HEALTH CARE POLICY ROUNDTABLE

Healthcare Coverage in Retirement

The Current State, Challenges and Opportunities for Improvement

February 20, 2019

HR Policy Association (HR Policy) represents the Chief Human Resource Officers of nearly 400 companies in the Fortune 700. Each year, the Association surveys its members on a variety of issues, in part to determine areas of concern deserving attention. A survey conducted in August of 2018 revealed dissatisfaction with certain aspects of retiree medical programs. While there was general approval of the affordability and availability of medical coverage for retirees age 65 and older, those eligible for Medicare, that was not the case for pre-65 retiree coverage.

This dissatisfaction is not only being expressed by employers, but by employees as well. A recent national poll published by the University of Michigan Institute for Healthcare Policy found that of those approaching retirement age, 45 percent of adults aged 50 to 64 are not confident they will be able to afford health care coverage in retirement, indicating that health care is a major worry for older Americans. According to the director of the poll, "We were surprised by the low percentage of these adults who bought their own coverage through the ACA exchanges, and the relatively high percentage who felt they had to keep a job or delay retirement in order to keep a plan." He went on to say, "Innovative policy solutions are needed to help adults in this group navigate their insurance options."

In response, the Association staff reached out to several members for further input. Several confirmed the University of Michigan's finding that pre-65 employees are deferring retirement as a direct result of the high cost of pre-65 health care coverage. However, these same employers said that the answer does not lie in improving retirees' and prospective retirees' ability to navigate their health care options. Rather, it lies in innovations that address cost and availability of pre-65 healthcare coverage, meaning a solution that offers more than just better navigation of currently available insurance options.

These employers believe that it is important for policymakers to look at options that specifically address this area of the healthcare cost curve. In addition, while most companies do not consider addressing post-retirement medical costs a top priority because they have capped their liability for these benefits, the majority surveyed felt that it was important for the Association to pursue two objectives. First, it should promote the thought leadership necessary to provide and sustain the assets needed to meet their financial post-retirement obligations. Second, it should tackle a growing social and workforce planning problem; *i.e.*, accessing affordable pre-65 medical coverage.

This paper examines how HR Policy members have addressed both their pre- and post-65 retiree medical liabilities. It briefly looks at the Affordable Care Act's (ACA) unfulfilled promises of lower cost and broader coverage in the individual marketplace and then examines workforce planning implications of an inefficient individual health insurance marketplace. It concludes with a recommended plan of action.

I. RESULTS OF THE 2018 CHRO SURVEY

The membership was asked for its opinions on the current state of retiree health care for both pre-65 and post-65 retirees. There were 150 companies participating in the survey, and they responded as follows regarding coverage:

- 16% Provide coverage to all retirees.
- 43% Provide coverage to some but not all retirees.
- 41% Do not now, have never provided coverage to retirees.

Regarding pre-65 retirees, for companies that do provide coverage to this group of retirees, half were pleased with the offerings in the marketplace and half were not.

At the same time, 45 percent of companies would like to be able to offer a benefit to employees between the ages of 55 and 64 to facilitate their ability to retire while only 26 percent disagreed. Finally, there was strong interest among the members—nearly 40 percent—in being able to offer coverage to pre-65 retirees without having to blend them with active employees.

What these survey results show us is that while the majority of the membership, nearly 60 percent, provides retiree health coverage, half the respondents are not pleased with the pre-65 coverage currently available.

II. EXECUTIVE SUMMARY: KEY TAKEAWAYS FROM INTERVIEWING HR POLICY MEMBERS

1. Most companies reported that they considered their post-65 retiree medical programs to be essentially on "auto-pilot" with the majority moving their post-65 retirees to an individual multi-carrier exchange with varying levels of subsidy.

2. Retiree disruption is considered a major impediment to change for those that still provide self-insured group solutions.

3. When accounting rules required companies to book the value of their post-retirement benefits on their financial statements, virtually all companies reviewed these liabilities and took action. Generally, employers terminated or reduced retiree medical coverage for employees deemed sufficiently far enough away from retirement to plan accordingly, while closing participation for those employees already retired or close to it.

4. Data indicates that many employers have some level of advanced funding set aside for their post-retirement healthcare liabilities[1] while addressing any remaining liabilities on a "pay-as-you-go" basis. Many employers have prefunded their retiree medical liability through VEBAs and 401(h) accounts and have done so for both represented and non-represented retirees. However, assets set aside in VEBAs can often be subject to an Unrelated Business Income Tax (UBIT), which has served to dampen employers'

[1] Employers are allowed to pre-fund medical obligations related to existing retirees through a Voluntary Employees' Beneficiary Association (VEBA), subject to potential Unrelated Business Income Taxes (UBIT). See *Wells Fargo & Co. v. Commissioner*, 120 T.C. 69 (T.C. 2003) which held that companies are allowed to pre-fund and deduct contributions for future medical obligations related to retired employees.

desires to pre-fund their post-retirement obligations.

5. Concerns were expressed about the pre-65 individual medical marketplace, which companies see as typically much more expensive (and less generous) than active employee coverage.

6. There appears to be a lack of "creative thinking" to address what has (for many employers) become the pre-65 conundrum. The post-65 market is very attractive to carriers because they receive Medicare subsidies for these individuals, and as a result many employers have moved their retirees to fully-insured individual Medicare Advantage or Medicare Supplement plans or group Medicare Advantage plans. However, carriers find the pre-65 market unattractive to the point that there seems to be little interest or willingness to try to figure out how to use the pre-65 individual market to feed the lucrative post-65 Medicare subsidized market.

7. With health care accounting for 17 percent of household income, employees appear to be delaying retirement because of the lack of affordable retiree healthcare coverage. For many companies, this results in employees who are present but neither engaged nor interested in being innovative. At the same time, many employees are not saving adequately for retirement which is impacting workforce planning. Because of the escalating cost of health care, one question that employers are asking is along the lines of financial wellness—what role should they play in preparing employees for retirement, including preparing them for the cost of health care in retirement?

8. There is support for initiatives aimed at addressing the cost of pre-65 individual medical coverage so that it would be on a par with the coverage available to active employees and post-65 retirees. What is missing is leadership to bring employers together to begin discussing this issue.

9. A question deserving consideration is whether there should be an interdisciplinary approach instead of a siloed one in addressing retiree health care inside large corporations. The current pattern is that retirement income is typically handled by finance and treasury, while retiree health is the responsibility of human resources. Should HR come together with finance and treasury to determine whether a different approach to financing retiree health care could generate a better outcome? Are there concepts and principles developed during the successful de-risking of the funding of retirement income programs that could be applied to retiree health care?

A Staff Perspective

In addition to the above points, the Association staff came away from their discussions with a question they believe deserves discussion.

In 2005 when the Association developed its Retiree Health Access concept, carriers uniformly rejected it on the basis that it was not in keeping with prevailing actuarial assumptions and carrier practices. It wasn't until the Association found one actuary in one carrier willing to take a fresh look at what underlay those assumptions and challenge the company's leadership that the merits of the approach finally began to be seen. Once that happened, the carrier discovered what an incredible opportunity the concept was.

Right now, health care solutions being provided large employers is in stasis. Hardly any employers are willing to make changes, and hardly any carriers are willing to propose something new and different that would be worth an employer investing in change. In such an environment, would it be prudent to review all the actuarial and underwriting assumptions that carriers have operated under for decades to see if circumstances have changed? We believe this task is important to undertake because of another significant issue that we believe is not being addressed.

There is no question that the demographics, composition and characteristics of the workforce have shifted significantly over the past thirty years, and we know they will continue to do so during the next twenty and likely accelerate. With advances in AI, machine learning, and advanced automation, we know that the way in which work is done and the staffing needed to do it is evolving. Although it may be safe for a carrier to sit tight and maintain the status quo, it is our belief that employers would be attracted to an organization willing to sit down with them to learn about, not only how the workforce has changed and continues to change, but also how companies are transforming the way work is done to create the workforce of the future.

Too often, the focus during meetings between employers and carriers is on presentations by carriers on the latest gadget or tweak to an established program and little consideration of the program's long-term sustainability. Seldom is there interest in addressing an employer's workforce challenges, long-term aspirations, emerging staffing models.

Neither the workforce of today nor current organizational designs will be the norm in the corporations of tomorrow, which means health care solutions in place today may not be suitable for the next generation of staffing. Right now, there seems to be far too much interest among carriers in continuing to push what is already on the shelf, not shaping solutions to meet changing directions. That to us is misguided. Employers, in our opinion, would be both encouraged by and attracted to a carrier willing to step forward to try to understand how its customer is evolving, what its pain points are, and discover how that customer is creating the workforce of the future.

III. THE CURRENT STATE OF RETIREE HEALTH CARE COVERAGE AND HOW IT WAS REACHED

The most recent census data available shows that there are nearly 42 million people aged 55 to 64 in America and that over 26 million of them are employed. Surprisingly, only a fraction of that number 7.4 million, receive coverage through the individual market. Most receive it through employer coverage or public programs.

Adoption of SFAS 106 Post-Retirement Welfare Liabilities

Until the early 1990s, employers were not required to report the value of post-retirement welfare liabilities (*i.e.*, not pension liabilities) on their balance sheets. Rather, these costs were reported on a "pay-as-you-go" basis.

This changed at the end of 1990. At that time, the Financial Accounting Standards Board issued its Statement of Financial Accounting Standard 106 (SFAS 106) on "Employers' Accounting for Postretirement Benefits Other Than Pensions." SFAS 106 required employers, starting in 1993, to show the net present value of all post-retirement welfare benefits on their balance sheets. The largest of these benefits was the value of retiree medical benefits for current and future retirees.

In anticipation of SFAS 106's reporting requirements, employers began to examine the value of their retiree medical commitments. They noticed that unlike retirement benefits under the Employee Retirement Income Security Act of 1974 (ERISA), federal law does not require that post-retirement benefits be vested. This gave employers the ability to change (and in some cases terminate) post-retirement welfare benefits. Only post-retirement benefits that are either contractually or equitably "vested" were protected from cuts. By requiring the reporting of post-retirement benefits, SFAS 106 served as the impetus for employers to re-examine what post-retirement welfare benefits they offered and to whom.

A Case of Sticker Shock for Senior Executives

Prior to imposition of SFAS 106, employers did not have to quantify for analysts or investors the level of liabilities associated with post-retirement benefits they had granted. These costs were simply handled on a "pay-as-you-go" basis flowing through the P&L accordingly. But when SFAS 106 required employers to measure the value of their post-retirement liabilities, many employers were surprised at what they would need to "book" and report as a current P&L expense. This got the attention of CEOs, CFOs and corporate boards, and it caused corporate human resource departments to re-examine the level of post-retirement welfare commitments.

ERISA's Treatment of Retirement Income Benefits v. Retiree Medical Benefits

A contributing factor in this discussion was the fact that ERISA, a law requiring pre-funding of retirement obligations, did not impose a similar pre-funding requirement on post-retirement welfare benefits. Generally, the law treated these benefits as 'non-vested' benefits (*i.e.*, subject to change – even retroactive change unless the employer had somehow contractually or equitably vested the post-retirement benefits). This feature allowed employers to adjust their post-retirement benefits in fairly dramatic ways.

Retiree Health Care Funding Challenges Under SFAS 106

Another very important distinction between employer-sponsored retirement and post-retirement health care benefits relates to the inability to pre-fund liabilities. ERISA articulates fairly robust requirements to fund defined benefit pension obligations but offers more limited pre-funding opportunities for post-retirement health care obligations. To the extent employers have pre-funded post-employment liabilities, they have done so using a Voluntary Employee Beneficiary Association (VEBA), a health reimbursement account which allows employers to contribute pretax money to a 501(c)(9) tax-exempt trust on behalf of its employees. Money in the trust can be used to pay for current eligible medical expenses and is often saved for medical expenses in retirement.

VEBA assets cannot revert back to the employer without a steep reversion tax, which means that any excess assets an employer places in a VEBA cannot be recaptured by the employer without penalty. This limitation has discouraged employers from more aggressively pre-funding their post-retirement liabilities[2].
Another wrinkle employers have encountered pre-funding post-retirement benefits through a VEBA is the Unrelated Business Income Tax (UBIT). Special rules apply in calculating the amount of VEBA income subject to UBIT. Any unrelated business income that the VEBA sets

[2] But see Footnote 1 regarding Wells Fargo case that allows pre-funding for both union and non-union employees once they have retired from employment.

aside for the payment of life, sick, accident or other benefits remains exempt from income, but only to the extent necessary to pay such benefits. As a result, any excess accumulated income beyond this amount will incur UBIT. The existence of UBIT can negatively impact the VEBA's otherwise tax-efficient nature. Notwithstanding these constraints, financial data shows that a number of companies, including many HR Policy Association members, currently maintain some level of VEBA pre-funding.

In addition to VEBA funding, some employers who sponsored ERISA defined benefit pension plans have pre-funded their post-retirement medical benefits through an Internal Revenue Code Section 401(h) account. Using that type of account, employers sponsoring a defined benefit pension plan have designated a portion of their pension contributions to pre-fund post-retirement health care benefits. Funds in a §401(h) account can be used to pay for post-retirement health care benefits for both union and non-union employees. Prior to the passage of the Pension Protection Act of 2006 (PPA 2006), a law that significantly impacted the amount an employer could contribute to a defined benefit plan, § 401(h) account usage was less common. Following its passage, employers took a number of steps to curtail their pension liabilities, including transferring segments of their retiree and deferred populations to insurance companies through a pension risk transfer transaction. However, none of these steps meshed well with pre-funding retiree medical benefits through a §401(h) account[3].

How Employers Responded to SFAS 106

Virtually all employers offering some level of retiree medical coverage reviewed their programs in response to SFAS 106. While the specific ways in which employers addressed their retiree medical liabilities varied greatly, several overarching patterns emerged.

First, employers segmented their total retiree medical liabilities into subgroups. For example, many employers segmented their retiree medical liabilities between liabilities associated with already retired employees who were collecting retiree medical benefits, already retired individuals who were eligible but not collecting retiree medical benefits, active employees who were immediately eligible to retire and collect retiree medical benefits, and actively employed individuals who were not immediately eligible for retirement.

Second, to further segment their retirement liabilities, employers looked at several factors including but not limited to:

1. To what extent are the retiree medical liabilities subject to collective bargaining?

2. Do any Summary Plan Descriptions (SPDs) seem to indicate that the employer did not have the right to change or terminate retiree medical coverage?

3. What were the ages of those individuals already collecting retiree medical benefits?

4. What funding (if any) was associated with specific groups of retirees?

[3] 401(h) accounts provide employers with an opportunity to pre-fund retiree medical obligations without the negative implications of the Unrelated Business Income Tax . However, for those that may terminate their defined benefit pension plan and have existing 401(h) assets, the employer first must liquidate all the funding in the 401(h) account.

5. Were any retirees part of an acquired group wherein the employer agreed by contract not to change the retiree medical program?

6. If the employer sponsored a defined benefit pension plan, what was the plan's early retirement age?

7. Are retirees in a separate retiree medical plan design?

8. Could the employer's defined benefit pension plan pay a supplemental pension payment to cover the cost of a Medicare supplemental program?

In considering these factors, many of which were viewed through the prism of potential damage to the company's brand, employers then made decisions about which retiree medical coverage they needed to honor versus which coverage the company felt comfortable terminating. Every employer faced a different situation but approached their analysis utilizing essentially the same factors listed above.

It is clear from listening to how several HR Policy member companies went through their decision-making process that each strove to strike a balance between overall affordability and dealing with reasonable employee expectations, along with potential legal actions and negative brand equity. The end result was a complex set of residual (closed) programs that can only be accurately explained by a benefits professional with deep institutional and historical knowledge. As part of that, many HR Policy members found themselves providing separate medical plans exclusively for grandfathered employees (*e.g.*, plans that offered unique deductible and copayment amounts to a closed group of retirees). Once companies created the administration processes to manage these programs, the closed nature of the group created a strong impetus to leave that group on auto-pilot.

Advent of the Post-65 Medicare Exchange

One of the most important developments in the retiree medical area was the advent of Medicare Exchanges. Because post-65 retirees are eligible for Medicare, insurance companies have been able to construct cost competitive, fully-insured programs that wrap-around (*i.e.*, supplement) Medicare.

In 2006, HR Policy launched Retiree Health Access (RHA) in conjunction with Aetna and a number of participating member companies. RHA has served more than 150,000 retirees with competitive access to Medicare Advantage, Medicare Supplement and Part D coverage, both group and individual solutions and a pre-65 group only solution. At the same time, several large employers adopted programs sponsored by consulting firms such as Willis Towers Watson, Mercer, and Buck, which provide post-65 only individual multi-carrier plans and retiree advocacy services.

In talking with HR Policy member companies, many indicated that they had shifted post-65 retirees to a Medicare Exchange offering plan options. Companies that have not moved their post-65 retirees to a Medicare Exchange believe they are committed to providing their retirees a more comprehensive level of coverage than is available through individual Medicare in combination with supplemental coverage and wish to position themselves as an advocate for navigating the changing landscape of health care and delivery.

In general, most HR Policy members interviewed felt the Medicare Exchange marketplace offered cost-effective choices for Medicare-eligible employees. One caution is that employers who have fixed their contributions by contributing to HRAs, which retirees may use towards purchasing coverage on Medicare Exchanges, may begin to feel pressure from retirees once the cost of the exchange's coverage begins to creep above the employer's reimbursement allowance.

IV. KEY CONCERNS AMONG HR POLICY MEMBERS REGARDING RETIREE HEALTH CARE

The Cost of Pre-65 Medical Coverage

In talking with HR Policy members, the one area in which they universally said they struggle is making available sustainable, cost-effective and comprehensive medical coverage for pre-65 retirees. Several of those interviewed said that even their senior executives were taken aback when they saw the monthly cost and, in many cases, the limited networks for pre-65 coverage.

Employees Delaying Retirement

Other companies indicated they had anecdotal evidence that employees were delaying retirement because of the cost of health care and uncertainty of coverage into retirement. This impacts their workforce planning efforts as well as increases worker's compensation and disability costs. It is of particular concern because as more baby-boomers become retirement eligible, many have not planned adequately for retirement and cannot afford the cost of health insurance. Further, a workforce marking time until retirement is possible will not generate the innovations needed for success in the marketplace.

Employers Caught Between a Rock and a Hard Place

Most HR Policy members indicated that they offered the same medical plan to pre-65 employees that was offered to active employees; however, the risk pool varied with some employers combining the risk with the actives and others separating the pools. In all cases, employer contribution limits were often tailored to offset the cost of the pre-65 claims and to align with the affordability and culture of the organization. This has resulted in much higher overall costs for the retirees which only exacerbates the cost pre-65 retirees face.

Inadequacies of the Individual Marketplace

Even though efforts have been made over the years (including the passage of ACA) to strengthen the individual marketplace, several HR Policy members said their experience has been that the individual marketplace is too costly for their pre-65 retirees, limits network access and offers narrow formularies. A few employers have steered their early retirees to the exchanges, but often get negative feedback due to network inadequacy and high cost, becoming upset when they are not allowed to come back to the employer-sponsored plan. Therefore, many employers feel compelled to extend some level of coverage to pre-65 retirees, even if that coverage is far more expensive than the employer pays for active employees.

Challenges of Retiree Medical Financing and Employer Subsidies

Unlike retirement programs where federal law has strict annual pre-funding requirements, post-retirement health care programs do not. As such, the majority of employers interviewed for this paper said that they provided some pre-funding for retiree medical coverage, primarily through a VEBA. To the extent post-retirement benefits have not been pre-funded, HR Policy Association members stated that they covered these costs on a "pay as you go" basis out of operating earnings. That makes it a balance sheet liability with variable costs year-over-year that finance departments look to avoid.

Employers use different types of subsidy methods in providing financial support to cover the employer's share (if any) of the annual cost of retiree medical coverage. Most of those interviewed reported utilizing a fairly complex set of factors based on a combination of year of hire, length of service, age, union status, and the like to compute the employer's subsidy. But even though these retiree medical arrangements are complex, employers felt they were equitable, long-standing and, most importantly, impacted a closed group of individuals. All these factors taken together leaves employers uninterested in making wholesale changes.

Further, while most employers have capped retiree medical liabilities, the reality is that increased life expectancies can drive up the value of retiree medical liabilities and make maintaining these programs more costly at the same time interest rate and equity market volatility expose pre-funded assets to investment risk.

V. RETIREE MEDICAL COVERAGE – A LOOK AHEAD

All employers interviewed expressed an interest in both learning about and encouraging solutions that could help them offer sustainable, cost-effective and comprehensive medical coverage to retirees, as well as moderate the cost growth of their existing retiree medical programs. There was a feeling that development of retiree health care programs has plateaued, and there needs to be creative thinking among employers to identify consensus needs, explore options, and consider opportunities.

Some employers reported working with service providers to look at ways to fund retiree medical costs by adding an insured layer of predictability to their retiree medical cost outlays, especially if this could have a positive impact on earnings per share and reducing balance sheet volatility in a way that was tax-efficient.

Other employers felt that given the fact that their existing retiree medical programs were closed to new entrants and that the covered populations were not agitating for change, addressing retiree medical costs is not as important as other business imperatives. In other words, absent someone coming up with a breakthrough concept, they are inclined to simply continue bearing the burden.

Perhaps the greatest opportunity is for HR, Finance, and Treasury to work together to consider the way retiree medical costs are funded and addressed. This may be one way to get fresh thinking put on the table. Questions were raised whether greater efficiencies and more creative thinking would occur if HR, Finance, and Treasury worked more closely in reviewing various options available in the market place and figuring out whether those options could be funded differently to improve financial performance.

As the subject of retirement benefits was being discussed, it was difficult not to think of the breakthrough thinking that has occurred over the last decade for de-risking defined benefit pension liabilities. During the past few years, there has been considerable work to develop de-risking solutions, and de-risking strategies are now widely deployed in addressing defined benefit pension liabilities. One idea put forward during the interviews was whether a similar de-risking strategy could be developed to help employers with their retiree medical liabilities. The idea would be to create a process by which retiree medical liabilities could be made less volatile for cash-flow and financial accounting purposes as well as tax-efficient by avoiding UBIT issues. Eliminating longevity and morbidity risks would also be considerations.

HR Policy members expressed a reticence to disturb their current retiree medical programs; therefore, any program to de-risk would have to improve earnings and cash-flow volatility while leaving existing retiree medical programs in place. Still, there was interest in exploring the concept.

A key question was which type of HR Policy member companies would benefit from such a solution? It seems that those sensitive to EPS changes driven by retiree medical liabilities as well as member companies with some level of retiree medical pre-funding may be interested in taking risks such as longevity risk, investment return and medical inflation off the table.

From discussions of this concept with those we interviewed, the staff's feeling was that if this approach were to be pursued, it would not be through a carrier but rather a finance organization with deep financial strength and expertise in risk management, one experienced in developing a solution that would allow companies to protect their future financial earnings per share from unexpected retiree medical cost increases. Ideally, the solution should provide a risk-transfer solution but leave the benefits being enjoyed by retirees untouched and provide a means of modifying or canceling the program depending on future circumstances. Further, what may be particularly attractive is a solution that would efficiently utilize pre-funded VEBA or 401(h) assets, or the opportunity to create a large tax deduction at inception.

In sum, as described in Section II above, the Association would be encouraged by someone willing to question the status quo, listen to how companies are changing, and help them get to where they would like to be.

VI. RECOMMENDED NEXT STEPS

In view of the above, our recommendation is that a small group of interested employers be convened to:

1. Review these findings.

2. Agree upon desired objectives.

3. Consider methods to achieve those objectives.

4. Develop a plan to approach the marketplace to identify those willing to consider new approaches for consideration by HR Policy members.

APPENDIX A

EXAMPLE OF A DE-RISKING STRATEGY APPLIED TO RETIREE HEALTH CARE

This example explores the potential impact of a de-risking strategy such as the one often pursued to de-risk defined pension liabilities. It illustrates a simplified view of the positive impact of a process by which pre and post-65 retiree medical liabilities could be made less volatile, and where longevity and investment (or free-cashflow) risks are transferred to a third-party (risk transfer insurer).

- In this simplified example which looks at the employer's entire pre and post-65 population (segmentation is also possible), the pre and post-65 retiree medical liability on the balance sheet is $154 M.
    - The population of 3,000 pre-65 lives consists of all 60-year-olds, with 20 years of life expectancy and a retiree medical liability to the employer that averages $5,000 annually. The population of 1,000 post-65 lives consists of all 65-year-olds, with 15 years of life expectancy and a retiree medical liability to the employer that averages $2,000 annually and assumes the benefit is constant each year ($5,000 pre-65 and $2,000 post-65). This example assumes a 3% discounted liability.
    - For purposes of this example the contributions that the pre and post-65 retirees pay is not important as this example only looks at the liability and risk carried by the employer.
    - Both pre and post 65 retirees are covered under a fully-insured health insurance program with post-65 retirees covered in a Medicare Advantage program. Nothing would change with respect to the employer's sponsorship of the retiree medical program or how retirees' access or receive benefits.
    - **The example assumes the pre-65 premium was $5,000 and post 65 premium was $2,000. When a pre-65 retiree attains age 65, the premium changes from $5,000 to $2,000. $154 M covers the premium for the participants for life. (It would not cover premiums, for example, if the employer increased benefits. The employer would be responsible for the amounts above our contract reimbursement.)**
    - The model would also apply if the employer has sent participants to a private exchange.
- In this strategy, the risk transfer insurer would evaluate the demographics of the 4,000 lives, the liability for each participant and generate a single premium that would be due from the employer at the outset. The risk transfer insurer would then be obligated to reimburse the employer or their designee (ex. Health Insurer) for the premiums due for the 4,000 covered lives for as long as they live. Because of the insurance contract the risk transfer insurer can never ask for more premium for the covered lives.

- Once risks are transferred, the retiree medical liability on the employer's balance sheet remains $154 M but they now have a corresponding asset that will move in tandem over time with the liability making valuing the liability each accounting period predictable.

- In this de-risking strategy, the key financial risks inherent in offering a retiree medical plan such as investment risk or availability of future free-cashflow, longevity risk and morbidity risk would be transferred from the employer to a third-party (risk transfer insurer).

- The retiree medical plan remains under the control of the employer with the ability to change benefit provisions and providers. There is no impact to the pre-65 or post-65 retirees and therefore no communication would be required to covered participants. However, for workforce planning purposes the employer may choose to communicate that an insurance contract has been purchased that guarantees coverage which may facilitate early retirement.

- Cost savings are further derived in several ways.

    - Any additional funding contributed by the employer, up to 100% of the single premium, would be tax deductible in the year in which it's paid to the risk transfer insurer.

    - The single premium is also the maximum the employer will pay before receiving a refund based on an unused benefits provision.

    - Significant cost savings are also obtained by the employer not being exposed to adverse scenarios. For example, relax the assumptions above of 20 or 15 years of life expectancy, and instead assume that 20% of the retirees live to age 80, 20% to age 85, 20% to age 90, 20% to age 95%, and 20% to age 100. Had the risks not been transferred, this liability previously valued at $154 M increases to an expected cost of $191 M creating significant adverse cashflows in all the outer years.

- As noted earlier, the approach would be equally rewarding for employers that have sent their retirees to the post-65 exchange. After the single premium is paid, the risk transfer insurer would make all annual HRA payments for the defined population irrespective of how long they lived. The cost savings highlighted above apply including the ability to deduct 100% of the single premium rather than a deduction each year HRA payments are made.

APPENDIX B

SUMMARY OF EMPLOYER APPROACHES AND RESPONSES TO RETIREE HEALTH CARE CHALLENGES

The approaches deployed in addressing retiree medical liabilities can be summarized as follows. Please note that employers often use a combination of these various approaches.

First, employers decided whether to provide employees with retiree health care.

Actions Taken	Commentary
1. No Provision of Retiree Medical Benefits	Generally confined to situations where the company was dealing with either: - extremely small number of retirees and changes were costly to implement with little upside; - retiree groups where contractual vesting appeared to be in place; - Groups of very old retirees where changes would be financially impactful and likely to generate negative publicity

If health care is to be provided to retirees, then an analysis is performed the retiree population and whether, and to what extent, it should be segmented.

Actions Taken	Commentary
2. Segmented Retiree Medical Liabilities between Retiree Groups	Companies generally look at each retiree group and approached each group differently: • Actively employed and not immediately eligible to collect retiree medical benefits; • Actively employed and immediately eligible for retiree medical benefits; • Retired and collecting retiree medical benefits; and • Retired for many years and Medicare eligible. In looking at their retiree medical eligible populations, companies often consider whether there is any pre-funding available

3. Looking at Retiree Medical Liabilities by business group / corporate structure	Companies that consider this factor typically do so in recognition of competitive differences within their corporate structure and the desire achieve a more tailored workforce planning structure.

Following segmentation, decisions need to be made regarding funding.

Actions Taken	Commentary
4. Different cost subsidy formulas for individuals who retain retiree medical access	A primary tool of reshaping retiree medical liabilities is providing different level of company subsidies based on the retiree's age and length of service. While addressing retiree medical liabilities in this way adds complexity and cost to both administration and communications, many companies take this approach as a way of lessening the financial impact retirees experience.
5. One-time defined benefit pension increases while lowering or eliminating retiree medical financial support	Some companies that sponsor defined benefit pension plans find it easier to provide one-time pension increases at the same time they reduce their financial support for their retiree medical programs.
6. Pre-funding through a VEBA	Where the population lends itself to pre-funding (*e.g.*, represented workers), companies pre-funded retiree medical liabilities through a Voluntary Employee Benefit Association (VEBA). One of the largest VEBA funding initiatives was the General Motors / UAW retiree medical VEBA. Assets in a VEBA are separate and apart from a corporation's creditors and not subject to attachment in the case of bankruptcy. In this vain, employers have also taken advantage of the *Wells Fargo* decision to pre-fund retiree medical liabilities for existing retirees (both union and non-union), while managing any related Unrelated Business Income Tax (UBIT).
7. Pre-funding through a Defined Benefit 401(h) account	While not used as actively as VEBA pre-funding, corporations that sponsor a defined benefit pension plan can designate a portion of their annual pension contribution to be used to reimburse the company for future retiree medical benefits related to the plan's retired individuals.
8. Implement different post-65 subsidy structures for different retiree populations	While trying to balance the cost of administration and communications, companies attempt to mitigate the financial impact of retiree medical changes by providing different levels of financial support for post-65 Medicare coverage.

9. Explore ways to mitigate corporate EPS volatility through insured funding arrangements	Companies explore ways to similarly try and immunize their retiree medical liabilities through the use of insurance funding techniques.

Once funding and segmentation are complete, employers turn to determining the best vehicle for providing retiree health care.

Actions Taken	Commentary
10. Place retirees (primarily pre-65 retirees) in separate medical plan risk pools	Companies that utilize this approach do so to isolate the cost of retiree medical and confine it to retirees only; i.e., no cross-subsidization by the company or active employees. This is generally confined to companies that have a large enough population of pre-65 retirees to make the administrative and actuarial expenses of maintaining a separate plan cost justified.
11. Allow pre-65 retirees to purchase medical coverage at COBRA cost until Medicare eligible	Some companies allow employees who are eligible for early retirement access to purchase medical care at the company's COBRA rate. These companies typically do not provide an explicit cost subsidy for retirees or their dependents.
12. Grandfather certain active employees in retiree medical coverage, while ending eligibility for others (usually employees further from retirement)	When employers began to look at their retiree medical benefits in the mid-1990s, many companies grandfathered (albeit with differing subsidy levels) active employees who either were retirement eligible or close to being retirement eligible.
13. Treat dependent(s) differently than employees when designing company subsidies	While trying to balance the cost of administration and communications, companies attempt to mitigate the financial impact of retiree medical changes by providing different levels of financial support between employees and their dependents.
14. Utilize a post-65 Medicare Exchange Vendor	Within the last 15 years, the Medicare supplemental marketplace has matured to the point that generous and cost-effective Medicare supplemental coverage is available on the individual market than through employer-sponsored programs. As a result, most large companies have worked to move their post-65 retirees to a Medicare exchange.