The Impact of Health Care Reform on Older Workers, Retirees and Employers

by Anna M. Rappaport, Steven Wojcik and Michael Baxter

The Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010 impacts everyone who uses or pays for the health care system. Among the new law’s effects will be changes in older workers’ health care choices as they transition from full-time employees to part-time work or other jobs and, ultimately, to retirement, and the retiree health benefit choices facing their employers. This article reviews the major issues surrounding these changes, including those affecting retiree health benefits, benefits for Medicare-eligible retirees and health care options for older Americans not yet eligible for Medicare. The authors conclude that although employers will be reacting in 2010 and 2011 with regard to some issues surrounding FASB ASC 715-60 and the early retiree reinsurance program, employers should consider waiting to make major changes until regulations are issued and the health plans for active employees have been fully vetted.

INTRODUCTION

As the baby boomers reach retirement age, they and their employers confront challenges made more complicated by the recent economic downturn, and many will have new options as a result of last year’s health care legislation. Employers struggle to keep workforces lean, deal with cost constraints and rising health care costs, manage talent and help older employees retire. Employees approaching retirement want to move into it in ways that will help them continue to have secure and fulfilling lives. For employees with long tenures, their employers have been their traditional source of health benefits, often throughout their working lives. Many have counted on their employers to continue to be the source of benefits during their early retirement, but employers have been cutting back on retiree benefits as the costs of these benefits continue to rise much faster than inflation. Other employees, either with shorter tenures or working for employers that offer few if any retirement benefits, know they must rely largely on themselves to plan for their own retirement and health coverage when they are no longer working.

With health care reform, all parties are asking the questions: Does this change retiree coverage and how? Will it impact older employees’ opportunity to phase into retirement or the timing of their retirement? Employers, too, have questions and are studying the implications for their future health benefits strategies. A number of the law’s provisions will directly impact older employees, retirees and employers offering retiree coverage—including the tempo-
The authors believe that many companies will wait before determining long-term strategy on retiree health benefits. New data provide some early indication of what benefits managers are thinking when it comes to health benefits for active employees. A May 2010 Towers Watson survey of 650 benefit professionals on the impact of health care reform on employers reported that 88% of responding employers are likely to continue to provide coverage to active employees, while only 3% are likely to pay the penalty to the government for not offering coverage or offering coverage that does not meet or exceed government-set comprehensiveness or affordability targets, and 9% don’t know. Many are contemplating changes, however. Sixty-eight percent of employers planned to reexamine their health benefit strategy for active employees by the end of 2010.

For retirees, the situation is very different. Seventy-seven percent of respondents in the Towers Watson survey expect that the law will reduce the number of companies offering retiree health benefits. Forty percent of benefit professionals say their company is likely to reexamine its health care strategy for retirees. Of those employers offering health coverage to retirees, 43% of the respondents indicate that their firms are looking into reducing or eliminating benefits for retirees, while 37% expect no change in retiree health benefits as a result of health reform.

**Growing Numbers of Older Workers Approaching Retirement**

The impact of the health care legislation on retiree health is all the more significant because of the number of aging baby boomers, leading to a rapidly growing population nearing traditional retirement. From 2008 to 2018, the aged-55-and-over population is projected to grow from 18% to 24% of the total workforce—and is growing at a faster rate than is projected for the general workforce as a whole, which includes people aged 16 and over. Adding to the effect of this demographic wave as it ages are a number of other factors. Life spans have increased, as have the number of active years people can expect before disability. Employees are becoming more responsible for financing their own retirement. At the same time, many boomers’ investment portfolios and/or housing values have plummeted in recent years because of the economic downturn and, as a result, some have postponed retirement out of financial necessity. Although many people have seen their 401(k) balance and other in-

Employees will have to consider:
- How the law changes their employee health benefits
- How it changes their future retiree health coverage
- Any changes in their decisions about the timing of phased and full retirement.

As employers implement the provisions of the legislation, they will need to consider:
- Reviewing the law and regulations to assess the impact on their plans
- Deciding what strategy to adopt for active coverage
- Reviewing the health coverage options for retirees that become available in the marketplace
- Deciding what is the best strategy for retiree coverage
- Communicating their strategy to retirees and employees.
vestment portfolios regain a sizable part of the value lost, many individuals who are nearing retirement want to continue working until they feel more secure about the economic recovery and what it will mean to them. Others who will be getting health care through exchanges starting in 2014 are delaying retirement until they see how the exchanges operate.

Many older workers today choose to work part-time, freelance as consultants if they can, work in completely different lines of work, many of which may not offer benefits, and/or transition from full-time status to part-time status before fully retiring. Health coverage has been a major challenge for older workers trying to work part-time or use one of these other options. Beginning in 2014, the new legislation should increase their options. These changes have the potential to affect their employment choices, as well as the health care benefits offered by employers.

**INCREASED HEALTH CARE OPTIONS FOR OLDER AMERICANS NOT YET ELIGIBLE FOR MEDICARE**

Currently, access to affordable health care is a critical issue for many Americans. Most people under the age of 65 depend on their current employer, a former employer or a spouse’s employer for health care coverage. Opportunities to purchase health care on the individual market are very limited and expensive, particularly for families in which one or more members have a preexisting or chronic health condition. Preexisting health conditions within the family also make it especially hard for an employee to change jobs. As a result, access to health insurance has been an important determining factor when it comes to deciding which job to take, when to retire, or if leaving work for other reasons is even possible.

The new law is expected to change the landscape considerably in the next few years. Americans aged 55-64 stand to benefit most from these changes. In many cases, the between 5.25 million and six million Americans aged 55-64 in 2014 who are expected to be working part-time or seasonally, according to Department of Labor projections, will not have employer-sponsored health coverage.

Beginning in 2014, people without employer coverage and those who work for small employers will be able to purchase health insurance through state-based American health benefit exchanges. The Towers Watson survey states: “By providing pre-65 retirees with access to health benefit coverage in the individual insurance market, health care reform will have a sweeping impact on many individuals who have been reluctant to retire.”

If the exchanges do turn out to provide affordable health care options for people, we agree. Several provisions in the law will help to assure that coverage through the exchanges is affordable. Americans will be required to purchase insurance or pay a penalty tax of the greater of $95 or 1% of household income in 2014, $325 or 2% of household income in 2015 and $695 or 2% of household income in 2016. Therefore, younger, healthier people who currently may not have coverage will be part of the market. The exchanges will charge premiums based on age and sex, but not health status, aiding those with prior health histories and preexisting conditions. Subsidies for individuals with incomes below 400% of the federal poverty level will be available.

Over time, beginning in 2017, states may permit large employers to participate in the exchanges as well, which will also likely improve affordability if the exchanges add them to the pool. Likely candidates will be state and local employees—often one of the largest employee groups in each state.

However, coverage may still cost more than people expect. Massachusetts, which adopted a health reform law in 2006, has struggled to keep coverage options in its exchange affordable and has had to scale back its health care subsidies for low-income people who qualify for assistance to purchase coverage. Many Americans probably do not realize what health care costs, and they will be surprised at the premiums for fairly priced coverage. Once the federal tax credits become available in 2014, people under 400% of the poverty level will be eligible for some relief, but others will not. According to the Kaiser Family Foundation benefits survey, the average annual premium for single individuals in 2009 was $4,824 and the employee contribution was $779, so the average employer contribution for single individuals in the company covered by the survey was more than $4,000.

Health care for people aged 55-64 costs considerably more than the average cost for all ages, and they are not yet eligible for Medicare. In 2010, Fidelity Investments estimated that a 65-year-old couple retiring in 2010 will need $250,000 to pay for medical expenses through retirement, not including long-term care. In a survey on the topic, Fidelity found that 47% of the respondents, all married individuals over the age of 65 not working full-time, were paying more for health premiums and out-of-pocket expenses than they had anticipated. This study assumes that the couple has Medicare coverage but not employer-sponsored retiree health, and does not consider...
health care reform, though it is not likely to significantly lower the estimate.

If the exchanges can in fact provide a viable alternative for affordable coverage, they should open up new options for older workers. Then health insurance will not be as much of a deciding factor in determining when older employees change jobs, change job status (from full-time to part-time) or even retire.

Employees who may seek alternative work options include the following:

- Those who have significant caregiving responsibilities
- Those who have a passion they wish to pursue (e.g., travel) and who are trying to transition to that new interest
- Spouses of retirees
- Those seeking a second career or a less demanding type of work
- Those seeking a different work/life balance
- Those in very physically and mentally demanding jobs who need to reduce the demands placed on them
- Those with health issues but still able to work, albeit in less demanding, more flexible employment
- Those with sufficient savings who are no longer dependent on work for income but who nevertheless enjoy work and can accept lower pay.

**Implications for Retiree Health Benefits**

The new law has provisions that will affect retiree health benefits over the long and short term. Changes made to health benefits for active employees may affect retiree benefit programs for future retirees, and other changes may be contemplated for early retiree coverage. In addition, changes to Medicare, Medicare Advantage and Medicare Part D prescription drug plans may influence retiree health programs, since retiree health benefits operate in partnership with Medicare. Because much of the impact of the law is unknown at this point, many plan sponsors are taking a wait-and-see attitude toward planning the future strategy for their retiree health plans, for both their pre-aged 65 and Medicare-eligible former employees. Instead, they have focused on short-term issues, including the federal reinsurance program for early retiree plans and the tax changes and other Medicare changes for post-aged 65 retiree plans.

**Temporary Early Retiree Reinsurance Program**

Immediately after enactment of the new law, the government established a temporary reinsurance program for retiree health benefits provided to early retirees (those not yet eligible for Medicare) for 2010 through 2013. On June 30, 2010, employer plans began submitting applications for approval to submit claims. The subsidies have encouraged eligible employer plans to continue offering such coverage for those between the ages of 55 and 64 until the exchanges start. The government will make a limit of $5 billion in subsidies available, and the reinsurance covers 80% of eligible claims between $15,000 and $90,000 per individual. Employers that wished to participate in this program applied for eligibility and submitted their qualifying claims as early as possible since acceptance into the program was on a first-come, first-served basis. The reinsurance program is slated to expire in 2014 or when the funds run out. The Employee Benefit Research In-

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**THE AUTHORS**

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The change in RDS tax status will spur more employers to consider options other than remaining the primary source of coverage for retiree health benefits from among Medicare Part D solutions. One option may be to drop coverage, but provide wraparound, secondary coverage and subsidize retirees’ Medicare premiums. Others that want to remain as primary sponsors of coverage may consider other options such as contracting with a Medicare prescription drug plan to enroll retirees as a group in Medicare Part D and negotiate better prices than individually at the retail level for their retirees. A few others may want to consider becoming a Part D plan and contracting with the Centers for Medicare and Medicaid Services (CMS) to cover their retirees directly. In this case, CMS would directly reimburse approved employer plans based on applicable Medicare payment rates.

Other changes in Medicare itself may also lead to changes in retiree health coverage. Several changes are particularly important:

- Payments to Medicare Advantage plans will be reduced beginning in 2011. The revisions will be phased in over three to six years, depending on geographic area. Financial incentives for quality will be implemented by giving bonuses to plans with quality ratings of at least four stars (out of five). Plans with loss ratios below 85% will be required to return some funds starting in 2014. Employers that sponsor Medicare Advantage plans may be affected, as plans may decide to reduce benefits or discontinue offering plans in counties where their retirees are located as a result of these changes. Furthermore, as plans reduce benefits and/or increase participant premiums and cost sharing, employers will likely reevaluate their participation.

- Medicare prescription drug payments are modified to gradually reduce the “donut hole.” A $250 rebate will be offered to retirees who reach the Part D coverage cap in 2010, and the beneficiary share of the Medicare Part D coverage gap will be gradually closed and replaced by a 25% coinsurance requirement by 2020. Drug manufacturers will be required to provide a 50% discount on brand-name drugs filled in the Medicare coverage gap beginning in 2011.

- New annual taxes (fees) will be imposed on the pharmaceutical industry starting with $2.3 billion in 2011. The fees will increase gradually over time. All of these changes will, in turn, change the prices and relative attractiveness of market options for Medicare Advantage, traditional Medicare and pre-

Retiree Plans Exempt From “Grandfathered” Plan Requirements

The regulations released on grandfathered plans in June 2010 clarified that retiree-only plans—plans that do not include an employer’s active workforce—are exempt from plan requirements that apply to active employee plans. Absent this exemption, requiring retiree plans to cover adult dependents to the age of 26 and to remove lifetime dollar limits on the overall value of health benefits and unreasonable annual limits would have raised premiums for retirees and raised costs for plan sponsors.

Changes in Benefits for Medicare-Eligible Retirees

Taxing the Retiree Drug Subsidy (RDS)

For post-aged 65 retiree health coverage, employers that receive federal subsidies for sponsoring primary prescription drug coverage likely adjusted their FASB ASC 715-60 (formerly FAS 106) accounting liabilities in 2010 to account for the taxation of subsidies that will start in 2013.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provided a 28% untaxed subsidy to employers that continue prescription drug coverage through a retiree benefit program. The new legislation changes the tax treatment and taxes the subsidy, producing an immediate increase in FASB ASC 715-60 liabilities. In addition, employers incorporating Medicare Advantage plans into their program will, depending on what they determine their share of the plans’ costs to be, potentially have significant increases in FASB ASC 715-60 costs for their programs, as well, since the government begins freezing payments to these plans in 2011 and then phases in cuts over the next couple of years. The review of FASB ASC 715-60 costs should be updated annually as strategies and requirements may change.

To illustrate prescription costs that employers may face in 2011, the table compares prereform costs with those incurred after reform takes place.

Institute estimates that the $5 billion will run out sometime in 2011.

It is possible that some employers will discontinue early retiree medical coverage when the subsidies end and the exchanges are established. However, at this point, it is still too early to tell how many employers will discontinue coverage and whether the exchanges will offer a good solution for early retirees.

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All of these changes will, in turn, change the prices and relative attractiveness of market options for Medicare Advantage, traditional Medicare and pre-
Building savings programs to help employees save for retiree medical
Dropping coverage, pre- or post-Medicare or both. Coverage may be dropped for a limited group such as new hires, all employees who have not met certain age and service requirements, etc.
Maintaining retiree health coverage but no longer remaining primary for prescription drug benefits
Adjusting post-Medicare retiree coverage to account for changes in the tax treatment of the subsidy and Part D changes that affect the subsidy
Limiting coverage to a fixed or maximum contribution to the cost paid by the employer and increasing the use of employer payments linked to length of service
Limiting eligibility based on length of service or date of hire
Offering a payment or voucher to help retirees buy marketplace coverage through state exchanges in lieu of an employer program
Matching or adapting changes made to active employee health benefits

As Medicare Part D expands, employers that subsidize or wrap around Medicare may scale back their contributions as the government covers more. Similarly, as Medicare preventive benefits increase, employer wraparound coverage for these services will decrease. As Part D benefits expand, employers that provide primary coverage for prescription drugs can expect that the minimum actuarial requirements for eligibility for the subsidy will grow and, though taxed, the subsidy will grow too as the donut hole fills in.

Depending on how the changes to Medicare work out, employers may choose to rethink their post-aged 65 retiree health coverage. Some of the strategic options that employers should consider include the following:

### TABLE

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<th>Employer Cost</th>
<th>Pre-reform Costs</th>
<th>Post-reform Costs</th>
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<tr>
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Unfavorable

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Unfavorable

$233:
The increase in total after-tax prescription drug costs per retiree for employers that provide retiree health benefits coverage

$0:
The change in total after-tax prescription drug costs per retiree for employers that purchase Part D for employees

*Note: Calculations assume a 35% average tax rate.*

IN ADVANCE OF STRATEGY

Before employers can determine a longer term strategy for retiree health, three key events need to take place:
1. Decisions need to be made about the structure for benefits for active employees.
2. Regulations need to be promulgated.
3. Employers need to see how state exchanges develop and how the marketplace will respond in order to be able to evaluate the alternatives available to employees.

• Allowing continuation of coverage during periods of limited employment as a phased retiree.
For employers with unionized workforces, it will be important to consider how to work with unions in building strategies for retiree health care.

OTHER PROVISIONS OF THE LAW AND IMPACT ON RETIREE BENEFITS

Temporary National High-Risk Pool

To address the difficulties people with preexisting conditions face in obtaining health insurance, the new law stipulates that between now and 2014, a temporary national high-risk pool will be established for these individuals. To be eligible, an individual must be uninsured for at least six months. Premiums will be subsidized. The National Business Group on Health projects that because of this required six-month gap in coverage, the high-risk pool will not affect older workers significantly. Some states have hesitated to expand or initiate high-risk pools because of the cost impact on state budgets.

“Cadillac” Tax

Beginning in 2018, the law imposes an excise tax of 40% of the plan value in excess of the threshold amounts on (a) insurers and administrators of employer-sponsored health plans that have per capita aggregate values exceeding $10,200 for individual employees and $11,850 for individual early retirees and (b) those employed in specific high-risk professions and industries and their retirees who have worked for at least 20 years. For family coverage, these values are $27,500 for active employees and $30,950 for early retirees and those employed in the specific high-risk professions. For retirees, the values are indexed with the Consumer Price Index beginning in 2020. Early retiree plans, too, will be subject to the tax, which may be a factor in the design of plans and contribution strategies going forward. A higher threshold applies to early retiree plans and for plans with workforces older than average. The Cadillac tax may be another reason that employers decide to discontinue coverage or provide a flat benefit to help retirees buy coverage through the exchanges.

BUILDING AN ACTION PLAN: CHECKLIST

The National Business Group on Health’s checklist presents a series of questions that employers need to address as they consider retiree health benefits in light of health reform:

☐ Given that there are many unknowns about the regulations and implementation of the new law, how soon do we need to decide on retiree health benefit design?
☐ Will the legislation change our FASB ASC 715-60 liability? If so, how much and when?
☐ Can we benefit from the temporary reinsurance pool for early retiree benefits? If so, what do we need to do to take advantage of this opportunity? What should we do about retiree health benefits this year, and what do we know about the timeline for later decisions?
☐ Should we maintain our retiree health benefits today? After 2014? For future retirees?
☐ How will retirees be affected if the benefit structure for active employees changes?
☐ Should we maintain our current level of retiree health benefits?
☐ Does our plan include benefit maximums or other provisions that must be changed as a result of the legislation?
☐ Would early retirees prefer to have access to the health benefit exchanges?
☐ Will retirees with smaller pension benefits be able to get subsidies through the health benefit exchanges?
☐ Will retirees in geographic areas where we have few (or no) active employees have access to more choices through exchanges than through a company program?
• Until 2014, early retiree health benefits will continue to be an important factor in retirement decisions.
• The national uninsured pool will probably not have much effect on whether an active employee will decide to fully retire.

Employers sponsoring retiree health plans should consider waiting to make major changes until regulations are issued and the health plans for active employees have been fully vetted. However, employers will be reacting in 2011 with regard to some issues surrounding FASB ASC 715-60 and the early retiree reinsurance program.

Endnotes