Retiree Health Plans 101

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benefits
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The authors discuss three key areas plan sponsors should consider when reviewing or implementing a retiree health care plan: compliance, design and funding, and communication.

Access to affordable health care is an important piece of the retirement puzzle. As health care costs continue to rise, funding of retiree benefits has become more challenging for health plan sponsors.

Nearly 43% of organizations offer retiree health care benefits, according to the International Foundation of Employee Benefit Plans 2018 *Employee Benefits Survey,* compared with 47% in 2016 and 44% in 2014.

This article will discuss three key areas that plan sponsors should consider when reviewing, amending or implementing retiree health care benefits: (1) compliance, (2) design and funding, and (3) communication.

Compliance

Whether the retiree health care plan covers only retirees or both retirees and active plan participants is an important consideration, because the applicable rules and requirements differ.

If a plan covers both active and retired participants, benefits for all participants (retirees and actives) must comply with several laws, including the Affordable Care Act (ACA), the Mental Health Parity and Addiction Equity Act, the Women's Health and Cancer Rights Act, and the Health Insurance Portability and Accountability Act (HIPAA) portability rules.

If, however, the plan is a separate retiree-only plan, it does not have to offer most of the benefits required by these laws. For example, a retiree-only plan can have annual or lifetime dollar limits on essential health benefits, is not required to cover dependent children up to age 26 and does not need to cover the full cost of preventive care as required by ACA.

In order to be considered a retiree-only health plan, the plan must be separate from any plan covering actives and must cover fewer than two participants who are current employees. Although no one factor is determinative in establishing whether a plan is a retiree-only plan, facts to consider include the following:

1. Whether there is an intent to establish or operate the retiree plan as a separate plan
2. Whether the retiree plan document reflects the intent to have the plan be a separate retiree-only plan
3. Whether the retiree plan and the plan for active participants have separate:
   - –Eligibility and/or enrollment requirements
   - –Benefits, Consolidated Omnibus Budget Reconciliation Act (COBRA) rates and/or insurance contracts
   - –Trusts and/or accounting
   - –Plan numbers and/or Forms 5500
   - –Recognition in the applicable collective bargaining agreements.

Regardless of whether a plan is a retiree-only plan or a plan that covers both active and retired participants, the plan should consider whether it needs to comply with ACA Section 1557. This section provides that plans that receive federal money from the U.S. Department of Health and Human Services (HHS) must comply with certain nondiscrimination requirements. The Section 1557 nondiscrimination requirements prohibit health plans from discriminating on the basis of race, color, national origin, sex, age or disability in certain health programs or activities, and they require plans to offer free communication assistance to disabled individuals and individuals with limited English proficiency.[1] Since many health plans that cover retired participants receive money from HHS in the form of Medicare Part D subsidies, these plans will need to comply with the Section 1557 nondiscrimination requirements if they wish to continue to receive these subsidies.

Design and Funding

When making decisions about retiree health care plan design and funding, it is important to define priorities. Who is eligible for coverage? How will benefits be provided? How much funding is available from employer contributions? Will active employee contributions or plan reserves help subsidize retiree costs? Are coverage and/or subsidies provided to all retirees or only certain groups? Will retiree coverage be sustainable?

Who Is Eligible for Coverage?

Plan sponsors should consider whether to cover the following groups:

- **Pre-65 (early) retirees:** The years between retirement and Medicare eligibility are the most costly for retirees and plan sponsors. With limited options for purchasing coverage on the individual market, group-based health care coverage is particularly valuable to early retirees. Individuals retiring early due to disability also are important to consider.
- **Medicare-eligible retirees:** Once a retiree reaches Medicare age, costs to the retiree and plan sponsor are significantly reduced. Medicare is the primary payer

for most medical expenses and provides subsidies for prescription drug coverage through retiree drug subsidy (RDS) or employer group waiver plan (EGWP) options. Older retirees are more likely to have fixed incomes or limited budgets, so stability of retiree premiums and limited out-of-pocket costs are key concerns for retirees in this age group.

- **Spouses and dependents:** Spousal coverage, including whether to cover surviving spouses, is an important consideration for retiree plans. In addition, because of ACA requirements to cover dependents to age 26, plans integrated with active coverage may have more dependent children who qualify for coverage.

takeaways

- The applicable rules and requirements for retiree health plans differ depending on whether the plan covers only retirees or both retirees and active plan participants. A retiree-only plan does not have to comply with several laws including the Affordable Care Act (ACA).
- Important questions to ask when designing a retiree plan include who will be eligible for coverage, how much funding is available from employer contributions, and whether active employee contributions or plan reserves will help subsidize retiree costs.
- Having a self-funded retiree plan provides plan sponsors flexibility in benefit design and administration, but fully insured benefits can provide access to health maintenance organization (HMO) and Medicare Advantage options that aren't available on a self-funded basis.
- Sources of funding for retiree health benefits include the retirees themselves, direct employer contributions, subsidies from active plan contributions or reserves, and government programs.

How Are Benefits Provided?

Options for providing coverage include self-funding, fully insured coverage, having retirees buy coverage in the individual market or a combined approach.

Self-Funded Coverage

Having a self-funded plan allows plan sponsors flexibility in benefit design and administration. Claims processing can be provided by the plan administration office, a third-party administrator or through an insurer. Savings can be generated by eliminating premium taxes and insurance company risk charges and margin. However, it is critical to have adequate reserves and appropriate catastrophic claims (stop-loss) coverage, particularly for non-Medicare retirees. Some coverage options such as health maintenance organization (HMO) or Medicare Advantage plans may not be available on a self-funded basis.

Fully Insured Coverage

Fully insuring benefits can provide access to HMO and Medicare Advantage options that are not available on a self-funded basis. In addition, because Medicare provides funding to Medicare Advantage insurers, premiums for these plans can be lower than other types of Medicare supplement benefits. Insuring benefits may also be more appropriate for smaller plans or plans that do not have adequate reserves to deal with the cash flow fluctuations of self-funding.

Individual Market Coverage

A retiree benefit strategy that continues to gain attention is use of the individual market. Under this option, the employer or plan sponsor typically provides funding in the form of a contribution to a health reimbursement arrangement (HRA). Retirees and dependents then use HRA funds to help buy individual coverage on their own. This allows the employer or plan sponsor to continue providing financial support while allowing retirees and their spouses to choose an individual plan that works best for them, often at a lower overall total cost than a traditional group plan.

While the individual market for pre-65 retirees is limited in many geographic areas, individual coverage is usually a feasible option for Medicare-age retirees. In most parts of the U.S., the individual Medicare market is robust with numerous benefit options. However, there are a couple of key caveats to this strategy. First, when designing an HRA benefit, it is important to understand the ramifications of a retiree standalone HRA versus an HRA that is integrated with active coverage.[2] Plan sponsors should consult with their legal and benefit advisors to understand the right option for each situation. Second, providing benefits through the individual market is a significant change from a traditional group plan. It is much harder for the plan sponsor to intervene on behalf of a retiree when benefit-related issues arise (eligibility, premium pay-

ment, claims, etc.). This may be a difficult transition for plan sponsors and retirees that are used to a paternalistic approach to retiree benefits. Therefore, employers and plan sponsors that go this route may want to engage private exchange vendors to help guide retirees through the process of reviewing and selecting individual market coverage.

Combined Approach

Plan sponsors should assess what options are best for each retiree category. For example, retirees who are not yet eligible for Medicare might be integrated with active coverage under a self-funded benefit, while Medicare retirees are insured under a separate plan or provided HRA funding for individual market coverage.

How Are Retiree Benefits Funded?

Sources of funding for retiree health benefits include:

- **Retirees:** Through self-pay premiums or contributions
- **Direct employer contributions:** For multiemployer plans, this may be in the form of a designated retiree plan contribution in a collective bargaining agreement (Note: A clearly designated contribution toward retiree coverage can help establish the separate nature of a retiree-only plan).
- **Subsidies from active plan contributions or reserves:** For a plan that is integrated with active coverage (not a retiree-only plan), subsidies may be provided from active contributions or plan reserves. The subsidy amount may be well-defined (for example, the plan will subsidize retiree coverage by $200 per month) or may be implied (for example, retirees will pay a $300 monthly premium, with the plan subsidizing the remainder).
- **Government:** Medicare is a significant funding source for retirees over age 65. Medicare Parts A and B cover a majority of retiree medical costs. In addition, retirees and plan sponsors can benefit from Medicare subsides through Medicare Advantage plans as well as RDS or a Medicare Part D EGWP. ACA subsidies through the state and federal health care exchanges also may be available to some pre-Medicare retirees.

In most cases, direct employer contributions or subsidies from an active plan create other postemployment benefit (OPEB) liabilities. Plan sponsors should consult a qualified actuary when implementing or considering changes to funding of retiree coverage.

Trustees and plan sponsors should consider what is available from each of these funding sources and how they can be coordinated to meet the goals of the plan and provide the best value for the retiree. Examples of retiree funding strategies include:

- **Set a fixed dollar retiree self-pay premium:** A plan might require each retiree to pay $200 per month. This gives the retiree a stable cost to budget but shifts a higher cost burden onto the plan, particularly during the more expensive non-Medicare years. Unless the retiree self-pay premium increases over time, the impact of future health care inflation also falls on the plan.
- **Provide a fixed dollar subsidy:** A plan might provide a subsidy of $300 per month (which could include contributions to an HRA). This shifts the burden of health care inflation to the retiree while fixing plan costs. Depending on the level of subsidy, the retiree self-pay premium for pre-Medicare retirees could be significant.
- **Provide employer funding/active plan subsidy based on age and/or service time:** Employees who have spent more time working in the industry can be rewarded with a higher subsidy in retirement. The table shows a sample retiree contribution scenario based on age and hours of service. The table represents the percentage of the plan cost the retiree must pay in the form of a monthly self-pay premium.

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Lawrence R. Beebe. International Foundation. 2017.
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TABLE

Sample Retiree Contribution Rate as Percentage of Cost

Age at Retirement	15,000 to 22,499 hours worked	22,500 to 29,999 hours worked	30,000 to 37,499 hours worked	37,500 to 44,999 hours worked	45,000+ hours worked
55	100%	90%	85%	80%	75%
56	100%	85%	80%	75%	70%
57	100%	80%	75%	70%	65%
58	95%	75%	70%	65%	60%
59	90%	70%	65%	60%	55%
60+	85%	65%	60%	55%	50%

- **Employer contributions and/or active plan subsidies provided only after a certain age:** For example, a plan may not provide employer/plan subsidies until age 60. If retirees also participate in a pension plan, alignment of retiree health care eligibility and subsidies with early retirement rules and benefit levels under the pension plan should be considered.

Is the Plan Sustainable?

Unlike a pension plan, health plans often fund retiree benefits on a pay-as-you-go basis, with current active plan reserves and/or employer contributions subsidizing retiree benefits. Although future benefits may not be guaranteed (like a pension benefit), most active employees and retirees expect benefits to continue through their retirement years, and plan sponsors may intend for retiree benefits to continue indefinitely. In order to avoid surprises down the road, it is important to understand how changes in the population, health care costs and retiree subsidies will affect the plan over time. Questions to consider include:

- What impact will health care cost trends have on the ability to continue coverage?
- Does the plan expect a large number of active employees to retire soon?
- What is the impact on retiree subsidies if the retiree population grows but the active population decreases?

It might be worthwhile for trustees and administrators to discuss these questions with the plan actuary or consultant. Modeling of future scenarios can help plan sponsors design and maintain a sustainable retiree benefit.

What If a Plan Cannot Subsidize Coverage?

Does a group-based plan still have value to a retiree if the retiree has to pay the full cost of the coverage? It might. For a retiree, health care coverage decisions can go beyond dollars and cents. Some retirees simply feel more comfortable with coverage that is the same or similar to the coverage they had as an active employee. Continuity of network providers and familiarity with benefit administration may be important. Group-based plans can provide benefits and broad provider networks that are not available in the individual market. In addition, group plans can charge a consistent premium regardless of age. In the individual market, premiums may vary by age, meaning premium costs can increase significantly as a retiree ages. Also, in many cases the benefits provided through individual Medicare Part D plans are not as comprehensive as those provided under a group plan, which can expose retirees to higher out-of-pocket costs for expensive medications.

Communication

Effectively communicating with participants on the types of benefits offered (including any restrictions or limitations of those benefits) is likely the most important step

a plan can take to reduce the chances that participants will bring a claim against the plan because they are dissatisfied with how the plan administered its benefits.

There are several reasons effective communication in the retiree health plan context is so important. Since the population is older, there is a greater chance of participants being confused about or misunderstanding plan terms. This population also is likely to be worried about and resistant to changes and to view any changes to their benefits as being bad or unfavorable. In addition, regardless of whether plan changes are being communicated to active participants or retirees, getting it wrong could lead to litigation or an investigation by IRS or DOL.

The need to communicate with participants effectively is illustrated by a recent case in the Ninth Circuit Court of Appeals.[3] In this case, the retiree health plan participants claimed that the plan's imposition of a lifetime maximum was improper because a summary of material modifications (SMM) that the plan had issued was not clear that a lifetime maximum was still in effect under the retiree plan. The court agreed with the plaintiff, finding that the SMM was not "written in a manner calculated to be understood by the average plan participant" and therefore violated ERISA's disclosure requirements.[4]

It is best to keep communications short, simple and specific and to include examples if possible when communicating with retirees (and with active participants). Because individuals tend to understand and respond better to material that is focused on their situation (instead of a one-size-fits-all approach), plans may want to consider tailoring their communications to target different groups. For multiemployer plans it is also beneficial to make sure union leaders and staff are familiar with the changes, so they can assist with communicating the correct message to the participants.

Plans also may want to consider having in-person meetings with their retirees. Small-group or one-on-one discussions usually are more effective ways of communicating with retirees, but larger in-person meetings also can be successful at conveying information to a retiree population. Some plans host a retirement fair or similar type of meeting with retirees and participants who are nearing retirement. These fairs often have larger group sessions on general plan information (e.g., types of payment options available, how to fill out a retirement application) as well as meetings with smaller groups on specific subjects (e.g., projected cost of health care during retirement or other health care options available to retirees). Some plans also offer a sign-up at the retirement fair for participants to schedule appointments for one-on-one discussions with plan staff at a later date.

In addition to the above suggestions, it may be helpful to retirees if plans that administer their open enrollment online also include videos to demonstrate how to go about completing each step on the plan's open enrollment website or other online platform.

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Summary

Developing and maintaining a retiree benefit program is no small task. By understanding the rules that apply to retiree plans, analyzing the benefit and funding options available and effectively communicating with plan participants, plan sponsors can provide a retiree plan that provides value to their retirees today and into the future.

Endnotes

1. Regulations previously issued by the Department of Health and Human Services (HHS) also required that plans not discriminate based on gender identity or termination of pregnancy. However, in response to a court's finding in December of 2016 that those provisions were not consistent with the law, HHS recently released proposed regulations that would replace the previously issued regulations under Section 1557. If enacted, the proposed regulations would eliminate the prohibition on discrimination based on gender identity or termination of pregnancy. The proposed regulations would also eliminate the requirement for health plans to include taglines in the most used 15 languages on all significant publications.
2. Beginning in 2020, there will also be two additional types of health reimbursement arrangements (HRAs) available for active employees, one of which will allow employees to purchase individual market coverage with HRA funds.
3. *King v. Blue Cross Blue Shield of Illinois.* 871 F.3d 730 (9th Cir. 2017).
4. In its decision of this case, the Ninth Circuit also found that the lower court erred in granting the plan's motion for summary judgment on the participant's claim for breach of fiduciary duty and remanded the case back to the lower court for proceedings consistent with the Ninth Circuit's findings.

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