

HEALTH CARE REFORM

Meeting the Needs of Retirees and the Requirements of the New Law

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It's Time to Re-evaluate Retiree Health Strategy

The Affordable Care Act of 2010 and Medicare Modernization Act of 2006 together create new opportunities to rethink retiree health benefits.

- Medicare continues to expand (Part D and Part B coverage reducing gaps)
- Medicare Advantage carrier reimbursement changes will force changes
- Changes in Part D reimbursement reduce relative value of Retiree Drug Subsidy (RDS)
- New rules encourage defined contribution approaches
- Early Retiree Reinsurance Subsidy may change emphasis for pre-65 retiree plans and subsidies
- Employment contract has changed and old vesting rules need to be revisited

POLLING QUESTION

What type of organization do you represent?

- State government or agency
- Local government
- School District
- Other governmental unit
- Insurance company or third party administrator
- Other (consultant, attorney, etc.)

Traditional Objectives for Retiree Health Coverage

Employer's Objectives

- Attract and retain qualified employees
- Create an incentive for long-term employee commitments
- Create a sustainable economic model that reduces long-term unfunded liabilities

Retiree's Objectives

- Adequate retirement income
- Post-retirement rewards that match commitment
- Security from the excessive out of pocket medical expenses
- Choice, access and support



Increasing Burden on Public Employee Plans

Providing retiree health coverage creates an increasingly heavy burden on public health plan sponsors.

- Costs for retiree health plans continues to increase faster than inflation
- Workers don't fully understand or appreciate the potential value or real cost of retiree health benefits
- Plan sponsors often neglect to promote the value as part of compensation
- Early retirees are the most expensive group for the employer to cover
- Many retiree health plans are antiquated in design and financial structure under the new landscape

POLLING QUESTION

What retiree health coverage do you provide for your early retirees?

- Pre-Medicare coverage through active employee plans
- Pre-Medicare coverage through outside insurance plans
- Funding only. Early retirees are not covered through our plans.
- We do not provide coverage for early retirees.

POLLING QUESTION

How do you provide retiree health coverage for Medicare eligible retirees?

- Medicare supplement through our primary medical plans for active employees.
- Medicare supplement plan separate from our active employee programs.
- Medicare Advantage plans
- Combination or choice of Medicare supplement or Medicare Advantage plans.

Medicare Continues to Expand

Medicare Coverage Gaps Decline

- ✓ Medicare Part A typically covers over 90% of inpatient expenses
- ✓ Medicare Part B covers approximately 75% of outpatient expenses (excludes Rx)
- ✓ Medicare Part D will eventually cover over 67% of outpatient Rx expenses
- ✓ 2009 CMS payments per Medicare Advantage enrollee over \$10,000 per year
- ✓ Out of pocket cost for average Medicare enrollee (\$2,500 – \$4,000 per year)



Medicare Continues to Expand

Medicare Coverage Gaps Decline

- ✓ 2010 average Medicare PDP premium—approximately \$36 per month
- ✓ In 2010, 79% of Medicare Advantage plans have a out-of-pocket spending limit for medical services (47% of all MA plans have a limit on out-of-pocket spending of \$3,400 or less)
- ✓ In 2011, Medicare Advantage plans are required to have an out-of-pocket spending limit for medical services, no greater than \$6,700 for in-network services.
- ✓ In 2011, Medicare Advantage plans are required to cover 18 preventive services without cost sharing.

How much of the gap can you afford to cover?

Medicare Advantage Plan Reimbursement

Select Medicare Advantage Payment Rates

2009 AVERAGE AVG. MONTHLY PAYMENT RATES

	PMPM	Annual	Variance from Avg
US Avg	\$849.00	\$10,188	
California	\$914.44	\$10,973	108%
Florida	\$1,013.41	\$12,161	119%
Illinois	\$822.14	\$9,866	97%
Louisiana	\$1,002.86	\$12,034	118%
Massachusetts	\$905.23	\$10,863	107%
New Jersey	\$993.11	\$11,917	117%
Pennsylvania	\$921.94	\$11,063	109%
Vermont	\$726.07	\$8,713	86%

Source: CMS Mathematica Policy Research Inc.

Medicare Advantage Plan Reimbursement



Medicare Advantage Payment Rates Will Decline

- Beginning in 2012 CMS payments to Private Sector are reduced
- Impact on plans favoring MA approach can be dramatic
 - Higher premium rate increases
 - Significant Plan Cuts
 - MA only strategy may need to be revisited
- Bonus payments tied to quality indicators can offset some of the burden
- Medicare Advantage plans to disclose medical loss ratios. For plans with medical loss ratios below 85%, the rebates to beneficiaries.

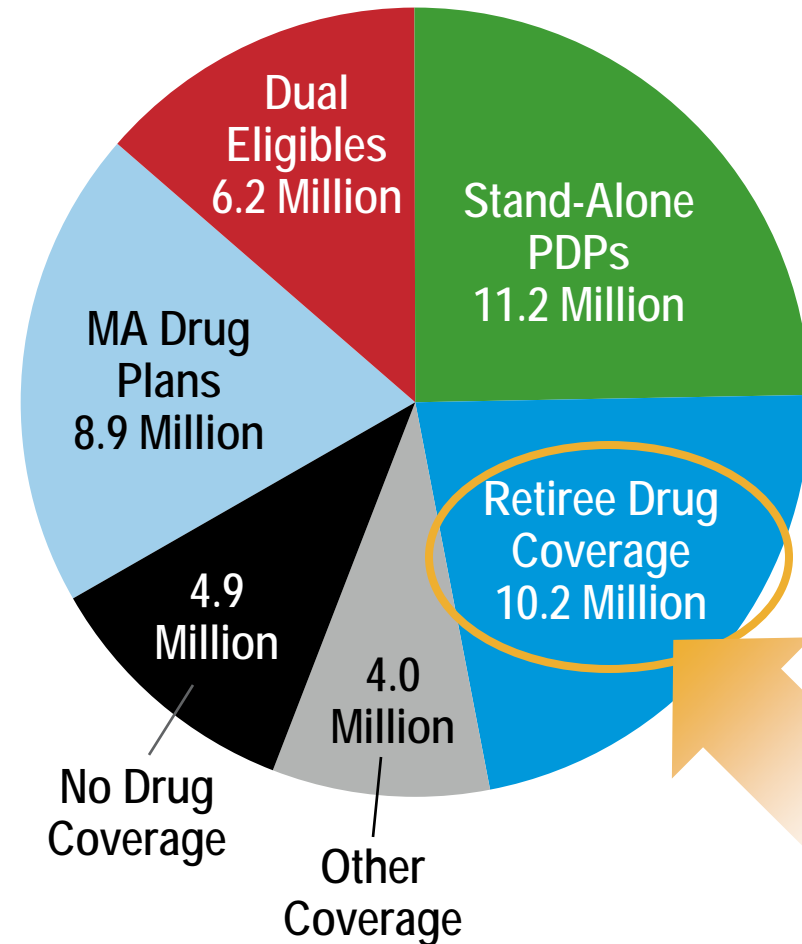
POLLING QUESTION

How do you provide Prescription Drug coverage to your Medicare retirees?

- Through a fully-insured or self-insured plan where you collect the Retiree Drug Subsidy.
- Through a fully-insured Medicare Prescription Drug Plan (PDP).
- Through a self-insured Medicare Prescription Drug Plan or an Employer Group Waiver Program (EGWP).
- Other
- We do not provide prescription drug coverage to Medicare retirees.

Medicare Part D Market Landscape

- U.S. population over the age of 65 expected to increase from 15% today to 20% by 2030
- 45.4 million beneficiaries today—1 million new retirees expected to enroll annually
- The greatest growth is expected in the PDP and MA-PD categories



Healthcare Reform Medicare Part D Key Changes

HEALTHCARE REFORM MEDICARE PART D KEY CHANGES TIMELINE

- Provides a \$250 rebate to people with Medicare in the coverage gap or “doughnut hole”
- Authorizes the Food and Drug Administration to approve generic versions of biologics

2010

2011

2012

2013 – 2020

- Manufacturers will provide a 50 percent discount on brand-name drugs and the government will provide 7 percent coverage on generic drugs for consumers in the coverage gap in 2011.
- Discounts and coverage will increase each year until 2020, when the consumer’s share of costs in the gap will be 25 percent for both brand-name drugs and generics.
- Raises drug plan premiums for individuals earning over \$85,000 and couples earning over \$170,000.
- Creates a single Annual Enrollment Period (AEP) for drug and health plan changes, which begins on October 15 and ends on December 7.

Eliminates prescription drug copayments for certain dual eligibles (people with both Medicare and Medicaid) who are receiving home- or community-based long-term care.

The coverage gap will be phased out through annual increases in discounts until 2020, when the consumer’s share of the costs will be reduced to 25 percent for both brand-name and generic drugs.

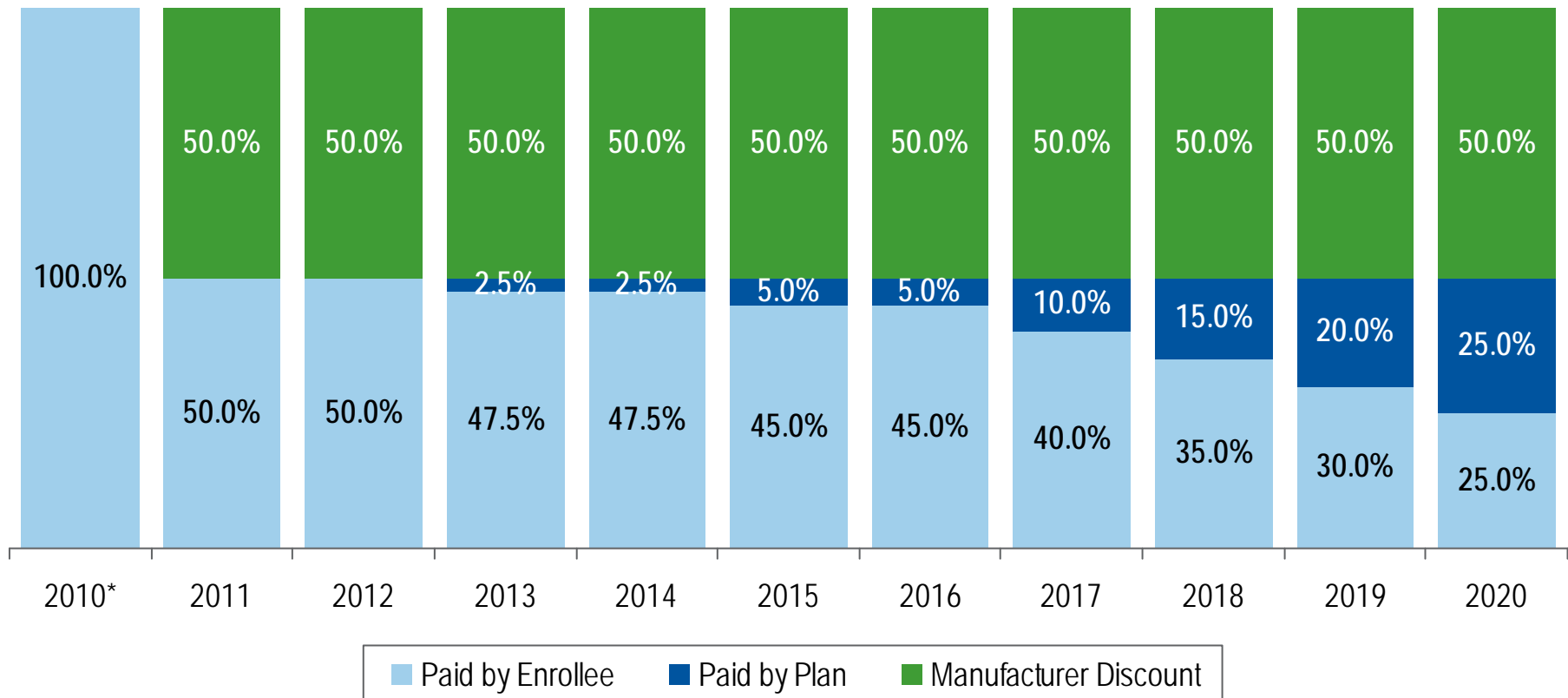


Healthcare Reform Medicare Part D

Key Changes *continued*



COST SHARING FOR BRAND-NAME DRUGS IN THE MEDICARE PART D COVERAGE GAP, 2010–2020

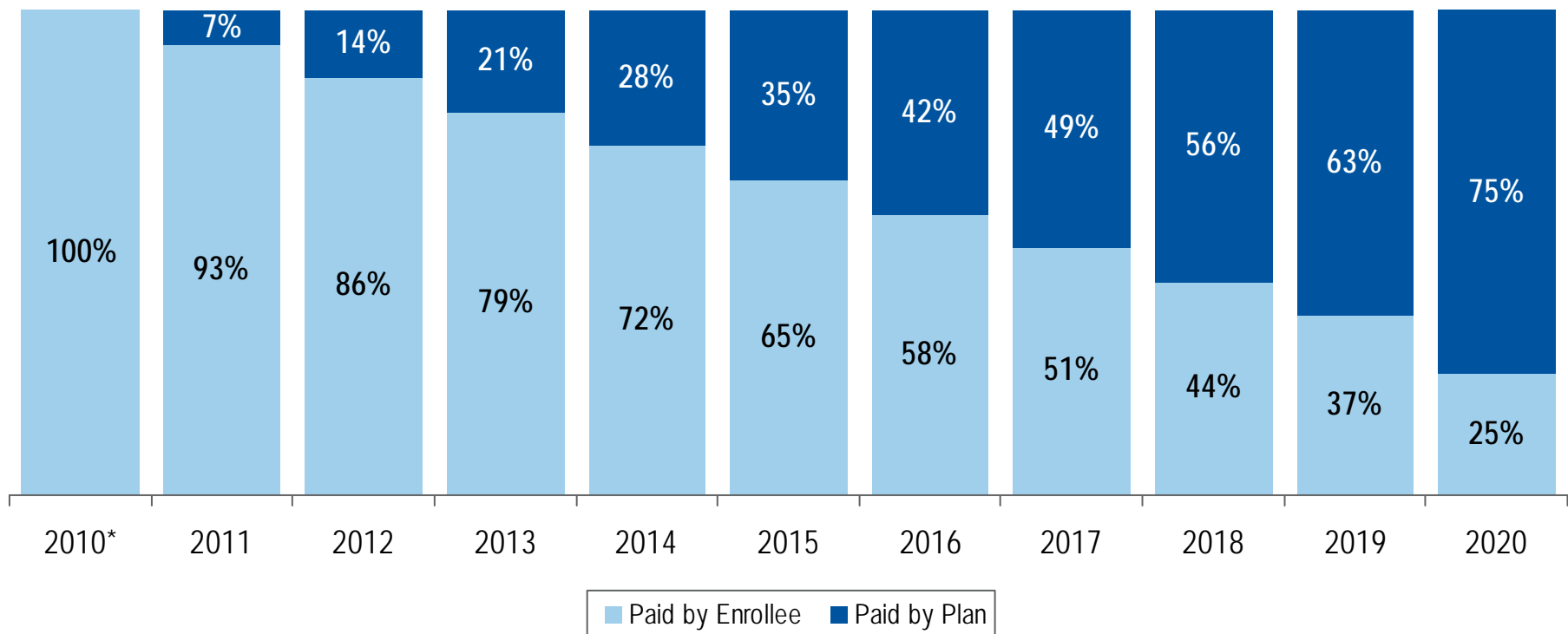


* In 2010, participants reaching the coverage gap will receive \$250 rebate.

Healthcare Reform Medicare Part D Key Changes *continued*



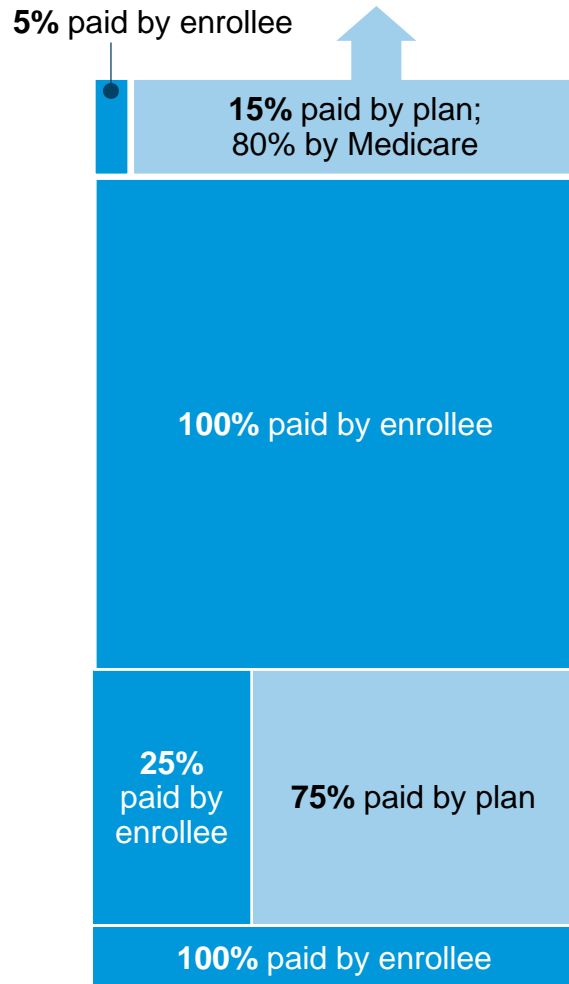
COST SHARING FOR GENERIC DRUGS IN THE MEDICARE PART D COVERAGE GAP, 2010–2020



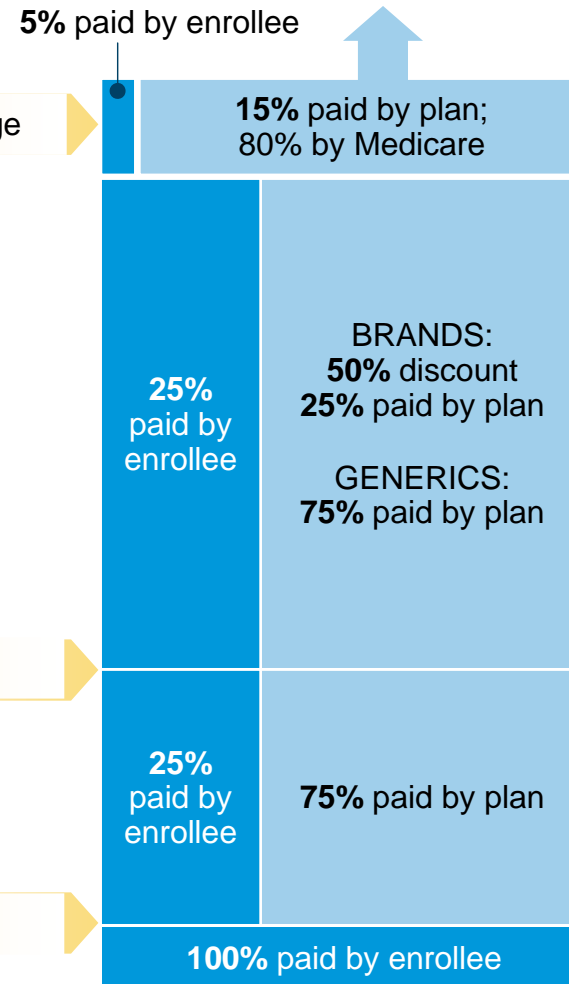
* In 2010, participants reaching the coverage gap will receive \$250 rebate.

Healthcare Reform Medicare Part D Key Changes *continued*

STANDARD MEDICARE PRESCRIPTION DRUG BENEFIT, TODAY



STANDARD MEDICARE PRESCRIPTION DRUG BENEFIT, 2020 WITH HEALTH REFORM



Catastrophic coverage

Initial coverage limit

Deductible

Medicare Part D Plan Sponsor Options

Retiree Drug Subsidy	<ul style="list-style-type: none">• Manage benefit and apply for the federal subsidy• Maintain existing retiree plan
Enhanced Plan EGWP	<ul style="list-style-type: none">• Contract with a PDP (Prescription Drug Plan) sponsor for coverage equal to or greater than the standard Medicare benefit
Direct PDP	<ul style="list-style-type: none">• Contract directly with Medicare to become a PDP• Administrative burden lies with the Plan (CMS contract holder)
Transition to MA-PD	<ul style="list-style-type: none">• Contract with an MA-PD sponsor to combine administration of medical / pharmacy benefit
Transition to PDP	<ul style="list-style-type: none">• Group enroll members into a PDP• Option to subsidize premium payments or pay part of member cost through secondary coordination

Employer Group Waiver Plan (EGWP)

Advantages and Challenges



➤ Advantages

- Likelihood for greater cost savings than RDS
- Subsidy realized up-front in premium payment
- Ability to transfer risk (fully insure)
- Some flexibility in plan design, formulary, and network
- Less member disruption than transition to individual PDP
- Significant reduction in FASB/GASB liability

➤ Challenges

- Some control ceded to CMS requirements (eligibility rules, plan design, communications, etc.)
- Implementation more complex than RDS
- Moderate member disruption
- Eligibility requires HICNs



Early Retiree Reinsurance Subsidy



The program:

- \$5 billion for qualified plans (until 2014 or depleted)
- Estimated to be worth 20% to 30% of total early retiree health care claim expenses
- Pre-Medicare retirees age 55 – 64
- Reimburses 80% of claims per retiree between \$15,000 – \$90,000
- Plans must use funds to lower retiree costs
- First come first serve basis—expected to last one to two years

Status:

- Applications now approved for over 3000 plans
- Claims filing procedures now being published
- Will the funding be expanded?

Assessing Benefits and Costs of the Retiree-Only Plan Exemption



- HIPAA and ACA exemption for a plan that covers only retirees, “retiree only plan”
- Benefits of taking the exemption
 - Sponsor flexibility to adopt parts of ACA that meet retiree objectives and reject those that do not
 - Exemption from MH/SD parity, HIPAA and future ACA regulations pertaining to employer benefits
 - Exemption from reporting to individual via W-2 or other mandated forms
 - Disclosure requirements to federal government
 - Expanded appeals process for internal and external reviews – very complex
 - Exposure to expedited participant litigation rights under claim and appeal regs
 - Coverage of “essential benefits” (to be determined by HHS)
- Potential disadvantages of exemption
 - Retirees may be treated in a different manner under the law than actives
 - Some participant rights are lost, but could be voluntarily extended
 - Potential extra work of establishing a “retiree only plan”

POLLING QUESTION

How do you fund your subsidy of retiree health benefits?

- Percent of total cost.
- Service-based monthly dollar amount.
- Flat dollar amount.
- We do not subsidize retiree health benefits.

Is it time for a Defined Contribution Approach?

Advantages of a Defined Contribution Approach

- Better control of budgeting—move away from unpredictable long-term predictions of medical inflation
- Part A, Part B and Part D federal subsidy may now be sufficient to sustain individual retiree market
- Medicare market and design are evolving to meet retiree health needs
 - Individual Exchanges
 - Association plans
 - Outsourcing program administration
- Individual market and Exchange may address early retiree needs
- Can reduce or eliminate long term post employment accounting obligations (GASB45) – DC plans exempt under GASB 45
- A number of plans are successfully managing such programs today

How Health Plans are Like Pension Plans



In many ways, a traditional health plan structure is like a defined benefit pension plan

- Promises poorly defined benefits, not dollars
- Employer is on the hook to provide the benefits, cost is the variable
- Unlike pensions, it isn't a defined benefit at all as copay, deductibles and coinsurance can be increased, limits put on benefits covered, annual and lifetime limit adjustments and increases in premiums
- Unlike pensions, health benefit plans can have significant variation in actual cost from projected costs, since there is no guarantee that an otherwise healthy person will not have large medical expenses in a given year
- GASB 45 now subjects Public Employers to rules that recommend pre-funding of the retiree health benefit costs, similar to defined benefit pension funding

How Does a Defined Contribution Approach Work?

Defined contribution health plan concepts:

- Defined Dollar Benefit - Employer promises defined dollars instead of undefined benefit cost reimbursements
- Defined Contribution –
 - Accumulation vehicles are available for active employees to build savings to help pay for retiree health costs
 - Amounts granted each year are fixed, not subject to later increase by improving benefit coverage
 - May involve plans offered by employer and/or outside purchase of individual market plans
 - Employees may agree to surrender unused leave benefits to accumulate cash for retiree medical costs

Defined Contribution Example Structure

Some Possible Defined Contribution Funding Arrangements

Example #1—Defined Dollar Benefit – Target Benefit

- For all qualified retirees, plan provides \$20 monthly premium assistance times years of service at retirement
 - Offers several plan options
 - Use It or Lose It feature
 - Retiree may or may not use employer's plans to receive the premium assistance

Advantages

- Simple to administer
- Removes funding uncertainty and liability of employer
- Presently enough fixed contribution to make retiree premium manageable
- Recognizes length of service

Disadvantages

- Puts entire medical inflation onto retiree beneficiary
- Without periodic COLA, retiree share of premium can become unaffordable over time

Defined Contribution Example Structure

Example #2

- For each hour worked, employer contributes \$0.58 into an individual premium account, Health Reimbursement Arrangement (\$1,200 per year)
 - Offers several plan options to purchase
 - Retiree can purchase plans outside employer options
 - Retiree can use accrued amount for reimbursement of premiums or medical expenses
 - Individual Account, HRA has no GASB liability

Advantages

- No GASB 45 liability
- Simple to administer
- Provides ample choice
- Amounts vary by length of service (rewards retirees with greater years of service)
- Participant can manage account through investment selections
- HRA administrator handles reimbursement requests

Disadvantages

- Risk of Investment return offsetting inflation is now employee risk

Defined Contribution Example Structure

Example #3—Shared Savings Qualified Accounts

- Plan sponsor contributes percentage of pay into HRA, according to bargained agreement
- Employee surrenders accumulated unused leave and vacation at retirement or annually into HRA at a pre-determined surrender value
 - Surrender of sick leave time may be at less than 100% of value
 - Annual surrender offsets value of pay increases over career
 - Accumulated balances are managed by employees

Advantages

- Shares some of the burden of medical cost inflation
- No GASB liability for defined contributions
- HRA provides a qualified tax exempt vehicle to accumulate cash
- HRA provides more flexibility to retiree

Disadvantages

- Retains some of the uncertainty of future medical trends
- Requires employer to stay involved in plan cost management

Is it time for a Defined Contribution Approach

Transitioning from a DB plan to DC retiree health plan—Questions to Ask:

- Are there sources of funding from other plans
 - Sick leave
 - Scheduled pay increases
- What is the impact to cash flow?
- Selecting an HRA Administrator?
- What is an affordable amount of premium sharing for retirees?
- Will you continue to “sell” plans to retirees?
- Which levels of coverage should be offered (how many options, out of pocket limits)?
- Will existing retirees be grandfathered?

A Case Study



- Entity benefit allowed employees to exchange unused sick leave at retirement:
 - For additional service credits in pension system
 - Months of retiree only medical coverage (8 hours of leave equals one month of coverage)
 - Maximum months of medical conversion was 180
- Many employees had sufficient balance to do both (1.5 years of pension service plus 15 years of medical coverage)

Implication to GASB

- Significantly increased pension cost for added service
- Pension cost far outweighed value of sick time at current salary
 - Earned at one value
 - Redeemed at the higher salary used to compute pension
- Projected value of retiree medical over 15 years exceeded value of sick leave by 150%
- For employees a win/win; for the entity a lose/lose



Negotiated Solution

- Establish individual HRA accounts for active employees
- Surrender excess sick leave each year at current rates of pay
- Leave minimum required balances of sick leave to avoid hardship
- Surrender remaining sick leave at retirement at 50% of rate of pay at retirement
- Eliminate Pension Service provision
- Surrender .75% of scheduled salary increase into HRA
- Employer contributes 1.5% of pay into HRA



Benefit to Employee

More Flexible Solution

- Would not have to spend HRA balance on employer provided health premium – can choose any plan
- Employee directed investment of balances
- Portable and vested. Terminated workers could take full balances
- Can be used for Retiree, spouse or dependents

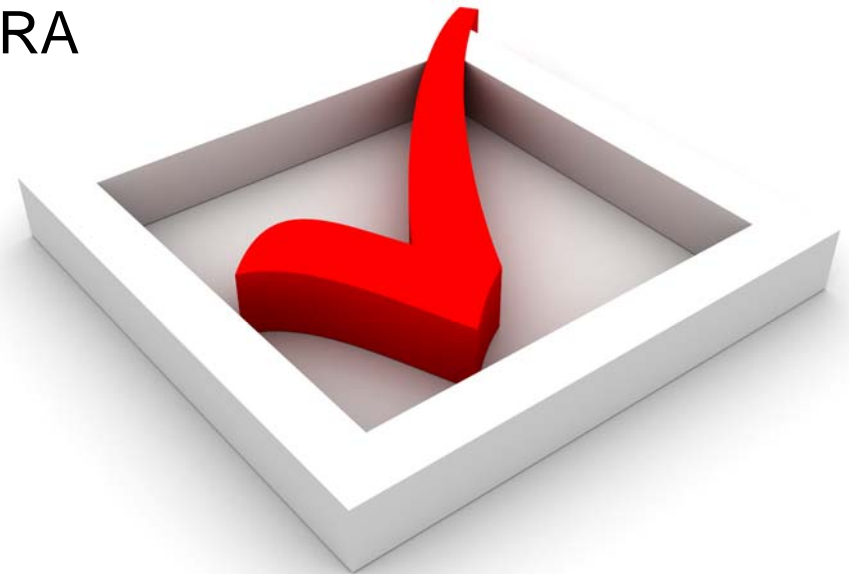
Greater Security

- Cash balance could be used in case health premiums were not needed for medical
- Vested ownership in cash



Benefits to Entity

- Eliminated all of the GASB 45 liability under defined contribution, individual account exemption
- Negotiated defined cash flow
- Improved unnecessary use of sick leave
- Bargain additional contribution into HRA from union, in lieu of pay increases avoiding pension costs
- Platform for other active benefit plans and cash





Other Retiree Plan Issues to Consider

- Outsourcing enrollment and administration
 - Cost vs. control vs. employee, retiree and stakeholder perception
- Wellness initiatives for seniors
- Insured plans vs. self-funding
- High deductible health plans for seniors
- Revising retiree health benefit eligibility and subsidy policies
- Whether to encourage retiree participation in the health insurance exchanges
- Communications issues for the many developing options
- Coordination with other retiree benefits

Start Planning Now



- 1 Re-evaluate your retiree health plan benefits and Define goals and objectives
- 2 Obtain data on retiree medical & Rx costs and retiree needs and expectations
- 3 Determine long term budget and coverage options—including pre and post Medicare offerings
- 4 Estimate cost/savings of each approach for plan and retirees (Federal 28% subsidy amount vs. Medicare Advantage & PDP vs. supplemental approach)
- 5 Set new vesting, funding and retiree contribution rules/levels
- 6 Select health care vendors that are experienced and committed to this market
- 7 Implement strategy. Communicate changes if applicable. Obtain subsidies. Calculate new accounting liabilities

Questions

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