

Confronting a Considerable – and Growing – Challenge in the Public Sector: Affording Retiree Health Coverage

Public sector employers are steadily approaching a moment of truth regarding retiree health benefits, as continued health care cost inflation, intense budget scrutiny and new accounting rules on the horizon focus attention on this valuable but costly benefit. The complexity and sensitivity of addressing retiree health benefits are exacerbated by the longstanding expectations of public sector employees that they will be provided with generous health insurance, both during their years of active employment and after retirement. Generous early retirement programs and broad-based changes in the size and demographic composition of the workforce and of the retiree population may further strain employers' ability to maintain and pay for their programs in their current form.

This *Public Sector Letter* discusses plan design alternatives that sponsors of public sector retiree health plans may wish to consider to temper costs while preserving much-appreciated health benefits for retirees. There are four key areas on which plan sponsors may wish to focus in redesigning their retiree health plans to be more efficient, equitable and affordable without shifting an untenable level of cost to participants:

- Reviewing eligibility rules,
- Improving purchasing economies,
- Rethinking how the plan's coverage complements Medicare, and
- Promoting individual accountability.

REVIEWING ELIGIBILITY RULES FOR RETIREE HEALTH COVERAGE

Prevalent among public sector retiree health plans are eligibility rules that allow — and in many cases encourage — early retirement. Because retirees (and their dependents) under the age of 65 are not yet eligible for benefits under Medicare (which pays well over half of the average health care expenses for its participants), plan costs for early retirees are higher. In fact because benefit plan payments are coordinated with Medicare for retirees age 65 and over, the total net plan sponsor cost for the few years before an early retiree turns age 65 can exceed the cost for all that retiree's post-65 years.

Some public sector plans even include a concept of “vesting,” allowing employees who leave active service before retirement but have worked a stipulated minimum number of years (*e.g.*, 10) to receive retiree medical benefits when they ultimately retire. This concept, which is unheard of among private sector employers, can add considerable cost.

Incentives that encourage employees to retire at even slightly older ages can significantly reduce plan sponsors' retiree medical costs. Benefits can be sweetened for employees who retire with longer service (*e.g.*, by tying the level of the cost subsidy to years of service). Alternatively, eligibility rules that define the minimum age at which an employee may retire with medical benefits can be raised (*e.g.*, from 55 to 60), if allowed under state law. In some

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cases where generous early retiree health benefits are provided, employer costs for early retiree health coverage can exceed pension costs for that same retiree.

When revisiting eligibility for retiree health coverage, plan sponsors should make sure that the eligibility criteria for *all* plans, including pensions, send a consistent message.

IMPROVING PURCHASING ECONOMIES

There are many potential benefits — and a few challenges — associated with “buying in bulk.” In health care purchasing, strength in numbers may yield savings in two ways:

- [Reducing Administrative Expenses](#)
Smaller public sector health plans

may find savings from participating in statewide health buying coalitions. Vendor fees and margins can be reduced when services are delivered through large purchasing agreements.

- **Negotiating Better Vendor Discounts**
Larger purchasers tend to have better negotiating leverage than smaller purchasers. The ability to achieve better prices as a large purchaser varies according to the benefits offered. One benefit with potentially significant efficiencies for large purchasers is prescription drugs.

Because prescription drug benefits are the single largest expense type for employers' health programs covering Medicare-eligible retirees, deeper discounts, improved rebate arrangements, and lower administration fees from pharmacy benefit managers (PBMs) can have a big bottom-line effect for plan sponsors.

In addition to achieving administrative cost savings and improved discounts, coordinated purchasing may be able to enhance quality.

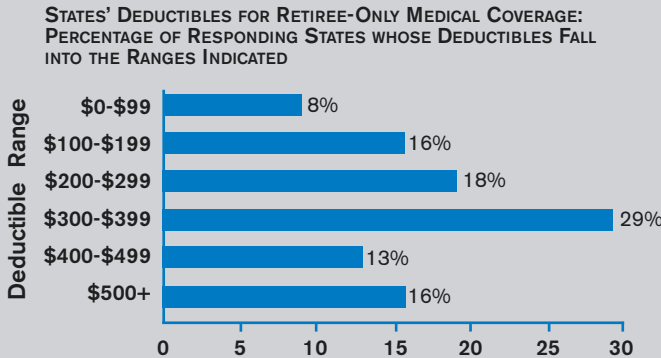
There are also challenges associated with coordinated purchasing. In order to achieve purchasing efficiencies, the various groups joining forces to purchase collectively likely will lose some flexibility with respect to customizing plan design and experience reports. Also, prescription benefits offered through PBMs are typically self-insured, requiring that the various participating groups create a common funding mechanism. One example of a "jumbo" purchaser being formed to maximize the efficiency of its prescription drug purchasing may be seen in the new National Legislative Association on Prescription Drug Prices, a multi-state consortium.¹

Another challenge to collective purchasing arises from the regional nature of health care delivery. Groups that may be considered "naturals" for joining forces to purchase benefits collectively may find their efforts foiled by the vagaries of the health care delivery systems that serve their members in different geographic locations. (Size and composition of managed care networks can range significantly from one area to another within a single state.)

Some plan sponsors have found that the "inconveniences" associated with collective purchasing are justified by the savings that can be achieved.

RETIREE HEALTH COVERAGE: PRELIMINARY RESULTS FROM THE SEGAL STATE HEALTH BENEFITS SURVEY

Preliminary results from the Segal State Health Benefits Survey reveal notable differences among states' deductibles for retiree-only medical coverage. The graph below illustrates findings for 34 states, most of which cover retirees in preferred provider organization (PPO) plans.



Preliminary results from the Segal State Health Benefits Survey are available for prescription drug coverage for retirees in 32 states. Findings include:

- A majority of these states (81 percent) offered copayment plans. For these plans, average retail and mail order copayments by broad type of drug (e.g., generic) are shown in the table below.

AVERAGE COPAYMENT*

| DRUG TYPE | Three-Tier Plans | | Two-Tier Plans | |
|---------------------|------------------|--------|----------------|--------|
| | Retail | Mail** | Retail | Mail** |
| Generic | \$ 8 | \$ 13 | \$ 10 | \$ 17 |
| Preferred Brand | 17 | 28 | 20 | 26 |
| Non-Preferred Brand | 32 | 50 | N/A | N/A |

* In some instances, there are hybrid plans, whereby cost sharing is the "greater of" the applicable plan copayment or coinsurance percentage of ingredient cost. The averages in this table do not reflect this provision.

** Copayments for mail order prescriptions are usually higher than the retail copayment because the day supply is usually more (e.g., a 90-day supply vs. a 30-day supply).

- Less than one fifth of the states (19 percent) offered prescription drug benefits with a coinsurance plan design and up-front deductible.

Final results from the Segal State Health Benefits Survey will be released later this year.

RETHINKING COORDINATION WITH MEDICARE

Health plans that provide benefits for Medicare-eligible retirees "coordinate" their payments with Medicare using a variety of rules that define how the portion of the health benefit costs *not* paid by Medicare will be shared between the plan sponsor and the retiree. Different rules can result in significantly different levels of net employer cost.

¹ The following nine states and the District of Columbia are participating in the nonprofit organization: Connecticut, Hawaii, Maine, Massachusetts, New Hampshire, New York, Pennsylvania, Rhode Island and Vermont.

Generally, one of the following three methods is used to coordinate benefits with Medicare:

➤ **Traditional** “Traditional” coordination of benefits (COB) compares the amount the plan sponsor’s plan would have paid in the absence of Medicare with the residual cost after Medicare has made its payment, and pays the lesser amount. This approach, which often results in no payment required by the retiree, was once the most prevalent approach and produces the highest net cost to the plan sponsor. The vast majority of private sector plan sponsors who used this approach in the past have changed to one of the other two approaches, described below, to help reduce their costs.

➤ **Exclusion** This coordination method applies the provisions of the plan sponsor’s benefit plan (deductible, coinsurance, etc.) to the remaining cost after Medicare has made its payment. That is, it defines the “eligible charge” to which benefit provisions apply as the net cost after Medicare’s payment.

➤ **Carve-Out** This method, sometimes also called “non-duplication,” typically produces the lowest net cost for the plan sponsor. Under this method, a plan sponsor determines the amount it would have paid in the absence of Medicare, then “carves out” the amount paid by Medicare and pays the remaining amount, if any. For many hospital and major medical expenses, this coordination method results in no payment by the plan sponsor. From the retiree’s perspective, the carve-out methodology requires out-of-pocket payments similar to those required by employees.

The accompanying table illustrates how a hypothetical claim would be paid under each of the three approaches mentioned in the preceding bullets.

COMPARISON OF PAYMENTS UNDER THREE TRADITIONAL APPROACHES TO COORDINATING COVERAGE WITH MEDICARE*

| | NO MEDICARE | TRADITIONAL COORDINATION OF BENEFITS | MEDICARE EXCLUSION | CARVE-OUT OR NON-DUPLICATION |
|---------------------|----------------|---|-----------------------|---------------------------------|
| Total charge | | | | |
| ➤Hospital | \$ 3,000 | \$ 3,000 | \$ 3,000 | \$ 3,000 |
| ➤Major medical | 3,200 | 3,200 | 3,200 | 3,200 |
| ➤Prescription drug | 800 | 800 | 800 | 800 |
| ➤Total | \$ 7,000 | \$ 7,000 | \$ 7,000 | \$ 7,000 |
| Payments | | | | |
| ➤Medicare | 0 | \$ 4,640 | \$ 4,640 | \$ 4,640 |
| ➤Plan | \$ 5,520 | 2,360 | 1,808 | 880 |
| ➤Retiree | 1,480 | 0 | 552 | 1,480 |

* This comparison is based on a hypothetical \$7,000 claim covered under a plan with a \$100 deductible and 80 percent coinsurance. All charges are at Medicare allowable levels.

Source: The Segal Company, 2003.

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REPLACING TRADITIONAL MEDICARE COB WITH A SUPPLEMENTAL APPROACH

A different approach to taking Medicare into account when designing retiree health benefits is administratively more elegant than traditional COB. This intuitively appealing supplemental approach *redefines* the plan sponsor’s benefit provisions in terms of Medicare and specifically defines how it will pay amounts not paid by Medicare. For example, a supplemental benefit plan may pay all but \$200 of Medicare’s Part A deductible, make no payment

for Part B expenses and provide a stand-alone prescription drug benefit. In addition, the plan may define an out-of-pocket limit to protect individuals with catastrophic health care expenses.

PROMOTING INDIVIDUAL ACCOUNTABILITY

Plan sponsors in both the private and public sectors have begun to investigate a theory that links cost controls to “consumerism”: the theory posits that if plan participants are more informed and more conscientious *consumers* of health care, benefit plans will operate more efficiently, resulting in both improved quality of care and lower cost, in short, better *value*. Two broad-based approaches to promoting consumerism in retiree health benefit plans are gaining some currency:

➤ **Define subsidy and offer options.** One approach is for plan sponsors to change the way they define how they pay for retiree health benefits.

For example, they may define the extent of their funding commitment in terms of an aggregate dollar amount based on an employee's years of service at retirement. This "account balance" may then be annuitized at the time of retirement and the annual amount credited as an offset to the retiree's share of the cost of health coverage. Retirees would be given a choice of benefit options with different benefit levels and features (including, possibly, the opportunity to purchase coverage from a spouse's employer or to buy individual insurance, such as commercial Medigap policies, or prescription drug coverage supplements). A retiree's contribution would be equal to the difference between the full cost of the option selected and the amount of the annual "credit." Retirees, therefore, would be expected to make more informed, efficient benefit elections based, in part, on the economic implications of their elections.

➤ **Build consumerism into plan design.** "Consumer-directed" plans, which often involve coupling an

employer allowance with high-deductible insurance coverage, may be extended to retirees. These plans are said to promote careful purchasing on the individuals' part by requiring participants to pay all health expenses up to a high-deductible threshold, drawing on the employer-funded allowance to help pay for some of their up-front expenses. The formula is designed to encourage participants to think twice before "purchasing" potentially unnecessary or overpriced care.

Neither of these approaches has yet been embraced in the public sector, due to the potentially significant shift of cost and risk to retirees (in the case of the former approach) and the generally untested nature of the plan design (in the case of the latter approach). Another consideration is the common political need (particularly of state governments) to offer coverage by insurers and networks located within their jurisdictions. As both of these approaches gain more widespread application, public sector plan sponsors may be advised to give them a closer look.

CONCLUSION

Rising costs and impending government accounting standards² are compelling public sector sponsors of retiree health plans to examine their plans more closely and to look for ways to reduce or control costs. While opportunities for major cost savings may be limited, there may be areas where small adjustments can yield meaningful savings. Rethinking and "modernizing" eligibility provisions and Medicare coordination, capitalizing on opportunities for more cost-effective purchasing, and considering designs that promote consumerism among plan participants can all help trim plan costs.



For more information about strategies for managing the cost of retiree health care, contact your Segal Company consultant or Stephen Parahus, vice president, at 212.251.5393 or sparahus@segalco.com.

² After the Governmental Accounting Standards Board (GASB) releases its final standard on reporting liabilities for retiree health and other postemployment benefits, an issue of The Segal's Company's *Public Sector Letter* will discuss issues related to the accounting requirement, including options for prefunding retiree health coverage.

U.S. SUPREME COURT RULING CONFIRMS STATE EMPLOYEES' ABILITY TO SUE THEIR EMPLOYER UNDER FMLA

The Family and Medical Leave Act (FMLA), which generally requires employers to allow eligible employees to take up to 12 weeks of unpaid leave over a 12-month period for certain reasons (e.g., to care for a spouse, child or parent that has a serious health condition), allows individuals to sue their employers for money damages for certain violations of the Act. In *Nevada Department of Human Resources et al. v. Hibbs et al.*, an employee who had taken time off to care for his ailing wife sued his employer under FMLA. The employer argued that such a suit was barred by the Eleventh Amendment of the Constitution, which generally provides that states are immune from federal lawsuits brought by individuals.

On May 27, 2003, the U.S. Supreme Court rejected the employer's argument, saying that Congress had overridden the state's immunity from such lawsuits by expressly stating its intention to do so in the language of FMLA. This decision differs from other High Court decisions that held individuals cannot sue states for money damages under the Americans with Disabilities Act (ADA) and the Age Discrimination in Employment Act (ADEA). In distinguishing those cases from this FMLA case, the Supreme Court stated that allowing such lawsuits against states was a valid exercise of Congress' power under the Constitution because gender discrimination – which FMLA was intended to prevent in workplace leave policies, given that women tend to be families' primary caregivers – is subject to a higher degree of scrutiny under the Constitution, and because Congress had sufficient evidence of past gender discrimination by states when it passed FMLA.

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