Public Money

Medicare Trumps the 'OPEB Fairy'

National health care reform can't bail out state and local retiree health plans.

By Girard Miller | May 21, 2009

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The Medicare trustees released their latest annual report on May 12, and the results, unsurprisingly, were gloomier than usual. The 2008-09 recession has drained tax revenues that were assumed in prior studies. Even with the hopeful assumption that the economy will start to recover by year-end, the latest trustees' report is sobering:

• The Medicare trust fund balance will drop below a full year of expenses in just two years.

• By 2017 the Medicare trust fund will be fully depleted. Flat broke. Medicare simply means children paying for their parents and grandparents, without any pre-funding scheme with actuarial reserves. Payroll tax revenues then will cover only half of ongoing annual expenses. Without Congressional action, trustees must make a 50 percent cut in benefits in just eight years.

• Medicare's 75-year actuarial deficit as a percentage of national payroll rose from 3.55 percent to 3.88 percent, which means that every worker and employer in America faces a doubling of today's tax rates — just to pay for today's level of Medicare benefits.

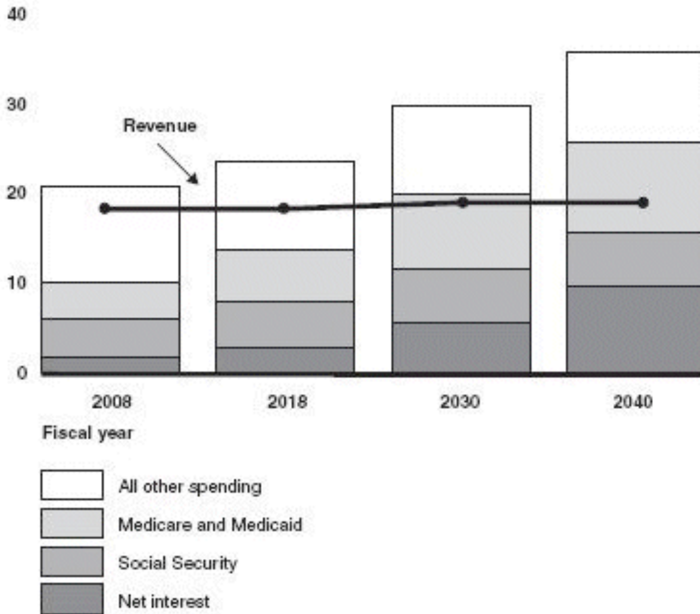
State and local governments must brace themselves for the now-inevitable increases in employer payroll taxes and to bargain hard for higher employee contributions for pensions and OPEB — before these tax rates take effect. Keep in mind that additional funding is also required for Social Security, which is another 2 percent of payroll. Without benefits reductions, the payroll tax must increase by 5.88 percent of covered compensation, which would require a 38 percent increase in total payroll taxes for every working American and every employer. (And don't forget that the Medicare tax hits all earnings, not just the first $106,000.)

In this context, one must wonder about state and local government officials who now hold out hope that when Congress enacts health care reform, it will magically reduce their liabilities for retiree medical care. In fact, the opposite is far more likely to occur. A reform of the Medicare program will likely combine reductions in benefits with an increase in the eligibility age, which will simply increase the costs of retiree benefits paid by state and local governments. Hardest hit will be those who offer full benefits without any kind of cost cap.

Health care reform is much needed in the United States. We have already bankrupted the auto companies in part because of legacy health care costs that unions and managers agreed to embed in the cost of American automobiles. Other American manufacturers have concluded that, despite their reservations about semi-socialized medicine, they might be better off shifting their costs for medical care and especially retiree medical to a nationalized program. However, the costs to operate a fully nationalized medical care plan are astronomical and aren't feasible.

As I wrote in my previous column on Build America Bonds last week, the Government Accountability Office has produced a chart that shows that Medicare, Medicaid, Social Security and interest on the federal debt will consume every dollar of federal revenue by 2027 (18 years). That study was published before the latest Medicare and Social Security trustees' reports.

Potential Fiscal Outcomes under Alternative Simulation: Revenue and Composition of Spending as Shares of GDP



Source: GAO's September 2008 analysis based on the Social Security and Medicare Trustees' assumptions.

Notes: Discretionary spending grows with GDP after 2008. The AMT exemption amount is retained at the 2007 level through 2018 and expiring tax provisions are extended. After 2018, revenue as a share of GDP is brought to its 40-year historical average of 18.3 percent plus expected revenues from deferred taxes (i.e., taxes on withdrawals from retirement accounts). Medicare spending is based on the Trustees' 2008 intermediate projections adjusted for the Centers for Medicare & Medicaid Services (CMS) alternative assumption that physician payment rates are not reduced as specified under current law.

This forces the Democrats in Washington to learn from the failed Clinton health care initiative: Reform must supplement and complement the employer-based system and provide coverage to uninsured Americans under age 65 as the first priority. That won't leave any money on the table to bail out state and local government employers for their post-retirement medical benefits. At most, the universal access now under discussion might provide a way for retired public workers whose employers offer nothing to gain access, but that would be little more than the "implicit rate subsidy" now offered by the most frugal of state and local governments.

From a state and local government employers' perspective, here are two issues likely to surface as the health care reform debate takes shape:

1. Any genuine success in curbing health care cost increases will benefit state and local government OPEB plans. One of the strongest drivers of OPEB costs is retiree medical benefits inflation, and if the feds can actually find ways to reduce health care costs through mandatory automation and other cost controls, that will spill over into the OPEB plans. The question is whether these savings are an illusion or a pipe-dream. The worst case would be that everybody starts assuming that medical inflation abates more rapidly than the actuaries already have, but the costs keep rising anyway. Then the unfunded liabilities will only get worse.

2. If Medicare benefits are reduced, or if the Medicare eligibility age of 65 is raised to conform with Social Security (now 66-67 for baby boomers), then costs to state and local employers will actually increase. That's because most public employees actually retire before age 65 already, and this will simply add another year or two of full medical benefits to the actuarial costs of the plan. In fact, if Social Security and Medicare ages for young workers are raised to 70 to reflect increased longevity, as some would expect in a national reform effort, the unfunded OPEB liabilities will ratchet even higher.

So, what can state and local employers do now to prepare themselves for the potential fall-out from national health care reform, Medicare reform, and Social Security reform? Here are some ideas:

• Put a dollar cap on annual OPEB benefits. The single most important cost-control measure a public employer can make (if their plan now provides for full insurance benefits at retirement) is to put a dollar cap on the benefit and to raise the benefit by no more than the rate of CPI inflation.

• Offer employees the choice of retiree medical benefits from the point of retirement until they become eligible for Medicare, or benefits after they become eligible for Medicare, but not both. For employers that do not start funding actuarially, this is the Hobson's choice you will eventually find yourselves making in eight to ten years, anyway.

• Reduce the benefits level for pre-Medicare retirees by increasing co-pays, deductibles or other costs to beneficiaries.

• Limit the period of pre-Medicare retiree medical benefits your plan will pay. For example, for public safety workers and teachers, the OPEB plan could provide for no more than ten years of benefits before reaching Medicare eligibility, and then a Medicare supplement thereafter. If an employee retires before age 55, and their ten years of benefits expire, then their benefit would drop to the level of the Medicare supplement.

• Eliminate inflation increases for retirees who terminate prior to reaching Medicare age. This would discourage early retirements and relieve both the OPEB plan and the pension plan of ever-rising costs that ultimately fall on the employer.

Employees and their labor representatives may complain about these real-world solutions, but the sad fact is that there will be even more drastic cutbacks for those who delay timely action. To make your plans sustainable, it is vital that you get ahead of the ever-rising OPEB cost curve.

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