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POLICY BRIEF

REFORMING RETIREE BENEFITS: Recent Changes in the University of Pennsylvania's Retiree Medical Plan

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In the Spring of 2004, the Retiree Benefits Task Force of the University of Pennsylvania was established by the University Provost and President. It was charged with examining and proposing alternative approaches to the medical plans offered to retired staff and faculty. This document describes the recommendations made by the Task Force to change the Retiree Medical Plan, the changes adopted by the University Administration, and subsequent results.

INTRODUCTION

Like many other institutions of higher learning, the University of Pennsylvania has long provided subsidized retiree medical plans for its retired faculty and staff members. In the past decade, however, the cost of these programs has increased substantially. And recent changes in accounting standards now require that the University "book" the future costs of the retiree medical program for all current employees as well as retirees. As a consequence, the University sets aside millions of dollars per year to partially pre-fund the retiree health benefit, and it also must show the as-yet-unfunded balance as a liability with its corresponding expense on its financial statements. The Task Force was asked to examine to what extent the retiree medical plans could be modified without seriously compromising the University's ability to attract and retain excellent faculty and staff members.[1] This examination was to include a review of what other academic institutions and commercial enterprises are doing to address this problem. Over a period of several months, the Task Force met and prepared a report and recommendations for changes in the retiree medical plan.

In its deliberations and when arriving at its recommendations, the Task Force reviewed a number of reports (see the bibliography) and members also spoke with benefits consultants as well as other experts around the University. The Task Force began by enunciating several key, though admittedly sometimes contradictory, principles guiding its recommendations. These included the following:

[1] The Provost's charge to the Task Force read as follows: "The University has provided generous health insurance programs for its retired faculty and staff members. Over the past decade the cost of these programs has significantly increased mainly because of two factors. First, the cost of all health insurance, for retirees as well for active employees, has seen annual increases approaching fifteen percent. Second, federal guidelines now require that the University "book" the future costs of the retirement health insurance programs for all current employees as well as retirees. The University must now set aside millions of dollars each year for this purpose, as well as show the as-yet-unfunded balance as a debit on its balance sheets. The Task Force should examine to what extent the retiree health programs could be modified without seriously compromising the University's ability to attract and retain excellent faculty and staff members. This examination should include a survey of what other academic institutions and commercial enterprises are doing to address this problem."

- The need to maintain group access to medical plans for retirees;
- The need to offer retirees choice over medical coverage including an indemnity plan for out-of-area retirees;
- The need to reduce FAS 106 liability levels and growth rates to the extent possible;
- The need to have retirees share in the costs of medical coverage, including pre-1996 retirees whose medical plan premiums are currently fully subsidized;
- The need to tighten eligibility requirements for retiree medical insurance;
- The need to carve-out the retiree prescription drug plan to be more flexible in view of future Medicare prescription drug changes;
- The need to simplify premiums and administration of retiree medical plans;
- The need to communicate and include changes on the calendar in time to roll them out in the targeted plan year.

After extensive review and consultation, the Task Force recommended several changes in key aspects of the retiree medical program subsequently adopted by the University Administration**.** These can be grouped under three headings, to be discussed in more detail below:

- **Benefit Eligibility:** New rules for who can participate in the program, based on a modified combination of age and service;
- **Plan Design**: New designs for healthcare plan offerings; and
- **Benefit Subsidy:** New arrangements for sharing the costs of the retiree medical plan between the University and the retirees.

In what follows, we summarize the retiree health plan environment and Penn's retiree medical plans; outline rationales for change; summarize the Task Force recommendations; and provide brief updates.

THE RETIREMENT HEALTH PLAN ENVIRONMENT

The Task Force made several observations regarding the national retiree health plan environment, other comparator institutions' offerings, and the University's current offerings for retiree medical plans.

1. The National Environment [2]

In designing a medical insurance plan for retirees, it is necessary to understand the risk confronting retirees when it comes to old-age health care costs. Recent studies provide estimates of a lifetime of coverage valued at about $175,000 for an age-65 couple,[3] divided into costs for prescription drugs (42%), Medicare premiums (23%), and the remainder attributed to copays and deductibles (Neuman, 2004; Fronstin/Salisbusy, 2003; Powell, 2004). Though these estimates are highly uncertain, it is evident that retirees lacking employer-provided retiree health benefits will pay more – one study indicated that an average 20% of monthly incomes could be devoted to medical expenses (Neumann, 2004). Access to a group retiree medical plan therefore helps cushion many retirees against a portion of these costs.

In the US, *active* employees may receive health insurance through their employers, mostly as a result of tax law which allows healthcare premiums to be paid for with pre-tax dollars and benefits to be nontaxable when received. *After retirement*, many retirees age 65+ receive Medicare benefits, a government program that pays about 60% of health care costs, and 13% receive Medicaid (a government program targeted mainly at the indigent). Since the government programs leave gaps, it is not unusual for the elderly to obtain additional coverage. For instance, 22% of the elderly today have individually-purchased health "Medigap" insurance, and about 29% have employer-sponsored retiree health insurance. Traditionally, larger employers offered retiree medical plans along the lines of a "defined benefit" or indemnity model, where reimbursement for hospital and major medical treatment was provided if Medicare did not pick up the costs. The result was that retirees have been shielded from having to pay for a substantial portion of the cost of their healthcare.[4]

But the marketplace is rapidly changing. During the 1980s and 1990s, healthcare costs grew far faster than the inflation rate, new medical treatments and expensive technology pushed up costs, and utilization rose. As a result, many employers began to redesign their retiree health care plans. To contain costs, for instance, many companies instituted *higher copayments* (e.g. patients had to pay a higher percent of the bill out-of-pocket); *higher deductibles* (e.g. patients had to pick up a higher dollar amount up to some limit,

[2] This section relies heavily on Schieber (2004).

[3] This amount represents average out-of-pocket medical expenses for a 65-year-old couple retiring today with Medicare. A couple retiring early, say at age 60, would face an even bigger burden, on the order of $200,000 (Powell 2004).

[4] "For a typical retiree covered by an employer-sponsored health plan today and eligible for Medicare, an average of about 65% of medical care costs will be covered by Medicare, 25% by the employer plan, and 10% out of pocket." (Schieber, 2004:5).

before the insurance kicked in); and *higher premiums* (e.g. retirees were required to share in the health plan premiums). In addition, many firms began offering *prepaid health plans* which emphasized prevention and cost containment, with a managed-care emphasis. Moreover, numerous firms restricted retiree healthcare coverage to those retirees who would meet defined *age and service* requirements; and several adopted *Flexible Spending Accounts* where workers could deposit pre-tax salary in these accounts and use the funds to reimburse themselves for copayments and deductibles (as well as IRS-qualified health-related products/expenses not covered by the plan such as contact lenses).

These changes proved inadequate to rein in retiree health plan inflation, such that healthcare costs for retirees rose faster than for active workers. As a result, many employers have altered and sometimes terminated their retiree medical plans. For instance, some companies require participants to *pay the entire retiree premium cost* (39% in 2000, up from 31% in 1997; Hoffman 2003). More than half of plans now provide only *partial prescription drug coverage*, sometimes as separate stand-alone; most emphasize mail-ordering of drugs. The majority of plans now set *eligibility standards* based on age and service. Further, some employers have dropped retiree medical benefits *for all new hires* (Kaiser 2004),[5] and others have *terminated* their retiree health plans for *all* employees.[6] An alternative approach has employers moving to a Health Saving Account (HSA) which is a *defined contribution* model.[7]

[5] As Neuman (2004) notes: "Sears Roebuck and Company recently announced that, starting January 2005, retiree health benefits will no longer be available for new hires and will be eliminated for all employees under age 40.1 Aetna recently announced it would cut subsidies for retiree health benefits for those who retire in 2004.2 Lucent Technologies, Inc. did not eliminate benefits but made severe cuts in retiree health coverage and substantially raised retiree contributions to premiums."

[6] Neumann reports: "The prevalence of retiree health coverage has declined dramatically over the past 15 years. Among large employers (200+ workers), who are far more likely than small or mid-sized employers to offer retiree health benefits, the percentage offering retiree coverage has dropped from 66 percent in 1998 to 38 percent in 2003." Mercer's Human Resource Consulting group reports that larger firms (500+ employees) providing retiree health plans fell from 46% to 29% between 1993 and 2001.

[7] Scandlen (2000) notes: "[E]mployers make funds available to employees, who would use that money to purchase coverage in the individual market. The money would remain tax-advantaged because it would be available solely for the purchase of health insurance. Employers might reimburse their workers for paid premiums, or they might use payroll withholding and send payments directly to the employee's chosen carrier. The employee would choose from any insurance plan available on the market and would be the policy holder. If the worker changed jobs, he or she would continue the exact same insurance plan, paying premiums directly from his or her own resources. When the worker got a new job, the new employer would make the contribution it could afford to the same plan."

A variant on this approach links the defined contribution to a "Consumer Driven Health Care Plan" (CDHP), which permits active workers to accumulate funds toward their retiree medical plan (CDHC, 2004).[8] Clearly, this is a time of great change in the retiree medical benefit marketplace.

2. Retiree Medical Benefits at the University and Selected Comparators

The University of Pennsylvania for some time had offered retiree medical insurance benefits to those who left the University at or after age 55 with at least 15 years of service (55+15), or age 62 with at least 10 years of service (62+10).[9] Given eligibility, those who left the University were not required to enroll in the retiree medical plan immediately on termination; rather, they could defer electing University-sponsored retiree medical benefits until a future date. Eligible retirees' dependents were also eligible for immediate or deferred retiree medical benefit coverage. When the Task Force first met, eligible pre-65 retirees were permitted to enroll in the University's retiree medical plans offered to active staff and faculty, while those age 65+ could enroll in an indemnity plan integrated with Medicare or in one of the two Medicare Risk HMOs. Most (93%) of Penn's Medicare-eligible retirees had been enrolled in the indemnity plan, the Blue Cross 65 Special Plan.

In terms of premiums, there were two main groups of current retirees, distinguished by when they had left the University. One group satisfied eligibility criteria prior to July 1, 1996, and retired members of this group (and their dependents) were not responsible for any portion of the premiums for University-provided retiree medical benefits. This first group the Task Force termed the *"pre-1996 retirees*." The second set of retirees (and dependents) included all who met eligibility requirements and left after July 1, 1996, referred to below as the *"post-1996 retirees"*. Members of this second group had since retirement paid a portion of their retiree medical insurance premiums. This premium-

[8] In this framework, the employer commits a fixed dollar amount for each worker's health plan; the account is unfunded and consists of employer monies only; the active worker uses the pre-tax health account to pay health care bills; unspent funds can be rolled over from one year to the next; at retirement, the account can be transferred to another unfunded retiree account; the employee must purchase a high-deductible ("catastrophic") health plan to cover major medical expenses; and employees receive information on provider quality and get discounted prices. Most CDHCs have a coverage gap or "doughnut hole", where, after their pretax account is exhausted, employees pay full health care costs out-of-pocket until they reach the deductible for the high-deductible insurance. The logic is that employees will be more cautious about utilization and have an incentive to curtail utilization, since they get to keep unspent money in the tax-protected account. Because CDHPs are still very new, relatively few large employers have adopted them, and relatively few catastrophic plans are on the market. Also some worry that adverse selection might result if CDHPs are one of several options offered – the healthy might choose them, leaving the sick behind in the other plans, and some might not get preventative care, since they save money if they don't go to the doctor or because it is too complex.

[9] All service had to be full-time and continuous.

sharing was a complex arrangement, set at 50% of the full premium (for life) if retirees left at age 55; for eligibles who left after age 55, the University subsidy rose by 2% per year of age to a maximum of 70% if the eligible individual retired at age 65. Of the entire group of 3,200 living retirees and dependents receiving medical care benefits from the University, approximately half (or 1,600) were in the pre-1996 retiree group for whom the University then paid 100% of the premium; the remainder paid between 50-70% of their retiree medical premiums. Under the existing retiree medical offerings (which had changed over time), all retirees (and dependents) also had medical co-payments and deductibles as well as other out-of-pocket costs.

The Task Force review of the environment for retiree medical plans at other institutions of higher learning also highlighted several interesting findings. Close to home, we learned that the University of Pennsylvania's Health System had eliminated retiree medical benefits for all new hires effective July 1, 2000. [10] At other schools, we found that, at the time of the Task Force review, some universities offered no retiree medical plan. Some schools offered only supplemental plans to Medicare for the 65+ group, while a few schools offered retiree medical indemnity plans. When it came to employer subsidies for retiree medical premiums, our review found that some schools subsidized none of the retiree medical premiums, while others paid a portion of the premiums to a cap. Others subsidized the entire premium but only for the lowest-cost plan and only for the retiree (thus premiums of family members were not subsidized).

RATIONALE FOR CHANGING PENN'S RETIREE MEDICAL PLANS

Projected future increases in University costs for retiree medical benefits over the next decade and substantial administrative complexity of the current plans implied that the University of Pennsylvania had to do more to contain retiree medical costs, while remaining committed to offering retiree medical coverage to eligible staff and faculty. The Task Force considered several environmental factors in its assessment:

[10] Some transitional grandfathering provisions were introduced for various combinations of age and service, including COBRA benefits for dependents, an annual cap of $150 for contributions by UPHS, and subsidized medical premiums for some individuals near retirement.

1. Accounting changes under FAS 106

The Financial Accounting Standards Board (FASB) in its Statement of Financial Accounting Standards No. 106 requires the University to report several values on its financial statements:

- *The present value of retiree medical benefits "accrued" to date*, using assumptions regarding mortality, claims costs, medical inflation, return on assets, discount rate, participation (% electing coverage), turnover, and retirement ages. These projected benefit costs must be calculated based on the liability to current retirees and potential liability to current employees who may later opt for the program. This liability, known as the accumulated projected benefit obligation (APBO), stood at $274 million in present value as month-end June 2004 [11] (ignoring the potential effect of the Medicare Drug Reform effective 1/1/06).
- *The annual expense for the retiree medical plan* must also be reported. This is typically higher than actual annual payments for retiree medical benefits (on a pay-as-you-go basis), since it requires amortizing the liability determined on the date FAS 106 went into effect. This amount is adjusted by added and terminated lives as well as deviations from actuarial assumptions made. This liability is amortized over the employees' working lifetimes (excluding the retirement years).
- *The balance sheet liability* which is the unfunded obligation minus plan assets (if any) that have been set aside in trust. This unfunded liability represents a real claim on University revenues, and therefore it has a negative effect on the University's credit status (for bond rating purposes).

When the Task Force first met, the annual expense for retiree medical benefits reported by the University was $30 million, a figure projected to rise in the future if nothing were done to cap premiums and/or benefit growth. The University projected contributing $16 million per year, of which $13 million represented annual cash outlays to retirees, and $3 million was devoted to retiree medical trust fund contributions. The difference between $30M and $16M represented an unfunded liability which would rise as retiree medical costs escalated. If the University were to prefund the full annual retiree medical expense, some way would have to be found to charge the employee benefit (EB) pool about twice

[11] The Task Force believes that this number may grow faster than projected due to very conservative assumptions regarding mortality tables, rates of return on investment, discount rates, and other factors. We urge the Administration to review and update these assumptions, not only for the purpose of valuing retiree medical obligations but all other benefit obligations as well.

what is being charged now, to cover the full $30 million annual expense instead of the current $16 million. Moving to full funding of the retiree medical expense would in turn require boosting the employee benefit rate from the current 32% of payroll to about 35%.[12] It should be noted that in addition to the above expenses, the University was also paying $13 million in Medicare payroll taxes each year (1.45% of salaries), included in the EB pool. The Task Force was concerned that raising the rate of prefunding to higher levels could require active workers to forego salary increases, and it also would imply that researchers would present less competitive bids for grant proposals due to higher EB rates.

2. Legislative and Regulatory Changes:

At the time the Task Force was meeting, the 2003 Medicare Prescription Drug, Improvement, & Modernization Act had been passed but is projected impact was unknown regarding possible impacts on medical plan and particularly prescription drug costs. But it was clear that Medicare changes would alter employer-based health insurance plan estimated costs and benefits. For instance, some employers expected to receive a subsidy to maintain a prescription drug plan comparable to that offered by Part D for Medicare-eligible retirees. Furthermore, a recent EEOC ruling permitted employers to coordinate benefits with Medicare without violating the Age Discrimination in Employment Act. Both changes, but particularly the Medicare bill, made the offering and costing of retiree medical plans more uncertain.

3. Administrative Complexity

The existing retiree medical contribution structure at Penn embodied 10 different layers of medical rates for each plan option. Since there were also five plan options available to pre-65 retirees, and three for Medicare-eligible retirees, this resulted in 80 layers of rates to calculate and explain. The complexity multiplied when retirees and their dependents were in split contracts because of their ages. The University subsidy also started at 50% for someone age 55 and increased by 2% per year of age to 70% for someone age 65; this approach discouraged early retirement. A last complexity was that eligible employees who left the University and who qualified for retiree medical coverage were permitted to defer electing such coverage until they deemed necessary. Consequently, the University needed to track potential participants and their dependents and, when they apply for coverage, seek verification of their eligibility status. As FAS 106 liability measures are

[12] Half of this (e.g. 1.5% of payroll) would be attributable to ongoing funding costs and would have to be incurred in the steady state, and the remainder would be required to amortize the unfunded past liability over a period of 15 years.

affected by participation, adjustments in the calculations were not made if the University was not notified of a retiree's death.

TASK FORCE RECOMMENDATIONS AND CHANGES ADOPTED

The Task Force recommended several changes in the retiree medical plan policies and offerings, guided by several key objectives:

- Seek to maintain a viable and competitive (relative to Penn's peer group) retiree medical plan for current and future retires;
- Balance the University's desire for cost predictability with the need to provide retirees with some medical care protection,
- Better manage future costs, including long- term cost reduction when compared to the current program;
- Simplify plan offerings, pricing and administration.

After lengthy debate, several changes were adopted in key aspects of the retiree medical program, in terms of benefit eligibility, plan design, and premium sharing. This took into account the long lead-time required in phasing in any changes, and the negative cost consequences of delaying change in the program offerings:

1. Benefit Eligibility: We proposed that the University immediately establish new eligibility rules determining which employees may participate in the program, based on a combination of age and service. Specifically we proposed that:

- Current employees and new hires would have to satisfy an age requirement of age ≥ 55 and service years ≥ 15 or age ≥ 62 and service years 10, and age + service must total at least 75 to be eligible for retiree medical plan coverage.[13]
- Those eligible under the new rules would have to enroll within 60 days from their last day of service and maintain continuous coverage thereafter. Those who elect not to enroll cannot elect coverage at a later date. Only eligible dependents enrolled on the last day of the employee's active benefit eligibility would be eligible for coverage, except for college-age students who have a qualifying event.
- Former employees eligible for coverage under the old rules who left prior to 7/1/96 would have no new dependents entitled for coverage after 2005. Eligible retirees who

[13] Employees who meet the old eligibility requirements within 3 years of the 1/1/06 start date of these new eligibility rules will be grandfathered.

left on or after 7/1/96 would be able to cover only eligible dependents as of the last day of employment.
- If an eligible former Penn employee were to be rehired full time at the University of Pennsylvania, that employee would have to elect active medical plan coverage while employed. On subsequent termination, the policies, procedures, and premiums in effect at the second termination date will apply.
- Retirees who waive coverage cannot re-enroll in the plan.

All of the above recommendations were adopted by the University Administration and are currently in effect.

2. Plan Design: We proposed that the University adopt several changes in the plan design, to be implemented in January of the target plan year. In practice this was to be in January, 2006. (See Tables 1 and 2)

- Pre-65 retirees were to be offered several retiree medical plans that emphasize managed care (POS and HMO plans) as well as a PPO plan, but not the traditional indemnity plan. Post-65 retirees would be offered the same plan choices plus an indemnity plan (due to the fact that many retirees live out of the service area for the managed care plans).
- The prescription drug plan for all retirees was to be carved out, to ease the transition from active to retired status and enable better tracking of utilization. Participants would be allowed to elect the Medicare Prescription Drug Plan if they preferred (under the Medicare new rules), for a reduction in their premiums.
- Participants would be able to elect changes in medical plans during an open enrollment period each year, subsequent to participant education and communication efforts.

The design eventually adopted included a second Indemnity Plan Y for Medicare-eligible retirees, which proved less expensive than the existing Indemnity Plan X and which would therefore give the retirees more flexibility depending on how much risk they are willing to undertake. The POS plan was eliminated because it had so few participants. In addition, out-of-pocket costs were increased for the medical and prescription drug plans.

3. Benefit Subsidy: We proposed a new arrangement for sharing the cost of retiree medical plan coverage between Penn and retirees, to be implemented in January of the target plan year. The proposed options included:

- For current employees, new hires, and retirees who left service on or after 7/1/96: the University would pay 60% of the lowest-cost medical plan option, and 60% of the prescription drug premium.
- For retirees who left service prior to 7/1/96, the University would pay 100% of the lowest-cost medical plan option and 60% of the prescription drug premium. An alternative option would be for the University to pay 100% of both the lowest-cost medical and the prescription premium. The choice between these two would depend on the Administration's assessment of the alternatives' affordability, the feasibility of communicating the changes to the pre-1996 group of retirees, and the University's view of the appropriateness of the change.

The final design actually adopted gave the 60% subsidy to current employees, new hires, and retirees who left service on or after 7/1/96. However, for dependents of new hires (or those starting 1/1/06 and later), the University would pay 30% of the lowest-cost medical plan option and 30% of the prescription drug premium for dependents. Retirees who left service prior to 7/1/96, would continue with the University's 100% subsidy for both the medical premium and the prescription drug premium.

Observations:

- In our view, these recommendations balanced what the Task Force perceived as the need to *maintain group access* to medical plans for retirees, with the need to offer age 65+ retirees some *choice* over medical coverage including an indemnity plan for out-of-area retirees. Accordingly the new design included both elements.
- Having retirees share in a higher percentage of the costs of medical and prescription drug coverage served to *reduce FAS 106 liability levels and growth rates*.
- The Task Force initially proposed that the full University *premium subsidy* for those who retired before 7/1/96 be set at the cost of the least expensive medical plan and 60% of the cost of the prescription drug plan, to encourage cost-containment in this group while reducing the FAS liability. After feedback from the University community, the Administration recommended that the full subsidy be continued even though there was no clear legal requirement to do so.

- Cost containment also motivated the recommendations to *tighten eligibility* requirements for retiree medical insurance and *simplify* premiums and administration.
- We felt it important to *carve out* the retiree prescription drug plan so as to be more flexible in view of future Medicare changes.
- We also emphasized the need to communicate and include changes on the calendar in time to roll them out for the target plan year.

IMPACT AND COMMUNICATIONS

In view of the importance of retiree medical benefits for faculty and staff, the Task Force recommended that the University Human Resources Office devote a substantial effort to educating both active and retired members of the University community regarding why the benefits package had to be changed and the potential impact of the changes. One thing that we are now cognizant of is the long lead time required for changes of this nature. This is because of the lengthy implementation period required for changes in plan design, due to the need for bidding out the plans, informing the participants, and implementing the new system. For others seeking to make similar changes, we would emphasize that taking action requires allowing time for transition.

The Task Force also sought to evaluate potential premium implications of the proposed changes in premium structure, in an effort to illustrate how the changes might be communicated to retirees. Projecting potential impact is inherently a tenuous exercise, since we did not know future plan year costs nor could we predict which retirees might opt for which plans. To help in the assessment and to illustrate the type of communication effort required, we offered a first-round assessment of possible changes in premiums under some reasonable assumptions regarding changes in plan costs. Table 3 shows what was sent to retirees, illustrating costs to Medicare-eligible retirees and the employer if the University picked up 60% of both medical and prescription costs for post-1996 retirees, and 100/60% of medical/Rx costs respectively for pre-1996 retirees, assuming prior year costs.

Comparing columns 3 and 9, we see that the post-1996 single retiree in the Medicare Advantage Plan C would experience a premium increase from $ 93 per month to $ 131; however if that retiree switched to the Medicare Advantage Plan D (a lower cost plan), his premium would rise by less, to $26 or $ 119 per month. The Task Force sought to provide some illustrative figures to indicate that although the costs represented a significant additional burden for retirees, the additional premiums would help keep down

co-payments and deductibles, thus protecting the truly ill from shouldering an ever-increasing source of the cost of retiree medical benefits. Since inflation projections were included in the illustrative rates, the actual rates set for 2006 at plan rollout proved similar to those in the illustration.

As part of the redesign, a voluntary discount dental plan was introduced on a fully contributory basis, offering enrolled retirees using participating providers an average discount of 28%. A group Long-Term Care Plan was also offered to retirees and other eligible family members, with premiums set by the insurer and paid by retirees (set as a function of age and the level of benefit elected).

FINANCIAL IMPACT ON THE UNIVERSITY

The proposed changes in plan offerings and subsidy patterns for retiree medical premiums had financial consequences for the University's unfunded liability as well as for the annual expenses associated with retiree medical insurance offerings. At the time we made the proposal, and if the University had immediately implemented the proposed changes in plan design and eligibility, without changing the premium structure as outlined above, the actuary engaged by the University estimated that the total accrued post-retirement benefit obligation due to retiree medical benefits would decline from $273.8 M (as of 2005 on) to $228.5M. The unfunded obligation that the University would have to recognize would decline from $178.3M to $132.9M [14]

IMPLEMENTATION

After the Administration had accepted the Task Force Report and adopted most of its provisions, considerable efforts were made by the Office of the Provost and the Division of Human Resources to communicate the new program to plan participants. Retirees, their beneficiaries and active employees learned about the preliminary redesign proposals on March 15, 2005 when they were published in the University's official newsletter. That

[14] If the University adopted both the plan design/eligibility changes and the changes in premium, estimated cost savings would have been greater. For instance, if the subsidy were set at 60% of the lowest cost option for medical benefits (100% for pre-1996 retirees) and 60% of the prescription drug option for all, the accrued post-retirement benefit obligation due to retiree medical benefits would fall from $273.9 M (from 2005 forward) to $188.5M and the unfunded obligation that the University must recognize would fall from $178.3M to $93M. If instead, the University subsidized 60% of the lowest cost option for medical benefits and the same fraction of the prescription drug option for the post-1996 retirees, but 100% of both the lowest cost medical benefit and drug plan for the pre-1996 retirees, the cost savings are less. Thus the projected accrued post-retirement benefit obligation due to retiree medical benefits would fall from $273.9 M (from 2005 forward) to $205.4, and the unfunded obligation that the University must recognize would fall from $178.3M to $109.9M.

article generated more than 300 comments, ranging from requests for clarification of the changes, to disagreements with the proposal to charge all retirees. (Currently more than half of all of retirees have fully subsidized retiree healthcare premiums.) In addition, presentations were made for the Committee on Personnel Benefits, the Faculty Senate, Deans, other select University groups, committees, and Senior Management. These groups then participated in communicating the redesign plan to their constituents. The final plan design was published in the University official newsletter on September 20, 2005, indicating a start date of January 1, 2006 for the new plans.

The first open enrollment for retirees was held from October 31 to November 10, 2005. The enrollment package, sent to the retirees' home addresses, contained the materials describing the new elements of the program including the new Medicare prescription drug program, the enrollment steps and brought out the implications of not enrolling, premium charts illustrating retiree and University contribution amounts; plan comparison charts; detailed instructions on how to enroll in the plan; a Notice of Creditable Coverage which shows that the University's prescription drug plan design is better than that of Medicare part D, and a description of the new discount dental plan and the long-term care plan. Thereafter there were several informational meetings and fairs where representatives from the key program providers, Medicare, the Social Security Administration and the third-party administrator were invited. At the meetings and fairs, retirees had the opportunity for one-on-one sessions with the providers and the benefits officers and staff from the Human Resources Division. A high degree of commitment and personal contact was required to insure the success of this transformational change.

ENROLLMENT RESULTS

During the enrollment period, more than 600 calls were received by Retiree Assist and the Human Resources- Benefits Office. Because of Medicare's complex provisions under the newly launched prescription drug program, retirees sought help in understanding the provisions of Medicare's plan versus the University's offering. Other questions related to reimbursement procedures by vendors, clarifications of the plan design changes, premium increases and methods of remitting premiums to Retiree Assist.

When the enrollment phase closed, approximately 90% of eligible retirees had enrolled in the medical plan offerings. Of those enrolled, 58% retired before July 1, 1996 and have fully subsidized premiums; the remaining 32% remaining retired after that date and are

required to contribute to the cost. [15] Of the 10% who did not enroll, four waived while the rest deferred enrollment (those retiring prior to January 1, 2006 were still allowed to do this). The smoothness of the open enrollment process and the high degree of enrollment can be attributed to the advance planning, scheduling, and coordinated efforts of the Division of Human Resources and the providers.

SUBSEQUENT DEVELOPMENTS

While the first-round enrollment process was a success, several ongoing challenges remain. One issue is that the database on retirees contained some discrepancies which surfaced when the files were sent to Medicare so that the University could obtain its subsidy for keeping its prescription drug plan. Another is that some retirees have failed to respond to communications from the University, perhaps because of advanced age or because they are unused to receiving written benefits communications. Still another consideration is that the enrollment process revealed that some surviving spouses were using their deceased retirees' numbers, and some have difficulty understanding why this will not work for modern-day recordkeeping. Other challenges included the following:

- Medicare's plan has been difficult to comprehend because of multiple offerings by approved Prescription Drug Providers (PDPs). In the Philadelphia area alone, 40 plans are being marketed to retirees. This has resulted in some double enrollment by retirees (i.e., in Penn's plan and in Medicare Part D) resulting in Penn's loss of the 28% subsidy.
- The carved-out prescription drug program may not always reimburse medications covered by retirees' previous drug plans, resulting in refusals by drugstores and retiree calls to Retiree Assist and the benefits office.
- Split contracts arise where the retiree is Medicare-eligible while the spouse is younger than age 65 (or vice versa) and either retired or still working. This causes problems because different options are available to the two. The University has taken the position that when the spouse eventually falls in that group, he/she should follow the retiree who was the former employee.
- Keystone and Aetna, the Medicare Advantage providers, have indicated that no enrollments are possible in their plans without first being enrolled in Medicare. This has caused some timing issues in enrolling in Penn's plans because of the 90-day period

[15] There were only 200 retirees below the age of 65, and most of them (90%) elected the PPO option while the rest were split between the two HMOs In the Medicare eligible group, over 90% stayed in the existing indemnity plan, , only two enrolled in the new lower cost indemnity plan and the rest joined the Medicare Advantage plans. Nineteen retirees did not choose Penn's prescription drug program.

needed for Medicare enrollment and the inability of retirees to make timely applications.
- In an effort to get some savings, Medicare has been moving some prescription reimbursements from Part B to Part D. This has required a continuous review of Caremark's program in order to make it equivalent to Medicare.

FOR FUTURE REVIEW

The Task Force discussed several other approaches but did not recommend that they be immediately implemented. Nevertheless, many of these items will likely require attention by a future task force or benefits committee charged with evaluating retirement benefits for faculty and staff. These include:

- A Health Saving Account (HSA) would permit the University to establish a funded account and finance benefits in a tax-deductible manner. With an HSA, the employees can make contributions to the trust which continues after retirement. In addition, the unused balances can be transferred to beneficiaries. A disadvantage is that offering an HSA is easiest when the employer has no plan, since it is unclear how to treat employees nearing retirement who have not accumulated much of an HSA entitlement.
- A catastrophic medical plan must also be established along with the HSA, thus providing lower-cost coverage for truly expensive medical events. This might, for instance, be offered to new hires.
- A Retiree Medical Account (RMA) is a notional account available upon retirement. The RMA is usually a stand-alone plan and may or may not be accompanied by a catastrophic retiree medical insurance plan. This has the disadvantage of not maintaining group access which the Task Force felt was important. In addition, unused balances are forfeited.
- Prefunding all retiree medical benefits would raise reported benefit costs by an estimated annual 3 percentage points of payroll. Many members felt that boosting the funding level could enhance benefit security, but at the same time, they recognized that more prefunding would compete with salary increases to current faculty and staff. Furthermore, it would make grant proposals from the University less competitive than peer institutions which lack a commitment to retiree benefits and funding.

Furthermore, ongoing changes in Medicare Part D may require that the University re-examine prescription drug coverage alternatives.

The Task Force also proposed that the Medicare subsidies be carefully evaluated and directed back into the retiree medical pool if possible, in the future. One option would be to reduce the level of retiree medical plan underfunding; another would be to mitigate part of the increase in premiums retirees might experience as a result of its proposals. Finally, the group recognized that many unknowns will affect retiree health benefits in the future, including Medicare and tax law changes that might disfavor employer-sponsored medical plans. The Task Force strongly advised that the University must remain attuned to these and other competitive challenges in the marketplace, to continue to attract, retain, compensate, and successfully retire employees. To track these, and in view of the importance of retiree benefits in the compensation package, and their utility in the attraction, retention, and retirement process for staff and faculty, the Task Force recommended that the University establish a standing committee or subcommittee of the Committee on Personnel Benefits to evaluate retiree benefit offerings on an ongoing basis.

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TABLE 1. RETIREE MEDICAL OPTIONS/PREMIUM SHARING

	Retiree Plan Options		Retiree Premium Sharing	
	Pre-65 Retiree	**Medicare - Eligible Retiree**	**Pre-65 Retiree**	**Medicare Eligible - Retiree**
	(1)	**(2)**	**(3)**	**(4)**
Eligible Former Employees Left service < July 1, 1996 at age ≥ 55 and ≥ 15 years of service or age ≥ 62 and ≥ 10 years of service. (service = full-time, continuous) No new dependents starting 1/1/06.	PPO HMO A HMO B RX	Indemnity Plan X Indemnity Plan Y Medicare Advantage Plan C Medicare Advantage Plan D RX*	a) University pays 100% of medic premiums for all plan options fo retiree and spouse/partner.** b) University pays 100% of prescription premium for retiree spouse/partner.	a) University pays 100% of medical premiums for all plan options for retiree and spouse/partner. b) University pays 100% of prescription premium for retiree and spouse/partner.*
Left service > July 1, 1996 at age ≥ 55 and ≥ 15 years of service or age ≥ 62 and ≥ 10 years of service. (service = full-time, continuous) Only eligible dependents enrolled on last day employed.	Same as above	Same as above	a) University pays 60% of lowest cost medical plan premium for retiree and spouse/partner.** b) University pays 60% of prescription premium for retiree and spouse/partner.**	a) University pays 60% of lowest cost medical indemnity plan premium for retiree and spouse/partner. b) University pays 60% of prescription premium for retiree and spouse/partner.*
All Current Full-Time Employees Age ≥ 55 and ≥ 15 years of service or age ≥ 62 and ≥ 10 years of service on the last day employed and age + service ≥ 75*** (service = full-time, continuous) Only eligible dependents enrolled on last day employed.	Same as above	Same as above	Same as above	Same as above
New Hires (full-time only) Age ≥ 55 and ≥ 15 years of service or age ≥ 62 and ≥ 10 years of service on the last day employed and age + service ≥ 75. (service = full-time, continuous) Only eligible dependents enrolled on last day employed	Same as above	Same as above	a) University pays 60% of lowest cost medical plan premium for retiree and 30% for spouse/ partner.** b) University pays 60% of prescription premium for retiree and 30% for spouse/partner.**	a) University pays 60% of lowest cost medical indemnity plan premium for retiree and 30% for spouse/ partner. b) University pays 60% of prescription premium for retiree and 30% for spouse/partner.*

* Participant may elect Medicare Prescription Drug Plan (PDP).
** Pre-65 premiums are blended with premiums for actives; University will consider moving to stand - alone approach.
*** Implement three (3) years from effective date.
The University reserves the right to amend, alter, change, or suspend the benefit offerings at any time and for any reason.

TABLE 2. RETIREE MEDICAL POLICIES/ADMINISTRATIVE PROCEDURES

Policies & Procedures	Decision by Administration (effective 1/1/06)	Current Practice
a) Electing Retiree Medical Coverage	Eligible employees must elect or waive retiree medical coverage 60 days prior to their last day of service. Employees who do not enroll cannot elect coverage after the above window. A decision to waive retiree medical coverage is irrevocable.	Eligible employees may elect retiree medical coverage after leaving service or at a later date.
b) Dependents of Employees Who Left Service Prior to 7/1/96	Eligible employees who left service prior to 7/1/96 may not add new dependents as of 1/1/06.	Eligible employees are allowed to add new dependents after their last day of service.
c) Dependent Coverage	Dependents are eligible if enrolled in an active medical plan when the employee left service. However, an eligible dependent child qualifies for benefits when medical coverage under another plan is canceled even if he/she was not previously enrolled in Penn's plan.	Dependents are eligible if they qualified for medical coverage under the active plan on the employee's last day of service.
d) Eligible Dependent Children of Deceased Retiree Medical Participant	No change in policy.	Retiree medical coverage continues for eligible dependents.
e) Surviving Spouse, Same Sex Domestic Partner and Dependent Children of Deceased LTD Employee		
1) Employee not Eligible for Retiree Medical Coverage	No change in policy.	Medical coverage continues under COBRA for 36 months.
2) Employee Eligible for Retiree Medical Coverage	No change in policy.	Retiree medical coverage continues for eligible dependents.
f) Change Retiree Medical Election Period	During the selection period in November, participants can elect medical changes for the following calendar year. Changes may be allowed outside of the annual selection period due to certain qualifying events.	Changes are allowed during a calendar year or a rolling year (one year from the last transaction date).
g) Reinstatement of Retiree Medical Coverage for a Retiree in Payment Arrears	Reinstatement of coverage is only permitted when past due premiums are paid during the 90-day period from the time the payment is first due; thereafter, coverage is permanently cancelled.	Medical coverage is cancelled when premium payments are 90 days past due. Coverage is reinstated after past due premiums are paid in full.
h) Covered Eligible Former Employee is Re-employed Full-time and Subsequently Leaves Service	Policies, procedures and contributions in effect at second termination date will apply.	Medical contributions and eligible dependents recorded at initial termination date apply when an employee leaves service for the second time.
I) Covered Eligible Former Employee is Re-employed	Employee must elect active medical coverage	Employee may elect active medical coverage or continue coverage in retiree medical plan.

The University reserves the right to amend, alter, change or suspend the benefit plans offerings at any time and for any reason.

TABLE 3. ILLUSTRATIVE RETIREE MEDICAL PREMIUMS: MEDICARE-ELIGIBLE PLANS BASED ON PROJECTED RATES PER PARTICIPANT

Left Service prior to July 1, 1996

	Old Premium-Sharing			Proposed Shift in Premium-Sharing					
	Contribution Amounts			PENN Contribution			Retiree Contribution		
	PENN	Retiree	Total	Prescription*	Medical**	Total	Prescription	Medical	Total
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Medicare Advantage Plan C									
Single	$309	$0	**$309**	$117	$102	**$219**	$78	$12	**$90**
Medicare Advantage Plan D									
Single	$297	$0	**$297**	$117	$102	**$219**	$78	$0	**$78**
Indemnity Plan X									
Single	$341	$0	**$341**	$117	$102	**$219**	$78	$44	**$122**

Left Service July 1, 1996 and after

	Old Premium-Sharing			Proposed Shift in Premium-Sharing					
	Contribution Amounts			PENN Contribution			Retiree Contribution		
	PENN	Retiree	Total	Prescription*	Medical**	Total	Prescription	Medical	Total
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Medicare Advantage Plan C									
Single	$216	$93	**$309**	$117	$61	**$178**	$78	$53	**$131**
Medicare Advantage Plan D									
Single	$208	$89	**$297**	$117	$61	**$178**	$78	$41	**$119**
Indemnity Plan X									
Single	$239	$102	**$341**	$117	$61	**$178**	$78	$85	**$163**

Prior to July 1, 1996

* The University's proposed share of prescription is 60% of the prescription premium.

** The University's proposed share of medical is 100% of the lowest medical premium.

July 1, 1996 and after

* The University's proposed share of prescription is 60% of the prescription premium.

** The University's proposed share of medical is 60% of the lowest medical premium.