Retiree Health Care
Lots of Concern and Discussion

“States Aim Ax at Health Cost of Retirement.”
—New York Times (Feb 13, 2011)

“Your Vanishing Health Coverage: Employers Are Cutting Retiree Health Benefits at a Rapid Rate.”
—Los Angeles Times (May 11, 2016)

“US local governments take budget knife to retiree health plans.”
—Reuters (October 15, 2012)

“Retiree health benefits: Facing extinction?”
—Marketwatch (April 10, 2013)

“State OPEB Funding Has Improved.”
—Plan Sponsor (May 16, 2016)

“How to pay for health care in retirement.”
—USA Today (November 1, 2014)

“Health-Care Cuts Driving Public Workers’ Retirement Delays”
—Governing (August 20, 2014)

“Four Options for Saving Medicare from Collapsing under its Own Weight.”
—National Center for Policy Analytics (April 11, 2016)
What is an OPEB Benefit?

**OPEB** = Other (than pension) Post-Employment Benefit

**Benefits Covered**
- Postemployment healthcare benefits
  - Medical
  - Prescription drugs
  - Dental
  - Vision
  - Hearing
  - etc.
- Other benefits if not funded by pension
  - Life Insurance
  - LTD/LTC
- COBRA

**Valued Net of Retiree Premiums**
- “Implicit subsidy” if blended with actives
New GASB Awareness

Awareness of and Concern about Changes in Accounting Methodology Is High

Awareness that GASB Statement No. 74 and Statement No. 75 will replace the requirements of GASB Statement No. 43 and Statement No. 45, respectively

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>79%</td>
<td>21%</td>
</tr>
</tbody>
</table>

Awareness of the potential of being required to use a lower investment return assumption to calculate liabilities and to report assets at market rate

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>87%</td>
<td>13%</td>
</tr>
</tbody>
</table>

Awareness of financial disclosures that will be required under Statement No. 74 and Statement No. 75 compared to those currently in effect under Statement No. 43 and Statement No. 45

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>91%</td>
<td>9%</td>
</tr>
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</table>

Source: SALGBA, Public Sector HealthCare Roundtable and Segal Consulting Public Sector Retiree Health Survey, 2016
GASB Statement Nos. 74 and 75

In June 2015, GASB released two final Statements related to Other Postemployment Benefits (OPEB)

- **Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions (Released as GASB Statement No. 75)**
  - Supersedes the requirements of GASB Statements No. 45 and No. 57
  - Deals with employer reporting
  - Effective for fiscal years beginning after June 15, 2017

- **Financial Reporting for Postemployment Benefits Other Than Pension Plans (Released as GASB Statement No. 74)**
  - Replaces the requirements of GASB Statement No. 43 and No. 57
  - Proposes new standards for financial reporting for OPEB benefit plans
  - Effective for fiscal years beginning after June 15, 2016
## New GASB Statements
### What’s Changing?

<table>
<thead>
<tr>
<th></th>
<th>GASB 43/45</th>
<th>GASB 74/75</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CAFR Disclosures</strong></td>
<td>Footnote</td>
<td>Balance Sheet Line Item, and expanded</td>
<td>Bond rating agency interest</td>
</tr>
<tr>
<td><strong>Discount Rate</strong></td>
<td>Judgment based</td>
<td>Direct calculation based on yield curve and funded status</td>
<td>Likely lower discount rate—higher liability</td>
</tr>
<tr>
<td><strong>Actuarial Method</strong></td>
<td>6 options (many use Projected Unit Credit)</td>
<td>Entry Age Normal (salary)</td>
<td>Increase in disclosures if currently use PUC</td>
</tr>
<tr>
<td><strong>OPEB Expense</strong></td>
<td>Based on ARC/AOC</td>
<td>Change in OPEB liability year to year, adjusted for deferred recognition of gains/losses</td>
<td>More complicated—some winners and some losers; Also increased volatility likely due to shorter amortization period(s)</td>
</tr>
</tbody>
</table>

GASB specifically states that the new standards are for accounting purposes only and are not for the purpose of establishing funding standards.
Main Levers to Manage Liability

➢ Advance Funding

➢ Adjust Eligibility/Access to Benefits
  • Increase age/service requirements
  • Leaner benefits for new hires

➢ Modify Benefits
  • Modified deductibles/copays

➢ Limit/Cap Employer Premium Share

➢ Utilize Alternative Models
  • Medicare Advantage/EGWP
  • Value-based incentives
  • Exchanges

Many employers and plans utilize a combination of multiple levers.
Main Levers to Manage Liability

➢ Advance Funding

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Many employers and plans utilize a combination of multiple levers.
Current Funding Practices

How Retiree Health Liabilities Are Financed

Pay-as-you-go financing is much more common than prefunding.

- Pay as You Go: 61%
- Prefund: 39%

Most of the jurisdictions that prefund have established a trust for the amount prefunded.

- Trust: 82%
- No Trust: 18%

More than half of the jurisdictions have a specific funding policy with respect to retiree health liabilities.

- Yes: 57%
- No: 43%

Source: SALGBA, Public Sector Healthcare Roundtable and Segal Consulting Public Sector Retiree Health Survey, 2016
Advance Fund vs. PAYG

- PAYG (net employer) costs count as contributions in disclosures.

- Advance funding is more expensive in the short term (because you need to fund above current PAYG costs), but results in lower annual costs the long term.
  - Investment return generates additional assets that can be used in future years to pay benefits.

Ways to initiate advance funding:

- Transfer of surplus from general plan.
- Divert (temporarily) pension contributions, if pension trust well-funded.
- Establish contribution policy, i.e.:
  - Percent of payroll.
  - Per capita, indexed for inflation.
  - “ARC”.
- Employee contributions, i.e.:
  - Percent of pay.
  - Must contribute to get retirement benefits.
  - Earmark portion of active plan contributions for OPEB trust.

Smaller Upfront Investment Generates....
...Significantly Lower Future Annual Costs.
Main Levers to Manage Liability

➢ **Advance Funding**

➢ **Adjust Eligibility/Access to Benefits**
  - Increase age/service requirements
  - Leaner benefits for new hires

➢ **Modify Benefits**
  - Modified deductibles/copays

➢ **Limit/Cap Employer Premium Share**

➢ **Utilize Alternative Models**
  - Medicare Advantage/EGWP
  - Value-based incentives
  - Exchanges

Many employers and plans utilize a combination of multiple levers.
Eligibility Rules

Four groups of participants to consider in the retiree medical plan:

1. New hires
2. Current actives
3. Current actives close to retirement
4. Current retirees

Consider implementing a retiree-only plan to allow for more flexibility in plan design and eligibility rules
Impact of ACA—Increased Focus on Retiree Only Plans

- Unless a plan is a “Retiree Only Plan”, it will be subject to all requirements of the Affordable Care Act

- Defined as a “Group Health Plan with no more than two active employees”

- General requirements for a Retiree Only Plan:
  - Summary Plan Description
  - Separate accounting
  - Separate benefits

Legal Counsel Should Review
Retiree Only Plans
ACA Compliance

Group Health Plan Mandates for grandfathered and non-grandfathered plan

- Dependent coverage to age 26
- Ban on lifetime/annual dollar limits
- Ban on preexisting conditions
- Preventive services without cost-sharing
- Hospital emergency room parity
- External appeals
- Cost-sharing limitation
- Clinical trial care coverage
- Provider nondiscrimination
Retiree Only Plans
ACA Compliance

Must comply with

• PCORI fees
• Transitional reinsurance fees
• Certain reporting requirements
• Excise tax on high-cost plans (40% tax)
Retirees and the Exchange

- Exchanges will not be offering Medicare supplemental plans, but early retirees can purchase coverage on the Exchanges.

- Age rating limitations applicable beginning in 2014 may make Exchange coverage more attractive compared to pre-2014 options in the individual market.

- Employer shared responsibility penalty is not triggered if retirees obtain premium assistance tax credits in the Exchanges.

- Under proposed rule from IRS published May 3, 2013, retirees may decline retiree coverage from their employers and still qualify for a tax credit in an Exchange.
Health Reimbursement Accounts (HRAs)

**ADVANTAGES**
- *Retirees who are not eligible for the federal subsidy* would have access to funds in their account.
- Distributions are not taxable to the retiree either when credited to the retiree's account or when distributed from the retiree's account.
- Unused account balances may be used in later years.
- Accounts may be used to pay health insurance premiums or medical, dental or vision expenses.
- Contributions could continue after the retiree becomes Medicare eligible.

**DISADVANTAGES**
- *Retirees eligible for the federal subsidy* must elect to freeze distributions from their account until the end of the year in which they are no longer eligible for the subsidy.
- Unused account balances are forfeited upon death of an unmarried retiree with no covered dependents (or upon the death or loss of eligibility of the spouse and all surviving covered dependents).
Main Levers to Manage Liability

➢ Advance Funding
➢ Adjust Eligibility/Access to Benefits
  • Increase age/service requirements
  • Leaner benefits for new hires
➢ Modify Benefits
  • Modified deductibles/copays
➢ Limit/Cap Employer Premium Share
➢ Utilize Alternative Models
  • Medicare Advantage/EGWP
  • Value-based incentives
  • Exchanges

Many employers and plans utilize a combination of multiple levers.
Typical Benefit Changes

- Modified cost sharing in current plans
  - Changes to deductibles, copays, out-of-pocket limits, etc.

- Consider pre-65 retirees separately from post-65, where Medicare offers a range of options

- If truly separate retiree plan (no actives, etc.), then not limited by ACA:
  - Annual/Lifetime limitation rules do not apply
  - Out-of-pocket maximums do not apply
  - No Minimum Value requirement
  - Grandfathered status and limitations not applicable
Main Levers to Manage Liability

➢ Advance Funding

➢ Adjust Eligibility/Access to Benefits
  • Increase age/service requirements
  • Leaner benefits for new hires

➢ Modify Benefits
  • Higher deductibles/copays

➢ Limit/Cap Employer Premium Share

➢ Utilize Alternative Models
  • Medicare Advantage/EGWP
  • Value-based incentives
  • Exchanges

Many employers and plans utilize a combination of multiple levers.
Cap on Plan or Employer Subsidy

- Can freeze employer costs at current levels, or when costs reach specific level (i.e. $12,000 PMPY)
- “Hard cap”—no future increases
- “Soft cap”—future increases below trend
  - Could be ad-hoc or indexed (medical-CPI)
Main Levers to Manage Liability

➢ Advance Funding

➢ Adjust Eligibility/Access to Benefits
  • Increase age/service requirements
  • Leaner benefits for new hires

➢ Modify Benefits
  • Higher deductibles/copays

➢ Limit/Cap Employer Premium Share

➢ Utilize Alternative Models
  • Medicare Advantage/EGWP
  • Value-based incentives
  • Exchanges

Many employers and plans utilize a combination of multiple levers.
ACA and Medicare Part D Changes

STANDARD MEDICARE PRESCRIPTION DRUG BENEFIT, 2010

- 5% paid by enrollee
- 15% paid by insured plan; 80% by Medicare
- 75% paid by insured plan
- 25% paid by enrollee
- 100% paid by enrollee

STANDARD MEDICARE PRESCRIPTION DRUG BENEFIT, 2020 WITH HEALTH REFORM

- 5% paid by enrollee
- 15% paid by insured plan; 80% by Medicare
- 25% paid by enrollee
- BRANDS: 50% discount 25% paid by insured plan
- GENERICS: 75% paid by insured plan
- 75% paid by insured plan
- 25% paid by enrollee
- 100% paid by enrollee

Deductible

Initial coverage limit

Catastrophic coverage
# Coverage Gap

You’ll Pay this Percentage for Drugs in the Coverage Gap

<table>
<thead>
<tr>
<th>Year</th>
<th>Brand-Name Drugs</th>
<th>Generic Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>45%</td>
<td>65%</td>
</tr>
<tr>
<td>2016</td>
<td>45</td>
<td>58</td>
</tr>
<tr>
<td>2017</td>
<td>40</td>
<td>51</td>
</tr>
<tr>
<td>2018</td>
<td>35</td>
<td>44</td>
</tr>
<tr>
<td>2019</td>
<td>30</td>
<td>37</td>
</tr>
<tr>
<td>2020</td>
<td>25</td>
<td>25</td>
</tr>
</tbody>
</table>
Medicare Rx (Part D) Coverage: What Happens Next?

1. Continue to provide current Rx benefit and participate in the Centers for Medicare and Medicaid (CMS) retiree drug subsidy (RDS) program
   - RDS provides for 28% subsidy for each retiree’s drug spend between $310 – $6,350 (in 2014)
   - Requires annual actuarial attestation
   - Requires CMS periodic reporting and annual reconciliation of costs
   - No member impact

2. Transition to an Employer Group Waiver Plan (EGWP)
   - EGWP provides for increased subsidy compared to RDS
   - Does not require CMS actuarial attestation, reporting, and reconciliation of costs
   - May be structured to “wrap” existing benefit plan
   - Some member impact, such as formulary changes and step therapy
   - Extensive regulatory oversight and modified communications requirements

For very large retiree groups, becoming a Part D Prescription Drug Plan (PDP) is also an option.
Medicare Advantage Enrollment Growth

TOTAL MEDICARE PRIVATE HEALTH PLAN ENROLLMENT
1999–2016

In millions of people:

% of Medicare Beneficiaries

18% 17% 15% 14% 13% 13% 13% 16% 19% 22% 23% 24% 25% 28% 30% 31% 31% 31%


6.9 6.8 6.2 5.6 5.3 5.3 5.6 6.8 8.4 9.7 10.5 11.1 11.9 13.1 14.4 15.7 16.8 17.6

NOTE: Includes MSAs, cost plans, demonstration plans, and Special Needs Plans as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses and beneficiaries in territories other than Puerto Rico.

Medicare Advantage Enrollment by State

SHARE OF MEDICARE BENEFICIARIES ENROLLED IN MEDICARE PRIVATE PLANS, BY STATE, 2016

National Average 2016 = 31%

NOTE: Includes MSAs, cost plans and demonstrations. Includes Special Needs Plans as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses and beneficiaries in territories other than Puerto Rico.

SOURCE: Authors’ analysis of CMS State/County Market Penetration Files, 2016.
Exchanges

- Medicare exchanges generally provide access to the individual MA market
- Some options to provide access to group MedSupp plans
- Key considerations for pursuing a Medicare Exchange include:
  - Balancing choice and uniform options for all retirees
    - Options vary by county and some retirees may only have MedSupp options and/or high premium options
  - Lack of coverage options for disabled/ESRD retirees and retirees without Part A
  - Generally requires conversion to a defined dollar benefit
    - Could achieve significant savings with similar conversion in current program
    - Some retirees will be exposed to higher premiums and costs, depending on location
  - Has the effect of “dis-associating” the employer from retired employees
  - Communication and education effort will be significant

Generally does not generate savings or liability reduction unless allowance is less than current average subsidy
Marketplace Enrollment 11/1/15-2/1/16

METAL LEVEL PLAN SELECTION
(12.7M Enrollees)

- Silver: 68%
- Bronze: 23%
- Gold: 6%
- Platinum: 3%
- Catastrophic: 1%

Marketplace Enrollment with Subsidies

- More than 8 in 10 individuals (nearly 8.1M, or 85%) who enrolled in a 2016 plan through the Marketplaces in the HealthCare.gov states qualify for a subsidy, with an average value of $290 per person per month
  - 38 states use the HealthCare.gov platform as of March 11, 2016

- The average subsidy covers about 73% of the gross premium

- The average net premium after subsidy is $106 per month

- Of those enrolled in the Marketplace, 3,262,215 are age 55-64 (26% of total enrollees). Another 2,682,762 (21%) are age 45-54

### What are Jurisdictions Doing?

#### Jurisdictions Taking Action to Address Current and Future OPEB Liabilities

<table>
<thead>
<tr>
<th>Action</th>
<th>Completed</th>
<th>Partially implemented</th>
<th>Alternatives identified</th>
<th>Preliminary discussions held</th>
<th>Not considered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes to eligibility for retiree health benefits</td>
<td>23%</td>
<td>11%</td>
<td>9%</td>
<td>23%</td>
<td>34%</td>
</tr>
<tr>
<td>Changes to cost share for retiree member coverage</td>
<td>23%</td>
<td>4%</td>
<td>11%</td>
<td>23%</td>
<td>39%</td>
</tr>
<tr>
<td>Changes to cost share for dependent coverage</td>
<td>21%</td>
<td>7%</td>
<td>23%</td>
<td></td>
<td>48%</td>
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<tr>
<td>Changes to benefit levels for retiree health plans</td>
<td>18%</td>
<td>4%</td>
<td>5%</td>
<td>29%</td>
<td>44%</td>
</tr>
<tr>
<td>Adding Medicare Advantage Employer Group Waiver Plan (MA EGWP) for eligible retirees</td>
<td></td>
<td></td>
<td></td>
<td>57%</td>
<td>11%</td>
</tr>
<tr>
<td>Introducing high-deductible plan for retirees and/or dependents</td>
<td></td>
<td></td>
<td></td>
<td>34%</td>
<td>7%</td>
</tr>
<tr>
<td>Providing a defined contribution health benefit plan to retirees and/or dependents</td>
<td></td>
<td></td>
<td></td>
<td>20%</td>
<td>11%</td>
</tr>
<tr>
<td>Offering Exchange coverage to non-Medicare retirees and/or dependents</td>
<td></td>
<td></td>
<td></td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>Eliminating the retiree health care benefits</td>
<td></td>
<td></td>
<td></td>
<td>4%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Source: SALGBA, Public Sector Health Care Roundtable and Segal Consulting *Public Sector Retiree Health Survey, 2016*
### Jurisdictions Are More Likely to Deem Changes “Important” than to Implement Them

<table>
<thead>
<tr>
<th>Policy Area</th>
<th>Importance</th>
<th>Very</th>
<th>Somewhat</th>
<th>Neutral*</th>
<th>Somewhat</th>
<th>Not at All**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cut Employer Subsidies for Retiree Health Benefits</td>
<td>30%</td>
<td>27%</td>
<td>9%</td>
<td>5%</td>
<td>29%</td>
<td></td>
</tr>
<tr>
<td>Carve Out Retirees to a Separate Plan</td>
<td>18%</td>
<td>27%</td>
<td>13%</td>
<td>9%</td>
<td>33%</td>
<td></td>
</tr>
<tr>
<td>Planning to Cut Eligibility</td>
<td>18%</td>
<td>18%</td>
<td>18%</td>
<td>8%</td>
<td>38%</td>
<td></td>
</tr>
<tr>
<td>Cut Benefit Levels</td>
<td>16%</td>
<td>32%</td>
<td>9%</td>
<td>14%</td>
<td>29%</td>
<td></td>
</tr>
<tr>
<td>Shift Non-Medicare Retirees to a State Exchange</td>
<td>9%</td>
<td>21%</td>
<td>13%</td>
<td>9%</td>
<td>48%</td>
<td></td>
</tr>
</tbody>
</table>

*Neither likely nor unlikely
**Unimportant or unlikely

Source: SALGBA, Public Sector HealthCare Roundtable and Segal Consulting Public Sector Retiree Health Survey, 2016
Case Study: Description of Situation

☑️ Large public sector employer with a $542M OPEB liability in 2015 that is expected to reach $1B by 2020

☑️ No assets, only a small trust that was not specific to OPEB

☑️ Population of approximately 19,000 active employees, 5,000 of which are eligible to retire

☑️ Capped benefit rate

☑️ When measured against their peers, this employer had a very generous eligibility requirement for OPEB
  • 60 and 5; 55 and 10

☑️ Contributions were based on years of service
Impact of Closing Plan to New Hires (in millions)
Plan Design: Total Replacement with Medicare Advantage

Impact on Over 65 Retiree Liability by Moving to MAPD (in millions)
Impact on Over 65 Retiree Cash Payments by Moving to MAPD (in millions)
Plan Funding: DC for Non-Grandfathered Actives

Impact of Defined Contribution on Active Liability (in millions)

Current

Defined Contribution
Case Study: Results

- Closed plan to new hires
- Grandfathered current retirees and those that reached age 60 with 20 years of service by effective date
- Moved all Medicare eligible retirees to Medicare Advantage plans with same or similar benefits
- Eligibility for OPEB was changed to 60 & 20
- All others received a defined contribution plan where the employer subsidy is based on years of service
- Moved to creating an OPEB trust with a desire to fully fund benefits in 40 years
- Reduced the 2020 liability by half
Retiree Health Redesign Strategies

Establish Parameters

- What role does the retiree medical program play in recruitment and retention/total rewards?
- Are there key late career hires? If so, what is an appropriate service requirement for retiree medical eligibility for them?
- What promises have been made to current retired and active employees?
- Could/should the program be different for new hires?
- What age should a long term employee target for retirement?
- How do you want your program to compare to your peers?
- What aspects of the program are available to change and what are “untouchable”?
- Is the current program sustainable?
- What is an acceptable cost for these types of programs
  - For the employer? For retirees?
Thank you!

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