

Massachusetts Government Financial Officers Association

GASB 45—WHAT’S NEXT? HEALTH CARE REFORM—WHAT’S FIRST?

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Topics

1. *OPEB Trust Funding and Implications*

2. Health Care Reform

- Early Retiree Reinsurance Program
- Changes to Medicare Part D
- Additional Plan Design Considerations



GASB 45—Terminology

- *Actuarial Accrued Liability (AAL)*

The AAL is the portion of the actuarial present value of total projected benefits allocated to years of employment prior to the measurement date.

- *Unfunded Actuarial Accrued Liability (UAAL)*

The UAAL is the difference between the AAL and Plan assets.

- *Normal Cost*

The Normal Cost is the portion of the actuarial present value of total projected benefits allocated to the year following the measurement date.

- *Annual Required Contribution (ARC)*

The ARC is equal to the normal cost and the amortization of the unfunded accrued actuarial liability. ***There is no requirement that the ARC is funded.***

Discount Rate for OPEB Liabilities

- The stream of benefits is discounted to a present value with an investment return assumption (discount rate).
 - Lower discount rate → higher liability
- GASB specifies that the discount rate to be used depends on level of funding—*even though funding is not required*.
 - Pay-as-you-go: Use the rate of return on the employer's assets.
 - Should be based on each town's expected returns
 - Should be a “long-term” view on what are mostly short-term assets
 - Typically 4.0% – 4.5% for most towns
 - Pre-funding in an OPEB Trust: Use the rate of return expected from the invested assets.
 - Similar to retirement systems
 - Could be in the 7.5% – 8.5% range

Discount Rate for OPEB Liabilities

- Fully funding the ARC could mean a doubling or tripling of a town's OPEB expenditures, and may not be realistic in this fiscal environment.
- Even partial pre-funding can be advantageous, as it both:
 1. Reduces the employer's Net OPEB Obligation (NOO), and
 2. May allow for a higher discount rate in the valuation, which will directly lower the actuarial liability.



Let's look at an example...

Example Full Funding

Assume 8.0% discount rate, and full funding of the ARC each year

Fiscal Year Ending June 30,	Projected Benefit Payments	ARC: Normal Cost + Amort. of UAAL	Additional Funding	Assets at End of Year	AAL at End of Year
2010	\$4,493,986	\$9,202,200	\$4,708,214	\$4,892,920	\$125,728,801
2011	5,100,518	9,630,666	4,530,148	9,992,221	133,621,868
2012	5,767,682	10,079,131	4,311,449	15,272,187	141,609,811
2013	6,325,428	10,548,531	4,223,103	20,882,740	149,821,771
2014	6,901,448	11,039,846	4,138,398	26,854,109	158,264,908

Example No Pre-Funding

Assume 4.5% discount rate, and no pre-funding

Fiscal Year Ending June 30,	Projected Benefit Payments	ARC: Normal Cost + Amort. of UAAL	Additional Funding	Assets at End of Year	AAL at End of Year
2010	\$4,493,986	\$14,340,252	\$0	\$0	\$222,014,880
2011	5,100,518	15,115,454	0	0	234,509,824
2012	5,767,682	15,918,734	0	0	247,270,945
2013	6,325,428	16,749,960	0	0	260,441,369
2014	6,901,448	17,614,953	0	0	274,041,096

Example Partial Funding

- What about funding an additional \$1,000,000 each year in an OPEB trust? How does it affect the discount rate?
- Compare present value of additional funding with present value of “full funding” requirement

Additional Funding	<i>VS.</i>	Additional Funding
\$4,708,214		\$1,000,000
4,530,148		1,000,000
4,311,449		1,000,000
4,223,103		1,000,000
4,138,398		1,000,000

- Looking at present value of these two cash flows, suggests an intermediate discount rate of 5.25%

Example Partial Funding

Re-run valuation at 5.25% discount rate, assuming \$1,000,000 additional funding each year.

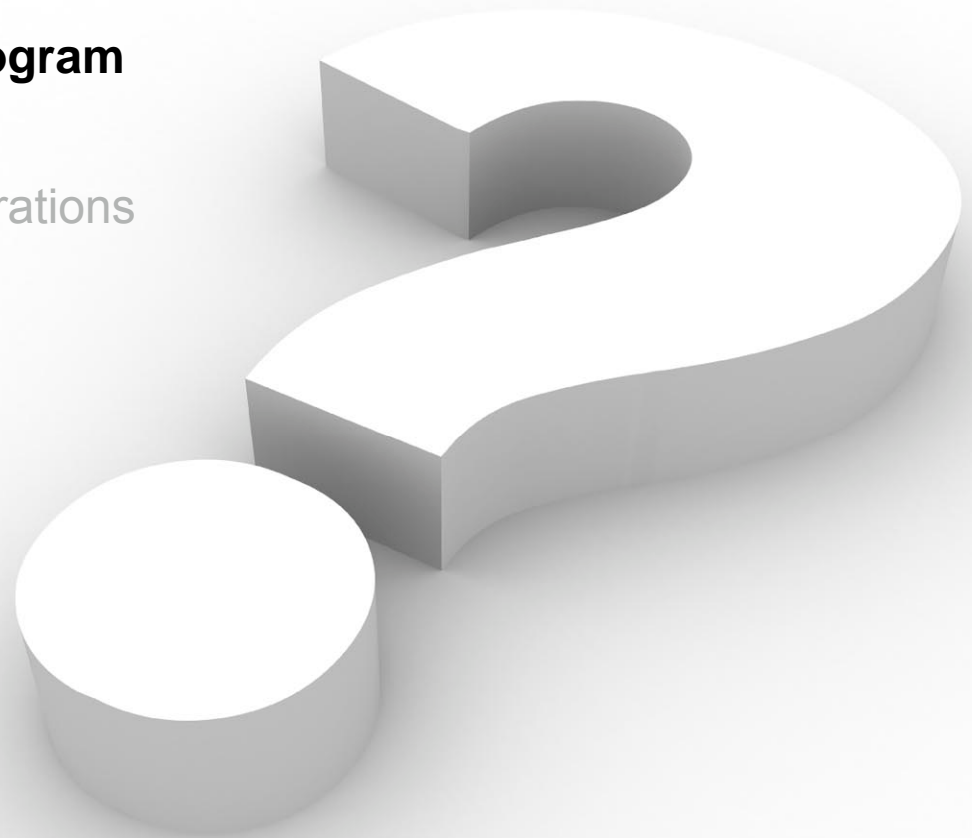
Fiscal Year Ending June 30,	Projected Benefit Payments	ARC: Normal Cost + Amort. of UAAL	Additional Funding	Assets at End of Year	AAL at End of Year
2010	\$4,493,986	\$12,544,380	\$1,000,000	\$1,039,230	\$193,534,849
2011	5,100,518	13,137,904	1,000,000	2,161,599	204,716,461
2012	5,767,682	13,759,588	1,000,000	3,373,758	216,113,341
2013	6,325,428	14,410,773	1,000,000	4,682,889	227,864,679
2014	6,901,448	15,092,860	1,000,000	6,096,751	239,986,751

Topics

1. OPEB Trust Funding and Implications

2. *Health Care Reform*

- **Early Retiree Reinsurance Program**
- Changes to Medicare Part D
- Additional Plan Design Considerations



Health Care Reform Timeline



Health Care Reform

Timeline for Calendar-Year Group Health Plans*

KEY HEALTH CARE REFORMS			
	Provisions Directly Affecting Existing Group Health Plans	Medicare Reforms	Other Health Reforms
2010	<ul style="list-style-type: none"> Retiree reinsurance program Tax-free coverage for children through end of year child turns 26 Small business tax credits 	<ul style="list-style-type: none"> \$250 reimbursement in Part D coverage gap ("doughnut hole") 	<ul style="list-style-type: none"> Temporary high-risk pool DOL to require Multiple Employer Welfare Arrangements (MEWAs) to register with DOL
2011	<ul style="list-style-type: none"> No lifetime dollar limits on essential benefits Only permitted annual dollar limits Extension of coverage for adult children until age 26 No preexisting condition exclusion for children under 19 Ban on rescinding coverage Flexible Spending Arrangements/Health Reimbursement Arrangements/Health Savings Accounts: over-the-counter medications reimbursable only with prescription 	<ul style="list-style-type: none"> Additional Prescription Drug Plan (PDP)/Medicare Advantage plan with prescription drug coverage (MA-PD) discounts for brand and generic PDP/MA-PD may waive copayments for first fills of generic Medicare Advantage payments frozen at 2010 levels Medicare Part D premiums increased for high-income beneficiaries New Medicare wellness benefits 	<ul style="list-style-type: none"> Higher penalty for Health Savings Account withdrawals for non-qualified expenses Medical loss ratio requirements for insurers (85% for large groups) CLASS program (voluntary, public long-term care program) Annual fee on pharmaceutical manufacturers and importers
2012	<ul style="list-style-type: none"> Employer W-2 reporting on 2011 coverage Standardized information disclosure (with notice of modifications 60 days in advance) Comparative effectiveness research fee paid by insurers and self-insured plans, beginning plan year ending after September 30, 2012 (\$2 per covered life; \$1 in first year) 	<ul style="list-style-type: none"> Medicare Advantage payments decreased 	
2013	<ul style="list-style-type: none"> FSA contributions capped at \$2,500 (indexed) 	<ul style="list-style-type: none"> Corporate health plans lose tax deduction for Part D Retiree Drug Subsidy reimbursements 	<ul style="list-style-type: none"> Increases in Medicare Hospital Insurance tax for high-income individuals Annual fee on medical device manufacturers and importers
March 1	<ul style="list-style-type: none"> Employer notice to employees about the Health Insurance Exchange 		
December 31	<ul style="list-style-type: none"> Plans to certify compliance with certain Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) standards 		

* Most of the law's provisions take effect at the start of a plan year. Plans that are not calendar-year plans would have different effective dates. For example, for a plan with a July 1 plan year, all but the last item listed in the left column for 2011 would take effect on July 1, 2011.

Health Care Reform Timeline *continued*



Health Care Reform

Timeline for Calendar-Year Group Health Plans*

KEY HEALTH CARE REFORMS			
	Provisions Directly Affecting Existing Group Health Plans	Medicare Reforms	Other Health Reforms
2014	<ul style="list-style-type: none"> No waiting periods longer than 90 days No annual dollar limits on essential benefits Employer free-rider penalty Free-choice vouchers Wellness program rules Employers to report to IRS on plan features (and provide statements to employees by January 31, 2015) 		<ul style="list-style-type: none"> Health Insurance Exchanges Individual mandate with federal subsidies Medicaid expansion to 133% of Federal Poverty Level Annual fee on health insurance providers
2015 December 31	<ul style="list-style-type: none"> Plans to certify compliance with other HIPAA EDI standards 		
2018	<ul style="list-style-type: none"> Excise tax on high-cost health plans 		
Effective Date to be set in regulations	<ul style="list-style-type: none"> Automatic enrollment by large employers (200 or more full-time employees) 		

* Most of the law's provisions take effect at the start of a plan year. Plans that are not calendar-year plans would have different effective dates. For example, for a plan with a July 1 plan year, all but the last item listed in the left column for 2011 would take effect on July 1, 2011.

Early Retiree Reinsurance Program (ERRP)

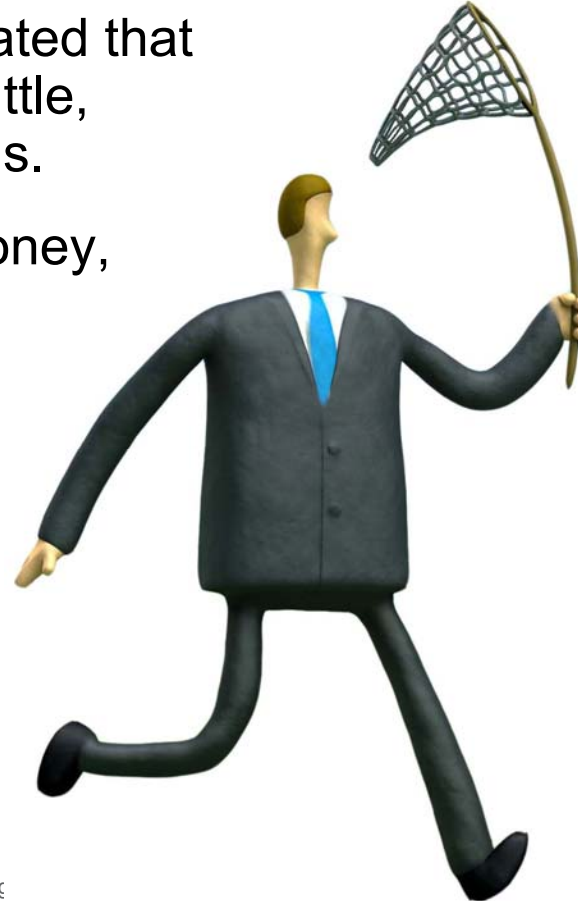
- Covers non-Medicare eligible retirees (and their dependents) age 55 and older
- Reimburses 80% of claims per individual between \$15,000 – \$90,000 per plan year



- Plans must use funds to lower retirees' or sponsors' costs
- Plans must have chronic care management programs (not yet defined)
- Scheduled to last until earlier of Exchanges beginning to operate in 2014 or money runs out
- Plan sponsors are acting quickly

Early Retiree Reinsurance Program & GASB 45

- Reimbursements will be made on a “first-come, first-served” basis.
- Recent EBRI study estimated that the \$5 billion will be exhausted within two years.
- Big accounting firms have indicated that they expect the ERRP to have little, if any, effect on OPEB valuations.
- Unlike Retiree Drug Subsidy money, there are restrictions on how the ERRP reimbursements can be used.



Early Retiree Reinsurance Program

Application Process

- Guidance published in May 5, 2010 Federal Register
- Application process is modeled on the Retiree Drug Subsidy (RDS) Program
 - Application may be paper
 - Only one application required (not annual and no specific deadline)
 - No actuarial attestation required
- HHS has stated that they will accept applications in the order in which they are received
- HHS will deny incomplete applications, and an application that is then resubmitted will be assigned a later filing date



It is critical that applications be complete when submitted the first time. HHS reserves the right to deny applications (and/or claims, in whole or in part) based on lack of funds

Early Retiree Reinsurance Program

Application Requirements

- Must project the amount of reimbursement expected during the first two plan years, and explain how reimbursements will be used
- Must describe programs that have generated or have the potential to generate cost savings for participants with chronic and high-cost conditions
- Must include an agreement, signed by the plan's authorized representative, to comply with the federal requirements for the program
 - HIPAA and PHI Disclosure
 - Fraud, Waste, and Abuse Detection Policies
 - Record Retention Requirements



Early Retiree Reinsurance Program

Transition Rule

- **Transition Rule:** Plan sponsors may apply for plan years that start before June 1, 2010, as long as the plan year ends after June 1, 2010.
- **Transition Rule:** Claims up to \$15,000 incurred prior to June 1, 2010, count toward the cost threshold and the cost limit. Claims over \$15,000 incurred prior to June 1, 2010, do not count toward the cost limit and cannot be reimbursed.
- **Example:** Plan year begins July 1, 2009. Early retiree has had paid claims of \$120,000 prior to June 1, 2010, and \$30,000 after June 1. The plan receives credit for \$15,000 in claims incurred before June 1 and receives reimbursement of 80 percent of the \$30,000 (i.e., \$24,000)

Topics

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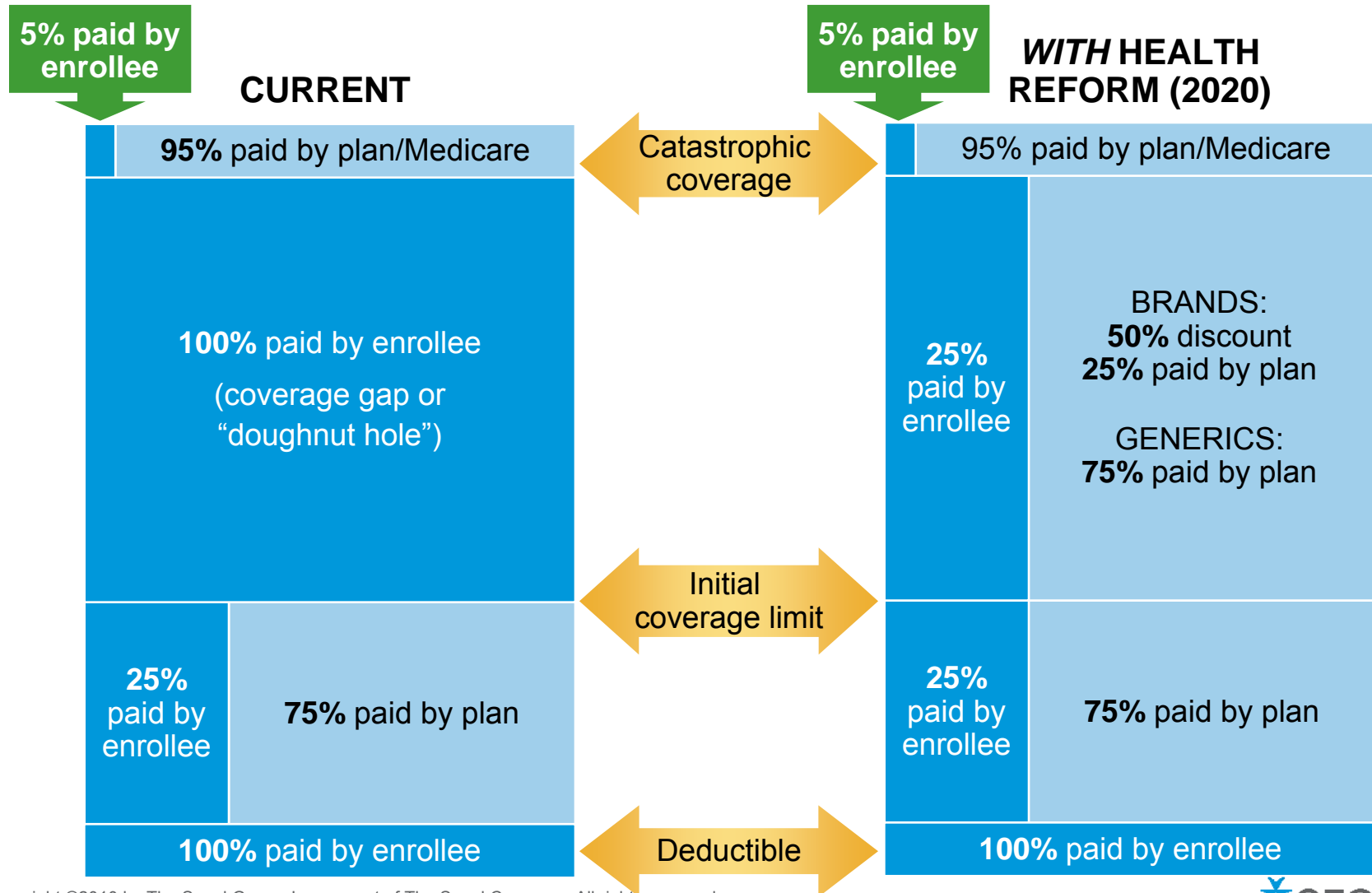
2. *Health Care Reform*

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- **Changes to Medicare Part D**
- Additional Plan Design Considerations



Medicare Part D Changes

STANDARD MEDICARE PRESCRIPTION DRUG BENEFIT



Medicare Part D Changes

- \$250 rebate for beneficiaries who reach doughnut hole in 2010
- In 2011, discounts on brand-name and generic drugs in “doughnut hole” for retirees in a Prescription Drug Plan
- Close doughnut hole by 2020 (gradually expands coverage to 75% of costs)
- Part D premium indexed based on income just like Part B (2011)
- Part D Retiree Drug Subsidy (RDS) becomes taxable starting in 2013 for employers with a tax liability (generally not an issue for public sector plans)



Opportunities Related to Medicare Part D Changes

- Standard Part D plans will no longer have coverage gap, resulting in less concern about out-of-pocket costs
- Standard Part D plans will still have more restricted drug formularies
- Increased funding to Standard Part D plans will increase attractiveness of these programs
- Might be more difficult for plans to meet actuarial equivalence and qualify for Part D Retiree Drug Subsidy



For towns that currently participate in the RDS program: These changes may influence the decision as to whether to continue the current plan with Part D subsidies or to consider redesigning the prescription drug program.

Medicare Advantage Plans

- Medicare Advantage reimbursements for 2011 are frozen at 2010 levels
- Medicare Advantage reimbursements will decrease over several years
- As a result, carriers will be reassessing whether to continue offering these types of plans



Freezing reimbursements to carriers offering Medicare Advantage programs ultimately shifts costs to participating retirees.

- Potential benefit cutbacks
- Out-of-pocket costs may rise
- Premiums may rise

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How Will Health Reform Affect Your Costs?

Some provisions may potentially reduce costs for plan sponsors indirectly and over the long term

The arguments:

- Reduced pool of uninsured may reduce cost shift from uncompensated care
- Pre-65 subsidy may help for a brief time
- New insurance marketplace will bring down costs throughout the system due to increased competition and reduced administrative costs
- Quality incentives/payment reforms will induce providers to coordinate care and redesign delivery systems around quality cost-effective care
- Comparative effectiveness research and health IT are additional tools
- Medicare Independent Payment Advisory Board will help control provider costs



- **These arguments are mostly untested.**
- **Some of these already done as a result of Massachusetts health reform.**

How Will Health Reform Affect Your Costs?

Other provisions will directly and indirectly add to costs:

- Direct cost of expanding coverage (no limits, shorter waiting periods, dependent eligibility extension)
- Direct add-on fees such as the \$2 PMPY fee to plans for comparative effectiveness research; health plan excise tax beginning in 2018
- New taxes on devices and insurers that will be passed through to buyers in the form of higher premiums
- Additional administrative costs to plan sponsors to comply with new rules (legal; actuarial; administrative fees to prepare Health W-2s; voucher administration costs, including additional auditing and monitoring)
- A new round of medical price inflation from providers as they attempt to make up losses from lower reimbursement rates from Medicare and Medicaid



Initial assessment of the new law will also increase plan sponsor cost in the short term.

New Administrative Requirements

- Employers will be required to disclose health benefit costs on the employee's annual Form W-2 in 2012 (reflecting coverage in 2011)
- Uniform disclosure standards for benefits explanations—standards to be issued in one year with compliance a year later

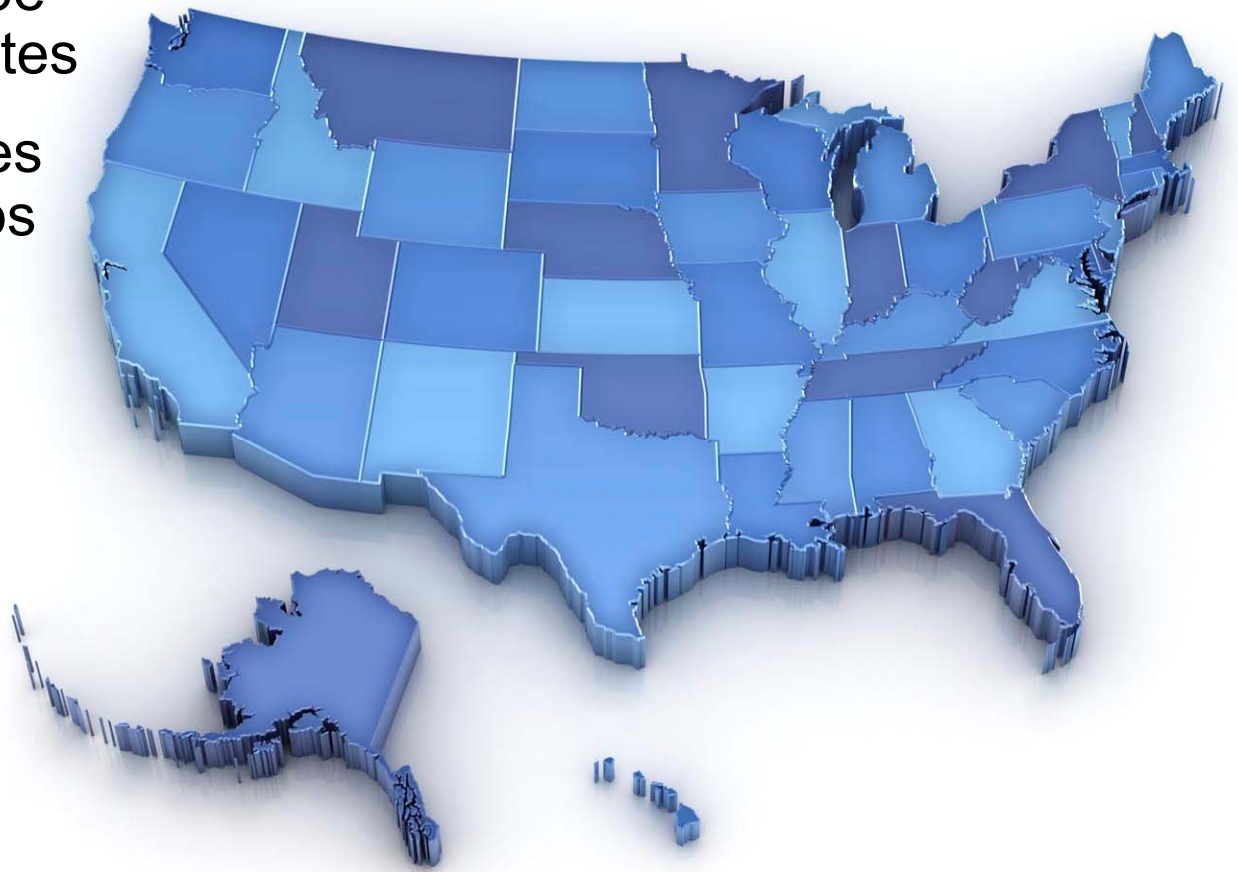


- Possible major issue for public sector to accommodate new line item on W-2.
- May involve actuarial calculations on a per-participant basis.
- Need guidance on reporting for retirees.
- Disclosure standards may require standardized language that requires complete revision of existing communications.

W-2
Wage and Tax
Statement
2011

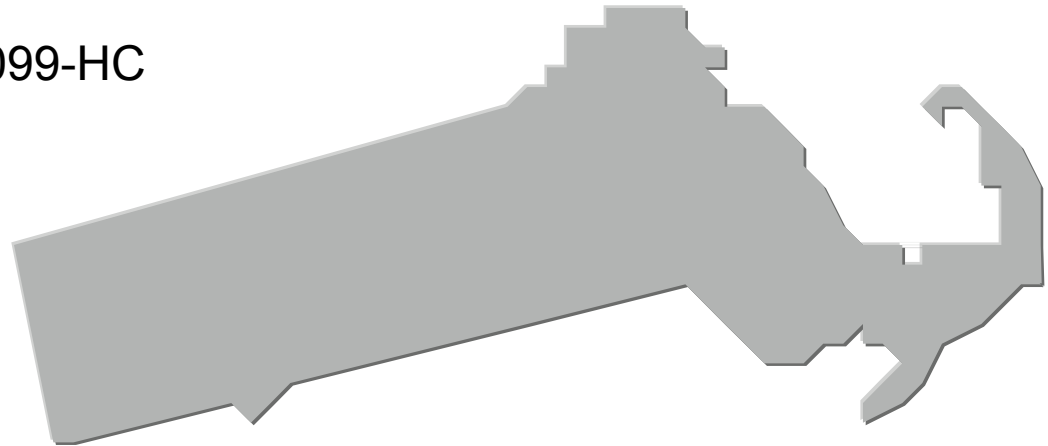
The Health Insurance Exchange—2014

- A new marketplace where individuals and small groups can choose from a menu of insurance products
- Final Exchanges will be established by the states
- **2017:** State Exchanges may allow large groups in Exchange



Health Care Reform in Massachusetts

- The Connector is an Exchange, but currently only available to individuals and some small employers
- Mandates more extensive under Federal Health Care Reform
 - **Example:** Prohibition of annual limits on essential benefits.
- Changes in administrative requirements
 - Requires W-2 reporting
 - Does not eliminate Form MA 1099-HC



Additional Plan Changes to Consider

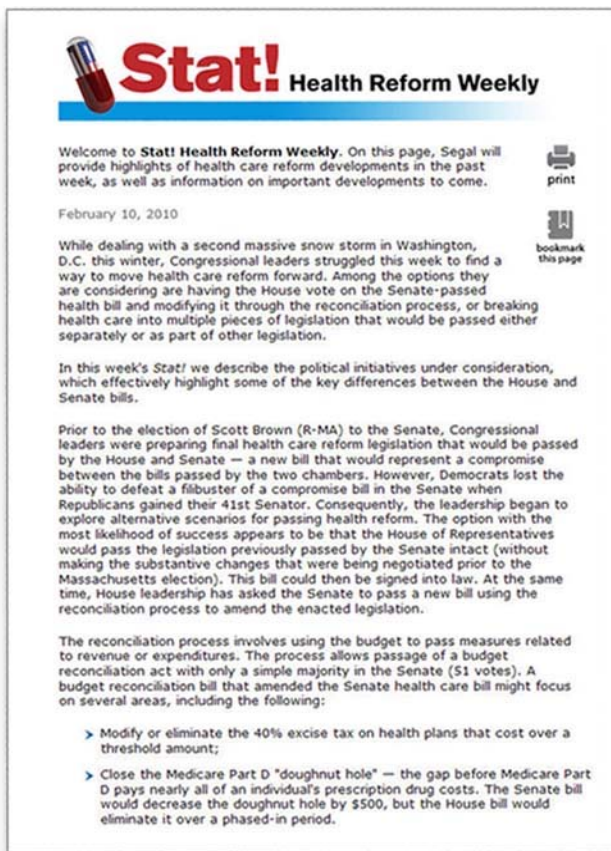
- Adopting M.G.L. Chapter 32B Section 18 (or 18A)
 - Immediate and significant reduction in GASB 45 liability
- Group Insurance Commission
- Changes to plan design (“Rate Saver” plans)
 - Higher copays for office visits, emergency room, prescription drugs
 - Introduce copays for hospitalization
- Total Health Management
 - Promote wellness
 - Condition/disease management
 - Care coordination
 - Patient safety

Segal Website Resources

Stat! Health Reform Weekly

Segal's Weekly Publication on Health Reform

<http://www.segalco.com/publications-and-resources/stat/>



And Other Resources:

- *Health Care Reform Timeline*
- *Health Care Reform Insights*
- *Bulletins*
- *NewsLetters*

Can be found on:

- Segal's Health Care Reform Guide page
<http://www.segalco.com/health-care-reform/>

Questions

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