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National Conference of State Legislatures Impact of Medicare Modernization and New Accounting Rules on States as Employers and Plan Sponsors

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Today's Discussion

■ **Background**

- Retirees consume more prescription drugs than employees
- A large portion of the costs for Medicare-eligible retirees are drug related
- Prescription drug costs increase than non-drug medical services


■ **The changes to Medicare effective January 1, 2006 will increase the attention and scrutiny on your retiree medical plans**

■ **The implementation of the new accounting rules will increase public knowledge of the cost of plans offered to retirees**

■ **While dealing with the impact of Medicare Modernization, states will have a chance to revisit their retiree plans before the accounting rules kick in**



Impact of Medicare Modernization on States as Employers and Plan Sponsors



Medicare Reform Review and Issues

Highlights of New Law that Impact Employer Plans

- **Most significant changes to Medicare since its creation**
- **Key Medicare provisions with an impact on Employer Plans**
 - Medicare will subsidize cost of prescription drug benefit that enrollees obtain from private carriers beginning in 2006 (new Part D)
 - 28% subsidy amounts are available to many employer plans that continue providing drug coverage to Medicare retirees
- **New pre-tax savings accounts - HSAs**
- **Discount prescription drug card effective spring 2004 until 2006**
- **Changes in Medicare benefits (generally starting in 2005)**
- **Medicare + Choice becomes Medicare Advantage**



Brief Recap of Recent Retiree Medical Events

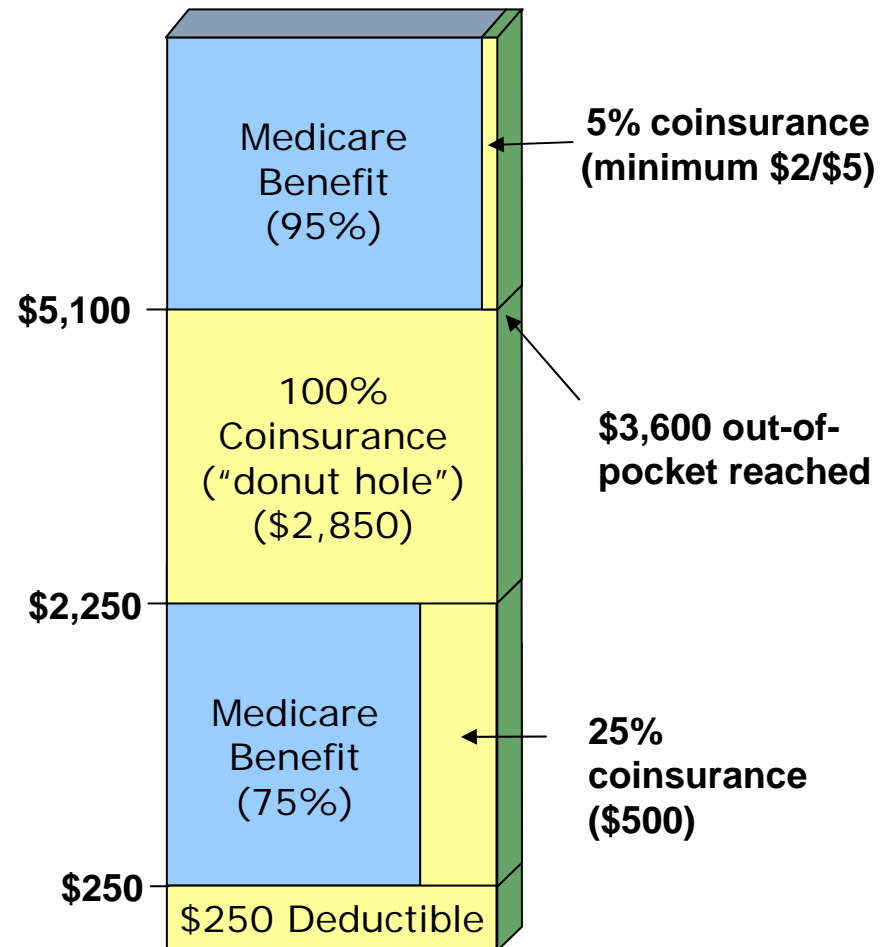
- **The Medicare Modernization Act was passed by Congress on November 25, 2003 and signed into law by President Bush on December 8, 2003**
- **Accounting rules for employers subject to FASB guidelines were finalized in April 2004**
 - *Key item: plan sponsors subject to FAS rules must generally begin reflecting impact of Act (if material) in financial statements issued in 2004*
- **GASB 45, which requires that governmental employers measure their retiree medical liabilities, was issued in August 2004.**
- **The Centers for Medicare and Medicaid Services (CMS) released the preliminary regulations for the Act on July 26, 2004**
- **Final regulations are expected in early 2005**

Medicare Prescription Drug Reform

Recap of relevant features

Medicare standard prescription drug design

- Plan sponsor payments don't count toward drug out-of-pocket threshold (\$3,600)
- Member pays roughly 25% of Medicare Part D premium (estimated \$35 Per Member Per Month (PMPM) in 2006)
- Amounts indexed





Proposed Rules

Recap of key features

Plan sponsors can offer their retirees a qualified 'substitute' drug plan

Their retirees decline Medicare drug coverage

CMS pays plan sponsor tax-free subsidy payments

If a retiree is not covered by a qualified 'substitute' plan, benefits are provided through licensed entities who have risk-bearing, insurance contracts with CMS:

Prescription Drug Plans (PDPs)

Medicare Advantage – Prescription Drugs (MA-PDs)

Federal payments go to the PDP or MA-PD

Subject to many requirements (such as coverage regions, enrollment process, benefit design)

PDPs can offer enhanced benefits

Plan sponsors can contract with a PDP or MA-PD to provide coverage to retirees

The Center for Medicare and Medicaid Services (CMS) may waive requirements

Plan Sponsor Options for Medicare Prescription Drug Coverage

<p>1</p> <p>Provide an “actuarially equivalent” prescription drug plan and get a federal subsidy for retirees</p>	<p>2</p> <p>Provide drug coverage that is secondary to or wraps around Medicare Part D (no subsidy;</p>	<p>3</p> <p>Provide drug coverage by contracting to enroll retirees in a Prescription Drug Plan or Medicare Advantage drug plan</p>	<p>4</p> <p>Provide drug coverage by applying to become a PDP or Medicare Advantage organization (will require a CMS waiver)</p>	<p>5</p> <p>Drop coverage and possibly pay retirees’ monthly Medicare Part D premium</p>
<p>Retirees must <u>not</u> enroll in Part D</p>	<p>Retirees must enroll in and pay Part D premiums</p>	<p>Retirees must enroll in and pay Part D premiums</p>	<p>Retirees must enroll in and pay Part D premiums</p>	<p>Retirees must enroll in and pay Part D premiums</p>

Medicare Reform Employer Impact

How do the options compare financially

Illustrative Employer 2006 Cash Costs for Rx Plan

	Average Employer PMPY	Part D Premium Reimbursement	Total Plan Cost	Government 28% Subsidy	Total Net Cost	% of Current
Option 1	Current Rx Plan	Na	\$2,100	NA	\$2,100	100%
	Current Rx Plan With 28% Subsidy	Na	\$2,100	(\$570)	\$1,530	73%
Options 2 and 3	Integrate with Part D (Sponsor pays Part D)	\$420	\$1,520	NA	\$1,520	72%
	Integrate with Part D (Retiree pays Part D)	\$0	\$1,100	NA	\$1,100	52%
Option 4	Plan sponsor becomes a PDP provider	TBD	TBD	NA	Could be < \$1,100	Could be < 50%
Option 5	Drop Coverage and Pay Part D	\$420	\$420	NA	\$420	20%
	Drop Coverage	Na	0	NA	0	0%



Actuarial Equivalence under Option 1

General issues

CMS' objectives for “actuarial equivalency” methodology

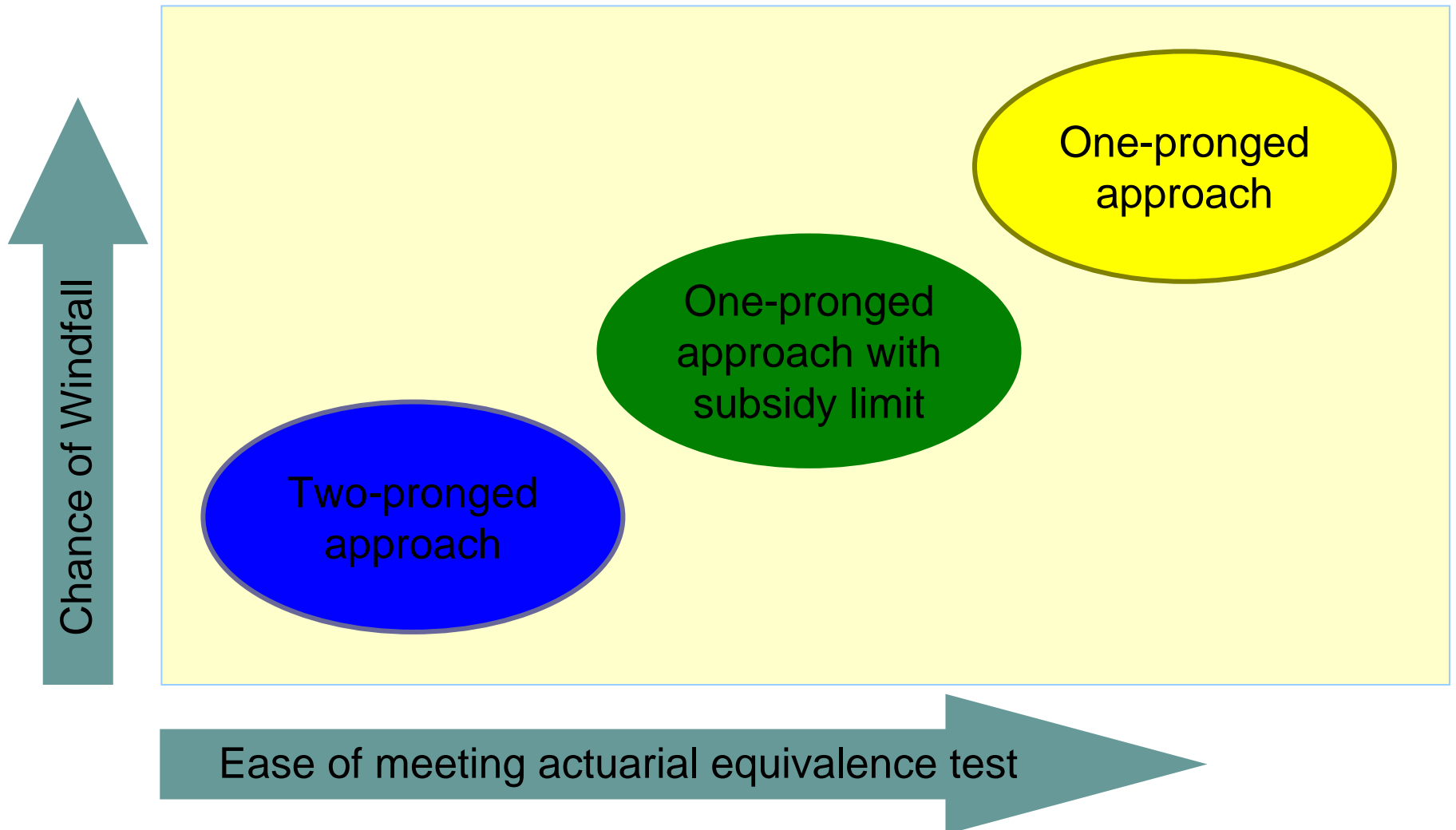
- Avoid plan sponsor “windfalls” while encouraging sponsors to maintain their current plans
- Minimize administrative burdens and stay within Medicare program budget estimates

Proposed equivalency does not reach a final conclusion

- Broad array of possible tests given
- CMS solicited comments on the tests under consideration

Actuarial Equivalence under Option 1

Testing options





Actuarial Equivalence under Option 1 Testing strategies

- **Once final regulations are released and official testing methods are understood, plan sponsors will want to determine how to maximize the federal government payments**
- **If a plan sponsor passes Actuarial Equivalence for all variations combined, this could allow sponsor to receive a subsidy for smaller subgroups that would not qualify on a stand-alone basis**
 - Will need to look at changes in status over time
- **If the plan does not qualify with all variations combined:**
 - Could separate group(s) causing the problem into a separate plan
 - Could consider plan changes to reach total equivalence



Actuarial Equivalence under Option 1 Requirements

Requirements for federal subsidy:

A Cost must be incurred under qualified plan by qualified retiree	B Cost must be for drugs covered by Medicare Part D	C Cost must be directly related to dispensing drug (cost of drug + dispensing fee, but not administrative fees)	D Cost must be actually paid by plan or retiree, net of discounts and rebates	E Gross costs (before copays) between \$250 and \$5,000 in 2006 are reimbursed at 28% (indexed in later years)
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Option 1 – Keep Current Plan Design in Lieu of Part D Benefit

■ Advantages

- Could be no change for beneficiaries
- Immediate communication requirements are reduced
- GASB “contribution” & liability relief
- May be only option for some groups

■ Disadvantages

- Requires annual certification of actuarial equivalence
- Administration and reporting requirements
- Some groups will not qualify as actuarially equivalent
- Financial savings not as great as other options for tax-exempt organizations



Option 2 – Amend Plan to “Wrap Around”/Integrate with Medicare

■ Advantages

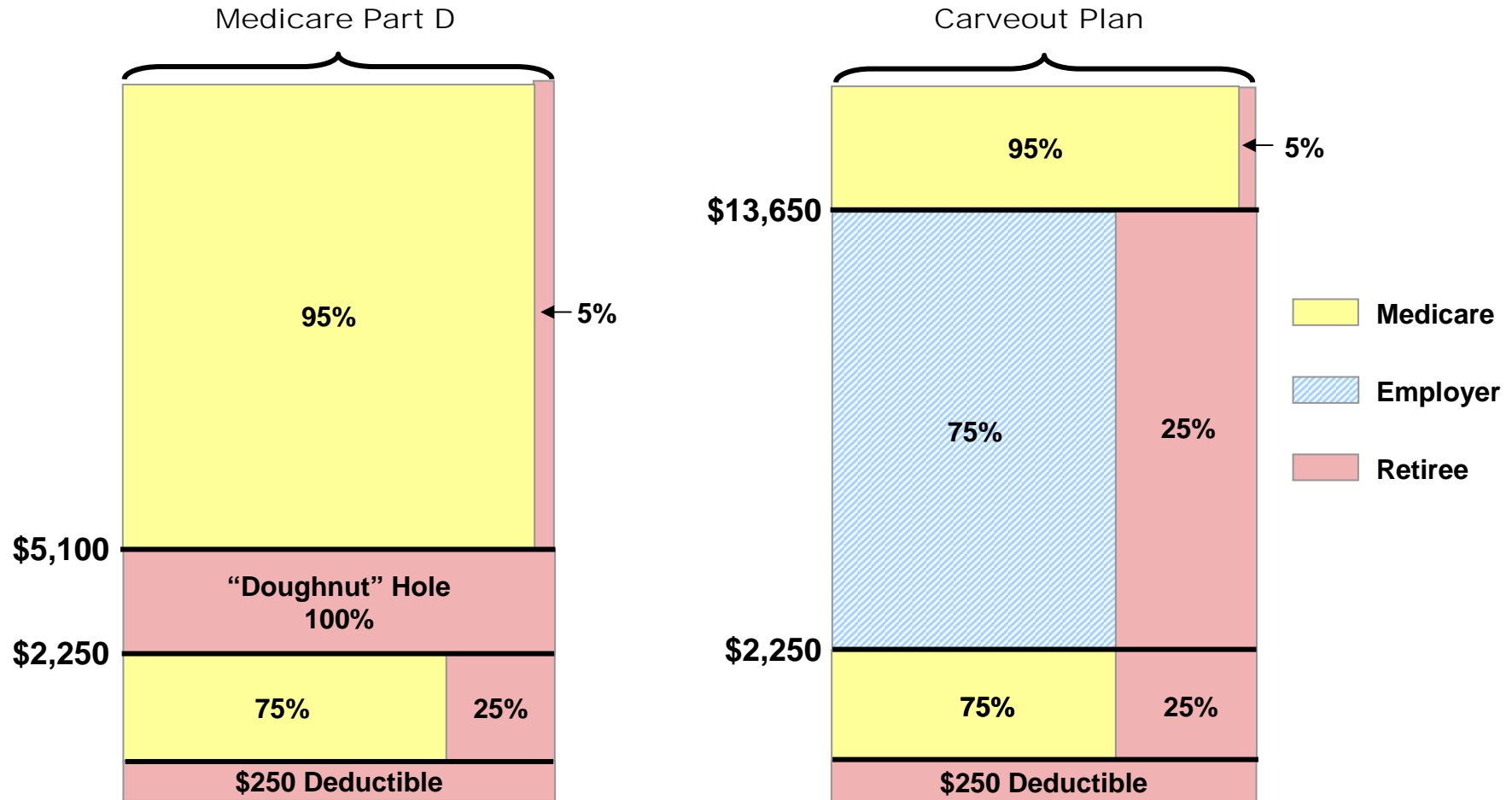
- Offers retirees drug coverage better than standard Medicare benefit
- No annual actuarial certification needed
- Some employers will save more than with the 28% subsidy option
- Immediate cash savings for employer
- Potential reduction in required retiree contributions to participate
- Sponsor can subsidize all, some or none of Part D premium

■ Disadvantages

- Must amend plan and communicate to retirees
- Does not maximize federal subsidies
- Retirees will have to pay Part D premium unless plan sponsor pays it
- For administrators, mechanics of integrating with Medicare are problematic or technically impossible
- May not reduce plan sponsor cost as much as other options

Amend Plan to Wrap Around Medicare

Example: \$250 deductible, 25% retiree coinsurance to \$3,600 out-of-pocket cost





Option 3 - Provide Coverage by Contracting to Enroll Retirees in a PDP

■ Advantages

- No annual actuarial certification needed
- Some employers will save more than with the 28% subsidy option
- Immediate cash savings for employer
- Sponsor can subsidize all, some or none of Part D premium
- Offers retirees drug coverage better than standard Medicare benefit
- Shifts some risk and administration issues to PDP
- Can also work with an MA-PDP

■ Disadvantages

- Must amend plan and communicate to retirees
- Does not maximize federal subsidies
- Retirees will have to pay Part D premium unless plan sponsor pays it



Option 4 - Provide Coverage by Applying to Become a PDP

■ **Advantages**

- Can mirror existing coverage
- Minimizes retiree disruption
- May provide greatest financial savings

■ **Disadvantages**

- Increased reporting and communications requirements
- Must file for waiver and meet minimum beneficiary requirements (1,500)
- Likely much more regulation
- State licensure required
 - Multi-state licensing a possible problem



Option 5 – Drop Drug Coverage

■ Advantages

- No annual certification needed
- Simple to administer
- Greatest savings potential; reflect in GASB costs after plan is amended
- Can pay for some or all of Part D premium
- Sponsor can arrange for preferred treatment with a specific PDP

■ Disadvantages

- Likely increased costs to retirees
- Potential age discrimination issues
- Retiree and public relations challenges



Implementation of Medicare Part D During 2005

Review final regulations (early 2005)

- Determine implications
- Evaluate resulting options
 - Efficiency/maximizing government payments
 - Employer impact
 - Retiree impact

Consider testing strategies (Feb – Mar)

- Short term vs. long term
- Aggregating or disaggregating plans

Select final approach for 2006 (Mar – Apr)

- Prepare actuarial valuation?



Implementation of Medicare Part D

Broad strategy and vendor issues

Reflect Medicare Part D only or consider broader changes?

May need to update strategy, if nothing else (early 2005)

- Contribution levels
- Sharing of subsidy (if applicable)
- Employer pre-funding approach
- Pre-65 vs. post-65 benefit differences

Finalize 2006 changes to plan provisions and contributions

(Apr – Jun)

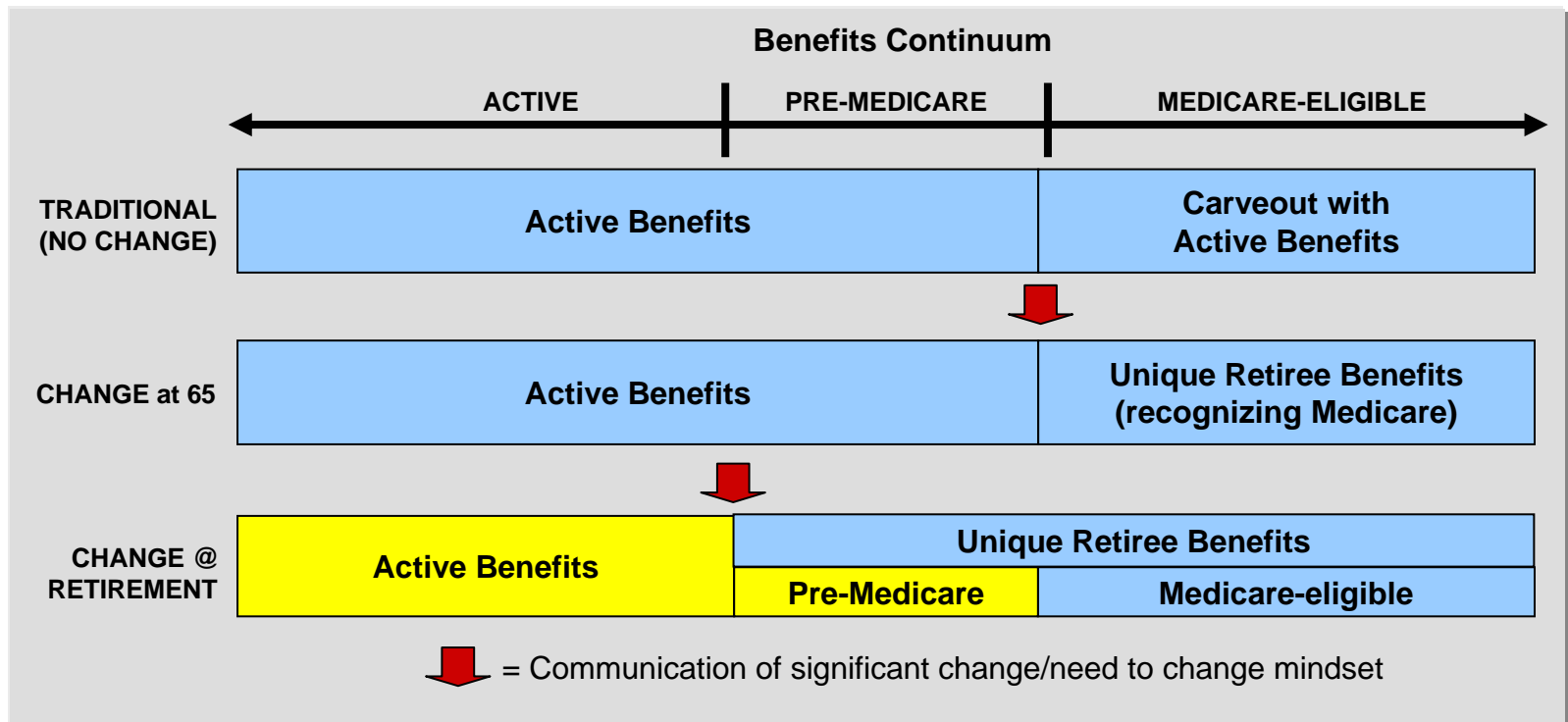
- Compliance with regulations
- Effect of strategy changes

Review vendor capabilities under revisions (Apr – Jun)

Implementation of Medicare Part D

Pre-65 vs. post-65 benefit differences

- **Strategic decision: Is coverage primarily a retirement benefit or an extension of active medical benefits?**





Implementation of Medicare Part D Communications and legal

Review plan documentation for changes (Mar – Jun)

- Update SPDs and Plan Document
- Define plans for testing purposes
- Plan amendments
- Union contracts

Develop retiree communications (throughout year)

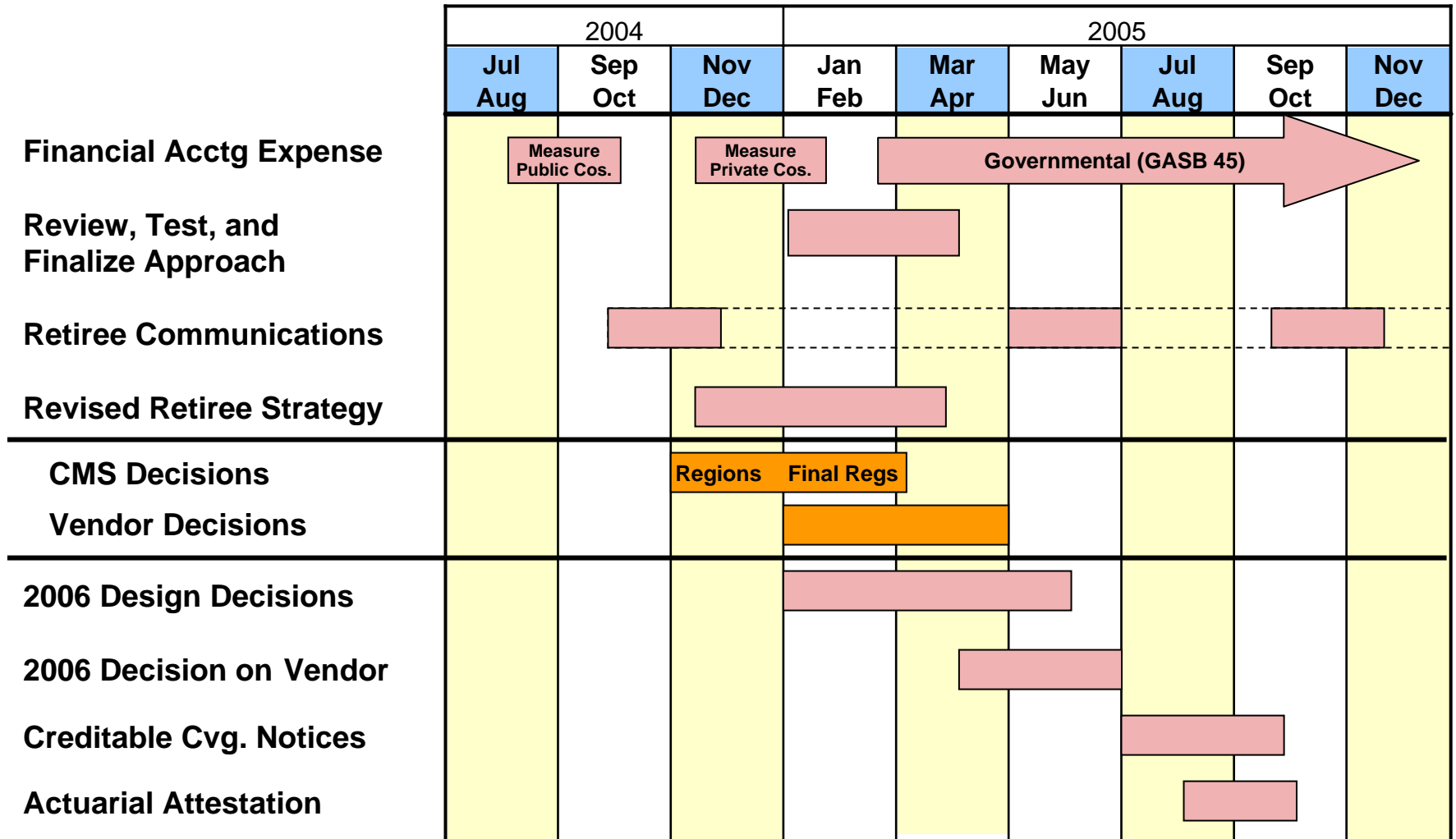
- Describe approach and what it means to them
- Detail changes to strategy, design, and contributions
- Send required notices

Prepare government filings (Aug – Sep)

- Actuarial equivalence attestation
- Subsidy support data

Medicare Reform

Timeline of activities (Mercer's best guess)





Impact of New Accounting Rules (GASB 45) on States as Employers and Plan Sponsors



Why Are the New Accounting Rules an Issue?

- **Two new statements for non-pension benefits**
 - Statement 45: Accounting and Financial Reporting by Employers for OPEB (issued June 2004)
 - Statement 43: Financial Reporting for OPEB Plans (issued April 2004)

- **Why is this important?**
 - For many entities, this will be the first public statement of the magnitude of these obligations
 - This will impact bond rating
 - Unfunded liability is potentially 50 times current retiree health-claim cash flow



Benefits Covered

- **Postretirement health benefits**
- **Postretirement life insurance benefits**
- **Legal benefits**
- **Other benefits (for example, long-term care)**



Requirements of Standards

- **Accrual of postretirement benefit cost during period of active employment**
- **Disclosure of unfunded actuarial accrued liability in Required Supplementary Information (RSI)**
- **Does not require funding, only expense accrual and disclosure**



Effective Dates

- **Annual revenues determined for fiscal years ending after June 15, 1999 (same as for GASB Statement No. 34)**
- **Phase 1 governments (revenues over \$100M)**
 - FY beginning after December 15, 2006
- **Phase 2 governments (revenues \$10M to \$100M)**
 - FY beginning after December 15, 2007
- **Phase 3 governments (revenues less than \$10M)**
 - FY beginning after December 15, 2008
- **One year earlier if pre-funded**



Health-Care Postemployment Benefits Included

- **Includes medical, dental, vision, hearing, and related benefits**
- **Whether provided through a defined benefit pension plan or separately**
- **Liability for health care includes “implicit employer subsidies”**



What Is an Implicit Employer Subsidy?

- **Cost of health care increases with increasing age**
- **Cost of health care is higher for retirees than employees of the same age**
- **If retirees pay same premium rate as active employees, there is an implicit employer subsidy due to blending of claims experience (unless employer pays nothing toward either actives or retirees)**
- **Implicit subsidy must be included in postretirement health-care liability even if retirees pay 100% of the blended premium rate**



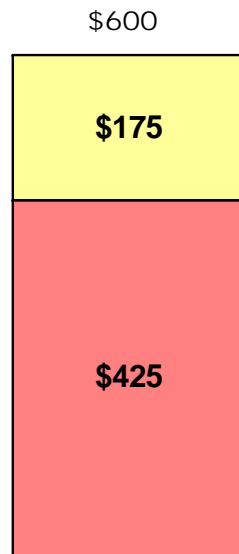
Example of Implicit Subsidy

- **Plan covers all active employees and retirees under age 65 (no dependents)**
- **Total participants**
 - 5,000 actives
 - 1,000 retirees
- **Average monthly premium for actives and retirees together: \$350**
- **Average monthly premiums if actives and retirees placed in separate plans:**
 - Active: \$300
 - Retiree: \$600
- **GASB Statement 45 requires valuation of retiree liability based on the \$600 monthly premium rate, even if employer uses \$350 rate to determine share paid by retiree**

Example of Implicit Employer Subsidy (continued)

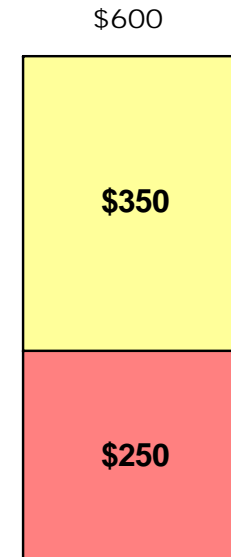
- **Suppose retiree pays 50% of blended rate, i.e., 50% of \$350 equals \$175**

- Employer liability for GASB is based on \$600 less \$175, or \$425



- **Suppose retiree pays 100% of blended rate**

- Employer liability is based on \$600 less \$350, or \$250



- **If retiree pays anything less than \$600 – then employer has liability**



How is the Valuation of the Liability Determined?

- **Similar to GASB 27 for pension plans**
- **Actuary works with plan sponsor to set assumptions**
 - Due to the high cost of coverage prior to Medicare, retiree medical liabilities are very sensitive to retirement rate assumptions
 - Premiums or claims cost assumption
 - Health-care trend
 - Participation rates for participants and retirees
- **Interest rate to use is the expected long-term yield on investments to be used to finance benefits**
 - Funded plans: expected yield on plan assets (may be 7% to 8%)
 - Unfunded plans: expected yield on employer assets (may be 2% to 4%)
 - The higher the interest rate, the lower the liability
 - May cause more plans to become funded to be able to use higher interest rate and disclose lower OPEB liability and expense



Potential Magnitude of the Liability

- **“Ballpark estimate”**

- 20 to 30 times employer paid portion of annual retiree medical claims for a typical mature plan that is funded
- Possibly twice this amount for unfunded plan

- **Example**

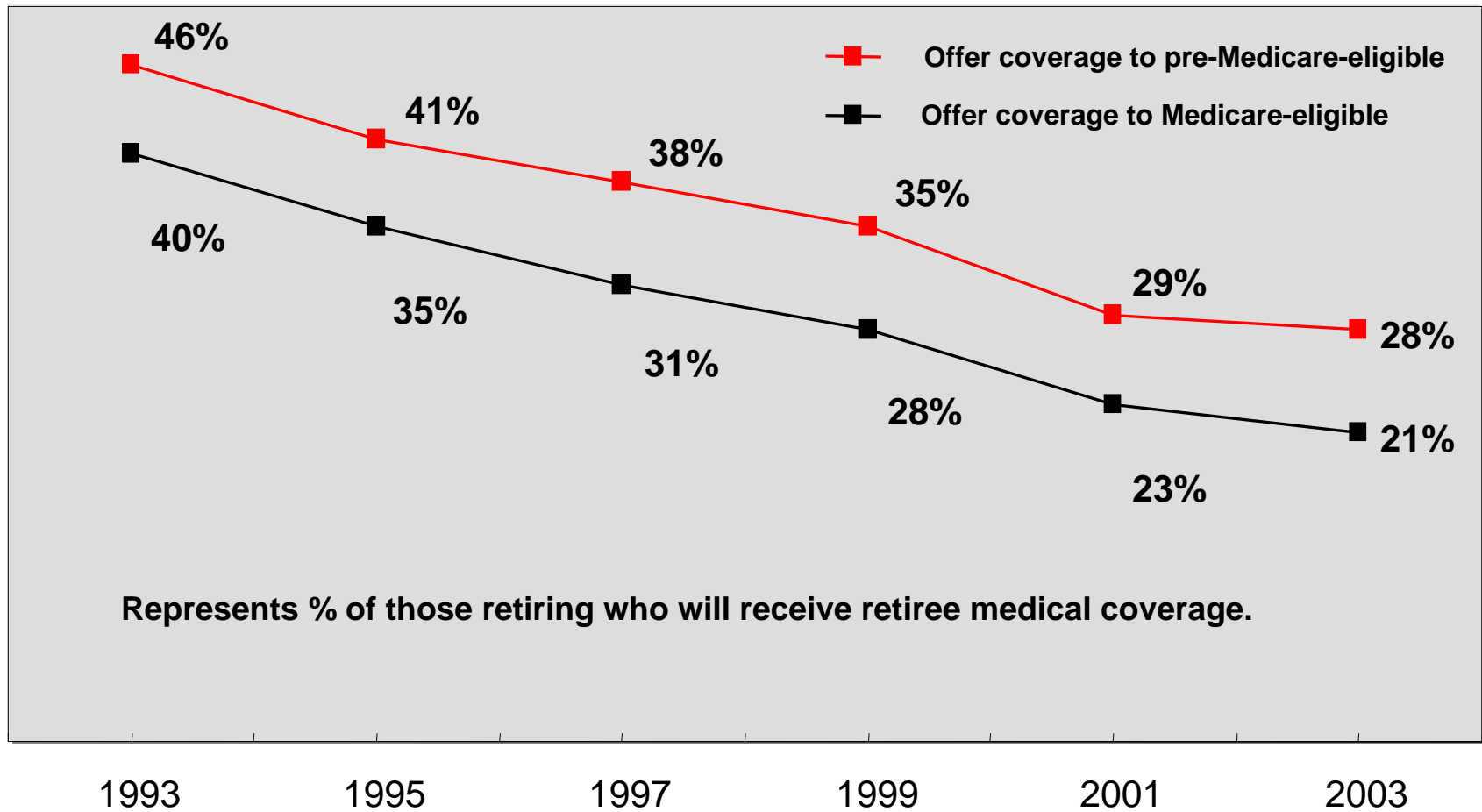
- Average monthly employer cost = \$300
- Total retirees = 1,000
- Total annual cost = $\$300 \times 12 \times 1,000 = \3.6 million
- GASB unfunded liability =
 - if funded: $25 \times \$3.6$ million = \$ 90 million
 - if not funded: $50 \times \$3.6$ million = \$180 million



How Will The Amount of These Retiree Medical Obligations Be Managed?

- **Non-governmental employers have been under similar accounting rules for more than 10 years (FAS 106)**
- **The application of FAS 106 forced a rethinking of retiree medical plan strategy**
- **Plan sponsors were faced with large, increasing unfunded liabilities for current and future retirees**
- **Plan sponsors began to understand the large employer subsidy associated with medical benefits during early retirement (retirement prior to age 65)**

Prevalence of Employer Sponsored Retiree Medical Coverage History since implementation of FAS 106



Source: 2003 Mercer National Survey of Employer Sponsored Health Plans



Retiree Medical Cost Management Strategies

- **In order to reduce or control the future growth of the annual FAS 106 accounting expense, plan sponsors looked at several different strategies including the following:**
 - Increased health and pharmacy management of plans
 - Cap on employer subsidy
 - Fixed dollar subsidy with no anticipated increase
 - Elimination of employer-provided benefit for post-65 retirees
 - Elimination of all benefits for future retirees
 - Change from defined benefit to defined contribution approach
 - No benefits for future hires
- **Caution: employee and retiree relations issues!**
- **Legal actions spawned with changes**



Other Retiree Medical Cost Management Strategies

- **Plan sponsors also considered ways to reduce the duration of benefits as well as the large early retirement subsidy by:**
 - Increasing the eligibility age for benefits
 - Decoupling the eligibility for retiree medical benefits from pension eligibility
 - Service-based employer subsidy
 - Employer subsidy based on retirement age (like an actuarial reduction)

- **Age is important for early retirements**
 - The longer the benefit is provided, the higher the liability – especially on the pre-65 side!!!



Funding Options Are Available for Governmental Employers

- **Under GASB 45, pre-funding is likely to allow for the use of a higher discount rate (depending on investment strategy) and therefore a lower initial unfunded actuarial accrued liability**
- **Pre-funding better matches the expense of the plan with the cash outlay**
- **Pre-funding secures the benefit and reduces the build up of an unfunded liability on the balance sheet**
- **Efficient funding vehicles are available including pre-funding by employees**
 - No tax implications for governments
 - IRC Section 115 trusts



What You Should Do Now

- **Determine your effective date**
- **Perform actuarial valuation of current plan**
 - Select funding methods
 - Select actuarial assumptions
- **Consider and evaluate possible plan changes**
 - Options to reduce liability
 - Effect of Medicare Part D
- **Explore advance funding options**



Sample Time Line for Typical Phase 1 Government (No pre-funding)

Spring 2005

Initial analysis and project planning

July 2005 – June 2006

Baseline valuation

Review alternatives

Propose plan changes

January 2007

Implement plan changes

July 2007

GASB 45 effective date



Questions?

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