

Health reform legislation may spur some employers to consider retiree health benefits. The author discusses some of the options employers have for offering health care and/or prescription drug benefits to retirees.

More Employers Studying Medicare Options

by **Adrienne Muralidharan**

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The costs of retiree health care and prescription drug benefits have soared in recent years, making them a target for employer budget cutting. New rules under the Patient Protection and Affordable Care Act (PPACA) may cause additional employers to consider dropping or reducing retiree benefits or changing their retiree benefit plan structure.

Currently, many employers that sponsor retiree health coverage provide a *Medicare Advantage* plan, which essentially combines traditional Medicare, including Medicare Parts A and B (hospital and medical coverage for Medicare-eligible retirees,

respectively), often with Medicare Part D (prescription drug coverage). Other benefits not covered under Medicare, such as vision and dental coverage, may be part of a Medicare Advantage plan.

Starting January 1, 2011, PPACA will require that Medicare Part B pay for 100% of the cost of preventive care. Because traditional Medicare now will offer more comprehensive medical coverage—bringing it more in line with coverage provided by a Medicare Advantage plan—some employers that offer Medicare Advantage plans may decide to drop health coverage and in-

stead offer only a standalone prescription drug plan to retirees. Under this scenario, retirees would rely on traditional Medicare for hospital and medical coverage and the standalone Part D plan for drug coverage.

Although drug coverage has historically made up just 10% of overall health care costs, the price of prescription drugs continues to climb at an alarming rate. This is particularly significant for people eligible for Medicare. People take, on average, three different prescription drugs by the time they are aged 65; as individuals age, that number increases—along with the cost.

One way employers are attempting to mitigate costs is by providing Medicare-eligible retirees with supplemental—or *wraparound*—coverage while encouraging retirees to get their primary prescription drug and medical coverage through Medicare.

Other employers may continue to sponsor retirees' drug coverage and receive reimbursements for this benefit through retiree drug subsidies or employer group waiver plans, explained below.

Health care reform doesn't eliminate the choices employers have for funding their Medicare-eligible retiree health plans, but it may encourage employers to reevaluate how they're funding coverage now.

Recent Trends

In 2007, after many years of litigation in the case *Erie County Retirees Association v. the County of Erie*, the Equal Opportunity and Employment Commission determined that an employer can create two separate classes of retirees—those eligible for Medicare and younger, ineligible retirees—without it constituting age discrimination because people over the age of 65 have access to comprehensive health coverage. Employers can continue to offer coverage to early retirees, and then remove them from employer-sponsored plans when they become eligible for Medicare.

Increasingly, employers are reducing or eliminating retiree health benefits altogether for Medicare-eligible individuals. A January 2010 report from the Employee Benefit Research Institute indicates that the percentage of employers with 500 or

more employees offering health insurance to Medicare-eligible retirees has dropped from about 40% in 1993 to 21% in 2009 (see figure).² According to the White House, the percentage of all large firms providing workers with retiree coverage has dropped from 66% in 1988 to just 31% in 2008.³

Among employers reducing but not eliminating coverage, many are requiring retirees to pay more, whether by offering only high-deductible plans (also known as *consumer-driven health plans*) or by increasing the costs associated with traditional insurance plans.

Retiree Drug Subsidy

Employers have the option of accepting federal reimbursements under the retiree drug subsidy (RDS), which is Medicare Part D-focused and administered by the Centers for Medicare and Medicaid Services. Historically, most employers that provided retiree drug coverage accepted the RDS. Offered since January 1, 2006 and implemented as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the RDS offers a 28% subsidy on each Medicare Part D-eligible claim a qualified retiree files (*qualified* meaning Medicare-eligible and participating in the employer coverage). In exchange for this subsidy, the employer must offer *creditable coverage*, or coverage as good as or better than that offered under Medicare's standard drug benefit.

Although the government originally encouraged employers to choose this option, it has become less popular. Many employers discovered that participation meant more administrative burden for an uncertain return. Not only do employers taking advantage of the RDS have to report monthly drug utilization, they also have to file reports quarterly and annually, which often requires going back and forth with the federal government to ensure the reporting is accurate. If the government disputes the validity of a claim, the employer must then review its records and provide supporting documentation or clarification. In addition, reimbursements are dependent solely on drug claims, which, although rising, still represent a relatively small slice of overall retiree health care costs.

The RDS allows employers a tax deduction for participating. That's going away

because of PPACA; the 28% RDS reimbursement will no longer be tax-deductible as of 2013. The effective date is tax years beginning on or after January 1, 2013, although accounting rules require employers to report their liability for retiree health care expense on financial statements immediately. That loss of a tax deduction effectively brings the reimbursement closer to 19%. Now, more employers are choosing to offer coverage through either a Medicare Advantage or a standalone prescription drug plan.

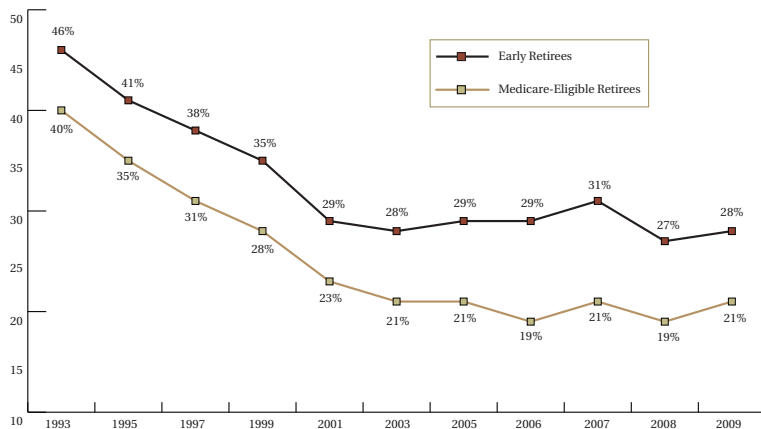
Different Plans, Different Solutions

How an employer approaches the issue depends on the size of its Medicare-eligible population and the organization's structure. Approaches include:

- **Employer group waiver plans (EGWP).** Employers that want to realize more savings while providing health and prescription drug coverage can choose to move away from RDS reimbursements and instead offer employer-sponsored Medicare Advantage, or standalone drug plans can restrict enrollment in the plan to retirees only, creating an EGWP. While this requires more administration overall, employers can shift more of the burden to a third party by contracting with a plan that already has a contract with the federal government. This allows employers to keep their distance from the federal government while offering retiree coverage. Under an EGWP, employers get a specific dollar amount per participant (a *capitated rate*) instead of relying on medical and drug use for actual claims reimbursement. If a participating retiree is especially sick and reaches catastrophic coverage or qualifies for a low-income subsidy, the employer gets even more back.
- **Elimination of coverage.** Eliminating coverage for Medicare-eligible retirees may make more sense, particularly for employers that are required to report their health care funding practices on financial statements. In such reports, employers must indicate what type of health

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Percentage of Employers With 500 or More Employees Offering Health Insurance to Retirees, 1993-2009



Source: *Employee Benefit Research Institute Issue Brief No. 338*, January 2010. Mercer National Survey of Employer-Sponsored Health Plans.

care coverage they have promised retirees and if they will be able to meet these obligations. *Unfunded health care coverage* (the promise of coverage not backed by actual dollars) is reported as a liability and could affect an organization's credit rating. By eliminating coverage for Medicare-eligible retirees, employers remove some potential liability from their books.

Administrative Burden vs. Avoiding Retiree Disruption

Employers continuing to offer coverage must determine how much they're willing to do. Do they have the infrastructure to handle monthly, quarterly and annual reporting under the RDS? Can they create—or contract with someone to create—the programs required under Medicare Parts C and D?

If they choose to go with an EGWP over the RDS, can they handle the required communications with beneficiaries and answer all their questions? The RDS is relatively hidden from retirees; most of the changes occur on the back end, so retirees rarely see them and don't require as much specialized communication. EGWPs, on the other hand, require far more communication and often cause more confusion among retirees.

If an employer wants the RDS but doesn't currently offer creditable coverage, it must improve its benefit until it's as

good as or better than that offered under Medicare Part D.

Employers that choose to offer an EGWP usually realize higher reimbursements than those accepting the RDS, but many also find their retirees experience additional confusion due to plan changes. Also, Medicare requires that all Medicare plans—employer-sponsored or not—send out specific documents on a periodic basis. Those documents often are lengthy and detailed, and may be sent more frequently than traditional insurance materials, resulting in more confusion.

Retirees already receive a lot of mail from Medicare plans. Providing them with the amount of paperwork required under Medicare often creates aggravation for both employers and retirees, whether they're using a third party or not.

If an employer chooses to drop its retiree coverage entirely, it inevitably encounters unhappy retirees who now find themselves facing a daunting array of Medicare options.

Alternative Funding Vehicles

Some employers may want to consider using privately funded vehicles to provide retiree health care coverage. These can be used independently to purchase group coverage for Medicare-eligible retirees or as umbrella accounts to provide retirees with an EGWP. Alternative funding vehicles include two options:

1. **A voluntary employees' benefi-**

ciary association (VEBA). Many employers, particularly those with certain contractual obligations—to unions, for example—prefer to form a trust known as a *VEBA*. A *VEBA* is considered a separate entity, which many employers find attractive. Employers can contribute a one-time monetary distribution or periodic distributions of capital to the trust, which is managed by an administrator. Because they are flexible, *VEBAs* can work well with other funding options, such as an EGWP. Employers use the *VEBA* in conjunction with federal funding to create an EGWP. The manager then can contract with a third party to take advantage of the government plan and enroll *VEBA* retirees into the EGWP.

However, *VEBAs* have a possible downside, especially for retirees: The success of a *VEBA* depends on management. A *VEBA* has no obligation to remain financially solvent. If a *VEBA* runs out of money, retirees are left without health coverage and must find it on their own.

2. **A 115 trust.** This type of trust, available to government entities, works similarly to a *VEBA*. A 115 trust can be used to purchase Medicare or other coverage for retirees and can be managed by a third-party administrator. A 115 trust also can become insolvent if not properly managed.

VEBAs may be preferred over 115 trusts primarily because they are no longer considered the responsibility of the employer. As a result, a *VEBA* reduces the employer's liability. Once retiree health care costs are shifted to a *VEBA*, that expense cannot revert back to the employer. On the other hand, if a 115 trust is closed out, the trust assets revert back to the employer along with any liabilities.

"Selling" Change to Medicare-Eligible Retirees

Employers that choose to encourage retirees into the open market can argue that doing so offers retirees more choice. The average retiree had 31 Medicare Advantage plans to choose from in 2010. Medicare plan selection services are available to help them make the transition. To help a retiree make an educated choice on Medicare coverage, such a selection

service will consider an individual client's health conditions and prescriptions, the doctors and facilities he or she visits, and his or her financial situation. Employers can offer this service through a referral arrangement. Ideally, the plan selection service an employer chooses assesses all the plans in a customer's area, provides an impartial analysis of Medicare options and works in the best interest of each individual client.

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Endnotes

1. EEOC Ruling on Retiree Benefits and Medicare, Findlaw.com, 2007.

2. Paul Fronstin. Percentage of Employers With 500 or More Employees Offering Health Insurance to Retirees, 1993-2009, *Employee Benefit Research Institute Issue Brief No. 338*, January 2010.

3. Fact Sheet: *The Early Retiree Reinsurance Program*, the White House, May 4, 2010.

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