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Healthcare Promises for Public Employees

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HEALTHCARE PROMISES FOR PUBLIC EMPLOYEES

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State and local governments have promised nearly $1 trillion in retiree healthcare benefits to public employees. Although retiree healthcare benefits represent a form of compensation, historically, state and local governments have not set aside any money to pay for the promised benefits. Compensating employees with promises of future benefits has enabled state legislatures to use public dollars for other priorities, while ignoring the growing liabilities associated with the healthcare promises. As these liabilities have come due, they have strained state and local budgets. Some public employers have simply cut the benefits, and public employees have had limited recourse to hold cities and states to their original deal.

At the same time, many public employers have actually begun to pay down their unfunded liabilities for retiree healthcare. In 2004, new disclosure requirements forced state and local governments to acknowledge the full scope of their commitments for post-employment benefits. By 2015, some 35 state legislatures had created irrevocable trusts to set aside assets for benefits due in future years. However, while some of the trusts—most notably some that cover state legislators and judges—have accumulated assets to cover the liabilities, other trusts have remained glaringly empty. Using newly collected data on over 100 state-administered retiree healthcare plans, this Article shows that stronger constraints on legislative control over funding decisions, as well as stronger measures of fiscal health at the state level, have been associated with better funding progress. Ultimately, this Article contends that although the trend toward prefunding is encouraging, the current legal framework regulating retiree healthcare benefits impedes serious funding efforts. Disclosure requirements and governance reforms can promote funding discipline and mitigate uncertainty in the short term. In the

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long term, any significant resolution requires a deeper rethinking of employer promises for post-employment healthcare benefits and of the institutions best suited to manage such promises for decades to come.

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INTRODUCTION

State and local governments have promised nearly $1 trillion in retiree healthcare benefits to public-sector employees.[1] Public-sector employees accept relatively lower cash salaries with the belief and expectation that retiree healthcare benefits—like pensions—constitute a part of their total compensation and that such benefits will be available to them once they retire.[2]

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1. *See* Byron Lutza & Louise Sheiner, *The Fiscal Stress Arising from State and Local Retiree Health Obligations*, 38 J. HEALTH ECON. 130, 130 (2014) (finding that "total unfunded accrued liability of state and local governments for the provision of retiree health care exceeds $1 trillion"); Alicia H. Munnell et al., *How Big a Burden Are State and Local OPEB Benefits?*, CTR. FOR RETIREMENT RES. B.C. 14 (2016), http://crr.bc.edu/wp-content/uploads/2016/03/slp_48.pdf (estimating the value of 2012–2013 other post-employment benefits to be $862 billion).

2. CAROL H. SPAIN ET AL., S&P GLOBAL RATINGS, RISING U.S. STATE POST-EMPLOYMENT BENEFIT LIABILITIES SIGNAL AN UNSUSTAINABLE TREND 13 (2016), http://www.nasra.org/files/Topical%20Reports/OPEB/SandPStateOPEB1609.pdf ("[S]tate governments have managed a longstanding tradeoff between lower wages than many private sector positions, but stronger benefits."); Andrew G. Biggs & Jason Richwine, *Overpaid or Underpaid? A State-by-State Ranking of Public Employee Compensation* 7–8 (AEI Econ. Pol'y Working Paper 2014-04 2014), http://www.aei.org/wp-content/uploads/2014/04/-

The challenge, put simply, is that public employers have not set aside money to pay for the promised benefits.[3] Compensating employees with promises of future benefits—rather than with cash—has enabled state legislatures to use public dollars for other competing priorities and needs, while ignoring the growing liabilities associated with the healthcare promises. As these liabilities have come due, they have strained state and local budgets[4] and prompted efforts to cut or curtail

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biggs-overpaid-or-underpaid-a-statebystate-ranking-of-public-employee-compensation_112536583046.pdf (observing that "salaries are only one component of total employee compensation, which also includes fringe benefits such as health coverage, pensions, and paid leave" and finding that "compared to pensions, implicit compensation through [retiree healthcare benefits] is far more variable from one state to another").

3. U.S. GOV'T ACCOUNTABILITY OFF., GAO-08-223, STATE AND LOCAL GOVERNMENT RETIREE HEALTH BENEFITS: CURRENT FUNDED STATUS OF PENSION AND HEALTH BENEFITS 21 (2008) [hereinafter GAO REPORT] ("Unlike most pension plans, retiree health benefits have generally been financed on a pay-as-you-go basis . . . . [S]tate and local governments have not set aside funds in a trust reserved for future retiree health costs. Instead, governments pay for each year's retiree health benefits from the current year's budget.").

4. *See, e.g.*, Press Release, Cal. State Controller, State Controller Yee Updates State Retiree Health Care Liability (Jan. 25, 2017), http://www.sco.ca.gov/eo_pressrel_18191.html (observing that "the mounting cost of providing health care benefits to public sector workers" is "one of the greatest fiscal challenges facing California"); Heather Gillers, *States Need $645 Billion to Pay Full Health-Care Costs*, WALL ST. J. (Sept. 20, 2017, 5:30 AM), https://www.wsj.com/articles/states-need-645-billion-to-pay-for-these-promises-and-thats-not-counting-what-they-owe-in-pensions-1505899801 (noting that "rising retiree health-care costs are compounding government pressures when many state and local officials are struggling to manage their ballooning pension liabilities and balance their budgets"); Kyle Glazier, *California Cites OPEB Progress in Labor Deal*, BOND BUYER (Sept. 10, 2015, 12:48 PM), https://www.bondbuyer.com/news/california-cites-opeb-progress-in-labor-deal (observing that retiree healthcare liabilities "are a growing concern for issuers of municipal bonds who have begun to realize that aging populations and in some cases years of underfunding have left them looking at the possibility of unsustainable costs in coming years"); *see also* Tyler Clifford, *Snyder Creates Task Force to Address Pension Reform*, CRAIN'S DETROIT BUS. (Feb. 7, 2017, 7:00 AM), http://www.crainsdetroit.com/article/20170207/NEWS/170209859/snyder-creates-task-force-to-address-pension-reform (noting that "more than 330 municipalities offer either retiree health care or a retiree defined benefit pension plan" and that "there is approximately $10 billion in total unfunded health care liabilities and $4 billion in unfunded pension liabilities"); Liz Farmer, *The Week in Public Finance: Unsustainable Health-Care Costs, an Oil State Not in Crisis and More*, GOVERNING (Sept. 9, 2016), http://www.governing.com/topics/finance/gov-finance-roundup-health-texas.html (noting that in recent years, "[retiree healthcare] benefits have been getting more attention from lawmakers").

the benefits.[5] Vulnerable employees and retirees have had limited recourse to hold cities and states to their original deal.[6]

More recently, many public employers have begun to pay down their unfunded liabilities for retiree healthcare. Over the last decade, as new disclosure requirements have forced state and local governments to acknowledge the full scope of their commitments for retiree healthcare, state legislatures have created irrevocable trusts to set aside assets for benefits due in future years. The proliferation

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5. *See, e.g.*, ALEX BROWN & JOSHUA FRANZEL, CTR. FOR STATE & LOCAL GOV'T EXCELLENCE & NAT'L ASS'N OF STATE RETIREMENT ADM'RS, SPOTLIGHT ON RETIREE HEALTH CARE BENEFITS FOR STATE & LOCAL EMPLOYEES IN 2014, at 2 (2014), http://slge.org/wp-content/uploads/2014/12/OPEB-Spotlight-12.14.pdf (reporting that in 2014, 61% of state and local government human-resource executives reported making changes to contain retiree healthcare costs); *see also* Laura A. Bischoff, *Retiree Health Care Cuts Looming for Cops and Firefighters in Ohio*, DAYTON DAILY NEWS (Mar. 30, 2017, 2:49 PM), http://www.daytondailynews.com/news/retiree-health-care-cuts-looming-for-cops-and-firefighters-ohio/znKbsUFZtZfPOHsi2xbbFO/ (reporting that as of 2019, "retired cops and firefighters will no longer receive health care benefits through the Ohio Police & Firefighters Pension Fund but instead will receive a stipend to buy coverage on the open market"); Jameson Cook, *Macomb County Government Retirees Argue for Health-Care Benefits*, MACOMB DAILY (Apr. 11, 2017, 1:48 PM), http://www.macombdaily.com/article/MD/20170411/NEWS/170419913 (describing how the county had reduced benefits for retirees and noting the nearly seven years of subsequent litigation over whether the retiree health benefits had vested pursuant to the labor contract in effect from 2008–2010).

6. *See infra* Section I.B. For employees, retirees, and beneficiaries, changes to the scope and availability of healthcare benefits in retirement frustrate expectations, limit planning, and expose such individuals to significant financial risk. Empirical evidence suggests that the availability of retiree health insurance affects savings behavior during working years, such that public employees covered by retiree health insurance accumulate substantially less wealth than similar private-sector employees without such insurance. *See* Robert L. Clark & Olivia S. Mitchell, *How Does Retiree Health Insurance Influence Public Sector Employee Saving?*, 38 J. HEALTH ECON. 109, 114 (2014) (finding that "state/local workers with retiree health insurance accumulated about $69,000 [or 15%] less net wealth than their uninsured private sector counterparts"). At the same time, public employees must contend with the rising costs of healthcare in retirement. Expenses not covered by Medicare are currently estimated to exceed $120,000 per retiree, not including the cost of over-the-counter medications, dental services, and long-term care. *See* Paul Fronstin & Jack VanDerhei, *Savings Medicare Beneficiaries Need for Health Expenses: Some Couples Could Need as Much as $350,000*, EMP. BENEFITS RES. INS. 5 fig.3 (2017), https://www.ebri.org/pdf/notespdf/EBRI_Notes_Hlth-Svgs.v38no1_31Jan17.pdf. In short, the cost of healthcare in retirement represents a kind of unexpected burden for which many are unprepared. *See* Tawny Elgatian, *Retiree Health Costs Seen as Unexpected Burden*, BLOOMBERG L. (Feb. 24, 2017), https://www.bna.com/retiree-health-costs-b57982084380/ ("Retirement calculators focus on withdrawal rates and interest on investments but fail to identify one of the biggest costs of retirement—the cost of health care."); *see also* Melissa McInerney et al., *How Much Does Out-Of-Pocket Medical Spending Eat Away at Retirement Income?* (CTR. FOR RETIREMENT RES. B.C., Working Paper 2017-13, Oct. 2017), http://crr.bc.edu/wp-content/uploads/2017/10/wp_2017-13.pdf (finding that the adequacy of retirement income is substantially reduced by high out-of-pocket healthcare costs).

of such trusts across 35 states has set into motion what this Article terms the *trust revolution* in retiree healthcare benefits.

Can the newly established trusts ensure that the promised benefits are paid? To answer that question, this Article analyzes newly collected data on over 100 state-administered retiree healthcare plans. Drawing on the empirical analysis, this Article makes four key contributions to the existing scholarship on post-employment benefits.[7]

First, this Article catalogs the form of and the legal framework for the retiree healthcare benefits traditionally provided to public-sector employees. In the absence of overarching federal regulation, no two retiree healthcare plans are alike in the benefits provided or in the governance structures imposed by the states. Nor is the legal status of the benefits consistent across plans. Under the current legal framework, public-employer promises to provide retiree healthcare benefits are legally binding only to the extent that there is a "contract" between the state and the plan participants. Yet the very nature of the benefit—that is, some form of subsidy for healthcare costs to be provided decades after the time of the initial agreement—makes contracting especially difficult. Public employers and employees rarely specify the complete range of permissible modifications to the benefits in place at the time of agreement. In practice, therefore, the scope of legal protections against benefit reductions turns on the public employees' ability to show that some combination of applicable statutory provisions, collective-bargaining terms, and employer conduct establishes a contractual obligation for the state government.

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7. In recent years, scholars have focused extensively on public-sector pensions; but the challenges posed by post-employment healthcare benefits have been largely overlooked. *See, e.g.*, Alicia H. Munnell et al., *The Funding of State and Local Pensions: 2012–2016*, CTR. FOR RETIREMENT RES. B.C. (2013), http://crr.bc.edu/wp-content/uploads/2013/07/slp_32.pdf; PEW CTR. ON THE STATES, THE WIDENING GAP UPDATE (2012), http://www.pewtrusts.org/~/media/legacy/uploadedfiles/pcs_assets/2012/pewpensionsupdatepdf.pdf; U.S. GOV'T ACCOUNTABILITY OFF., GAO-12-322, STATE AND LOCAL GOVERNMENT PENSION PLANS: ECONOMIC DOWNTURN SPURS EFFORTS TO ADDRESS COSTS AND SUSTAINABILITY (2012); Jack M. Beermann, *The Public Pension Crisis*, 70 WASH. & LEE L. REV. 3, 5 (2013); Jeffrey R. Brown & David W. Wilcox, *Discounting State and Local Pension Liabilities*, 99 AM. ECON. REV. 538, 538–42 (2009); Gordon Butler, *One Fund Solution and the Pension Crisis*, 64 CLEV. ST. L. REV. 769 (2016); Jonathan Barry Forman, *Funding Public Pension Plans*, 42 J. MARSHALL L. REV. 837, 867–73 (2009); Richard E. Mendales, *Federalism and Fiduciaries: A New Framework for Protecting State Benefit Funds*, 62 DRAKE L. REV. 503 (2014); Amy B. Monahan, *When a Promise Is Not a Promise: Chicago-Style Pensions*, 64 UCLA L. REV. 356 (2017); Robert Novy-Marx & Joshua D. Rauh, *Public Pension Promises: How Big Are They and What Are They Worth?*, 66 J. FIN. 2011, 1215–16 (2011). The scholarship on public-sector retiree healthcare benefits has been quite limited. For recent work on the subject, see ROBERT L. CLARK & MELINDA SANDLER MORRILL, RETIREE HEALTH PLANS IN THE PUBLIC SECTOR: IS THERE A FUNDING CRISIS? (2010); Jenna Amato Moran, Comment, *The OPEB Tsunami: Riding the Wave of Public Sector Postemployment Health Benefits*, 58 BUFF. L. REV. 677 (2010); John Sanchez, *The Vesting, Modification, and Financing of Public Retiree Health Benefits in Light of New Accounting Rules*, 41 J. MARSHALL L. REV. 1147 (2008).

The second contribution of this Article is to chronicle how financial-reporting changes enacted by the Governmental Accounting Standards Board ("GASB") in 2004 spurred dramatic changes in funding policies. In its 2004 pronouncement, GASB determined that even in the absence of strict legal protections for retiree healthcare benefits, public employers have a constructive obligation for the benefits "because of the understanding by employees that there is a promise of a benefit to be received in the future in exchange for their current services."[8] Failing to include the value of such obligations in annual financial reports would leave taxpayers, bondholders, and ratings agencies with an incomplete assessment of the financial health of the reporting government.[9] Accordingly, GASB moved to require public employers to report the value of the benefits already earned and those expected to be earned by employees in the future, together with the value of any assets set aside to pay for such benefits.[10] Although the rules in no way imposed any funding requirements on plan sponsors, the rules nevertheless created strong incentives—at least from an accounting perspective—to establish and make contributions to GASB-compliant trusts.[11] Whereas pay-as-you-go funding had been the long-standing norm, by 2015, two-thirds of state-administered retiree healthcare plans had established irrevocable trusts to set aside assets for benefits not yet due.

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8. GOVERNMENTAL ACCOUNTING STANDARDS BD., STATEMENTS OF GOVERNMENTAL ACCOUNTING STANDARDS NO. 45: ACCOUNTING AND FINANCIAL REPORTING BY EMPLOYERS FOR POSTEMPLOYMENT BENEFITS OTHER THAN PENSIONS 77 (2004) [hereinafter GASB 45].

9. GOVERNMENTAL ACCOUNTING STANDARDS BD., OTHER POSTEMPLOYMENT BENEFITS: A PLAIN-LANGUAGE SUMMARY OF GASB STATEMENTS NO. 43 AND NO. 45, at 1, http://www.gasb.org/resources/ccurl/553/517/opeb_summary.pdf (last visited Aug. 1, 2017) (stating that without the inclusion of accrued retiree healthcare liabilities, "the readers of financial statements, including the public, have incomplete information with which to assess the cost of public services and to analyze the financial position and long-run financial health of a government").

10. GASB has no enforcement power, but most state and local governments seek to comply with GASB standards. JOHN H. LANGBEIN ET AL., PENSION & EMPLOYEE BENEFIT LAW 913 (6th ed. 2015) (noting that some state and local governments are required by statute to comply with GASB standards, while others do so to maintain good standing in the municipal bond markets).

11. In its latest guidance, GASB set forth the following criteria for retiree healthcare trusts:

> Contributions from employers . . . and earnings on those contributions are irrevocable. [Retiree healthcare] plan assets are dedicated to providing [retiree healthcare] to plan members in accordance with the benefit terms. [Retiree healthcare] plan assets are legally protected from the creditors of employers, nonemployer contributing entities, the [retiree healthcare] plan administrator, and the plan members.

GOVERNMENTAL ACCOUNTING STANDARDS BD., STATEMENTS OF GOVERNMENTAL ACCT. STANDARDS NO. 75: ACCOUNTING AND FINANCIAL REPORTING FOR POSTEMPLOYMENT BENEFITS OTHER THAN PENSIONS, at i–ii (2015) [hereinafter GASB 75], http://www.gasb.org/jsp/GASB/Document_C/DocumentPage?cid=1176166144750&acceptedDisclaimer=true.

Establishing the trusts, however, has not ensured actual funding. While some retiree healthcare trusts have accumulated assets to offset accrued liabilities, other trusts have remained glaringly empty. For example, as of 2015, the Rhode Island retiree healthcare plans for legislators and judges were more than 100% funded, while the plan for state employees was just 15% funded.[12] In the same year, the Massachusetts plan for state employees was just 4% funded.[13] Why have some retiree healthcare plans established dedicated trusts, while others have not? Why have some public employers made contributions to fund the accrued liabilities, while others have contributed almost nothing?

This Article's third contribution is the empirical analysis showing that previously overlooked differences in plan-level governance, as well as in state-level fiscal conditions, are associated with the striking variation in funding progress. At the plan level, greater administrative experience with post-employment trusts—as evident in retiree healthcare plans administered by *pension* systems—has been associated with a higher rate of trust formation. Once the trusts are in place, stronger constraints on legislative control over annual funding decisions—typically through the delegation of authority to plan actuaries—have been associated with more disciplined contributions to the trusts and overall higher funding levels. Higher funding levels have likewise characterized a subset of plans that cover judges and legislators. At the state level, the empirical analysis highlights the competition for limited public resources. Insofar as pension and retiree healthcare plans draw from the same public funds and are considered collectively in state credit ratings, retiree healthcare plans in states with relatively well-funded pension plans appear less likely to have trusts. Where trusts have been established, better pension plan funding is associated with worse funding discipline for retiree healthcare plans. By the same token, retiree healthcare plans in states with stronger fiscal positions have exhibited better funding discipline and higher funding levels.

Finally, this Article assesses the security of retiree healthcare benefits in the wake of the trust revolution. Significant accumulation of assets could limit instances where fiscally stressed public employers seek to reduce or eliminate benefits. But the current legal framework regulating retiree healthcare benefits impedes the serious funding efforts needed to meet existing retiree healthcare obligations. Even with the proliferation of retiree healthcare trusts, so long as there is uncertainty over whether such obligations constitute binding legal contracts, some state and local governments will be reluctant to commit resources to irrevocable trusts.[14] While additional disclosure requirements and specific governance reforms

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12. GABRIEL ROEDER SMITH & CO., RHODE ISLAND STATE EMPLOYEES' AND ELECTING TEACHERS OPEB ACTUARIAL VALUATION REPORT A-2 (2015), http://controller.admin.ri.gov/documents/Other%20Post%20Employment%20Benefits/5_Actuarial%20Valuation_06-30-2013.pdf.

13. THOMAS G. SHACK III, COMMONWEALTH OF MASSACHUSETTS, COMPREHENSIVE ANNUAL FINANCIAL REPORT FOR THE FISCAL YEAR ENDED JUNE 30, 2015, at 134 (2015), http://www.mass.gov/comptroller/docs/reports-audits/cafr/fy2015-cafr.pdf.

14. Some commentators have warned state and local governments to avoid creating trusts to not strengthen the legal protections for nonpension benefits. *See, e.g.*, DANIEL DISALVO & STEPHEN EIDE, THE OPEB OFF-RAMP: HOW TO PHASE OUT STATE AND

can promote transparency and funding discipline in the short term, this Article suggests that any significant long-term resolution requires a deeper rethinking of employer promises for post-employment healthcare and of the institutions best suited to manage such promises for decades to come.

The analysis proceeds in three parts. Part I presents the history of retiree healthcare benefits in the United States. After describing the legal status of retiree healthcare benefits and the traditional approach to funding, Part I chronicles the disclosure changes enacted by the GASB in 2004 and the impact of such changes on public employers' funding policies. Part II introduces newly collected data and turns to an empirical analysis of the varied responses to the new GASB rules. Finally, Part III assesses the impact of the trust revolution on the security of the promised benefits and the future of retiree healthcare in the United States.

I. THE PROMISE OF HEALTHCARE BENEFITS IN RETIREMENT

In the era of the gig economy and the "Uberization of everything," the idea that an employer would subsidize health insurance not only for its current employees, but also for its *retired* employees, may seem increasingly difficult to fathom.[15] Yet, such practices were once commonplace among both private and public U.S. employers. In the 1970s, nearly three-quarters of all employer-sponsored health plans extended coverage to retired employees.[16] Soaring healthcare costs in the 1980s, together with a change in accounting rules in 1990, prompted many private-sector employers to terminate their retiree healthcare benefits.[17] Accordingly, while the vast majority of private employers have eliminated retiree healthcare benefits,[18] most state and local government employers continue to

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LOCAL GOVERNMENTS' RETIREE HEALTH CARE COSTS 13 (2016); Daniel DiSalvo & Stephen Eide, *Stop! Why States and Localities Should Stop Providing Retiree Healthcare*, BOND BUYER (Apr. 1, 2016), https://www.bondbuyer.com/opinion/stop-why-states-and-localities-should-stop-providing-retiree-healthcare (suggesting that prefunding is a "mistake" that would "affir[m] governments' commitment" to retiree healthcare benefits).

15. *See, e.g.*, Paul M. Secunda, *Uber Retirement*, 2017 U. CHI. LEGAL F. 435, 440–41.

16. Brief of Amici Curiae Labor & Benefits Law Professors in Support of Respondents at 2, M&G Polymers USA, LLC v. Tackett, 135 S. Ct. 926 (2015) (No. 13-1010), 2014 WL 4749499, at *2 (noting that in the middle of the last century, health insurance was inexpensive and, by 1974, nearly three-quarters of employer-sponsored health plans extended coverage to retirees with the intention that such benefits would vest).

17. *See infra* note 74 and accompanying text; *see also* Kathryn L. Moore, *The New Retiree Health VEBAs*, *in* NEW YORK UNIVERSITY REVIEW OF EMPLOYEE BENEFITS AND EXECUTIVE COMPENSATION 7-1, 7-3 to 7-4 (Alvin D. Lurie, ed. 2008).

18. *See generally* Paul Fronstin & Nevin Adams, *Employment-Based Retiree Health Benefits: Trends in Access and Coverage 1997–2010*, EMP. BENEFIT RES. INST. 5 (2012), https://www.ebri.org/pdf/briefspdf/EBRI_IB_10-2012_No377_RetHlth.pdf ("Very few private-sector employers currently offer retiree health benefits, and the number offering them has been declining. . . . In 2010, 17.7 percent of workers were employed at establishments that offered health coverage to early retirees, down from 28.9 percent in 1997."). More recently, employers ranging from General Electric and Honeywell to Meritor and Howard University have sought to curtail retiree health benefits. *See, e.g.*, Danielle Douglas-Gabriel, *Howard University Ends Group Health Plan for Some Retirees*, WASH.

provide such benefits for public employees.[19] This Part first describes the range of public-sector plans and the range of the systems that states have set up to administer them. It then turns to the nature of the retiree healthcare promise and the traditional approach to plan funding. Whereas plan design, governance, and even legal status vary across plans, until GASB reformed the reporting requirements for retiree healthcare benefits sponsored by public employers, pay-as-you-go funding was the standard approach among state-administered plans.

A. Variation in Employer Plans

In addition to traditional pension benefits, state and local governments provide a wide range of retiree healthcare benefits to public-sector retirees who have met the applicable eligibility criteria.[20] Retiree healthcare benefits include continued access to employer-sponsored health insurance for retirees not yet eligible for Medicare (the so-called early retirees[21]), as well as a variety of plans for retirees ages 65 and older (the so-called Medicare-eligible retirees) to supplement Medicare or offset certain out-of-pocket costs. In 2014, 84% of state employees had access to retiree healthcare benefits after turning 65, while 86% had access to employer-sponsored retiree healthcare benefits for early retirees.[22]

Despite the widespread availability of retiree healthcare plans, in the absence of overarching federal regulation, the quality and cost of the healthcare benefits have varied widely across plans. As Table 1 illustrates, heterogeneity in

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POST (May 5, 2017), https://www.washingtonpost.com/news/grade-point/wp/2017/05/05/howard-university-ends-group-health-plan-for-some-retirees/?utm_term=.262e6803677c; *GE Retirees Decry Health Care Changes*, CTPOST.COM (Apr. 27, 2017, 1:31 PM) http://www.ctpost.com/business/article/GE-retirees-decry-health-care-changes-11103777.php; Jacklyn Wille, *Honeywell's Retiree Health Cuts Divide Federal Judges*, BLOOMBERG BNA: PENSION & BENEFITS DAILY (Dec. 20, 2016), https://www.bna.com/honeywells-retiree-health-n73014448828/.

19. CLARK & MORRILL, *supra* note 7, at 5–6.

20. As a matter of terminology, retiree healthcare benefits are considered a type of non-pension or "*other* post-employment benefit" ("OPEB"). OPEBs include retiree healthcare benefits, as well as life insurance, disability, and long-term care insurance. Of these, the health benefits are by far the most common and the costliest OPEB and hence the focus of this Article. Ronald A. Wirtz, *OPEBs: What Lies Beneath the Balance Sheet*, RES. BANK MINNEAPOLIS: FEDGAZETTE (Apr. 7, 2011), https://www.minneapolisfed.org/publications/fedgazette/OPEBs-what-lies-beneath-the-balance-sheet (noting that within the category of non-pension postemployment benefits, healthcare is the "elephant in terms of cost").

21. For early retirees, prior to the passage of the Affordable Care Act, continued access to employer coverage saved many from the "financial disaster" of having to obtain individual insurance coverage. For such early retirees, pre-existing medical conditions and other underwriting criteria had made obtaining quality individual health insurance "forbiddingly expensive, if not completely impossible." Richard L. Kaplan et al., *Retirees at Risk: The Precarious Promise of Post-Employment Health Benefits*, 9 YALE J. HEALTH POL'Y L. & ETHICS 287, 291 (2009).

22. U.S. BUREAU OF LABOR STATISTICS, NATIONAL COMPENSATION SURVEY: EMPLOYEE BENEFITS IN THE UNITED STATES tbl.42 (Mar. 2014), http://www.bls.gov/ncs/ebs/benefits/2014/ownership/govt/table42a.pdf.

state law and in collective-bargaining dynamics has produced public-sector retiree healthcare plans that differ in the eligibility criteria to qualify for the benefits, the generosity of the plan terms, and the proportion of the premiums covered by employers.[23] The benefits range from unsubsidized access to employer-sponsored health insurance to full coverage of retiree health-insurance premiums.[24] A number of plans today offer fixed-dollar monthly subsidies for Medicare eligible retirees.

23. Michael Nadol et al., *Managing Public-Sector Retiree Health-Care Benefits under the Affordable Care Act*, GOV'T FIN. REV., Apr. 2014, at 11, 11–13; CLARK & MORRILL, *supra* note 7, at 26–83.

24. PEW CHARITABLE TR. & MACARTHUR FOUND., STATE RETIREE HEALTH PLAN SPENDING 10–12 (2016), http://www.pewtrusts.org/~/media/assets/2016/09/state_retiree_health_plan_spending.pdf [hereinafter PEW REPORT].

TABLE 1: Selected Provisions Showing Range of Retiree Healthcare Benefits

Plan Name	Summary of Benefits
Alabama State Employees Health Insurance Plan	Continued coverage under existing plans for active employees is available both for retirees who have not reached the age of 65 and for those eligible for Medicare. Employees retiring after 25 years of service receive the full amount of the state share premium. For each year less than 25, the state share is reduced by 4% and the retiree's share is increased accordingly.[25]
Arizona State Retirement System—Health Benefit Fund	The system offers a "health insurance premium benefit to supplement the cost of retiree health insurance." Retirees who have five or more years of credited service are eligible for a monthly premium benefit, which ranges from $75 to $260 per month, depending upon years of service and coverage selected.[26]
California Employers' Retiree Benefit Trust	The health plans available to retired state employees are the same plans available to active employees, including supplemental plans for retirees enrolled in Medicare. For most retirees, the state pays 100% of the average premium cost for the retiree and 90% of the average additional costs for his or her dependents. Retired state employees are eligible to receive this contribution after 20 years of service. Retired employees with 10 years of state service receive 50% of this amount, increasing 5% annually until the 100% level is earned.[27]
Iowa Post-retirement Medical Benefits	The state permits retirees to enroll in the plans available to active employees. However, retirees must pay the entire health insurance premium.[28]

25. STATE EMPS. INS. BD., STATE OF ALABAMA, THE STATE EMPLOYEES' HEALTH INSURANCE PLAN 14 (2018), https://www.alseib.org/PDF/SEHIP/SEHIPHandbook.pdf.

26. *Retiree Health Insurance Premium Benefit and Optional Health Insurance Premium Benefit Programs*, ARIZ. STATE RET. SYS., https://www.azasrs.gov/content/retiree-health-insurance-premium-benefit-and-optional-health-insurance-premium-benefit (last visited Mar. 3, 2018).

27. MAC TAYLOR, CAL. LEGISLATIVE ANALYST OFF., THE 2015–16 BUDGET: HEALTH BENEFITS FOR RETIRED STATE EMPLOYEES 7–8 (2015), http://www.lao.ca.gov/reports/2015/budget/retiree-health/retiree-health-benefits-031615.pdf.

28. IOWA DEP'T OF ADMIN. SERVS., COMPREHENSIVE ANNUAL FINANCIAL REPORT FOR THE FISCAL YEAR ENDED JUNE 30, 2017, at 120 (2017), https://das.iowa.gov/sites/default/files/acct_sae/cafr/fy17_cafr.pdf; *Retirees*, IOWA DEP'T OF ADMIN. SERVS., https://das.iowa.gov/human-resources/employee-and-retiree-benefits/retirees-0 (last visited Mar. 21, 2018).

The variation has also extended to the organization and governance of retiree healthcare plans. Among plans administered at the state level, for example, some cover only state employees (or even specific groups such as judges and legislators), while others cover both state and local government employees.[29] Some retiree healthcare plans are administered by state *pension* systems, while others are administered by departments of administration, health departments, or similar state agencies.[30] In certain cases, new systems have been created to manage retiree healthcare benefits.[31] Among plans that cover more than one employer, some have maintained individual accounts to track each employer's assets and liabilities (even if assets are pooled for investment purposes) while other so-called cost-sharing plans have pooled the assets and liabilities of all the participating employers.[32]

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29. In Alabama, for example, the State Employees' Health Insurance Plan covers only state government employees and retirees, while the Public Education Employees' Health Insurance Fund is a health insurance plan for active and retired employees of state and local educational institutions. THOMAS L. WHITE JR., OFFICE OF THE STATE COMPTROLLER, STATE OF ALABAMA, COMPREHENSIVE ANNUAL FINANCIAL REPORT FOR THE FISCAL YEAR ENDED SEPTEMBER 30, 2014, at 118–27 (2014), http://comptroller.alabama.gov/pdfs/CAFR/cafr.2014.Alabama.pdf [hereinafter AL 2014 CAFR].

30. The California Public Employees Retirement System, for example, administers the California Employers' Retiree Benefit Trust Fund for state employees and employees of participating local employers. CA. PUB. EMP. RET. SYS., COMPREHENSIVE ANNUAL FINANCIAL REPORT FOR FISCAL YEAR ENDED JUNE 30, 2014, at 45 (2014), https://www.calpers.ca.gov/docs/forms-publications/cafr-2014.pdf [hereinafter CALPERS 2014 CAFR]. In Indiana, the State Personnel Department administers the State Personnel Plan for retired state employees. SUZANNE CROUCH, IND. AUDITOR OF STATE, STATE OF INDIANA, COMPREHENSIVE ANNUAL FINANCIAL REPORT FOR FISCAL YEAR ENDED JUNE 30, 2014, at 112 (2014), http://www.in.gov/auditor/files/Entire_2014_CAFR.pdf.

31. In Alabama, for example, the State Employees' Insurance Board is a state agency established by the Alabama Legislature to administer the State Employees' Health Insurance Plan. The Board's members include the five members of the State Personnel Board, the Director of Finance, the Secretary–Treasurer of the Employees' Retirement System of Alabama, two elected active employees of the state, and two elected retirees covered under the Plan. *See The State Employees' Health Insurance Plan FAQs*, ALA. STATE EMPLOYEE'S INS. BD., http://www.alseib.org/PDF/SEHIP/FAQ/SEHIPFAQ-AboutSEHIPPlan.pdf (last visited Feb. 10, 2018). Rhode Island set up a separate retiree healthcare system in 2010. 36 R.I. GEN. LAWS ANN. § 36-12.1-5 (West 2015) ("An OPEB System is hereby established and placed under the management of the OPEB Board for the purpose of providing and administering OPEB Benefits for Retired Employees of the State of Rhode Island and their dependents . . . .").

32. For example, the California Employers' Retiree Benefit Trust Fund is an agent multiple-employer plan with 427 employers. *See* CALPERS 2014 CAFR, *supra* note 30, at 31. The Alabama Retired Education Employees' Health Care Trust is a multiple-employer, cost-sharing, defined benefit healthcare plan with 197 participating employers. *See* AL 2014 CAFR, *supra* note 29, at 127.

B. The Legal Status of Healthcare Promises

For any given set of benefits, the two critical questions are as follows: first, what is the legal status of the benefits in place, and second, how will such benefits be funded? The following sections tackle each issue in turn.

Consider an individual who commences work for a state agency. The public employer sponsors a retiree healthcare plan alongside a traditional pension plan for its employees. The pension plan provides a monthly pension benefit at retirement roughly equal to 2% of the employee's salary multiplied by the number of years worked.[33] Although employees *accrue* benefits for each year worked, benefits do not *vest* until the employees complete five years of service. If employees terminate employment before completing five years of service, they are not entitled to any pension benefits. After five years of service, our hypothetical employee would have a vested pension benefit equal to 10% of the employee's salary. The benefits continue to accrue for each additional year of service. After 20 years of service, the same employee would have a pension benefit equal to 40% (2%*20 years) of the employee's salary.

The retiree healthcare plan covers a portion of the employee's health-insurance premiums in retirement. Each year, the state sets the monthly dollar amount of the employer contribution for active employees (for example, $700 for an individual plan in 2017). The proportion of that contribution to which employees are entitled in retirement depends on their years of service. Until employees complete ten years of service, they are not eligible for any retiree healthcare benefits. After ten years of service, an employee is entitled to 50% of the contribution upon retirement from the public employer. With each additional year, the contribution increases by 5%, reaching 100% after 20 years of service. Thus, an employee who retires from the public agency with 20 years of service would be eligible to receive the full employer contribution each month to offset the costs of health-insurance premiums in retirement.

Assuming both the pension and retiree healthcare benefits as described are in place when the employee commences employment on Day 1, can the employer choose to eliminate the benefits on Day 2? After the employee has completed ten years of service? After the employee has retired?

To sum up in one sentence, although there is significant state-by-state variation, employers generally have greater latitude to modify healthcare benefits than pension benefits. The following paragraphs describe the historical path to this result and the current framework for evaluating the legal status of retiree healthcare benefits.

Public-sector pension benefits were once considered "gratuities" that, in the words of one court, sprang "from the graciousness and appreciation of sovereignty" and that could be "given or withheld at the pleasure of a sovereign

33. The final calculation of the pension benefit may use the employee's average salary over the years of service or over the final few years.

power."[34] By the mid-twentieth century, however, nearly every state had moved away from the gratuity approach, with most state courts adopting the position that public pension plans create "some type of contractual relationship between the state and the employee."[35] In some states, constitutional provisions now explicitly specify that public pension plans create contracts between the state and the plan participants. In other states, courts have found contractual arrangements in the statutory provisions that govern public pension systems. States differ on the application and bounds of the contractual approach, but the notion that state pension programs establish contracts with employees, that the benefits vest after some period, and that states are not free to reduce benefits that have already accrued has been firmly established.[36]

For pension plans in the private sector, Congress went a step further. In enacting the Employee Retirement Income Security Act of 1974 ("ERISA"), Congress mandated accrual, vesting, and funding requirements for all employer-sponsored pension plans, thus restricting employers' ability to reduce accrued benefits and mandating that such benefits be funded as they are earned. The approach reflected a determination that, as a matter of public policy, the accrual, vesting, and funding of pension benefits should *not* be left to contracts between individual employers and employees.[37]

Neither Congress nor the states have extended the same kind of accrual, vesting, or funding requirements to retiree healthcare benefits.[38] The historical

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34. Eddy v. Morgan, 75 N.E. 174, 178 (Ill. 1905).

35. Amy B. Monahan, *Statutes as Contracts? The "California Rule" and Its Impact on Public Pension Reform*, 97 IOWA L. REV. 1029, 1035 (2012). In a smaller subset of states, courts have held that pension benefits create a property right subject to due-process requirements. Two states continue to apply the gratuity framework in limited circumstances. *See* JENNIE HERRIOT-HATFIELD ET AL., A LEGAL GUIDE TO STATE PENSION REFORM 1–2 (2012), http://www.nasra.org/Files/Topical%20Reports/Legal/PensionLegalGuide_RELEASE.pdf.

36. Amy B. Monahan, *Public Pension Plan Reform: The Legal Framework*, 5 EDUC. FIN. & POL'Y 617, 618–19 (2010).

37. *See, e.g.*, Roberta Romano, *Comment on Easterbrook and Fischel, "Contract and Fiduciary Duty"*, 36 J.L. & ECON. 447, 449 (1993) (observing that there may be "something especially difficult about the contract specification and monitoring costs of employee pensions that necessitates the federal regulatory framework of the Employee Retirement Income Security Act of 1974"). Scholars have long recognized the "imbalance in power between management and workers in real world markets," a dynamic that is only amplified when the subject of negotiation is a complex, decades-long financial arrangement laden with uncertainty about long-term costs. *See, e.g.*, Brendan S. Maher, *Regulating Employment-Based Anything*, 100 MINN. L. REV. 1257, 1297–1302 (2016); *see also* Catherine L. Fisk, Lochner *Redux: The Renaissance of Laissez-Faire Contract in the Federal Common Law of Employee Benefits*, 56 OHIO ST. L.J. 153, 160 (1995) (arguing that "classical contract doctrine is ill-suited for the task of identifying and resolving conflicts between the expectations of parties to an employee benefits relationship").

38. *See* Michael S. Gordon, *Introduction to* EMPLOYEE BENEFITS LAW, at lxxxv, lxxxviii–xciii (Steven J. Sacher et al. eds., 2d ed. 2000) ("The answer as to why ERISA didn't do more respecting health and other welfare plans is quite simple: Unlike pension plans, there was no crisis in health plans in 1974. No one was complaining about the loss of health benefits

justification for the distinction points to the low—even *de minimis*—costs of retiree healthcare some four decades ago and thus the lack of political interest in regulating such benefits.[39] But now that the cost argument no longer applies, does the distinction hold up from a theoretical perspective? After all, both pension and retiree healthcare benefits provide something of monetary value in retirement as a form of deferred compensation for the employee's service.[40] A key distinction cited to justify the disparate legal status of pension and healthcare benefits is the difficulty in measuring accrual rates for the latter. That is, because pension benefits are typically calculated as a percentage of salary multiplied by the number of years worked, it is relatively straightforward to determine the accrued and vested benefits in a given year. For example, the hypothetical employee described above accrues pension benefits at the rate of 2% of salary in each year, with full vesting after five years. Of course, since the employee's lifespan is not known, the total value of the benefits over an employee's lifetime remains uncertain.[41]

In the case of healthcare benefits, the form of the benefits traditionally chosen by most public employers is not as amenable to calculation of yearly accruals. In many cases, the benefits are intentionally structured as all-or-nothing. That is, an employee may be eligible to receive certain benefits upon *retiring* with at least ten years of service, but nothing if the employee retires even a day before completing the ten years of service or terminates employment before retirement age. While the all-or-nothing formulation with respect to years of service commonly characterizes pension benefits (that is, the pension benefits vest only after an employee works for an employer for a specified number of years), the conditioning of benefits on retiring from the employer is a distinguishing feature of retiree healthcare plans.

Further, although some retiree healthcare plans have recently taken the form of defined-dollar subsidies that provide post-retirement income,[42] traditionally

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as they were about pensions."); *see also* Brief of Amici Curiae Labor & Benefits Law Professors in Support of Respondents, *supra* note 16 (noting that retiree health insurance during the 1960s and 1970s "was inexpensive; indeed, some employers considered the cost of these benefits to be *de minimis*").

39. *See, e.g.*, LANGBEIN ET AL., *supra* note 10, at 910 (noting that although retiree health plans differ from the "garden variety welfare benefit plan," because such plans are not treated as pension plans under ERISA, the statute's vesting and funding rules do not apply).

40. David A. Pratt, *The Past, Present and Future of Retiree Health Benefits*, 3 SUFFOLK U. J. HEALTH & BIOMEDICAL L. 103, 113 (2007) ("[A] plan that provides health benefits across a worker's retirement period functions as a type of pension plan, a pension plan that pays in specie rather than in dollars . . . ."). In *M&G Polymers USA, LCC v. Tackett*, 135 S. Ct. 926, 936 (2015), however, the Supreme Court emphasized that under ERISA, Congress specifically defined those plans that "resul[t] in a deferral of income by employees" as *pension plans*, and those that provide for medical benefits, as *welfare plans*. The Court interpreted the definitions to suggest that plans that provide medical benefits in retirement do not result in the deferral of income.

41. Pension benefits are also commonly subject to cost-of-living adjustments, which add uncertainty to the ultimate "price tag" for the benefits.

42. PEW REPORT, *supra* note 24, at 11 (citing 12 states that structure retiree healthcare plans in this way). Notably, in its guidance, GASB distinguishes between retiree

such benefits have been structured to provide retirees a percentage of the employer contribution for active employees in any given year. In the latter case, the cost of such benefits has been contingent not only on the lifespan of a retiree, but also on healthcare costs at a particular point in time. The pervasive argument has been that retiree healthcare benefits "do not accrue throughout an employee's career and cannot, in any meaningful sense, be valued over time."[43] Accordingly, retiree healthcare has long been considered a "status benefit," such that an employee becomes entitled to the benefit—i.e., that the benefit accrues—only after attaining the requisite *retiree* status.[44]

Can the employer, therefore, take away the retiree healthcare benefits a day before the employee retires? One day after? At what point, if any, does the benefit become a vested right? At present, the ability of a public employer to modify retiree healthcare benefits for employees or retirees depends on the highly idiosyncratic combination of applicable statutory provisions, collective-bargaining terms, and case law in a particular jurisdiction.[45] In each case, the challenge is to determine whether the arrangement at hand constitutes a contractual obligation of the state.[46] Consequently, the status of retiree healthcare benefits can vary widely from case to case. In 2015, for example, a California appellate court held that after the memorandum of understanding between the City of South Pasadena and its police union expired, the city was permitted to unilaterally reduce its medical insurance contribution for retirees.[47] Two years earlier, however, a California superior court

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health plans that provide for unrestricted income in retirement and those that provide income that may only be used for certain healthcare-related expenses. GASB considers the former to be a *pension* and not a retiree healthcare plan. GOVERNMENTAL ACCOUNTING STANDARDS BD., GUIDE TO IMPLEMENTATION OF GASB STATEMENTS 43 AND 45 ON OTHER POSTEMPLOYMENT BENEFITS: QUESTIONS AND ANSWERS 5 (2005) ("The use of the health insurance subsidy provided as an additional monthly cash payment to retirees and beneficiaries is effectively not restricted to payment of health insurance and, therefore, the subsidy should be considered retirement income.").

43. AMY B. MONAHAN, INVIOLABLE—OR NOT: THE LEGAL STATUS OF RETIREE MEDICAL BENEFITS FOR STATE AND LOCAL EMPLOYEES 7 (2016).

44. *Id.*

45. *See, e.g.*, John R. Dorocak & James Estes, *State and Local Government Funding of Health and Retirement Benefits for Employees: Current Problems and Possible Solutions with California Health Benefits as an Example*, 62 SYRACUSE L. REV. 303, 321–23 (2012); Moran, *supra* note 7, at 701–15; Sanchez, *supra* note 7, at 1181–83.

46. Although the legal status of retiree healthcare benefits is far from uniform, the variation is commonly overlooked. *See, e.g.*, EILEEN NORCROSS & OLIVIA GONZALEZ, RANKING THE STATES BY FISCAL CONDITION 23 (2016), https://www.mercatus.org/system/files/Norcross-Fiscal-Rankings-2-v3_1.pdf (stating that retiree healthcare benefits "do not carry the same legal protection as pensions and represent a liability that may be impaired, reduced, or eliminated").

47. S. Pasadena Police Officers' Assn. v. City of S. Pasadena, No. B254176, 2015 WL 1094691, at *6 (Cal. Ct. App. Mar. 9, 2015). The court found that the case lacked "unmistakable evidence . . . evince[ing] a legislative intent to create [implied] private rights of a contractual nature enforceable against' the City" and emphasized that employee "assumption[s]" that a benefit will continue do not create implied agreements. *Id.* (quoting another source).

held that a Los Angeles city ordinance freezing the retiree health-insurance-premium subsidy or requiring current employees to contribute additional amounts constituted an illegal impairment of a right that had *vested* upon the acceptance of employment.[48]

Courts assess the legal protections available in a particular jurisdiction by first considering any applicable constitutional protections for retiree healthcare benefits. Several state constitutions explicitly prohibit the impairment of "accrued benefits," but state courts have disagreed as to whether such "accrued benefits" encompass retiree healthcare and other non-pension, post-employment benefits. For example, while the non-impairment clause in Michigan has been interpreted to exclude retiree healthcare benefits, similar clauses in Alaska, Hawaii, and Illinois have been extended to retiree health obligations.[49] The Supreme Court of Alaska held that the term *accrued benefits* in the Alaska Constitution includes "all retirement benefits that make up the retirement benefit package that becomes part of the contract of employment *when the public employee is hired.*"[50]

After considering any relevant constitutional provisions, the next step is to consider the extent to which the applicable state statutes or ordinances create a contractual obligation with respect to the provision of retiree healthcare.[51] Because

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48. L.A. City Attorney's Ass'n v. City of L.A., No. BS135294, at *11 (Cal. Sup. Ct. Sept. 13, 2013), http://www.lacaa.org/docs/13-09-13-order-granting-writ.pdf. That same year, a federal district court found that where a county board of supervisors consistently ordered—via annual approval of a resolution—health and dental insurance subsidies to be paid to retirees, the conduct did not establish intent to promise a benefit in perpetuity. Sacramento Cty. Retired Emps. Ass'n v. Cty. of Sacramento, 975 F. Supp. 2d 1150, 1165 (E.D. Cal. 2013). Thus, the board was permitted to reduce the health benefits provided to retirees. *See id.*

49. Pontiac Police & Fire Retiree Prefunded Grp. Health & Ins. Trust Bd. of Trustees v. City of Pontiac No. 2, 873 N.W.2d 783, 793 (Mich. Ct. App. 2015) (holding that healthcare benefits are not "accrued financial benefits," for purposes of the state's constitutional prohibition on diminishing or impairing accrued financial benefits of pension plans and retirement systems). Article XII, section 7 of the Alaska Constitution provides that "[m]embership in employee retirement systems of the State of its political subdivisions shall constitute a contractual relationship. Accrued benefits of these systems shall not be diminished or impaired." ALASKA CONST., art. XII, § 7. The Supreme Court of Alaska held that "accrued benefits" include retiree health benefits. Duncan v. Retired Public Employees of Alaska, 71 P.3d 882, 887 (Alaska 2003). The Illinois Supreme Court has held that health-insurance subsidies for state retirees that flowed directly from membership in one of the state's public pension systems were constitutionally protected by the state's pension protection clause. *See* Kanerva v. Weems, 13 N.E.3d 1228, 1240 (Ill. 2014); *see also* Underwood v. City of Chicago, 62 N.E.3d 375, 382–83 (Ill. App. Ct. 2016). Hawaii's Supreme Court similarly held in 2010 that retiree health benefits provided by the health benefits plan for state retirees were an "accrued benefit" arising from membership in an employee retirement system of the State and thus were protected by the Non-Impairment Clause of the Hawaii State Constitution. Everson v. State, 228 P.3d 282, 295 (Haw. 2010).

50. *Duncan*, 71 P.3d at 888 (emphasis added).

51. Massachusetts state law, for example, provides that changes to healthcare plan design and contribution rates for current employees must be accomplished through the collective-bargaining process. However, municipalities have the authority to change retiree

finding that such a contract exists has the effect of binding future legislatures, the burden on the claimant is to show "unmistakable evidence of legislative intent to form a contract."[52] Barring such unmistakable intent to restrict the authority of future legislatures, statutes providing healthcare benefits to retirees generally have not been held to create contractual obligations for state and local governments.[53]

If neither the state constitution nor the applicable statutory provisions establish contractual obligations to provide retiree healthcare benefits, such obligations may arise from so-called implied contracts and from employer conduct that induces reasonable employee reliance on the employer's promises.[54] In both types of cases, the absence of an express agreement shifts the focus of judicial review to the employer's actions and the extent to which such actions—as either a matter of quasi-contract or on promissory estoppel grounds—create binding obligations.[55] In the promissory estoppel cases, the reasonableness of the employees' reliance on the employer's conduct is also assessed, which, in the context of retiree healthcare benefits, requires a court to determine whether it was reasonable for employees to expect retiree healthcare promises to create long-term, binding obligations on the employer.[56]

Finally, in cases where retiree healthcare benefits are provided through a collective-bargaining agreement ("CBA"), the legal status of such benefits is controlled by the terms of the agreement.[57] In many cases, however, such CBAs are

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healthcare insurance benefits unilaterally so long as the benefits meet the minimum standards set by the Commonwealth. *See* MASS. GEN. LAWS ANN. ch. 32B, § 9A (West, Westlaw through ch. 175 of 2017 1st Ann. Sess.); City of Somerville v. Commonwealth Emp't Relations Bd., 24 N.E.3d 552, 558 (Mass. 2015).

52. MONAHAN, *supra* note 43, at 9.

53. *Id.*

54. *See, e.g.*, Retired Emp. Ass'n of Orange Cty., Inc. v. Cty. of Orange, 266 P.3d 287, 301 (Cal. 2011) (holding that under California law, a vested right to health benefits for retired county employees can be implied under certain circumstances from a county ordinance or resolution); *see also* Andrews, Jr. v. Lombardi, No. KC20131128, 2017 WL 532353, at *34 (R.I. Sup. Ct. Feb. 2, 2017) (finding "the necessary offer, acceptance, and consideration to form an implied-in-fact contract from the relations of and communications" between certain retirees and the City of Providence where "the promise of healthcare benefits was part of the post-retirement benefits package that the City offered to Plaintiffs in exchange for diligent and continuous employment in their dangerous jobs as firefighters and police officers" and "[p]laintiffs accepted and performed their end of the bargained-for exchange through continued and faithful service to the City").

55. Promissory estoppel requires finding that the employer's retiree healthcare promises could have been expected to, and in fact did, reasonably induce employee action, and that upholding the promise is the only means of avoiding injustice and unfairness. *See, e.g.*, MONAHAN, *supra* note 43, at 9–10.

56. *See, e.g.*, Allen v. Bd. of Educ. of the Union Free Sch. Dist. No. 20, 168 A.D.2d 403, 404 (N.Y. App. Div. 1990).

57. In general, not all states provide collective-bargaining rights to public employees. U. S. GOV'T ACCOUNTABILITY OFFICE, GAO-02-835, COLLECTIVE BARGAINING RIGHTS: INFORMATION ON THE NUMBER OF WORKERS WITH AND WITHOUT BARGAINING RIGHTS 8–9 (2002) (observing that 26 states have laws "that provide collective bargaining rights to essentially all public employees," while "12 states essentially do not have any laws for

silent or ambiguous—often intentionally so—as to the duration of the retiree healthcare benefits provided in the agreement.[58] CBAs commonly include language promising "lifetime" health benefits, while simultaneously limiting the duration of the CBA or preserving the employer's right to alter or terminate benefits.[59] Judicial approaches to the interpretation of such contracts differ across jurisdictions. The Wisconsin Supreme Court, for example, has applied a presumption in favor of vesting post-employment healthcare benefits, which the court found to be a form of deferred compensation for past services rendered.[60] Conversely, the Supreme Court of Tennessee has declined to apply such a presumption, holding instead that retiree

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collective bargaining among state and local employees," and the remaining "12 states have laws that provide bargaining rights to specific groups of workers."). Further, recent years have witnessed the decline of and recent restrictions on public-sector unions. *See, e.g.*, Press Release, Bureau of Labor Statistics, Union Members–2016 (Jan. 26, 2017), https://www.bls.gov/news.release/archives/union2_01262017.pdf (noting declines in union membership); *Unions Decline in Public Sector*, N.Y. TIMES, Jan. 24, 2014 at B2; Clay Masters, *Iowa Moves to Restrict Collective Bargaining for Public Sector Workers*, NPR (Feb. 14, 2017, 5:09 PM), https://www.npr.org/2017/02/14/515242288/iowa-moves-to-restrict-collective-bargaining-for-public-sector-workers; *see also* Maria O'Brien Hylton, *Friedrichs and the Move Toward Private Ordering of Wages and Benefits in the Public Sector*, 23 CONN. INS. L.J. 177, 183 (2016) (analyzing the consequences of the 2011 Wisconsin Budget Repair Bill, which "largely eliminated collective bargaining for state public employees").

58. Maria O'Brien Hylton, *After* Tackett*: Incomplete Contracts for Post-Employment Healthcare*, 36 PACE L. REV. 317, 318–19 (2016) (documenting how private-sector employers and unions "came to the same strategic conclusion . . . that silence was preferable to an explicit commitment."); *see also* Robert A. Hillman, *The Supreme Court's Application of 'Ordinary Contract Principles' to the Issue of the Duration of Retiree Healthcare Benefits: Perpetuating the Interpretation/Gap-Filling Quagmire*, ABA J. LAB. & EMP. L. (*forthcoming*) (reporting, based on interviews, that "union and management lawyers familiar with collective bargaining, particularly on vesting of healthcare benefits, concede they are willing to live with uncertainty because of the dangers of even raising the issue during bargaining"). An analysis of 50 public-sector CBAs available in the online database maintained by the Office of Labor-Management Standards of the U.S. Department of Labor, as of 2014, revealed that 22% of the CBAs included the ambiguous phrase that benefits "will continue," but did not specify a period of duration or conditions associated with that continuance; meanwhile 18% were completely silent on the question of vesting. Brief of Goldstein & Russell, P.C., as Amicus Curiae in Support of Neither Party at 3, M&G Polymers USA, LLC v. Tackett, 135 S. Ct. 926 (2015) (No. 13-1010), 2014 WL 3687262, at *3.

59. Notably, even where current employees are represented by unions, such unions do not generally represent or consider the interests of retirees. The interests of retirees may not align with the interests of current employees, and union involvement in the (re)negotiation of post-employment benefits is fraught with potential conflicts among union members. *See, e.g.*, Roth v. City of Glendale, 614 N.W.2d 467, 473 (Wis. 2000) (expressing concern that retirees may be "voiceless" in such negotiations and that "unions that are negotiating on behalf of current employees may unilaterally bargain away contractual promises made to retirees, thereby frustrating the expectations of employees who have earned retirement benefits by providing past services").

60. *Id.* (noting in support of the presumption of vesting that because unions do not represent retirees, they may bargain for greater benefits for active employees at the expense of benefits for retirees).

healthcare benefits will not vest unless there is express language—through terms such as *lifetime benefits*, *vested rights*, or *contractual obligation*—documenting the parties' intent to do so.[61] As is quite common in cases adjudicating the retiree healthcare benefits of public-sector employees, the Tennessee court looked to the private sector for guidance.[62]

The consideration of case law from the private sector reflects the broad similarities in the public- and private-sector legal frameworks for retiree healthcare benefits. As in the public sector, retiree healthcare benefits in the private sector are protected only to the extent of any contractual agreement with the employer.[63] In 2015, the U.S. Supreme Court resolved a circuit split as to the presumptions used to interpret ambiguous terms in private-sector CBAs. In *M&G Polymers v. Tackett*, the employer had entered into a CBA that promised that union employees who reached a certain age and years of service would receive a full company contribution for healthcare benefits in retirement. The benefits were to be provided for the duration of the agreement. The CBA was subject to renegotiation after three years. After the CBA expired, the employer decided that retirees had to begin contributing toward the cost of their health insurance. The retirees challenged the employer decision, alleging that they had a vested right to lifetime contribution-free healthcare benefits.

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61. Davis v. Wilson Cty., 70 S.W.3d 724, 725, 727–28 (Tenn. 2002) (holding that "health care benefits were welfare benefits that did not vest automatically and that there was no clear and express language in the resolutions that the health care benefits were intended to vest or could not be terminated"). Other courts have declined to apply a presumption in either favor. *See, e.g.*, Poole v. City of Waterbury, 831 A.2d 211, 224 (Conn. 2003) (applying "well-established principles of contract interpretation" to address the issue of vesting).

62. *See Davis*, 70 S.W.3d at 727.

63. Barring contrary provisions in CBAs, private-sector employers may eliminate retiree healthcare benefits at any time. *See, e.g.*, Curtiss-Wright Corp. v. Schoonejongen, 514 U.S. 73, 78 (1995) ("Employers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans"); *see also* MONAHAN, *supra* note 43, at 7–8. Notably, however, ERISA does subject retiree-healthcare-plan administrators to certain fiduciary obligations. Dana M. Muir, *Fiduciary Status as an Employer's Shield: The Perversity of ERISA Fiduciary Law*, 391 U. PA. J. LAB. & EMP. L. 391, 406 (1999) (discussing the fiduciary regime that applies to non-pension benefits plans under ERISA). Accordingly, in the private sector, plan participants have alleged the plan administrators breached their fiduciary obligations by representing to plan participants that the employer could not modify retiree health benefits. *See, e.g.*, Gregg v. Transp. Workers of Am. Int'l, 343 F.3d 833, 837 (6th Cir. 2003) (finding a breach of fiduciary duty where an employer told employees that benefits "can be continued indefinitely after retirement at the same monthly rate" and that the rate might "go up a few cents" when the employer in fact retained the right to change the plan); James v. Pirelli Armstrong Tire Corp., 305 F.3d 439, 455–56 (6th Cir. 2002) (finding a breach of fiduciary duty where the defendant informed employees that their benefits would not be changed during their lifetimes when the defendant retained the right to change the benefits); Hatmaker v. Consol. Nuclear Sec., LLC, No. 3:15-cv-351-TAV-HBG, 2016 WL 8711457 at *6–8 (E.D. Tenn. May 9, 2016) (holding that the proposed class of retirees stated a valid fiduciary breach claim based on the employer's alleged misrepresentations about the security of retiree health benefits).

The absence of explicit provisions to address the vesting of healthcare benefits, while quite common in such agreements,[64] baffled some on the Court.[65]

In a unanimous decision, the Justices held that "when a contract is silent as to the duration of retiree benefits, a court may not infer that the parties intended those benefits to vest for life."[66] Instead, ordinary contract-law principles apply, including the principle that contractual obligations generally cease upon the termination of the CBA. In cases where a contract is found to be ambiguous, the court may consider extrinsic evidence to determine the intentions of the parties.[67] Justice Ginsburg noted in a concurrence that, for purposes of determining whether the contract provides for the vesting of retiree healthcare benefits, clear and express language is not required.[68] Instead, both explicit and implied terms of an agreement

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64. *See supra* note 58 and accompanying text.

65. During oral arguments, Justice Scalia expressed great surprise about the failure of a private-sector employer and an employee union to address the vesting of retiree healthcare benefits in the CBA:

> You know, the nice thing about a contract case of this sort is you can't feel bad about it. Whoever loses deserves to lose. (Laughter.) I mean, this thing is obviously an important feature. Both sides knew it [the issue of vesting] was left unaddressed, so, you know, whoever loses deserves to lose for casting this upon us when it could have been said very clearly in the contract. Such an important feature. So I hope we'll get it right, but, you know, I can't feel bad about it.

Transcript of Oral Argument at 21–22, M&G Polymers USA, LLC v. Tackett, 135 S. Ct. 926 (2015) (No. 13-1010).

66. M&G Polymers USA, LCC v. Tackett, 135 S. Ct. 926, 937 (2015).

67. *Id.* at 938 (Ginsburg, J., concurring).

68. *Id.* In the 2015–2018 period, several decisions relied on this argument, with courts refusing to accept the employers' claims that the absence of specific language providing for lifetime healthcare doomed retirees' claims. *See, e.g.*, Tackett v. M&G Polymers USA, LLC, 811 F.3d 204, 209 (6th Cir. 2016). The Sixth Circuit stated:

> Thus, while the Supreme Court's decision [in *Tackett*] prevents us from presuming that absent specific durational language referring to retiree benefits themselves, a general durational clause *says nothing* about the vesting of retiree benefits, we also cannot presume that the *absence* of such specific language, by itself, evidences an intent *not to* vest benefits or that a general durational clause says *everything* about the intent to vest.

Id. (internal quotations omitted); *see also* Reese v. CNH Indus. N.V., 854 F.3d 877, 882 (6th Cir. 2017), *rev'd*, 138 S. Ct. 761 (2018). The court in *Reese* held that

> [t]o find ambiguity in this case, partially from the silence as to the parties' intentions, does not offend the Supreme Court's mandate from *Tackett* that we not infer vesting from silence. There is surely a difference between finding ambiguity from silence and finding vesting from silence. The latter is impermissible after *Tackett*; the former permits the court to turn to extrinsic evidence to determine the intent of the parties—precisely the goal in any contract dispute.

Id.; Fletcher v. Honeywell Int'l, Inc., 238 F. Supp. 3d 992, 999 (S.D. Ohio 2017) (finding that a "clear statement" that the company agreed to provide lifetime retiree healthcare benefits is not necessarily required to establish vesting). In February of 2018, the Supreme Court issued a *per curiam* opinion finding that the Sixth Circuit's approach in *Reese*, which the Supreme

could evidence such intent. The Court's elimination of the presumption in favor of vesting—long espoused by the Sixth Circuit—has been described as a kind of "lifeline" to those employers seeking to amend benefits.[69] Numerous such amendments have followed, and since the decision was handed down in 2015, *Tackett* has already been cited in several cases concerning public-sector benefits.[70]

Court characterized as using "*Yard-Man* inferences . . . to render a collective-bargaining agreement ambiguous as a matter of law, thus allowing courts to consult extrinsic evidence about lifetime vesting" could not be squared with the Supreme Court holding in *Tackett.* CNH Indus. N.V. v. Reese, 138 S. Ct. 761, 763 (2018) (per curiam). Specifically, the Court rejected the lower court's finding of ambiguity, again reiterating that "a contract is not ambiguous unless it is subject to more than one reasonable interpretation, and the *Yard-Man* inferences cannot generate a reasonable interpretation because they are not 'ordinary principles of contract law.'" *Id.* (quoting M&G Polymers USA, LLC v. Tackett, 135 S. Ct. 926, 937 (2015)).

69. Robert C. Pozen & Ronald J. Gilson, *Debt-Saddled Municipal Budgets Get a Lifeline*, WALL ST. J., Mar. 1, 2015, at A13; *see also* Gilbert Brosky, *Ding-Dong,* Yard-Man *Is Dead! Supreme Court Decision in* Tackett *a Huge Win for Employers in the Retiree Healthcare Arena*, EMP. CLASS ACTION BLOG (Jan. 28, 2015), http://www.employmentclassactionreport.com/benefits/ding-dong-yard-man-is-dead-supreme-court-decision-in-tackett-a-huge-win-for-employers-in-the-retiree-healthcare-arena/; Robert Pozen, *Renegotiating Retiree Health Care Plans After New Supreme Court Guidance*, HEALTH AFFAIRS (May 7, 2015), http://healthaffairs.org/blog/2015/05/07/renegotiating-retiree-health-care-plans-after-new-supreme-court-guidance/.

70. *See, e.g.*, S. Pasadena Police Officers' Ass'n v. City of S. Pasadena, No. B254176, 2015 WL 1094691, at *4 (Cal. Ct. App. 2015) (citing *Tackett* for the proposition that "when a contract is silent as to the duration of retiree benefits, a court may not infer that the parties intended those benefits to vest for life"); Harper Woods Retirees Ass'n v. City of Harper Woods, 879 N.W.2d 897, 905 (Mich. Ct. App. 2015) (concluding that "that the Supreme Court's reasoning in *Tackett* is consistent with Michigan's contract jurisprudence regarding CBAs, which applies with equal force in both the public and private sectors" in this regard); Pontiac Police & Fire Retiree Prefunded Grp. Health & Ins. Tr. Bd. of Trustees v. City of Pontiac No. 2, 873 N.W.2d 783, 791 (Mich. Ct. App. 2015) (citing *Tackett* for the proposition that because the "retirees' rights to healthcare benefits flow from the pertinent CBAs, they are governed by ordinary contract principles"); Vallejo Police Officers Ass'n v. City of Vallejo, 223 Cal. Rptr. 3d 280, 291 n.9 (Ct. App. 2017) (noting that *Tackett* "says nothing to prohibit the use of extrinsic evidence to determine the parties' intent"). Some judges, however, have vigorously rejected the application of *Tackett* to public-sector benefits. *See, e.g.*, Matthews v. Chicago Transit Auth., 51 N.E. 3d 753, 784 (Ill. 2016) (Theis, J., concurring) The Court in *Matthews* opined that

> *Tackett* and its progeny . . . would control our analysis, if this dispute arose under the Labor Management Relations Act . . . and ERISA. It did not. Therefore, those cases are inapposite . . . nothing about *Tackett*'s holding is "critical" to resolving the issue in this case because federal law does not govern the interpretation of CBAs with state and local governments . . . . Here, the plaintiffs' employer was a municipal entity and the interpretation of the 2004 CBA rests, not on federal law, but on Illinois law.

Id.

Legislative efforts to require a presumption in favor of vesting absent clear and convincing language to the contrary have not been successful.[71]

In sum, the provision of retiree healthcare benefits today entails complex, decades-long financial arrangements laden with uncertainty about long-term costs. Public employers and employees rarely address directly the thorniest terms of such arrangements. As a result, the parties to the arrangements—including individual employees and retirees—must assess whether the particular combination of statutory provisions, collective-bargaining terms, and employer conduct would be deemed by a court to create a binding obligation on the employer.

C. The Great GASB and the Shift from Pay-As-You-Go to Prefunding

The lack of legal certainty as to employers' ability to reduce or eliminate retiree healthcare benefits has necessarily shaped funding policies. Traditionally, retiree healthcare benefits have been funded on a pay-as-you-go basis, whereby public employers covered in each year the cost of benefits only for current retirees. Critically, employers did not aside any assets for the benefits promised to and earned by current employees.

The pay-as-you-go approach to funding has made it easy for most state and local governments to promise their employees relatively generous benefits in retirement. Promising such benefits has served as a valuable recruiting tool and one that had no impact on the employers' balance sheets. The costs were reflected only in the income statements when the benefits were ultimately paid to the retirees, typically decades after the promises for such benefits were made. Accordingly, many state and local governments did not measure the value of the retiree healthcare promises that had been made to public employees, nor did they consider how such promises would affect budgets beyond the short term.[72] Indeed, many were surprised by the magnitude of the total accrued liabilities. In the case of Detroit, for example, the City's bankruptcy filings revealed unfunded retiree healthcare obligations totaling $6.4 billion, as compared to $3 billion in unfunded liabilities for pension benefits.[73]

The pay-as-you-go approach persisted for nearly five decades. Year after year, state and local governments contributed and reported only the amounts paid on behalf of current retirees. The practice persisted in the public sector even as the Financial Accounting Standards Board ("FASB") imposed accrual-based

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71. *See, e.g.*, Bankruptcy Fairness and Employee Benefits Protection Act, S. 2418, 113th Cong. (2014). The proposed legislation would have also required employers to provide specific information to employees about the duration of their retiree healthcare benefits.

72. DAVID ZION & AMIT VARSHNEY, CREDIT SUISSE, YOU DROPPED A BOMB ON ME, GASB 6–7 (2007), http://online.wsj.com/public/resources/documents/DroppedB.pdf (describing the $1.5 trillion in "hidden" retiree healthcare liabilities for state and local governments). Then New Jersey Governor Corzine remarked in 2007 that "[t]he constant focus on short-term priorities without consideration of long-term costs has led to financial decisions that hang over the state today, tomorrow, and far into the future." *Id.* at 16.

73. *See* Robert C. Pozen, *The Retirement Surprise in Detroit's Bankruptcy*, BROOKINGS (July 25, 2013), https://www.brookings.edu/opinions/the-retirement-surprise-in-detroits-bankruptcy/.

accounting on private-sector retiree healthcare benefits in 1992.[74] More than a decade after the changes in the private sector went into effect, GASB—the private, not-for-profit organization responsible for accounting and financial reporting standards for state and local governments—followed with similar changes to public-sector benefits.[75]

In its 2004 pronouncement ("GASB Standard No. 45"), GASB declared that retiree healthcare and other non-pension, post-employment benefits constitute a form of deferred employee compensation that should be recognized in the year in which the employee performs services for the employer. GASB noted further that "the employer has a constructive, if not legal, obligation for promised benefits to the extent the benefits are attributable to services already received and it is probable that conditions for an employee's eligibility to receive benefits will be met."[76] Following through on its logic, GASB then extended its previously adopted standards for pension plans to state and local government retiree healthcare plans. In a dramatic shift for public employers, GASB Standard No. 45 required for the first time that employers with retiree healthcare plans disclose the following: (1) the value of the benefits already earned and those expected to be earned by employees in the future; (2) the value of any assets set aside to cover such benefits; and (3) the difference between the two categories. It also required public employers to calculate the annual required contribution ("ARC")—defined as the amount a public employer would have to contribute annually to cover the cost of benefits accrued in that year and to pay off any accrued, unfunded liabilities in no more than 30 years—and to disclose the percentage of the ARC contributed in the reporting year.[77]

By bringing to light—and to the attention of credit rating agencies, taxpayers, and legislators—the value of unfunded promises and the growing percentage of state and local government budgets needed to cover retiree healthcare benefits, the new rules created powerful incentives for state and local governments to mitigate the gap between the retiree healthcare assets and liabilities. To address the latter, states began to explore ways to reduce coverage for retirees.[78] At the same

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74. FIN. ACCOUNTING STANDARDS BD., STATEMENT OF FINANCIAL ACCOUNTING STANDARDS NO. 106: EMPLOYERS' ACCOUNTING FOR POSTRETIREMENT BENEFITS OTHER THAN PENSIONS 5 (1990) [hereinafter FASB 106]. As many have observed, after FASB 106 went into effect and the magnitude of the liabilities became clear, "private employers began a determined course of reducing the liabilities they owed by cutting retiree health benefits." *See, e.g.*, Moran, *supra* note 7, at 678; Sanchez, *supra* note 7, at 1161 (noting that "[i]n 1993, forty percent of private employers offered retiree health benefits; by 2001, only twenty-three percent did"). The private sector's move to terminate, rather than prefund, retiree healthcare plans may have been driven in part by the limitations of the tax code, namely the absence of a structure that, in the context of *pension* benefits, allows contributions and earnings of *pension* funds to be tax deferred. *See* LANGBEIN ET AL., *supra* note 10, at 912–13.

75. GOVERNMENTAL ACCOUNTING STANDARDS BD., FACTS ABOUT GASB 1 (2013–2014), www.gasb.org/jsp/GASB/Document_C/GASBDocumentPage&cid=1176163065939.

76. GASB 45, *supra* note 8, at 78.

77. *Id.* at 99.

78. MONAHAN, *supra* note 43, at 6 ("Many U.S. jurisdictions are currently exploring the possibility of reducing or eliminating retiree medical coverage . . . ."); *see also infra* Part III.

time, the GASB rules encouraged public employers to establish retiree healthcare trusts and to prefund retiree healthcare liabilities in the same way that they prefund pensions. Saving and investing current assets would allow public employers to take advantage of market returns.[79] At the same time—and perhaps more importantly—the new GASB rules offered immediate accounting benefits to public employers that set up retiree healthcare trusts. Such employers were permitted to use a higher discount rate to calculate the present value of accrued liabilities, which would immediately reduce the value of the unfunded liabilities that GASB now required public employers to report. As lawmakers quickly realized, from an accounting perspective, establishing a retiree healthcare trust and making even relatively small contributions to it would have immediate and substantial benefits.[80]

Actuarial calculations prepared in 2015 by California's Controller illustrate the effect of prefunding on the discount rate and on the liability calculation: with pay-as-you-go funding, the assumed discount rate is 4.25%, and the state's 2015 actuarial accrued liability for retiree healthcare benefits totals $74.19 billion. A plan to fully fund the retiree healthcare obligation over a 30-year period justifies a discount rate of 7.28% (the expected rate of return on the assets in the trust), and in turn, the state can report an actuarial accrued liability of just $48.5 billion (rather than $74.19 billion). As the Controller has underscored, in the long-run, prefunding just 10% of the total obligation ultimately takes $3.29 billion off of the state's unfunded liability because of investment returns and compound interest.[81]

II. THE RISE OF HEALTHCARE TRUSTS: AN EMPIRICAL ANALYSIS

This Part considers the consequences of the GASB rules enacted in 2004. Some basic statistics point to striking developments. As Table 2 shows, by 2015, 35 states had established at least one irrevocable retiree healthcare trust.[82] Across all 101 state-administered retiree healthcare plans, 66 plans had trusts. While the

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79. The new disclosure requirements took effect just as the 2008 financial crisis began to strain the budgets of state and local governments. GAO REPORT, *supra* note 3, at 21, 36 ("Unfunded [retiree healthcare] liabilities on their own are large enough to represent a fiscal pressure for state and local governments but are also likely to be considered part of the broader fiscal challenge of managing increasing health care costs. State and local governments faced increasing fiscal pressures in 2008, in part because of recession-induced revenue shortfalls.").

80. In many cases, state actors have been explicit about the motivations for the retiree healthcare trusts. *See, e.g.*, GEORGIA COMPREHENSIVE ANNUAL FINANCIAL REPORT FOR THE FISCAL YEAR ENDED JUNE 30, 2006 at 92 (2006), https://archive.org/stream/cafr-GA-Georgia-2006/GA%20State%20of%20Georgia%202006_djvu.txt ("In response to the GASB Statements, the General Assembly has made statutory changes to create a trust fund, in which employer contributions for future retiree health costs may be accumulated and invested, and which is expected to facilitate the separate financial reporting of these benefits.").

81. Press Release, California State Controller's Office, State Controller Yee Updates Unfunded Retiree Health Care Liability (Jan. 26. 2016), http://www.sco.ca.gov/eo_pressrel_16936.html.

82. Almost all the trusts are governmental trusts established pursuant to IRC § 115; a handful of plans have established § 401(h) health-benefit subaccounts or Voluntary Employees' Beneficiary Associations. *See* GAO REPORT, *supra* note 3, at 8.

median funding levels for retiree healthcare trusts remained just below 21%, some 12 trusts had funding levels greater than 70%.[83] Meanwhile, five trusts remained entirely unfunded.

TABLE 2: Prevalence of Retiree Healthcare Trusts in the United States as of 2015

States That Have at Least One Retiree Healthcare Trust			**States Without Retiree Healthcare Trusts**[84]	
Alabama	Kentucky	Ohio	Arkansas	New Jersey
Alaska	Louisiana	Oregon	Idaho	New York
Arizona	Maine	Pennsylvania	Illinois	Oklahoma
California	Maryland	Rhode Island	Iowa	South Dakota
Colorado	Massachusetts	South Carolina	Minnesota	Washington
Connecticut	Michigan	Tennessee	Mississippi	Wisconsin
Delaware	Missouri	Texas	Montana	Wyoming
Florida	Nevada	Utah	Nebraska	
Georgia	New Hampshire	Vermont		
Hawaii	New Mexico	Virginia		
Indiana	North Carolina	West Virginia		
Kansas	North Dakota			

What distinguishes the 66 plans with trusts from the 35 plans—including those in Illinois, New Jersey, and New York—without retiree healthcare trusts? And for those plans with trusts, why have some benefited from disciplined annual contributions while others remain largely or entirely unfunded? To find the answers, this Part turns to a first-of-its-kind empirical analysis of public-sector retiree healthcare plans.

A. Data & Analytical Approach

This Article compiles an original dataset that tracks state-administered retiree healthcare plans. A review of state statutes and comprehensive annual-

83. Analyses of total state assets and total state liabilities for retiree healthcare benefits suggest that approximately 7% of these liabilities were funded as of 2015. *See* ALEX BROWN & JOSHUA FRANZEL, CTR. FOR STATE & LOCAL GOV'T EXCELLENCE & NAT'L ASS'N OF STATE RETIREMENT ADM'RS, SPOTLIGHT ON RETIREE HEALTH CARE BENEFITS FOR STATE & LOCAL EMPLOYEES IN FISCAL YEAR 2015, at 1 (2017), https://slge.org/wp-content/uploads/2018/02/Spotlight-on-Retiree-Health-Care-Benefits-for-State-Employees-in-FY-2015.pdf.

84. Of the states without trusts, two—Nebraska and South Dakota—report having no retiree healthcare liabilities.

financial reports identifies 101 such plans.[85] For each plan, the dataset tracks trust formation and funding as of 2014 and 2015, the latest years for which comprehensive data is available.[86] In particular, for each year, the data tracks three distinct metrics as the dependent variables of interest: first, whether a trust has been established for each plan in the dataset; second, funding discipline for each plan, as measured by the proportion of the reported ARC contributed to the plan;[87] and third, the reported ratio of plan assets to plan liabilities.

To understand the patterns in trust formation and funding, this Article looks both to plan-level differences in institutional design and to state-level measures of fiscal health. While prior research on retiree healthcare plans in the public sector has focused on state-by-state comparisons, such work has not considered key differences in how individual plans—and now the newly established retiree healthcare trusts—are designed and governed.[88] As Table 3 illustrates, there is important variation in institutional design not just across plans from different states, but also—as in the case of Connecticut, for example—across plans from the same states.

85. While a few state financial reports include funding information for plans specific to state university systems, the dataset does not include such plans.

86. The existence of a trust is verified by review of applicable state statutes. Plan funding data is obtained from either state or plan actuarial reports.

87. ARC is a GASB term of art. It refers to the amount a public employer would have to contribute annually to cover the cost of benefits accrued in that year and to pay off any accrued unfunded liabilities in no more than 30 years. Since GASB has no enforcement power, the ARC is not technically required, but serves as a useful benchmark to assess annual contributions to retiree healthcare trusts. *See* GASB 45, *supra* note 8, at 9–10.

88. *See, e.g.*, BROWN & FRANZEL, *supra* note 5; PEW REPORT, *supra* note 24.

TABLE 3: Trust Adoption Across Selected Retiree Healthcare Plans: Examples Selected to Show Variation Across Plans

State	Plan	Administration	Trust (Year)
Arkansas	Arkansas State Employees Health Insurance Plan	State and Public School Life and Health Insurance Board	No
	Arkansas State Police Medical and Rx Plan	QualChoice	No
California	California Employers' Retiree Benefit Trust Fund	Public Employees Retirement System	Yes (2007)
Connecticut	State Employee Plan	State Comptroller: Healthcare Policy and Benefit Division	Yes (2011)
	Retired Teacher Healthcare Plan	Teachers' Retirement Board	No[89]
Rhode Island	State Employees Plan	State Employees' and Electing Teachers Other Post-Employment Benefits System ("Retiree Healthcare System")	Yes (2010)
	State Police Plan	Retiree Healthcare System	Yes (2010)
	Board of Education Plan	Retiree Healthcare System	Yes (2010)
	Teachers Plan	Retiree Healthcare System	Yes (2010)
	Legislators Plan	Retiree Healthcare System	Yes (2010)
	Judicial Plan	Retiree Healthcare System	Yes (2010)

Drawing on prior research on the funding of public pension plans, this Article focuses on the variation in control and transparency as explanatory variables, while recognizing that public employers have limited resources to allocate to all

89. The Association of Retired Teachers of Connecticut has indicated that the Teachers Retirement Board received approval in 2014 to establish a Teachers Retirement Board Healthcare Trust Fund; however, no relevant legislation could be identified to date.

forms of employee compensation.[90] Extensive review of the statutory provisions for each plan reveals significant differences in how state-administered retiree healthcare plans are governed and funded, in the degree of transparency about unfunded liabilities, and in the constituencies covered by the plans. The institutional features considered and coded, and the hypothesis associated with each one, are described below. Summary statistics are presented in Table A1 of Appendix A.

Administration of retiree healthcare plan by retirement (i.e., pension) system: For each plan in the dataset, this variable identifies whether the retiree healthcare plan is administered by a state pension system. For plans administered by pension systems, the variable is coded as 1; otherwise the variable is coded as 0. Approximately 47% of the plans in the sample are administered by pension systems. The hypothesis is that situating retiree health plans under the same administrative "roof" as pension plans should mitigate the distinction between the two types of post-employment benefits. Moreover, pension boards' expertise and familiarity with the trust mechanism and with prefunding benefits should increase the likelihood of trust formation for retiree healthcare plans. Indeed, some pension systems actively advertise their trust services for local government plans.[91] Although the creation of a trust requires legislative approval, legislators may be swayed by pressure from and the institutional expertise of the pension-system boards. Once the trust is in place, however, pension-system administrators are likely to have relatively limited control over actual contributions made—or not made—into the trusts. The same variation in funding discipline that characterizes pension plans (all of which have trusts) can be expected to characterize retiree healthcare plans with trusts.[92] Therefore,

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90. Analysis of funding patterns among U.S. public pension plans suggests that the variation in institutional design—particularly with respect to the allocation of control over funding decisions and the availability of mechanisms to monitor and enforce funding commitments—is likely to be associated with variation in funding discipline among retiree healthcare plans. *See, e.g.*, STATE BUDGET CRISIS TASK FORCE, REPORT OF THE STATE BUDGET CRISIS TASK FORCE, FINAL REPORT 20 (2014), https://www.pgpf.org/sites/default/files/state_budget_crisis_task_force_finalreport_011420 14.pdf; Amy B. Monahan, *State Fiscal Constitutions and the Law and Politics of Public Pensions*, 2015 U. ILL. L. REV. 117 (2015); Natalya Shnitser, *Funding Discipline for U.S. Public Pension Plans: An Empirical Analysis of Institutional Design*, 100 IOWA L. REV. 663 (2015).

91. Some state retirement systems, such as CalPERS, have been actively marketing their retiree healthcare trust services to local governments. CalPERS charges such local governments fees for trust administration and asset management. *See California Employers' Retiree Benefit Trust (CERBT) Fund*, CALPERS (Feb. 5, 2018), https://www.calpers.ca.gov/page/employers/benefit-programs/cerbt ("CERBT charges employers a single fee rate to cover all program costs" including compliance, investment management, legal services, ongoing administration, record keeping, reporting, start-up, transfer of assets, termination, and trustee/custodial services). Private service providers in the business of public plan consulting have also been quite active in encouraging public entities to set up trusts. *See, e.g.*, *Debunking the Top 6 Myths of OPEB Prefunding*, PUB. AGENCY RET. SERVS. (Mar. 29, 2016), http://www.pars.org/2016/03/debunking-the-top-6-myths-of-OPEB-prefunding/ ("[I]t is clear that [retiree healthcare] trusts are much more flexible than many first think . . . they lower liabilities, act as a rainy day fund, help to improve credit ratings and be accessed to pay for OPEB costs at any time . . . .").

92. Shnitser, *supra* note 90 at 687–91.

administration by a retirement system is not expected to be associated with better funding discipline or higher funding levels.

Actuarial determination of annual contributions: For each plan in the dataset, this variable categorizes the applicable funding policy. Specifically, it tracks whether annual contributions to the plan are determined by an actuarial calculation (coded as 1) or whether contribution amounts are set in statute or subject to any kind of caps or restrictions (coded as 0). Table 4 offers examples of both types of provisions.

TABLE 4: Examples of Statutory Provisions for the Determination of the Employer Contribution

Retiree Healthcare Plan	Provisions for Determination of Employer Contribution
Rhode Island *(actuarial determination)*	Section 36-12.1-19(a) provides that "Rhode Island shall make its contribution for the maintenance of the system . . . by annually appropriating an amount equal to a percentage of the total compensation . . . . The percentage shall be computed by the actuary employed by the OPEB Board and shall be certified by the OPEB Board to the director of administration . . . . In arriving at the yearly employer contribution the actuary shall determine the value of: (1) The contributions made by the members; (2) Income on investments; and (3) Other income of the system" Section 36-12.1-19(b) states that the "[a]ctuary shall compute the yearly employer contribution that will: (1) Pay the actuarial estimate of the normal cost for the next succeeding fiscal year; (2) Amortize the unfunded liability of the system as of June 30, 2006, utilizing a time period not to exceed thirty (30) years."[93]
New Mexico Post-Employment Healthcare Plan *(statutory determination)*	Section 10-7C-15 provides that "[e]ach participating employer shall make contributions to the fund pursuant to the following provisions: (1) for participating employees who are not members of an enhanced retirement plan, the employer's contribution shall equal: (a) one and three-tenths percent of each participating employee's salary for the period from July 1, 2002 through June 30, 2010 . . .

93. 36 R.I. GEN. LAWS ANN. § 36-12.1-19(a)–(b) (West 2009).

	(d) two percent of each participating employee's salary beginning July 1, 2012 . . . Notwithstanding any other provision in the Retiree Health Care Act and at the first session of the legislature following July 1, 2013, the legislature shall review . . . the employer and employee contributions . . . in order to ensure the actuarial soundness of the benefits provided under the Retiree Health Care Act."[94]

Approximately 27% of all the plans in the sample and 41% of the plans that have trusts are subject to statutory provisions that provide for actuarial determination of annual contributions. To be clear, contributions based on actuarial analyses are not necessarily more generous than those set in statute, and indeed statutorily set contributions can and do exceed actuarially determined rates.[95] Furthermore, state legislatures can and do override the actuarial calculations and contribute less than the amount determined by the actuarial analyses set forth in the statute.[96] Yet the delegation of the contribution calculation does provide an anchor point for any subsequent modifications and shields the contribution amount—at least to some extent—from budgetary politics and legislative revisions. Therefore, the delegation of rate setting to an actuarial body is expected to be associated with better funding discipline and higher funding levels.

Cost-sharing plans: For each plan in the dataset, this transparency variable tracks whether the plan is a cost-sharing plan (coded as 1; all other plans coded as 0) that allows multiple employers to pool together their assets and liabilities, rather than apportion liabilities to each individual employer. Approximately 39% of the plans in the sample are cost-sharing plans. On the one hand, the inclusion of multiple employers in cost-sharing plans may increase political support for trust formation, particularly from municipalities facing significant unfunded liabilities. On the other hand, under GASB Standard No. 45, employers in cost-sharing plans are subject to less-stringent disclosure requirements about the liabilities associated with their employees. Whereas an employer that participates in a single-employer or an agent plan (in which multiple employers pool assets but only for investment purposes) must disclose the funding data for its employees, an employer in a cost-sharing plan reports such statistics only for the plan as a whole. Thus, because employers in cost-sharing plans are subject to less-stringent disclosure requirements, and there is less

94. N.M. STAT. ANN. § 10-7C-15 (2009).

95. *See, e.g.*, GABRIEL ROEDER SMITH & CO., NORTH DAKOTA RETIREE HEALTH INSURANCE CREDIT FUND, ACTUARIAL VALUATION AS OF JULY 1, 2016, at A3 (2016), https://ndpers.nd.gov/image/cache/retiree-health-credit-valuation-2016.pdf ("The contributions that are made by employers are based on fixed contribution rates that are set by statute (and not based on the actuarially determined rate). The statutory contribution rate is higher than the actuarial contribution rate.").

96. Even across plans with actuarially determined contributions, some plans did not receive 100% of the ARC over the 2014–2015 period. *See infra* Figure 2; *see also* Shnitser, *supra* note 90, at 693 (discussing a similar dynamic in the context of pension funding).

transparency about their retiree healthcare obligations, cost-sharing plans may face less pressure to achieve sound funding goals.

Plans that cover only state judges or elected officials: This variable identifies whether each plan covers only a select group of state employees. Plans that cover only judges or elected officials are coded as 1; all other plans coded as 0. Approximately 13% of plans in the sample fall into the former category. Coverage of such select—and presumably relatively powerful—constituencies is expected to be associated with a greater likelihood for trust formation, better funding discipline (until full funding is reached), and funding levels.

Total retiree healthcare liabilities-to-personal-state-income ratio: This variable measures the total obligations (including funded and unfunded liabilities) relative to the personal income in each state.[97] States with relatively expansive benefit programs may be simultaneously drawn to the advantages of prefunding through a trust and concerned about the ability to marshal dollars for the contributions. Higher ratios, which ultimately demand relatively greater state resources to be channeled toward retiree healthcare benefits, are expected to be associated with worse funding discipline and lower funding levels.

Funding ratio for state pension plans: This variable measures the aggregate ratio of assets to liabilities for each state's pension plans in the year prior to the reporting year.[98] Greater funding levels across a state's pension plans can indicate a commitment to the funding of retirement benefits generally (either by disciplined contributions, lower benefit levels, or some combination of both). However, to the extent that such a commitment uses up available state resources, it can also cut against healthcare trust funding. Retiree healthcare trusts may also be less of a priority for plans that offer very limited (and relatively inexpensive) post-employment benefits. In addition, because credit rating agencies do not consider retiree healthcare liabilities in isolation, but together with pension and other forms of debt, states with relatively better-funded pension plans may be subject to less pressure from credit rating agencies and public debt markets.

State cash solvency: This variable provides a measure of the state government's cash position relative to current or short-term liabilities.[99] A better cash-solvency position is expected to be associated with greater likelihood of trust formation, as well as better funding discipline and funding levels, although it could also indicate a state government's preference to hold onto resources rather than contribute them to retiree healthcare plans.

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97. NORCROSS & GONZALEZ, *supra* note 46, at 20. *State personal income*, as calculated by the Bureau of Economic Analysis, is defined as the "the sum of net earnings by place of residence, property income, and personal current transfer receipts." *Id.* at 20 n.15 (quoting *State Personal Income 2014*, BUREAU ECON. ANALYSIS (Mar. 25, 2015), https://www.bea.gov/newsreleases/regional/spi/2015/spi0315.htm).

98. Data compiled by the George Mason University Mercatus Center. *See* NORCROSS & GONZALEZ, *supra* note 46, at 47–48 tbl.A7.

99. *See id.*

Credit rating: Drawing on Standard & Poor's state credit-rating data from 2013 and 2014, this variable assigns a numerical value (on a scale of 1–8) to each state rating. For the regression analysis, a dummy variable identifies plans in states with a rating of AA- or lower. To the extent that large, unfunded retiree healthcare liabilities may hurt credit ratings, states with lower credit ratings may be under greater pressure to establish and fund retiree healthcare trusts.[100] However, such states may also lack the funds to contribute to the trusts.

Percentage of public employees covered by unions: This variable tracks the percentage of public employees in each state that are covered by public-sector unions.[101] Although unions have historically targeted higher benefit levels and stronger legal protections (and so greater union representation may be associated with larger unfunded liabilities), their focus has begun to shift to funding discipline and funding levels.[102]

B. Trust Formation: Results and Discussion

The first empirical inquiry focuses on the determinants of trust formation. What distinguishes the plans with trusts from the plans without trusts? Figure 1 offers preliminary evidence that the identity of the plan administrator plays a role. In effect, retiree healthcare plans that are administered by pension systems look more like pension plans in terms of funding. Retiree healthcare plans that are administered by state health and human-resources agencies, meanwhile, look more like healthcare arrangements for active employees. For the latter group, expenses are funded only as they are incurred on an annual basis. Although GASB Standard No. 45 may provide enough incentives for plans to move to a trust model—no matter the plan administrator—the transition costs are likely to be greater for plans administered outside pension systems.

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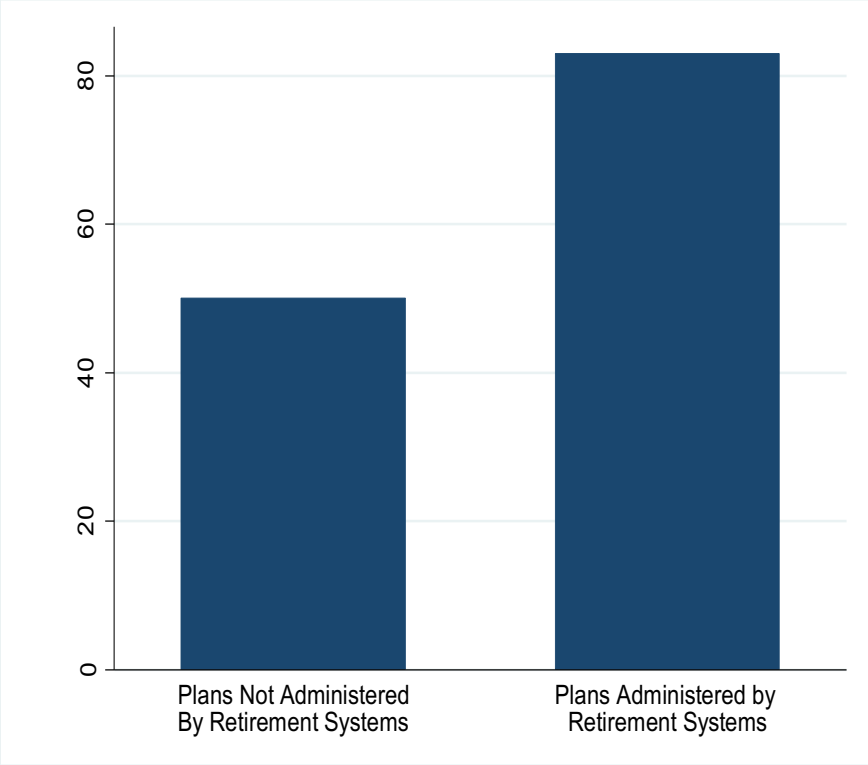
100. Ratings agencies such as Standard & Poors have confirmed that retiree healthcare obligations are "important to credit quality." *See* SPAIN ET AL., *supra* note 2, at 12; *see also* STATE OF NORTH CAROLINA, DEPARTMENT OF TREASURER, DEBT AFFORDABILITY STUDY 15 (2017) (reporting that the state's unfunded liability for retiree healthcare is $32.5 billion dollars and advising that the liabilities are "receiving increased attention" from the credit rating agencies), https://www.nctreasurer.com/slg/Debt%20Affordability/Final%20DAAC_2017.pdf.

101. *See Union Membership & Coverage Database from the CPS*, UNIONSTATS.COM, http://www.unionstats.com/ (last visited Aug. 1, 2017).

102. *See* Peter W. Saltzman, *Long-Term Funding for Retiree Health Benefits*, CA. PUB. EMP. REL. J. No. 178, at 5–8 (2006) (describing the 2005 negotiations between the Bay Area Rapid Transit District and the Amalgamated Transit Union as among "the first in the country in which the long-term funding of [retiree healthcare] liabilities was addressed and resolved").

FIGURE 1: Plan Administration and Prevalence of Retiree Healthcare Trusts as of 2015



The logistic regression analysis presented in Table 5 confirms that the coefficient on pension-system administration is positive and statistically significant. Retiree healthcare plans in states where the *pension* plans are better funded, meanwhile, are less likely to have trusts. The result likely reflects the limited public resources available for all forms of employee benefits and the lower priority that retiree healthcare plans have in the queue for taxpayer dollars. Notably, several of the plan features and state characteristics analyzed in Table 5 do not appear to have statistically significant association with the likelihood of trust formation. The result likely reflects the relatively technical and bureaucratic nature of trust formation at the state level, which is unlikely to attract significant attention from interest groups, as well as the competing incentives of public employers in cost-sharing plans. In addition, the analysis necessarily considers only a moment in time. To the extent that many trusts were established prior to 2015, the lack of statistical significance for state-level measures of fiscal health is not surprising.

TABLE 5: Likelihood That Retiree Healthcare Plan Had a Trust in 2015

This table presents a series of logit regressions using a binary dependent variable that indicates whether a plan had a trust associated with it in 2015. Standard errors are clustered by state.

	Binary Dep. Var. = 1 if Trust is in Place; 0 Otherwise			
VARIABLES	Model 1	Model 2	Model 3	Model 4
Plan Administered by Retirement System	1.584**	1.442**	1.835**	1.741*
	(0.664)	(0.656)	(0.845)	(0.904)
Cost-Sharing Plan		0.455		0.389
		(0.469)		(0.520)
Judges or Legislators-Only Plan		0.354		0.008
		(0.933)		(1.018)
State Retiree Healthcare Liabilities to Personal Income Ratio			-2.236	-2.887
			(11.119)	(10.936)
State Cash Solvency in Prior Year			0.051	0.055
			(0.189)	(0.188)
Funding Ratio for State Pension Plans in Prior Year			-0.053*	-0.053*
			(0.029)	(0.029)
Percentage of State Public Employees Represented by Unions in Prior Year			-0.001	0.000
			(0.019)	(0.018)
Credit Rating AA- or Below in Prior Year			-0.898	-0.891
			(1.194)	(1.264)
Constant	-0.000	-0.146	4.016*	3.885
	(0.363)	(0.366)	(2.282)	(2.375)
Observations	101	101	101	101
R-squared	0.0967	0.104	0.149	0.153
Robust standard errors in parentheses				
*** p<0.01, ** p<0.05, * p<0.1				

C. Funding Discipline & Funding Levels: Results and Discussion

The mere creation of a trust does not, in and of itself, ensure the funding of retiree healthcare plans. Indeed, to the extent that the GASB rules permit plan sponsors to justify favorable actuarial assumptions with expectations of *future* contributions to the trusts,[103] a public employer's decision to establish a trust does not necessarily even reflect a commitment to funding discipline.[104] The Louisiana

103. *See* GASB 45, *supra* note 8, ¶ 13. GASB stated that "the investment return assumption (discount rate) should be the estimated long term investment yield on the investments that are *expected* to be used to finance the payment of benefits." *Id.* (emphasis added).

104. Indeed, scholars like Josh Rauh and Robert Pozen have expressed concern that the GASB rules and particularly GASB Standard No. 75, discussed in Part III *infra*, will allow state and local governments to benefit immediately from rosy assumptions without any way of ensuring that plan sponsors follow through with the annual contributions required to reach full funding. *See* Robert C. Pozen & Joshua D. Rauh, *Relief for Cities' Budget Busting Healthcare Costs*, WALL ST. J., July 26, 2015, at A13.

state legislature, for example, approved the creation of a retiree healthcare trust in 2008, but the trust was not funded as of year-end 2015. The State of Connecticut also committed to prefund its retiree healthcare liabilities in 2008, but deferred payments because of budget constraints, prompting the State Treasurer of Connecticut to advocate for a "stronger funding policy."[105]

The Treasurer's plea is consistent with evidence from public-sector funding of pension benefits. The evidence suggests that trust creation is more likely to have a meaningful impact on retiree healthcare funding if it is coupled with reforms that facilitate disciplined annual contributions to the trust. Control over the determination of the annual contribution to the benefit plan is particularly significant.[106] Of the plans that have irrevocable trusts, 41% receive contributions that are determined by an actuarial calculation.[107] Contributions for the rest of the plans are statutorily fixed or determined at the discretion of the legislative body. As Figure 2 and 3 show, plans for which contributions are determined actuarially receive a greater proportion of the ARCs and are better funded.[108] Tables 6 and 7

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105. Press Release, Office of the State Treasurer Denise L. Nappier, Other Post-Employment Benefits (OPEB) Trust Fund Nears Entry to Higher-Returning Investments (Feb. 7, 2013), http://www.ott.ct.gov/pressreleases/press2013/PrR020713OPEBreturns Higher.pdf. Examples from other jurisdictions abound. For example, in New York City, the retiree health benefits trust has been used as a kind of rainy-day fund for the City. *See* Carol Kellermann, *Make NYC's Retiree Health Benefit Trust More Trustworthy*, HUFFINGTON POST: THE BLOG (May 26, 2016, 2:26 PM), http://www.huffingtonpost.com/carol-kellermann/make-nycs-retiree-health_b_10149194.html (observing that "since the creation of the fund, deposits have been made in good economic times, but it has been raided for budget relief in bad times" and advocating for "explicit guidelines requiring annual deposits and limiting withdrawals only to special circumstances, such as when there are unexpected spikes in retiree health-insurance premiums"). To date, the city administration has resisted any measures to impose additional protections on the retiree healthcare trust fund. *See* Sally Goldenberg, *Councilman Wants Protections for Retiree Health Care Fund*, POLITICO (Feb. 23, 2015, 6:45 PM), https://www.politico.com/states/new-york/city-hall/story/2015/02/councilman-wants-protections-for-retiree-health-care-fund-019917 (reporting that De Blasio has indicated that "[w]e are confident in this responsible approach, and do not believe a charter amendment to dictate spending priorities is either necessary or appropriate").

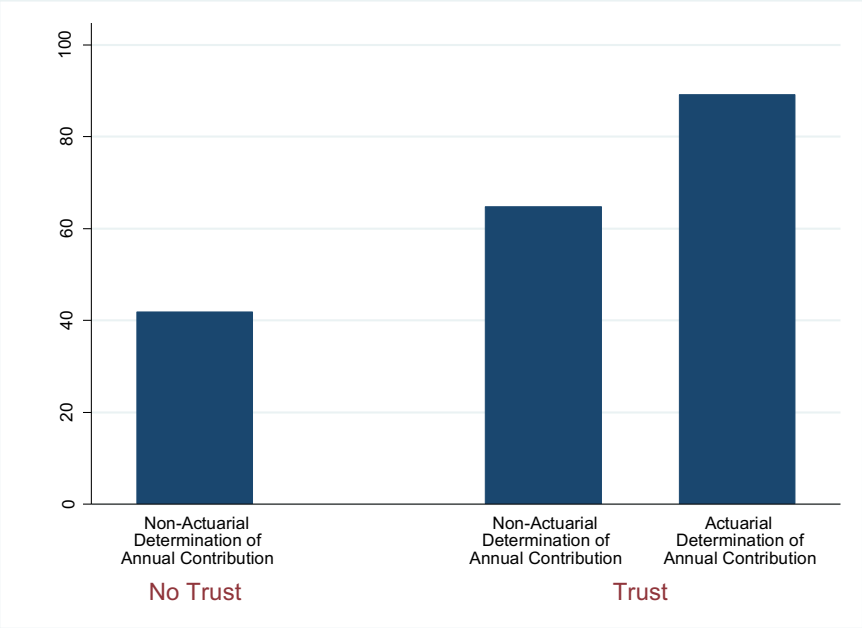
106. *See supra* notes 93–96 and accompanying text.

107. *See, e.g.*, 36 R.I. GEN. LAWS ANN. § 36-12.1-19 (West 2009) (requiring the actuary to compute, and the state of Rhode Island to contribute "a yearly employer contribution that will: (1) Pay the actuarial estimate of the normal cost for the next succeeding fiscal year; (2) Amortize the unfunded liability of the system as of June 30, 2006 utilizing a time period not to exceed thirty (30) years"). Others have limited the ability of public employers to incur additional unfunded liabilities. *See, e.g.*, ME. REV. STAT. ANN. tit. 5, § 286-B (2013) ("Unfunded liabilities may not be created except those resulting from experience losses.").

108. State and local governments are also experimenting with other means of promoting and enforcing retiree healthcare plan funding. For example, the funding—as opposed to just the scope of retiree healthcare benefits—has become the subject of CBAs and state legislation. *See, e.g.*, Glazier, *supra* note 4 (describing California's "recent agreement with one of its employee unions to have employees prefund some of their retirement benefits"). Meanwhile states like Hawaii have required automatic draws on certain tax

below confirm that the greater constraints on legislative control over annual contributions are associated with stronger funding discipline and higher funding levels.

FIGURE 2: Average Percentage of ARC Received in Fiscal Years 2014–2015



revenues to make up any gaps between the actuarially required contribution amounts and the amounts actually contributed in a given year. HAW. REV. STAT. ANN. § 87A-42 (West 2015) ("In any fiscal year . . . in which a county public employer's contributions into the fund are less than the amount of the annual required contribution . . . the director of finance shall deduct the amount necessary to meet the county public employer's annual required contribution from the revenues . . . and transfer the amount to the board for deposit into the appropriate account of the separate trust fund.").

FIGURE 3: Average Funding Levels in 2015

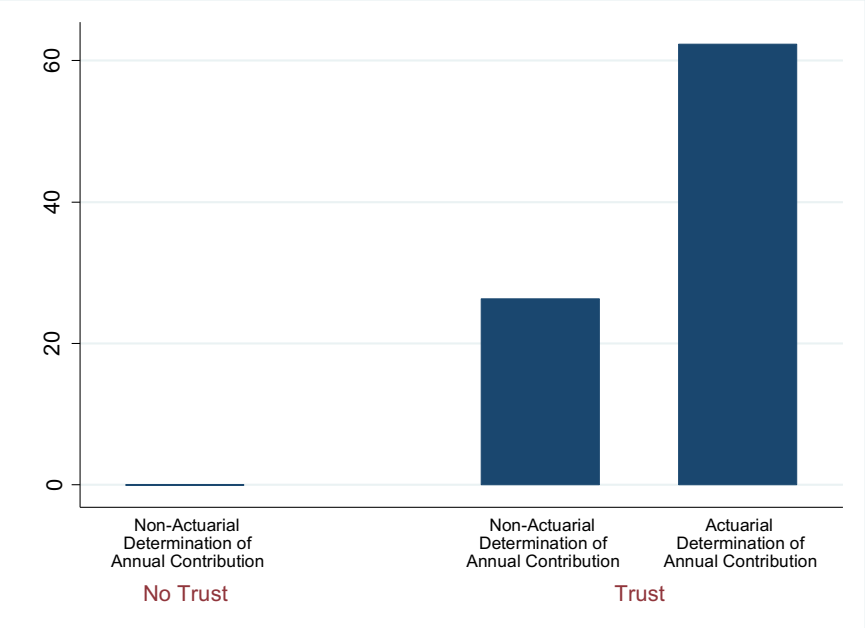


TABLE 6: Institutional Features, State Fiscal Health and Plan Funding Discipline in 2014–2015 Across Retiree Healthcare Plans with Trusts

This table presents the results of a series of pooled OLS regressions of institutional variables of interest on plan funding discipline, as measured by the percentage of ARC contributed in a given year. The regressions include a year dummy (not shown), and standard errors are clustered by state and year.

	Dep. Var. = Percentage of ARC Contributed			
VARIABLES	Model 1	Model 2	Model 3	Model 4
Statute Provides for Actuarial Determination of Annual Contribution	24.376***	23.716***	24.174***	22.664***
	(7.403)	(7.437)	(7.452)	(7.242)
Plan Administered by Retirement System		-1.941		-6.511
		(6.873)		(7.046)
Cost-Sharing Plan		-4.815		-9.056
		(6.699)		(5.646)
Judges or Legislators-Only Plan		14.099		3.410
		(9.147)		(7.709)
State Retiree Healthcare Liabilities to Personal Income Ratio			-306.457***	-302.985***
			(101.397)	(100.993)
State Cash Solvency in Prior Year			6.421***	6.832***
			(2.110)	(2.086)
Funding Ratio for State Pension Plans in Prior Year			-0.689**	-0.627**
			(0.263)	(0.258)
Percentage of State Public Employees Represented by Unions in Prior Year			-0.236	-0.250
			(0.171)	(0.160)
Credit Rating AA- or Below in Prior Year			13.804**	17.588***
			(5.774)	(5.652)
Constant	63.091***	64.774***	132.835***	136.214***
	(4.478)	(9.329)	(22.501)	(23.395)
Observations	132	132	132	132
R-squared	0.092	0.114	0.250	0.272
Standard errors in parentheses				
*** p<0.01, ** p<0.05, * p<0.1				

TABLE 7: Institutional Features, State Fiscal Health, and Plan Funding Levels in 2015 Across Retiree Healthcare Plans with Trusts

This table presents the results of a series of OLS regressions of institutional variables of interest on plan funding, as measured by the reported ratio of assets to liabilities. Standard errors are clustered by state.

	Dep. Var.= Funded Ratio			
VARIABLES	Model 1	Model 2	Model 3	Model 4
Statute Provides for Actuarial Determination of Annual Contribution	36.057**	34.144***	26.637*	31.725**
	(15.416)	(11.375)	(14.086)	(14.032)
Plan Administered by Retirement System		0.627		4.921
		(14.888)		(10.599)
Cost-Sharing Plan		2.552		-0.782
		(8.770)		(9.847)
Judges or Legislators-Only Plan		106.038**		101.255**
		(41.314)		(43.388)
State Retiree Healthcare Liabilities to Personal Income Ratio			-527.756***	-378.581**
			(141.270)	(149.721)
State Cash Solvency in Prior Year			11.182***	7.550**
			(2.471)	(3.275)
Funding Ratio for State Pension Plans in Prior Year			-0.721	-0.631
			(0.605)	(0.616)
Credit Rating AA- or Below in Prior Year			29.434	-5.361
			(30.382)	(37.249)
Percentage of State Public Employees Represented by Unions in Prior Year			0.449	0.172
			(0.431)	(0.393)
Constant	26.268***	11.060	83.050*	69.292
	(7.612)	(8.072)	(41.213)	(48.507)
Observations	66	66	66	66
R-squared	0.085	0.440	0.215	0.493
Robust standard errors in parentheses				
*** p<0.01, ** p<0.05, * p<0.1				

While the choice of plan-level funding provisions is statistically significant across a variety of specifications, the coefficients on other plan-specific characteristics—such as transparency and administration by a retirement system—are not statistically significant over the period analyzed. As noted in Section II.A, decreased transparency across cost-sharing plans can cut in competing directions, while the identity of the plan administrator is likely to matter less once a trust is in place and funding provisions have been set by statute. Plan-funding ratios do appear to be significantly higher across plans that cover only judges and legislators, as compared to those that cover other types of employees. This finding suggests that judges and legislators recognize the importance of plan funding and are able to mold the relevant institutions to facilitate the desired result. Table B1 of Appendix B confirms that the results are not driven by plan size. While plans for judges and legislatures cover relatively smaller groups of employees, controlling for the size of payroll does not change the result.

The results in Tables 6 and 7 also underscore the extent to which retiree healthcare plans are intertwined with state politics and fiscal policies. As expected, positive indicators of fiscal health are associated with better funding discipline for retiree healthcare trusts. By the same token, plans with retiree healthcare liabilities

that are relatively larger in proportion to state resources are associated with worse funding discipline and lower funding levels. Worse funding discipline also characterizes plans from states with relatively better-funded pensions, a finding that underscores the risks of analyzing either program in isolation. A poor credit rating in a prior year is associated with better funding discipline. This result likely reflects the ratings agencies' increased focus on retiree healthcare liabilities and, accordingly, the pressure from such agencies to show efforts to address funding gaps. Finally, the coefficient on the unionization variable is not statistically significant, which is consistent with the traditional union focus on benefit levels and applicable legal protections.

To ensure that results are not driven by the cases in which annual contributions or funding ratios are either close to 0 or exceed 100%, and to account for certain limitations of the data as currently reported,[109] Tables B2 and B3 of Appendix B present alternate specifications of the dependent variables. Table B2 uses a binary dependent variable that indicates whether a plan has received at least 70% of the ARC in given year. Under this specification, 53% of the observations are coded as "1" for having received at least 70% of the required contribution; the rest are coded as "0." Table B3 uses a binary dependent variable that indicates whether a plan has reached a ratio of assets to liabilities that equals or exceeds 10% in 2015. Under this specification, 62% of the observations are coded as "1" for having reached the 10% funding threshold; the rest are coded as "0." The results are consistent with the findings from Tables 6 and 7. In these specifications, however, the coefficient on the variable that identifies judge- and legislator-only plans is not statistically significant in the analysis of funding ratios. This suggests that coverage of such specific state employees does not help distinguish plans that have reached the 10% funding threshold from those that have not. Instead, the variable appears to identify plans that are considerably better funded than the average plan in the sample.

In sum, the empirical findings in this Article offer the first insights into the complex political economy of retiree healthcare funding. Over a decade, retiree healthcare trusts have become the norm, rather than the exception. Moreover, institutional features—most notably administration by pension systems, constraints on legislative control over annual funding decisions, and the involvement of powerful stakeholders, like judges and legislators—have been associated with more-robust patterns of trust formation and funding. Finally, while the contours of the trust revolution are clear, the empirical analysis underscores the importance of continuing to monitor funding patterns, particularly as states revise their initial responses to the 2004 GASB rules and adapt to additional standardization requirements in effect as of 2017.[110]

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109. *See infra* note 110.

110. The data analyzed in this Article reflects only the first decade of public-employer decisions after the enactment of GASB Standard No. 45. To the extent that the trusts and the related institutions are relatively new, funding patterns may reflect one-time transfers, unusual funding sources, or gradual ramping up to actuarially sound funding. A reassessment of such patterns over a longer period should offer greater insights about the longer-term

III. THE ROAD AHEAD FOR RETIREE HEALTHCARE BENEFITS

A decade after GASB first required state and local governments to disclose the funding levels of retiree healthcare plans, two-thirds of state-administered plans now have irrevocable trusts to set aside assets for future benefit payments. The developments have drawn mixed reactions. Some have expressed concern about the rise of the trusts, warning that the trusts could strengthen legal protections and foster a kind of "doubling down" on retiree healthcare benefits.[111] Others, meanwhile, have lamented the limited progress on plan funding and the significant number of trusts that remain either entirely or mostly empty.[112] In the intervening period, GASB has issued additional new rules, the Affordable Care Act ("ACA") was enacted (and subsequently targeted for repeal), and public employers have made numerous changes to their retiree healthcare plans.

This Part reviews recent developments with an eye to the long-term viability of retiree healthcare benefits in the United States. First, it demonstrates that within the current legal framework, the establishment of retiree healthcare trusts is not likely to alter the legal status of the benefits in material ways, particularly as public employers seek to prevent this possibility through drafting choices in the enabling statutes. Accordingly, even with the proliferation of retiree healthcare trusts, so long as there is uncertainty over whether such obligations constitute binding, legal contracts, some state and local governments will be reluctant to commit resources to irrevocable trusts. While additional disclosure requirements and specific governance reforms—as indicated by the empirical results in Part II—can promote transparency and funding discipline in the short term, they are unlikely to resolve the challenges inherent in "contracting" for healthcare benefits decades into the future. Long-term viability of such benefits in the public sector may require state and local governments to reconsider the form of benefits provided and the allocation of risk between employers and employees. This Part concludes by mapping out the spectrum of possible reforms and the tradeoffs inherent in each.

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trajectory in retiree healthcare funding. Reassessing the data after 2017 will also allow researchers to take advantage of certain standardization requirements promulgated by GASB in 2015. Previously, GASB Standard No. 45 has allowed plan sponsors significant discretion in the selection of actuarial assumptions used to calculate funding ratios and annual contributions. The analysis here relies on the plan data as reported by the plan sponsors. As standardized calculations become available, it will be important to consider whether, and how, plan sponsors alter their funding patterns. *See* GASB 45, *supra* note 8, ¶ 13 (leaving significant room for interpretation in its guidance that "the investment return assumption (discount rate) should be the estimated long-term investment yield on the investments that are expected to be used to finance the payment of benefits").

111. Stephen Eide & Daniel DiSalvo, *A Health Benefit We Can't Afford: Retiree Medical Expenses Are Busting the City's Budget*, N.Y. DAILY NEWS (Mar. 30, 2016, 5:00 AM), http://www.nydailynews.com/opinion/eide-disalvo-health-benefit-afford-article-1.2581772 ("Prefunding amounts to doubling down on a perk that has long outlived its justification, and repeating the mistakes of pensions. New York has been prefunding pensions for decades and still remains $52 billion short in what it has promised to workers and retirees.").

112. Pozen & Rauh, *supra* note 104.

A. A Matter of Trust? The Security of Healthcare Promises Today

While the amounts set aside in the trusts may be used only to satisfy the claims of plan participants, this Section considers whether the partial prefunding of liabilities through a trust could affect the nature of the legal obligation to provide retiree healthcare benefits.[113] It also assesses the efforts of plan sponsors to explicitly limit the impact of plan funding choices on the legal status of plan benefits. As public employers face calls to avoid establishing retiree healthcare trusts, an understanding of the trusts' legal implications is particularly critical.[114]

Under the current framework, the retiree healthcare trust could affect the legal status of benefits in at least three circumstances. The first is in the case where the applicable statutes or ordinances are, in fact, deemed to create a contractual obligation with respect to the provision of retiree healthcare benefits. In such cases, courts analyze any proposed changes under the Federal Constitution's Contract Clause or the applicable state constitution's contract clause.[115] In determining whether a change to the plan is constitutional under the Contract Clause, courts consider whether it constitutes a substantial impairment of the contractual relationship, and if so, whether it is nevertheless justified by "an important public purpose" and is "reasonable and necessary."[116] The funding status of retiree healthcare plans may be a factor in the evaluation of these requirements.[117] In both the pension and retiree healthcare context, courts have held that the proposed modification to the benefits must be "materially related to the theory of a pension/medical subsidy system and its successful operation" and have explicitly considered the funding level of the retiree benefit plan at issue. For example, in *Los Angeles City Attorney's Association v. City of Los Angeles*, the court held that because the goal of the contested freeze ordinance was to "resolve the City's pending fiscal emergency, the ordinance [was] not materially related to the theory of a pension/medical subsidy system and its successful operation." The court observed that "the economic viability of the medical subsidy system is quite robust given that it is pre-funded and its operation includes assumptions for increasing medical

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113. *See, e.g.*, Sanchez, *supra* note 7, at 1180 (noting that "the law is unclear whether the vesting of [post-retirement health benefits] may occur once a state decides on pre-funding as a means of financing [post-retirement health benefits]").

114. Some commentators have warned state and local governments to avoid creating trusts to not strengthen the legal protections for nonpension benefits. *See, e.g.*, DISALVO & EIDE, *supra* note 14, at 11–12; DiSalvo & Eide, *supra* note 14.

115. MONAHAN, *supra* note 43 at 10.

116. *See, e.g.*, Andrews, Jr. v. Lombardi, No KC20131128, 2017 WL 532353, at *38–40 (R.I. Super. Ct. Feb. 2, 2017); *see generally* Monahan, *supra* note 35, at 1041.

117. *See, e.g.*, *Lombardi*, 2017 WL 532353, at *38–40 (applying the Contract Clause analysis and finding that because "the City presented sufficient credible evidence . . . that the staggering unfunded retiree healthcare liability" created an "unprecedented emergency" of the sort that could give rise "to the City's legitimate use of the police power," the modifications to the retiree healthcare benefits satisfied the requirement that there be "a significant and legitimate public purpose" for the contested modifications).

coverage costs and inflation."[118] Given the prefunding of the benefits, the City could not argue that benefit reductions were necessary to ensure the viability of the retiree healthcare plan. Thus, as a practical matter, a funded trust may reduce the scope of permissible justifications for modifying a contract with public employees.

By similar logic, a trust may also limit benefit cuts in the collective-bargaining context, where, in connection with the establishment of the trust, the CBA explicitly establishes a retiree healthcare funding policy and requires public employers and employees to make contributions to the trust on an accrual basis. Indeed, recent evidence suggests that state employers and public-sector unions are embracing explicit funding commitments in their CBAs. For example, the recent agreement between the state and the Professional Engineers in California Government sets out, for the first time, employer and employee contributions to the retiree healthcare trust fund. It also includes a vesting schedule that links the credited years of service to the percentage of retiree health-insurance premiums to be covered by the employer.[119]

Finally, the trust may matter in cases where the courts consider employer conduct as evidence of intent. As described in Part I, employer conduct may be introduced as extrinsic evidence when the written agreement between the employer and the employees is ambiguous or when the claim is based on a theory of implied contact or promissory estoppel. In such cases, evidence of the establishment and funding of a trust may be interpreted as reflecting the employer's intent to provide retiree healthcare benefits that accrue and vest over the employees' working years. Although a series of cases from California, for example, emphasizes that public-employer practices and policies do not translate into implied contract rights unless the plaintiff meets the heavy burden of establishing legislative intent to create such rights, extrinsic evidence can satisfy this standard.[120] Courts may draw parallels with

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118. L.A. City Attorneys Ass'n v. City of L.A., No. BS135294, at 15 (L.A. Super. Ct., Sept. 13, 2013), http://www.lacaa.org/docs/13-09-13-order-granting-writ.pdf. For the same principles applied to pension systems, see, e.g., Valdes v. Cory, 139 Cal. App. 3d 773, 784 (1983) (finding that "[t]o be sustained as reasonable, alterations of employees' pension rights must bear some material relation to the theory of a pension system and its successful operation").

119. *See* PROF'L ENG'RS IN CAL. GOV'T, 2015–2018 UNIT 9 MEMORANDUM OF UNDERSTANDING BETWEEN THE PROFESSIONAL ENGINEERS IN CALIFORNIA GOVERNMENT (PECG) AND THE STATE OF CALIFORNIA 69 (2018), http://pecg.org/wp-content/uploads/Unit-9-MOU-2015-2018-for-web.pdf.

120. *See, e.g.*, Ret. Emps. Ass'n of Orange Cty., Inc. v. Cty. of Orange, 742 F.3d 1137, 1141 (9th Cir. 2014) (citing "the 'heavy burden' to show that the County intended to create an implied, vested contract right" and emphasizing that "[e]ven long-time government policies regarding retiree health benefits do not necessarily create lifetime rights"); Ret. Emps. Ass'n of Orange Cty., Inc. v. Cty. of Orange, 266 P.3d 287, 296 (Cal. 2011) (noting that the suspension of "legislative control" in favor of an implied contract right requires "unmistakable" evidence so "that neither the governing body nor the public will be blindsided by unexpected obligations," but holding that it is possible to establish requisite intent through extrinsic evidence.); *see also L.A. City Attorneys Ass'n*, No. BS135294, at 2–3 In *Los Angeles City Attorneys Ass'n*, the court found that while the "Los Angeles Administrative Code section 4.1103.2 creates a vested right in a medical subsidy that covers part or all of the cost

cases where an employer's continued provision of retiree healthcare benefits after the expiration of the CBA was admitted as evidence to show that the employer intended for the benefits to continue.[121] Similarly, in recent months, courts have looked to funding history,[122] internal accounting methodologies,[123] and buy-out calculations[124] to resolve ambiguous contractual provisions and ascertain employer intent with respect to retiree healthcare benefits. Further, to the extent that the lack of funding has been cited to support the distinction between the legal status of retiree healthcare benefits and pension benefits, the convergence of funding practices makes the distinction harder to support.[125] As an analytical matter, the fact that under GASB rules, retiree healthcare benefits now must be measured and reported on an

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of a medical plan to eligible employees," the practice of pre-funding retiree health benefits does not "demonstrate a vested right to perpetually *increasing* subsidy but rather reflects prudent financial practice on the part of the city." *Id.* (emphasis added).

121. *See, e.g.*, Fletcher v. Honeywell Int'l, Inc., 238 F. Supp. 3d 992, 1008 (S.D. Ohio 2017) ("Honeywell's course of conduct in continuing to provide coverage after the CBA expired provides strong support for the Court's finding that Honeywell agreed to provide lifetime retiree healthcare benefits."); Anderson v. Town of Smithfield, 2005 WL 3481627, at *6 (R.I. Super. Ct. 2005) (unpublished opinion); *see also* Poole v. City of Waterbury, 831 A.2d 211 (Conn. 2003); Myers v. Schenectady, 244 A.D.2d 845, 847 (N.Y. App. Div. 1997) (finding defendant city's "[19 year] practice of continuing to provide fully paid health insurance coverage . . . even after the expiration of the various collective bargaining agreements pursuant to which [retirees] obtained such benefits, constitutes very substantial evidence that the provisions in question were intended to provide benefits to retirees for the entire period of their retirement").

122. Kendzierski v. Macomb Cty., 901 N.W.2d 111, 116 (Mich. Ct. App. 2017) (looking to a bond funding proposal and a letter from the Macomb County Executive that referenced *lifetime* benefits and a 20-year history of funding such benefits to establish the intent of the parties). *But see L.A. City Attorneys Ass'n*, No. BS135294, at 10 (finding that a practice of pre-funding retiree health benefits does not "demonstrate a vested right to perpetually increasing subsidy but rather reflects prudent financial practice on the part of the city").

123. Reese v. CNH Indus. N.V., 854 F.3d 877, 883 (6th Cir. 2017), *rev'd*, 138 S. Ct. 761 (2018) (finding that extrinsic evidence indicated intent for healthcare benefits to vest for life, where the employer, in an accounting document, calculated retiree healthcare costs based on the employees' life spans, and where the employer's representatives repeatedly told employees that retirees would have healthcare coverage for their lifetimes). Notably, in its 2018 *per curiam* opinion, the Supreme Court rejected the lower court's finding that the CBA was ambiguous in the first place, concluding instead that "the only reasonable interpretation of the 1998 agreement is that the health care benefits expired when the collective-bargaining agreement expired in May 2004." CNH Indus. N.V. v. Reese, 138 S. Ct. 761, 766 (2018).

124. UAW v. Kelsey-Hayes Co., 854 F.3d 862, 871 (6th Cir. 2017), *cert. granted and judgment vacated*, Kelsey-Hayes Co. v. Int'l Union, 2018 WL 1037569 (Feb. 26, 2018) (considering—as part of extrinsic-evidence review—the fact that the employer offered to buy out retirees' healthcare coverage using values based on retirees' life expectancies).

125. *See, e.g.*, Turner v. Local Union No. 302, Int'l Bhd. of Teamsters, 604 F.2d 1219, 1225 (9th Cir. 1979) (finding in favor of the appellees, who argued, in part, that there is a "vast difference" between pension and retiree-health benefits, as evidenced by the fact that "[p]ensions are paid from an actuarially predetermined fund and are guaranteed for life. Health and welfare benefits are negotiated periodically and are paid from a fund consisting of employer contributions and last only the life of the collective bargaining agreement.").

accrual basis, may undermine some of the traditional justifications for the claim that such benefits do not accrue during employees' working years.[126]

To be clear, any of the possible consequences described above are likely to arise only in the absence of an express agreement between the parties, or where such agreement is ambiguous as to the scope or duration of the benefits to be provided. Moreover, a review of the enabling statutes for retiree healthcare trusts reveals that public employers have sought to limit the legal consequences of the trusts by directly addressing the relationship between plan funding and plan benefits. As Table 8 shows, a number of state governments have included statutory language expressly stating that the creation of the trust does not create a contractual obligation to provide benefits, nor does it otherwise define or expand participants' rights to such benefits. Although no court has yet interpreted such provisions, prior deference to legislative intent suggests that such language would carry significant weight.[127]

TABLE 8: Selected Statutory Provisions Addressing the Impact of Retiree Healthcare Trusts and Funding on the Legal Status of Benefits

State	Year	Statutory Provision
Kentucky	2010	"The establishment of Kentucky Retirement Systems insurance trust fund shall not diminish or expand the rights of any recipients, employees, or dependents to health benefits." KY. REV. STAT. ANN. § 61.701 (West 2009).
Michigan	2015	"The funding of postemployment health care benefits by a county, city, village, or township as provided in this act shall not constitute a contract to pay the postemployment health care benefits." MICH. COMP. LAWS ANN. § 141.2518 (West 2015).
Tennessee	2015	"Nothing in this part shall be construed to define or otherwise grant any rights or privileges to other post-employment benefits. The rights and privileges, if any, shall be governed by the terms of the state's post-employment benefit plans." TENN. CODE ANN. § 8-27-806 (West 2015).

126. *See, e.g.*, Studier v. Michigan Pub. Sch. Emps. Ret. Bd., 698 N.W.2d 350, 358 (Mich. 2005) ("Health care benefits . . . are not accrued . . . . [N]either the amount of health care benefits a public school employee receives nor the amount of the premium, subscription, or membership fee that MPSERS pays increases in relation to the number of years of service the retiree has performed."). Notably, the dissent in this case cited the 2004 GASB guidance for the proposition that "cash payments and other retirement benefits, such as health care benefits, are conceptually similar transactions—both involve deferred compensation offered in exchange for current services-and should be accounted for in a similar way." *Id.* at 678.

127. *See supra* Section I.B.

B. Disclosure and Governance Reforms

While the mere establishment of retiree healthcare trusts does not make the promised benefits more secure, the examination of existing plans points to certain best practices for plan administration that, together with new GASB rules in effect as of 2017, can be expected to promote transparency and encourage stronger funding discipline.[128] As an initial matter, states seeking to start prefunding retiree healthcare benefits should review the administrative structure for such benefits. As the results in Part II suggest, retiree healthcare plans administered by pension systems—which possess the relevant expertise and have incentives to manage additional assets—have been associated with a higher rate of trust formation. The results in Part II, as well as similar findings in the pension literature, indicate that public employers should also consider limiting the role of state legislatures in annual contribution decisions. The delegation of authority over such decisions to actuarial bodies—and thus the relative distancing from the political process—has been associated with better funding discipline.[129]

New reporting requirements for public employers—in effect for the 2017 fiscal year—will also shed even greater light on retiree healthcare funding. Pursuant to the latest GASB pronouncement ("GASB Standard No. 75"), state and local governments will be required—for the first time—to include unfunded retiree healthcare liabilities on their *balance sheets*. Previously, the total unfunded liabilities were reported in supplementary materials, while only the annual retiree healthcare costs were included on the balance sheets.[130] The new reporting requirements make retiree healthcare costs much more prominent, which in turn

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128. GASB 75, *supra* note 11. Notably, the new standards in GASB Standard No. 75—which bring the disclosure and reporting requirements for retiree healthcare benefits closer to those in place for pension benefits—were adopted over the opposition of some public employers. *See generally* GOVERNMENTAL ACCOUNTING STANDARDS BD., ONLINE COMMENT LETTERS-PROJECT 34-1E, ACCOUNTING AND FINANCIAL REPORTING FOR POSTEMPLOYMENT BENEFITS OTHER THAN PENSIONS (Oct. 1, 2014), http://www.gasb.org/jsp/GASB/Document_C/DocumentPage?cid=1176164132380&acceptedDisclaimer=true. The Ohio Public Employees Retirement System, for example, opposed the disclosure of retiree healthcare liabilities on the balance sheet, arguing that "OPERS' health care plan is not contractually required or socially obligated and the Board actions to modify the plan demonstrate that lack of obligation." Letter from Karen Carraher, CPA Executive Director, OPERS, to Director of Research and Technical Activities, Governmental Accounting Standards Board (Aug. 22, 2014). The International Association of Firefighters objected to the application of pension-accounting rules to retiree healthcare benefits, since the latter "do not receive the same legal protections as pensions, and are frequently subject to modification or even termination." Letter from Harold A. Schaitberger, General President, International Association of Fire Fighters, to Director of Research and Technical Activities, Governmental Accounting Standards Board (Aug. 26, 2014).

129. *See supra* Part II; *see also supra* note 90 and accompanying text.

130. GASB 45, *supra* note 8, at summary. Pursuant to GASB Standard No. 75, state and local governments will no longer have to report how annual contributions to their plans compare to the ARC benchmark. GASB 75, *supra* note 11, 191–92. Thus, while additional information about each plan will be required, the benchmark commonly used to compare funding discipline across plans will be deemphasized.

should subject such costs to even closer scrutiny from legislators, credit rating agencies, taxpayers, and plan participants.[131]

GASB Standard No. 75 also incentivizes plan sponsors to establish written contribution policies, rather than relying—as many plans currently do—on one-time or ad hoc appropriations to retiree healthcare plans. In specifying how plan sponsors must translate the value of future liabilities into present-day dollars, GASB Standard No. 75 provides that the discount-rate calculation hinges on the value of the assets set aside—and the assets *expected to be set aside*—in the trusts.[132] Under this approach, the more assets a plan sponsor expects to set aside for the plan, the higher the permissible discount rate and accordingly, the lower the value of the accrued liabilities.[133] The critical task of projecting future contributions falls on the plan actuary. For plans with contribution policies established by statute or contract, the actuary must use professional judgment to assess the written policies and the history of prior contributions. For plans without written policies, GASB Standard No. 75 limits the projected future contributions to the average of the contributions *actually* made in the preceding five-year period.[134] Written contribution policies—particularly if combined with limits on legislative authority to modify or renege on the commitments—can serve as anchor points and political shields and are likely to be associated with stronger funding discipline.

Efforts to promote funding discipline should be accompanied by efforts to promote transparency about the allocation of retiree-healthcare liabilities and the scope of permissible modifications to plan benefits. GASB Standard No. 75 addresses the former by requiring all public employers, including those in the so-called cost-sharing plans, to disclose the ratio of assets to liabilities attributable specifically to their employees.[135] While the new requirement helps individual public employers understand their retiree healthcare liabilities, both employers and employees should also have access to a summary of the benefits that describes not only the benefits as currently provided (already required by GASB) but also the

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131. *See, e.g.*, Press Release, Office of the New York State Comptroller, DiNapoli Proposes Option to Help State & Local Governments Pay for Retiree Health Care (Apr. 13, 2015), https://www.osc.state.ny.us/press/releases/apr15/041315.htm (stating that "New York is behind the eight ball on this issue" and proposing legislation to "establish the legal structure for creating trusts that the state and local governments could use to start saving the funds needed to pay for these [retiree healthcare] benefits").

132. All plan sponsors must use the entry-age cost method to calculate the actuarial present value of projected-benefit payments. The standardization of methodology is an important departure from prior GASB guidance and a key step in facilitating the comparison of retiree healthcare liabilities across plans. *See* GAO REPORT, *supra* note 3, at 6–7.

133. Plans that do not set aside any assets and continue the pay-as-you-go approach must discount liabilities using the relatively low municipal bond rate.

134. GASB 75, *supra* note 11, at 14–15.

135. *Id.* at vii. Under GASB Standard No. 45, employers participating in either single-employer or agent plans have been required to disclose the ratio of assets to liabilities attributable to each employer, but employers in cost-sharing plans have been required only to disclose the aggregate funding levels of the plans. As a result, a significant proportion of public employers—particularly municipalities—have not had to calculate or disclose their unfunded retiree healthcare liabilities. *See* Munnell et al., *supra* note 1.

permissible scope of benefit modifications. Individual employees should not have to perform their own legal analyses of the sort described in Part I to determine whether their benefits are secure.

C. Re-Envisioning Retiree Healthcare

The accounting and disclosure changes promulgated by GASB over the last decade have brought to the fore a larger question about the long-term future of employer-sponsored, post-employment benefits for public-sector employees. The future of employer-sponsored retiree healthcare benefits in the United States is intertwined with the future of healthcare reform. For example, the ACA's establishment and regulation of health-insurance exchanges, together with Medicare reforms, arguably made employer-sponsored retiree health insurance a less-essential benefit.[136] Whereas retirees not yet eligible for Medicare once faced extremely limited and expensive alternatives to employer-sponsored healthcare, the ACA's public health-insurance exchanges—and the corresponding availability and renewal rules, prohibitions on exclusions and discrimination, and controlled rate setting—aimed to ensure access to health insurance *outside* the employer context.[137] The ACA's provision of premium tax credits to eligible individuals who purchased insurance on an exchange meant that for a subset of early retirees, health insurance obtained through the exchanges may have been less costly than the insurance available through a former employer.[138] Public employers have noticed the potential cost savings. Some—like Detroit and Chicago, among others—have terminated their benefit programs for retirees, thereby forcing the so-called early retirees onto the public exchanges.[139]

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136. Most notably, the ACA aims to close Medicare Part D's so-called donut hole, which has required Medicare beneficiaries to cover 100% of drug costs after reaching a specified threshold and before becoming eligible for catastrophic coverage. Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111–152, 124 Stat. 1029, 1036–40 (amending 42 U.S.C. §§ 1395w-102, 1395w-152 (2012)); *see generally* Susan E. Cancelosi, *The Bell Is Tolling: Retiree Health Benefits Post-Health Reform*, 19 ELDER L.J. 49, 113–17 (2011).

137. Patient Protection and Affordable Care Act, Pub. L. No. 111–148, 124 Stat. 119, 173–78 (codified at 42 U.S.C. § 18031(b)–(d) (2012)).

138. *See* Jeremy D. Goldhaber-Fiebert et al., *Will Divestment from Employment-Based Health Insurance Save Employers Money? The Case of State and Local Governments*, 12 J. EMPIRICAL LEGAL STUD. 343, 353 (2015) (observing that 33% of state and local government retirees had incomes in the 138%–400% range of the Federal Poverty Line range, which would make them eligible for subsidies or cost sharing on the health insurance exchanges); Nadol et al., *supra* note 23, at 14 (discussing the report of the Retiree Health Benefits Commission, which found that 58% of annuitants in the Chicago city plan in 2014 would pay less under the state's exchange).

139. *See* Alana Semuels, *Cities Are Eliminating the Healthcare Benefits Once Promised to Retirees*, ATLANTIC (Oct. 14, 2014), https://www.theatlantic.com/business/archive/2014/10/cities-are-eliminating-the-healthcare-benefits-once-promised-to-retirees/381375/; Fran Speilman, *Emanuel Completes Three-Year Phaseout of Retiree Health Care Subsidy*, CHI. SUN TIMES (Sept. 11, 2015, 10:01 PM), https://chicago.suntimes.com/chicago-politics/emanuel-completes-three-year-phaseout-of-retiree-health-care-subsidy/; Arin Mikailian, *Glendale to Change Health Benefit for Retired*

For public employers seeking to preserve retiree healthcare benefits, the challenge is to specify the appropriate allocation of risk between employers and employees. Who will bear the risk of retirees living longer than expected? Who will bear the risk that healthcare costs may increase in the future? And who will bear the risk that the public employer will lack either the funds or the political will to continue with the chosen arrangement?

The options for longer-term reform fall along a spectrum. Eliminating retiree healthcare benefits entirely represents one extreme, leaving employees to bear the entire risk of health coverage in retirement.[140] On the other end of the spectrum, employers can continue to provide either fully or partially subsidized health insurance for retirees, with the benefit expressed as a percentage of the health-insurance premiums covered on behalf of current employees. For so long as such benefits remain in place, employers bear the longevity risk, as well as the risk of any increases to the cost of healthcare. Under the current legal regime, in most jurisdictions, employees bear the risk that the employer may cease to offer the benefits at any point or to curtail them significantly. As described above, most employers that have traditionally offered premium subsidies have pursued a variety of incremental cost-cutting measures in recent years.

Between the two extremes are models that seek either to specify the amount of the "defined benefit" that will be paid to retirees or to transform the benefit into a defined contribution arrangement. By expressing the benefit in terms of dollars and by linking the amount of dollars to years worked, both models facilitate the establishment of clear accrual and vesting rules. Such rules, in turn, permit employers and employees to determine how much noncash compensation an employee has earned at any given point and to ensure that, subject to the vesting rules, accrued benefits for work already performed are adequately protected.

The first model transforms the retiree healthcare benefit into a dollar subsidy to be used by retirees to offset the costs of healthcare in retirement. Instead of taking on the obligation to provide subsidized health insurance in retirement, the employer commits to providing a certain number of dollars each year.[141] Employers

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City Workers, L.A. TIMES (Oct. 7, 2015, 6:55 PM), http://www.latimes.com/socal/glendale-news-press/tn-gnp-glendale-to-end-health-benefit-for-retired-city-workers-20151007-story.html (describing how, in October of 2015, the city of Glendale voted to end the provision of subsidized health insurance to its seven hundred retirees, with the ACA as a "game changer" in the decision). One set of economists projected that state and local governments adopting a similar set of reforms for early retirees (i.e., those not yet eligible for Medicare) would save nearly $18 billion over ten years. *See* Goldhaber-Fiebert et al., *supra* note 138.

140. This Part assumes that Medicare remains in place but that employers no longer play any role in providing or subsidizing health insurance for retirees. The risk is particularly significant for the early retirees who do not have access to Medicare.

141. With this paradigm in mind, consulting companies, brokers, and insurers have been promoting so-called private exchanges that allow individual employers to offer employees multiple plans with different sets of benefit options. KAISER FAMILY FOUND., EMPLOYER HEALTH BENEFITS 2015 ANNUAL SURVEY 8 (2015). In a 2016 report, for example, the New Jersey Pension and Health Benefit Study Commission recommended providing state

bear the longevity risk in this case, while the risk of rising healthcare costs shifts onto the plan participants.[142] In the latter model—which follows the contours of the 401(k) retirement plan and which has seen growing employer interest—employers shift to a defined contribution arrangement for retiree healthcare benefits.[143] Rather than committing to provide a certain monthly benefit in retirement, employers provide annual dollar contributions during the employees' working years. The contributions are channeled into individual "savings" accounts for retiree healthcare expenses. Upon leaving or retiring, employees can access the sums in their accounts. Employees bear the longevity risk and the risk of higher healthcare costs. Notably, however, under this model, employees bear no default risk, because employers are required to make their contributions on an annual basis and such contributions are protected from both employer and the employee creditors.

As with pension benefits, any move away from the traditional defined-benefit paradigm involves significant tradeoffs. Success depends on the generosity of the annual contributions or subsidies, the relevant vesting and portability provisions, and the ability of employees to manage the assets in their individual accounts. While this Article has identified certain challenges with the current form of employer-sponsored retiree healthcare benefits, it leaves a full examination of alternative models to future research. Longer life spans and costlier healthcare, together with the changing nature of work in the United States, make such research ever-more important.

CONCLUSION

Unfunded retiree healthcare obligations present serious challenges for public employers and employees alike. While the high cost of healthcare in retirement necessitates careful planning and preparation on the part of both parties, the entrenched ambiguity in traditional post-employment healthcare plans necessarily frustrates this aim. Over the last decade, GASB accounting standards have forced state and local governments to confront the liabilities associated with their retiree healthcare plans. Policymakers have responded with a flurry of activity in the halls of state government.[144] Most states have begun to prefund the benefits,

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retirees with an annual funding allotment to purchase coverage through such a private exchange. The move would allow the state of New Jersey to reduce and cap its "exceedingly costly" contributions to retiree healthcare by offering a menu of plans that would, on average, result in higher out-of-pocket costs for participants. NEW JERSEY PENSION & HEALTH BENEFIT STUDY COMM'N, SUPPLEMENTAL REPORT ON HEALTH BENEFITS 2–3 (2016), http://www.state.nj.us/treasury/pdf/NJPensionCommission-Supplemental-Report-on-Health-Benefits.pdf.

142. As with pension benefits and the cost-of-living adjustment, employers could potentially build in a cost-of-healthcare adjustment to share the risk with employees.

143. Observers have noted the growing popularity of various defined contribution arrangements including HRAs and retiree medical savings accounts. *See, e.g.*, SEGAL CONSULTING, TRENDS: HEALTH PLAN NEWS AT A GLANCE FOR THE PUBLIC SECTOR, SECOND QUARTER 2016 (2016), https://www.segalco.com/media/2483/trends-ps-2ndquarter2016.pdf (observing that public employers are considering defined contribution options for retirees).

144. In addition to all the legislation to establish trusts, legislators have, in recent years, introduced a variety of policy proposals to address retiree healthcare obligations in their

but the current legal framework regulating retiree healthcare benefits impedes serious funding efforts. At the same time, state and local governments are experimenting with new models for the provision of employer-sponsored health insurance. The coming years will undoubtedly bring significant changes to the form and financing of post-employment benefits. The hope is that such changes will mitigate the economic and legal uncertainty that currently characterizes retiree healthcare benefits in the public sector.

own states. For example, the following legislation was introduced but ultimately failed: in California, Assembly Member Travis Allen introduced a bill to "prohibit a public agency, state employer, employee organization, or public employee from entering into a memorandum of understanding that provides postemployment health care benefits without a strategy for permanently prefunding members' postemployment healthcare benefits." Assembly Bill 537, Legis. 2015–2016 Reg. Sess. (Cal. 2015). In Connecticut, State Representative Melissa Ziobron and others introduced a bill to "close the gap between state employee and private sector benefit plans and to make [the Connecticut] state budget responsive to current economic realities." Proposed H.B. 5057, Feb. Sess. 2016 (Conn. 2016). In Kansas, the appropriations committee sought to "implement[] a health insurance exchange platform for public-employer retirees," and to "eliminate[] retirees from participation in the state health care benefits program." H.B. 2716, 86th Legis., 2016 Reg. Sess. (Kan. 2016).

APPENDIX A

TABLE A1: Summary Statistics for 2014–2015

	Mean	Standard Deviation
Retiree Healthcare Trust Exists	0.65	0.47
Retiree Healthcare Plan Administered by Retirement System	0.47	0.50
Percent of ARC Contributed	63.36	37.51
Funding Ratio	25.37	47.95
Statute Provides for Actuarial Determination of Annual Contribution	0.27	0.44
Cost-Sharing Plans	0.39	0.49
Judges-or Legislators-Only Plan	0.13	0.34
Retiree Healthcare Liabilities-to-State-Personal-Income Ratio	0.05	0.09
State Cash Solvency in Prior Year	0.19	4.03
Funding Ratio for State Pension Plans in Prior Year	69.41	12.69
Credit Rating AA- or Below in Prior Year	0.19	0.39
Percent of State Public Employees Represented by Unions in Prior Year	36.17	18.91

APPENDIX B

TABLE B1: Institutional Features, State Fiscal Health, and Plan Funding Levels in 2015 Across Retiree Healthcare Plans with Trusts, Controlling for Size of Payroll

This table replicates the findings of Table 7 but adds natural log of payroll as an approximation of plan size. Payroll data is not available for one plan in this subsample. Standard errors are clustered by state.

	Dep. Var.= Funded Ratio
VARIABLES	
Statute Provides for Actuarial Determination of Annual Contribution	34.658**
	(16.598)
Plan Administered by Retirement System	3.731
	(11.707)
Cost-Sharing Plan	-7.252
	(13.481)
Judges or Legislators-Only Plan	129.586**
	(53.007)
Payroll	6.118
	(4.431)
State Retiree Healthcare Liabilities to Personal Income Ratio	-432.701**
	(168.286)
Funding Ratio for State Pension Plans in Prior Year	-0.848
	(0.771)
State Cash Solvency in Prior Year	8.657**
	(3.372)
Credit Rating AA- or Below in Prior Year	-6.950
	(37.904)
Percentage of State Public Employees Represented by Unions in Prior Year	0.289
	(0.418)
Constant	-0.321
	(47.189)
Observations	65
R-squared	0.515
Robust standard errors in parentheses	
*** p<0.01, ** p<0.05, * p<0.1	

TABLE B2: Likelihood That Retiree Healthcare Plan with Trust Received at Least 70% of ARC in 2014–2015

This table presents a series of pooled logit regressions using a binary dependent variable that indicates whether a plan in given year has received at least 70% of the ARC. The regressions include year dummies (not shown) and standard errors are clustered by state.

Binary Dep. Var. = 1 if Percentage of ARC Contributed Equals or Exceeds 70				
VARIABLES	Model 1	Model 2	Model 3	Model 4
Statute Provides for Actuarial Determination of Annual Contribution	1.969***	2.028***	2.627**	2.630**
	(0.743)	(0.762)	(1.046)	(1.057)
Plan Administered by Retirement System		0.176		-0.187
		(0.673)		(0.728)
Cost-Sharing Plan		-0.177		-0.471
		(0.557)		(0.472)
Judges or Legislators-Only Plan		1.483		0.610
		(1.185)		(1.046)
State Retiree Healthcare Liabilities to Personal Income Ratio			-29.581***	-29.553***
			(11.431)	(11.026)
State Cash Solvency in Prior Year			0.612***	0.630***
			(0.224)	(0.211)
Funding Ratio for State Pension Plans in Prior Year			-0.084**	-0.080*
			(0.041)	(0.042)
Percentage of State Public Employees Represented by Unions in Prior Year			0.002	0.001
			(0.019)	(0.018)
Credit Rating AA- or Below in Prior Year			1.698**	1.544**
			(0.760)	(0.780)
Constant	-0.928**	-1.174*	5.469*	5.573*
	(0.425)	(0.599)	(2.842)	(2.997)
Observations	132	132	132	132
R-squared	0.152	0.190	0.345	0.356
Robust standard errors in parentheses				
*** p<0.01, ** p<0.05, * p<0.1				

TABLE B3: Likelihood That Retiree Healthcare Plan with Trust Had a Ratio of Assets to Liabilities That Equaled or Exceeded 10% in 2015

This table presents a series of logit regressions using a binary dependent variable that indicates whether a plan in 2015 has reached a ratio of assets to liabilities that equals or exceeds 10%. Standard errors are clustered by state.

	Binary Dep. Var. = 1 if Funding Ratio Equals or Exceeds 10			
VARIABLES	Model 1	Model 2	Model 3	Model 4
Statute Provides for Actuarial Determination of Annual Contribution	1.903**	2.028**	3.209*	3.182*
	(0.761)	(0.877)	(1.730)	(1.731)
Plan Administered by Retirement System		0.954		0.824
		(0.877)		(1.615)
Cost-Sharing Plan		0.532		0.364
		(0.831)		(1.232)
Judges or Legislators-Only Plan		1.767		0.540
		(1.144)		(0.822)
State Retiree Healthcare Liabilities to Personal Income Ratio			-66.324**	-68.193***
			(26.013)	(24.426)
State Cash Solvency in Prior Year			1.495***	1.499***
			(0.473)	(0.452)
Funding Ratio for State Pension Plans in Prior Year			-0.124*	-0.124*
			(0.071)	(0.074)
Credit Rating AA- or Below in Prior Year			2.801***	2.085*
			(0.739)	(1.178)
Percentage of State Public Employees Represented by Unions in Prior Year			0.039	0.030
			(0.032)	(0.037)
Constant	-0.154	-1.198	9.424*	9.237
	(0.402)	(0.875)	(4.974)	(5.990)
Observations	66	66	66	66
R-squared	0.127	0.218	0.521	0.536
Robust standard errors in parentheses				
*** p<0.01, ** p<0.05, * p<0.1				