

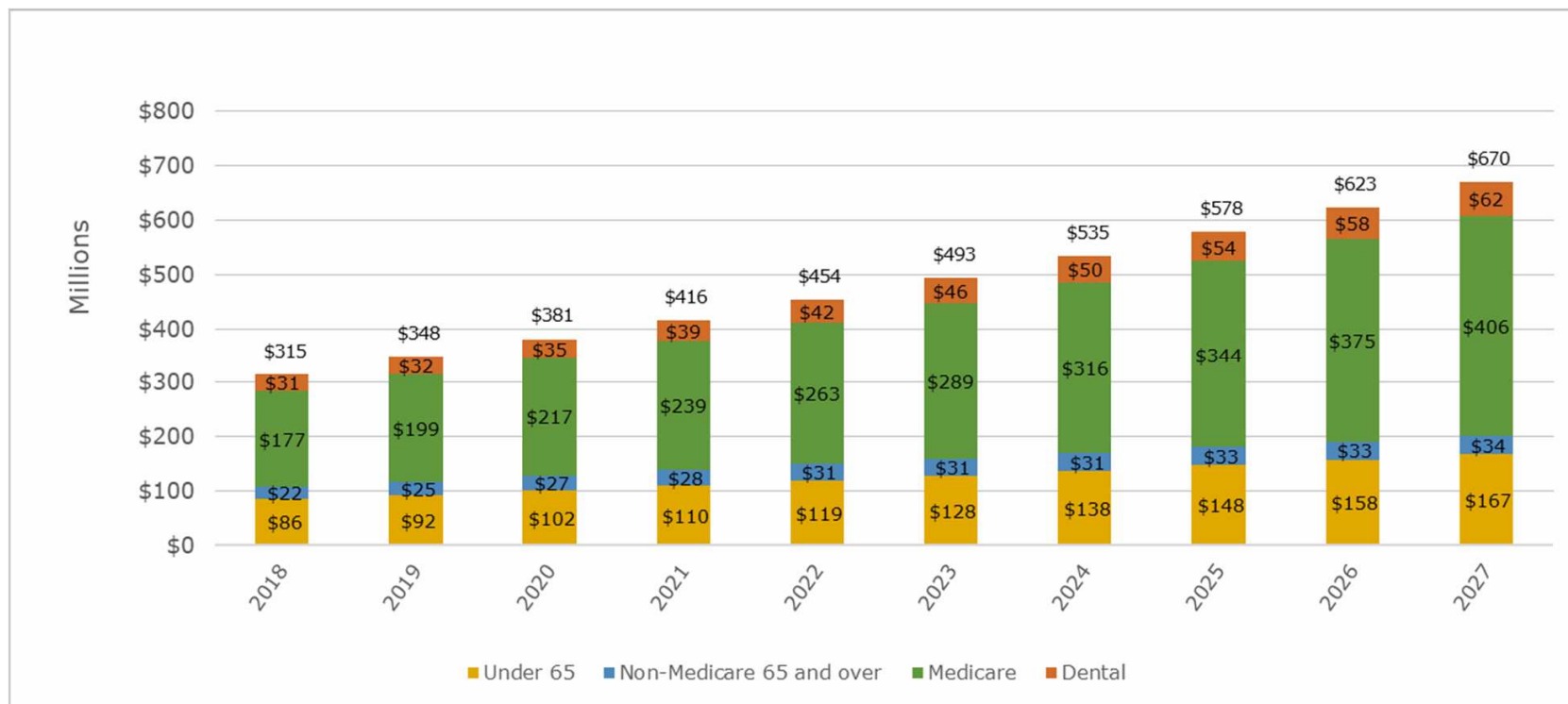
# Retiree Health Benefits Design Working Group

CUCEA/CUCRA meeting UCR, April 2018

- John Meyer, CUCRA
- Roger Anderson, CUCEA
- Gary Schlimgen, UCOP

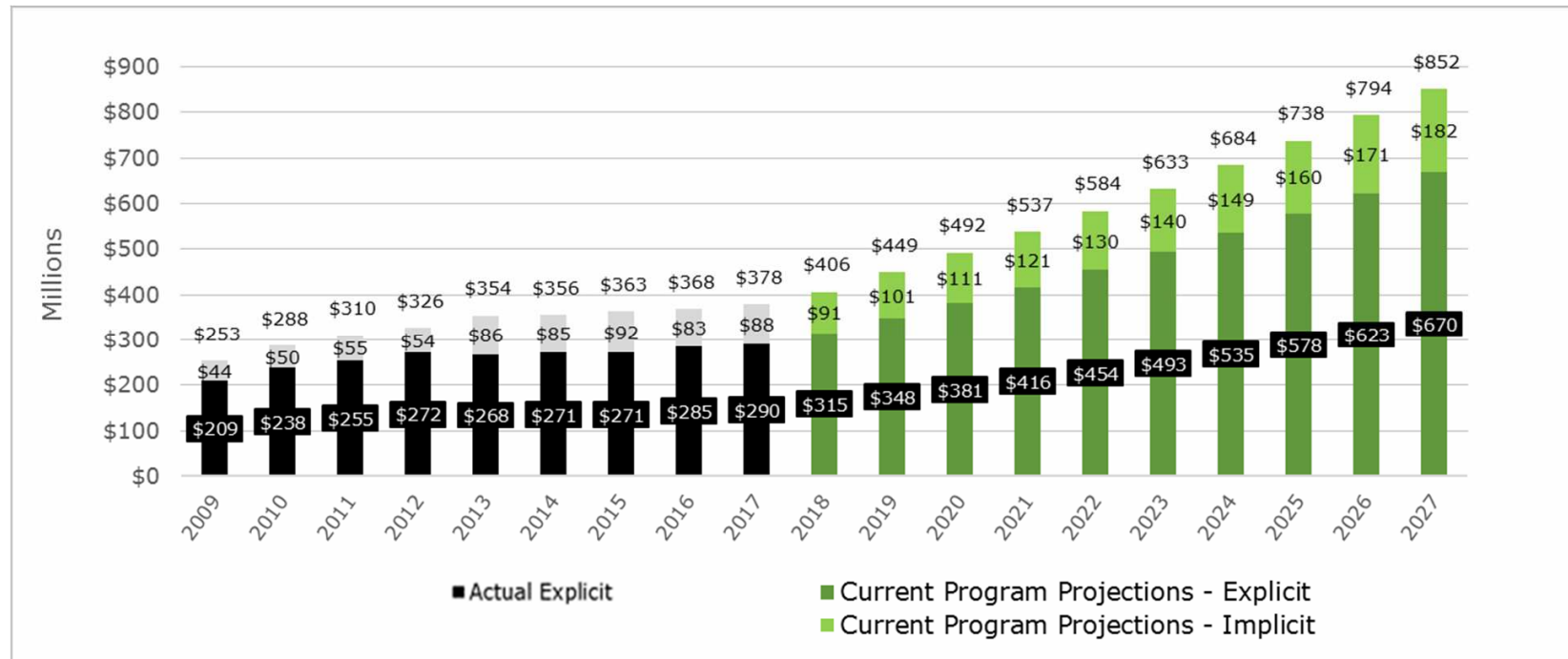
## University Explicit Cost of Retiree Health Program

- Over the next 10 years, without any programmatic changes, pay-as-you-go cash costs are expected to increase from the current \$315 million annually to \$670 million. The split in costs is as follows:
  - ~ 10% for dental benefits
  - ~ 25% for retirees under 65
  - ~ 5% for non-Medicare retirees 65 and over
  - ~ 60% for Medicare retirees



# University Explicit and Implicit Cost of Retiree Health Program

- Non-Medicare retirees participate in plans with active employees
- Non-Medicare retirees pay blended rate premiums based on the total plan cost; since older retirees have higher health care costs than active employees, there is an implicit subsidy being provided to these retirees
- The graph shows the breakdown of University cost by implicit and explicit pay-as-you-go costs University Implicit and Explicit Pay-As-You-Go Cash Costs



# **Our Final Charge**

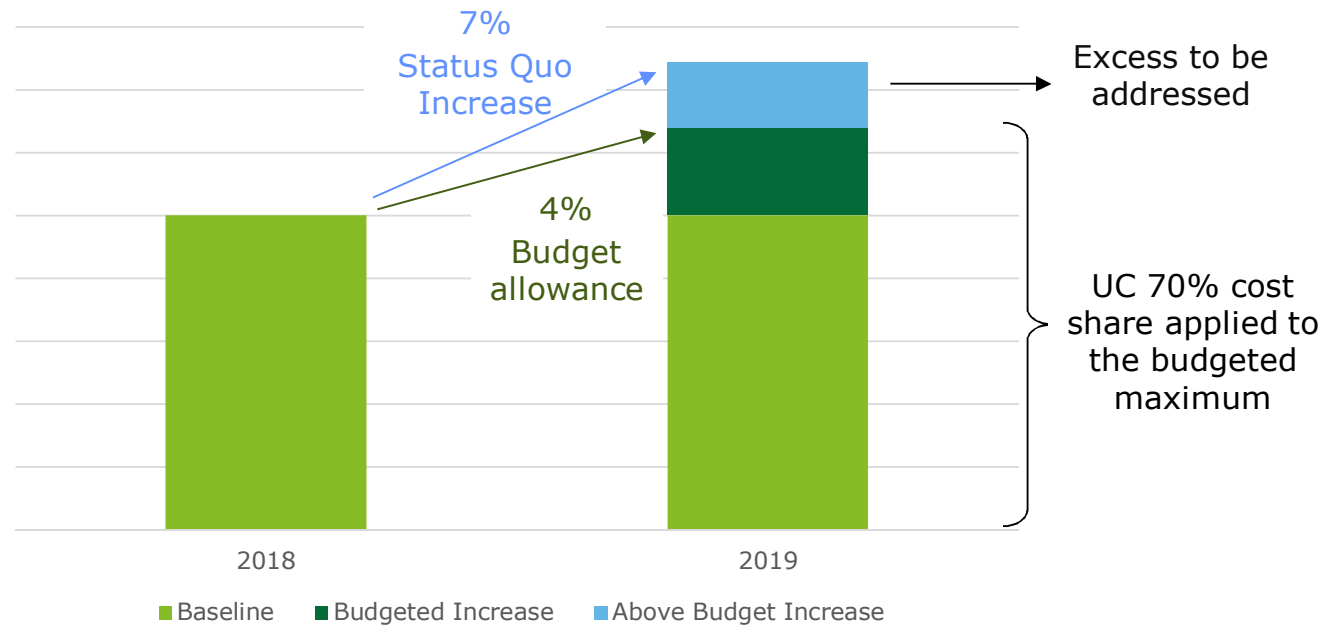
...will explore potential strategies and develop options for UC leaders to consider to ensure the long-term financial viability of the retiree health benefits program. The Working Group will design strategies to effectively manage costs to be able to sustain the benefits and will evaluate the implications of the different options to both UC and retirees.

# The 70% Policy

- There are currently three exceptions to the 70/30 policy:
  - **Dental benefits**
  - **Medical benefits for non-Medicare retirees age 65 and over**
  - **The “implicit subsidy” (explained later)**

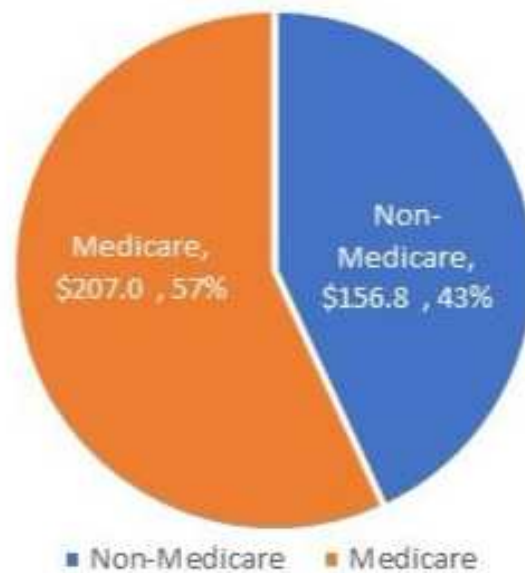
# Budget and Contribution Share

Hypothetical Illustration



# Current costs

Total Retiree Medical Cost Split (\$M)



## Total costs per subscribers per month for different groups (From Deloitte)

Group	Subscribers	Percent in group	UC explicit \$/month	UC implicit \$/mo	Retiree cost (Inc B) \$/mo	Total \$/mo	% Retiree
Pre-Medicare	6,901	18%	\$735	\$597	\$315	\$1,648	19%
Non-Medicare	1,698	4%	\$766	\$1,231	\$127	\$2,124	6%
Medicare (CA)	26,205	68%	\$498	\$0	\$213	\$712	30%
VIA Benefits	3,483	9%	\$250	\$0	\$0-\$500	\$250-\$750	0% - 67%
Totals/ averages	38,287	100%	\$530				

Excludes split family coverage (~4,200 subscribers) and Labs (~1,700 subscribers)

Total Cost includes explicit costs, Part B premium, and the cost of implicit subsidy

## Total costs per subscriber per month , % paid, and Enrollment (From Deloitte)

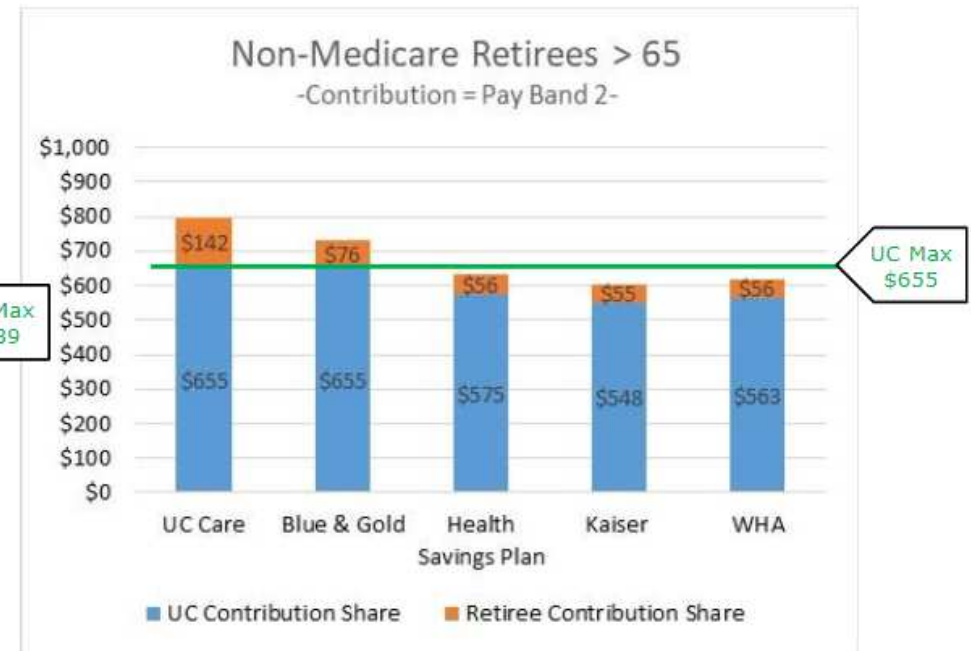
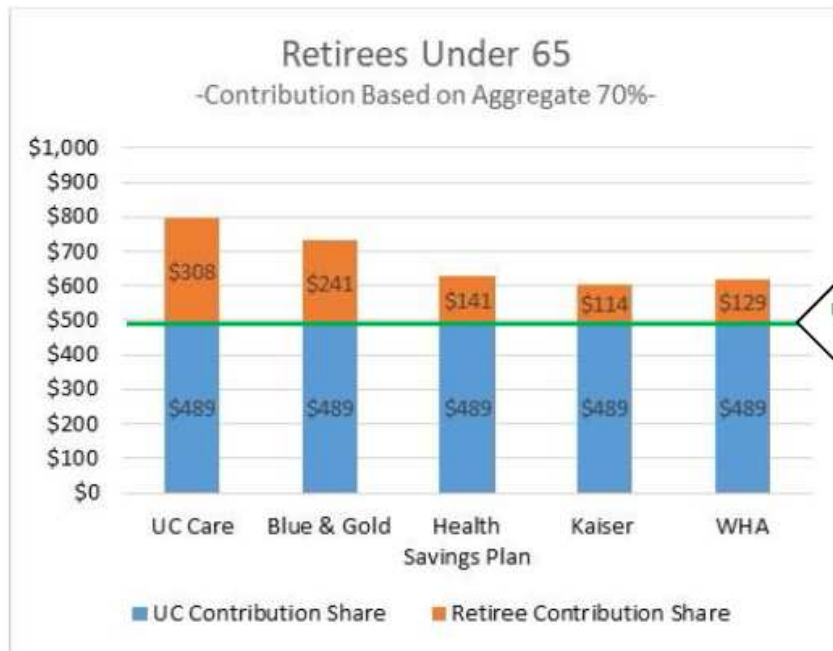
Type of plan	Subscribers	% enrollment	Total Cost/mo	% total cost (implicit + explicit + retiree)	% paid by retiree
Medicare (CA)	26,205	75%	\$712	55%	30%
Non-Medicare	8,599	25%	\$1,742	45%	16%

Excludes split family coverage (~4,200 subscribers) and Labs (~1,700 subscribers)

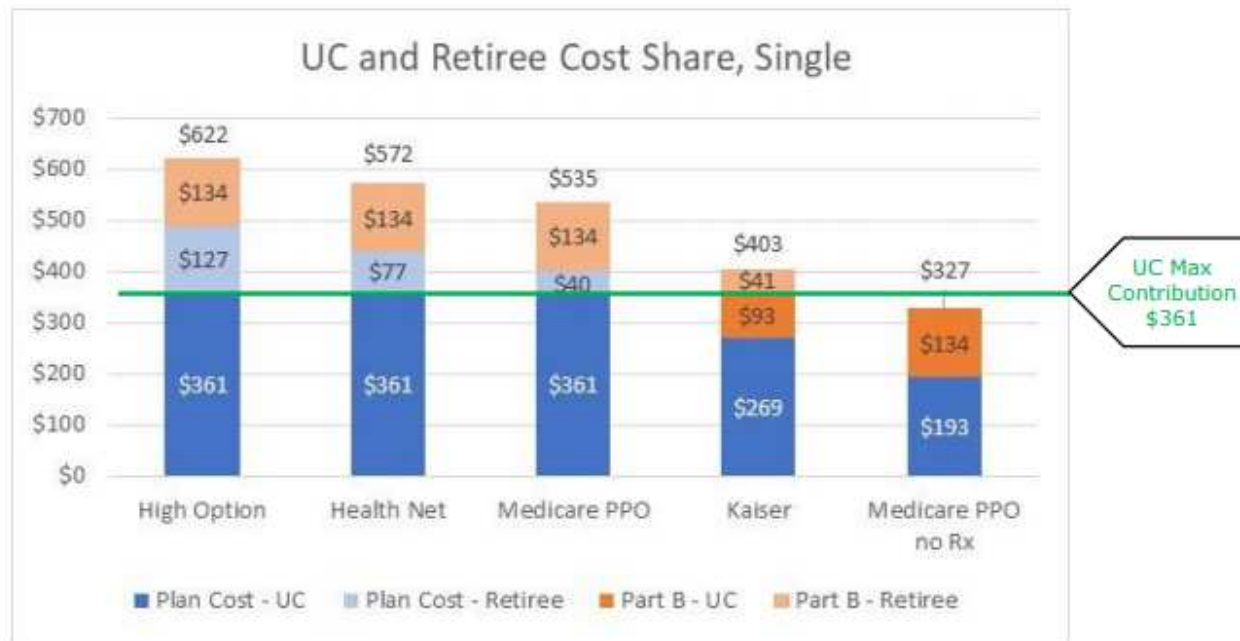
Total Cost includes explicit costs, Part B premium, and the cost of implicit subsidy

Medicare (CA) does not include VIA Benefits

# UC Contribution



# UC Contribution for Medicare retirees



Contribution chart shows single coverage

# Alternatives for reducing costs

Work Group's consideration of all alternatives serves to highlight bad as well as good (or less bad...)

- Over 65 non-Medicare retirees
- **Over 65 Medicare retirees**
- Under 65 retirees

# Cost Reduction Alternatives by Type

Program Cost Reduction	Benefit Type / Value	Contribution Share/Strategy
<b>No cost-shift to members</b>	<b>Increases to member cost-sharing</b>	<b>Changes to amount or distribution of UC/member contribution share</b>
<ul style="list-style-type: none"> <li>• Medicare Exchange*</li> <li>• Medicare Advantage PPO*</li> <li>• Seniority Plus PPO displaces HMO in select regions</li> <li>• UCMC family rate enhancement</li> </ul>	<ul style="list-style-type: none"> <li>• Terminate High Option</li> <li>• Increase Medicare PPO cost-sharing</li> <li>• Terminate UC Care</li> <li>• Substitute HRA plan model for current UC Care plan model</li> <li>• Increase member Blue &amp; Gold cost-sharing</li> <li>• Increase member Seniority Plus cost-sharing</li> </ul>	<ul style="list-style-type: none"> <li>• Introduce dental contributions</li> <li>• Increase contributions to non-Medicare over 65 retirees</li> </ul>

\*Absence of a cost-shift depends in part on how implemented

# Non-Medicare >65: Contribution Anomaly (only explicit)

(\$ Millions)	Non-Medicare Retirees >65		Pre-Medicare and Medicare	
	\$ Cost	Cost Share	\$ Cost	Cost Share
Retiree	\$2	14%	\$114	30%
UC	\$17	86%	\$275	70%
Total	\$19		\$389	

**1,765**  
non-Medicare  
retirees age  
65 and over

## Medicare Plan Options: Eliminating High Option

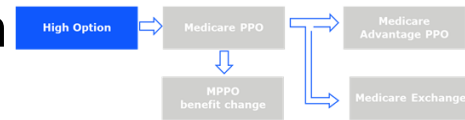
### **Perspective on High Option**

- Highest per-capita cost Medicare plan for UC
- Richest plan design with open provider access
- 10% of Medicare enrollment
- Highest average age among Medicare plans
- Must make positive enrollment choice to be in the High Option plan. All enrollees must be Medicare eligible.

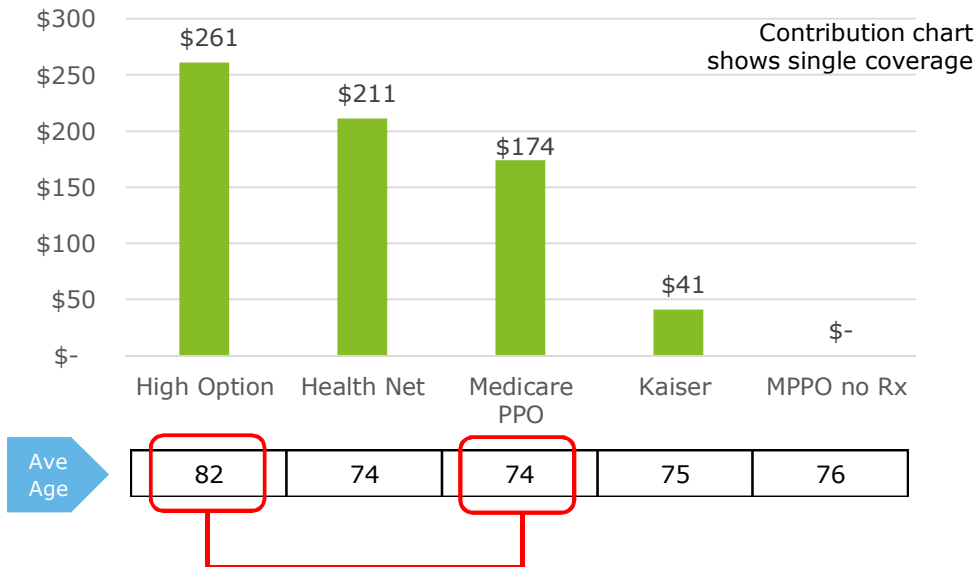
### **Considerations**

- Eliminate High Option, reducing the aggregate Medicare premium from status quo, and correspondingly reducing the cost of UC's 70% share
- The aggregate premium differential between High Option and Medicare PPO for the High Option population is \$4.8 million, which equates to 0.9% of the overall retiree health costs.

# Medicare Plan Options: Eliminating High Option

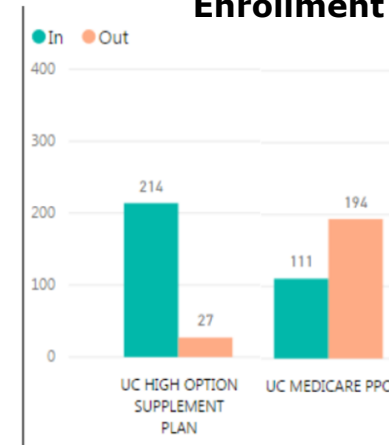


Monthly Retiree Cost  
Includes Estimated Part B



- Medicare plans are not risk-adjusted; majority of the difference in High Option v. PPO plan cost is the higher risk/cost of High Option members

2018 Open Enrollment

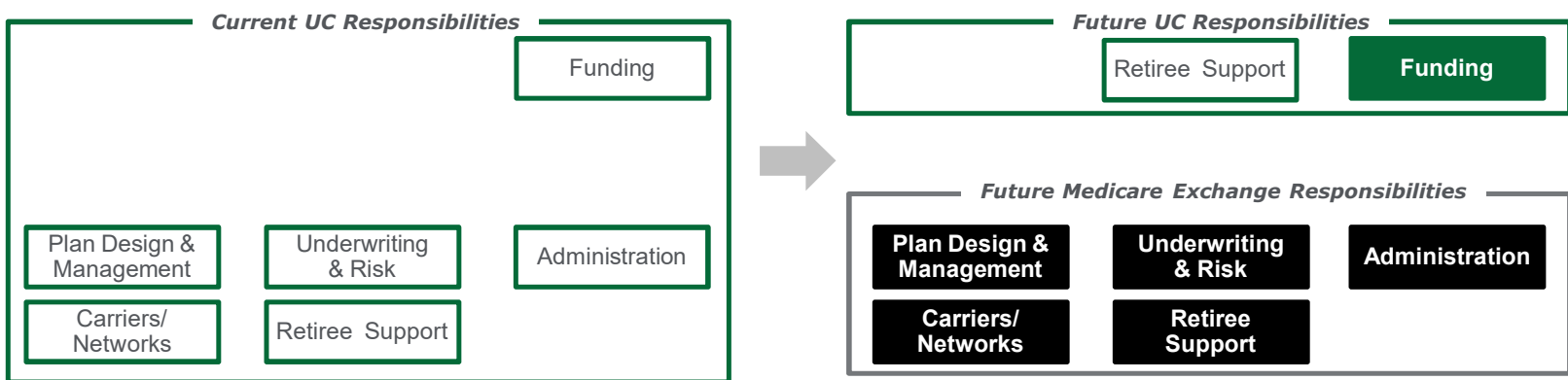


- Because there is no default enrollment in High Option, retirees enter only by making a positive enrollment during open enrollment
- Despite this hurdle and the higher cost, High Option continues to attract new enrollees and experiences few disenrollments.

# Medicare Plan Options: Medicare Exchange inside California

## Overview

- Terminate group plans and introduce a UC-sponsored Health Reimbursement Arrangement (HRA), retirees can use to buy individual coverage through Medicare Exchange
  - Converts UC to defined-contribution model, removes 70% aggregate premium share as basis for UC costs
- Exchange contracts with carriers as a broker for individual insured Medicare Advantage, Medicare supplement, and Medicare prescription drug plans; UC would presumably use same Exchange administrator inside and outside California
- Exchange supports retiree education, decision making, and enrollment through licensed agents
- Not recommended as a choice offering due to potential risk selection issues – apply to all or based on retirement date
- Outside California, most UC members could find higher-value options (cost and benefits)



# Medicare Plan Options: Medicare Exchange inside California

<i>Pros</i>	<i>Cons</i>
<b>Effect on Retirees</b>	
<ul style="list-style-type: none"> <li>• Provides retirees with a greater range of plans options, including both supplement and Medicare Advantage products</li> <li>• Individual market may offer greater value where members can better match plans with their needs</li> <li>• Separate plans may be selected for the retiree and his/her spouse based on specific needs/preferences of each</li> <li>• Currently, the UC HRA contribution fully pays the individual Medicare plan premiums for ~90% of retirees outside California</li> </ul>	<ul style="list-style-type: none"> <li>• Retirees take on increased responsibility for decisions and actions (aided by exchange vendor)</li> <li>• Individual Medicare plans generally have higher cost sharing than group plans</li> <li>• Medicare Advantage plan designs may vary by county</li> <li>• Medical underwriting may apply in certain circumstances when moving into or across Supplement Plans</li> </ul>
<b>Effect on UC</b>	
<ul style="list-style-type: none"> <li>• Assuming \$3,000 per Medicare member annual HRA amount, UC is projected to save ~\$50M in pay-as-you-go costs based on 2017 contributions and Medicare enrollment               <ul style="list-style-type: none"> <li>◦ UC HRA amount for retirees outside of California has remained at \$3,000 per member for 2014-2018</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Requires substantial consultation with stakeholder groups</li> <li>• Change management and communication needs will be significant</li> <li>• Vendor performance will reflect on UC</li> </ul>

## Medicare Plan Options: More Con arguments about Exchange

1. Premiums will be age adjusted to increase premiums for older people. This will be seen as unfair since Pre-Medicare and Non-Medicare premiums are age (risk) to the risk associated with active employees with implicit costs.
2. Premiums increase with tobacco use or low or high weight.
3. Prescription costs can be very great (see AARP calculator).  
Limited formulary?
4. Unclear which services in present UC plans are covered.
5. Billing for retirees can be much more cumbersome.
6. Too much temptation for UC to paid too little into HRA.  
Note that UC has kept present (VIA Benefits) HRA at \$3000 from 2014 to 2018 in spite of continued inflation.
7. Deductions, coinsurance, legal implications must be understood.
8. F plans may not be offered to new enrollment beginning in 2019.

Summary – Potential Cost Savings: Medicare		Potential UC Savings (\$M)
Elimination of High Option		\$0.2
Eliminate High Option; maintain MPPO rate		\$3.3
Replace High Option and Medicare PPO with Medicare Advantage PPO*		\$6.2
Increase Seniority Plus inpatient hospital copay from \$250 to \$500		\$0.4
Increase Seniority Plus Rx out-of-pocket max/specialty copay to capture more Medicare reinsurance		\$1.5
Introduce Health Net Medicare Advantage PPO in select counties		\$1.4
Replace High Option, Medicare PPO and Seniority Plus with Medicare Advantage PPO*		\$12.1
Full replacement Medicare Exchange in California		\$54.6

## Summary – Potential Cost Savings

Increased Contributions for Dental (for all retirees and dependents)	Potential UC Savings Total and (\$/month)
10% contribution for dental benefits	\$3.8M (\$4.51)
20% contribution for dental benefits	\$7.5M (\$9.50)
30% contribution for dental benefits	\$11.1M (\$14.63)

## Summary – Potential Cost Savings

Increased Pre-Medicare and Non-Medicare Retiree Contributions	Potential UC Savings
Implement approximate contribution equivalency (\$) between non-Medicare >65 and Medicare enrollees	\$2.0M
*Other proposed savings for Pre-Medicare and Non-Medicare retirees	\$0M
**Proposed savings from Implicit Subsidy	\$0M

\*Note that Pre-Medicare and Non-Medicare members account for more than \$156M in explicit and implicit costs.

\*\*Note that Pre-Medicare and Non-Medicare members account for much of more than \$100M in implicit costs.

## Topics still needing more discussion and consensus:

1. Cost increases addressed on a per capita basis
2. Possible implicit contributions for Medicare plan risk adjustment
3. Projections for retiree and UC costs for different alternatives including status quo. Sustainability?
4. General Policy for risk adjustment, pooling age adjustment
5. Effect of cost increases on enrollment and risk profile of surviving plans
6. Income tax implications
7. Income banding, note increased premiums for Medicare Part B
8. Other issues?

## Funding approaches

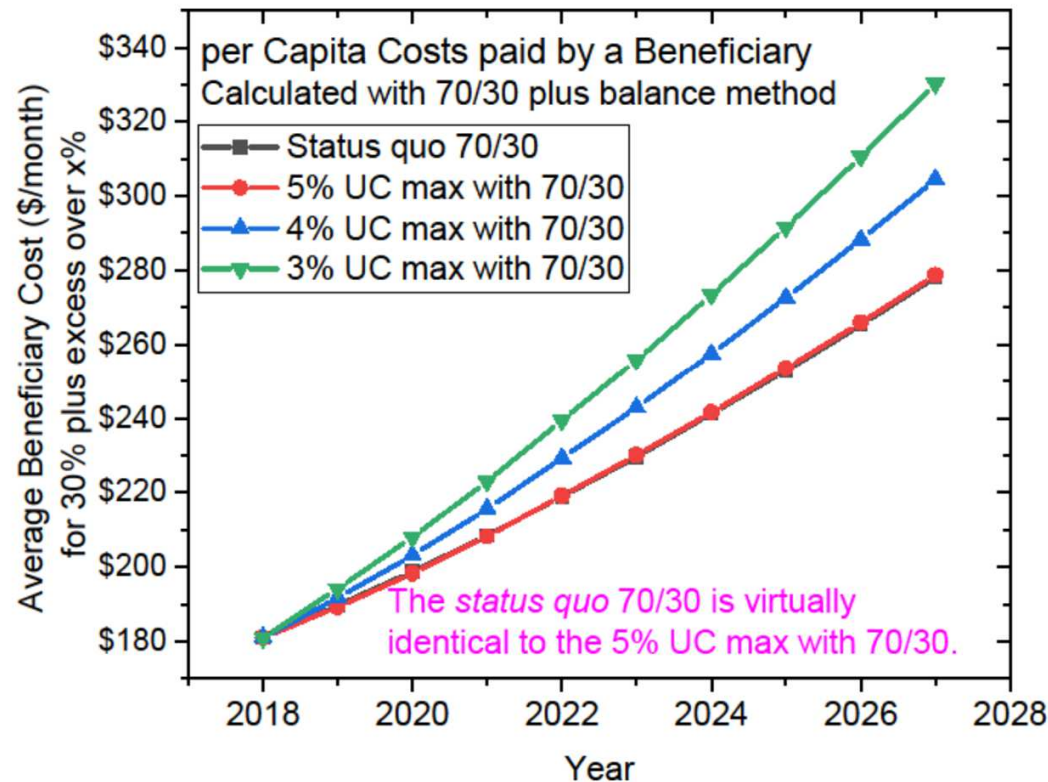
### 1. Cut plan benefits to mitigate increased costs and keep 70/30

This approach is presently being pursued by WG. Problem is that this approach will result in continually decreasing benefits for each year, and to define the benefits in future years will mean one time cuts each year. ...

### 2. 70/30 Plus Balance Method:

Allow beneficiaries to pay more than 30%. Beneficiaries would pay 30% of Explicit costs up to x% and paying all costs above x%.

Here the key recommendations are those which maximize plan value, but present plans could be kept. Slide 4 is based on this approach.



This slide is mostly illustrative for the overall picture. We really need projections for individual plans with different UC contributions.

In the year 2027 the difference between the *status quo 70/30 case* and the *70/30 with a 4% UC max case* is \$26 per month. (~\$27M additional annual cost spread over all beneficiaries)

# Next Steps

- May meetings: development of preferred recommendations by Work Group