Public Plan Approaches to Retiree Health Coverage

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Retiree Healthcare Strategy
Via Benefits by WTW
Providence, Rhode Island

International Foundation
OF EMPLOYEE BENEFIT PLANS

Topics

- Retiree Health Coverage Overview
- Early Retirees
  - Overview
  - State of the market (stabilization, future of certain tax credits)
- Medicare Retirees
  - What's new—Inflation Reduction Act
  - Medicare basics
  - 'Case studies'

Retiree Healthcare Is Challenging

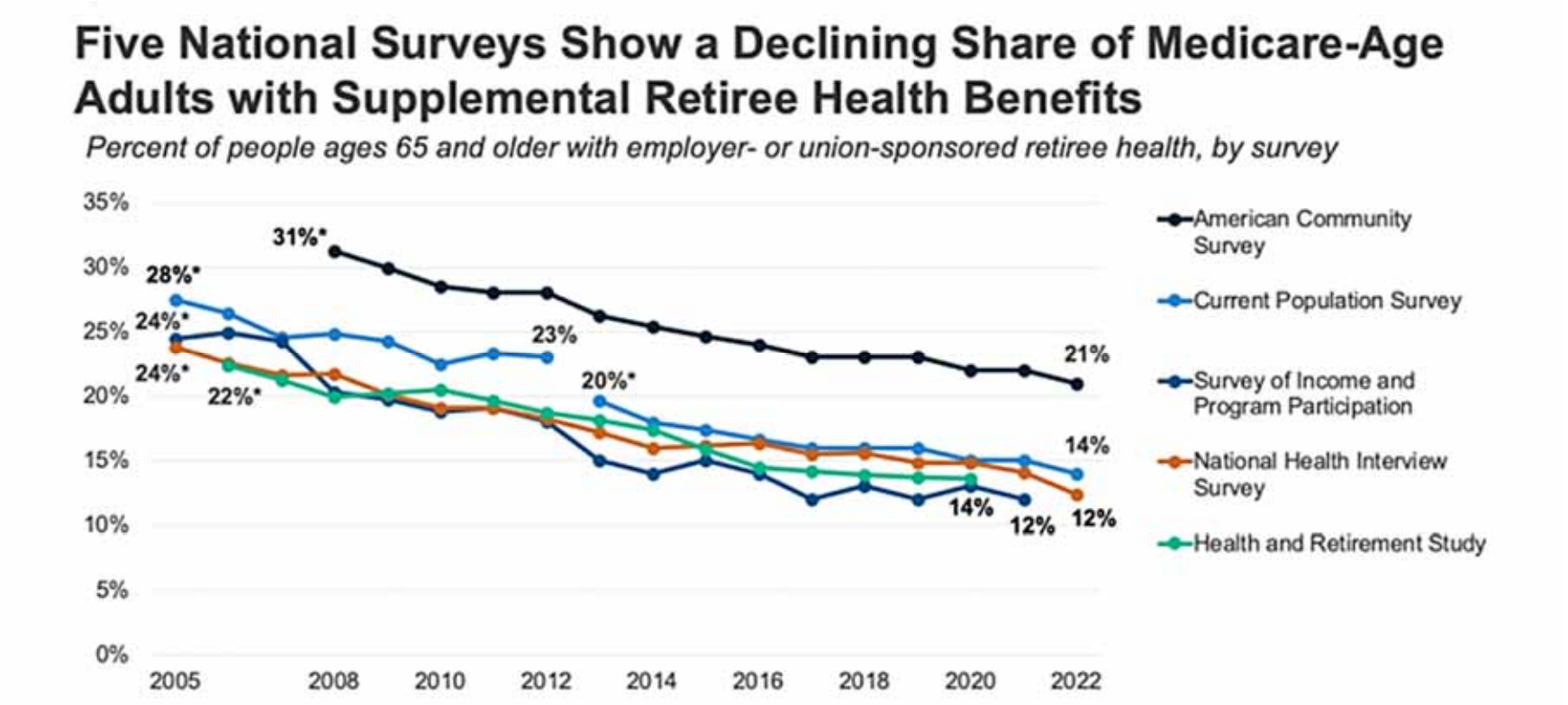
Experts say the average couple will need over $315,000 to cover healthcare costs in retirement*

Retirees need help managing this costly item

Today's employees will need help when they retire

* Fidelity: www.fidelity.com/learning-center/wealth-management-insights/how-to-prepare-for-health-care-costs-in-retirement#

Yet Retiree Health Coverage Is Declining



Source: Kaiser Family Foundation: Retiree Health Benefits: Going, Going, Nearly Gone? Published: Apr 12, 2024

Polling Question

What is contributing most to the decline in retiree health coverage? (rank them)

A. Union membership has declined, reducing pressure on employers to provide benefits
B. Improvement in Medicare benefits reduces need for employer coverage
C. Rising cost of healthcare requires employers to emphasize support of active employee health

WTW Best Practices in Health Survey 2024

Does your organization provide access to and/or financial support toward retiree healthcare benefits to any current retirees, current employees or new hires?

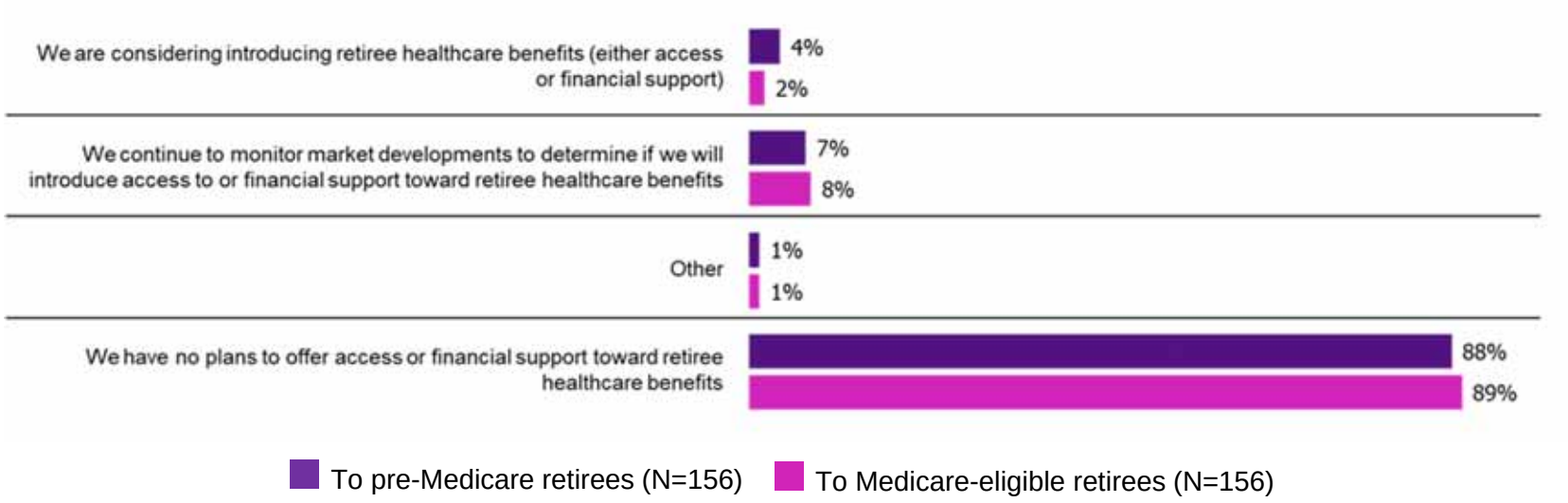
	Only to Pre-Medicare retirees	Only to Medicare-eligible retirees	Both Pre-Medicare and Medicare-eligible retirees	No access or financial support
Current retirees (N=359)	8%	4%	38%	50%
Current employees (N=339)	14%	2%	28%	56%
New hires (N=317)	9%	1%	17%	72%

Note: Row percentages may not sum up to 100% due to rounding.
Source: WTW 2024 Best Practices in Healthcare Survey.

Most Employers Do Not Intend to Offer a New Plan in the Future

Based on organizations without retiree medical plans

Which response below best characterizes whether your organization will introduce retiree healthcare benefits in any form to current employees or retirees?



Note: Percentages may not sum up to 100% due to rounding.
Sample: Based on no access or financial support provided to current retirees, current employees or new hires.
Source: WTW 2024 Best Practices in Healthcare Survey.

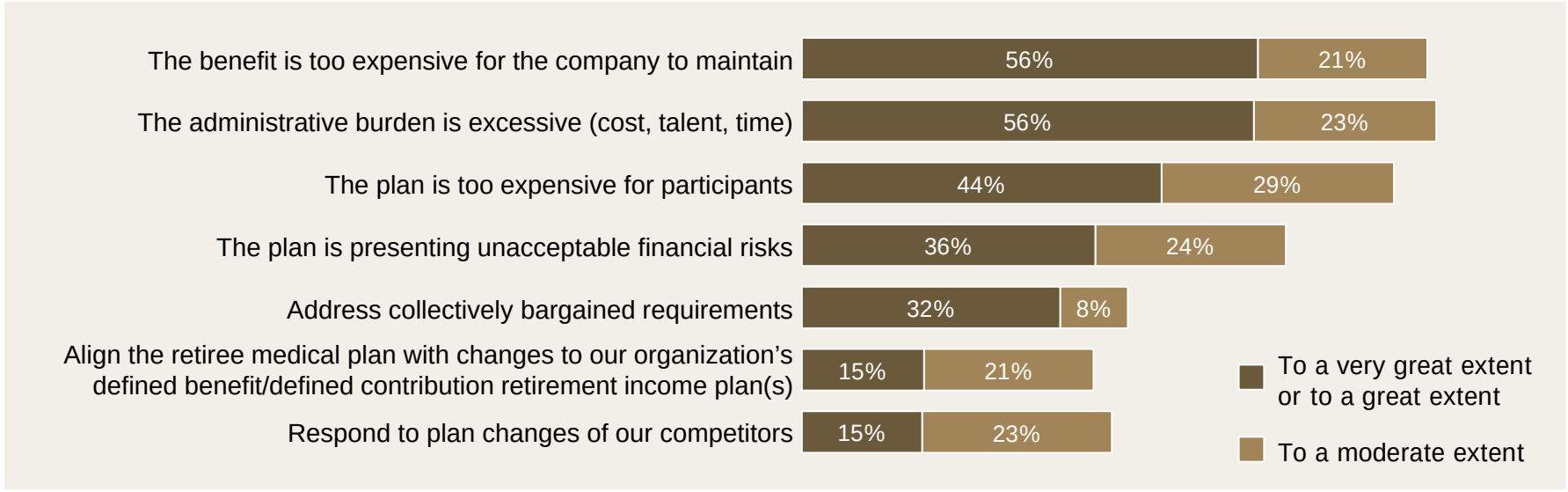
Objectives for Retiree Medical Plan

What are the top 3 objectives that your retiree medical plan achieves for your organization? (N=193)

Sample: Based on providing access to coverage and/or financial support for retiree healthcare benefits to current retirees, current employees or new hires.
Source: WTW 2024 Best Practices in Healthcare Survey

Cost Concern Is the Most Common Reason to Change Retiree Healthcare Benefits

To what extent are the following important factors in your decision to change your retiree healthcare benefits? (N=72)



Note: Percentages may not sum up to 100% due to rounding. "Not applicable" excluded.
Sample: Based on providing access to coverage and/or financial support for retiree healthcare benefits to current retirees, current employees or new hires and make or plan to make changes to its retiree healthcare benefits.
Source: WTW 2024 Best Practices in Healthcare Survey.

How Would You Design Retiree Health Coverage If Starting Today?

Why offer	Design (how)
Attraction/retention	Subsidy or not (liability implications)
Retirement readiness—Allow employees to retire on time	Delivery vehicle—Plan types
Provide comprehensive benefits planning (lifetime benefits)	Administrative burden

Polling Question

If you were starting a benefit for retiree healthcare today, what would be your primary goal?

Unique Challenges in Changing Retiree Healthcare

Challenge	Description
 **Consider any change a negative (takeaway)**	Immediate objection without consideration
 **Loud voices**	Politically, with leadership (and benefits committees), with press
 **Inability to spend more**	Fixed income combined with increasing cost of food and housing creates difficulty paying more than planned for healthcare
 **Lack of understanding**	Many on group plans don't understand Medicare and apprehensive of ability to navigate change

Pre-Medicare Retiree Health Coverage

The Challenge of Pre-Medicare Retiree Coverage

- Most expensive group to cover
- Often blended with other groups (actives/Medicare retirees)
- Plan cost often drives out best risk—Healthier retirees opt out of coverage, even foregoing subsidy
- Until recently (Affordable Care Act), no viable alternative to group coverage and lack of government subsidies (unlike Medicare)

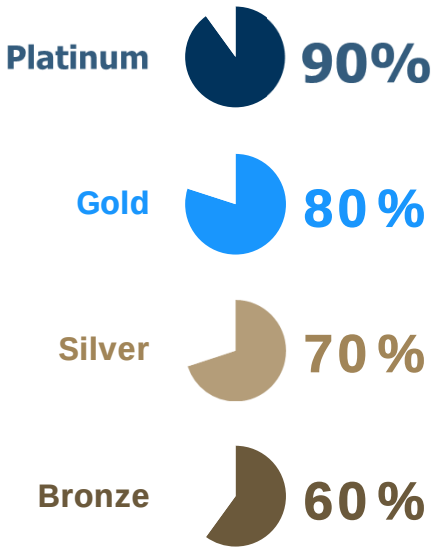
Individual Market Carriers Compete in a Regulated Marketplace

Here are the Affordable Care Act (ACA) rules you need to know:

1. Essential Health Benefits
2. Metal Tiers
3. Individual and Family Plans
4. Tax Credits for Low Income Households
5. On-Exchange and Off-Exchange Plans
6. Rating Rules—3:1 ratio

Characteristics of ACA Individual Market Plans

Plan Values



Protection and Benefits

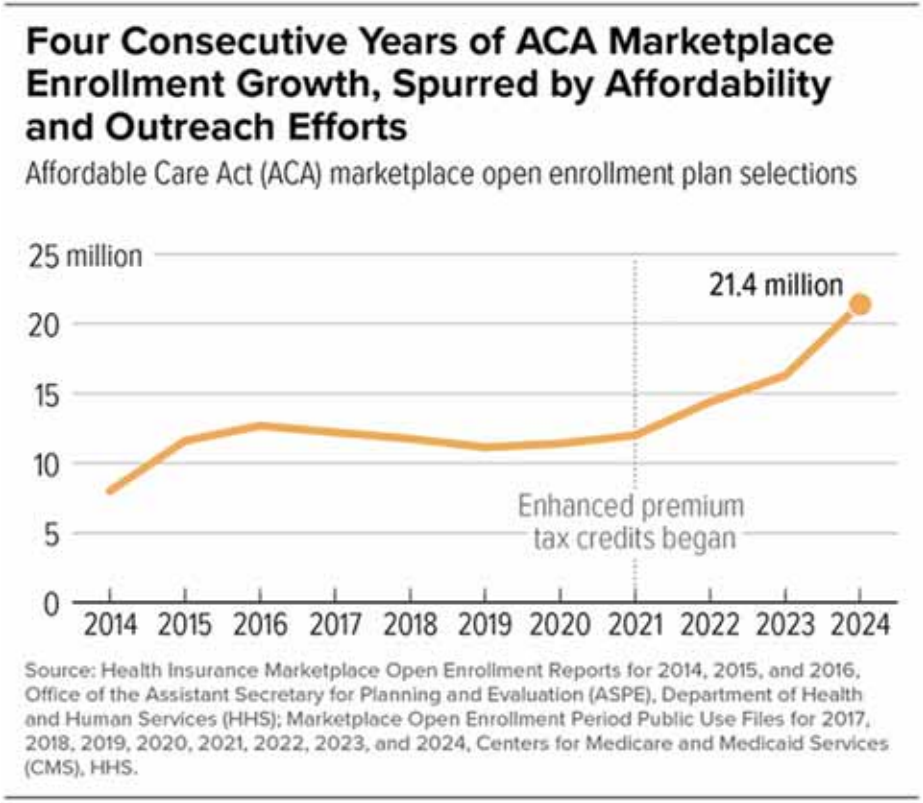
- Guaranteed issue, renewable
- No preexisting condition exclusions
- Cover all essential health benefits
- No lifetime or annual limits
- Preventive care covered at 100%
- HRA compatible
- Federal premium tax credits (direct subsidy towards premium) are an option

Rating Requirements

- Single risk pool rating*
- Rates vary by four factors
  1. Age (3:1 rating band for ages 64:21)**
  2. Geography
  3. Family size
  4. Tobacco use

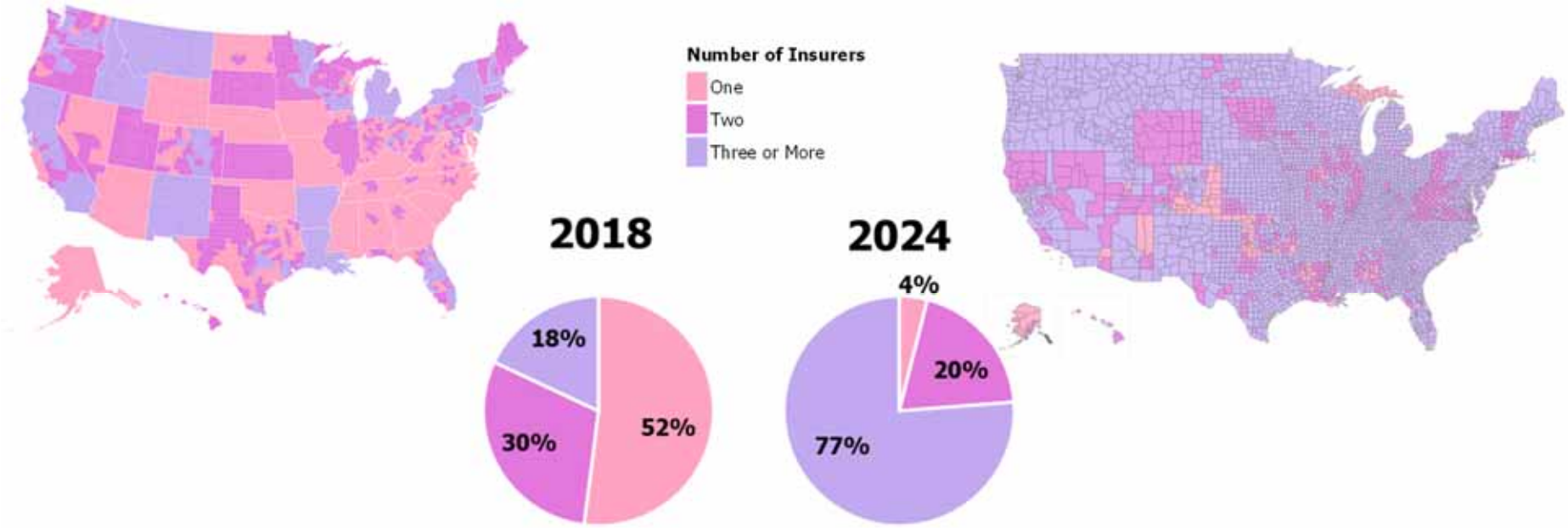
*ACA plan rates are set based on claim experience within a single risk pool including both on-exchange and off-exchange plans within a region.
**States may accept the federal 3:1 curve or adopt an alternative (e.g., community rating); most states use the standard federal age curve.

ACA Market Size



ACA Market: Increasing Choice, Sustained Premium Stability

Share of counties with 3+ insurers up from 18% to 77% since 2018.
National average premiums increased 5% in 2024.



Sources: Kaiser Family Foundation, 2018; Ideon, 2024.

Premium Tax Credit Overview

- Reduce premiums for plans purchased on a health insurance marketplace
- Amount of tax credit is based on income and cost of local plans
- Original law was up to 400% of federal poverty level (household of 2: $81,760), currently no cap on income
- Considered ‘Advance’ because it reduces premiums during the year, before tax filing
- Tax credit is reconciled when filing federal taxes

Premium Tax Credit Overview

Household Information	
State	**National Average**
Yearly household income	$100,000
Coverage available from job?	No
Number of people in family	2
Number of adults enrolling in ACA coverage	2
Age of enrollees	62, 62

Results

You are likely eligible for financial help

Based on the information you provided, your income is equal to **507%** of the poverty level. An estimate of your cost for coverage in 2024 is provided below. To find out your actual amount of financial help and to get coverage, you must go to Healthcare.gov or your state's Health Insurance Marketplace.

$17,231 per year!

Estimated financial help:	**$1,436** per month ($17,231 per year) as a premium tax credit. This covers 67% of the monthly costs.
Your cost for a silver plan:	**$708** per month ($8,500 per year) in premiums (which equals 8.5% of your household income).
The most you have to pay for a silver plan:	**8.5%** of income for the second-lowest cost silver plan
Without financial help, your silver plan would cost:	**$2,144** per month ($25,731 per year)

Source: Kaiser Family Foundation Health Insurance Marketplace Calculator.

What's New:
(1) Inflation Reduction Act: Cost Pressure on Part D
(2) Medicare Advantage Update
(3) HELPS Act (Public Safety)

Inflation Reduction Act Changes Have Broad Impact on Market

Change	Impact
Part D (Prescription drug): $2,000 out-of-pocket maximum and changes to 3rd party subsidies	• Protects some of the most vulnerable retirees • Drive premium growth and potential plan changes • CMS demonstration project to stabilize premiums
Negotiation of prescription drug prices	• Reduces Medicare costs for widely used prescriptions • Potential to shift cost to actives?
M3P	• Adds administrative cost • May reduce incentives for retirees to manage cost
Extension of enhanced tax subsidies expires 12/31/25	• If not renewed, potential to slow pre-65 market growth and premium stabilization

Medicare Advantage News

2023: $454 billion of federal spending (KFF 8/9/23)

The New York Times

TheUpshot

'The Cash Monster Was Insatiable': How Insurers Exploited Medicare for Billions

By next year, half of Medicare beneficiaries will have a private Medicare Advantage plan. Most large insurers in the program have been accused in court of fraud.

EDITORS' PICK

Forbes 3/1/24

CMS' Medicare Advantage Payment Cuts Come With Risks

Avik Roy Forbes Staff
The Apothecary Contributor Group

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Why are seniors voting with their feet—and their pocketbooks—to enroll in private MA plans? It's because those MA plans provide a more generous insurance benefit, with higher quality health outcomes, at a lower price.

10-8-2022

Payments to MA plans far exceed FFS spending due to favorable selection into MA plans and higher MA coding Intensity

MedPac report March, 2024

2025 CMS Final Notice (4/1/24) Impact to Medicare Advantage

- 2025 is the second consecutive year for an overall decrease in payment when excluding risk score trend
- Some Medicare Advantage plans have reported increasing claim costs and have stated the proposed 2025 payment changes are inadequate to cover projected cost increases

Individual Market Impact	Group Plan Market Impact
• CMS expects stable premiums and benefits in 2025 • Plans may seek to maintain $0 premium by reducing benefits	• Typically based on actual group experience • Rising claim trend with constrained payment increases may drive rate increases • Rate guarantees may be revised with material changes to law/regulations

Initial Findings for 2025

Medicare Advantage and Prescription Drug plans (MAPD)

Most employers experiencing significant rate increases

Average premium increase ~$600 (30%)
across 48 plans with 200,000 members

Standalone Group Medicare Advantage plans with Rx EGWPs

Stable medical rates, rising pharmacy rates

Average medical premium increase of $30 per year
across 15 plans with 180,000 members

Improvement to the Healthcare Enhancement for Local Public Safety Officers Act

- Tax exclusion available to more retirees
- Eliminated direct payment requirement (pension → insurer)

Medicare Coverage for Retirees

Polling Question

What are retirees' top concerns about Medicare? (rank them)

A. How and when to sign up
B. Will it cover my providers
C. Prescription coverage and cost
D. Legislative changes that reduce benefits

Poll Results and Discussion

History of legislation on Medicare is IMPROVEMENTS to the benefits over the past 20 years

Medicare Benefits From Plan Sponsors

Retiree Medical Design Options for Plan Sponsors

Medicare Supplement With Retiree Drug Subsidy

- Medicare supplement plan pays part of cost not paid by Medicare; no CMS $$
- Employer sponsored group Rx plan qualifies for Retiree Drug Subsidy (RDS)
- Administration remains with the plan sponsor

Medicare Supplement With Rx EGWP

- Medicare supplement plan pays part of cost not paid by Medicare; no CMS $$
- Group Medicare Part D plan with 3rd party $$
- EGWP typically self insured
- Employer sets plan design
- Administration remains with the plan sponsor

Group Medicare Advantage

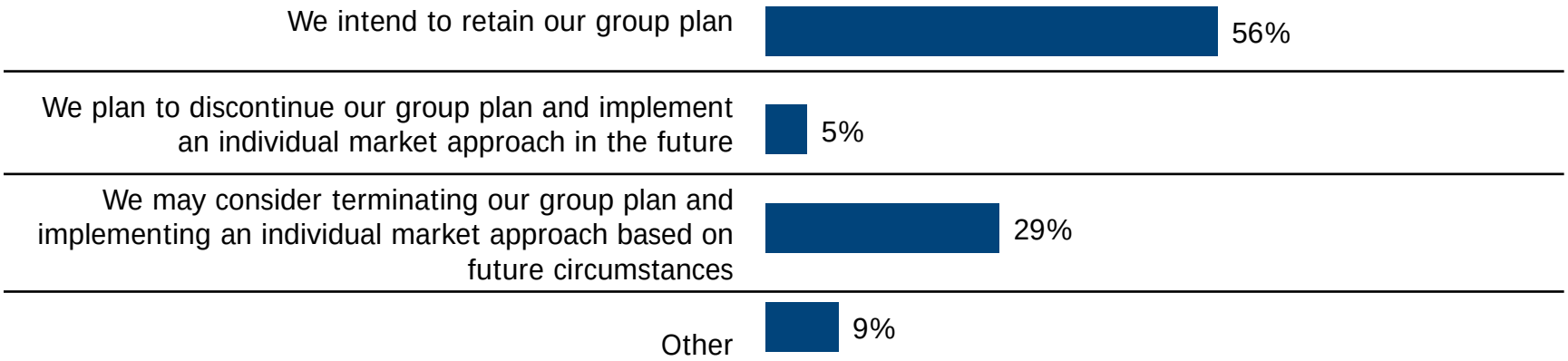
- Insured group Medicare Advantage plan with cost largely paid by CMS
- Employer sets plan design
- Future rates reflect employer claim experience and CMS funding levels
- Typically includes Rx although can be structured as MA separate from Rx
- Administration remains with the plan sponsor

Individual Marketplace (exchange)

- Plan sponsorship limited to employer HRA subsidy
- Access to federal subsidies
- Expanded plan choice for retirees
- Marketplace provides communications, enrollment and ongoing advocacy
- Reduced administrative burden for plan sponsor

Many Employers Intend to Retain Their Group Plan for Retirees

Which best describes your organization's current thinking on group health plans for retirees? (N=154)



Sample: Based on those who provide access to a traditional employer-sponsored group health plan to current retirees, current employees or new hires.
Source: WTW 2024 Best Practices in Healthcare Survey.

Case Studies—Best Practices in Retiree Health Coverage (Three Counties)

- Situation
  - County provides subsidized, retiree group coverage to thousands of members
  - Group plan is a traditional Medicare supplement and a prescription drug plan
  - Subsidy is a percentage of premium cost, varies by tenure and department, and is uncapped
  - Increasing retiree health costs putting pressure on other benefit programs
  - Large and growing OPEB liabilities

Case Studies—
Best Practices in Retiree Health Coverage

	County A Stay the Course	County B Group Medicare Advantage and Prescription Drug Plan	County C Individual Medicare Marketplace (a.k.a. Medicare exchange)
Action	Keep current plan but change plan design: increase cost sharing and deductible	• Replace traditional plan with 2 Medicare Advantage plan options—high and low premium • Plan designs similar to historical plan • Additional benefits included	• Replace traditional plan with an annual contribution to a Health Reimbursement Arrangement (HRA) • HRA contribution tied to an index (e.g., Medical CPI) • Provide retirees with personalized guidance to choose from wide range of individual plan choices and enroll
Results	Benefit cost reduced 12% for one year, increased 8% year 2	• Initial concerns raised by retirees—Medicare Advantage may have care management • Benefits costs reduced ~30% • OPEB reduction ~25% • Retirees reduced premium cost by ~40%	• Initial concerns raised by retirees—HRA model and individual market is unknown • 98% of retiree satisfied with plan choice • Benefit cost reduced ~40% • OPEB reduction ~30% • Retirees' average savings of $1,800 per year

Case Studies—
Best Practices in Retiree Health Coverage

	County A Stay the Course	County B Group Medicare Advantage Plan (with Employer Group Waiver Plan)	County C Individual Medicare Marketplace (a.k.a. Medicare exchange)
Considerations	• Will need to repeat process annually to offset medical trend • Not maximizing use of federal subsidies • Considering ending health benefits for future retirees • OPEB growth has potential to impact bond ratings	• Consistency in plan design with historical plan • County retains control of medical and Rx plan designs, remains responsible for managing carrier(s) • Benefit costs reduced with federal subsidies • Risk pool limited to County retirees • Some retiree support offloaded to administrator or insurer	• Retirees benefit from carrier and plan choice and competition • Benefit costs are predictable and sustainable for County and retirees • Retirees part of a large Medicare risk pool, can take advantage of federal subsidies • Significant reduction to County's administrative burden—all retiree interactions through the exchange, no medical or Rx plan to manage (only manage HRA)

Considerations for Retiree Benefit Strategy

- Are benefits sustainable?
- Are costs manageable and predictable?
- How significant is the administrative burden?
- Are plans affordable for retirees (are retirees leaving plan)?
- Do retirees have a choice of plans—How are they supported?
- Is the plan maximizing federal subsidies?
- What design is most prevalent with peers?

Medicare Fundamentals

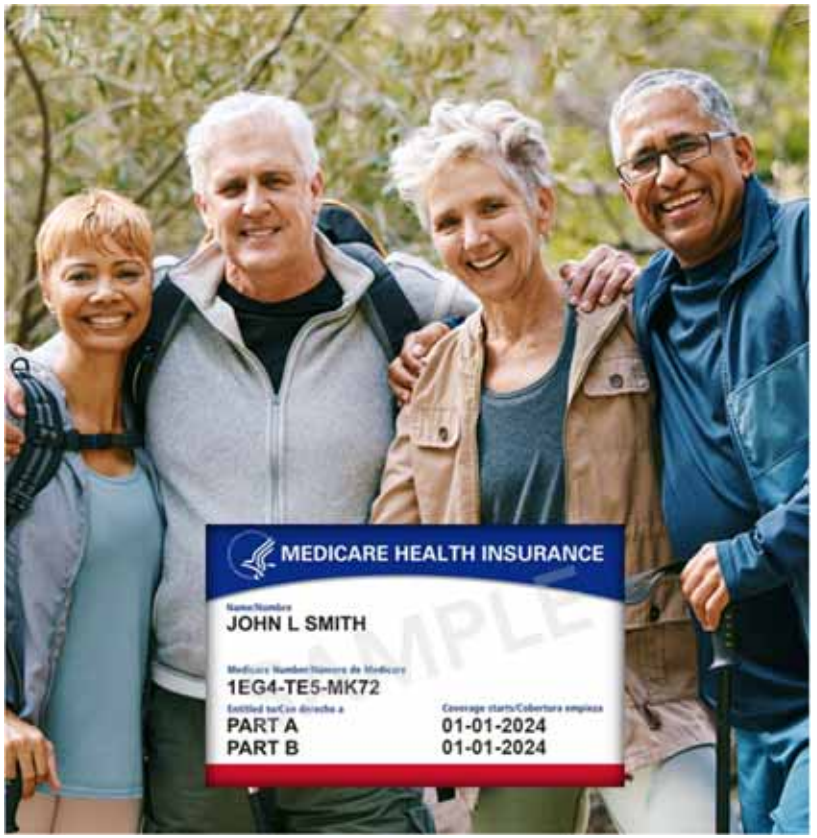
Components of Medicare

'Original Medicare': Administered by the Federal Government (established 1965)

Part A – Hospital	**Part B – Doctors**

Administered by Private Insurance Companies

Part C – Medicare Advantage (est. 1999)	**Part D – Prescriptions (est. 2006)**



‘Original’ Medicare

Part A

Hospital inpatient

- What it covers: Inpatient hospital care, short-term skilled nursing facility care, some hospice care, some home health
- Premium-free, if worked at least 10 years (40 quarters); Otherwise pay premium
- Typically covers 80% of hospital costs
- $1,632 hospital deductible (each benefit period)

Part B

Medical Outpatient

- What it covers: Doctor visits, outpatient care, home healthcare, durable medical equipment, medical services, some preventive care
- Enroll at age 65 if you are no longer covered by employer healthcare
- Pay $174.70 monthly premium, can increase based on income
- Typically pays 80% of costs
- Annual deductible of $240
- Late enrollment penalties

Medicare Part D—Prescription Drugs

Part D

Prescription drugs

- Offered by private companies
- Monthly premiums vary by carrier
- Formularies vary by carrier—important to choose wisely to save money
- Drugs at retail and mail-order pharmacies
- May delay enrollment if active employee or covered by active employee (spouse) on employer plan with ‘creditable’ prescription drug coverage
- Late enrollment penalties

2024 Income-Related Monthly Adjusted Amounts (IRMAA) Brackets for Medicare Parts B and D

Modified Adjusted Gross Income (MAGI)		Part B Premium Per Person	Part D Premium Per Person
Single	Couple		
< $103,000	< $206,000	$174.70	Premium (varies)
$103,000 to $129,000	$206,000 to $258,000	$244.60	$12.90
$129,000 to $161,000	$258,000 to $322,000	$349.40	$33.30
$161,000 to $193,000	$322,000 to $386,000	$454.20	$53.80
$193,000 to $500,000	$386,000 to $750,000	$559.00	$74.20
> $500,000	> $750,000	$594.00	$81.00

Medicare Part C—Medicare Advantage

Part C

Medicare Advantage

Stands in place of original Medicare

- Medicare health plans offered by private companies
- Must provide coverage that meets or exceeds Part A and Part B services to members
- Most individual plans include Part D prescription drug services in individual plans

Added Benefits With Many Medicare Advantage Plans

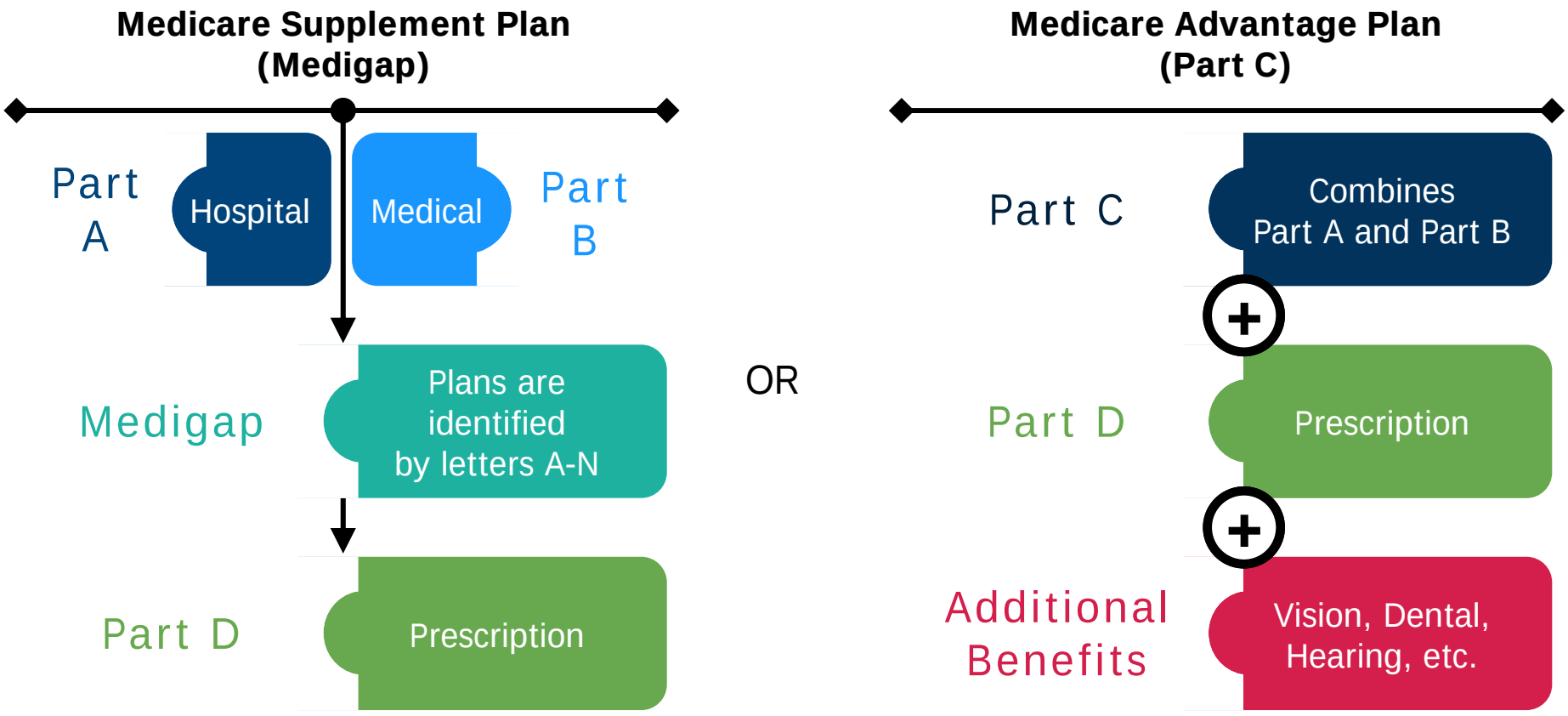
- Routine chiropractic
- Free gym memberships
- Coverage of OTCs
- Transportation
- Hearing care coverage
- Fall prevention kits
- Enhanced telemedicine
- Dental
- Vision
- Part B premium give back
- Personal Emergency Response System

Medicare Supplement Plans (Medigap)

Medigap Benefits Chart	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan K	Plan L	Plan M	Plan N
Medicare Part A Coinsurance & Hospital Costs	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medicare Part B Coinsurance or Copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Blood (First 3 Pints)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A Hospice Care Coinsurance or Copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Skilled Nursing Facility Coninsurance	X	X	100%	100%	100%	100%	50%	75%	100%	100%
Medicare Part A Deductible	X	100%	100%	100%	100%	100%	50%	75%	50%	100%
Medicare Part B Deductible	X	X	100%	X	100%	X	X	X	X	X
Medicare Part B Excess Charges	X	X	X	X	100%	100%	X	X	X	X
Foreign Travel Emergency	X	X	80%	80%	80%	80%	X	X	80%	80%

- Fill the ‘gaps’ in Medicare Parts A and B
- Sold by private insurers
- Standardized plan designs (A-N)
- Plans C and F not available to new Medicare entrants as of January 2020

Two Ways to Get Additional Coverage



Individual Medicare Plans Are Very Affordable

Average **Medigap Plan G in Columbus OH is $195/month**
(with 100% Medical coverage after $240 deductible, male age 73)

Average Rx plan is $63/month

Average **MAPD** individual plan premium is **$33 a month**

Nationally two-thirds of the MAPD plans have a **$0 a month** (26 in Columbus OH)

When to Enroll

7-month window surrounding your retiree's 65th birthday month

Month 1	Month 2	Month 3	Birthday Month	Month 5	Month 6	Month 7

Initial Enrollment Period (IEP)

Enroll into Medicare as early as the **first day** of the month your retiree turns 65

Enroll through **SSA.gov** or by **calling** 1-800-772-1213

If receiving Social Security before age 65, enrollment in Parts A and B is **automatic**

Working Past Age 65

Working Past Age 65— Special Enrollment Period (SEP)	General Enrollment Period (GEP)
• If no premium for Part A, sign up (unless contributing to an HSA) • On retirement, there is an 8-month enrollment period for Medicare. If already enrolled in Part A, beneficiary can enroll in Part B without a late enrollment penalty • Employer or HR department provides a verification form • Part B late enrollment penalty of 10% each year • Avoid a penalty if actively working **AND** are covered by an employer group health plan	• January 1–March 31, coverage takes **effect** the first day of the following month • A late enrollment **penalty** may apply

Health Savings Accounts (HSA) and Medicare

- Once enrolled Medicare, employees can no longer contribute to their HSAs
- To avoid a tax penalty, employees should stop contributing to their HSAs at least 6 months before applying for Medicare (if applying after 65)
- Once enrolled in Medicare, employees can use HSA funds to pay Medicare premiums and out-of-pocket expenses
- HSA funds cannot be used to pay Medicare Supplement premiums

Key Takeaways

- Increasing costs and liabilities are forcing plan sponsors to re-evaluate retiree health care options
- Enhanced federal tax credits in the pre-65 individual marketplace has driven market growth, increased competition and more stable premium levels
- New legislation enhances Medicare Part D coverage—reduces gap between group and individual market plans

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Session Evaluation