

GASB 45, Health Care, and Public Schools and Colleges

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Many employees of California's schools and colleges have been willing to accept lower salaries during their working lives in exchange for the benefit of health insurance coverage in retirement. The gain from that trade-off is now in jeopardy. Most public schools and college districts are currently facing health cost increases that are well above the rate of increase of the Consumer Price Index. Some of these districts are moving to eliminate or reduce health care coverage to their current employees and to their retirees. One of the major drivers of the movement to deny employees of their hard won health benefits is the newly established Governmental Accounting Standards Board 45 (GASB 45) reporting standards.

GASB – Not a Governmental Agency

The first thing one should understand about the Governmental Accounting Standards Board (GASB) is that it is not a federal agency. It has no ability to enforce its requirements on public employers. GASB is an independent, private-sector organization that provides national, state, and local governments with a view of what GASB believes should be considered as accepted accounting principles. It does not answer to either state or federal government. The self stated goal of GASB is to help taxpayers and government officials determine the ability of their level of government to financially provide services and repay its debt. GASB believes, in its own words, that it is an *“independent body free from inappropriate political pressure or commercial influence”* and that it brings *“objectivity and integrity to the process of issuing neutral, unbiased accounting and financial reporting standards that are relevant in the government environment.”* There is no evidence to suggest that the claim of neutrality, unbiased accounting, or relevance is valid or invalid.

Even though GASB does not have enforcement authority, its standards do become part of what are called “generally accepted accounting principles.” The Code of Professional Conduct of the American Institute of Certified Public Accountants requires that auditors follow the standards adopted by GASB. Audits will likely include information regarding compliance with the GASB standards.

GASB 45

GASB 45 establishes guidelines for how public employers should report the costs of employer provided retiree health plans. Prior to GASB 45, public employers were only required to report the annual amount that they actually pay for benefits for current

retirees. Beginning in 2007-08, GASB 45 calls on districts to publicly provide periodic actuarial reports that disclose any long term retiree healthcare liabilities. The standard allows for up to 30 years to spread the liability of retiree health benefits. The reported liabilities are to be included in the district's financial statement. Districts will continue to report on the how much the medical coverage of their current retirees cost. They will now also have to report on the cost of future benefits that current employees earn during the fiscal year as well as the value of benefits earned in prior academic years. Except for the cost of the accounting, no new costs for benefit coverage are created by GASB 45. Budgets only include current year expenses.

Shock and Awe

As districts begin to follow the GASB 45 reporting guidelines they will find that they have what, at first glance, are horrific obligations. The Los Angeles Community College District was quoted an Actuarial Accrued Liability of \$632 million. Currently the district is spending about \$26 million per year in retiree medical costs. The Los Angeles Unified School District had an estimated liability of \$4.9 billion. Currently the LAUSD spends approximately \$177 million per year for retiree health benefits.

There is no requirement to actually fund the liability, only to report them. District budgets will only be affected by GASB 45 if a district decides to fund retiree benefits in a new way. Most districts have traditionally paid for retiree benefits as the employees retired. Some have done so without any financial problem for more than fifty years.

Actuarial Projections

It must be noted that actuarial projections on retiree health benefit costs are highly speculative – especially over a thirty year period of time. Very slight changes in the assumptions related to costs and return on investment result in huge changes in the projected liability. The factors that actuaries use such as rate of return on investments, health care costs and the demographic makeup of the employees and retirees change from year to year. A good actuarial has the option to provide either a best-case and a worst-case scenario or both. Districts should ask for both.

GASB 45 Timeline

The new accounting standards take effect in 2007-08 for districts with total annual revenue of \$100 million or more. For districts with revenues from \$10 million to \$100 million, the effective date is 2008-09 and for districts with revenue less than \$10 million the date is 2009-10.

According to a report issued by Labor Research Partners in 2005, 41 of the 72 California Community College Districts operated on the pay-as-you-go option. Many have had an

actuarial study done. 13 Districts reported that they have little or no liability.

Los Angeles Community College Experience

Most districts currently pay for their retiree health care on a “pay-as-you-go basis” (paying only the amount of actual benefit costs for retirees in any given year). The Los Angeles Community College District has had retiree health benefits for more than 30 years and has been operating on a “pay-as-you go” system all of this time without any major problem. Here is the cost to the district of benefits (including health benefits for retirees) over the last 15 years.

LACCD

Unrestricted General Fund
Appropriations (in millions)

	Certificated Salaries	Classified Salaries	Benefits	Unrestricted Total	% of benefit. increase over previous year
1989-90	107.649	48.861	41.185	227.585	
Percentage	47.3%	21.5%	18.1%		
1990-91	103.281	48.788	43.038	231.351	4.5%
Percentage	44.6%	21.1%	18.6%		
1991-92	102.199	51.466	44.208	228.335	2.7%
Percentage	44.8%	22.5%	19.4%		
1992-93	101.519	51.932	47.718	234.902	7.9%
Percentage	43.2%	22.1%	20.3%		
1993-94	99.679	52.573	50.255	239.006	5.3%
Percentage	41.7%	22.0%	21.0%		
1994-95	101.167	54.714	47.317	238.471	-5.8%
Percentage	42.4%	22.9%	19.8%		
1995-96	99.747	58.759	50.848	244.159	7.5%
Percentage	40.9%	24.1%	20.8%		
1996-97	114.067	62.480	52.664	274.626	3.6%
Percentage	41.5%	22.8%	19.2%		
1997-98	119.803	66.723	53.662	277.310	12.5%
Percentage	43.2%	24.1%	19.4%		
1998-99	122.854	66.846	50.955	281.537	-5.0% no PERS

Percentage	43.6%	23.7%	18.1%		
1999-00	134.288	71.930	54.875	290.480	7.7% no PERS
Percentage	46.2%	24.8%	18.9%		
2000-01	155.157	79.121	61.552	367.517	12.2% no PERS
Percentage	42.2%	21.5%	16.7%		
2001-02	185.100	88.970	62.541	411.692	1.6% no PERS
Percentage	45.0%	21.6%	15.2%		
2002-03	181.983	87.187	76.787	409.281	22.8%
Percentage	44.5%	21.3%	18.8%		
2003-04	173.731	79.972	85.429	390.547	11.3%
Percentage	44.5%	20.5%	21.9%		

It is clear that the percentage of expenditures on benefits compared to the total appropriation has not increased greatly over the period covered.

The Los Angeles Community College District hired an independent actuarial company in 2005 to determine its retiree health care liability. The Actuarial Accrued Liability was found to be \$623.2 million. As noted above, actuarial results can vary widely based on the assumptions made concerning the increase in the cost of health care, return on investments, effects of Medicare coverage for retirees, and likely life expectancy.

Pay-As-You-Go Comparison

The LACCD report contained the following comparison of the cost of continuing to fund the retiree health benefits of current employees using a pay-as-you-go and several other methods (a level contribution for the next 20 years, a level percentage of the unfunded accrued liability, and a level percentage of payroll for the next 20 years). Note that for 2005, GASB would require a payment of almost \$55 million while pay as you go would only require about \$26 million. I have found that the doubling of cost by moving from pay-as-you-go to be a common result.

It is important to note that even after ten years, the amount the LACCD would have to pay for the benefits of retirees is less than the amount required by GASB 45 in 2005. Meanwhile, all of the excess funding has not been available to provide service to students or salary increases to employees.

LACCD	Pay as You Go	Level Contribution	Level % of Unfunded	Level % of Payroll Accrued Liability	Annual Required By GASB 45
2005	\$25,969,881	\$65,460,000	\$56,446,082	\$51,099,000	\$54,989,936
2006	\$28,921,655	\$65,460,000	\$55,340,904	\$52,631,970	N/A
2007	\$31,507,093	\$65,460,000	\$54,328,776	\$54,210,929	N/A
2008	\$33,892,132	\$65,460,000	\$53,394,546	\$55,837,257	N/A
2009	\$36,108,400	\$65,460,000	\$52,526,490	\$57,512,375	N/A
2010	\$38,185,158	\$65,460,000	\$51,714,229	\$59,237,746	N/A
2011	\$39,860,247	\$65,460,000	\$50,948,524	\$61,014,878	N/A
2012	\$41,215,022	\$65,460,000	\$50,218,859	\$62,845,325	N/A
2013	\$42,519,060	\$65,460,000	\$49,517,075	\$64,730,684	N/A
2014	\$43,819,415	\$65,460,000	\$48,838,115	\$66,672,605	N/A
Total	\$361,998,063	\$654,600,000	\$523,273,600	\$585,792,769	N/A
Increase over pay as you go		\$292,601,937	\$161,275,537	\$223,794,706	

Many pundits believe that the current pay-as-you-go method of paying retiree health benefits will lead to major problems in upcoming years as the mounting liability begins to come due. The fact that this has not occurred yet in districts (like the Los Angeles Community College District and the Los Angeles Unified School District) that have had such a benefit for more than thirty years seems to have had little effect on reducing any fears that they might have concerning the impropriety of using the pay-as-you go methodology. The probable emergence of a single-payer universal health care system (which would relieve districts of their retiree health care responsibilities) in California or the United States over the next twenty years also has little impact on their fears.

Standards Effect on Benefits

The large relative cost (as opposed to pay-as-you-go) of pre-funding retiree health benefits in the private sector has clearly led many private companies to abandon the welfare of their employees. The threat of future unsustainable liabilities is playing a part in the effort to eliminate defined benefit retiree health plans. As a result of a GASB-like requirement adopted by the Financial Accounting Standards Board (FASB) in the private sector, the Employee Benefit Research Institute (EBRI) found that *“some employers placed caps on what they were willing to spend on retiree health benefits. Some added*

age and service requirements, while others moved to some type of 'defined contribution' health benefit. Some completely dropped retiree health plans for future retirees." The Kaiser Foundation released a report that found that "In response to these cost increases and changes adopted in the early 1990s by the Financial Accounting Standards Board (FASB) that requires firms to account for their future retiree health obligations, employers have implemented a number of strategies to curb these costs. Of note, our survey found that roughly half of all large (1,000 + workers) private-sector employers that offer retiree health benefits to 65+ retirees have imposed caps on their future obligations, nearly half already hit the cap, and another third say they are likely to hit the cap in the next three years."

Public agencies also have begun to cut back on retiree health care benefits. For example, a few years ago the Los Angeles Community College District (LACCD) negotiated increased requirements for new employees to be eligible for retiree health benefits. In addition, retirees now get the same benefits as those active members even if they have been reduced since the employee retired.

Some in the LACCD are now suggesting that new employees not be eligible for retiree health plans. They propose that the District negotiate a two-tier system of retiree benefits with one set of benefits for current employees and retirees, and another for new employees. Others have suggested that a percentage of the state funded cost-of-living adjustment be used to begin to build a fund to pay for future retiree health benefits. These proposals are being driven by the increased pressure caused by the threat of GASB 45, the recent escalation of the cost of health care, and the drive by some to eliminate all social net provisions.

GASB 45 and Public Agencies

Not much has been said concerning whether GASB 45 makes sense for public agencies. Public institutions are very different from private companies because they do not go out of business. They have a regular stream of guaranteed income and huge assets in land and buildings. The need for public agencies to protect workers benefits into retirement is different than that of private employers since the income of the public institutions will continue. If a public institution ceases to exist, the assets can be sold off to pay for the ongoing health care requirements in a way that may not be available to a private sector business.

Drivers of Increased Health Care Costs

In the discussion revolving around GASB 45, not much emphasis has been placed on the real underlying reasons for the increased cost of health care. The *California Health Care Coalition* (CHCC) is one of several groups compiling data on the causes of high premium costs. The data that they have collected demonstrates the strong relationship between

skyrocketing health costs, badly practiced medicine and hospital bills. The CHCC is active in adopting common standards for provider participation, collaborating with CalPERS and other purchasers to build local purchasing coalitions, negotiating collectively with providers, educating the public, and studying hospital and other costs in targeted areas of California. In the words of the CHCC: *“Three premises underlie our strategy. First, shifting health care costs to the users of care will do little to address the basic “supply-side” problems of excessive charges and poor quality care. Second, health plans alone are unable to assure quality and stabilize costs. Third, the industry has consolidated and so must purchasers. We cannot be an effective force for health reform without first organizing ourselves in the healthcare marketplace.”*

Research by the CHCC and the *California Education Committee for Health Care Reform* has made clear that the increased cost has come from the supply side, not the demand side of the equation. The usual explanations for increased costs (an aging population, the high cost of new technology, the provider costs driven by trial lawyers, the development cost of new wonder drugs, and the irresponsible consumer) have not been found to be the dominant drivers of the inflation in medical insurance premiums.

In fact, although some industry-paid analysts say that health care costs are rising due to aging, technology, increased utilization, and increases in such diseases as diabetes, the major cost increase driver of the health care cost increases has been found to be on the supply side of the systems (the providers of health care) through a combination of excessive prices (and profits), pervasive medical error and quality deficiencies. High prices and high administrative costs are the critical causes of the substantial increases in health care spending that most districts have experienced. The often hidden truth is that the United States has the highest per-capita health care cost in the world but provides only a minimum of service and quality to those who can afford to participate.

There has been a tendency to blame the consumer of health care and efforts have been made to change patient behavior through higher co-pays and the like. This has been shown to just shift the cost of care from the employer to the employee but it also seems to drive up the total cost of care when routine care is replaced by emergency care. As one example presented to the *Education Committee for Health Care Reform* (I am a representative to the group from the California Federation of Teachers), a \$5 co-pay has been shown to discourage a person who makes less than \$25,000 a year from visiting a doctor and the postponement of the visit causes greater costs later.

Poor care is also a major driver of cost. Various studies presented to the *Education Committee for Health Care Reform* have show that best medical practices are used only 50% of the time. 80% of diabetes patients are receiving the wrong treatment. 75% of coronary artery bypass graft surgeries are not effective and do not increase longevity. Quality experts have demonstrated that between 20 and 30 percent of health care spending is attributable to poor quality care.

Health Plan Failures

The major health plans and insurance carriers have failed to address costly failures of the delivery system. Instead, they pass on rising costs to their customers, rationalizing increases by claiming that prices are up, utilization is up, and the users of health care is at fault because they don't take adequate care of themselves. At the same time, these health plans and insurance carriers keep secret the prices they negotiate with providers and are silent about their own failure to monitor and correct for physician-driven overuse of inappropriate services, pervasive provider failure to follow professional treatment standards, inefficient resource use, and high medical error rates.

Large Regional Variations

Research by the CHCC and others has shown very large regional variations in rates of use of diagnostic tests and procedures, mortality rates and infections and complications that are unrelated to the severity of the medical conditions. In addition, costs vary greatly from hospital to hospital in the same region and in the state. Heart surgery in Sacramento costs three times what it does in San Diego. The CHCC reports that the average hysterectomy in Sacramento ranges from \$13,921 to \$43,931 depending on the hospital. The average cost of paid claims at Sutter Health hospitals was 73% greater than the average cost of all other CalPERS paid claims in the state. Operation margins vary greatly from the statewide average for the non-profit (non-Sutter) hospitals at 2.5% to Memorial Hospital in Modesto at 21.1%.

It has been shown in a number of studies presented to the *Education Committee for Health Care Reform* and the CHCC that there are more elective surgeries in areas where there is a high concentration of surgeons. Greater use of diagnostic tests occur where heavy investments have been made in expensive technologies. Admissions to hospitals depend on the number of beds available. To illustrate the variety of medical approaches regionally, Daryl Cordoza, the CFO of Hill Physicians, remarked to the Health Benefits Committee of CalPERS that "if there is a woman on the streets of Redding over the age of 21 with an intact uterus, she must be a tourist."

Consolidation of Health Care Providers

The ability of health care providers and insurers to sharply escalate costs has arisen as a result of the elimination of competition. Only 50 hospital systems now exist in California and these are part of six national chains. All of these have been found to have billing frauds and irregularities. Some hospitals have up to 90% of local market share.

And it is not just the hospitals and the doctors. Two large pharmacy benefit managers (Caremark and Express Scripts) control 50% of the nation's supply. Pharmaceutical companies are absorbing competitors, achieving monopolies in some types of drugs, and

driving up the cost to United States users. Prescription drug sales are now advertising driven, with consumers requesting certain highly advertised drugs and doctors prescribing heavily promoted drugs. People in the United States pay 80% more for drugs than does the rest of the world.

In summary, there are widespread and medically unjustified variations in hospital admissions, elective surgery rates, provider charges, average cost per case, and patient outcomes.

California Health Care Coalition

CHCC is attempting to *“establish and apply performance standards for hospitals and physicians. The burden of proof must shift to high cost institutions to demonstrate that their higher charges or premiums are justified by special circumstances or better patient results.*

“Negotiate directly with health care providers, plans and intermediaries on cost, quality and transparency issues. Contracts should establish full financial transparency and performance accountability, with providers required to provide detailed cost, utilization and outcome data. These data are needed to determine whether rates are justified and treatments are appropriate and effective.

“Restructure networks to include only those who are able and willing to meet our cost, quality and reporting standards. Providers who are unable or unwilling to meet CHCC performance standards will risk elimination from our networks. We can no longer tolerate inappropriate, ineffective and inefficient care.

“Promote competition in local health care markets and eliminate the anti-competitive business practices of consolidated provider systems. Hospital conglomerates and other provider systems should not be allowed to require inclusion of all facilities in their network as a condition for accessing any one of them

“Support and promote industry-wide performance reporting and information disclosure standards. Purchasers and patients need timely, reliable data comparing hospitals and physicians on quality and cost-efficiency. We cannot reliably compare hospitals on cost and quality unless the comparisons are based on a common set of performance measures that are fully and freely disclosed from a reliable third party entity. “

How to Cut Benefit Costs and Increase Quality

The first step that districts should be taking, rather than rushing into prefunding or eliminating retiree health care, is to address the real reasons for increasing costs. They should join *Health Access California*, the *California Health Care Coalition*, and the *California Education Committee for Health Care Reform* in order to increase the

influence of these organizations. Until purchasers organize to demand delivery system reform and performance accountability from health plans and providers alike, the problems with our health delivery system will continue and the cost pressures on public sector employers, unions, and workers will grow.

Districts should be spending more time on fixing the provider problems by identifying the best hospital for each type of operation and inform or encourage patients to go there, encouraging preventive primary care, developing locally based coalitions (like those being formed under the umbrella of the *California Health Care Coalition*) to get the information needed to bargain effectively, require doctors to write prescriptions through a computer system that checks for negatives and correct dosage (see the Leapfrog research on the issue at www.leapfroggroup.org), and eliminate high cost, low quality doctors and hospitals from participation in health plans.

Health Access California is another organization working in California, primarily at the legislative level, to address health care issues. They begin by focusing on the uninsured. “Over six million Californians are uninsured, out of 35 million. These are families that work hard, play by the rules, and pay their taxes, yet don't get basic health coverage. Over 80% of the uninsured are in working families, with the uninsured person either a worker, or the dependent of a worker. The uninsured are not uninsured by choice. Over 85% of the uninsured are either not offered or not eligible for health insurance from their employer. (UCLA Center for Health Policy Research). Buying health insurance as an individual is often not an option, as coverage is too expensive for the low- and middle-income families that are the vast majority of the uninsured. Coverage simply is not available for many, because of "pre-existing conditions." (Families USA)”

Health Access California has also found that “uninsured families live sicker and die younger. The uninsured often delay or avoid getting needed care, including screenings and preventive care, ongoing treatments for chronic conditions, and emergency care, resulting in severe health impacts. (American College of Physicians). The uninsured are more likely to die prematurely than insured patients with similar problems, for every type of ailment or problem, from emergency trauma to cancer. (Institute of Medicine).”

In fact, nearly half of all personal bankruptcies are the result of health problems or large medical bills.

Health Access California has worked through legislation, the budget, and the ballot box to improve the health care conditions of the uninsured, the underinsured, and all health care consumers in California. Their goal is to have access to health care for all without financial barriers or consequences.

Fiscal Sense?

Since GASB-like standards are likely to increase the pressure to eliminate for new employees whatever retiree health care is left for current employees and retirees. If this is not the planned result, it is certainly a likely result. GASB 45 has become an integral part of the attack on worker safety nets. Actuarial results are also being used by management to deflate faculty and staff salary and benefit increases.

Since using any of the alternatives to pay-as-you-go is much more expensive, why would a district move to pre-fund its obligation? The Community College League of California (CCLC) has provided a number of reasons for advance-funding - none of which demonstrate that it is the most responsible and least costly method. I have yet to see anyone say that pre-funding is either the best or the least costly way to go.

The CCLC has listed a number of possible consequences of not fully funding retiree health benefits in future years. The CCLC stated that *“District auditors will be required, beginning in the years listed above, to report on the status of funding of past-employment benefits, including any liability.”* This is true, but not a problem, unless there is a public outcry that the district has a huge debt and a Board of Trustees buckles under the pressure. It is incumbent on a district to explain why the actuarially derived debt is not a real problem any more than a mortgage on a home is a real problem.

A second finding is that *“Not funding the actuarially determined liability could result in substantially higher expenses in future years.”* This MAY be true but past experience does not so indicate. In the LACCD (as shown in a earlier table), even with the huge increases in health care costs over the last few years, the percentage of the district’s Unrestricted General Fund Appropriations spent on benefits, of which retiree health benefits is a part, has remained fairly constant since 1989-90 - mostly in the 18% - 21% range. It has ranged from a low of 15.2% (due to no PERS contribution) in 2001-02 to a high of 21.9% in 2003-4. It was 21% in 1993-94 and 20.8% in 1995-96. The huge increase expected has just not occurred in the past. The cost would go down if universal single payer health care is provided in California or in the United States.

CCLC also notes that *“Negative audit reports could impact on the ability of districts to borrow funds or issue bonds at advantageous rates.”* To my knowledge, this has not happened either in the private sector since the FASB standards were adopted or in the public sector since GASB was adopted. It might happen, but there is no evidence that it will. In fact, those that do bond rating look at a variety of factors to determine the credit worthiness of a district. Over reacting to the sticker shock of GASB 45 may cause districts to make bad economic decisions which will likely have more impact on their bond rating than any perceived retiree benefit liability. To date, the level of the unfunded liability for retirement benefits has not played a major role in the rating that employers receive.

Accreditation could be a problem just as the accreditation agencies have posed problems in other areas. WASC already has attempted to push unproven standards on colleges and

has shown, in the case of Compton College, that it can be arbitrary and capricious. We need to fight the accreditation scandal whether or not they use GASB to put forward their agendas.

No Hasty Decisions

Leaving the pay-as-you-go method of funding and adopting a more expansive method will deprive students of classes and employees of wage increases. I don't believe that it is fiscally responsible, at this time, to move away from pay-as-you-go into another way of funding retiree benefits. In any case, we don't need to make any hasty decisions. Even the worst doom-and-gloomers agree that any problems will not occur in the near future. Most experts agree the accrued liability is not, in the short run, a real debt. Others point out that that any problems that may occur will not occur in the next five years but more likely over a 30 year span.

Districts should take the time necessary to study the scope of any real problems posed by continuing their pay-as-you go coverage of retiree health benefits and should not rush to "solutions" which in the long run harm everyone – students and employees alike.