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Changing Dynamics and Risk Sharing in Employer-Provided Retiree Medical Benefits

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Agenda

- Background and current situation
- Results of modeling
- Policy issues
- The Future

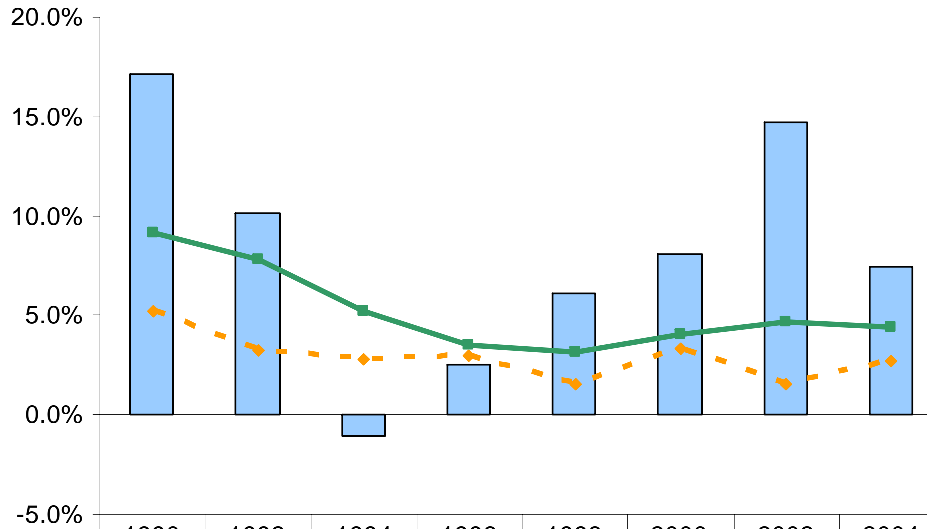
Background and Current Situation

- Major financial pressure on employers – global competition and outsourcing
- Aging workforce
- Benefits drive employment/retirement decisions
- Major focus on employee benefit plan risk
- Health costs crowding out pay and retirement benefits
- Health costs increasing much more rapidly than CPI long term
- Retiree health and conventional benefits in state of decline
- Medicare changes create opportunity and uncertainty

Health Care Cost Increases in Perspective
Results over the last 15 years

- Employer plan costs have risen all health care costs
- Health care costs have risen faster CPI

CPI and Active Employee Health Care Cost: Annual Percentage Increase

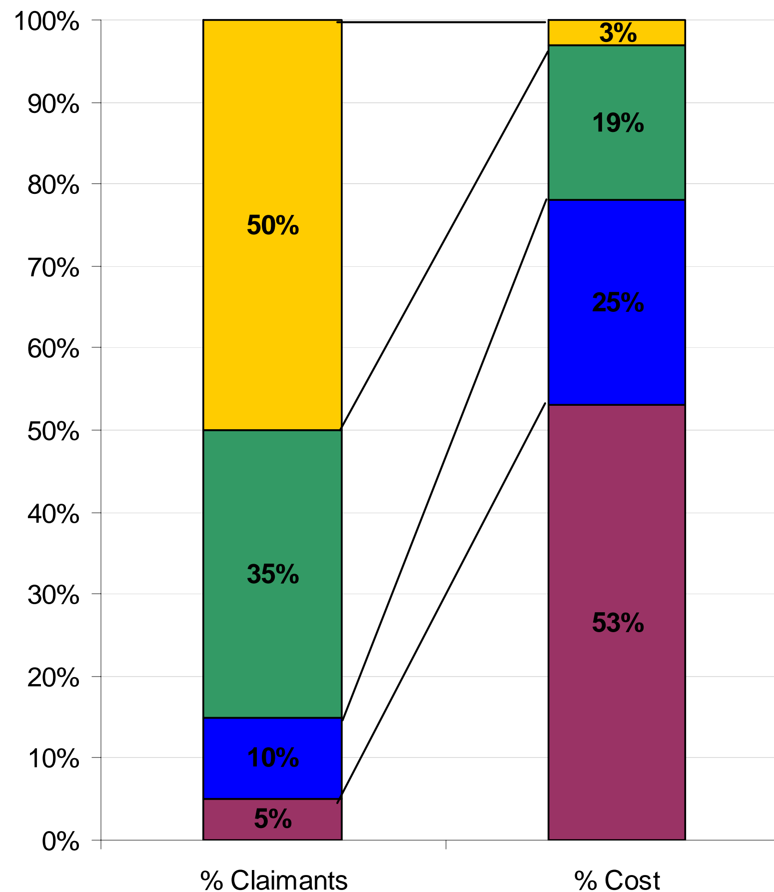


	1990	1992	1994	1996	1998	2000	2002	2004
Employer Trend	17.1%	10.1%	-1.1%	2.5%	6.1%	8.1%	14.7%	7.5%
CPI: All Items	5.2%	3.2%	2.8%	3.0%	1.6%	3.4%	1.6%	2.7%
CPI: Medical	9.2%	7.8%	5.2%	3.5%	3.2%	4.1%	4.7%	4.4%
Ratio: Medical/All	1.77	2.44	1.86	1.18	2.05	1.21	2.97	1.64

Average Annual Increase	1990-2004
CPI: All Items	3.1%
CPI: Medical	5.5%
Employer Trend	8.2%

Claim Distribution for Medical Benefits

- Market alternatives heavily influenced by (claim distribution)
- Selection: major factor in managing medical benefits



Employer Approaches to Retiree Health

Traditional approaches

- **Plan defines benefits as medical reimbursement and defines what costs will be paid**
- **Large part of risk is with employer**
- **Plans managed by**
  - Reasonable and customary limits
  - Use of networks
  - Cost sharing
  - Disease management, etc.
  - Recently through consumerism, focusing on people spending their own dollars
- **Common to link to active plan (particularly for early retirees)**

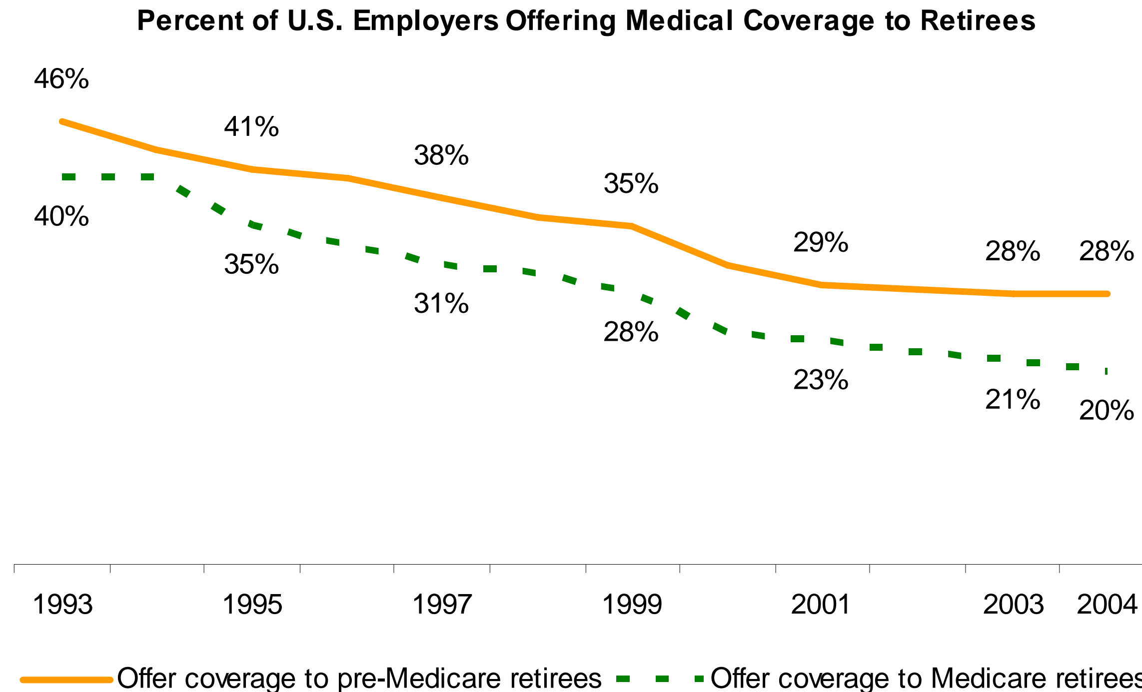
Defined contribution approaches

- **Plan defines benefits as an amount of money to pay for benefits**
  - Can be annual
  - Can be lump sum over a lifetime
- **Participant bears much more risk**
- **Program also likely to include method of converting funds to medical benefits**
  - Marketplace options
  - Employer insured plan
  - Employer self-insured plan

Funding can be used with either approach

Retiree Medical Coverage is in Decline

- **Fewer employers (with 500+) are offering coverage**
- **Impacts decision to retire and security in retirement**



Two Groups Of Retirees

Net yet Medicare eligible

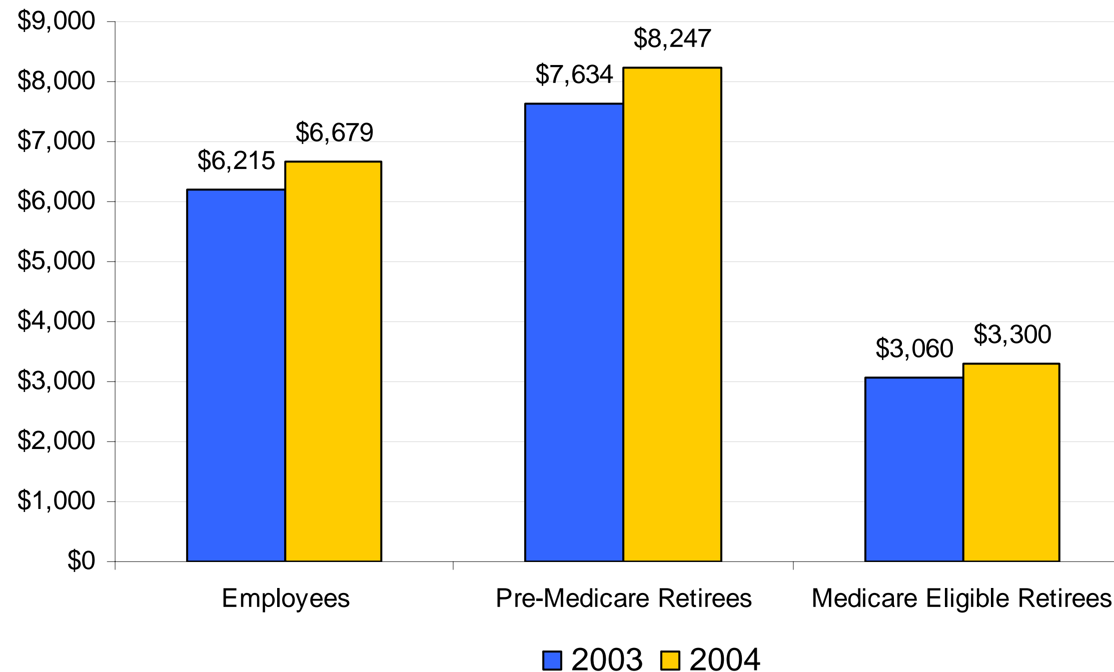
- **Without employer coverage, many can not afford to retire**
- **Coverage is costly – to employer, retiree, or both**
- **For those in poor health, access + cost are major issues**
- **Coverage among 55-64 population not employed**
  - 48% employer coverage
  - 18% uninsured
  - 24% public programs
  - 10% individual coverage

Medicare eligible

- **Employer coverage supplements Medicare**
- **Market also offers supplemental coverage and MA plans**
- **Prior to MMA, Medicare covered less than half of total cost**
- **Biggest gaps in Medicare**
  - Drugs, significant coverage under Part D starting in 2006
  - Nursing home care

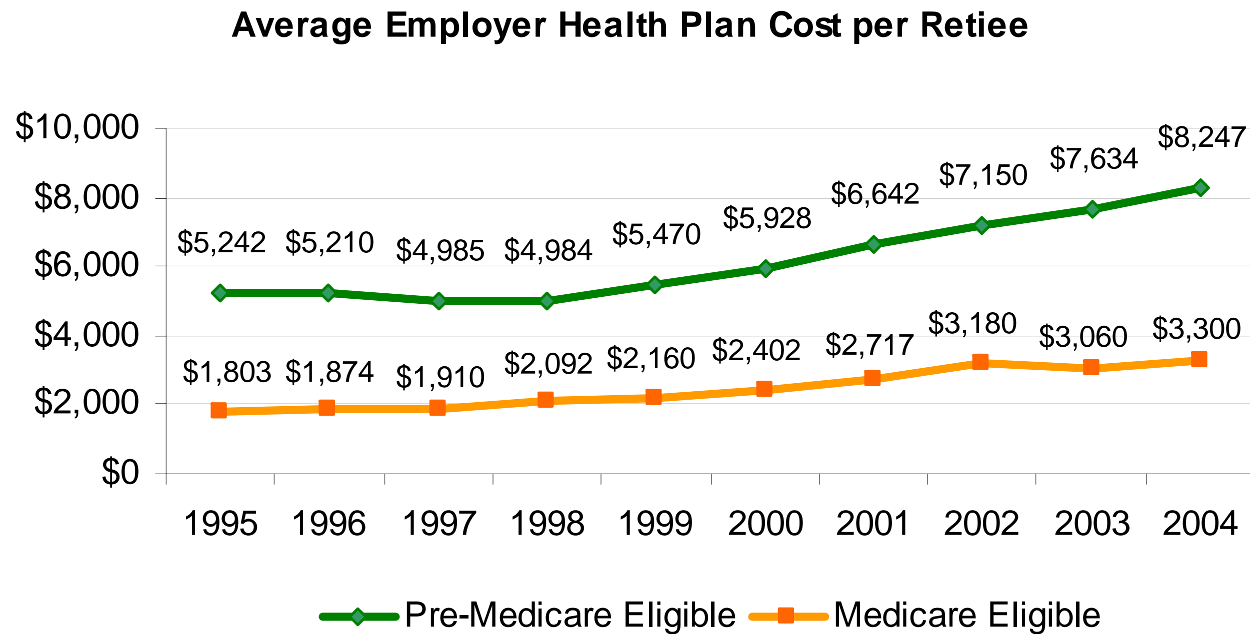
Average Employer Plan Per Capita Costs

- **Early retirees are most expensive**
- **Drivers of cost differences: age, Medicare, handling of disability**



Employer Per-capita Costs For Retiree Health 1995-2004

- **Cost increases driven by CPI, design changes, selection**



Medicare Modernization Act

- **Adds prescription drug coverage**
  - Requires payment of Part D premium
  - Incomplete coverage – deductibles, coinsurance and “donut hole”
- **Range of choices for employers**
  - Most common --- take 28% subsidy
- **Revised Medicare risk contracts – now Medicare Advantage**
  - Experience before MMA driven by government payment levels
  - Lot of skepticism
- **Part B premiums increased**

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Modeling Future Costs

- **Mercer modeling of future costs and resources**
  - Per capita costs in 2031 under several scenarios
  - Present values of benefits at retirement age
  - HSA accumulations and values of benefits needed
- **Penner and Johnson modeling of costs**
  - Health care spending for married couples projected to grow from 16% of after-tax income in 2000 to 35% in 2030

Modeling Individual Costs
Annual Cost in 2031

Hypothetical Average Cost for Individual Retirees in 2031

	Estimated 2006 Cost[6]	Trend Assumption for Projection to 2031		
	Mercer Survey Projected[3]	1999-2004 Experience Repeated[4]	1995-2004 Experience Repeated[5]	Representative FAS 106 Trend
Pre-Medicare				
Employer Plan Cost (ErPC)[6]	$5,712	$44,928	$20,284	$25,099
Retiree Benefit Out-of-Pocket 1	$1,008	$7,928	$3,580	$4,429
OOP + 50% ErPC	$3,864	$30,392	$13,722	$16,978
OOP + 100% ErPC	$6,720	$52,856	$23,864	$29,528
Medicare-Eligible				
Employer Plan Cost[6]	$1,423	$11,720	$7,545	$6,253
Retiree benefit OOP	$1,290	$10,627	$6,841	$5,670
Medicare Premiums[2]	$1,459	$12,018	$7,737	$6,412
Total Retiree Out-of-Pocket	$2,749	$22,645	$14,578	$12,082
OOP + 100% ErPC	$4,172	$34,365	$22,123	$18,335
Trend pre-Medicare		8.6%	5.2%	6.1%
Trend Medicare-Eligible		8.8%	6.9%	6.1%

See Appendix for notes

Modeling Value of Benefits at Retirement Employee Age 35 Now Retiring at 60 in 2031

- **Five scenarios modeled for cost increases**
- **Range of total value at retirement –**
  - $.5 million to $2.3 million (10% annual cost increase)

Employee Age 35 in 2006, Retiring at Age 60 in 2031[1] (Thousands)

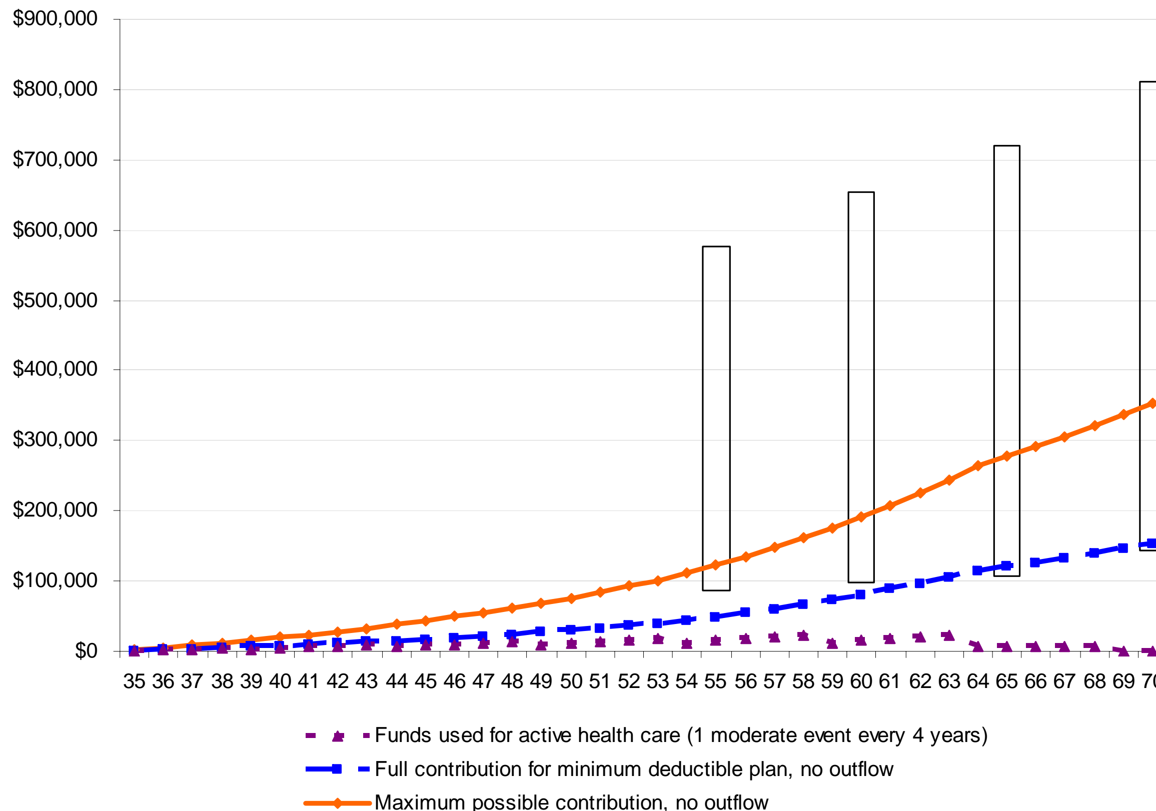
Trend Assumption for Projection to 2029

Retiree Cost Basis	1999-2004 Experience Repeated	1995-2004 Experience Repeated	Representative FAS 106 Trend
Out-of-Pocket (OOP)	$214.1	$98.1	$76.0
OOP + 33% ErPC[2]	$614.6	$281.6	$218.0
OOP + 67% ErPC	$1,027.1	$470.6	$364.3
OOP +100% ErPC	$1,427.6	$654.1	$506.4

1. Assumes an interest rate of 5%
2. Employer Plan Cost

Modeling Health Savings Accounts Accumulations vs. Expected Costs

- **Maximum accumulations not enough to meet needs**
- **To get maximum --- participant can't use funds for current needs**



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Policy Issues Going Forward

- **Extent and nature of government involvement in health care**
  - What is provided through government programs
  - Regulation of private sector insurance
  - Regulation of employee benefits
- **Uninsured**
- **Tension between market based competition and collective action**
  - Limits on competition driven by nature of claim distribution
  - Risk adjustment is alternative to underwriting
- **Big problems for early retirees**
- **Fine-tuning of Medicare Modernization Act**
- **Bringing Medicare into financial balance**

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Future Issues

- **Health system generally**
- **Medicare**
- **Employer role in retiree health**
- **Challenges implications for retirees**

Future Issues: Health System Generally

- **Costs increasing as % of GDP**
- **Employer based vs. universal coverage vs. market based**
- **Question of sustainability based on total cost**
  - Views differ as to limit
- **Continued issues surrounding uninsured**
- **Private insurance challenged**
  - Conflict between underwriting and the need to cover all
- **Unclear what methods of system management might work**
  - Managed care, consumer directed health care, rationing
  - Use of alternative medicine, nurse practioners
  - Defined fee schedules
  - Utilization guidelines and definition of formulary
  - Medical necessity plus reasonable and customary limits

Future Issues: Medicare

- **Long term cost projections → need for change**
  - Costs projected to increase from 2.6% of GDP in 2004 to 13.6% in 2079
  - Trust fund projected to be exhausted by 2020
- **Big question: role of competition and market alternatives**
- **Big question: cost sharing with participants**
  - Contributions
  - Co-pays and deductibles
- **Big question: who will be covered**
- **Big question: what will be covered**
- **Big question: how will providers be paid**

Future: Employer role in retiree health

- **Bigger question: employer role in health generally**
- **If employer stays:**
  - Offer coverage vs. funds to pay
- **Only largest employers likely to offer coverage**
- **Different issues depending on Medicare eligibility**
- **Cost control and risk management will be part of the issue**
- **Funds to pay**
  - Systematic pre-retirement savings programs

Future: Challenges for retirees

- **Securing health coverage and dollars to pay for it**
- **Health coverage = major factor in retirement decisions**
- **Before Medicare eligibility**
  - Cost is high (likely to increase)
  - Access is a potential problem
  - Both likely to get worse in the future
  - Market change is possibility
- **After Medicare eligibility**
  - Money is main problem
  - Access not an issue at present
  - Market alternatives will be a factor

Appendix

Hypothetical Average Cost for Individual Retirees in 2003

- **Assumes an employer plan that covers 85% of total cost.**
- **Assumes Medicare-eligible retiree pays Part-B premium (assumed to be $85 per month in 2006) and Part-D premium ($36.60 per month) out-of-pocket. In addition, the retiree pays benefit expenses out of pocket.**
- **Employer plan cost does not include retiree out-of-pocket costs. The individual Pre-Medicare cost before Medicare enrollment is derived from an amount that includes covered dependents, assuming 1.65 risk units per covered retiree. (Individual cost = total cost/1.65.) Medicare cost was derived from an amount that includes covered dependents, assuming 1.60 risk units per covered retiree.**
- **Based on Mercer Survey data from 1999 through 2004, the Pre-Medicare annual trend is 8.6%, and the Medicare annual trend is 8.8%.**
- **Based on Mercer Survey data from 1995 through 2004, the Pre-Medicare annual trend is 5.2%, and the Medicare eligible annual trend is 6.9%.**
- **Based on 2004 Mercer Survey data for individual retiree cost in 2004, projected to 2006 using the average "starting costs" of two historical periods; the Medicare groups cost adjusted for impact of MMA assuming employer plan is secondary to Medicare Parts B and D with non-duplication of benefits integration. (Assumed Part D offset of $976 to employer cost or 55.6% of the $1,755 estimated part D cost)7. Based on pre-Medicare benefits integrated with Medicare A, B and D using the non-duplication of benefits approach ("carveout").**