014). DiSalvo writes frequently for scholarly and popular publications, including *National Affairs*, *City Journal*, *American Interest*, *Commentary*, *Los Angeles Times*, *New York Daily News*, and *New York Post*. He is coeditor of *The Forum: A Journal of Applied Research in Contemporary Politics*. DiSalvo holds a Ph.D. in politics from the University of Virginia.

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## Executive Summary

A decade after the Great Recession, state and local governments still face barriers to providing their citizens with ample services. Among the larger fiscal challenges is Other Post-Employment Benefits (OPEB) for public employees. The costs of these programs have been rising, which constrains spending on other priorities.

State and local governments often back-load employee compensation into retirement by promising generous retirement benefits. However, many governments have failed to set aside money to pay for these benefits. While pensions have received the lion's share of public attention, the Federal Reserve estimates that the long-term liability for providing health-care coverage for retired public workers is over \$1 trillion. These rising costs constrain governments' ability to address pressing problems and have helped drive a few cities into bankruptcy.

OPEB reform is particularly difficult because it requires untying a political Gordian knot. To make these programs sustainable, governments or workers or both must make greater contributions to the plans, or benefits must be cut. But politicians dislike raising taxes or cutting services to pay for higher contributions; and workers do not want higher contributions to reduce their pay, nor do they want their future benefits diminished.

Recently, North Carolina joined a small number of states that have taken steps to address the OPEB problem, providing a model for how to phase out OPEB entirely, in a predictable and orderly fashion.

- ✓ First, in 2006, North Carolina raised the number of years required to qualify from retiree health care from five to 20 years.
- ✓ Second, in 2017, as part of its budget bill, the state passed legislation eliminating health-insurance coverage in retirement for employees hired after January 1, 2021.

While these changes will not save much money in the short run, they will eliminate the state's OPEB liability in the long run. Barring backsliding, the state will begin to realize savings in the coming decade.

North Carolina's plan provides a model that other states and localities should consider. To date, only three states—Nebraska, Kansas, and South Dakota—have eliminated their OPEB liabilities. In each of these cases, the health-care liability was relatively small, and the state did not employ many workers.

North Carolina thus offers an instructive approach for larger states with big retiree health-care liabilities but weak public-sector unions. States in that basket include Alabama, Georgia, South Carolina, and Texas. In all four states, unions represent less than 10% of the public workforce. In 2016, Alabama had an OPEB liability of \$10.3 billion; Georgia, \$18 billion; South Carolina, \$11.6 billion; and Texas, \$88.2 billion.<sup>1</sup>

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## Introduction: What Is OPEB?

Compared with workers in the private sector, public employees are much more likely to receive medical, dental, and vision coverage, as well as life insurance, after they leave their jobs. While the packages on offer vary widely, some 70% of state and local government employees are eligible for some post-employment benefits besides a pension. Thus, the rising cost of health care puts especially high pressure on public-sector employers.<sup>2</sup> As of 2015, the Federal Reserve estimated state and local governments' long-term bill for OPEB to be \$1.1 trillion.<sup>3</sup>

In technical terms, these benefits are called “Other Post-Employment Benefits” (OPEB); many simply refer to them as “retiree health care” or “retiree medical” because the health-coverage portion of these benefits tends to be the largest and most expensive (I use these terms interchangeably in this report).<sup>4</sup>

There are two basic types of retiree medical coverage, depending on the retiree's age. Public workers who retire before age 65 remain on their existing health-insurance plan until age 65, when Medicare takes effect. Technically called a “rate subsidy,” this benefit allows former workers to keep the same insurance coverage and pay the same premium rate as active employees. Government employers often pay some or all of the premium for the retiree. Some plans also cover spouses and dependents. These plans become more valuable as retirees age, as older people are more likely to encounter health problems.

For retirees over 65, who qualify for Medicare, many government employers continue to reimburse Part B premiums. Medicare Part B covers “medically necessary” supplies and services to treat a health condition, including outpatient care, preventive services, ambulance services, and medical equipment. Additionally, many state and local governments provide, through a private provider, Medicare supplemental or “Medigap” coverage, which covers Medicare's copays and deductibles. Insofar as such insurance fills the holes in coverage provided by Medicare, which is not a comprehensive health-insurance plan, some describe them as “lifetime medical.”

Retiree health care is a “status benefit”; it is uniform for all employees who qualify. Therefore, police, firefighters, teachers, janitors, and administrators all receive the same OPEB package, regardless of their final average salary or number of years on the job. To qualify, workers are usually required to perform a certain number of years of continuous service, which can range from as little as five to as many as 30. Workers in the protective services—police, firefighters, and corrections officers—are more likely to retire early and draw on these benefits for longer, which makes OPEB benefits particularly valuable.

Most OPEB plans are not prefunded, contractual obligations. That means that employers can modify or eliminate them, largely at their discretion. In contrast, outside municipal bankruptcy, pensions cannot be diminished for currently vested workers or those already retired.

OPEB packages vary considerably.<sup>5</sup> Some government employers are generous; others offer few or no health-care benefits. Local governments with fewer than 200 employees do not usually provide retiree health coverage. Other governments offer retiree benefit plans that include not just medical coverage but coverage for vision, dental, and life insurance. In some jurisdictions, employers pay the premium; in others, the worker pays it; in



still others, they split the cost. Once a retiree is eligible for Medicare, many states offer extra prescription drug coverage. Deductibles and copays also vary by state.

## The Changing OPEB Context

Public-sector retiree health care is an arcane issue.<sup>6</sup> There are few sources of data.<sup>7</sup> Until 2008, states and localities did not calculate or disclose how much they had promised in future benefits. Nor did they set aside money to pay for them.<sup>8</sup> OPEB is usually funded on a pay-as-you-go basis.

In 2004, OPEB costs garnered attention when the Government Accounting Standards Board (GASB) issued Statements 43 and 45, which required state and local governments to begin reporting OPEB liabilities in the footnotes of their Comprehensive Annual Financial Reports (CAFRs) by 2008.

As the numbers have emerged over the last decade, it has become clear that the costs for these benefits were rising rapidly.<sup>9</sup> By forcing state and local governments to recognize and report these costs, the new accounting rules have probably caused many governments to pump the brakes on spending.

Debate is now under way about what state and local governments owe their retirees; whether the promises made are affordable; and whether OPEB benefits help attract and retain high-quality workers.

The numbers have also revealed the extent of the gulf between the public and the private sectors.<sup>10</sup> Larger private-sector firms began to offer retiree health-care coverage in the 1940s, but new accounting rules issued in the 1980s drove most firms to halt the practice. The portion of large and midsize firms offering retiree health benefits fell from 45% in 1988 to 24% in 2017.<sup>11</sup> Smaller companies were less likely to offer such benefits. Today, only 15% of private-sector workers have access to employer-provided retiree health benefits. In contrast, 70% of state and local workers are eligible for employer-provided retiree health benefits.

Some states and cities have begun to revisit their OPEB policies. Illinois tried to halt promises to pay retiree medical, but the state supreme court struck down the proposal in 2014. In 2016, Chicago sought to eliminate OPEB as well.<sup>12</sup> Public-employee unions sued, tying the matter up in the courts.<sup>13</sup>

When Detroit filed for bankruptcy in June 2013, half the city's \$11.4 billion in unsecured claims were for OPEB. To emerge from Chapter 11, Detroit cut OPEB more deeply than pensions. In their recent bankruptcies, the cities of Vallejo and Stockton, California, both cut OPEB.

Kansas (in 2016) and South Dakota (in 2014) eliminated their OPEB liabilities in a single year.<sup>14</sup> They did so by removing the subsidies for retiree coverage, but these states still allow access to the state-sponsored health-insurance plans, with retired employees paying both the employer and employee share of the plan premium.

However, the states that have already addressed their OPEB problem tend to be those where the number of public employees is small and the liabilities are relatively low, such that eliminating OPEB is picking low-hanging fruit. Prior to eliminating OPEB, Kansas had a retiree health-care liability of only \$472 million in 2015 and South Dakota had a liability of \$67.8 million in 2013. These figures are relatively manageable compared with those of many other states, some of which—including North Carolina—have liabilities in the billions.

## The North Carolina Experiment

North Carolina's State Health Plan (SHP), which serves approximately 750,000 current and former employees, has long been in financial trouble, largely because of the cost of retiree health care. In 2005, the unfunded liabilities for retiree health care totaled \$24 billion, and that figure has continued to grow.<sup>15</sup> Today, SHP is saddled with \$34.4 billion in unfunded liabilities for retiree health care. The average annual health-care cost per retiree is roughly \$4,000. Total state retiree health-care costs, including for pre-Medicare-eligible retirees, are \$892 million per year—Medicare-eligible retirees alone cost \$634 million per year.

According to Pew Charitable Trusts, the state's unfunded retirement and health-care costs as a share of personal income are one of the worst in the country.<sup>16</sup> In 2018, State Treasurer Dale Falwell noted: "Every man, woman and child in the state would have to pay almost \$3,200 each to cover our current promises of health care for state and local government retirees."<sup>17</sup> In 2017, the state treasurer's office found that "the state's pensions and OPEB liabilities are approaching 20% of the general fund budget."<sup>18</sup>

SHP is funded through policyholder premiums (19%) and state appropriations (80%). Although the state general assembly appropriates 4% of SHP growth annually, it is not enough to keep the plan solvent by 2023, as health-care costs have risen by 7% per year on average.

North Carolina's first attempt to address this issue came in 2005, when it increased the number of years of service required to receive the full state-funded retiree health-care benefit from five to 20. The legislation, which applied only to new employees, also stipulated that retirees with 10–20 years' experience could receive 50% premium subsidies, and retirees with 5–10 years' service could enroll in SHP but would have to pay the full premium. The projected \$11–\$13 million in 10-year savings from this legislation was a drop in the bucket compared with the overall liability.<sup>19</sup>

In 2010, after Republicans won control of both chambers of the North Carolina state legislature for the first time since 1870, the state embarked on a more ambitious reform effort.<sup>20</sup> At the time, employees could choose the basic 70/30 plan, which charged no premiums, or the 80/20 plan, which charged a small premium (\$22.76 per month, as of July 2011) but had lower out-of-pocket expenses.<sup>21</sup> In 2011, the legislature, after a battle with the governor, passed a bill to start charging premiums for the first time, although it would not be implemented immediately.<sup>22</sup> The legislation also shifted control of SHP from a legislative committee to the state treasurer's department, which initiated a pricing transparency policy that has been the subject of significant legal wrangling.<sup>23</sup>

In 2017, workers began to pay premiums for the first time: \$25 per month for the 70/30 plan; \$50 per month for the 80/20 plan. It should be noted that most public employees pay less for their health insurance than private-sector employees.

Most important, in 2017 a provision inserted into SB 257 (the budget bill) stipulated that employees hired after January 2021 would no longer have access to health-care benefits in retirement.<sup>24</sup> This is a long-term solution, as those currently working are not affected. Given that it now takes 20 years of service to qualify for retiree health coverage in North Carolina, it will be 2041 before the state reaps real savings. In the meantime, estimates are that it will realize savings of just \$3.6 million per year. However, the pool of workers within reach of 20 years of service will also likely decline as current workers quit or retire. That means that the change will eventually reduce the OPEB normal cost, which was \$1.3 billion for FY 2015–16.<sup>25</sup> The result is that the current retiree health-care costs

will begin to decline before 2041, at which point costs will move steadily to zero.

## The Case for the North Carolina Approach

While North Carolina's approach might seem like tough medicine, it is worthy of serious consideration. Tackling a government's OPEB problem is likely to yield long-run benefits to state fiscal health, allowing governments more room to spend on other pressing priorities.

First, it is not clear that retiree health-care benefits actually serve to attract and retain a high-quality workforce. Given the huge variation in retiree health benefits offered by state and local employers, new employee expectations regarding whether they will receive retiree health benefits or how generous they will be are likely hazy, to the extent that they have them at all. Since it now takes so long to qualify for the benefit, and so many workers are mobile, few people who work for state or local government will ever see the benefit. For those at the start of their career, 20 years seems a long way off. At the other end, for those who qualify, access to health care may encourage early retirement.<sup>26</sup> Government then loses some of its most experienced employees.

Second, offering retiree health-care benefits may cause public workers to insufficiently accumulate wealth for retirement. One study found that state and local workers with retiree health coverage had about \$69,000 (or 15%) less net wealth than their uninsured private-sector counterparts.<sup>27</sup>

Third, not all career government employees will be thrown onto the health-insurance exchanges created by the Affordable Care Act (ACA). Some people who retire before age 65 will be able to access health insurance through their spouse or will take on new employment. Taking on a new job after retiring from a public-sector role is especially likely for workers leaving government payrolls with relatively small pensions.

Fourth, for those retirees who are not covered by a spouse and do not find employment elsewhere, ACA's exchanges provide a backstop for pre-Medicare-eligible retirees that did not exist before. In 2018, a married couple without dependents earning less than \$65,840 qualified for a subsidy—and many pensions in North Carolina and elsewhere fall below that figure.

Therefore, the exchanges provide an avenue for people to secure health care at a reduced cost.

Fifth, while there is concern about pushing older and less healthy retirees onto ACA exchanges, which could drive up the costs of insurance plans offered on the exchanges, public workers do offer the system a new source of potential enrollees, which could help stabilize insurance markets.

Sixth, in the long run, as there are fewer and fewer workers (and eventually none) eligible for health care in retirement, there will be an underappreciated positive effect on health-care costs for existing employees. As the pool of those insured is confined to current workers, who are generally younger and healthier than retirees, insurance should become cheaper, or at least slow its rate of cost increases.

Finally, the most expensive part of retiree health care in North Carolina and elsewhere is not coverage of those under 65 (although those retirees cost more on a per-plan basis) but rather, coverage of those over 65 and on Medicare. It makes little sense for the state to spend such an outsize amount on those who are guaranteed access to a baseline of health coverage through Medicare. Although Medicare is not a comprehensive insurance plan, additional coverage should be affordable for many public-employee retirees, who tend to earn middle-class salaries and, if they spend sufficient time in government, often exit with pensions.

## An Alternative: RMTs

Instead of offering generous retiree medical benefits, state and local governments should consider encouraging the creation of Retiree Medical Trust (RMTs),<sup>28</sup> which are run by and for their beneficiaries. Police and firefighters in California, Washington, and Oregon have already initiated such programs.

The key feature of RMTs is that the plans are run by employees or their unions, *not* by employers. In that sense, RMTs function like defined-contribution plans for retiree medical benefits. Employees benefit because they can keep valuable retirement benefits; employers benefit because the liabilities are no longer on their books.

RMTs might be particularly attractive in states that, unlike North Carolina, have powerful public-sector unions. In the post-*Janus* world, where attracting and retaining members has become vital for the survival

of public unions, RMTs represent a new service that unions can offer their members.<sup>29</sup>

A credible commitment by government employers to eliminate OPEB would incentivize the creation of RMTs. Workers with the most generous OPEB packages and those most likely to retire early and draw on benefits longer would be highly motivated to create an RMT once the government employer made it clear that it was intent on eliminating retiree medical benefits.

Government employers might spur the creation of RMTs by launching transparency campaigns to explain current policy, which is often not well understood, even by employees. These campaigns would highlight eligibility requirements and coverage levels. They could also illustrate the fiscal impact of the costs of current benefits and explain how they constrain spending on salaries and much else. Finally, governments might propose to cover the likely transition costs.

## Conclusion

North Carolina provides a model for phasing out OPEB entirely, in a predictable and orderly fashion: first, by increasing eligibility requirements; and second, by phasing out benefits for new hires at a future date, so that few current workers will be affected.

Some states may not be able to take the same route as North Carolina, where only 9% of public employees belong to unions. The state, however, is not unique in having high OPEB liabilities and relatively weak public-sector unions. Alabama, Georgia, South Carolina, and Texas are well positioned to follow North Carolina's lead: in 2016, Alabama had an OPEB liability of \$10.3 billion; Georgia, \$18 billion; South Carolina, \$11.6 billion; and Texas, \$88.2 billion.<sup>30</sup> In all four states, unions represent less than 10% of the public workforce.

Political dynamics outside the South and the Southwest will be very different. Government unions will likely strongly contest any reduction or the elimination of a valuable benefit. Besides union power, some of the most sensitive groups to OPEB cuts are those in the protective services (police and corrections officers), who tend to retire earlier and draw on retiree health benefits longer.

In the long run, generous retiree medical benefits serve little public purpose. Only a small slice of government employees who serve their entire careers in public



service in the same state (and sometimes the same jurisdiction) will receive these benefits. They are thus an illusory promise that is unlikely to do much to attract or retain high-quality workers. To the contrary, generous retiree medical benefits may encourage experienced employees to retire early, thus depriving governments of talented workers with deep institutional knowledge.

Furthermore, OPEB promises can have serious fiscal consequences. They can constrain state and local spending on other pressing priorities, which can compromise the quality of life. Liabilities associated with OPEB have already helped drive a few cities into insolvency.

Ultimately, a more sustainable mode of securing health-care coverage in retirement for public employees would better serve them as well as the public. Besides ACA exchanges, an RMT or a tax-preferred personal health savings account for supplementing Medicare would be superior.



## Endnotes

- <sup>1</sup> "Update: 50-State Survey of Retiree Health Care Liabilities," Pew Charitable Trusts, December 2018.
- <sup>2</sup> "State, Local Government Spending on Health Care Grew Faster than National Rate in 2012," Pew Charitable Trusts, Jan. 28, 2014.
- <sup>3</sup> U.S. Department of Labor, "National Compensation Survey: Employee Benefits in the United States," Bureau of Labor Statistics (BLS), March 2015, table 42.
- <sup>4</sup> Byron Lutz and Louise Sheiner, "The Fiscal Stress Arising from State and Local Retiree Health Obligations," *Journal of Health Economics* 38, no. 1 (December 2014): 136–46; Alicia H. Munnell, Jean-Pierre Aubry, and Caroline V. Crawford, "How Big a Burden Are State and Local OPEB Benefits?" Center for Retirement Research at Boston College, March 2016.
- <sup>5</sup> While some public employee pensions are more generous than others, the basic model of the defined-benefit pension predominates throughout the country.
- <sup>6</sup> Robert L. Clark and Melinda Sandler Morrill, "The Funding Status of Retiree Health Plans in the Public Sector," *Journal of Pension Economics and Finance* 10, no. 2 (April 2011): 291–314.
- <sup>7</sup> Difficulties associated with gathering OPEB data include the fact that states may not report one total figure. As a result, previous researchers have gone beyond states' Comprehensive Annual Financial Reports to look at benefit plan documents and reports from other government agencies. Principal sources for OPEB data include research by the Pew Charitable Trusts, the U.S. Government Accountability Office, and State Budget Solutions.
- <sup>8</sup> Robert L. Clark, "Will Public Sector Retiree Health Benefit Plans Survive? Economic and Policy Implications of Unfunded Liabilities," *American Economic Review* 99, no. 2 (May 2009): 533–37.
- <sup>9</sup> Alicia Munnell and Jean-Pierre Aubry, "An Overview of the Pension/OPEB Landscape," Center for Retirement Research at Boston College, Working Paper No. 2016-11 (Oct. 1, 2016).
- <sup>10</sup> Larry Grudzien, "The Great Vanishing Benefit, Employer Provided Retiree Medical Benefits: The Problem and Possible Solutions," *John Marshall Law Review* 39, no. 3 (Spring 2006): 785–826.
- <sup>11</sup> BLS, "National Compensation Survey."
- <sup>12</sup> The city argues that the state supreme court's decision did not apply to its program.
- <sup>13</sup> Krislov Law, "City of Chicago v. 'Korshak' Retiree Healthcare Litigation" updated Oct. 22, 2019.
- <sup>14</sup> Thurston Powers and Erica York, "Other Post-Employment Benefit Liabilities, 2017: Unfunded State Other Post-Employment Benefits Near \$1 Trillion," American Legislative Exchange Council (ALEC), March 2018; Thurston Powers, "Post-Employment Benefits in New York, New Jersey, and Connecticut: The Case for Reform," Manhattan Institute for Policy Research, October 2019.
- <sup>15</sup> General Assembly of North Carolina, "Fiscal Research Legislative Actuarial Note for HB 578," 2011; Brian Balfour, "State Health Plan for Employees and Retirees Reform," Civitas Institute, Sept. 4, 2012.
- <sup>16</sup> "Updated: 50-State Survey of Retiree Health Care Liabilities," Pew Charitable Trusts.
- <sup>17</sup> "North Carolina Health Plan with Less than 5 Percent Funded Ratio," press release, Office of the State Treasurer, Dec. 6, 2018.
- <sup>18</sup> State of North Carolina, "Debt Affordability Study," Department of the Treasurer, Feb. 1, 2017, p. 20.
- <sup>19</sup> General Assembly of North Carolina, "Legislative Actuarial Note for SB 837," 2005.
- <sup>20</sup> Chris Kardish, "How North Carolina Turned Red So Fast," *Governing*, July 2014.
- <sup>21</sup> Balfour, "State Health Plan for Employees and Retirees Reform."
- <sup>22</sup> Sara Burrows, "Even with Compromises, State Health Plan Still Faces Bankruptcy," *Carolina Journal*, May 25, 2011.
- <sup>23</sup> General Assembly of North Carolina, "Senate Bill 265" (session law), 2011.
- <sup>24</sup> General Assembly of North Carolina "SB 257," 2017–18 legislative session, subsections 35.21(c) and (d).
- <sup>25</sup> General Assembly of North Carolina, "Legislative Retirement Note," 2017, p. 2. See also Fiscal Research Division, "NC 2017 Legislative Session Fiscal and Budget Policy Highlights," Sept. 27, 2017.
- <sup>26</sup> John B. Shoven and Sita Nataraj Slavov, "The Role of Retiree Health Insurance in the Early Retirement of Public Sector Employees," *Journal of Health Economics* 38 (December 2014): 99–108; Maria D. Fitzpatrick, "Retiree Health Insurance for Public School Employees: Does It Affect Retirement?" *Journal of Health Economics* 38 (December 2014): 88–98.
- <sup>27</sup> Robert L. Clark and Olivia S. Mitchell, "How Does Retiree Health Insurance Influence Public Sector Employee Saving?" *Journal of Health Economics* 38 (December 2014): 109–18.
- <sup>28</sup> E. J. McMahon, "Shrinking the Retiree Healthcare Iceberg," Empire Center for New York State Policy, Oct. 25, 2012.
- <sup>29</sup> See *Janus v. American Federation of State, County, and Municipal Employees, Council 31*, 138 S.Ct. 2448 (2018), which limited the power of public-sector unions to compel nonmembers to contribute fees.
- <sup>30</sup> "Update: 50-State Survey of Retiree Health Care Liabilities," Pew Charitable Trusts.





