CIGNA SENIOR & RETIREE SERVICES

The New Health Care Gap: Sustaining the continuum of health care benefits for early retirees

Kenneth L. Sperling
Senior Vice President
CIGNA Senior & Retiree Services

2008

Abstract

This paper will help address some of the basic issues facing employers with an aging workforce, including how employers will:

- meet both the needs of their employees and their business by transitioning workers into a healthy and secure retirement,
- provide solutions that are comprehensive, affordable and easy to use, and
- control current and future liabilities tied to retiree benefits while providing benefits to current employees.

Background

The availability of health care coverage for individuals not yet eligible for Medicare is becoming increasingly elusive. Several factors have contributed to both the trend and the rising importance of this issue, including:

- the aging of the baby boomer population driving a greater proportion of the workforce into a retirement-ready category. There are currently 87 million people in the U.S. over the age of 50, and this number will increase over the next 30 years;
- the reality of Financial Accounting Standard 106, and its companion Government Accounting Standard 43/45, requiring employers to accrue for the liability of post-employment benefits over the active employee's lifetime;
- the shift in workforce dynamics from lifelong tenure to shorter-term employment, causing a re-prioritization of benefits from deferred arrangements (defined benefit pensions, retiree medical) to current arrangements (direct pay, defined contribution, cash balance); and
- rising health care costs hindering employers' ability to compete in a global marketplace.

Today, only 33% of employers with more than 200 workers offer retiree health benefits, down from 66% in 1988[1]. For small employers, retiree health benefits are almost non-existent. Even among large employers who offer benefits, the scope of the employer commitment has changed dramatically. FAS 106 liabilities have driven a desire to limit subsidies for retiree medical, generating an average annual premium contribution for single coverage of $2,724 for pre-65 coverage, increasing 15.1% in 2006[2]. Even with this dramatic increase in retiree cost-sharing, the average employer share of the premium for a single pre-65 retiree exceeds $4,000 in 2007.

Benefits managers currently find themselves between a rock and a hard place. Facing a limited pool of health care dollars, they need to prioritize between investing in the health and security of the active employees producing income to the company, or shift resources toward non-income producing retirees based on their expectation of post-employment health care coverage. Eliminating coverage has workforce implications; the employee in his/her early 60s might want to retire but will not without affordable,

[1] Kaiser/HRET Employer Health Benefits Survey, 2007

[2] Kaiser/Hewitt Retiree Health Survey, 2006

comprehensive health coverage as a bridge to Medicare. The individual insurance marketplace is especially unfriendly to a group that may have more frequent and chronic health issues, with up to 30% of applicants failing to qualify for comprehensive benefits. Whereas coverage for individuals eligible for Medicare is affordable, competitive, and accessible, the pre-65 individual marketplace exhibits none of those characteristics.

Current Strategies for Pre-Medicare Retiree Benefits

Employers who currently sponsor health coverage for pre-65 retirees generally follow one of the following strategies:

Continue active coverage until age 65

These companies may employ different subsidy structures based on age, years of service, and cost, but plan designs for pre-65 retirees mirror the plans provided to active employees. Once Medicare becomes primary, the employer plan typically provides supplemental coverage.

Offer unsubsidized access to coverage

These companies have eliminated their subsidies for all or a portion of their early retirees, but still feel an obligation to allow retirees access to coverage regardless of their health condition. As can be expected, employers in this position will likely experience significant adverse selection, as those who can qualify for individual coverage may find it at a substantially lower cost and opt out of the employer plan. Due to risk pool concerns, insurers have been reluctant to accept this population on an insured basis. If the employer is forced to self-insure and claims exceed premium collected from retirees, the company's auditors may determine an unplanned FAS 106 liability exists.

Pre-fund retiree health care premium

While these strategies are the exception, some companies have established notional accounts where employees are provided "credits" that can be used at retirement to apply toward retiree medical premiums. Other employers are using account-based programs including Health Reimbursement Arrangements (HRAs) and Health Savings Accounts (HSAs) as vehicles to hold employer and employee monies earmarked to retiree medical premiums and out-of-pocket expenses. And still another vehicle gaining recent attention is the Voluntary Employees Beneficiary Association (VEBA) trust account, which captures and protects employer and/or employee contributions towards retiree medical coverage. The recent agreements between America's leading automobile manufacturers and the United Auto Workers to establish a VEBA trust for their retiree health financial obligations is an example of a cooperative agreement to secure health care coverage for retirees while helping the employer remain competitive in a global marketplace. Governmental organizations actually have an incentive in the GASB regulations to pre-fund as well as the ability to raise capital through Other Post Employment Benefit (OPEB) obligation bonds. For these organizations, the risk of ignoring this liability can have far-reaching implications to overall credit ratings, the cost of capital, and ultimately the taxes levied on local residents.

Eliminate coverage for pre-Medicare retirees entirely

Companies that have chosen to eliminate coverage entirely have made the decision that the cost and liabilities associated with this group is untenable. What these companies fail to realize is while the accounting liability for post-employment health benefits may indeed be gone, the cost of these benefits may remain. According to Mercer's 2006 national survey of employer-sponsored health plans, the average retirement age for individuals with employer-sponsored early retiree coverage is 61. The average retirement age for individuals without this coverage is 64. The conclusion is obvious—without guaranteed access to affordable coverage, those eligible to retire are choosing to remain in the workforce and retire at a point where they can use COBRA coverage as a bridge to Medicare benefits. During these "pre-retirement" years they are still incurring claims under their employer's benefits provided to active employees, and while under COBRA their claims are most likely in excess of COBRA premiums—also at the employer's expense. These costs are being hidden under the active employee umbrella, but they are costs to the employer nonetheless.

Issues in Structuring Pre-Medicare Retiree Benefits

Many benefit managers envision a structure whereby they enter into a group contract with an insurer to guarantee access to coverage, report individuals who qualify for coverage, remit their subsidy (if applicable) to the insurance carrier, and little more. The insurer would provide an end-to-end solution and the employer would have redefined its responsibility toward providing retiree medical benefits to a financial transaction—similar to how 401(k) plans operate today. Enrollment, billing, claims resolution, customer service, and communications would be the responsibility of the insurer.

In developing an appropriate model to deliver on this vision, a health plan that utilizes a consultative approach can help address the issues and considerations that fall into the following four categories:

Administration

From an administration perspective, a number of key enrollment and billing questions exist regarding how to support early retirees. Employers will want to consider: What entity will take the initial eligibility file? What process will be in place when someone becomes eligible for coverage? What enrollment vehicles will be available (web, paper, IVR, telephonic)? Who will do the billing of monthly retiree contributions? How will the plan coordinate with COBRA? Does there need to be a separate administrative capability for pre-funding vehicles?

Service

Is there a benefit to an enhanced customer service model for pre-Medicare retirees? Would increased administrative support, holistic health coaching and targeted clinical programs help these members? What clinical programs would add the most value (congestive heart failure, osteoarthritis, osteoporosis, or other conditions)? Should these specialized services be bundled, or structured as a menu for employers (or even individuals) to choose from?

Coverage

What are the best plan designs for this pre-Medicare population? The same coverage as actives (at a higher, unsubsidized cost), leaner benefits with annual maximums (to maintain affordability) or high deductible/low cost plans (for asset protection)? What are the appropriate levels of pharmacy and preventive care coverage? If retiree health savings vehicles are implemented, will employees utilize them? Would employees be allowed to use these funds to pay premiums on non-employer plans? What solutions are best for post-65 retirees: Medicare Advantage plans (HMO, PPO or Private Fee for Service), prescription drug coverage, Medigap or Medicare Supplement? Would other insurance (i.e., life, dental, vision, long-term care), legal or financial services products on a packaged and discounted basis be useful?

Risk

With the potential for healthier individuals to leave their employer-sponsored plan and qualify for lower cost insurance in the individual market, it is important to mitigate any adverse selection through the design of the benefit plan. Features such as pre-funding, limited initial coverage or one-time elections at point of retirement are a few of the options available to address this risk. Other insurer/employer partnerships can also address this issue. These include coalitions (or other large purchasing pools), premium renewals based on claims and predictive risk, premium stabilization reserves to mitigate spikes in claim experience, or maintaining a base of subsidized retirees with predictable risk to offset other retiree populations. The goal is not to cherry-pick the healthiest risk, it is to have a balanced risk pool that is both sustainable and affordable for all. This is perhaps the most perplexing problem that must be addressed in order for a real solution to exist for this population.

Solutions for Pre-Medicare Retiree Benefits

Back to the questions at the beginning of this paper: How do employers manage to:

- Meet the needs of employees and the business by transitioning workers into a healthy and secure retirement,
- Provide solutions that are comprehensive, affordable and easy to use, and
- Control current and future liabilities tied to retiree benefits while providing benefits to current employees?

The answer is threefold. First, the problem must be addressed without a one-size-fits-all solution. Each employer is in a different position with respect to subsidies for current retirees, subsidies for future retirees, and the ability of retirees to afford coverage before reaching Medicare eligibility. Placing multiple employers in a common pool will invariably lead to one group subsidizing another, forcing those employers with more stable risk to exit the pool, leading to a gradual erosion of the pool and skyrocketing cost for those who remain. Both sustainability and affordability will be lost. Each employer deserves a customized coverage and risk solution tailored to their specific needs and experience.

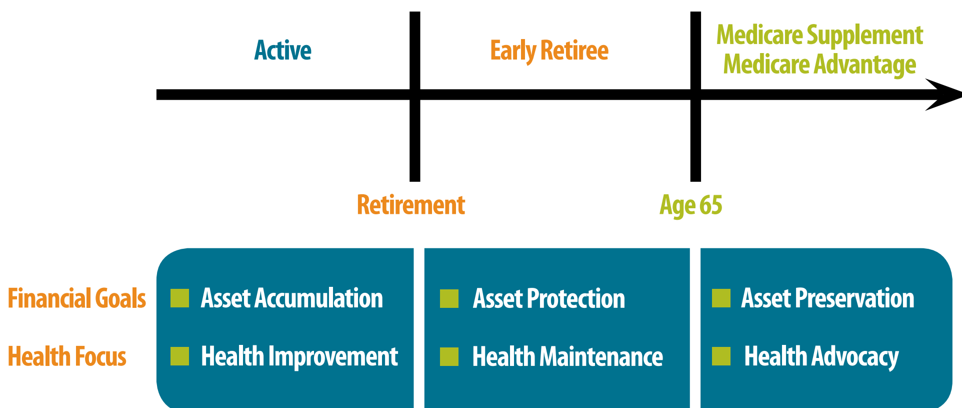
Second, coverage and clinical solutions should follow the needs of the individual at different stages of life, and consider the asset management as well as health needs of that individual.

CIGNA approaches health care coverage as a continuum—from active employment, to early retiree status, to Medicare eligibility. Just as people's financial priorities change throughout their lives, their health insurance priorities change as well *(Figure 1)*

- During active employment, the health plan should focus on prevention and appropriate behaviors, or **health improvement** activities, to allow that individual to enjoy the highest and most productive quality of life. Their financial plan should focus on preparing for retirement, or **asset accumulation**.
- During the early retirement years the individual is most likely dealing with the onset of chronic disease. The health plan should focus on **health maintenance**, stopping the progression of disease to a more acute state which would adversely affect the person's lifestyle. Insurance coverage should allow for **asset protection**, protecting the equity in their homes, 401(k) balances, and hard-earned personal savings from a catastrophic medical event.
- During the latter stages of retirement, the individual likely has multiple health conditions, and their health plan can best help them effectively navigate the health care system by being their personal **health advocate**. Their financial plan should focus on **asset preservation**, ensuring they don't outlive their money.

FIGURE 1

HEALTH AND FINANCIAL PLANNING BASED ON LIFE STAGES



Third, we must abandon the assumption that health is ever-worsening—especially within this high-cost segment. A well-executed care management strategy can slow the demand for health care services by addressing illness and disease early, before it becomes a crippling obstacle to obtaining and affording coverage. CIGNA is bringing our depth and breadth of expertise developed with the working population to deliver the products and services that drive value to the employer and the retiree.

We employ a holistic health advocacy model for seniors to help reduce the incidence and severity of disease and chronic conditions. These health advisory services include activities such as:

- **Predictive Modeling** to identify high-risk individuals before they become high-cost claimants, reaching out to influence behavior and medication adherence;
- **Gaps in Care Identification** to identify those situations where individuals are not receiving safe, effective treatment;
- **Advance Coverage Determination** to provide peace of mind for consumers.
- **Care Calls by Registered Nurses and/or Social Workers** specially trained in geriatrics, behavior change, motivational interviewing and coaching help support the senior in health care decision-making, care transition and improvement.
- **Support** regardless of the next transition step in their health journey;
  - **Health maintenance and prevention**;
  - **Chronic condition/disease management**.

Why are these actions important? Because it has been shown that they improve compliance with treatment, reduce unnecessary emergency room visits as well as hospital admissions and readmissions, and help individuals remain independent and in their home by avoiding unnecessary placement in long-term and specialty care facilities.

With this approach, CIGNA is moving beyond simply providing health care solutions for active employees to developing health services that address the unique needs of employers' early retirees and Medicare-eligible retirees. Our goal is to integrate our award-winning clinical and service capabilities to improve the health care experience of our senior members.

In Closing

There are two realities of the pre-Medicare retiree market:

(1) Many large organizations have made decisions to reduce subsidies or eliminate coverage, and these decisions are irreversible.

(2) The insurance market has not responded with products and solutions to meet the needs of these retirees.

The end result of this mismatch is a larger workforce issue, keeping older Americans in jobs when they want to retire due to their inability to access and/or afford retiree health care coverage before they reach the age of Medicare eligibility. If the solution to Medicare's current fiscal woes ends up raising this age beyond 65, this problem will only intensify.

Access to coverage which is unaffordable for the average retiree is no access at all. However, there is an opportunity to develop creative solutions that meet the needs of the retiree, the employer, and the insurer. CIGNA is meeting that challenge.

www.cigna.com

"CIGNA" is a service mark and the "Tree of Life" logo is a registered service mark, of CIGNA Intellectual Property, Inc., licensed for use by CIGNA Corporation and its operating subsidiaries. All products and services are provided exclusively by operating subsidiaries, including Connecticut General Life Insurance Company and CIGNA HealthCare of Arizona, Inc., both of which are Medicare Advantage Organizations with a federal Medicare contract, and not by CIGNA Corporation.

819066 03/08