FOR COMMENT: Report of Retiree Benefits Task Force

The final report on the Review of the University Tax-Deferred Retirement Plan and Retiree Medical Plan is now presented For Comment. *After the Task Force completed its final report, the federal government issued regulations on the new Medicare Part D prescription drug benefit. We are currently reviewing the impact of these regulations on our programs. We welcome your suggestions and would appreciate receiving them by* June 1, 2005. *Please send all comments to Raymond Simon in the Office of the Associate Provost; his e-mail address is* simonr2@pobox.upenn.edu.

—Peter Conn, Interim Provost *—Amy Gutmann, President*

Final Report on the Review of the University Tax-Deferred Retirement Plan and Retiree Medical Plan

I. Introduction and Charge

In the Spring of 2004, the Retiree Benefits Task Force was charged by the Provost and President with examining and proposing alternative approaches to the Tax-Deferred Retirement Plan and the medical plans offered to retired staff and faculty.

The Task Force was asked to consider two aspects of retirement benefits in its charge:

- *University Contributions to the Tax-Deferred Retirement Plan (TDR)*
  The University's program of contributions to the TDR was designed to provide, in combination with Social Security benefits, a continuing stream of income that would permit faculty and staff to maintain a standard of living when they left active service after reaching "normal" retirement age. In recent years, the age at which faculty and staff members leave active service has risen, but the TDR program has not been modified to reflect this change. The Task Force was asked to evaluate to what extent University contributions to the TDR program might be modified without compromising the original goals of the program; it was suggested that a survey of other universities' practices might be useful.
- *University Contributions to Retiree Medical Plans*
  The University has long provided subsidized retiree medical plans for its retired faculty and staff members. Over the past decade the cost of these programs has significantly increased, mainly because the cost of all health insurance for retirees as well for active employees has experienced annual double digit increases. Additionally, accounting standards now require that the University "book" the future costs of the retiree medical program 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 liability with its corresponding expense on its financial statements. Accordingly, the Task Force was asked to examine to what extent the retiree medical plans can be modified without seriously compromising the University's ability to attract and retain excellent faculty and staff members. This examination was to include a review of what other academic institutions and commercial enterprises are doing to address this problem.

The members of the Task Force met over a period of several months and concluded their efforts with this report and recommendations summarized here, also discussed in more detail below:

1. Based on our assessment of other universities' plans and our review of contributions provided to retirement plans by this University versus others, we concluded that *no change should be made in the University's current TDR contribution policy.*
2. The Task Force recommended *several changes in key aspects of the retiree medical program:*
   a) *Benefit Eligibility:* New rules for who can participate in the program, based on a modified combination of age and service;
   b) *Plan Design:* New designs for healthcare plan offerings; and
   c) *Benefit Subsidy:* New arrangements for sharing the cost of retiree medical plan premiums between the University and retirees.

II. Regarding the Tax-Deferred Retirement Plan (TDR)

The Task Force was asked to evaluate whether University contributions to the TDR should be altered in view of the fact that faculty and staff may now continue to work beyond what was once the University's "normal" retirement age. The Task Force reviewed plans adopted at Yale University and proposed but rejected at the University of Chicago which included capping university contributions to employee retirement saving accounts, after a particular threshold was reached.

A. Proposals from Other Universities

1. The Proposed Chicago Plan[1]

In the aftermath of the 1992 elimination of mandatory retirement for faculty, a Task Force was formed to respond to the rising costs of tax-deferred contributions for very senior employees who continued to work after age 70. The Task Force computed that this law change would produce an annual budget gap of $4M (after an initial period). The group's expressed aim was to implement new retirement policies that would reduce this budget gap to zero while maintaining hiring rates and a constant tenure-track faculty size. Several changes were proposed (though no overall or partial cost-saving estimates were provided).[2] Of most interest to our group was Chicago's proposal for a *Defined Replacement Ratio Pension Plan* (DRRPP) as part of the University's Defined Contribution (DC) Plan. This plan, proposed but not implemented at Chicago, involved the following:

a) The University had been contributing 7.5% of salary and faculty members contributed 5%. Participants could invest in TIAA-CREF or Vanguard funds;

b) The DRRPP modification would stop the 7.5% University contributions whenever a faculty member's "notional" accumulation was deemed "high enough" to provide "adequate" income. Specifically, the University would *assume* that a faculty member's account had been invested half in the CREF stock index fund and half in the TIAA bond fund over his entire time on the job (*irrespective of the employee's actual investment choices*)—this is the "notional" account;

[1] Report of the Task Force on Faculty Retirement, *University of Chicago Record*, Feb. 4, 1993.

[2] Other proposals in that report included the following:

a) The formation of a *Standing Committee on Retirement Issues* which would report annually to the Provost on costs and faculty response.

b) The offering of an *early-retirement option plan* where faculty committing to retire at age 65 would receive a bonus worth about 2 times his last three years' average pay, with the multiple falling as retirement was delayed; the bonus zeroed out at age 70. There was also an enhanced half-time option.

c) Provision of up to *$3,000 for a financial planner* whose services were used within 12 months of the announced intention to retire (for people retiring between age 65-70);

d) *Subsidized supplemental health insurance* (supplemental to Medicare). Early retirees would get free health insurance, whereas normal retirees would pay a premium that would rise either at the rate of actual cost increases, or the rate of increase in Social Security benefits, whichever was lower. For both groups, deductibles and co-pays would also rise at the same rate as Social Security benefits. Revisions in the supplemental health insurance arrangements would be reviewed and possibly changed every 5 years.

c) The University would cease contributing when any faculty member's notional account was large enough, at age 68, to buy a level lifetime annuity worth 75% of his last salary; this would be a joint-and-survivor annuity if he had a spouse (apparently Social Security benefits or any other income were not counted);

d) If the notional account value ever fell below this threshold, the University would resume contributions to the faculty member's account (presumably only as long as the person continued to work);

e) Transition issues:

- Active faculty members would not have University contributions cut off prior to the plan's normal retirement age;
- Active faculty members would have to include retirement accounts from other institutions in the computations if they were held at TIAA-CREF or Vanguard;
- Non-rookie hires would be assigned the "average size of the standardized portfolio" for the same number of years of service.

2. The Yale Plan[3]

Following the lifting of mandatory retirement, Yale University implemented several changes in retirement practices, with the goal of encouraging faculty and staff retirement at the "traditional" retirement age of 70. While other policies were also implemented, here we concentrate on the changes made to Yale's contributions to the tax-deferred annuity plan.[4] Prior to the change, the Yale University Retirement Annuity Plan (YURAP) had a tiered structure. Employees had to contribute 2.5% of salary up to the Social Security taxable earnings level (the "Plan Base," or $31,350 in 1993) and 5% over the Base; the University contributed 7.5% below the Base and 13% above the Base. Several changes were made:

a) The University dropped the "normal retirement age" from 70 down to 68.

b) It reduced the University's YURAP contribution from 13% to 12.5% over the Base, once a staff member reached age 68;

c) It reduced the University's YURAP contributions to zero, once an individual attained an "expected level of retirement income":

- This expected level would be based on a projection of what a "hypothetical worker" would accumulate in a notional account as of the Normal Retirement Age, assuming 35 years of service and an investment split 50-50 between TIAA and the CREF stock account.
- This notional account would be assumed to be converted into a graded lifetime annuity determined at each person's current age; his Social Security benefits would also be added if the employee was age 65+ (it is unclear what happens if the individual were not single).
- University contributions would cease when the sum of the graded annuity plus the worker's expected Social Security benefits exceed a *target replacement ratio*. The target starts at a 40% replacement rate for those with 15 years of service and rises to a maximum of 70% for those with 35 years of service.
- Ending University contributions would be triggered if the formula called for cessation in *two* successive years. If the formula called for the University to resume contributions due to capital market declines or interest rate cuts, this would require the University to start contributing again.

d) Transition issues:

- Current employees with at least 15 years of service would not have contributions cut off until age 70.
- Non-rookie hires would not have their contributions cut off until they had worked there 20 years. (It is unclear whether prior plan accumulations would be counted; probably not.)

B. Task Force Assessment

The logic of the marketplace indicates that employers must pay employees according to their value to the enterprise or risk losing them. Total compensation should therefore reflect their productivity.

Capping University contributions at a given threshold would have an undesirable effect, reducing compensation in synchrony with strong capital market performance, rather than with the faculty member's value to the University. Further, any specific employee might not hold exactly the 50-50 stock/bond mix assumed by the notional accounts. So an employee invested mostly in stocks might suffer a market loss just when the University ceased contributing due to the cap. This would run against the goal of attracting valued employees and getting older workers to retire. In addition, retirement annuitization is not currently required by Penn. If it were, it would have to be a joint-and-survivor annuity (required by ERISA unless the retiree's spouse legally opts out). So different caps would then have to be applied to workers depending on their marital status, an outcome likely to be perceived as unfair by many (and impractical—what about nonmarried partners? What if somebody is divorced or widowed or gets married—should the University cap vary according to marital status each year?) These issues make the cap difficult to implement and administer, and further they imply that the practice would be seen as unfair.

Moreover, the value of the retiree annuity depends on the interest rate and market value on the date the annuity is computed. It would be arbitrary for the University to cap contributions to an employee's account simply due to fluctuations in interest rates, stock market returns, etc. In fact, University contributions could become quite volatile due to the cap, which is not a sensible risk-management objective. If the University wanted to buy insurance against these fluctuations, it would likely be extremely expensive. Furthermore, there are many types of annuities: fixed in nominal terms, graded (rising over time), inflation indexed, etc. It is not clear which to select. Additionally, if a faculty member came to Penn from some other university or employer with an accumulated account, it would be awkward to force the employee to count that prior pension against Penn's cap and surely it would be detrimental to the hiring of non-rookie faculty. Finally, ERISA and other federal legislation generally prohibits changing or eliminating benefits at specific ages, though years of service and other thresholds may be legally permissible. It was unclear to the Task Force whether the age-linked thresholds described above would be legally admissible and surely would be submitted to legal challenge.

C. Recommendation

For all these reasons, the Task Force recommended *no change in the University's current TDR contribution policy.*

III. Regarding the University-Provided Retiree Medical Plan Offerings

The Task Force was asked to consider whether and how the University's retiree medical programs could be modified without seriously compromising the University's ability to attract and retain excellent faculty and staff.[5] 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:

- 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.

In what follows, we summarize the retiree health plan environment and Penn's retiree medical plans; outline rationales for change; summarize our recommendations; and offer other thoughts.

[3] Revisions to Faculty Retirement Policies and The Yale University Retirement Annuity Plan, August 18, 1993.

[4] Among the other changes implemented were an Early Retirement Subsidy Plan for tenured faculty leaving before age 70; a Planned Retirement Program providing a bonus to people committing to retire once having accumulated 15 years of service; a revised Phased Retirement Program for faculty with at least 15 years of service committing to retire within 3 years.

[5] 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."

A. The Retiree Health Plan Environment

This section offers observations about the national retiree health plan environment, comments on other comparator institutions' offerings, and reviews the University's current offerings for retiree medical plans.

1. Retiree Medical Plans in the National Environment[6]

Before determining what type of retiree medical plan an employer might offer, or whether to offer one at all, it is helpful to better understand the risk that retirees confront when it comes to health care costs in retirement. Recent studies provide estimates of a lifetime of coverage valued at about $175,000 for an age-65 couple[7] (Neuman, 2004; Fronstin/Salisbusy, 2003), a total representing prescription drugs (42%) and Medicare premiums (23%), with the remainder involving copays and deductibles.[8] 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 (Neuman, 2004). Evidently, access to a group retiree medical plan helps cushion many retirees against a portion of these costs.

In the U.S., most *active* employees obtain health insurance through their workplaces, mainly due to tax law which allows 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 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. The result is that today's average retiree is shielded from having to pay for a substantial portion of the cost of his health care out-of-pocket.[9]

Nevertheless, the marketplace is changing. 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. During the 1980s and 1990s, however, as health care costs rose faster than the inflation rate, medical treatments and technology grew more expensive and more common, and utilization rose, employers began to redesign their retiree health care plans. To contain costs, firms instituted *higher copayments* (e.g. the patient might have to pay higher amounts (e.g. 20%) out-of-pocket, while the insurance would pick up the remainder; copayments could be higher for brand-name drugs instead of generics); *higher deductibles* (e.g. the patient might have to pay a higher upfront flat dollar amount or 100% of the medical bill up to some limit, after which the copayment schedule would kick in); and *higher premiums* (e.g. retirees had to help pay for the retiree health plans by paying larger dollar contributions to remain covered). In addition many retiree health plans offered *prepaid health plans* that emphasized prevention and cost containment, with a managed care emphasis. Moreover, many firms limited retiree health care coverage to retirees who would meet *certain 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, and purchase a long list of IRS-qualified health-related products/expenses not covered by the plan (e.g. contact lenses).

These changes proved inadequate to rein in retiree health plan costs. A recent Bureau of National Affairs (BNA) article (2003) showed that health care costs rose at double-digit levels for five years in a row with 12% in 2003 and 16% the previous year. Furthermore, retiree plan cost increases remained well above those for active workers. The result is that employers are continuing to alter and sometimes terminate their retiree medical plans. One option is for companies to require participants to *pay the entire premium cost* (39% in 2000, up from 31% in 1997). Over half of plans today provide only *partial prescription drug coverage*, sometimes as separate stand-alone; most emphasize mail-ordering of drugs. Most plans *set eligibility standards* based on age and service though some employers have stopped offering retiree medical benefits at all, *for new hires* (Neuman, 2004),[10] while other employers have *terminated* their retiree health plans for *all* employees.[11] An alternative approach has employers moving to a Health Saving Account (HSA) which is a *defined contribution* model.[12] A variant on this approach would link a defined contribution approach to a "Consumer Driven Health Care Plan" (CDHP), which permits active workers to accumulate funds toward their retiree medical plan (CDHC, 2004).[13] Clearly, this is a time of great change in the retiree medical benefit marketplace.

2. Status of Retiree Medical Benefits at the University of Pennsylvania's Health System (UPHS) and Other Selected Comparators

Our review of the environment for retiree medical plans at other institutions of higher learning, while not comprehensive, did point to some interesting patterns. Closest to home, we learned that the University of Pennsylvania's Health System has eliminated retiree medical benefits for all new hires effective July 1, 2000. 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.

Turning to other schools, we found that some (e.g. Brown) offer no retiree medical plan. Several schools offer supplemental plans to Medicare for the 65+ group, as does Penn (Harvard, MIT, Stanford, University of Chicago, Yale, Johns Hopkins, NYU, Northwestern, Princeton, Stanford). A few schools (Columbia, Cornell) offer retiree medical indemnity plans. When it comes to employer subsidies for retiree medical premiums, our review found that some schools subsidize none of the retiree medical premiums (Northwestern and Brown). Others pay a portion of the premiums to a cap (Columbia and MIT). Others subsidize the entire premium (Dartmouth and Stanford) but only for the lowest-cost plan and only for the retiree (thus premiums of family members are not subsidized).

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

[7] 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).

[8] Each member of a 65-year old couple is estimated to face anticipated medical costs over his remaining life expectancy in present value of the following (Powell, 2004):

- $6,400 for Medicare Part A inpatient deductibles and coinsurance;
- $15,900 for Medicare Part B premium;
- $1,600 for Medicare Part B deductibles;
- $19,100 for Part B coinsurance;
- $39,700 for prescription drugs (or $26,400 factoring in the new Medicare prescription drug bill); and
- $12,700 for other medical benefits and expenses not covered by Medicare.

[9] "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).

[10] 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. Aetna recently announced it would cut subsidies for retiree health benefits for those who retire in 2004. Lucent Technologies, Inc. did not eliminate benefits but made severe cuts in retiree health coverage and substantially raised retiree contributions to premiums."

[11] Neuman (2004) 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.

[12] 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."

[13] 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 pre-tax 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.

3. Current Retiree Medical Plans at the University of Pennsylvania

The University of Pennsylvania has for some time provided retiree medical 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). All service must be full-time and continuous. Given eligibility, those who leave the University are currently not required to enroll in the retiree medical plan immediately on termination; rather, they may defer electing University-sponsored retiree medical benefits until a future date. Eligible retirees' dependents are also eligible for immediate or deferred retiree medical benefit coverage as well.

At present, eligible pre-65 retirees may enroll in the University's retiree medical plans offered to active staff and faculty, while those age 65+ may 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 are currently enrolled in the indemnity plan, the Blue Cross 65 Special Plan.

In terms of premiums, there are two main groups of current retirees, distinguished by when they left the University. One group satisfied eligibility criteria prior to July 1, 1996, and retired members of this group (and their dependents) currently pay no premiums for University-provided retiree medical benefits. In what follows, we refer to this first group as *"pre-1996 retirees*." The second set of retirees (and dependents) includes all who met eligibility requirements and left after July 1, 1996, referred to below as the *"post-1996 retirees."* Members of this second group do pay a portion of their retiree medical plan premium. Members' premium-sharing is currently set at 50% of the full premium (for life) if they left at age 55; for eligibles who left after age 55, the University subsidy rises by 2% per year of age to a maximum of 70% if the eligible individuals retired at age 65.

Of the entire group of 3,200 current retirees and dependents receiving medical care benefits from the University, approximately half (or 1,600) are in the pre-1996 retiree group, for whom the University currently pays 100% of the premium, and the remainder pays between 50-70% of their retiree medical premiums. Under the current retiree medical offerings, which have changed over time just as have active workers' plans, all retirees (and dependents) also bear medical co-payments and deductibles as well as other out-of-pocket costs.

B. Rationale for Changes in 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 imply that the University of Pennsylvania must do more to contain retiree medical costs while remaining committed to offering retiree medical coverage to eligible staff and faculty. To this end, the Task Force recommends several changes in the retiree medical plan policies and offerings. Our work was guided by the following objectives for the retiree medical program. It should:

- Seek to maintain a viable and competitive (relative to Penn's peer group) retiree medical plan for current and future retirees;
- 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.

The Task Force took several environmental factors into account in its assessment and recommendations:

1. Accounting Changes Under FAS 106

The Statement of Financial Accounting Standards (FAS) No. 106 now requires the University to report several amounts on its financial statements:

a) 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 are calculated based on the liability to current retirees and potential liability to current employees who may later opt for the program. This liability is known as the accumulated projected benefit obligation (APBO). On June 30, 2004, this APBO stands at $274 million in present value[14] (ignoring the potential effect of the Medicare Drug Reform to go into effect 1/1/06).

b) The annual expense for retiree medical plans, which is higher than 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).

c) 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).

The annual expense for retiree medical benefits reported by the University is currently $30 million, a figure projected to rise in the future if nothing is done to cap premiums and/or benefit growth. Currently the University contributes $16 million, of which $13 million represents annual cash outlays to retirees, and $3 million is devoted to retiree medical trust fund contributions. The difference between $30M and $16M represents an unfunded liability which rises as retiree medical costs escalate. 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 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%.[15] It should be noted that in addition to the above expenses, the University pays $13 million in Medicare payroll taxes each year (1.45% of salaries) that are 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:

The 2003 Medicare Prescription Drug, Improvement, & Modernization Act is likely to have important impacts on medical plan and particularly prescription drug costs over the next several years. Nevertheless, several future changes in Medicare influencing how retiree health plan offerings will have to change remain to be clarified, along with estimated costs and benefits from these. For instance, some employers may receive a subsidy to maintain a prescription drug plan comparable to that offered by Part D for Medicare-eligible retirees. Exactly how this will work is as yet unknown. Furthermore a recent EEOC ruling permits employers to coordinate benefits with Medicare without violating the Age Discrimination in Employment Act. Both changes, but particularly the Medicare bill, make the offering and costing of retiree medical plans more uncertain. These could reduce or increase employer and retiree exposure to retiree health plan changes, but few details are available at present.

3. Administrative Complexity

The current retiree medical contribution structure at Penn embodies ten different layers of medical rates for each plan option. Since there are also currently five plan options available to pre-65 retirees, and three for Medicare-eligible retirees, this results in 80 layers of rates to calculate and explain. The complexity multiplies when retirees and their dependents are in split contracts because of their ages. The University subsidy also starts at 50% for someone age 55 and increases by 2% per year of age to 70% for someone age 65; this approach discourages early retirement. A further complexity is that eligible employees who leave the University and who qualify for retiree medical coverage are permitted to defer electing such coverage until they deem necessary. Consequently, the University must try to track potential participants and their dependents and, when they apply for coverage, seek verification of their eligibility status. Since the FAS 106 liability is affected by participation, adjustments in the calculations are not made if notifications are not sent when a retiree's death occurs.

C. Recommendations

The Task Force discussed several design alternatives and their potential implications, taking into account possible impacts on recruitment, retention, fiscal, and human resources. After much debate, we recommended several changes in key aspects of the retiree medical program, in terms of benefit eligibility, plan design, and premium sharing. We offer these as options for consideration by the Administration. In so doing, we emphasize the long lead-time required in phasing in any changes, and the negative cost consequences of delaying change in the program offerings.

[14] 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.

[15] 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.

1. Benefit Eligibility: We propose that the University immediately establish new eligibility rules determining which terminating employees may participate in the program, based on a combination of age and service. These changes in eligibility policy would be implemented immediately. Specifically we propose that:

- Current employees and new hires must satisfy an age requirement of age ≥ 55 and service years ≥ 15, and Age + Service must total at least 75 to be eligible for retiree medical plan coverage.[16]
- Those eligible under the new rules would have to enroll within 60 days from their last day of service and maintain continuous coverage thereafter. 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 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.

2. Plan Design: We propose that the University adopt several changes in the plan design, to be implemented in January of the target plan year. This target year could be January 2006 or, if deemed essential to wait a year to evaluate as yet unknown Medicare plan changes, by January 2007:

- Pre-65 retirees would be offered several retiree medical plans that emphasize managed care (PPO or POS and an HMO 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 will be carved out, most likely to Caremark, the plan currently provided to active employees. This will ease the transition from active to retired status and enable better tracking of utilization. Participants will be allowed to elect the Medicare Prescription Drug Plan if they prefer it (when it is offered as of 1/1/06 under the new Medicare 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.

3. Premium Subsidy: We propose 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, which could be adopted in January 2006 or the year after, include:

- For current employees, new hires, and retirees who left service on or after 7/1/96: the University will pay 60% of the lowest-cost medical plan option, and 60% of the lowest-cost prescription premium.
- For retirees who left service prior to 7/1/96, we recommend that the University pay 100% of the lowest-cost medical premium, and 60% of the lowest-cost prescription premium. An alternative option would be for the University to pay 100% of both the lowest-cost medical and 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 changes.

Comments:

- Our recommendations balance 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.
- We also proposed ways to *reduce FAS 106 liability levels and growth rates* by having retirees share in the costs of medical coverage, including pre-1996 retirees whose retiree medical plan premiums are currently fully subsidized.
- We proposed offering a full University *subsidy for this pre-1996 group* for the lowest-cost medical plan, so as to encourage cost-containment in this group while reducing the FAS liability. Cost containment also motivated the recommendation to *tighten eligibility* requirements for retiree medical insurance and *simplification* of premiums and administration.
- We felt it important to *carve out* the retiree Rx plan so as to be more flexible in view of future Medicare Rx changes.
- In all this, we emphasized the need to communicate and include changes on the calendar in time to roll them out for the target plan year.

[16] 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.

D. Estimated FAS 106 Impacts of Task Force Proposals

The Task Force changes in the University plan offerings and subsidy patterns for retiree medical premiums would have financial consequences for the University's unfunded liability as well as for the annual expenses associated with retiree medical offerings. The actuary engaged by the University provided some estimated cost impacts associated with these alternatives *(see Attachment 3)*.

Under current policies, the retiree medical plan offered by the University implies that the University will face for 2005 an Annual Expense computed as per FAS 106 of $29.9M (line 1, column a) and an Accumulated Post-retirement Benefit Obligation (APBO) of $273.8M (line 3, column a). The retiree medical plan represents an unfunded liability of $178.3M (line 6, column a), after taking into account approximately $95.5M in the trust fund.

If the University were to implement our proposed changes in plan design and eligibility next year, without changing the premium structure as outlined above, the actuary estimates that the Annual Expense would fall to $21.2M, the APBO to $228.5M, and the unfunded obligation to $132.9M (line 6, column b).

If the University were to adopt both the plan design/eligibility changes and the changes in premiums, the cost savings would be larger. For instance, if the medical and drug subsidy were set at 60% for post-1996 retirees (100/60% for pre-1996 retirees), the annual expense would fall to $13.9M, the APBO would fall to $188.5M, and the unfunded obligation would fall to $93M (line 6, column c). If instead, the University subsidized 60% of the lowest cost option for medical/drug benefits for post-1996 retirees, but paid 100% of both the lowest cost medical benefit and drug plan for the pre-1996 retirees, the cost savings are less substantial (column d). In the latter case, the annual expense would be $16.2M, the APBO would be $205.4M, and the unfunded obligation $109.9M.

Which of the cost-saving options might be selected by the Administration will likely depend on several factors. One is the extent to which reducing the retiree medical underfunding problem strengthens the University's bond ratings and borrowing costs into the future; currently at least one rating group has made a point of noting the retiree medical shortfall in arriving at its assessment. Another determinant might be how the University balances the interests of pre-1996 retirees, post-1996 retirees, and currently active workers. Raising retiree contributions to medical plan premiums is well within current practice, according to benefits consultants, and it may be necessary to continue offering retirees access to group health plans.

E. Potential Impact and the Role for Communication

In view of the importance of retiree medical benefits for staff and faculty, the Task Force recommends that the University Human Resources devote a substantial effort to educating both active and retired members of the University community regarding why the benefits package must be changed, and what the impact of the changes may be. One thing that we are now more cognizant of, and draw the Administration's attention to, is the lead time required to implement any change, simply because of the lengthy implementation period required for changes in plan design changes. Consequently, we would alert the Administration to the fact that delaying changes has some costs as well as benefits.

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 do not know future plan year costs nor can we predict with any precision which retirees might switch to which plan.

To help in the assessment, and to illustrate the type of communication effort required, we offer a first-round assessment of possible changes in premiums under some reasonable assumptions regarding changes in plan costs. *Attachment 4* posits, for the sake of illustration, that the University picks up 60% of both medical and prescription costs for post-1996 retirees, and 100/60% of medical/Rx costs respectively for pre-1996 retirees. We note that the rates in this table are only *illustrative*, since they embody a number of key assumptions (e.g. they assume that drug costs amount to about 60% of the total retiree medical costs, they use 2005 estimated relative premium levels, and they assume no Medicare drug benefit is introduced.) Each of these assumptions is subject to change, and with it, the dollar figures given. The goal is to illustrate how changes in premiums and offerings could be formulated in a way to make the options and changes most transparent to retirees and prospective retirees.

To this end, *Attachment 4* compares the possible changes in premiums

payable by those opting for either a single or family plan, for individuals leaving either before or after mid-1996.[17] Column 1 indicates that the total premium for a retiree with the Aetna HMO, for instance, is anticipated to total $309 per month if the University subsidized the entire amount. Under our proposal the pre-1996 retiree would pay approximately $90 per month if he remained in the Aetna plan, but he could moderate this expense by moving to a lower-cost plan. For instance, the Keycare 65 plan would cost 13% less. A faculty or staff member who retired after mid-1996 would face a slightly higher monthly rate for the Aetna plan, but again could save more than 9% by switching to a lower cost plan. In other words, those who select a lower cost plan would face lower premium increases than otherwise. Of course these cost increases would represent additional burden for retirees, but having higher premiums helps keep down co-payments and deductibles so as to protect the very ill from shouldering an ever-increasing portion of the retiree medical premium.

IV. Additional Considerations

The Task Force also discussed several other approaches but it did not include them in its recommendations at this time. The items noted below will likely deserve attention by a future task force or benefits committee charged with evaluating retirement benefits for faculty and staff:

1) 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. The disadvantage is that establishing the HSA is easiest when an employer has no plan, since it is unclear how to treat employees nearing retirement who have not accumulated much of an HSA entitlement.
2) A catastrophic medical plan might 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.
3) A Retiree Medical Account (RMA) is a notional account available upon retirement. The RMA is usually a stand-alone plan and not usually accompanied by a catastrophic retiree medical insurance plan. This has the disadvantage of not maintaining group access which the Task Force felt important.
4) Prefunding all retiree medical benefits. This 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 boosting funding would compete with salary increases to current staff and faculty, and furthermore, it would make grant proposals from the University less competitive than our peer institutions which lack a commitment to retiree benefits and funding.

The Task Force did not recommend these approaches, but we suggest that such programs may be feasible and possibly worth revisiting for new hires or for all employees in the future.

[17] We again must emphasize that these changes are intended to be illustrative only, and the exact values may differ when the University receives specific bids on the various plans in future years.

In closing, the Task Force had four additional considerations to pass on to the Administration:

- If our recommendations are adopted, and if at some future date the University receives substantial subsidies from Medicare to continue retiree medical benefits, the Task Force proposes that these subsidies be carefully evaluated and, if possible, directed back into the retiree medical pool. One option would be to reduce the level of retiree medical plan underfunding; another would be to mitigate part of the increase in premium retirees might experience as a result of these policy changes.
- The Personnel Benefits Committee had previously mentioned the need for a retiree-pay-all dental plan; accordingly, we requested information regarding the viability of such a plan but details have not yet been furnished by the provider. Assuming that negotiations are completed in time, the Task Force would support making some form of dental care benefit available to eligible retirees on an "access only" basis.[18]
- There are a great many unknowns which will affect retiree health benefits in the future, including anticipated (and other) Medicare and tax law changes that might disfavor employer-sponsored medical plans. The Task Force strongly believes 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.
- 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 recommends that the University establish a standing committee or subcommittee of the Personnel Benefits Group to evaluate retiree benefit offerings on an ongoing basis.

[18] Currently, retirees can enroll in the Penn Faculty Practice Plan (PFPP) on an individual basis if they were participating in that plan when they retired. Although the University is not involved in the management of this plan, retirees have complained that two years ago, the PFPP imposed substantial premium increases accompanied by a design change from an unlimited to an annual maximum benefit.

Task Force Membership

Chair:	Olivia Mitchell, Wharton
Faculty:	Eric Bradlow, Wharton
	Nader Engheta, SEAS
	David Freiman, Medicine
	Rebecca Maynard, GSE
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	Jerry Rosenbloom, Wharton
	Amy Wax, Law
Staff:	Anna Loh, PPSA
	H.J. Omar Mitchell,WPSA
Administration:	Elenita (Leny) Bader, Executive Director, Human Resources, Benefits
	Janice Bellace, Associate Provost
	Bonnie Gibson, Vice President for Budget and Management Analysis
	John (Jack) Heuer, Vice President of Human Resources
	Elizabeth Salasko, Associate General Counsel
Staff to Committee:	Raymond Simon, Office of the Associate Provost

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Attachments

1) Proposed Directions for Retiree Medical
2) Current and Proposed Retiree Medical Policies
3) FAS 106 Cost Estimates
4) Illustrative Retiree Medical Premiums, Current vs. Proposed

Attachment 1: University of Pennsylvania—Proposed Directions for Retiree Medical

	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 as of yr 2005.	PPO or POS Plan HMO Plan Rx	PPO or POS Plan (Medicare carve out) HMO Plan Indemnity Plan Rx	a) University pays 100% of the lowest cost medical premium.*** b) University pays 60% of the lowest cost prescription premium.	a) University pays 100% of the lowest cost medical premium. b) University pays 60% of the lowest cost prescription premium.*
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 the last day employed.	PPO or POS Plan HMO Plan Rx	PPO or POS Plan (Medicare carve out) HMO Plan Indemnity Plan Rx	a) University pays 60% of the lowest cost medical premium.*** b) University pays 60% of the lowest cost prescription premium.	a) University pays 60% of the lowest cost medical premium. b) University pays 60% of the lowest cost prescription premium.*
All Current Full-Time Employees ** Age ≥ 55 and ≥15 yrs of service on the last day employed and age + service ≥ 75.**** (service = full-time, continuous) Only eligible dependents enrolled on the last day employed.	Same as above	Same as above	Same as above	Same as above
New Hires (full-time only) ** Age ≥ 55 and ≥15 yrs of service on the last day employed and age + service ≥ 75.**** (service = full-time, continuous) Only eligible dependents enrolled on the last day employed.	Same as above	Same as above	Options: a) University pays some of the lowest cost medical premium [0-60%].*** b) University pays some of the lowest cost prescription premium [0-60%].	Options: a) University pays some of the lowest cost medical premium [0-60%]. b) University pays some of the lowest cost prescription premium [0-60%].*

* Or may elect Medicare Prescription Drug Plan (PDP) starting January 1, 2006.
** Must enroll within 60 days from the last day of service
*** Pre-65 premiums are blended with premiums for actives; University will consider moving to stand—alone approach.
**** Implement three (3) years from effective date.

Attachment 2: University of Pennsylvania—Current and Proposed Retiree Medical Policies

Policies & Procedures	Recommendation	Current Practice
a) Electing Retiree Medical Coverage	Eligible employees must elect or decline retiree medical coverage within 60 days from the last day of service. Employees who do not enroll cannot elect coverage after the above window.	Eligible employees may elect retiree medical coverage after leaving service or at a later date.
b) Dependents of Employees Who Left Service < 7/1/96	Eligible employees who left service < 7/1/96 may not add new dependents as of 7/1/05.	Eligible employees are allowed to add new dependents after their last day of service.
c) Dependent Coverage	Dependents are eligible if enrolled in active medical plan when employee left service. However, an eligible dependent child qualifies for benefitswhen 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 e) Surviving Spouse, Domestic Partner and Dependent Children of Deceased Long Term Disability Employee	No change in policy.	Retiree medical coverage continues for eligible dependents.
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 open enrollment in November participants can elect medical changes for the following calendar year. Plan Qualifying Event changes are allowed outside of the annual open enrollment period.	Changes are allowed during a calendar year or a rolling year (one year from the last transaction date).
g) Reinstatement of Retiree Medical Coverage	Reinstatement of coverage is only permitted when past due premiums are paid during the 90 day period; 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.	Retiree 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.

Attachment 3: University of Pennsylvania Retiree Medical Task Force—FAS 106 Cost Estimates

(In $Millions)

Line		Baseline (a)	New Options Only (b)	New Options and Contributions (Proposal*) (c)	New Options and Contributions (Alternate Proposal**) (d)
	FAS 106 Cost				
1	Annual Expense	$29.9	$21.2	$13.9	$16.2
2	Relative to Baseline		($8.8)	($16.0)	($13.7)
	Funded Status				
	Accumulated Post-retirement				
3	Benefit Obligation (APBO)	$273.8	$228.5	$188.5	$205.4
4	Relative to Baseline		($45.3)	($85.2)	($68.4)
5	Assets	$95.5	$95.5	$95.5	$95.5
6	Unfunded Obligation	$178.3	$132.9	$93.0	$109.9

*** Proposal: Contribution Schedule:**
University pays 100% of medical, 60% of Rx for pre-1996 retirees (all percentages apply to lowest cost option)
University pays 60% of medical, 60% of Rx for post-1996 retirees

**** Alternate Proposal: Contribution Schedule:**
University pays 100% of medical, 100% of Rx for pre-1996 retirees
University pays 60% of medical, 60% of Rx for post-1996 retirees

Attachment 4: Illustrative Retiree Medical Premiums, Current vs. Proposed—Medicare Eligible Population

Note: these are for illustrative purposes only, and the precise figures as well as relative values may change for 2006 and beyond

Left Service prior to July 1, 1996

	Current Premium-Sharing			Proposed Shift in Premium-Sharing					
	Contribution Amounts			PENN Contribution			Retiree Contribution		Total
	PENN	Retiree	Total	Prescription*	Medical**	Total	Prescription	Medical	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Aetna HMO Single	$309	$0	$309	$117	$102	$219	$78	$12	$90
KeyCare 65 Single	$297	$0	$297	$117	$102	$219	$78	$0	$78
65 Special Single	$341	$0	$341	$117	$102	$219	$78	$44	$122

Left Service July 1, 1996 and after

	Current Premium-Sharing			Proposed Shift in Premium-Sharing					
	Contribution Amounts			PENN Contribution			Retiree Contribution		Total
	PENN	Retiree	Total	Prescription*	Medical**	Total	Prescription	Medical	
	(1)	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**	**(8)**	**(9)**
Aetna HMO Single	$216	$93	$309	$117	$61	$178	$78	$53	$131
KeyCare 65 Single	$208	$89	$297	$117	$61	$178	$78	$41	$119
65 Special 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 lowest 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 lowest prescription premium.
** The University's proposed share of medical is 60% of the lowest medical premium.