Retiree Coverage in a Post-ACA World

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Discussion Guide

• ACA After Six Years
  – Current Status of Retiree Medical Programs

• Coverage Options
  – Medicare Advantage/EGWPs
  – Part D Drug Coverage
  – Public Exchanges
  – Private Exchanges

• Legislative Forecast
ACA After Six Years

- Most employers/unions continue to embrace health plans
  - EBRI study\(^1\)
    - No real change in percent of large employers offering health plans (99% over 1,000 lives and 92% - 95% for employers between 100 and 1,000 lives)
    - Decline among smaller employers has been steady since 2008
      - Some consolidation among Taft Hartley plans
- Past (hopefully) the initial ACA challenge - Compliance
  - Fees and taxes
  - Benefit design/eligibility mandates
  - Reporting requirements

\(^1\)Source: July 2016 EBRI Notes: Fewer Small Employers Offering Health Coverage; Large Employers Holding Steady
ACA After Six Years

- After a few years of favorable medical trend, tide turned—There has been no real “bending of the cost curve”
  - Health care cost trends at 5% to 6% while CPI close to 0%
  - Prescription drugs (not only specialty drugs but generic trends as well)
  - Concerns about provider cost shifting to employer-sponsored plans
- Consolidation also a cost issue
  - Providers (hospitals, physician groups)
  - Insurance companies
  - PBMs
- Focus is back to managing cost/care (from compliance)
Cost is a Major Issue

FIGURE 2

ANNUAL CHANGES IN THE MILLIMAN MEDICAL INDEX

2016 Milliman Medical Index – Family of Four, PPO
Focus—Cost of Retiree Plans

• Specific focus on retiree medical costs are critical

• Understanding current and future cash flow, including
  – Expected number of retirements, particularly when compared to expected number of actives
  – The ratio of retirees to actives will be important for
    • Collective bargaining (particularly for plans where active contributions support both actives and retirees)
    • Understanding cash cost (pre-Medicare retirees typically cost more than active employees of the same age)

• Your projections should reflect any increase in the ratio of retirees to actives
  – Particularly in industries where hours/work may be decreasing
Focus—Cost of Retiree Plans

• Impact of ACA fees on retiree cost
  – While Excise Tax on high cost health plans ("Cadillac Tax") is deferred, it is not gone
    • Even with higher limits for Taft Hartley plans, likely to impact pre-Medicare retirees relatively soon
    • Depending on calculation mechanics, may impact all levels of coverage eventually due to index at CPI (which is usually lower than medical inflation)
  – Be aware of the returning fully insured plan fees, especially for Medicare Advantage products
    • Fees waived in 2017, but back in 2018—Can be as much as $30 PMPM for certain plans (more to come)
The ACA and Cost

- Creation of Center for Medicare and Medicaid Innovations (CMMI)
  - Demonstration projects to change provider incentives
    - Pioneer Accountable Care Organizations (ACOs)
    - Bundled payments
  - Identify and remove “waste”
    - Independent Payment Advisory Board
    - Patient Centered Outcomes Research Institute (PCORI)
      - e.g. National Institute for Health and Clinical Excellence (NICE) in UK
- So far, not much has come of this
- Payment reform is not likely to come quickly either
ACA Takeaway

• The US health insurance market has (forever) changed
  – New players emerged (some successfully and some not so much) and existing players facing threats
  – Very little of this change (including insurers abandoning the Public Exchanges) has impacted employer-sponsored health plans so far

• Changes occurring in the delivery system
  – Largely not dependent on the ACA

• Financial pressure likely to change the way healthcare is paid for and therefore delivered
  – Employer landscape changes
  – Individual expectation management

• End state is unclear
  – Best to wait until after January 20, 2017
Impact of Rising Costs

• Employer-sponsored health plans have had to lead in market and pricing reforms
  – Quality initiatives, health plan performance requirements, network management, disease management, alternative contracting

• But health plans have had mixed success with cost management
  – Traditional single employer plans have continued to shift cost to employees
    • Increasing deductibles and copayments, limits on reimbursements and coverage levels
    • According to the recently published 2016 KFF survey, premiums have increased 20% since 2011, compared to CPI increases of 6%
  – Pressure and more cost shifting in multiemployer plans as well
Cost Issues—Prescription Drugs

• Many employers believe prescription drugs are greatest health care cost challenge
  – Specialty drugs
    • Hepatitis C
    • Cancer, Multiple Sclerosis, Cystic Fibrosis and others
    • PCSK9—Cholesterol management at $1,300 per month?
  – Generic drugs
    • High cost generics, including those recently off patent (Crestor)
    • Random price increases
  – Biosimilar drugs
  – Pharmacy benefit manager (PBM) consolidation is likely to reduce competition and increase cost (even though purchasing power should improve)
Cost Issues—Other factors

• Besides PBM consolidation, provider consolidation is also driving cost
  – Hospital system consolidation
  – Hospital systems purchasing physician groups, clinics and outpatient facilities
    • Done to provide more integrated care, and to build ACO strength
    • But adds facility fees and other charges
  – Aetna/Humana, CIGNA/Anthem
    • DOJ interest in the impact of these potential mergers to marketplace
• Cost shifting may also be occurring
  – Medicare and Medicaid continue to squeeze providers—Employer plans may be the “balancing item”
  – Uncollected member cost sharing under ACA public exchanges
Retiree Health Programs

• Retiree health care plans subject to same pressures and more
  – Cost increases (some exacerbated due to higher utilization)
  – Historically little to no funding
  – Delivery options becoming less favorable
    • Medicare Advantage plan funding decreases
    • EGWP and Medicare Part D shifts
    • Fully-insured plan tax (particularly for certain Medicare plans)
  – “Cadillac” tax particularly challenging for pre-Medicare retirees (insufficient actuarial adjustment due to age)
    • Consolidations Act changes may help somewhat
Retiree Health Programs

- Retiree health care plans do have additional flexibility
  - No “pay or play” mandate
  - Retiree-only plans not subject to all requirements of ACA

- Other considerations
  - Polymer v. Tackett Supreme Court decision
    - Retiree medical benefits not vested
  - Stockton and Detroit bankruptcies
    - Bankruptcy law trumps state law
    - Trade off between pension and health benefits
Retiree Health Programs

• Medicare-eligible Retiree Plan Considerations
  – Medical Plan Options
    • Traditional Medicare Supplemental Plans
    • Medicare Advantage Plans
  – Rx Options
    • Retiree Drug Subsidy (RDS)
    • Employer Group Waiver Plan (EGWP) and secondary wraps through Prescription Drug Plans (PDPs)
  – Market Options
    • Group/Individual
    • Private Exchange
Overall increase in revenues for Medicare Advantage (MA) and Part D products for 2017 of 3.05%

Changes in methodology resulting in a net decrease in CMS revenue for employer group plans
- Shift of dollars from group to individual market based on health status
- County price “rebasing” which has hit certain counties hard
- New methodology will be fully phased in over two years (2017 and 2018)

Federal funding to group MA premiums certain areas likely to decrease 3% to 7% in 2017, more in 2018

Small offset for plan sponsors in 2017 due to insured plan tax holiday
Consolidated Appropriations Act, 2016

- Passed December 2015
- Included various provisions affecting ACA requirements and cost
  - Delayed implementation of excise tax on high cost health insurance plans ("Cadillac Tax") two years to 2020
  - Eliminated annual fee on health insurance providers for 2017
    - Material impact on certain products (Medicare Advantage plans)
  - Suspended 2.30% sales tax on medical devices for two years (January 1, 2016 – December 31, 2017)
- Good news for employer plans
Retiree Health Programs

• Public Exchanges
  – Only an option for those not eligible for Medicare
  – Retirees may qualify for subsidy on the Public Exchanges
    • Based on household income which can be difficult to estimate for retirees due to employee pensions or other employment
  – Retiree must not have employer-sponsored coverage
    • Unlike actives, retirees can waive coverage and get Exchange subsidy
    • Question as to what it means to waive HRA contributions (forfeit, or just defer receipt and/or use?)
  – Tax impact of providing a stipend in lieu of coverage
Change to Sponsorship Model—Private Exchanges

- Alternative procurement arrangement for employer-sponsored health insurance
- Uses a defined contribution approach
  - No shared responsibility payment
  - Fixes company subsidy at certain amount and requires retiree to select a plan and pay the difference
- Medicare Exchange takes advantage of a robust individual plan marketplace
  - Many options from a premium and point of use cost sharing perspective
- Issues
  - Risk sharing, design constraints, size/value
  - Longevity of model (no federal subsidy)
  - Greatest ROI to least well-managed plans
  - Model is immature for pre-Medicare retirees
Tools—Prescription Drug Cost

- **Purchasing options**
  - Carve out to PBM
  - Competitively bid program—RFP or price check
  - Coalition pricing
  - Specialty drug carve out

- **Design**
  - More tiers (up to 5 for certain Part D plans)
  - Cost sharing
  - Management programs
    - Prior authorization
    - Quantity limits
    - Step therapy
    - Coordination with medical plan
Tools—Prescription Drug Cost

• Trading “Choice” for Price
  – Narrow networks
  – Restrict formulary
  – Mandatory generics, generic only plans

• Delivery
  – Audits
  – Contract issues—Discounts vs. rebates?
  – Rebate/pricing transparency
Tools—Medical Cost

• Purchasing options
  – Competitively bid program—RFP or price check
  – Coalition pricing?
  – Fully insure or self-insure?
• Design
  – Cost sharing—What do HDHPs achieve?
  – Network management
  – ACOs and alternative payment strategy—How does that translate to employer-sponsored plans?
  – Management programs
    • Cost vs. care management
    • Measuring effectiveness
    • Consumerism
Tools—Medical Cost

- Understanding your data
  - Review of claim experience is critical
  - Can validate strategy, suggest design gaps, identify problems/concerns
  - Credibility
  - Key elements for all group sizes
    - High cost claims
    - Preventative service utilization

- Benchmarks
  - Some benchmarking can be helpful
  - Key elements
    - Must be adjusted to reflect your demographics
    - Should reflect your plan design
    - Granular enough to be actionable
**Plan Design and Delivery**

- **Assessing Effectiveness of Benefits Strategy—Sample Client Study**

**Trend Drivers:**
- **Inpatient**
  - Decreased utilization and cost per service for inpatient medical
- **Outpatient**
  - Increased utilization of drugs administered in an outpatient setting
- **Professional**
  - Overall utilization increases
Plan Design and Delivery

- Assessing Effectiveness of Benefits Strategy
  - Understanding Your Data

Distribution of Average Per Head Claim Cost—Active and Pre-Medicare Retirees

Data from Milliman Health Cost Guidelines™
Plan Design and Delivery

- Assessing Effectiveness of Benefits Strategy
  - Sample Client Study

Emergency Room and Urgent Care Facility Utilization (per 1,000)

![Bar chart showing utilization](image)
Predictions are Like Fingerprints . . .

. . . everybody has them.
Predictions for Benefits Legislation and Regulations

- By the end of the 114th Congress

- No blockbuster new benefits legislation in 2017
  - 2015 Excise/"Cadillac" Tax delay was such an item

- Getting some legs in 2017, more likely enacted in 2018
  - Corporate income tax, repatriation of overseas corporate cash
  - Full repeal of the Cadillac Tax
Even if your union has no defined benefit plan governed by multiemployer tax law
  – Any taxpayer bailout of multiemployer defined benefit plans resonates throughout the entire benefits industry
  – September 30, 2016 PBGC report headlines expected next week (or so)

Holding our breath for compliance with conflict-of-interest/fiduciary rules
  – Extension of April 2017 compliance date?
Predictions for Benefits Legislation and Regulations

- Most disruptive 2017 compliance issue for defined contribution plan sponsors with Individually Designed Plans
  - Determination Letters from IRS end
  - In 2017 for certain, afterwards, they may revisit this decision
- Never too early to complain about future compliance issues (extended to December)
  - Recasting of Form 5500 for Plan Years starting in 2019
    - New Schedule J
    - New attachments to Schedules SB and MB
- Social Security will become insolvent when payroll tax collection ends
  - Which will be never!
Legislative Conclusions

• Broad US tax policy will not change before 2018 (a year after the new Administration and 115th Congress settles in)

• When there are new federal benefits tax laws or regulations, the federal agencies consistently underestimate the time needed to comply and the (hard-dollar and soft-dollar) costs to comply

• “Saving” Social Security and Medicare will require a political solution
Retiree Coverage in a Post-ACA World

- Make sure you have complete financial understanding of retiree programs
  - Current and future cash cost
  - Ratio of active to retirees and contribution burden
- No easy answers but some potential opportunities
  - Keep providers honest and competing for your business
  - Bargaining issues—How to balance all the priorities
  - Can local unions unite to drive change in the marketplace

Website Resources
https://www.ifebp.org/inforequest/ifebp/0167495.pdf
2017 Educational Programs
Health and Welfare

**63rd Annual Employee Benefits Conference**
October 22-25, 2017
Las Vegas, Nevada
www.ifebp.org/usannual

**Certificate Series**
February 27-March 4, 2017
Lake Buena Vista (Orlando), Florida

July 24-29, 2017
Denver, Colorado
www.ifebp.org/certificateseries

**Health Care Management Conference**
May 1-3, 2017
New Orleans, Louisiana
www.ifebp.org/healthcare

**Certificate of Achievement in Public Plan Policy (CAPPP®)**
Part I and Part II, June 13-16, 2017
San Jose, California
Part II Only, October 21-22, 2017
Las Vegas, Nevada
www.ifebp.org/cappp

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**Self-Funding Health Benefit Plans**
Item #7563
www.ifebp.org/SelfFunding