

Use of Individual Medicare Marketplaces for Public Sector Retiree Health Care

A Guide For Elected Officials



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Introduction

Pension security for public employees has attracted a great deal of attention, but without retiree health care coverage, retirement is not very secure. Retiree health care plays a critical role in overall compensation offerings, especially in professions such as public safety, which include jobs that have traditionally had earlier retirement ages. Retiree health care coverage varies across the country, ranging from no coverage, to access to health insurance with no financial support, to comprehensive plans with little cost to the retiree.

The state and local governmental workforce is aging. In 2018, 41.3 percent of state government workers and 44.8 percent of local government workers were between the ages of 45 and 64, compared with 34.6 percent of private sector workers.¹ While different worker cohorts have different age requirements for retirement, and not all workers participate in Social Security via their current job,² 12.1 percent of state and local government employees are over 62 years of age.³ Although retiree health care does not typically have the same constitutional or statutory protections as pensions, 89 percent of retired state government employees under age 65 and 87 percent of retired state government employees over age 65 receive retiree health care benefits. Among local government employees, 62 percent of retirees under age 65 and 65 percent of those age 65 or older receive retiree health care benefits.⁴ Benefit levels can vary based on factors such as date of hire, date of retirement, and/or vesting eligibility.

While some states and localities have developed trusts and/or prefund at least some of their retiree health care costs, many are operating on a pay-as-you-go system, in which benefits are paid

The Aging State and Local Government Workforce — Quick Facts:

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Different worker cohorts have different age requirements for retirement, and not all workers participate in Social Security via their current job.

12.1 percent of state and local government employees are over 62 years of age.

87 percent of retired state government employees over age 65 receive retiree health care benefits.

65 percent of local government retirees over age 65 receive retiree health care benefits.

Benefit levels can vary based on factors such as date of hire, date of retirement, and/or vesting eligibility.

Sources: IPUMS CPS, NASRA, BLS

annually out of general fund revenue, as opposed to accumulating assets to prepare for the cost of future retirees. The approach of not adequately funding retiree health care has resulted in substantial unfunded liabilities due to the lack of accumulated assets. As of FY 2017, approximately \$673 billion, or 93 percent, of state other post-employment benefit (OPEB) liabilities were not funded by assets. As a result, governments are promising a benefit for which they have only set aside 7 percent of the total cost—a circumstance that may cause some to question policymakers' commitment to funding the benefit. On a per capita basis, state OPEB unfunded liabilities vary substantially, ranging from zero or near zero to more than \$8,000.⁵

Changes in the accounting and reporting standards for employers that sponsor retiree health care benefits,

GASB — Quick Facts:

Changes by GASB to the accounting and reporting standards for employers that sponsor retiree health care benefits have made concerns about unfunded liabilities even more acute among state and local employers.

GASB Statement 45, issued in June 2004, was the first-of-its kind accounting and financial reporting standard requiring government employers to measure and report all OPEB liabilities.

GASB Statement 75 (replacing GASB 45 in 2015) brought the importance and impact of liabilities even more to the forefront.

With GASB 75, the net OPEB liability (NOL) must be included in the balance sheet of the plan and in the income statement of the employer, rather than in the notes of the plan, as was previously allowed for reporting the unfunded actuarial accrued liability (UAAL) under GASB 45.

issued by the Governmental Accounting Standards Board (GASB), have made concerns about unfunded liabilities even more acute among state and local employers. In particular, GASB Statement 45, issued in June 2004, was the first-of-its kind accounting and financial reporting standard requiring government employers to measure and report all OPEB liabilities.⁶ While government employers were paying increased attention to reporting of these costs with Statement 45, the issuance of GASB Statement 75 (replacing GASB 45 in 2015) brought the importance and impact of liabilities even more to the forefront. With GASB 75, the net OPEB liability (NOL) must be included in the balance sheet of the plan and in the income statement of the employer, rather than in the notes of the plan,⁷ as was previously allowed for reporting the unfunded actuarial accrued liability (UAAL) under GASB 45.⁸

Rising retiree health care costs and changes in accounting standards are making unfunded liabilities more prominent, and states and localities are taking a variety of actions to mitigate these costs. These include changing eligibility requirements (e.g., increasing the age for eligibility or number of years of service required for receiving benefits), reducing the employer contribution to premiums, reducing coverage for non-Medicare eligible and/or Medicare-eligible retirees, and modifying plan choices and administration, among other strategies.⁹ As state and

local government employers continue to compete with the private sector to attract and retain talented workers, these changes to retiree health care benefits can be particularly problematic, undercutting the traditional social contract of lower pay in exchange for long-term job and retirement security, which has attracted many individuals to public sector work.¹⁰

Lawmakers wear many hats, so it can be difficult for them to have a firm grasp of the complicated issues involved in the provision of retiree health care for state and local government workers. With this in mind, the purpose of this report is to provide elected and appointed officials with a basic understanding of an individual Medicare marketplace. Also known as an individual Medicare exchange, this is a model that some state and local governments are adopting with noticeable savings. For example, a transition by the City of Memphis to the individual Medicare marketplace resulted in savings of approximately \$2,000 per year in out-of-pocket costs for retirees, as well as reductions in premiums and coinsurance costs. Memphis achieved an annual savings of \$5 million and reduced its OPEB obligations by \$319 million.¹¹ When the Ohio Public Employees Retirement System (OPERS) transitioned their Medicare-eligible retirees to the individual Medicare marketplace, OPERS saved more than \$12 billion, with more than \$625 million saved in 2016 and 2017.¹²

This report covers what individual Medicare marketplaces are, why state and local government plan sponsors are using them to deliver retiree health care, and what elected and appointed officials should know about them. It also addresses key implementation considerations, from the decision to transition and selection of a vendor, to communicating with various stakeholders and measuring outcomes. Finally, the report describes challenges and opportunities that states and localities face in using an individual Medicare marketplace. Links to additional resources are included at the end of the report. With this noted, all state and local governments face a unique set of financial, governance, and service challenges—there is not one best approach to addressing public retiree health care costs.

Overview of Individual Medicare Marketplaces

When state and local governments transition to an individual marketplace for Medicare-eligible retirees, they contract with a marketplace vendor, who then provides retirees with health insurance plan options and personal support for enrolling in a plan. The employer/plan sponsor then typically covers all or a portion of the retiree's health care costs through a health reimbursement arrangement, or HRA, a notional account that is used to reimburse the retiree for the premium and other medical expenses. These accounts are used to reimburse retirees tax-free for qualified medical expenses up to a fixed dollar amount per year, and unused amounts may be rolled over to subsequent years.

These marketplaces can be offered in conjunction with or separately from those for early retirees.

Individual Medicare marketplaces, though sometimes confused with the health insurance exchanges created by the Affordable Care Act (ACA), are not the same. Individual Medicare marketplaces are run by private vendors, specifically to service Medicare-eligible retirees and have been used for over a decade.

As of December 2019, three state retirement systems (Ohio, Nevada, and Rhode Island) and a number of local governments have transitioned to the individual Medicare marketplace model. According to analyses by the Kaiser Family Foundation, in 2018, 3 percent of state and local governments with 200 or more workers who offer retiree health benefits reported that they offer benefits through a private or corporate exchange. This is slightly lower than the 5 percent of private firms with 200 or more workers who offer retiree health benefits through a private exchange.¹³

Key definitions

Key term	Definition
Individual Medicare Marketplace	An alternative to group Medicare health plans, in which the sponsor of a state or local government's plan contracts with a marketplace vendor who enrolls their Medicare-eligible retirees into individual Medicare plans. The marketplace vendor also manages the reimbursement of medical premiums to the retiree through a health reimbursement arrangement (HRA).
OPEB	Other post-employment benefits (or OPEB) are benefits (other than pensions) that employers provide to their retired employees. These benefits principally involve health care benefits, but also may include life insurance, disability, legal, and other services. ¹⁴
GASB	Established in 1984, the Governmental Accounting Standards Board (GASB) is the independent, private-sector organization that establishes accounting and financial reporting standards for U.S. state and local governments that follow Generally Accepted Accounting Principles (GAAP). ¹⁵
GASB 45	Issued in June of 2004, GASB Statement 45 (Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions) was the first-of-its kind accounting and financial reporting standard requiring government employers to measure and report all OPEB liabilities.
GASB 75	Issued in June of 2015, GASB Statement 75 (Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions) replaced GASB 45. A key difference between GASB 45 and GASB 75 is the inclusion of the net OPEB liability (NOL) in the balance sheet of the plan and in the income statement of the employer, rather than in the notes of the plan.
HRA	Health reimbursement arrangements (HRAs) are employer-funded notional accounts from which employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year. Unused amounts may be rolled over to be used in subsequent years or not. The employer funds and owns the account.

Considerations for Elected and Appointed Officials

As states and localities consider how to effectively address looming OPEB liabilities while best meeting retiree needs, and the potential use of an individual Medicare marketplace, elected and appointed officials should consider the following:

1 Motivation for moving to an individual Medicare marketplace

What are the goals of transitioning from a group health plan to an individual Medicare marketplace? Does moving to an individual Medicare marketplace help achieve these goals? For example, will delivering retiree health care through a marketplace result in enough savings to help preserve the retiree health care benefit or make it sustainable? Does transitioning help reduce OPEB liabilities and annual health care costs? Does transitioning to an individual Medicare marketplace make sense for the employer/plan sponsor and/or for the retirees? What will moving to a marketplace do for them?

2 Cost implications

Will moving to an individual Medicare marketplace result in employer and/or retiree cost savings? Both short-term and long-term costs are important to consider. How do the plans on the individual Medicare marketplace compare with your current group Medicare plan (e.g., out-of-pocket expenses at point of service for retirees)? Is it important for the plan sponsor to reduce the risk of large claims that are endemic to self-funded group plans? Will it enable employers/plan sponsors to put more funding toward pension benefits? Elected and appointed officials need to think about the cost-sharing element of the benefit going forward. Does the move reduce the administrative burden for the plan sponsor? Does it allow them to redirect resources to other areas of need like active employee health care?

3 Paternalism

Traditional group retiree health care plans offered by states and localities take a paternalistic approach. With individual Medicare marketplaces, the decision-making responsibility is largely shifted to the retiree, with the help of a trained benefits advisor. This may feel like a big change to retirees who may have had fewer decisions to make when enrolling in their group Medicare plan. Will retirees feel overwhelmed? Will increased health care plans choice be desirable—and beneficial—to retirees? Will the increased decision-making responsibility be difficult for them as they age? Do they have the knowledge needed to make informed decisions?

4 Stakeholder needs

Where do stakeholder groups fit in? Will any changes to retiree health care create a pushback from unions and retiree associations? If so, how the plan sponsor deals with that will be key. It is important to understand the full range of retirees' and stakeholders' interests and concerns. Involve all stakeholder groups that will be affected (e.g., the overall employee base; cohorts with specific needs, such as public safety personnel; employee group representatives), and reach out to those who will be affected as soon as possible—ahead of board, legislative, or committee meetings and human resource (HR) office decision points.

5 Political environment

As is the case with all forms of retiree health care in the United States, any significant changes to the American health care policy landscape (e.g., move to a single payor system or to Medicare-for-all, other health care reforms) would have an impact on individual Medicare marketplaces. Consider whether

the marketplace will look the same five years from now as it does today. Given the lead time required to implement change, it may make sense to start discussions well in advance and fine-tune plans as policy conditions evolve.

Implementation of Individual Medicare Marketplaces by States and Localities

When switching to an individual Medicare marketplace, states and localities have a number of considerations to make pre-implementation, during implementation, and once the marketplace has been adopted. These include the decision to transition, the selection of a vendor, communications with stakeholders, and the measurement of outcomes.

Decision to Transition

As budget allocations for group retiree health care plans continue to rise, public employers and/or retirement plans need to find options that best meet their needs at the lowest cost. In the next 5 to 10 years, the average projection for annual health care inflation rates used by states is 7.2 percent; beyond 10 years, the average assumption for annual increases used by states is 4.5 percent.¹⁶ State and local government health expenditures have increased by an average of 4.2 percent annually between 2008 and 2017; employer contributions to insurance premiums have increased annually by an average of 5.2 percent; and employee contributions to insurance premiums have increased annually by an average of 4.5 percent.¹⁷ Further, employer cost for employee compensation related to health insurance has increased by 29.45 percent between 2010 and 2019.¹⁸

Focusing on the potential cost savings, reduction of claims risks, and better options for retirees can help with obtaining buy-in, as can making the case for keeping long-term retiree health care. Elected and appointed officials need to be mindful of trade-offs that can occur as a result of switching, and plan for how they will offset those increases. In addition, retirees may have concerns about the switch (e.g., viewing the system having given up on health insurance for

retirees). For many officials, the decision to switch comes down to a realization that the current path is fiscally unsustainable.

The decision to transition to an individual Medicare marketplace is a significant one, and the individuals and groups involved in the decision-making process will vary by state. This may depend on the organizational culture, legislative policy environment, and statewide or local benefits structure. Those participating in the decision-making process may include elected and appointed officials, pension board trustees, health care/benefits directors, finance officers, executive leadership, labor management committees, benefit advisory committees, and communications directors.

Selection of a Vendor

Selecting a vendor that meets the needs of both the employer and the Medicare-eligible retirees who will be using the marketplace is critical to the success of the transition. In some respects, vendors all offer a similar product, in terms of access to individual plans. However, the customer service or “shopping experience” can vary markedly, making careful consideration of potential vendors—and their comprehensiveness—essential. Typically, states and localities will put out an RFP (request for proposals) to elicit bids from potential vendors and may go through a formal procurement process.

Once receiving bids, states and localities should take the time to verify what bidders tell them: they should ask for references and then verify the key points with the references (e.g., how many people has the vendor enrolled in a single year?). While questions to ask references and/or potential vendors will vary by

jurisdiction needs and preferences, key issues to raise can include the following:

Checklist of Questions for Potential Vendors

- ☒ When retirees call, can the vendor help with difficult issues, like questions about Medicare Part B late penalties or qualifying for “extra help”?
- ☒ Does the vendor have enough staff to answer the volume of calls they receive?
- ☒ How many plans do they have? Are any large carriers missing?
- ☒ What kind of customization do they offer for telephony, communications, or reporting?
- ☒ What are the fees?
- ☒ Do they use onshore call centers, automated attendants, or other customer service approaches?
- ☒ Is there a sufficient firewall between benefit advisors and commission structure?
- ☒ Is the marketplace vendor fully integrated (e.g., do retirees need to call a different company about their HRA)?

When asking for references, it can be beneficial to ask for the contact information of a client that has terminated the vendor as well as for current clients.

While the vendor can respond to many of these questions through a written questionnaire, on-site visits may be beneficial as well (both the potential vendor visiting the employer, and the employer visiting the vendor). These on-site visits provide an opportunity for presentations, demonstrations, and subject matter experts from a cross-functional team (i.e., not just benefits and HR, but also IT and finance) asking detailed questions about things like IT interface, financial reports, and more.

References from other jurisdictions are generally

based on the perspective of benefits administrators and the HR department. This can overlook the retiree perspective, so for this reason, it can be beneficial to involve retirees through activities such as focus groups and/or mock enrollments with multiple vendors.

Communications with Stakeholders

Effective communication with multiple stakeholders before, during, and after the implementation process can be the difference between a successful and an unsuccessful transition to an individual Medicare marketplace. These stakeholders include retirees, unions, retiree associations, the employer(s), active employees, benefit advisory committees, elected and appointed officials and other decision-making authorities, and the vendor.

Ohio Public Employee Retirement System (OPERS), an early adopter of the individual Medicare marketplace, has 146,000 individuals enrolled in an individual Medicare marketplace; 102,000 of those are retirees. OPERS took an expansive and diverse communications approach, correctly assuming that many retirees may need help understanding Medicare. It utilized its existing education team and did group presentations on issues such as Medicare and Medigap. As OPERS got closer to implementation of the marketplace, it explored more specifics in these presentations. During open enrollment in the individual Medicare marketplace, it partnered with Extend Health (now Willis Towers Watson), its marketplace vendor, to have 250 co-facilitated, in-person sessions to explain the specifics of the process. OPERS even did some of these presentations out of state, in areas where many retirees had relocated.

OPERS’s communications were in-person, electronic, and via print materials. It offered a series of two-to-five-minute videos on related topics and produced print letters and toolkits. It also engaged groups of ten-to-twelve retirees through a Connector Advisory Panel to make sure that it was not losing touch with the wants and needs of OPERS retirees. These efforts

were well-staffed and conducted in close coordination with the vendor, yet these preliminary communications spanned two years before communications were entirely in the hands of the vendor.

One critique that OPERS heard from retirees was that they were receiving too much information; OPERS had tried to teach them everything all at once. It may have been more effective to link the timing of information with specific activities (e.g., parse out education on HRA reimbursements closer to when retirees started submitting for reimbursements).

Measurement of Outcomes

It is necessary to have a plan for the evaluation of outcomes in order to understand what is working and not working, and how to improve transition success. The measure of success that most frequently comes to mind is cost savings, both for the retiree and the employer (e.g., reduced claims risk, savings in annual premiums, reductions in administrative burden, reduced OPEB liabilities). For example, OPERS' transition to the individual Medicare marketplace, along with other health care system changes implemented over the past several years, have resulted in savings exceeding \$12 billion.¹⁹

These cost savings can translate into the ability to recruit for additional public sector personnel and can increase the sustainability of retiree health care programs.

In addition to looking at cost savings, metrics also should focus on enrollment numbers, outreach, and follow-up; utilization of HRAs (e.g., what kinds of balances are employees leaving? Are employees filing for reimbursement of costs?); and customer service (e.g., number of calls received by vendor, first call resolution rates, how long the caller waited to get a live person, percentage of dropped calls). Assessing member satisfaction (e.g., with the process, costs, customer service, and network of health care providers to fit enrollees' individual needs) can also pinpoint both areas of success and areas for improvement. Do employees feel like they made the right enrollment choice? Is the HRA user-friendly?

Challenges and Opportunities

Some of the issues facing states and localities considering transitioning to an individual Medicare marketplace may be unique, but there are many common challenges and opportunities. Transitioning to an individual Medicare marketplace can reduce the burden on benefit or human resources departments for administration of retiree health care plans. In many instances, HR personnel are overwhelmed with the many demands of administering retiree health care benefits (e.g., the cycle of going to procurement every 3-5 years, explaining these benefits to retirees). Transitioning to an individual Medicare marketplace is one way to jettison some of these administrative burdens. At the same time, transitioning to an individual Medicare marketplace may bring a different set of administrative responsibilities (e.g., trading vendor management of medical and pharmacy companies for managing the Medicare marketplace company and their administration of the HRA, ensuring retirees get adequate HRA education).

Individual Medicare marketplaces can be a good solution for many systems, but it is not a one-size-fits-all approach. Transitioning to an individual Medicare marketplace does not necessarily work for everyone, or for everyone within a system. For example, it is important to make sure there are ample choices in all the geographic regions where retirees reside, including more rural areas. Or, as retirees relocate, problems may arise in terms of network coverage and equity, unless they enrolled in a Medigap plan that has no network restrictions. In addition, the utility of the many options offered by an individual Medicare marketplace may be lower for those with limited decision-making capacity. The model does, however, provide individualized assistance from benefit advisors, which can help streamline those decisions. Decisions also need to be made as to how to deal with participants with different vesting timeframes.

It is important to consider how transitioning to an individual Medicare marketplace will impact the benefits that retirees receive (Will it increase the benefits? Decrease the benefits?). Plan designs

for individual Medicare plans vary from very comprehensive (zero out-of-pocket medical costs) to plans with greater cost sharing at point of service. Some may look comparable to group plans but are not necessarily equivalent. The cost of marketplace products may vary, and while Medigap plans do not change their benefits, Medicare Advantage plans and Plan D drug plans can change from year to year. Once an employer has moved to an individual Medicare marketplace, reverting to a group model would involve a procurement and implementation project for a new group carrier. It also requires addressing the concerns of those who do not want to leave the individual plan in which they have enrolled. Therefore, in addition to it being critical to evaluate the cost savings and the ability of the marketplace to be effective and save money, it is also necessary to fully understand the contract terms with the individual Medicare marketplace vendor.

When thinking about transitioning to an individual Medicare marketplace, there can be a strong focus on the mechanics of the transition. The importance of communications and the human element to successful implementation should not be overlooked. Individual Medicare marketplaces can be involved; communication needs to be early and consistent. It is important not to minimize the time needed and emotional impact of the switch to retirees. Allow enough time to listen to retirees' concerns and understand what they are going through. People want to feel heard. It can be helpful to talk to those who have transitioned to individual Medicare marketplaces. Turn to others for resources on implementation plans and tools for communication.

Conclusion

As states and localities consider how to handle the rising costs of group retiree health care plans, individual Medicare marketplaces are one option for public employers or retirement systems as they look for reduced health care costs and better value for retirees. To make the best decision for their jurisdictions, elected and appointed officials need to understand what individual Medicare marketplaces are, how they work, and the challenges and opportunities that come with switching to an individual Medicare marketplace. It is only with this knowledge that elected and appointed officials can make informed decisions about how best to contain rising health care costs while meeting the health care needs of their retirees.

Additional Resources

[Other Post-Employment Benefits by State](#) (OPEB) FY2017 Snapshot (SLGE/NASRA, 2019)

[Local Government Strategies to Address Rising Health Care Costs](#) (SLGE, 2014)

[Understanding Finances and Changes in Retiree Health Care](#) (SLGE, 2012)

SLGE/AARP Elected and Appointed Officials Pension Primer series

[Proactive Pension Management: An Elected Official's Guide to Variable Benefit and Contribution Arrangements](#) (2019)

[Understanding Public Pensions: A Guide for Elected Officials](#) (2017)

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