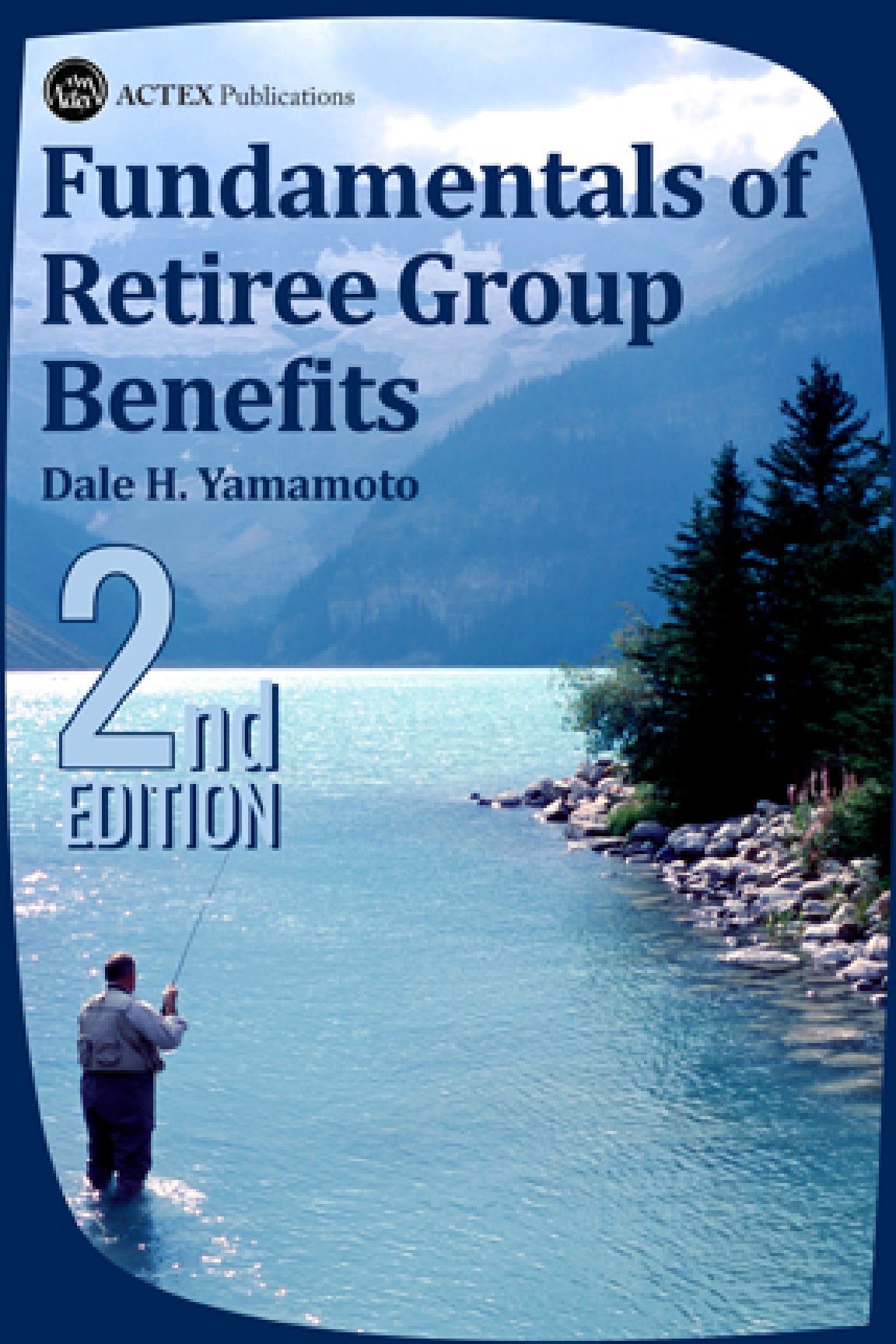
ACTEX Publications
Fundamentals of Retiree Group Benefits
Dale H. Yamamoto
2nd EDITION

Fundamentals

of Retiree Group Benefits

Second Edition

Dale H. Yamamoto

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PREFACE

The first edition of this book was written in the early 2000s and finalized in 2006. I had mentioned that the book should have been written in 1980 when more employers were offering group benefits to their retirees. Today, fewer and fewer are offering the benefit to new retirees but most employers who offered the benefits back in 1980 are still providing them to their retirees even though current employees are not eligible for the benefit when they retire. Therefore, even though recent surveys of employers seem to imply that retiree group benefits have gone the way of the dinosaur, many employers are still dealing with the legacy benefits that were started years ago.

Accounting rules have evolved over the last few years and there has been an increased sophistication and understanding in how to evaluate the programs. Courts have resolved some long standing issues involving retiree benefits and the recent health reform legislation in the U.S. will likely change the landscape of retiree benefits in the future.

Retiree group benefits continue to have the reputation for being difficult to understand. Half retirement benefit and half group insurance—few professionals have mastered both fields. In addition, complex finances blend the world of pension mathematics and health plan pricing.

This book attempts to provide a fundamental understanding of almost all of the elements that make up the world of retiree group benefits. Some things may have been missed and things will definitely change. I hope there is something of interest to everyone.

Because of the complex nature of the subject, I owe a great deal of gratitude to several friends who volunteered their time to review the drafts of this book. In alphabetical order, they are Paul Fronstin (Employee Benefit Research Institute), Frank McArdle (retired from Aon Hewitt), Tricia Neuman (Kaiser Family Foundation), Jeff Petertil (independent consultant), Adam Reese (PRM Consulting Group) and Allen Steinberg (retired

from Aon Hewitt). Each one of these reviewers is well-known in this field and provided invaluable input to make this a much better book.

I also want to thank Gail Hall of ACTEX for her encouragement to complete this project. She recognized that some time had lapsed since the original publication and thought perhaps there had been changes that should be included in a revised version of the original text. Of course, my reaction was that the original book should have a long shelf life and probably little has changed. But upon reflection, I was aware that plan designs had indeed changed in the last ten years; new court cases have settled situations that were vague; and the accounting world has changed some of its rules. So, it became obvious that a new revision was needed. And, Gail did what she originally did with the first edition, she gave me deadlines. Some of those deadlines were missed but, ultimately met.

Finally, I thank my wife Louise for sacrificing valuable free time so that I could write this book. Perhaps the completion of this second edition will allow more time to do what retirees do….have fun.

Dale H. Yamamoto
April 2015

DEDICATION

This book is dedicated to my parents who demonstrated the very difficult to translate moral obligation that the Japanese call "giri." *Giri* is one of the reasons for this book and the time that I have spent during my career in volunteering for a variety of professional activities. As I said earlier, *giri* is difficult to translate but in this case, I would interpret it as my obligation to repay the actuarial profession that has given me so much.

TABLE OF CONTENTS

1 INTRODUCTION

Retiree life and medical benefits were introduced to U.S. employee benefit programs in the late 1960s. The medical plans were first designed to supplement the Medicare program and were viewed as a "no cost" benefit. At the time, the benefits were very inexpensive because medical costs were relatively low and there were few retirees. Life insurance benefits for retirees were often added as a natural expansion of retiree benefits.

Later on, a relatively small number of large employers expanded their offerings to include long-term care insurance and continuing-care retirement communities. These benefits are usually offered to employees at their own cost (i.e., employee-pay-all). More commonly, large employers may include severance, dental, vision and hearing benefits.

In some respects, these benefits are similar to pension plans. They are provided to employees after they have contributed their services to their employer. Many times, the benefits are continued for the retirees' lifetimes, although employers typically reserve the right to change or even discontinue the benefits. Like pension plans, some plan designs even vary based on service. But unlike pensions, these retiree group benefits are generally not extensively prefunded.

Retiree group benefits have gained much more attention since the early 1990s. The primary reason was the accounting rules that became effective for most companies in 1993, issued by the Financial Accounting Standards Board (FASB). These rules (FAS No. 106)[1] required employers to account for retiree group benefits while an employee is working rather than waiting until he or she is retired and the payments are made. A rule released by the Governmental Accounting Standards Board (GASB) has had a similar

[1] Financial Statement of Accounting No. 106, *Employers' Accounting for Postretirement Benefits Other Than Pensions,* Financial Accounting Standards Board, December 1990. See footnote 7 for additional information.

accounting effect on U.S. states and municipalities since its implementation that started in 2006 with subsequent modifications.

Other factors have also forced attention on retiree group benefit plans, namely the growing expense tied to rising health care costs. In 1960, when many employers were adopting retiree health care plans, the U.S. spent $27 billion on health care-related costs. This represented 5.2 percent of the gross domestic product (GDP). By 1980, the spending grew to $256 billion or 9.2 percent of the GDP and in 1990 $724 billion or 12.5 percent of GDP. Spending continued to grow in the 1990s, reaching $1 trillion in 1995 or 13.8 percent of GDP and it reached $2 trillion in 2005 (16.1 percent of GDP).[2] Health care spending was expected to reach $3 trillion in 2014, $4 trillion by 2019 and over $5 trillion in 2023 (19.3 percent of GDP).[3] Most executives are very aware of how their companies' medical plan costs have increased over the same period. Couple this with an increasing number of retirees due to maturing populations (in some cases exacerbated because of downsizing and early retirement incentive plans) and greater financial pressures. One can conclude very quickly that retiree medical plans cost REAL money!

The purpose of this book is to provide the reader a fundamental knowledge of the key issues with retiree group benefits. It is important to recognize how both pensions and health care interact with each other as well as differences in the delivery of the benefits. A secondary purpose of this book is to put under one cover, all of the disparate focuses of these complex benefit offerings, including the history of the benefits, Medicare, design strategies, funding options, legal considerations, accounting and actuarial calculation methods.

Employer-sponsored retiree group benefits continue to be an important source of coverage for Medicare-eligible retirees with 35 percent of Medicare beneficiaries covered under employer plans in 2010.[4]

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[2] Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, Data from the National Health Statistics Group. February 2013.

[3] CMS, *National Health Expenditure Projections 2013-2023*, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2013.pdf

[4] See Figure 2.9 in Chapter 2.

MEDICARE

The Medicare program in the U.S. is usually the primary health insurance source for citizens and permanent legal residents age 65 and over. Unlike other industrialized countries, the U.S. does not have a socialized national health care system for its population in the traditional sense. It could be argued that a mix of socialized health insurance programs serves a large portion of the population, as many people are covered by Medicare (both the aged and the disabled) and Medicaid (for low income persons) as well as federal subsidies for lower income individuals under the Affordable Care Act.

The U.S. has primarily an employment-based health care financing system for the under age 65 population. For persons covered under employer-provided health plans, as well as many individual health plans, the former employees and their family members are provided care in a private system that is reimbursed by the health plans. The form of reimbursement may go through the patient in a fee-for-service system. Under this approach, the provider (e.g., a physician, hospital, lab), typically provides the patient a bill, the bill is submitted to the health plan for payment and if the plan does not pay the full amount of the bill, the patient pays the remainder. A second form of reimbursement may be that the providers are part of the health plan (i.e., physicians are paid a salary and on staff and the health plan owns the hospital). Under this type of system, the patient goes to the provider and generally pays a nominal copay to use the facility or see a physician. There are also variations in between these two.

Most beneficiaries covered under the Medicare system are in a traditional fee-for-service plan. In 2010, 22 percent of all beneficiaries were instead in Medicare Advantage plans that are primarily managed care programs.[5] Most of the Medicare beneficiaries are over age 65, although 8.5 million long-term disabled persons are also covered in 2012 (17 percent of total Medicare beneficiaries). Medicare is the primary provider of health coverage for the aged as long as the person is not covered as an active employee (or the spouse or dependent of an active employee) in an

[5] According to the Kaiser Family Foundation, the number of Medicare beneficiaries in Medicare private plans reached an all-time high of nearly 16 million beneficiaries in 2014 and the Congressional Budget Office (CBO) projects Medicare Advantage enrollment will reach 22 million beneficiaries by 2020. Tricia Neuman and Gretchen Jacobson, *Medicare Advantage: Take Another Look*, May 07, 2014
http://kff.org/medicare/perspective/medicare-advantage-take-another-look/

employer-provided health plan. This creates a very large difference in the employer plan costs when a retiree turns age 65. Typical employer plan costs per person in 2014 were about $10,000 for a pre-65 retiree and $4,000 for a post-65 retiree.

The introduction of prescription drugs to the Medicare program in 2006 created a new set of delivery models under the program and opportunities for employers to coordinate their programs around the new benefit.

The existence of Medicare, at age 65 (or prior in the case of long-term disability), creates a challenge in the design and valuation of the retiree medical plans. Employer plan costs per person without Medicare eligibility can be two to four times higher than for those of the same age with Medicare as the primary insurer. The challenge is exacerbated by the fact that employer designs have evolved over the years. Even with recent legislative changes to Medicare, important design differences exist between traditional Medicare fee-for-service and employer designs (e.g., no out-of-pocket maximums under traditional Medicare).

Other governmental systems may have similar distinctions by age. Canada's provincial plans, for example, do not cover certain prescription drugs after a person becomes age 65.

PLAN DESIGN CHANGES

Plan design changes intended to reduce employers' future obligations started in the early 1980s and continued into the early 2000s. Early changes concentrated on who pays what share of the premium cost of the medical benefits—the employer or the retiree. More recent changes have focused more on the control of health care spending.

Plan Changes

Most of the retiree medical plan changes made in the early 1980s consisted of:

- Introducing or slightly increasing the level of retiree contributions;
- Adopting policies of setting retiree contributions as a fixed percentage of plan cost; and
- Changing the method of coordinating benefits with Medicare.

Subsequently, companies have been reassessing the design of their plans by introducing features similar to pension plans, such as:

- Redefining eligibility requirements to be more stringent (e.g., requiring a person to be at least age 60 with 15 years of service versus age 55 with 5 or 10 years of service in prior designs);
- Introducing service-related benefits (e.g., the employer portion of plan cost varies depending on the employee's years of service at retirement);
- Adjusting retiree contributions based on the employee's age at retirement (i.e., early retirement reductions);
- Setting the employer subsidy to the retiree medical plans as a fixed dollar amount and not a percentage of plan costs (e.g., the company will annually pay for up to $75 per year of service at retirement and the retiree pays the excess), and
- Providing an account-based employer subsidy for retiree group benefit plans (e.g., the employee "earns" $1,500 for each year of service that they work, so an employee with 20 years of service at retirement has $30,000 to use for purchase of employer plan options or for any other medical expense).

Future Plan Design Considerations

Most of the early plan design changes shifted the costs from the employer to retirees. It is likely that future changes will also continue to shift cost to retirees. But if retiree health plans are to remain an employer-provided benefit, future changes will need to result in reduced total costs in order to make the plans affordable.

The basic framework for these changes will be similar to methods that employers have used to reduce health care costs for their active employees. These recent changes were seldom applied to retiree plans because of the thought that "retirees are different." This is especially true for those eligible for Medicare.

Retirees are different from active employees in many ways. It is harder to get communication to them because they do not come to work regularly. Many have family physicians that they have been seeing for a long time, making it uncomfortable and difficult to change. Some move away from where they worked, and it is difficult to physically meet for a company-

sponsored event. Despite these obstacles, many health care management strategies used for active employee plans can work for retiree plans. They may, however, have to be designed with a different emphasis for retirees.

Future efforts will be to change the value proposition of retiree healthcare including:

- Providing an account-based employer subsidy (generally non-funded accounts),
- Consumerism initiatives to encourage efficient care,
- Information and tools with which to make informed decisions,
- Overall total cost management,
- Other methods to effectively coordinate the employer plan with Medicare, and
- Supporting retirees so that they can obtain coverage in the marketplace—either individual coverage in the federal/state exchanges if under age 65, or Medicare Advantage and Medigap policies if Medicare-eligible.

Most of the plan design changes outlined here do not have the same dramatic accounting cost reductions achieved by some of the fixed dollar benefit designs introduced in the early 1990s. The overall retiree health care costs, however, will be controlled. If a fixed dollar benefit design has not been adopted, these changes will reduce future cost increases, justifying a lower accounting cost.

To the extent that controlling health care costs in this fashion is successful, it may alleviate the perceived need for employers to increase other benefits (e.g., pension benefits) because the retiree's out-of-pocket health care costs are better contained. More importantly, most of the changes will be a "win-win" for the company and its retirees.

In cases where cost control is not enough, some employers are making the hard decision that they can no longer afford to subsidize retiree group benefit coverage. Prior to 2014, employers were sensitive to the fact that without employer-sponsored coverage, some individuals may not be insurable or able to gain access to affordable individual coverage. This led to more access-only retiree coverages, especially for pre-65 retirees, who were required to bear the full cost of the plans. But as a result of the Affordable Care Act (ACA), pre-65 retirees are guaranteed access to

individual health insurance coverage on favorable terms through the state or federally administered health care exchanges, making it easier for employers to reassess whether and how they should provide pre-65 retiree coverage. In addition, a growing number of large employers are shifting toward offering retirees access to coverage through non-group Medicare plans, commonly with a fixed employer defined contribution subsidy. Retirees can then apply to the Medicare plan of their choice, with aid in choosing a plan through a third-party facilitator called a "private exchange" arranged by the employer.[6]

Some employers may also consider providing a fixed subsidy in a health reimbursement account that retirees can use to purchase health insurance in the state marketplaces. Some retirees may be better off receiving the federal premium credits than the employer's account contribution, so careful communication will be needed.

Other employers may consider using one of the many private exchanges that have been established. These exchanges are independent of the health reform state exchanges and provide an array of plan options from a variety of health plans to their members. Most of the private exchanges will handle the ongoing administration and communication to retirees and coordinate any type of subsidy the employer wants to provide to its retirees.

PREFUNDING

Although not often a popular notion for controlling retiree group benefit costs, a large number of major employers currently have some assets set aside for a portion of their retiree obligations. Most employers will argue that their internal rates of return far outweigh returns they can achieve by prefunding retiree group benefit plans. The key impetus for prefunding will be more philosophical than financial.

Some large employers (e.g., auto manufacturing companies), in settlement of union contracts, have established trust funds to pay for future retiree health care benefits.

Due to the rules on selecting a discount rate under the Governmental Accounting Standards Board (GASB) Statement No. 45, governmental entities may conclude that prefunding makes sense from a financial

[6] *Retiree Health Benefits at the Crossroads*. See [32].

statement perspective as well as the fact that prefunding reduces net future liabilities.

LEGAL ISSUES

Retiree group benefits have been the subject of litigation. Many court cases involve collectively bargained contracts, although there also have been many involving salaried employees. Early court cases tended to favor the plaintiffs, and employer plans were required to continue or maintain provisions in their plans indefinitely. After several of these cases were decided, employers began to include language in their communication of retiree group benefit plans, reserving the right to amend or terminate the plans in the future. Since that time, courts have tended to favor the employers' side because of this type of language in their legal documents as well as plan description summaries provided to employees and retirees. In addition, courts have ruled on age discrimination issues within a retiree medical program and the level of prefunding an employer may set aside.

NATIONAL HEALTH CARE POLICY

The employer's role in the health care delivery system has an uncertain future. The Medicare program may be changed. The Patient Protection and Affordable Care Act passed in 2010 will likely affect employer decisions to continue coverage for pre-Medicare retirees. With affordable and guaranteed access to health insurance for this population, there is less concern that, without employer-sponsored coverage, retirees will not be able to find health insurance.

ACCOUNTING

The change in accounting treatment of retiree group benefits in the early 1990s had a dramatic impact on the designs of these programs. The Financial Accounting Standards Board introduction of Statement of Financial Accounting No. 106 (FAS 106)[7] in 1990 increased many employers' retiree group benefit costs by factors of five to ten times their previously recognized costs. Although not changing the true nature or cost

[7] FAS 106 was issued in December 1990 and effective for fiscal years beginning after December 15, 1992. The Financial Accounting Standards Board reorganized all of its accounting standards in 2009 into one codification. FAS No. 106 is now included in Accounting Standards Codification (ASC) 715-60—Compensation—Retirement Benefits—Defined Benefit Plans—Other Postretirement.

of retiree group benefit plans, the requirement to accrue the benefits similar to pension plan accounting generally accelerated the accounting recognition of the cost of the plans from tomorrow to today.

The accounting treatment is very similar to pension plan accounting concepts, with some special additional assumptions such as probability of future participation in the plans and assumptions to anticipate the future costs of the program, including estimating the current year claim costs as well as future costs.

In 2004 the GASB issued Statements 43 and 45 to provide standards of accounting for retiree group benefit plans (and their trust funds) and for state and local governmental employers' financial statements, respectively. Patterned after the FASB standard, it initially required disclosures. A current revision is expected to require balance sheet recognition and have a similar accounting impact on the delivery of retiree group benefits to these governmental entities.[8] This standard is not likely to create the same level of plan termination and benefit cutbacks that occurred in the private sector, but some erosion in the prevalence of the benefit has been observed. The reason is because of the difference in culture and nature of employee benefits in the public sector, in which defined benefit plans continue to be more prevalent than in the private sector, which has seen a dramatic reduction in defined benefit plan offerings.

As of the writing of this text, the accounting profession is attempting to establish international standards. By doing so, some changes will occur that will require amendments to ASC 715-60.

ACTUARIAL METHODS AND ASSUMPTIONS

The projection of retiree group benefit payments blends the actuarial practices of pension and health actuaries. Pension actuaries have the background and knowledge to project long-term demographic changes and costs, and health actuaries have the expertise to estimate the current costs of health care and their likely costs in the short-term and future.

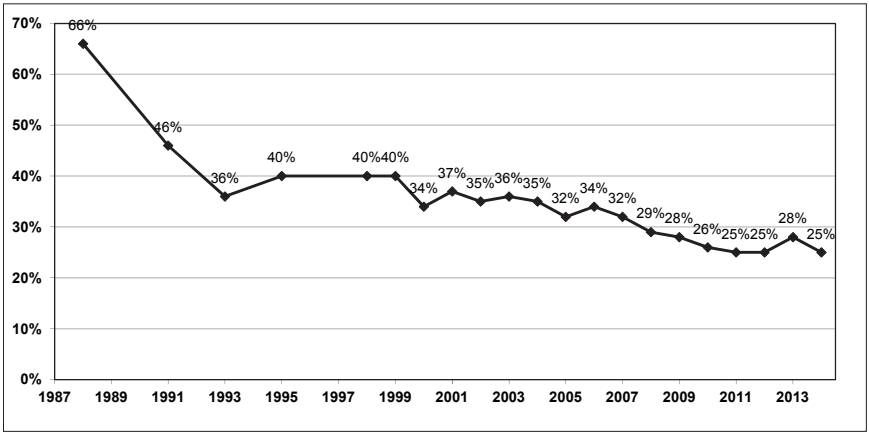
[8] Statement No. 43, *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans*, [19]; and Statement No. 45*, Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions*, [20]. Actual first effective for financial statements beginning after December 15, 2005 for GASB 43 and after December 15, 2006 for GASB 45.

This textbook provides the fundamentals of plan design, accounting, funding and legal issues of these post-employment benefits. Although many references in this textbook focus on the U.S. medical system (i.e., no national health plan until age 65), the principles are applicable to other countries.

2 EROSION OF RETIREE HEALTH BENEFITS

No matter what survey the reader is studying, the theme is always a downward slope of employers offering retiree health care benefits. The titles of two papers have used the term "erosion" of retiree health benefits.[1] Although written four years apart from each other and ten years ago, many of the same issues that were common to these papers remain true today. It is also likely that these same issues will continue during the next several years. Each paper cites surveys from various sources, graphically showing this erosion.

Percentage of Large Firms (200+ Employees) Offering Health Insurance to Retirees, 1988-2014



Source: Kaiser/HRET survey of employer-sponsored health benefits, 1999-2014; KPMG survey of employer-sponsored health benefits, 1991, 1993, 1995, 1998. The Health Insurance Association of America (HIAA), 1988.

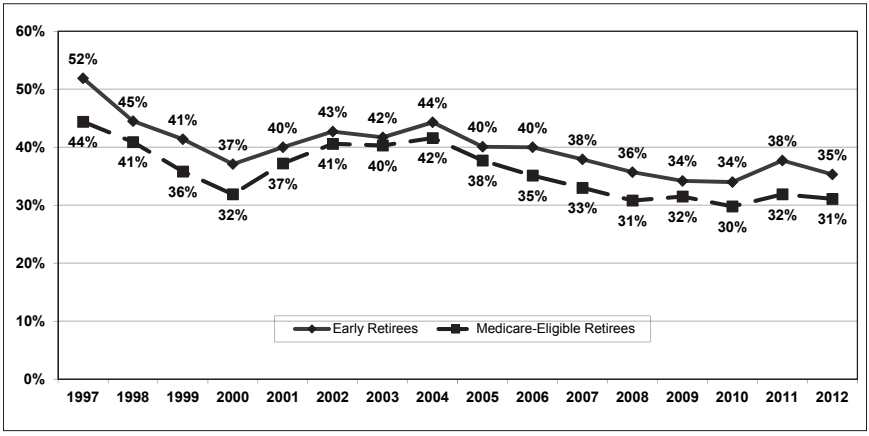
Figure 2.1

[1] Paul Fronstin, *The Impact of the Erosion of Retiree Health Benefits on Workers and Retirees*, [16] and U.S. General Accounting Office (GAO), *Retiree Health Benefits: Employer-Sponsored Benefits May Be Vulnerable to Further Erosion*, [42].

Figure 2.1 shows the typical downward slope of retiree group benefit prevalence. The largest decline took place in the early 1990s when the then new accounting standard, ASC 715-60 (FAS 106), became effective.

Figure 2.2 shows the prevalence of retiree health care benefits over a shorter time period but with a split between pre- and post-Medicare eligible retirees, and with larger employers featured in the analysis.

Percentage of Private-Sector Establishments with 1,000+ Employees Offering Health Insurance to Retirees, 1997-2012



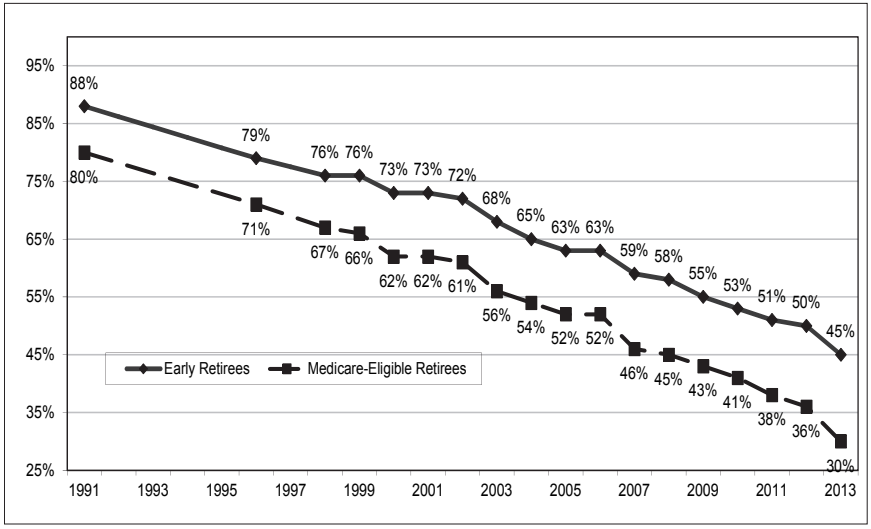
Source: EBRI (expanded by the author for 2012) from various tables at http://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=1

Figure 2.2

The upward movement in 2011 as demonstrated in Figure 2.1, like a similar uptick in 2013, does not, unfortunately, signal a reversal in trend. Other survey data show a more continued downward slope including those from consulting firms (Aon Hewitt, Towers Watson, Mercer).

Figure 2.3 shows a similar graph for larger employers who have historically been more likely to provide retiree health care. The downward trend for this group is less dramatic than Figure 2.1, but continues beyond 2001. Here, the gap between pre- and post-65 prevalence appears to be widening.

Percentage of Large Employers Offering Health Insurance to Retirees, 1991-2013

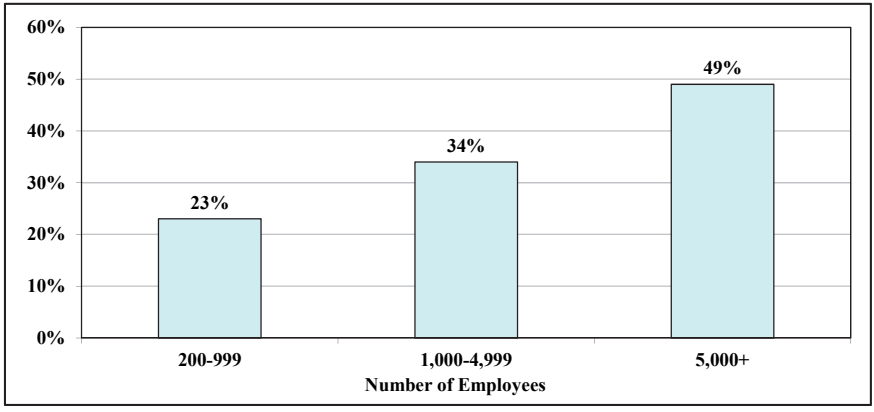


Source: © Aon Hewitt

Figure 2.3

The prevalence of retiree health care declines significantly by the size of employer. Figure 2.4 shows the differences in 2014.[2]

Percentage of Employers Offering Retiree Health Insurance Coverage by Size of Firm, 2014



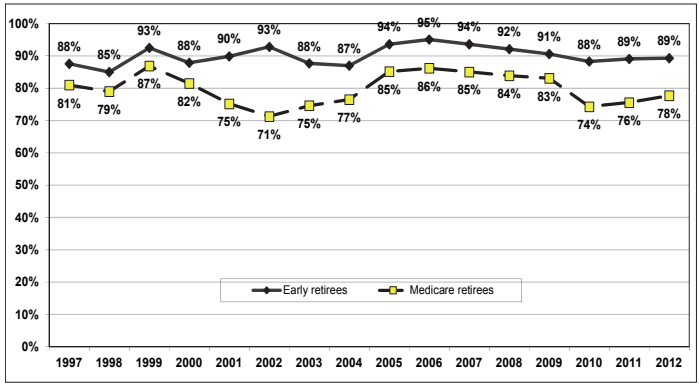
Source: 2014 Kaiser/HRET Employer Health Benefit Survey

Figure 2.4

[2] *Employer Health Benefits 2014 Annual Survey*, September 2014. [28]

The data for public sector employers (Figures 2.5 and 2.6) does show some variation from the steep downward slope. Those large local governments offering retiree health care are relatively stable during the 15-year observation period. State governments have been less likely to eliminate retiree health care coverage but have generally followed a trend similar to the private sector in terms of modifying the plan designs to require greater contributions and cost sharing by retirees, but a few have eliminated the benefit for current employees as the new GASB accounting standard became effective.

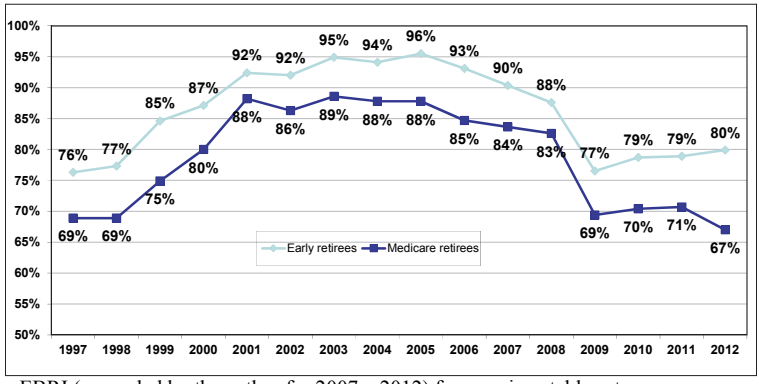
Percentage of Local Governments with 10,000+ Employees Offering Health Insurance to Retirees, 1997-2012



Source: EBRI (expanded by the author for 2007 – 2012) from various tables at http://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=1

Figure 2.5

Percentage of State Governments Offering Health Insurance to Retirees, 1997-2012



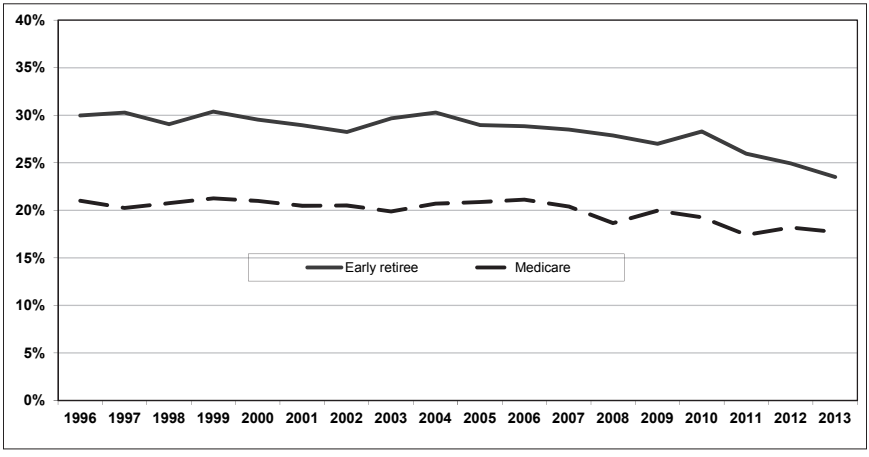
Source: EBRI (expanded by the author for 2007 – 2012) from various tables at http://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=1

Figure 2.6

The new public sector accounting standards went into effect between 2006 and 2009 for trust funds and government entity financial statements.[3] These standards require public sector employers to disclose the value of retiree health plan obligations on their financial statements on an accrual basis similar to the ASC 715-60 (FAS 106) rules for private sector employers. The private sector accounting change is commonly "blamed" as the reason for the decline in employer-sponsored retiree health care benefits. Many have instead viewed the accounting standard as an "eye-opener" to the real current value of the benefits that were often considered nominal.

Figure 2.7 shows an interesting trend line – the number of retirees with employer-sponsored health benefits between 1996 and 2013 was relatively stable through 2005. This is over the same period of time when many surveys show dramatic reductions in the number of employers offering retiree health coverage. This phenomenon occurs because, when employers change their plans and drop coverage, they almost always "grandfather" current retirees and some active employees so that their coverage is not completely eliminated. The slight declines after 2005 indicate that "new" retirees are finally being impacted by earlier changes.

Percentage of Retirees with Employer-Sponsored Health Benefits



Source: Author's analysis of Current Population Survey, March Supplements 1996-2013

Figure 2.7

[3] Statement No. 43, *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans*, [19] and Statement No. 45, *Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pension Plans* [20].

Besides the prevalence of employers offering retiree health care, both papers note that many other employers are reducing their benefits design by increasing various cost-sharing elements (e.g., increasing deductibles, out-of-pocket maximums and copays), restricting eligibility and increasing retiree contribution requirements. The common cost control method of placing caps on the employer obligation will continue to have a very big impact on the cost-shifting to retirees.

The introduction of the new Medicare prescription drug program seemed to have caused some employers to drop coverage for Medicare-eligible retirees starting in 2006. Back in 2005, nine percent of respondents to the Kaiser/Hewitt survey of large private sector employers indicated that they planned to discontinue drug coverage in 2006.[4] With the government taking on more responsibility in financing health care for these retirees, it could delay much further action to reduce coverage, at least in the short-term, or prompt employers to change the design of their retiree health plans for Medicare-eligible retirees to take advantage of the greater reimbursement for Medicare drug costs. In the same survey, 91 percent of employers planned to continue their drug coverage, representing 98 percent of all retirees.

The GAO report cited the Hewitt study that estimated employers will have cost savings from the introduction of the Medicare drug benefit and would likely retain the employer coverage.[5]

The Congressional Budget Office (CBO) assumed in their estimates of the new program that 2.7 million Medicare beneficiaries would lose their employment-based benefits. Another CBO study concluded that 17 percent of Medicare Part B enrollees would lose their employer-sponsored plans.[6] And another study estimates that about a quarter of retirees (2.1 million) will lose their coverage.[7]

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[4] *Prospects for Retiree Health Benefits as Medicare Prescription Drug Coverage Begins* [31].

[5] Hewitt Associates, *The Implications of Medicare Prescription Drug Proposals for Employers and Retirees*, Kaiser Family Foundation, July 2000.

[6] Holt-Eakin, Douglas, CBO letter to Senate Budget Committee, November 20, 2003.

[7] Thorpe, Kenneth E., *Implications of a Medicare Prescription Drug Benefit for Retiree Health Care Coverage: An Update Based on the Medicare Conference Agreement*, Emory University, November 17, 2003.

Estimates made by an EBRI analysis found that two to nine percent of current Medicare beneficiaries would lose their employee benefits because of the new Medicare benefit.[8] They cite other factors that may also force employers to drop benefits such as business conditions, accounting, and cost trends. The GAO paper adds other factors such as the Erie County age discrimination case[9] and the aging baby boom generation as contributions to the decision to drop coverage.

With the above "predictions" in mind, look back at Figure 2.3 that shows the prevalence of retiree health coverage from 1991 through 2013. In 2006, 63 percent of employers offered pre-65 coverage and 52 percent offered post-65 coverage. Both percentages dropped significantly in 2007 (59 percent and 46 percent, respectively) – four points for pre-65s and six points for post-65s. By 2013, the prevalence for pre-65 retirees has dropped to 45 percent and 30 percent for post-65 retirees. Of significance is the difference between employers offering pre-65 and post-65 coverage. There was an 11 percentage point difference in 2006 which increased to a 15 percentage point difference in 2013. Of the employers offering post-65 coverage in 2006, 42 percent dropped coverage by 2013 (1.00 – 0.30 ÷ 0.52) and 8 percent (0.04 ÷ 0.52) of that drop could be due to the introduction of the Medicare prescription drug benefit. The overall drop in prevalence could, of course, also be linked to an expanded Medicare program. It is difficult to assess the interdependency of the many external influences of plan design.

The significance of the above observations is that external influences will affect retiree group benefits in some fashion and these need to be considered when anticipating the future of the programs.

In addition to employer-sponsored coverage, retirees have access to other types of coverage. In 2012, 44 percent of pre-65 retirees had employer-sponsored coverage but another 41 percent had some other type of health insurance coverage.

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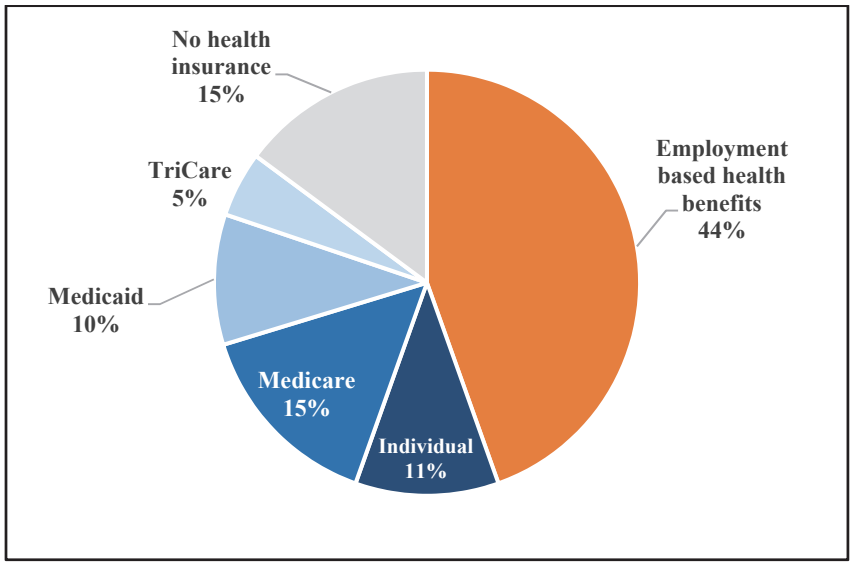
[8] Salisbury, Dallas and Paul Fronstin, *How Many Medicare Beneficiaries Will Lose Employment-Based Retiree Health Benefits if Medicare Covers Outpatient Prescription Drugs? EBRI Special Analysis SR-43*, Employee Benefit Research Institute, July 2003.

[9] *Erie County Retirees Association v. County of Erie*, 220 F.3d 193 (3rd Cir. 2000) cert. denied, 69 U.S.L.W. 3409 (U.S. March 5, 2001) (No. 00-906). See Chapter 6.

Retirees Age 55 to 64 with Health Coverage, 2012



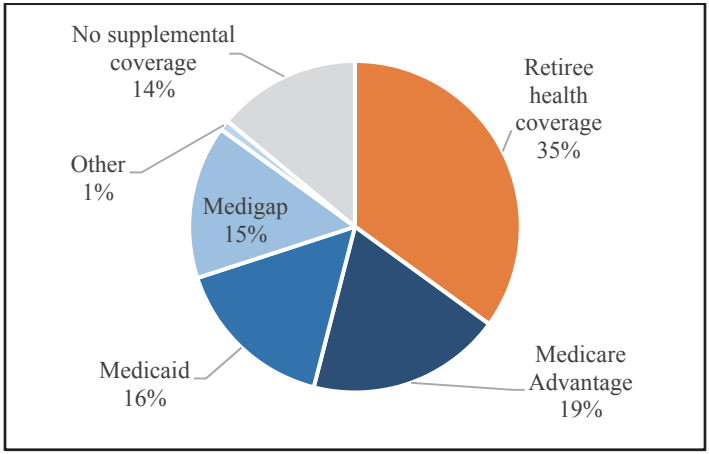
Source: Kaiser Family Foundation analysis of 2012 Current Population Survey

Figure 2.8

With the PPACA marketplaces in place in 2014, it would be expected that individually purchased coverage will increase from the 11 percent level in 2012. In fact, many experts have viewed that the lack of employer-sponsored retiree health insurance has "trapped" many individuals in employment within this age group. Countering those views are many surveys of individuals expecting to delay retirement due to other financial considerations.

Most post-65 retirees have had Medicare coverage. In addition, 86 percent of those with Medicare had some other supplemental coverage.

Medicare Retirees with Supplemental Health Coverage, 2010

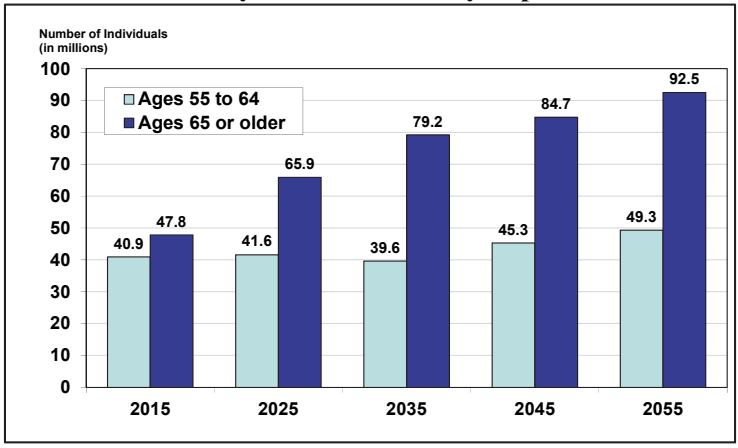


Source: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2010.

Figure 2.9

The post-65 population is expected to nearly double between 2015 and 2055. This will put an increasingly severe strain on the health care system because the average cost of care is higher for this population than all others. Figure 2.10 shows the projected growth of the pre-65 and post-65 retiree population.

Baby Boom Generation Will Greatly Increase the Elderly and Near-Elderly Population



Source: U.S. Census Bureau, "Table 9: Projections of the Population by Sex and Age for the United States," selected years 2015 to 2040, 2014

Figure 2.10

Figure 2.11 provides a relative comparison of costs by age. Both male and female costs per capita continue to increase until age 90 and then begin to slow down, and female costs actually decline after age 90. Most clinical experts anecdotally believe that the observed decline is because individuals reaching these ages are healthier than average and there is less heroic medicine performed. A 75 year old female costs 2.9 (3.44 ÷ 1.21) times a 40 year old female and a 75 year old male costs 5.1 (3.78 ÷ 0.74) times 40 year old male.

Total Costs by Age

Source: Author's expansion of tables in Society of Actuaries study[10] assuming continued private sector costs after age 65 (Medicare eligibility).

Figure 2.11

IMPACT ON RETIREES

The impact of eroding coverage on individual retirees is varied and depends on a number of factors. This loss of coverage will affect retirees differently. Some may have other coverage available through their spouse or from another association program or public program for which they may be eligible. Some early retirees may use the health continuation coverage

[10] *Health Care Costs—From Birth to Death*, Society of Actuaries, June 2013, Charts 5 and 10. See Appendix E.

(COBRA) available from their former employer, but that coverage is generally only offered for 18 months.

Prior to health reform, some retirees were in poor health and therefore not eligible for individual insurance coverage. The GAO paper shows the percentage of employed and retired individuals who reported their health to be fair or poor (updated by the author).[11] Prior to the establishment of the ACA health marketplaces in 2014, these individuals were not likely to be eligible for individual medical policies. Without access to a nationalized program like Medicare, they entered the uninsured statistics.

Table 2.1

Individual's Assessment of Health

Age	Percentage Reporting Fair or Poor Health	
	Employed	Retired
55 to 64	9.4%	22.5%
55 – 59	9.1	21.2
60 – 64	9.7	23.0
65 and over	12.7%	30.6%
65 – 74	12.5	26.3
75+	13.4	34.6

Source: GAO analysis of the current population survey updated by the author.

The new health marketplaces provide insight into health insurance costs by area of the country. Table 2.2 shows 2015 average rates for a Gold Plan[12] for a 30 year old and 60 year old in various cities.

[11] Author update of GAO analysis of the March 2000 Current Population Survey using the March 2013 Current Population Survey.

[12] Plan design pays about 80 percent of eligible health care costs.

Table 2.2

Average 2015 Rate of Gold Plans by City[13]

	Monthly Premium 30-Year Old	Monthly Premium 60-Year Old
New York City, NY	$ 516	$ 516
Miami, FL	368	879
Chicago, IL	287	687
Denver, CO	293	701
Minneapolis, MN	242	577
Fargo, ND	316	755
Los Angeles, CA	306	732

Note that the premium rates for New York City are the same for the 30 year old and the 60 year old. This reflects that state's decision to maintain its long-standing community-rating rules that do not allow individual health insurance rates to vary by age. For all other locations, the 60 year old rate is 2.39 times the 30 year old rate, which is the standard federally established age factor difference for the two ages.[14]

The average premium rates of Gold Plans result in annual premiums ranging from $6,200 to $10,500 per year for a 60 year old. Under the new health marketplaces, other plan designs are available that are either richer or leaner than Gold Plan designs, resulting in many choices for the retirees to consider.

Another interesting phenomenon that occurs with the calculation of the federal premium subsidies may also help early retirees if they have income

[13] Straight arithmetic average of available Gold plans by city calculated by the author from the federal (Miami, Chicago, Fargo) and state (New York, Denver, Los Angeles) marketplace sites for 2015.

[14] The ACA limits the range of a premium based on age to no more than a 3:1 ratio, which prevents insurers from charging an adult age 64 or older more than three times the premium for the same coverage charged to a 21-year-old in the non-group insurance market. The federally established age curve applies unless a state specifies a different set of ratios. http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating.html#age

less than 400 percent of the federal poverty level (FPL). For the 2015 subsidy calculation, the FPL for a household of one is $11,670 and $15,730 for two. Thus, households may be eligible for subsidies with household incomes up to $62,920 for a two person household. The subsidies are designed to limit the monthly premium a person pays based on a percentage of income. The premium limit for a one-person household shown in Table 2.3 varies by household income as a percentage of the FPL and is the percentage of income used as the maximum premium limit.

Table 2.3

Individual Household Subsidy Table

Household Income As a Percent of FPL		2015 Income Level		Premium Limit	
Low	**High**	**Low**	**High**	**Initial**	**Final**
0%	133%	$ 0	$ 15,520	2.00%	2.00%
133%	150%	15,520	17,510	3.00%	4.00%
150%	200%	17,510	23,340	4.00%	6.30%
200%	250%	23,340	29,180	6.30%	8.05%
250%	300%	29,180	35,010	8.05%	9.50%
300%	400%	35,010	46,680	9.50%	9.50%
400%	999%	46,680	999,999	100.00%	100.00%

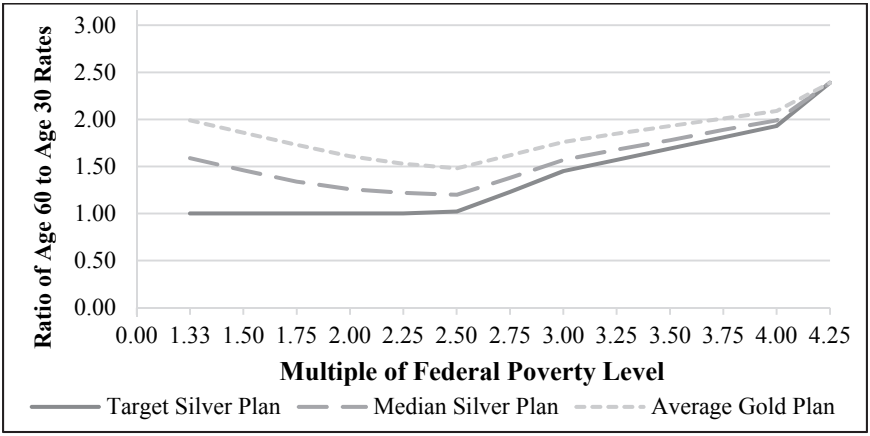
For an individual making $15,520 or 133 percent of the FPL for a one person household ($11,160 × 1.33), the premium for the second lowest Silver plan (benchmark plan) in their area is limited to 3.00 percent of their income. If the individual had income of $17,510, the premium would be limited to 4.00 percent of income. For income between the ranges shown in Table 2.3, the percentage is interpolated.

For 2015, the benchmark plan premium in Chicago was $191 per month for a 30 year old and $457 for a 60 year old. For an individual earning $17,510, the premium rate for the benchmark plan is limited to 4.00 percent of income or $58 per month ($17,510 × 0.0400 ÷ 12). Their federal premium credit is therefore equal to $133 ($191 - $58). If, for example, one selects the benchmark plan, the premium, after the federal premium credit, would be $58.

A similar calculation done for a 60 year old would start with the $457 premium. The federal premium credit would also limit the premium for the benchmark plan to the same $58, so the credit would be equal to $399 ($457 - $58).

If, however, either of these individuals select a different plan, he or she would also pay the incremental premium difference between the full premium of the selected plan and the full premium of the benchmark plan. For example, the median Silver plan in Chicago costs $220 for a 30 year old and $526 for a 60 year old. The 30 year old would pay $87 ($58 + $220 - $191) instead of $58 and the 60 year old would pay $127 ($58 + $526 - $457) instead of $58. The ratio of the resulting net premiums ($127 ÷ $87 = 1.46) is less than the ratio of the total premium rates ($526 ÷ $220 = 2.39). The 2.39 ratio is the full age difference in the cost of health care allowed under the ACA between a 60 year old and 30 year old. There are thus further age subsidies provided for individuals with lower incomes.

As income increases, the age subsidies will go away as the premium subsidies become smaller for those selecting the benchmark plan. In addition, this premium credit formula creates an interesting pattern when comparing the ratio of the net premium for a 60 year old compared to a 30 year old premium assuming the same income if they elect other plans. The following chart shows the ratio at varying income levels.



Ratio of age 60 premium rates to age 30 premium rates for the Chicago rating area in 2015 for various multiples of the federal poverty level for an individual.

Figure 2.12

Figure 2.12 shows two patterns. One is the decreasing and then increasing pattern of the ratio of the age 60 premium compared to the age 30 premium and the second is that the ratio is greater the higher the cost plan the individuals select. If the individuals select the benchmark plan, the ratio is 1.00 until income reaches 2.5 times FPL.

The ratio declines until the income is at 2.5 times the FPL and starts to increase up to the limit of the federal subsidy limit of 4.00 times FPL. The reason it begins to increase at 2.5 times FPL is because the subsidy for the 30 year old goes away because their premium without the federal subsidy is less than the income-based premium limit. The 60 year old still receives a subsidized premium until their income exceeds 4.0 times FPL. The ratio for the benchmark plan is 1.00 until the subsidy goes away for the 30 year old but continues for the 60 year old.

Note also that the chart shows an increase in the ratio from 4.0 times FPL to 4.25 times FPL. The increase actually occurs as soon as income exceeds 4.0 time FPL by a penny. Keep in mind that the inflection points shown in Figure 2.12 were calculated for the Chicago rating area and will vary for other premium rating areas.