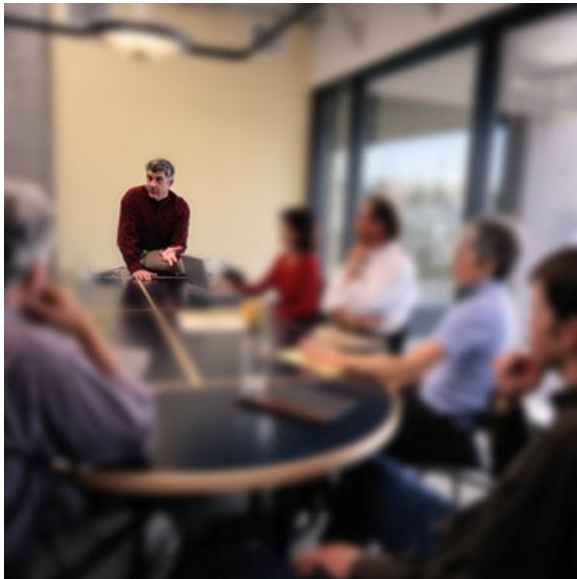


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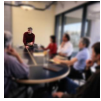
MARSH MERCER KROLL
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December 8, 2009

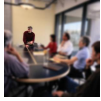
PEBA

The Need to Know on Retiree Healthcare Benefits



The Need to Know on Retiree Healthcare Benefits

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Agenda

- Introductions
- Marketplace Overview
- Strategies for Managing Retiree Medical Spend
 - Pre-Medicare Eligible Retirees
 - Medicare Eligible Retirees
- Next Steps

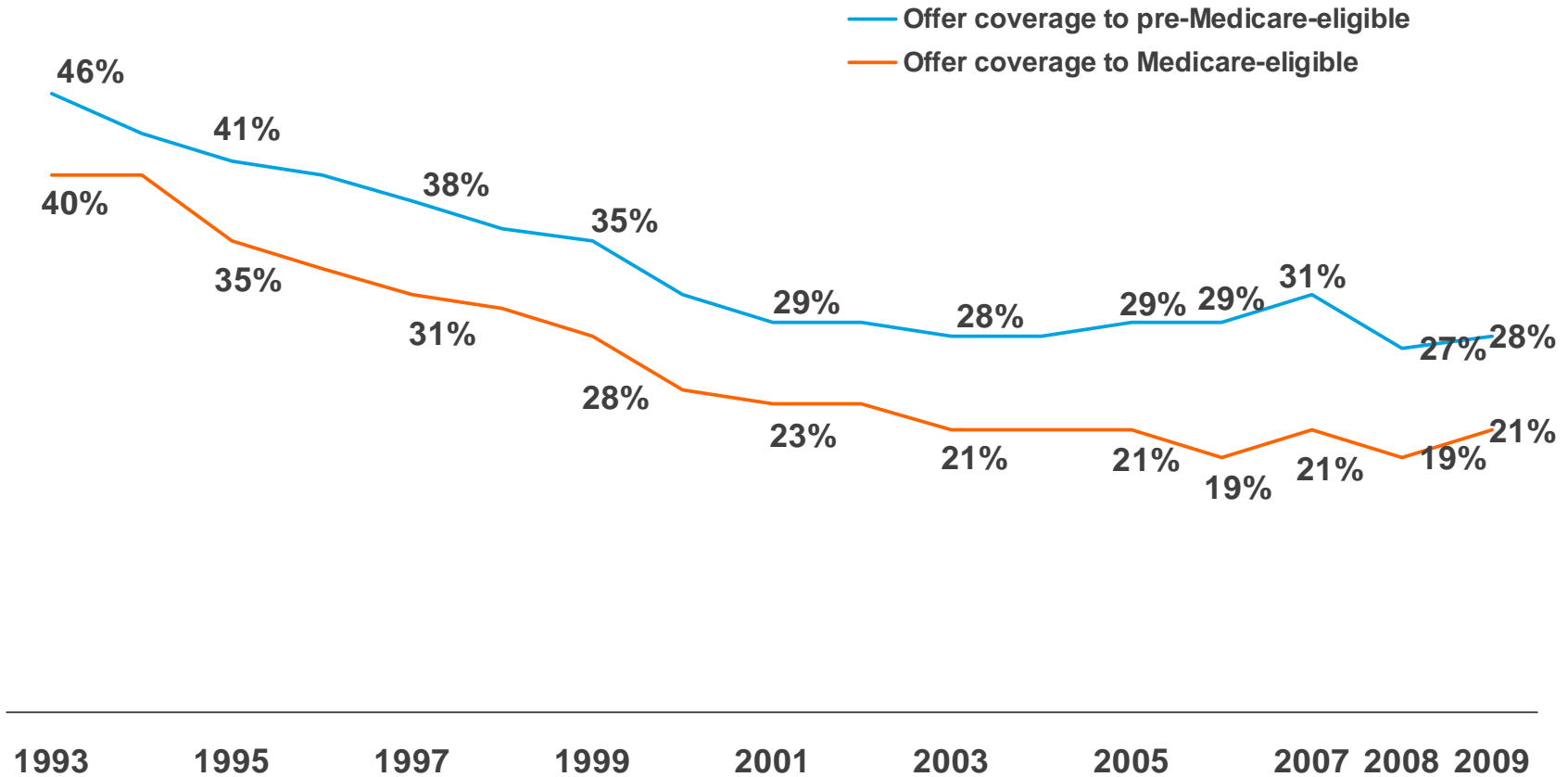


Marketplace Overview

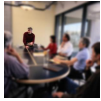


Availability of retiree medical coverage to new hires

For employers with 500 or more employees



Source: Mercer's National Survey of Employer-Sponsored Health Plans



Quick Quiz

What percent of companies in the S&P 500 have a retiree medical liability?

- A) 31%
- B) 46%
- C) 54%
- D) 62%
- E) 75%



Every employer is caught in the retiree medical crunch

▪ **Employers with No Subsidy**

- If employer offers access, affordability is likely an issue
- If retiree medical coverage is unavailable, employees may defer retirement with potential negative impact on productivity

▪ **Employers with a Low or Fixed Subsidy**

- Affordability – both in absolute dollars and in annual change – is likely a significant, growing issue
- Retirees blame employer for large increase in contributions
- With caps being hit, plan may no longer qualify for Retiree Drug Subsidy

▪ **Employers with a High Subsidy**

- Both level and volatility of FAS 106 expense is becoming unmanageable
- Levers available to manage cost may be severely limited
- Value of employer role reduced due to Medicare reform



Strategies for Managing Retiree Medical Spend



Why is a pre-Medicare retiree medical benefit important?

Consider:

Industry	Percent of Employers Offering Coverage to Pre-Medicare Eligible Retirees	Average Age of Employees at Retirement
Wholesale/Retail	6%	65
Government	75%	59

Source – Mercer National Survey of Employer-Sponsored Health Plans

So what does this imply?

- Employees would like to retire early, but don't because they can't afford healthcare after retirement
- Even if you don't have a retiree medical program, you're still paying health benefits for employees who can't afford to retire through the active medical program or through COBRA



What if someone retires before Medicare eligibility?

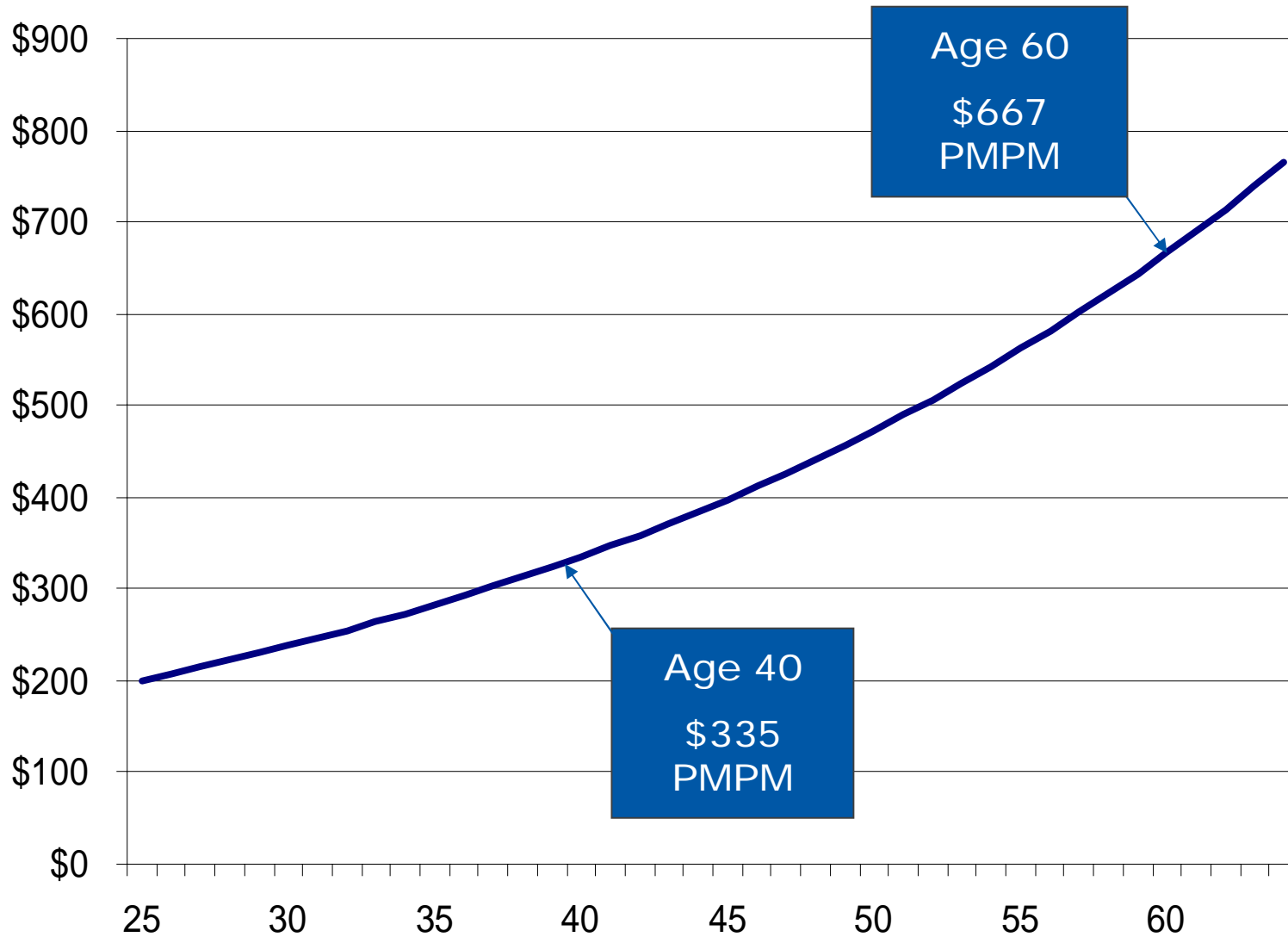
- **Option 1: Purchase standard individual policies, but**
 - May include pre-existing condition limitations
 - Pricing varies
 - Marketplace difficult to navigate

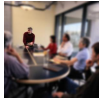
- **Option 2: HIPAA coverage**
 - All states must offer coverage without preexisting conditions to terminated employees with prior qualifying group coverage
 - Rates typically very high
 - May not provide national coverage or allow retiree to change residence
 - Marketplace often difficult to navigate

- **Option 3: Offering an Employer-sponsored plan solves these problems**
 - No pre-existing conditions
 - Rates “less high”, e.g. 50% of individual plan cost
 - Easier for retirees to navigate
 - But, generates different concerns...



What's the affordability problem?





Employers with caps face a unique problem

Case in point: Employer offers a 90% subsidy up to an \$8,000 cap

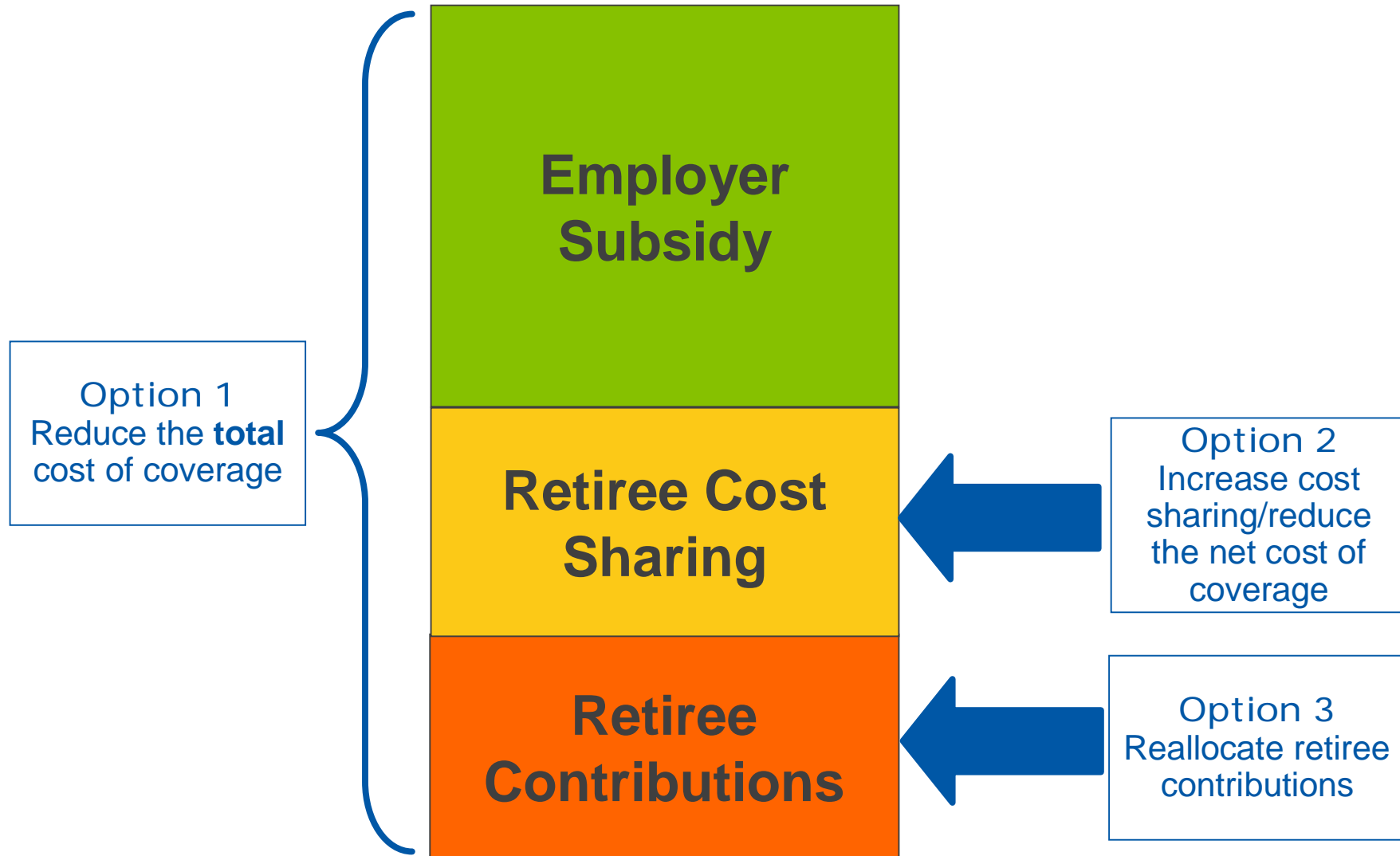
	2007	2008	2009	2010	2011
Premium	7,500	8,250	9,075	9,983	10,981
Employer Cost	6,750	7,425	8,000	8,000	8,000
Retiree Contribution	750	825	1,075	1,983	2,981
Contribution Change		10%	30%	84%	50%

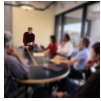
- Much attention to this group as employers have hit caps
- Retirees blame employer for large increase in contributions
- Retiree may not be able to afford coverage ... but may not realize it until costs escalate during retirement



What can employer's do to improve affordability?

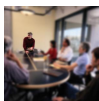
Three broad strategies to consider



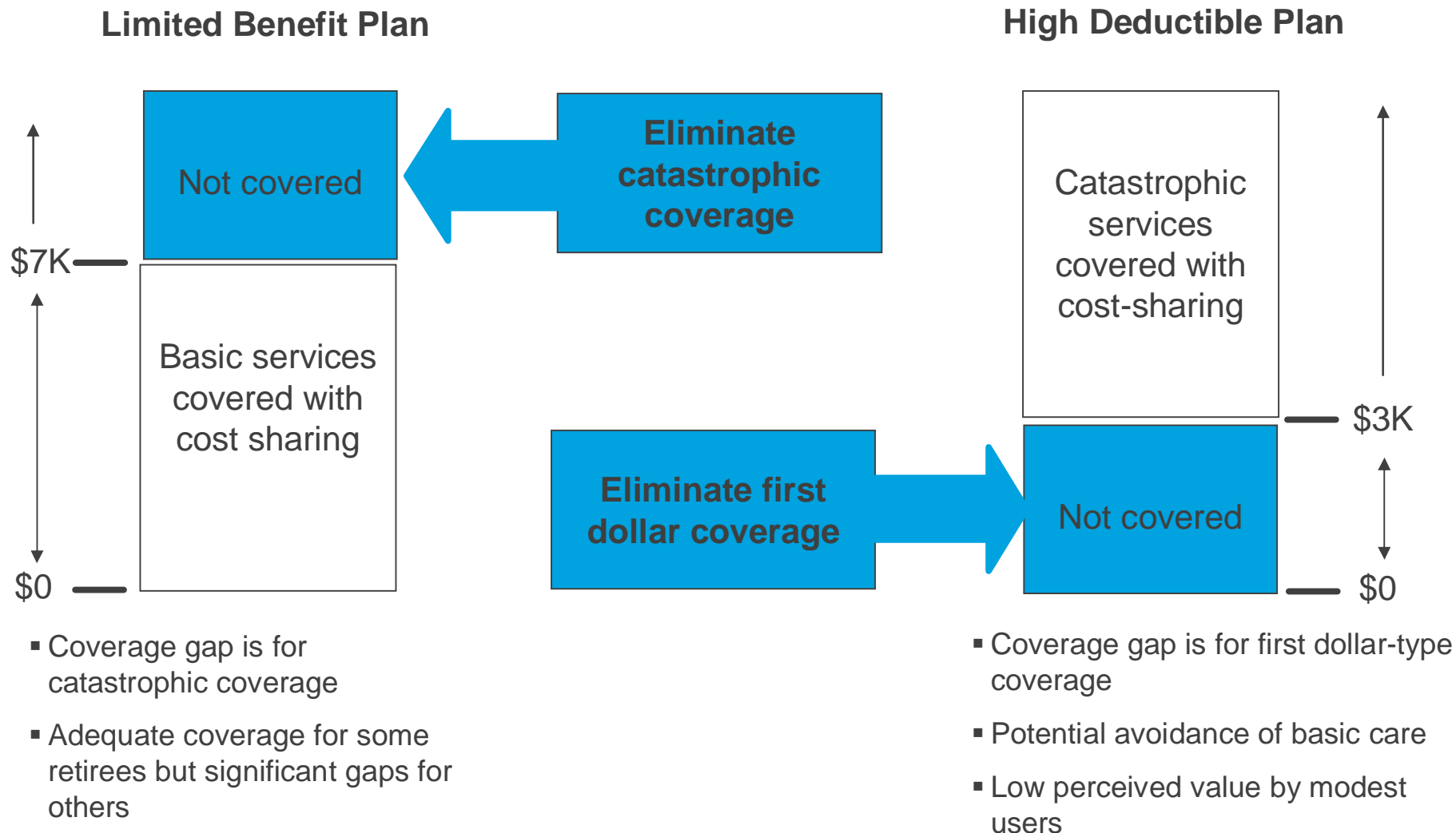


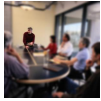
Option 1 - Reducing the total cost of coverage

Strategy	What is it?	Who is it for?
“Traditional” cost management	Aggressive vendor and plan management strategies that minimize ASO fees, maximize network discounts, improve pharmacy rebates, etc.	Employers who have not reviewed their vendor arrangements in 1-2 years Employers who pay a large portion of the cost of coverage
Aggressive, focused care management	Disease and care management programs targeted at engaging the retiree population	Large pre-Medicare populations Engaged in care management for actives Employers who use the same strategy for actives and pre-Medicare retirees
Evidence Based Design	Reduce cost sharing (typically pharmacy) for retirees with specific diagnoses where evidence shows that improved care compliance will reduce medical spend	All of the above Prevalence of specific conditions that would respond to evidence based design is higher than normal



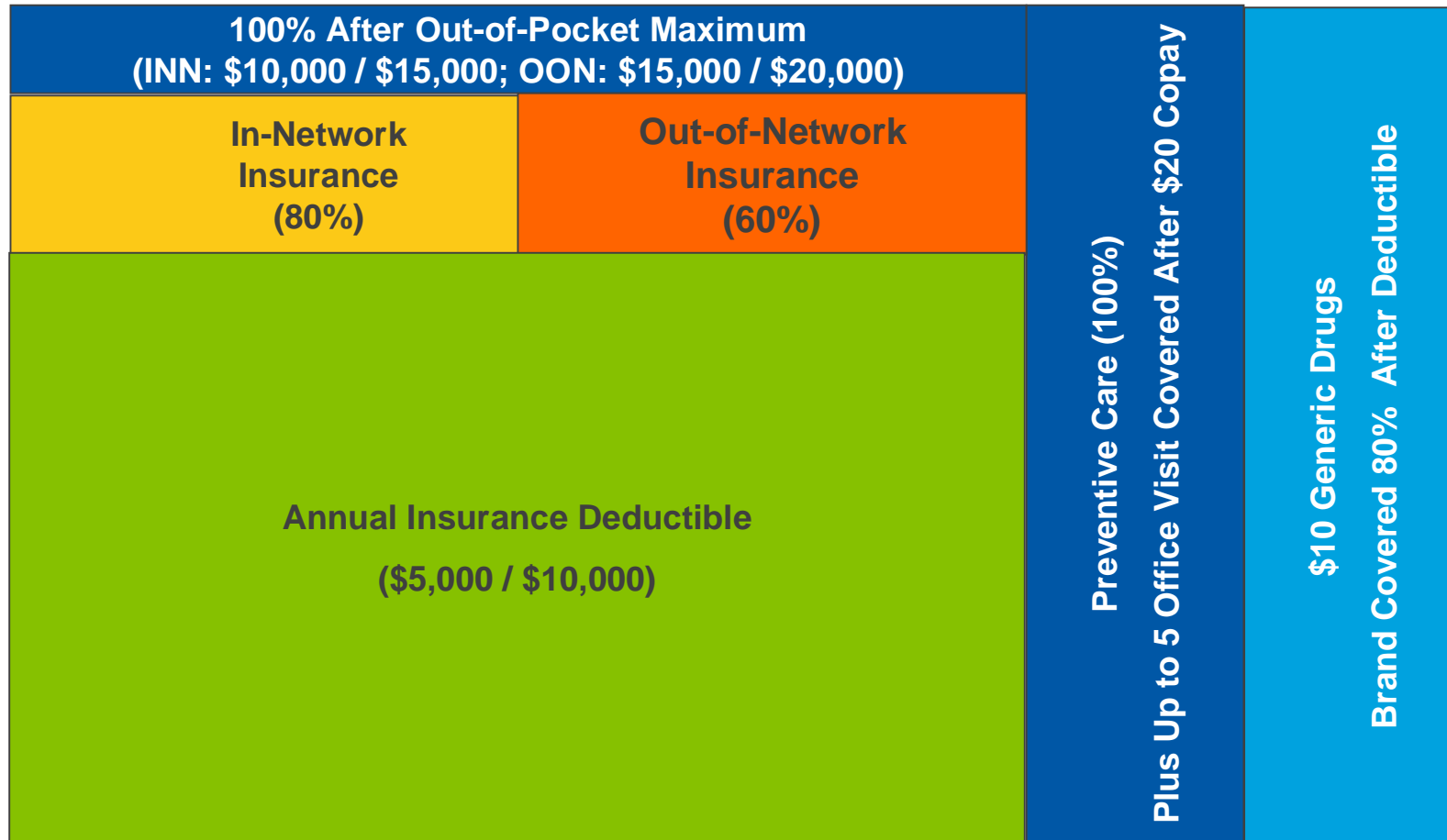
Option 2 - Reducing the net cost of coverage





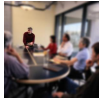
Option 2 - Reducing the net cost of coverage

Sample design - high deductible plan with limited benefits



- Offers some first dollar benefits while preserving catastrophic protection

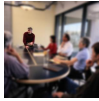
Note: Plan design shown above is not HSA compliant



Option 3 - Reallocating retiree contributions

Creative options

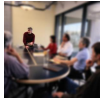
- **Consider defined contribution instead of defined benefit approach:**
 - *Sample design – Account equal to \$4,000 per year of service*
 - Employees accrue fund for retiree medical claims during active employment
 - Value of employer coverage is transparent to retirees
 - More tax-effective than traditional 401(k) plans
 - Rewards long service employees
 - Limits volatility of employer cost
- **Vary subsidy based on retirement age and/or service**
 - Consistent with defined benefit plans
 - Tends to penalize early retirees with short service the most
- **Differentiate contributions for retirees and spouses**
- **Reduce subsidy for Medicare eligible retirees**, where benefit is less critical, and increase subsidy for pre-Medicare retirees



Affordability of coverage for pre-Medicare retirees

Conclusions

- There is no silver bullet solution to the affordability problem
- The best solution may be a combination of solutions
- May need to do something for retirees that you haven't done for actives
- Any redesign needs to consider the impact on productivity and succession planning
 - What happens to the business if employees can't afford to retire?
 - What happens to active healthcare costs if older employees can't afford to retire?
- Outsourcing solutions have historically focused on Medicare eligible retirees, but pre-Medicare solutions are also emerging



Medicare Eligible Retirees Many options. Which is right for you?



Basic Strategies

Not to be forgotten!

Medical Benefit Options

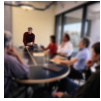
Choosing the right Medicare Option

Life After Part D

Moving beyond the Retiree Drug Subsidy

Accounts, Reimbursement and Buyouts

Delivering the employer subsidy



Basic strategies

- Before discussing advanced strategies, employers need to make sure they have the basics covered
 - Do you know when your plan is primary to Medicare?
 - When you do a medical claim audit, are claims that coordinate with Medicare considered?
 - Have you had an independent third party review your final RDS reconciliation?
 - How do your FAS 106 assumptions compare to reality?

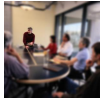




Basic strategies

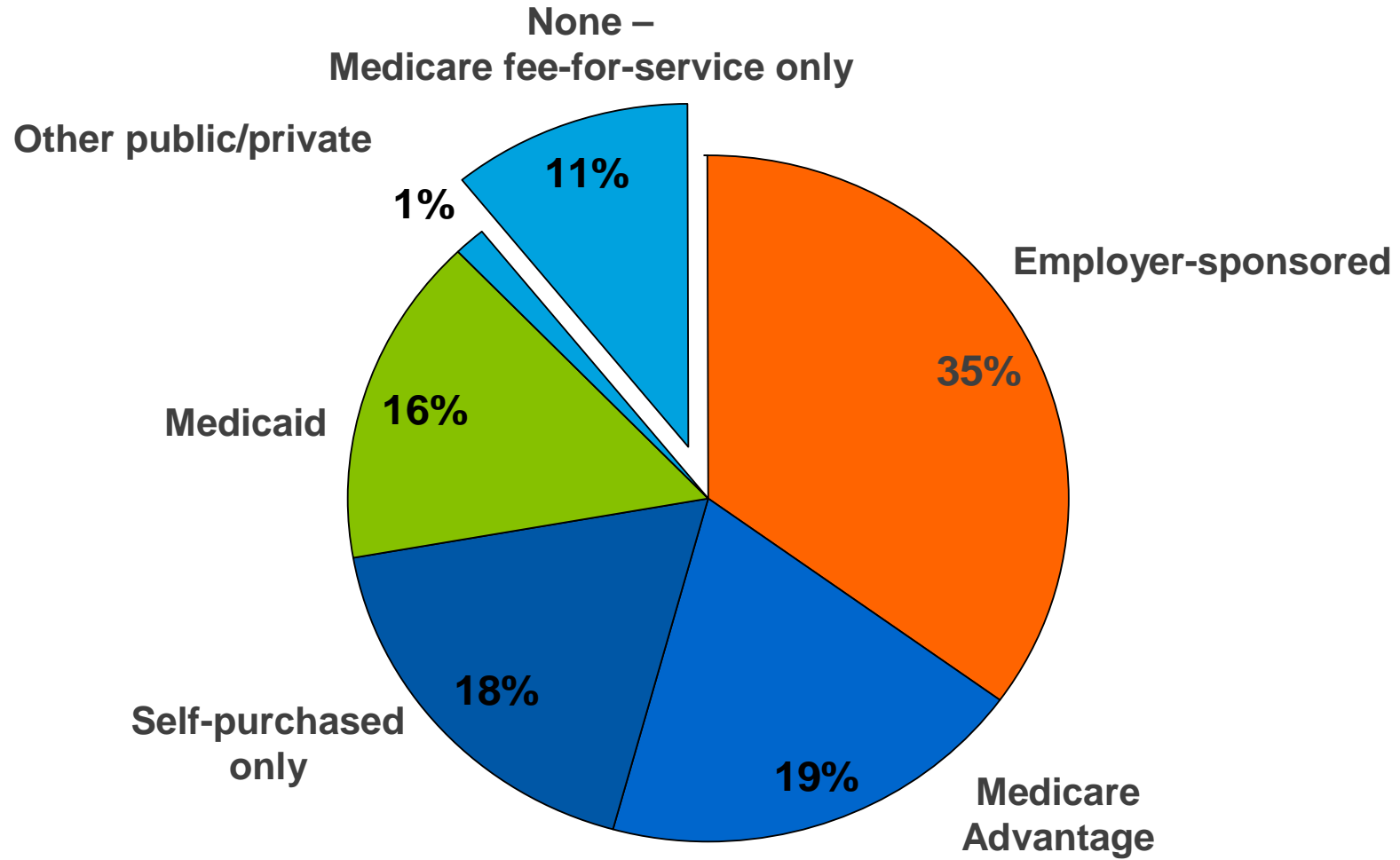
Options to consider

Action	Possible Outcome
Review Covered Services in Summary Plan Description (SPD)	Change approach to Medicare coordination Eliminate coverage for services not covered by Medicare Only consider expenses up the Medicare allowable charge limit
Audit Medical Claim Administration	Confirm that plan is being administered consistent with SPD Uncover claim payment errors Clarify areas of SPD where coverage levels are not specific
Audit RDS Submission	Confirm compliance with all CMS requirements for covered drugs on behalf of eligible retirees/dependents Identify retirees/dependents and drugs that were incorrectly excluded from RDS submission
Review FAS 106 Assumptions	Adjust valuation assumptions to be consistent with current/projected experience



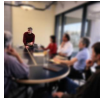
Medical benefit options

Sources of supplemental coverage for Medicare beneficiaries



Total Number of Beneficiaries = 39.8 Million

Source - Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Access to Care File, 2006.



Medical benefit options

Medicare Advantage 101

- Medicare Advantage is actually Medicare Part C
- Medicare Advantage plans come in three main flavors
 - HMO
 - PPO
 - Private Fee For Service (PFFS)
- PFFS plans got a huge boost under the Medicare Modernization Act of 2003 (MMA) and have rapidly grown to almost 2 million members
- The popularity of PFFS is obvious:
 - For retirees, the plans offer rich benefits and low premiums with no network restrictions
 - For health plans, PFFS plans are attractive because CMS is currently reimbursing in excess of the expected claim costs
 - For providers, they get just as much as they get from Medicare, only faster
- In recent years, several employers have implemented PFFS plans as an option or total replacement for existing self-insured plans
 - Fully insured coverage may be cheaper than current self-insured plan with no change in design



Medical benefit options

PFFS Plans are widely available...for now

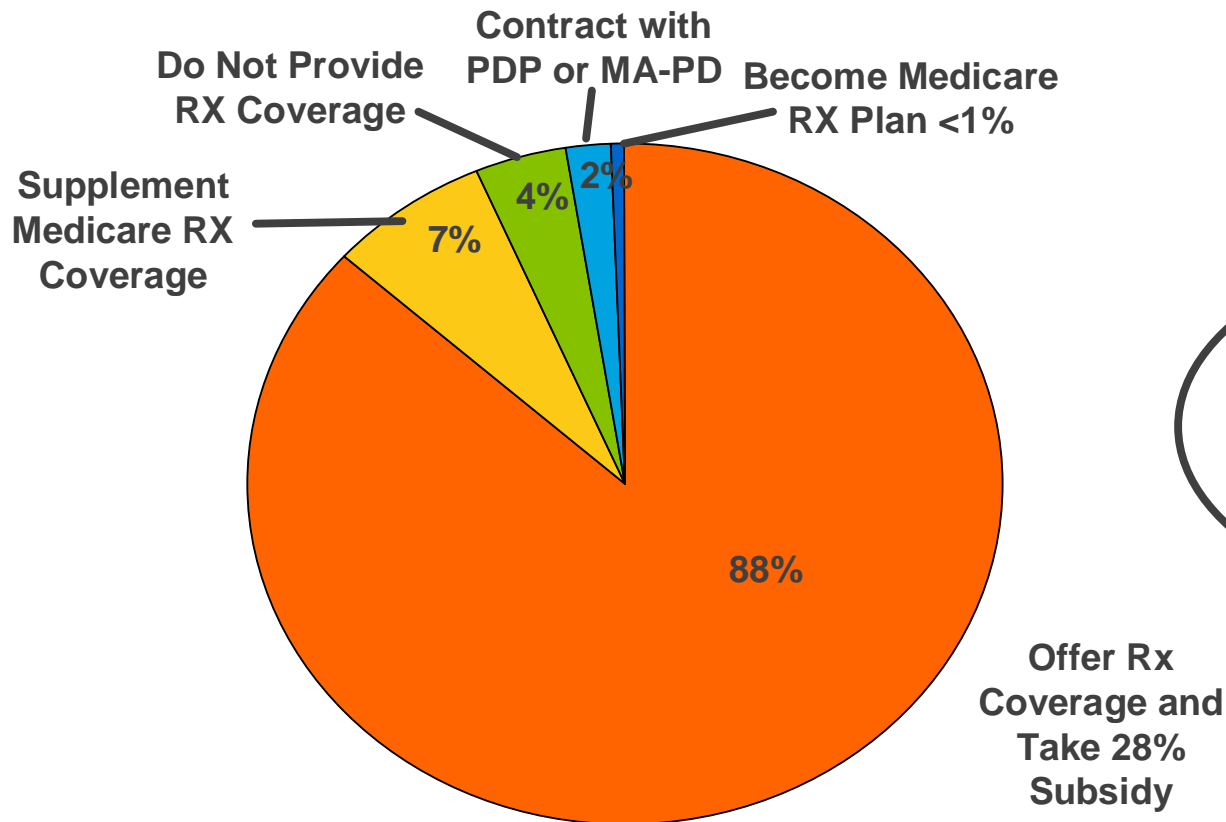
- PFFS plans have been in the cross hairs of Democrats for some time
 - Plans are overpaid
 - Shifts favorable risks from government to private plans
 - Carriers have engaged in questionable marketing practices
- In 2008, Congress approved certain changes to PFFS plans that will take full effect in 2011
 - New legislation will require carriers to have contractual arrangements with providers for their PFFS
 - Translation of legislation to actual implementation is unclear
 - Legislation did **not** significantly reduce federal subsidies to PFFS plans
- Most proposed healthcare reform legislation includes funding reductions to all Medicare Advantage plans
 - Uncertainty has caused some employers to delay implementation
 - Nevertheless, carriers continue to invest in Medicare Advantage plans, including PFFS, and have expressed interest in continuing into 2011 and beyond
 - Participant satisfaction with the plans is high and enrollment continues to grow



Life after Part D

What are employer's doing?

Based on 2007 Strategies



Only 55% of employers say they are somewhat or very likely to apply for the RDS in 2010. Why? What else will they do?

Note – Based on employers with 1,000 or more employees offering retiree health benefits

Source - Kaiser/Hewitt Survey on Retiree Health Benefits, December 2006



Life after Part D

RDS alternatives

- Why are some employers seeking alternatives to the RDS?
 - Fail actuarial equivalence – usually the Net Value test
 - RDS alternatives are more cost effective
 - Frustration with RDS application and reconciliation processes
 - Low number of retirees makes RDS administration burdensome
 - Increasing comfort with alternative solutions which may facilitate an exit strategy
- In both the proposed House and Senate healthcare reform bills, the tax free nature of the RDS would go away
- What do the RDS alternatives look like?



Life after Part D RDS alternatives

Strategy	What is it?	Why would I use it?
Standard Part D Plan	Employer-specific Part D plan with benefits similar to individual market	More cost effective than RDS, especially if tax free nature of subsidy is irrelevant Risk transfer to Part D plan Able to offer Standard design Can be added to PFFS plan or stand alone
Enhanced Part D Plan	Employer-specific Part D plan with benefits richer than individual market	Same as Standard Part D but with richer benefits Richer benefits may be required if current design needs to be duplicated Can be added to PFFS plan or stand alone
Supplemental Coverage that Wraps Around Part D	Employer plan pays secondary to retiree's Part D plan similar to medical coordination	Way to offer coverage richer than Standard plan without risk transfer
Become a PDP	Employer contracts with vendor to offer its own Part D plan	More cost effective than RDS and employer wants to retain risk Employer size justifies frictional costs



Accounts, reimbursements and buyouts

What can I do after I hit the cap?

- Most employers who hit their cap for Medicare eligible retirees continue to offer the same plan design and pass along contribution increases
- Is there a better way?

Strategy	What is it?	Why would I use it?
Convert cap to an account	Present value of future benefits is converted to an account Retirees can use account until empty	Employer plans are terminated and replaced with individual or group insured options Retirees have the tools and ability to manage the account
Convert cap to a premium reimbursement account	Retirees buy coverage and can be reimbursed for costs up to the employer cap	Similar to converting the cap to an account except that account never goes to zero
Offer retirees the option of exchanging future benefits for a cash buyout	Retirees are offered taxable income in place of a percentage of present value of future benefits	Employers looking to permanently exit If buyouts are offered as an option, need to consider adverse selection potential



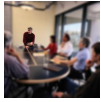
Emerging options for Medicare eligible retirees

Conclusions

- Before moving on the advanced topics, make sure you've covered the basics
- Alternatives to current approaches – even for long-time grandfathered groups of retirees – can be very attractive:
 - Reduce employer and/or retiree costs
 - Transfer risk to a third party
 - Minimal retiree disruption
- Sooner or later, alternatives to the RDS are worth a closer look to see how they fit into your strategy
- You can separate your retiree medical benefit plan from your employer subsidy
 - You can offer a plan and no subsidy
 - You can offer a subsidy and no plan
- The best solution may be a combination of solutions



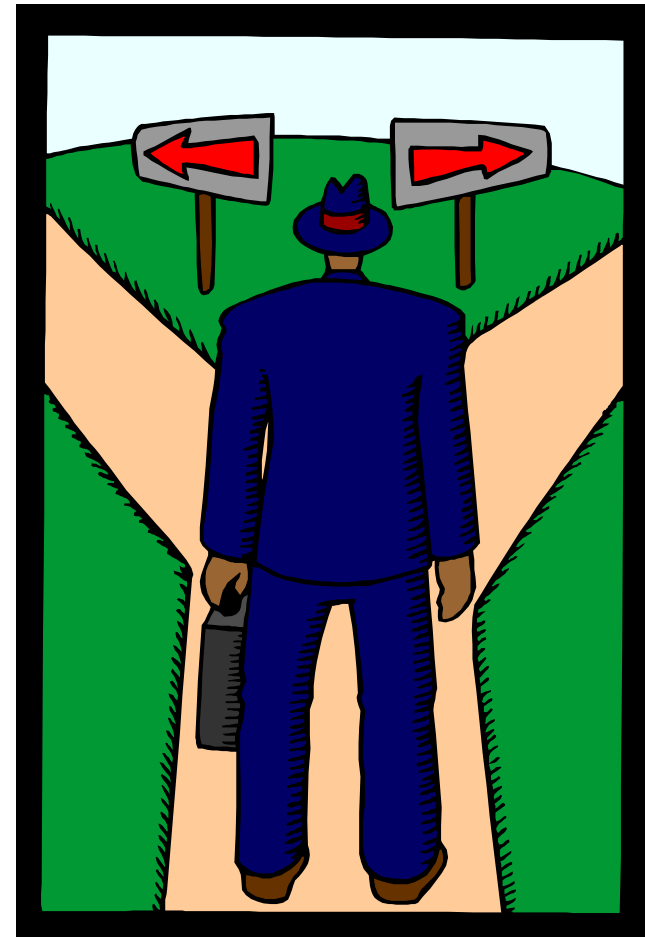
Next Steps



Wrap-Up

Where do you go from here?

- Lots of ideas to consider, but where to start?
- What issues are most important?
 - Reducing cash costs
 - Reducing the level of liabilities
 - Reducing the volatility of liabilities
 - Reducing/eliminating insurance risk
 - Improving retiree affordability
 - Reducing employer administrative responsibilities
- Best solution follows proper identification of the problem





Q&A

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