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The Other Debt Bomb in Public-Employee Benefits.

Underfunded health-care obligations may be close to $1 trillion. Many cities and states are in for big trouble.

Public-pension funds have garnered attention in recent years for being underfunded, but a more precarious situation has received much less notice: health-care obligations for public retirees.

Unlike pension plans, governments are not required to contribute to separate trusts to support health-care promises. As a result, only 11 states have funded more than 10% of retiree health-care liabilities, according to a November 2013 report from the credit-rating agency Standard & Poor's. For example, New Jersey has almost no assets backing one of the largest retiree health-care liabilities of any state—$63.8 billion.

Only eight out of the 30 largest U.S. cities have funded more than 5% of their retiree health-care obligations, according to a study released last March by the Pew Charitable Trust. New York City tops the list with $22,857 of unfunded liabilities per household.

What exactly are retiree health-care obligations? State and local governments typically pay most of the insurance premiums for employees who retire before they are eligible for Medicare at age 65. That can be a long commitment, as many workers retire as early as 50. Many governments also pay a percentage of Medicare premiums once retired workers turn 65.

Total U.S. unfunded health-care liabilities exceeded $530 billion in 2009, the Government Accountability Office estimated, but the current number may be closer to $1 trillion, according to a 2014 comprehensive study released by the National Bureau of Economic Research.

Governments usually finance health-care spending with current revenues from property taxes and other sources. They'll need to reverse this spending growth to have enough revenue to pay for essential services such as schools and police.

For years, state and local governments could promise more health-care benefits without much accountability. To provide more transparency, the Government Accounting Standards Board since 2006 has required governments to disclose retiree health-care benefits in their financial reports.

In 2014 the GASB proposed major improvements to the disclosure requirements. Perhaps most important, the new rules would require state and local governments to include these liabilities on their balance sheets, rather than in financial footnotes.

The GASB also proposed that all governments use the same discount rate—equal to the interest rate on AA-rated municipal bonds. Governments use an assumed investment yield when figuring out the amount of current assets needed to finance future benefits. Many governments have assumed unrealistically high yields to understate the current funding shortfall.

At the same time, some state and local governments are attempting to reduce their health-care obligations. This is much easier legally than reforming pension benefits, which often are protected

expressly by state constitutions. But reductions in retiree health-care obligations are still subject to collective bargaining and sometimes litigation.

Since 2010 more than 15 states have passed laws to reduce health-care cost-of-living adjustments—automatic benefit increases linked to the consumer-price index. Courts in eight states upheld these reductions on grounds that cost-of-living adjustments should not be considered a contractual right. Only Washington's law was struck down in 2011, and the case is now on appeal.

Some state and local governments—Nevada and West Virginia, for example—have increased deductibles and scaled back premium subsidies. Others like Ohio and Maine have reduced the health-care benefits provided to retirees.

Several years ago Pennsylvania changed early retirement eligibility to 20 years of service from 15. In Massachusetts, however, public employees with 10 years of part-time service still qualify for retiree health care.

In a few jurisdictions, public retirees now must purchase health insurance through Affordable Care Act exchanges, rather than directly from a private insurance company. This allows retirees to receive premium subsidies from the federal government, reducing the burden on state and local governments. Of course, this does not change the actual costs of retiree health care.

The GASB should adopt its recent proposals despite significant resistance from governmental groups and officials like Ohio Auditor Dave Yost, who testified against the rule, arguing that health-care benefits should not be considered liabilities since they are not legally binding like pensions.

Taxpayers could use the new information to examine the trajectory of their city and state's retiree health-care obligations, and consider reform. One possible approach: Tie the level of health-care subsidies to the number of years in public employment above a reasonable minimum. Another idea: Apply the reductions in health-care benefits mainly to new or younger workers, while maintaining the benefits of retired employees.

In any event, states and cities should set up separate trusts with enough investment assets to support over time whatever health-care benefits they have promised. Then these commitments will have more credibility with public employees, and governments can avoid a time bomb that could explode on future budgets.

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