How Public Sector Employers Can Manage Retiree Health Liabilities

Changes in the Governmental Accounting Standards Board (GASB) reporting requirements will increase the liabilities of many state and local government health plans in 2018. Although many public employers already have taken steps to control their retiree health benefit liabilities, additional actions may be helpful in the near future. The private sector has experienced similar changes and has been very aggressive in working to minimize their effect. This article describes strategies that many private companies have used to avoid a significant liability increase and can serve as a road map for public sector employers in dealing with GASB changes.

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Public sector employers already face growing financial challenges in offering retiree health benefits and will be hit even harder this year when revised Governmental Accounting Standards Board (GASB)[1] reporting requirements significantly increase employer liabilities. (See the sidebar "What's Going On?") State and local governments can benefit by looking to private sector employers that encountered similar challenges in the 1990s, which were exacerbated by changes to accounting requirements. Since then, private sector employers have developed a number of effective approaches to provide benefits and strategies to deal with the changes.[2]

Options to address the challenges that will result from the new GASB standards include using traditional tactics such as adjusting the plan design, redesigning the employer's retiree contribution and eligibility strategies, or modifying the prescription plan by implementing a Medicare Part D employer group waiver plan (EGWP) plus a wrap. Although most public sector employers have been making incremental modifications in recent years to control rising costs, they may want to consider making more significant changes if they have not already done so. Other options include using private Medicare exchanges and Medicare Advantage (MA) plans and eliminating separate prescription drug coverage for Medicare retirees, which we discuss in depth in this article.

Traditional Options

Many employers in both the private and public sector have modernized their retiree health plan design, as well as their contribution and eligibility approaches, with great success by using the following strategies:

- **Adjusting plan design.** Over the years, many employers have redesigned their plans by changing the deductibles,

coinsurance and copayment levels. In addition, some have altered the way their plan coordinates with Medicare (i.e., reducing the level of reimbursement provided after Medicare pays its portion of the claims). These methods shift costs to members as they use the plan.

- **Redesigning the plan retiree contribution.** As the cost of medical care and prescription drugs continues to rise at a rate greater than general inflation, many public sector employers have implemented a monthly retiree premium cost share for all retirees. Sharing the cost in this manner avoids having the sickest retirees pay the most for using their benefits. Another strategy is to change the plan's premium cost share for the retiree plan from a percentage of the cost to a flat-dollar amount (i.e., defined contribution),[3] which would protect the plan from inflation and rising health care costs.
- **Changing plan eligibility strategies.** Specific strategies include updating age and service requirements. More significant changes include eliminating the retiree health benefit for certain groups (e.g., new hires and/or spouses of future retirees). Since these changes could have political consequences and could affect retirement patterns, employers always need to consider who wins and who loses under any change in the eligibility formula.
- **Implementing an EGWP plus a wrap.** Many plans have transitioned from participating in the Medicare retiree drug subsidy (RDS) program to a Medicare Part D EGWP plus a wrap to maximize revenues from the Centers for Medicare & Medicaid Services (CMS), often while mirroring the current plan of benefits. An *EGWP* is a group-sponsored Medicare Part D prescription drug plan, which may have an enhanced benefit beyond the Standard Part D benefit and qualifies for all subsidies available to other Medicare Part D plans. A change in Medicare Part D coverage as part of the Patient Protection and Affordable Care Act of 2010 (ACA) resulted in CMS revenues for EGWP (i.e., direct subsidy, coverage gap discount, federal reinsurance, low-income subsidy) that are typically greater than those for RDS and are available only to Medicare Part D plans. In addition, EGWP revenues can offset other postemployment benefits (OPEB) liabilities under GASB rules, while RDS revenue cannot. Employers that still participate in the RDS should review the feasibility of an EGWP, which has the potential to reduce both liabilities and annual cash expenditures while offering comparable coverage.

With the expansion of Medicare offerings, the change in worker retirement needs and the pressures of growing retiree/active-worker ratios suggest a need to revisit these strategies. In addition, due to the updated GASB requirements, employers may need to look to the additional options discussed below.

Using Private Medicare Exchanges

One option that private sector employers pioneered is becoming increasingly common among public sector employers: replacing retirees' current group Medicare medical and prescription drug plans with a private Medicare exchange. With this option, the employer makes a defined contribution to a sponsored health reimbursement arrangement (HRA) for retirees to use to purchase individual coverage.[4]

A *private Medicare exchange* is a marketplace through which retirees can evaluate the differences in cost and coverage among available health plan options and/or insurers and purchase the plan that best meets their needs within their price range. Available health plans could include Medicare supplement, Medicare Advantage (MA) and Medicare Part D plans. These exchanges typically offer high-level call center support to help retirees evaluate and choose a health plan. A website supplements the call center. Companies and nonprofit organizations own and operate private Medicare exchanges.

To help retirees purchase coverage under a plan offered through a private Medicare exchange, employers can make an annual deposit to an HRA in each retiree's name. Retirees can then be reimbursed tax-free from their HRA to help pay for the cost of coverage. Some employers implement tiered contributions (e.g., based on years of service or family status) and/or annually indexed increases for HRA contributions to help offset a portion of premium increases. Retirees pay their monthly premium and are reimbursed through their HRAs for all or a part of the premium. The reimbursement amount depends on how much money the employer deposits to their HRAs and the amount of the premium for their chosen plan.[5]

Retirees currently covered under a public employer's medical retiree health plan who move to a private Medicare exchange could potentially choose from several plan options. The number of choices and rates may vary depending on where retirees live, age, gender, smoking status and the private Medicare exchange the employer chooses.

The cost of insurance in the individual Medicare market, including the plans available through a private Medicare exchange, often is competitive when compared with the cost of public employer-sponsored group Medicare coverage. The reasons include the large number of individuals in the Medicare risk pool as well as the large increase in the number of retired Baby Boomers. As Boomers continue to age into Medicare eligibility, the overall average age of participants in the individual plans offered by private Medicare exchanges has decreased and often is lower than the average age of public employer Medicare populations. Younger retirees tend to have fewer health needs and, thus, lower expenses. These lower expenses have slowed the growth in the average cost of plans available through a private Medicare exchange. In addition, the larger number of individuals in the Medicare risk pool results in more stable year-over-year premium rate increases than most other group plans. Other factors resulting in lower costs under a private Medicare exchange include carrier competition and pricing efficiencies, which have led to competitive premiums.

Under a private Medicare exchange, retirees may elect to *buy up* and purchase coverage that costs them more. If they do, they would likely pay less to receive care or services when needed. As an alternative, retirees can *buy down* and purchase coverage that costs them less. If they do, they would likely pay more to receive care or services when needed.

Generally, individuals who pay higher premiums are older, get sick more often and/or have chronic health conditions—particularly those with high prescription drug use. If some Medicare participants must pay more for coverage under a private Medicare exchange,

What's Going On?

Over the next year, Governmental Accounting Standards Board (GASB) Statement No. 75 (GASB 75) will replace GASB Statement No. 45 (GASB 45), which has been in effect for more than ten years.[1] This will increase public employers' reported financial liability for retiree health benefits or other postemployment benefits (OPEB) in their financial statements.

Here are the most significant changes:

- Where GASB 45 allows for gradual recognition of the unfunded OPEB liability, GASB 75 requires the entire liability to be reported on the balance sheet.[2] As a result, an employer's reported OPEB liability could increase significantly.
- The discount rate used to calculate the OPEB liability under GASB 75 for unfunded plans must be based on a municipal bond index. Using this index, the discount rate will likely be lower than the discount rate used to calculate the liability under GASB 45. The lower discount rate will result in a higher OPEB liability.
- Under GASB 45, many of the changes that occur between valuations (e.g., changes in actuarial assumptions, plan experience and benefit design changes) could be recognized in the employer's income and expense statement over 30 years. Under GASB 75, these changes must be recognized immediately or over a much shorter time. As a result, the annual expense for OPEB will vary much more dramatically from year to year than it does currently. This will increase the volatility of the employer's income and expense statement.

Why This Is Important

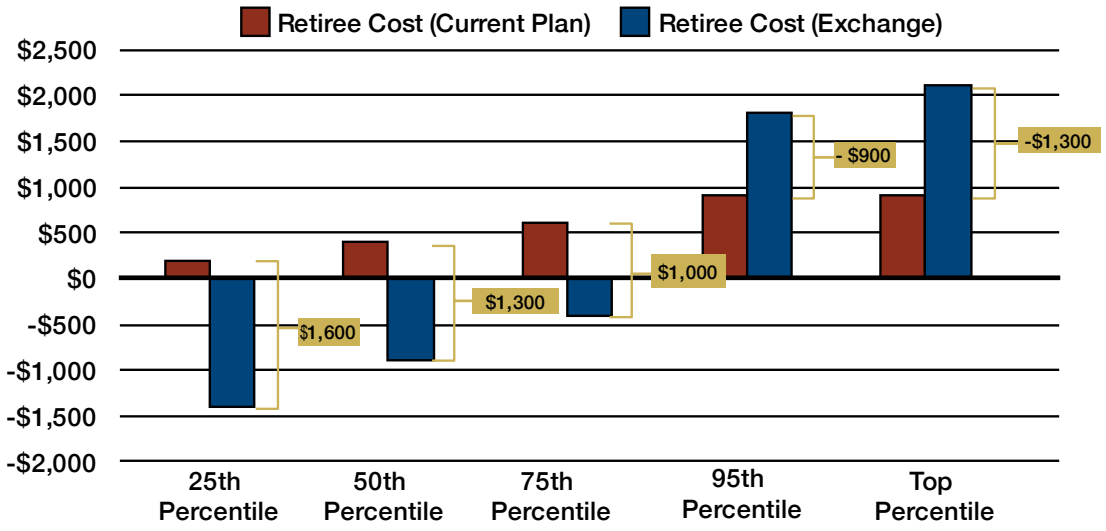
The higher reported liability could have the potential to affect the employer's bond rating and influence its ability to borrow. For certain public sector employers, this may also increase the perceived need to fund the OPEB plan, similar to what is currently done for pension plans. Finally, the increased volatility in the annual OPEB expense could also place strains on annual budgets.

As a result of these changes, many public sector employers will want to look for ways to ensure that these liabilities are under control.

1. GASB 75 is effective for employer fiscal years beginning after June 15, 2017.
2. GASB mandates that all state and local governmental entities that provide OPEBs report the cost of these benefits on their annual financial statements.

FIGURE 1

Illustrative Impact Analysis
Moving to a Private Exchange—With Catastrophic Protection*



Change in total out-of-pocket costs from the projected costs in the current plan to the projected costs in the individual market. Positive values represent savings, and negative values represent additional cost for the retiree.

*The percentiles above represent utilization profiles of sample Medicare participants, based on total claims. The lower the percentile, the lower the overall utilization of the participant.

Source: Segal Consulting.

the employer can consider establishing a catastrophic coverage program to limit retirees' risk of potentially high prescription drug out-of-pocket costs.

By switching from an employer-sponsored Medicare medical and prescription drug plan to a private Medicare exchange, employers eliminate third-party plan administration costs and much of their administrative responsibilities. However, the transition may require a significant investment of staff resources and time. Typically, a transition of this kind needs an implementation time frame of at least a year, particularly if the employer uses a procurement process to choose an exchange vendor.

Transition to a private Medicare exchange requires a thorough communications campaign. The campaign must educate retirees about the transition, help them understand their new health plan options, ensure they understand the need to elect new health coverage, and explain how and when to do so.

Most private Medicare exchange vendors provide some level of communications support to aid in the transition. However, if that level of support does not meet the employer's standards or the retirees' needs based on the complexity of the change, the employer may want to purchase additional communications assistance from an employee benefits communications consulting expert to support its retirees.

Public sector employers could see a significant reduction in their OPEB liability for the cost of retiree health and improve their cash flow by moving to a defined contribution approach with a private Medicare exchange. As with all options, the impact will depend on the degree to which the employer contributes to the HRA and whether the subsidy changes (e.g., stays flat or increases to offset future trend increases).

It is important to consider how switching to a private Medicare Exchange would affect retirees. As with any plan redesign, changes would affect

some more than others. Figure 1 is an illustrative example of a retiree impact analysis that should be performed during the evaluation process. Note that the retiree impact will vary from employer to employer based on the current plan design and the defined contribution provided. For participants where the total cost is negative, the defined contribution provided is projected to exceed the total out-of-pocket costs in the individual market by that amount.

Using Medicare Advantage Plans

Another common option for public sector employers involves implementing *MA plans,* which are private health plans offered by insurance companies to retirees looking for health coverage in the Medicare marketplace. These plans (formally known as Medicare + Choice) are part of the Medicare Modernization Act enacted in 2003 and now cover about a third of all Medicare beneficiaries.

MA plans replace health coverage offered through Medicare Parts A and B (if prescription drugs are part of the MA plan, the plan also would cover Part D). They also often provide additional benefits, such as vision and hearing care.

These plans are typically fully insured, generally require the payment of deductibles before the plan pays benefits and require coinsurance and/or copayments at the time of care. Insurance companies that provide these plans receive a per person (capitated) payment from CMS to subsidize the cost of coverage. This capitated payment varies by county, the health and demographics of the members covered by the insurance company within that county and the overall quality of care provided by the insurance company.

Insurance companies that provide MA plans manage all of the claims, risk adjustment and clinical programs that are included as part of their plan. Insurance companies are incentivized to manage risk, maximize CMS funding through risk-adjustment strategies and minimize claim cost through medical-management strategies, while maintaining a high level of member satisfaction. The better the insurance companies are with this management process, the greater the payment they receive from CMS. These greater CMS payments to the insurance companies can be passed from the employer on to participants in the form of lower insurance premiums and/or a higher level of benefits.

MA plans can be health maintenance organizations (HMOs) or preferred provider organizations (PPOs). In the employer group insurance marketplace, if 51% of a PPO group's membership lives in the network service area of the MA plan, the product may be a *passive* PPO. This means that the plan offers the same level of benefits regardless of whether a retiree uses an in-network or out-of-network provider, as long as that provider accepts Medicare. For individual insurance market plans and for groups that do not meet the 51% threshold, members must visit in-network providers to receive the highest level of benefits the plan offers.

Over the past few years, many employers have implemented national group passive PPO MA plans. In such situations, benefits provided by the passive PPO MA plan can mirror the plan the employer offered before switching to the MA plan. See the table for a comparison of individual vs. group MA plans. Moreover, in making the switch, the employer can achieve significant savings—in some cases, more than 25%. These savings result from the insurance company's ability to manage claims and receive the highest possible subsidy offered by CMS. Insurance companies often implement robust care-management programs (e.g., house calls from clinicians, disease-management programs, wellness programs) in order to receive the highest reimbursement available from the federal government. This ultimately lowers the MA plan premium.

While moving to an MA plan has been cost-effective for many employers and employees, public sector employers must carefully analyze the benefits, opportunities and potential savings that would accrue to their specific plan as well as any potential problems. For example, one large public sector employer that looked into implementing an MA plan discovered the savings opportunities and vendor choice were currently very limited in that particular state.

Savings opportunities vary according to a number of factors, including the presence of an MA plan, the profile of the employer's retiree population and where retirees reside.

Eliminating Prescription Drug Coverage for Medicare Retirees

Many public sector employers already have changed their Medicare prescription drug plan by moving to an EGWP plus a wrap (as detailed earlier in this article) as a way to

TABLE

Comparing Medicare Advantage (MA) Plans

	Individual	National Group/Passive Preferred Provider Organization (PPO)
Geographic Availability	Limited to individuals in areas with viable contracted networks	National service area includes all U.S. counties
Plan Type	Primarily health maintenance organization (HMO)	Primarily nondifferential PPO*
Provider Access	Contracted providers only	Virtually all Medicare providers
Design Variations	Limited to plans filed within each geographic market	Unlimited benefit variations customized to each group's needs (within general Centers for Medicare and Medicaid Services (CMS) guidelines)
Benefit Levels	Limited benefit enhancements beyond original Medicare	Can provide more comprehensive benefits equal to original Medicare plus employer secondary plan
Prescription Drug Coverage	Minimum brand-drug coverage in the "donut hole." Generic coverage also may be limited.	Typically provides coverage within the "donut hole," which significantly reduces retiree out-of-pocket costs
Financial Support	100% of funding provided by CMS	Employer subsidies result in more comprehensive benefits, reducing retiree cost sharing.

*In a *nondifferential, or passive, PPO,* retirees can go to any provider (in or out of network) for the same cost-share structure.

Source: Segal Consulting.

maximize their CMS revenues. Those that have not yet taken this step may want to consider doing so.

As an alternative, some public sector employers are considering eliminating their Medicare retiree prescription drug plans and instead directing retirees to the Part D plans available in the individual marketplace. The infamous "donut hole" problem will be resolved in 2020,[6] which will make eliminating prescription drug coverage more palatable to employers because a comparable plan may be available in the individual market at a much lower cost for most employees.

State and local governments could eliminate a significant portion of their OPEB liability by eliminating the Medicare retiree prescription drug benefit. Eliminating the benefit typically reduces year-to-year cash payments associated with paying benefits for Medicare-eligible participants by one-half to two-thirds, since prescription drug costs tend to make up the majority of Medicare retiree claims. These governments also would see some reduction in benefit administration responsibilities.

Eliminating the Medicare retiree prescription drug plan would require retirees to purchase their own prescription drug coverage in the individual market and pay the full cost of coverage. However, employers can choose to offset some of the costs by funding an HRA or lowering the required contributions for medical coverage.

Although individual marketplace Medicare Part D plans provide comprehensive prescription drug coverage, the cov-

erage generally is not as comprehensive as that provided by prescription drug benefits offered by many state and local governments. As a result, out-of-pocket costs for Medicare retirees would rise, and those with high prescription drug use would see the greatest increases.

Medicare retirees would have more prescription drug plans to choose from compared with the typical one-size-fits-all plan offered by employers. However, with added choice comes the additional responsibility for retirees to choose the one plan out of many that best meets their needs. In addition, some plans have more restrictive formularies[7] than those offered by employers. Moreover, there is a penalty for late enrollment if retirees do not sign up for individual marketplace Medicare Part D coverage within a specific amount of time after their current coverage ends.

Employers could use a private Medicare exchange with or without an HRA, as described above, to facilitate retiree enrollment in Part D plans. Some exchanges, however, are reluctant to service just a prescription drug plan, which limits potential options, and others might charge a significant amount for doing so. If the employer does not use a private exchange, retirees would have limited support for choosing a plan.

Yet again, it is important to understand how eliminating drug coverage would affect participants across all spectrums of utilization. This will vary from employer to employer, depending on how comprehensive the plan is and the subsidy retirees receive. The people who will be worse off tend to be those at the high end of the utilization spectrum. (See Figure 2 for an illustrative impact analysis.)

One additional drawback to consider is that fewer Medicare retirees might enroll for prescription drug coverage. This may lower their medication compliance, which could adversely affect their health. That, in turn, could increase the employer's medical claims budget.

Important Considerations

It is important to think through how each change in retiree health care coverage will affect all retirees. Moreover, the appetite for change will depend on political pressures and the culture affecting each plan. Public employers also should consider legal requirements, union agreements and any commitments that the plan may have communicated to participants and retirees in the past. All changes should be vetted with the organization's attorneys before anything is put into effect.

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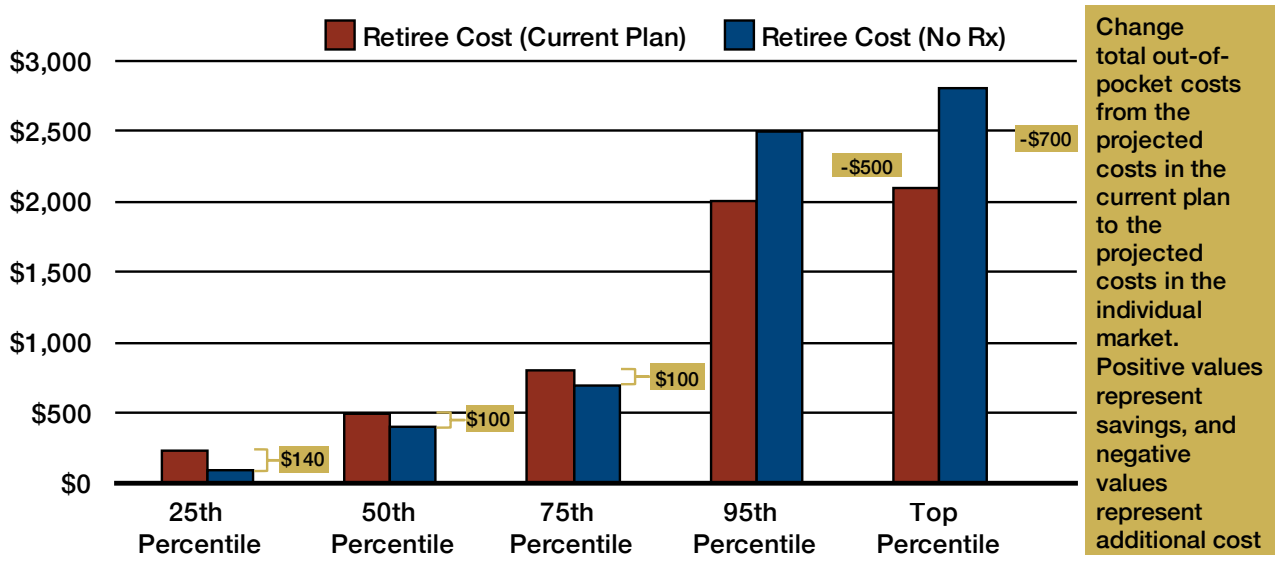
Key Takeaways

Changes in the GASB reporting requirements will increase the liabilities of many state and local government health plans in 2018. Although many employers have already taken steps to control their retiree health benefit liabilities, additional actions may be helpful in the near future. The good news is that the private sector has already experienced similar changes and has been very aggressive in taking steps to minimize their effect. Strategies that many companies have already used can serve as a road map for public sector employers.

Using private Medicare Exchanges, implementing MA plans and/or eliminating prescription drug coverage for Medicare retirees are three of the more innovative strategies that could potentially make sense in the public sector, in addition to more traditional options, such as modifying plan designs,

FIGURE 2

Illustrative Impact Analysts
Eliminating Drug Plan—With Catastrophic Protection*



*The percentiles above represent utilization profiles of sample Medicare participants, based on total claims. The lower the percentile, the lower the overall utilization of the participant.

Source: Segal Consulting.

changing retiree contributions, updating eligibility rules or implementing an EGWP. After decisions are made, managing the transition by understanding the impact to employees and retirees and communicating appropriately are keys to the success of the transition. Employers that have not already begun making changes may want to start thinking about what they want to do to avoid a significant liability increase. BQ

Endnotes

1. GASB sets standards for financial reporting for governmental employers and benefit plans (including retiree health benefit plans) to promote consistency and transparency in financial reporting.
2. One advantage public sector employers have over private sector employers is that their health plans have generally provided more comprehensive coverage, which gives them more opportunities to reduce their liabilities.
3. A *defined contribution (DC)* represents a fixed dollar amount or contribution by the employer, often to a health reimbursement arrangement (HRA). This is not related to a DC retirement plan (e.g., a 401(k) or 403(b)) where an employer may fund a retirement plan account during active service.
4. An *HRA* is an employer-funded, tax-advantaged employer health benefit plan. It allows employees or retirees to be reimbursed tax-free for individual health insurance premiums and eligible out-of-pocket medical expenses (e.g., deductibles, copayments, coinsurance). Employers typically contribute to their employees' and retirees' HRAs each year.
5. In order for this process to work, the HRA must be a retiree-only plan and cannot be available to active employees.
6. The *donut hole* emerged in 2003 when Medicare was expanded to include prescription drug coverage through the creation of Medicare Part D as part of the Medicare Modernization Act. After participants met their deductible, Medicare Part D plans originally covered prescription drugs up to a certain cost threshold, after which they had to pay 100% of the cost of drugs until their total reached the yearly out-of-pocket spending limit. With the introduction of the Affordable Care Act (ACA) in 2010, Medicare Part D was updated, and steps were taken to gradually close the donut hole until it reaches a member cost share of 25% in 2020.
7. A *formulary* is a list of prescription drugs available to participants.

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