2015 Retiree Health Care Survey

Retiree Health Care Design and Strategy in a Post-Reform Environment: Continued Growth of Exchange-Based Strategies
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Executive Summary

Five years after the largest transformation to the national health care system since the introduction of Medicare and Medicaid in 1965, the employer-sponsored retiree health care market continues to rapidly evolve.

Federal health care reform has created the impetus for change at a time when escalating health care costs and benefit liabilities threaten to crowd out other mission-critical investments that plan sponsors need to make in the current economic and competitive environment.

Plan sponsors are finding that new strategies can create significant savings opportunities for all stakeholders, and allow them to effectively reposition their retiree health care programs for the future. Creative solutions to support these new strategy options are quickly forming, with a variety of new products and services designed to take full advantage of health care reform.

Specifically, individual market exchange-based strategies to support retiree benefits continue to gain prominence in the market. These strategies often include a “defined contribution” subsidy, which allows the plan sponsor to gain better control over its ongoing program costs while taking advantage of new efficiencies in the market. This movement is well under way for participants eligible for Medicare, and is beginning to slowly emerge for pre-Medicare retirees coincident with the introduction of the new 2014 public marketplaces.

Additionally, many plan sponsors have taken steps to pursue other strategies, including:

- Moving from the Retiree Drug Subsidy (RDS) strategy to the Medicare Part D Employer Group Waiver Plan (EGWP) to leverage additional sources of Medicare Part D funding brought about by health care reform;
- Converting their group-based, secondary-paying post-65 retiree medical indemnity plan to a Medicare Advantage medical plan to preserve benefits and reduce cost; and
- Taking steps to mitigate future excise taxes that become effective as early as 2018 but must be reflected in plan liabilities today.

If plan sponsors have not done so already, the time is now to review current retiree health care strategies, and to consider alternatives for the future that better support cost and risk management objectives while continuing to support key retiree benefit commitments.
In November 2014, approximately five years after the passage of federal health care reform, Aon Hewitt conducted a survey to understand plan sponsors’ current thinking and future expectations with respect to U.S. retiree health care strategies. The survey focused specifically on plan sponsors that offer health care benefits to retirees and their families, and on the sponsors’ final 2015 and expected ongoing strategies related to the retiree health care aspects of federal health care reform.

The survey collected responses from 349 private and public plan sponsors representing 3.2 million retirees. Approximately 78% of respondents are private entities and 22% are public entities. For a complete summary of survey respondents, see the “Participant Profile” section at the end of this report.

Exhibit 1 shows the basic types of retiree health care benefits offered to the various current and future retiree populations for the plan sponsors participating in the survey. As expected, the data shows the continued trend toward reducing or eliminating retiree health care coverage, which generally began with the introduction of retiree welfare accounting standards in the early 1990s for private employers.

**Exhibit 1—Type of Coverage Provided to Eligible Populations**

*What type of retiree medical coverage does your firm currently provide?*

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Subsidized and Uncapped: Group Program</td>
<td>19%</td>
<td>14%</td>
<td>29%</td>
<td>20%</td>
<td>34%</td>
<td>26%</td>
</tr>
<tr>
<td>Subsidized and Capped: Group Program</td>
<td>15%</td>
<td>15%</td>
<td>35%</td>
<td>25%</td>
<td>39%</td>
<td>26%</td>
</tr>
<tr>
<td>Subsidized: HRA + Exchange</td>
<td>3%</td>
<td>5%</td>
<td>4%</td>
<td>16%</td>
<td>4%</td>
<td>20%</td>
</tr>
<tr>
<td>Access Only: Group Program</td>
<td>26%</td>
<td>16%</td>
<td>4%</td>
<td>13%</td>
<td>8%</td>
<td>11%</td>
</tr>
<tr>
<td>Access Only: Exchange</td>
<td>3%</td>
<td>8%</td>
<td>21%</td>
<td>7%</td>
<td>2%</td>
<td>5%</td>
</tr>
<tr>
<td>No Retiree Coverage</td>
<td>34%</td>
<td>43%</td>
<td>3%</td>
<td>19%</td>
<td>2%</td>
<td>12%</td>
</tr>
</tbody>
</table>
Under the new law, employer-sponsored welfare plans that cover both actives and retirees are subject to new group insurance market reforms, such as the extension of dependent coverage to age 26 and no lifetime dollar limits on essential health benefits. About half of plan sponsors have stand-alone retiree health care plans and can avoid the new group insurance market reforms for their retiree populations. Going forward, more plan sponsors may choose to split their legal plans in order to exempt retiree-only plans from any new group insurance market requirements that may be introduced in the future.

This report presents findings from this survey in three sections: “Key Survey Findings,” “Medicare-Eligible Retiree Strategy,” and “Pre-Medicare Retiree Strategy.”
Key Survey Findings

Federal Health Care Reform Creates the Impetus for Change

The legislation is driving many plan sponsors to review existing retiree health care strategies and consider alternatives to leverage key cost and risk management opportunities.

Exhibit 2 shows that 62% of respondents either already have made retiree strategy changes as a result of reform or expect to do so in the near future. Of these plan sponsors, 35% have already completed their strategy analysis and taken action, 23% intend to review their strategy within the next one or two years, and the remaining 42% are in the process of evaluating specific changes. The rest of the respondents are either still considering whether to evaluate their current strategy (19%) or not planning to review their current strategy at this time (19%).

Exhibit 2—Impact of Reform on Long-Term Plan Sponsor Strategy

Are the changes under federal health care reform impacting your long-term retiree health care benefits strategy?

<table>
<thead>
<tr>
<th>Reform Impacting Retiree Strategy</th>
<th>Strategy Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes 62%</td>
<td>We intend to review our strategy within the next 1–2 years</td>
</tr>
<tr>
<td>No 19%</td>
<td>We have made initial strategy decisions/changes</td>
</tr>
<tr>
<td>Still considering 19%</td>
<td>We are currently in the process of evaluating changes</td>
</tr>
</tbody>
</table>

n=349  n=216

Over time, and as the market learns more about the changes introduced by health care reform, we expect that many more plan sponsors will choose to review their retiree health care strategies and make changes to position their programs favorably for the longer term.
New “Efficient Frontier” of Retiree Health Care Strategy

As plan sponsors evaluate the changes introduced by health care reform relative to their basic program objectives, they are finding that two fundamental approaches are emerging: 1) modified group-based benefit sourcing; and 2) individual market-based benefit sourcing; which represent new and more efficient methods of supporting retiree health care benefits in a post-reform environment (Exhibit 3).

**Exhibit 3—New “Efficient Frontier” of Retiree Health Care Strategy**

<table>
<thead>
<tr>
<th>Health Care Reform</th>
<th>Universal Sponsor Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>• RDS and Medicare program changes</td>
<td>• Support overarching business and HR strategies</td>
</tr>
<tr>
<td>• Benefit design requirements and coverage mandates</td>
<td>• Manage cost, risk, and ongoing program management burden</td>
</tr>
<tr>
<td>• Health insurance exchanges</td>
<td>• Simplify administration</td>
</tr>
<tr>
<td>• Excise tax</td>
<td></td>
</tr>
</tbody>
</table>

Two Fundamental Approaches

Modified group-based sourcing strategies

Individual market-based sourcing strategies

Future Outlook: A New Paradigm

The data shows that the market is evolving rapidly toward tax-effective, defined contribution individual market-based benefit sourcing—initially for Medicare-eligible retiree groups, and then for pre-Medicare retiree groups sometime after 2014, if the changes introduced by health care reform are implemented as expected and the public marketplace stabilizes to plan sponsor satisfaction. Private administrative platforms, or “exchanges,” will continue to emerge and develop to support the expanding individual health care market and provide retirees with a variety of customer service options and decision-support tools.

While a viable and stable individual health care market is not expected to emerge for pre-Medicare participants until at least 2016, many plan sponsors are not waiting for that viable individual market before they migrate Medicare-eligible populations to what has become a large, expanding, competitive, and cost-effective Medicare-eligible individual health care market.
In addition to allowing a reduction in subsidy costs driven by the competitiveness and efficiency of the individual market, individual market-based strategies allow the plan sponsor to eliminate the self-insured claims volatility inherent in the current group program. Additionally, and more importantly, these strategies can be structured to insulate the plan sponsor from the impact of changes to the Medicare program over time, including pure federal cost-shifting strategies.

Plan sponsors will continue to rely on group-based strategies in certain situations, but with health care reform-driven modifications, including:

- Splitting active and retiree legal plan structures to avoid current and new group insurance market reform requirements;
- Changing from collecting the Retiree Drug Subsidy (RDS) to an alternate Medicare Part D strategy, including contracting with a group-based Part D plan;
- Leveraging new group-based Medicare Advantage strategies to manage costs and improve retiree health; and
- Managing the projected impact of the excise tax, potentially in conjunction with leveraging high-deductible health plans (HDHPs) and health savings accounts (HSAs).

Plan sponsors are generally finding that a “one-size-fits-all” solution won’t make sense; they will ultimately choose to segment their strategies to effectively apply these two broad approaches across their retiree populations in support of key objectives. In many cases, plan sponsors will choose to apply individual market-based sourcing where possible, and fall back on modified group-based sourcing for certain populations (e.g., bargained groups or those subject to more restrictive benefit commitments) for at least the near term.

The plan sponsors’ participant eligibility and subsidy strategies will continue to drive cash and accounting costs, but the level of plan sponsor involvement in ongoing benefit delivery will be driven by the benefit sourcing strategy, with individual market-based sourcing the long-term alternative of choice for many plan sponsors.
Medicare-Eligible Retiree Strategy

Health care reform introduced a variety of changes for Medicare-eligible populations—including changes to the Medicare Part D and Medicare Advantage programs—that impact both group and individual market-based health care strategies.

Medicare Part D Strategy

One of the more significant changes was the elimination of the tax-favored status of the Retiree Drug Subsidy (RDS) beginning in 2013. This change resulted in an accounting change for many tax-paying private entities coincident with the passage of the legislation, and created momentum for plan sponsors to take action.

At the same time, the legislation introduced improvements to the Medicare Part D program including a phase-out of the Medicare Part D coverage gap or “donut hole” by 2020, with a 50% pharmaceutical manufacturer discount on brand drugs incurred in the coverage gap immediately available beginning in 2011. These improvements are available only to retirees enrolled in the Part D program, and are encouraging plan sponsors to develop Medicare Part D-based strategies to reduce program cost while preserving retiree prescription drug benefit value.

Exhibit 4 shows that, due to these changes, almost 60% of plan sponsors surveyed changed or expect to change either their Medicare Part D or their broader strategy for Medicare-eligible participants.

Exhibit 5 shows that the movement away from the RDS strategy has begun, with a significant drop-off for 2013 and beyond, coincident with the change in RDS tax status.
**Exhibit 4—Medicare Participant Strategy Analysis**

Since 2010, have you altered, or do you anticipate altering, your Medicare Part D or broader post-65 retiree benefit strategy?

<table>
<thead>
<tr>
<th>Plan Sponsors Altering Post-65 Strategy</th>
<th>Expected Timing of Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>No 42%</td>
<td>Made changes prior to 2015 54%</td>
</tr>
<tr>
<td>Yes 58%</td>
<td>Made changes for 2015 or later 18%</td>
</tr>
<tr>
<td></td>
<td>Currently exploring what actions to take and when 28%</td>
</tr>
</tbody>
</table>

n=349

**Exhibit 5—Phase-Out of RDS Strategy**

Have you filed, or do you plan to file, to collect the federal Medicare Part D retiree drug subsidy (RDS) for the following plan years?

<table>
<thead>
<tr>
<th>Plan Year</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>62%</td>
<td>38%</td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>60%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>55%</td>
<td>45%</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>44%</td>
<td>56%</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>40%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>33%</td>
<td>67%</td>
<td></td>
</tr>
<tr>
<td>2016+</td>
<td>19%</td>
<td>58%</td>
<td>23%</td>
</tr>
</tbody>
</table>

n=349
Many plan sponsors that have already decided to make changes have generally moved forward with a group-based Medicare Part D approach, leveraging the Employer Group Waiver Plan (EGWP) process. That said, a significant number of plan sponsors have already decided to move directly to the individual market in whole or in part.

Exhibit 6 shows that 39% of plan sponsors that have already decided on changes have moved forward with the group-based Medicare Part D Prescription Drug Plan (PDP)/EGWP, with another 33% leveraging the individual Medicare-eligible market under a defined contribution subsidy approach.

Additionally, another 6% of plan sponsors are leveraging the individual Medicare-eligible market by either terminating drug coverage outright (3%) or terminating drug coverage with Part D premium support (3%). In totality, these responses indicate that approximately 39% of plan sponsors surveyed are leveraging the individual Medicare-eligible market in whole or in part. Clearly, the changes introduced by health care reform are making the individual market a viable benefit sourcing strategy for many plan sponsors.

Exhibit 6—Medicare Participant Strategy: First Movers

What specific post-65 retiree benefit strategy change are you making or have you made since 2010?

- Group-based Medicare Part D plan (EGWP) 39%
- Defined contribution strategy with individual market-based benefit sourcing 23%
- Group-based national Medicare Advantage with RDS 8%
- Group-based national Medicare Advantage with Medicare Part D (EGWP) 8%
- Other 6%
- Terminating drug coverage 3%
- Terminating drug coverage with Part D premium support 3%
- Individual Part D enrollment with out-of-pocket cost reimbursement 0%

n=145
In addition to reviewing their broader, longer-term strategies and implementing changes, plan sponsors continue to modify their programs for Medicare-eligibles in a number of ways in an attempt to manage cost and address retiree needs.

Exhibit 7 shows the variety of other more traditional changes plan sponsors have made since 2010. Plan sponsors responded multiple times in some cases to effectively describe their approach.

Exhibit 7—Medicare Participant Strategy: Other Strategy Changes

What, if any, other post-65 retiree benefit strategy changes are you making/have you made since 2010?

| Change premium subsidy strategy/implement a subsidy cap | 32% |
| Change plan design or Medicare coordination strategy | 26% |
| Change benefit participation or eligibility requirements | 14% |
| Other | 13% |
| Defined contribution strategy with group-based benefit sourcing | 10% |
| Implement local Medicare Advantage plans | 9% |

n=145

Of plan sponsors contemplating future changes to their Medicare Part D or broader strategy for Medicare-eligible participants, Exhibit 8 shows that sponsors are focusing on a variety of approaches. Defined contribution individual market-based sourcing is the most popular, followed by contracting with a group-based Medicare Part D Prescription Drug Plan (PDP)/EGWP. Group-based Medicare Advantage strategies are also on plan sponsors’ minds, and a relatively small minority are expecting to eliminate Medicare-eligible participant prescription drug coverage altogether.
Exhibit 8—Medicare Participant Strategy: Future Outlook

Of those contemplating future changes to post-65 retiree medical or Medicare Part D strategy, what option(s) are you favoring?

- Defined contribution strategy with individual market-based benefit sourcing: 26%, 4%, 3%
- Group-based Medicare Part D Plan (EGWP): 7%, 6%, 3%
- Group-based national Medicare Advantage with Medicare Part D (EGWP): 4%, 6%, 2%
- Terminating drug coverage: 3%, 5%, 3%
- Terminating drug coverage with Part D premium support: 3%, 2%, 2%
- Group-based national Medicare Advantage with RDS: 2%, 3%, 4%
- Other: 2%, 1%, 2%
- Individual Part D enrollment with out-of-pocket cost reimbursement: 4%, 3%

n=94

Going forward, plan sponsors are likely to continue to adjust their programs for Medicare-eligibles in several ways in an attempt to manage costs and address retiree needs.

Exhibit 9 shows the variety of other changes plan sponsors are considering for the future. Plan sponsors responded multiple times in some cases to effectively describe their expected approach.
Exhibit 9—Medicare Participant Strategy: Other Future Strategy Considerations

What, if any, other post-65 retiree benefit strategy changes are you considering for the future?

None: 55%
Change plan design or Medicare coordination strategy: 22%
Defined contribution strategy with group-based benefit sourcing: 18%
Change premium subsidy strategy/implement a subsidy cap: 18%
Change benefit participation or eligibility requirements: 13%
Other: 7%
Implement local Medicare Advantage plans: 6%

n=349

Medicare Part D Employer Group Waiver Plans (EGWPs)

In general, there are two types of group-based Medicare Part D Prescription Drug Plan (PDP)/EGWP strategies for plan sponsors to consider:

1) The “EGWP + Wrap” approach, where the sponsor contracts for a standard Part D plan design with a wrap-around benefit that preserves the current plan design and formulary strategy as much as possible (minimizes retiree disruption).

2) The “Enhanced/Customized EGWP” or “EGWP Plus” approach, where the sponsor contracts for the Part D plan design that most closely resembles the current plan design and formulary strategy, but without a separate wrap-around plan.

Prior to April 2012, the EGWP + Wrap strategy was generally seen as the superior approach because it allowed the plan sponsor to maximize the savings from the 50% pharmaceutical manufacturer discount. Guidance released by the Centers for Medicare and Medicaid Services (CMS) in April 2012 was interpreted by many to allow the Enhanced/Customized EGWP to realize the same 50% pharmaceutical manufacturer discount opportunity for 2013, putting this strategy on par with the EGWP + Wrap from a financial perspective.
CMS provided additional clarifying guidance in April 2013 that confirmed the two strategies can adjudicate the 50% pharmaceutical manufacturer discount prior to determining the retiree copay, generally leaving only potential retiree plan design, formulary, and covered medication disruption as potential differentiators between the two EGWP alternatives. Plan sponsors need to evaluate both the qualitative and quantitative aspects of these two options to understand which approach best meets their program needs.

Of plan sponsors leveraging or planning to leverage the Medicare Part D Prescription Drug Plan (PDP)/EGWP strategy in future, Exhibit 10 shows that many are focused on the EGWP + Wrap approach at this time. However, the market may need more time to evaluate these options, in general and in light of the recent CMS guidance.

**Exhibit 10—Medicare Participant Strategy: EGWP Market Prevalence**

*Which of the following Medicare Part D EGWP strategies are you implementing or favoring?*

![Pie chart showing 91% favoring EGWP + Wrap and 9% favoring Enhanced EGWP, n=68](chart.png)

Many large plan sponsors implementing Medicare Part D Prescription Drug Plan (PDP)/EGWP strategies are doing so on a self-insured basis to maximize cash flow. These Part D EGWPs provide plan sponsors with three Part D revenue items, with the direct capitation rate and federal reinsurance payments funded by the federal government and the 50% pharmaceutical discount funded by manufacturers.
Federal subsidies and pharmaceutical discounts directly reduce the cost of the EGWP, but self-funded sponsors retain a fair amount of flexibility in terms of use of the revenue. Sponsors need to determine through their premium subsidy/contribution strategy whether some or all of the three general sources of revenue from the EGWP will be shared with retirees. Fundamentally, the plan sponsor needs to determine how it intends to define the “cost of the plan” for retiree contribution purposes. The ultimate decision will depend upon the plan sponsor’s cost-sharing philosophy, past practices and retiree commitments, accounting objectives, etc., and should include input from legal counsel. If a material portion of the savings is retained by the plan sponsor, sponsors with subsidy caps in place may be able to reduce or eliminate their liability over time. Note, however, that CMS rules prohibit charging retirees more than the true net cost of the EGWP.

Exhibit 11 shows how plan sponsors moving forward with a Medicare Part D Prescription Drug Plan (PDP)/EGWP strategy have decided to apply the Part D revenue items when determining retiree contributions. In many cases, the Part D revenue is being shared with retirees in the form of a reduction in contributions, but in other cases subsidies are being fully retained by plan sponsors to offset company costs.

**Exhibit 11—Medicare Part D EGWP Revenue Strategy**

*How are each of the following Medicare Part D EGWP revenue items being treated for retiree contribution purposes?*

- **Direct Federal Capitation Payment**
  - Fully retained by the plan sponsor to offset company costs: 43%
  - Shared with retirees through the premium subsidy strategy: 57%

- **Federal Reinsurance**
  - Fully retained by the plan sponsor to offset company costs: 37%
  - Shared with retirees through the premium subsidy strategy: 63%

- **50% Pharma Discount**
  - Fully retained by the plan sponsor to offset company costs: 59%
  - Shared with retirees through the premium subsidy strategy: 41%

n=68
Medicare Advantage Strategy

In the past, many plan sponsors leveraged insured, local, regional, or national “Medicare + Choice” or Medicare Advantage plan strategies to provide both medical and prescription drug coverage to Medicare-eligible participants. Depending upon the model and carrier chosen, savings were at times significant—as many plans managed care more effectively than did traditional Medicare.

These strategies experienced significant challenges over time and, prior to health care reform, many plan sponsors did not consider Medicare Advantage a viable long-term strategy. A major challenge was providing a national footprint without contracting with many vendors, because the program is very locally focused. Additionally, federal reimbursements to the plans did not keep pace with health care inflation, which in many cases led to dramatic increases in plan premiums, reductions in benefits, and plans exiting certain markets.

Exhibit 12 shows that, because of the challenges the program experienced over time, only one-third of plan sponsors surveyed currently offer some type of group-based Medicare Advantage program, with their strategies generally split between national and local/regional approaches.

Exhibit 12—Medicare Advantage: Group Market Prevalence

Do you currently offer local/regional or national group-based Medicare Advantage plans to any of your post-65 retirees?

<table>
<thead>
<tr>
<th>Medicare Advantage Offered</th>
<th>Medicare Advantage Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes 33%</td>
<td>National 60%</td>
</tr>
<tr>
<td>No 67%</td>
<td>Local/regional 40%</td>
</tr>
</tbody>
</table>

n=349 n=114
Health care reform made three changes to the Medicare Advantage program in an attempt to reduce cost and improve the quality of the care provided to beneficiaries:

- Created a mandate for CMS to move to parity in cost between traditional Medicare and Medicare Advantage plans (Medicare Parts A and B);
- Introduced a Medicare Advantage quality initiative (the STAR program); and
- Introduced an 85% minimum loss ratio requirement on insured health plans, impacting Medicare Advantage plans for 2014.

Changes in payments to Medicare Advantage plans over time, as CMS achieves parity in funding between traditional Medicare and the Medicare Advantage program, will likely result in a restructuring of the Medicare Advantage market—including higher premiums, reductions in benefits, and in some cases, carriers exiting local markets. Additionally, these changes may lead to a certain level of merger and acquisition activity among Medicare Advantage players.

The STAR program, designed to reward high-quality plans with increased funding from CMS, is expected to moderate the impact of the payment changes on higher-performing plans and result in lower-performing players exiting the market over time.

The minimum loss ratio requirement is not expected to have a major impact on Medicare Advantage plans; the change may result in lower premiums by squeezing carrier margins, only partially offsetting the effect of the broader payment changes.

Plan sponsor feedback indicates that, even after the health care reform changes, the market is still very skeptical of Medicare Advantage strategies (Exhibit 13). Clearly, consistent program stability and ongoing high performance will be needed to gain plan sponsor confidence over time.
In light of the PPACA changes, what are your perspectives on the Medicare Advantage program going forward?

Exhibit 13—Medicare Advantage: Future Outlook

<table>
<thead>
<tr>
<th>Response</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsure</td>
<td>43%</td>
</tr>
<tr>
<td>We are not interested in group or individual Medicare Advantage strategies due to these changes</td>
<td>24%</td>
</tr>
<tr>
<td>Changes raise concerns, but we will consider leveraging individual Medicare Advantage strategies</td>
<td>14%</td>
</tr>
<tr>
<td>We consider Medicare Advantage to be a viable group-based strategy going forward</td>
<td>10%</td>
</tr>
<tr>
<td>Changes raise concerns, but we will take advantage of short-term group-based Medicare Advantage strategies</td>
<td>9%</td>
</tr>
</tbody>
</table>

n=349

In spite of the current market skepticism concerning the Medicare Advantage program, many carriers are encouraging plan sponsors to leverage the Employer Group Waiver Plan (EGWP) process to facilitate a national group-based Medicare Advantage medical solution, with the objective of reducing program cost with no change in retiree benefits.

Under this approach, to preserve retiree benefits the plan sponsor would replace the current traditional secondary-paying Medicare medical indemnity plan with a Medicare Advantage PPO that is actuarially equivalent to the current medical design. This program can be offered nationally on a “passive” basis when at least 51% of the group’s members live in counties where the carrier’s provider networks are “adequate,” and with no network restrictions or network steerage, similar to the current strategy.

Exhibit 14 indicates that there is a fair amount of interest in this strategy if it could be structured to benefit both the plan sponsor and retirees in at least the near term.
Exhibit 14—Medicare Advantage “Passive” PPO Strategy to Replace Indemnity Plan

*If you could replace your current group-based Medicare medical supplement strategy with a national Medicare Advantage PPO to generate material savings for at least the near term, with no change in retiree benefits, would you consider such an approach?*

- 37% Yes, we would consider capturing the savings
- 54% Unsure
- 9% No, concerned about viability

n=233

Individual Market Strategy

A robust individual health insurance market for Medicare-eligible retirees has been in place since the introduction of the Medicare Part D program in 2006, but the market has been significantly enhanced due to the Medicare Part D and Medicare Advantage changes outlined above.

Beneficiaries can choose from a wide variety of Medicare Advantage, Medigap, and individual Part D plans offered through a range of health plans across the country, with very few barriers to purchasing coverage. With limited exceptions, plans are guaranteed issue and guaranteed renewable without medical underwriting.

Federal subsidies to Medicare Advantage and Part D plans, targeted cost management strategies, intense competition between plans, and a growing Medicare-eligible population drive efficiency and create cost-effective options for retirees.

As a result, more and more plan sponsors see the individual market as the optimal benefit sourcing strategy, potentially in conjunction with a defined contribution subsidy strategy. When subsidies are provided, plan sponsors typically use health reimbursement arrangements (HRAs) to deliver premium and/or out-of-pocket cost reimbursement to participants on a tax-favored basis.
Plan sponsors moving to these strategies typically partner with an administrative coordinator or “exchange” platform to facilitate guided access to the individual market, support retiree understanding and decision-making, and perform enrollment/administrative functions, at little or no cost to the plan sponsor. The main source of revenue for the exchange platform is the commission revenue built into the health plan premiums, which allows the plan sponsor to leverage this approach with minimal administrative cost.

Exhibit 15 shows that a significant number of plan sponsors surveyed are already leveraging individual market-based benefit sourcing strategies for Medicare-eligibles for all or a portion of their groups. A multi-carrier private exchange partnership is the most popular exchange strategy for these plan sponsors, not surprising given the broad choice in carriers, plan designs, and premium levels these exchanges can provide to retirees.

**Exhibit 15—Medicare Participant Individual Market-Based Strategies: Current Prevalence**

Are you currently facilitating guided access to the individual Medicare retiree plan market through an exchange offering a broad selection of designs and premiums for medical, prescription drug, and dental coverage for any portion of your post-65 retiree population?

<table>
<thead>
<tr>
<th>Exchange Strategy</th>
<th>Currently Facilitating Individual Market Strategy in 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>No exchange partnership</td>
<td>12%</td>
</tr>
<tr>
<td>Single carrier exchange</td>
<td>18%</td>
</tr>
<tr>
<td>Multi-carrier exchange</td>
<td>70%</td>
</tr>
</tbody>
</table>

n=349  n=109

For those not yet leveraging an individual market strategy, Exhibit 16 indicates that there is significant short- and long-term interest in directly leveraging the individual Medicare-eligible health care market, with 61% of respondents at least considering this approach for some portion of their population in the future. Additionally, while an exchange partner offering multiple carrier options is initially appealing to some sponsors, most have not yet determined their preferred approach. Sponsors with meaningful numbers of retirees dispersed across the country will likely gravitate toward multi-carrier exchanges because of the broad choice and diversification opportunities.
Exhibit 16—Medicare Participant Individual Market-Based Strategies: Future Outlook

Do you intend to facilitate guided access to the individual Medicare retiree plan market through an exchange offering a broad selection of designs and premiums for medical, prescription drug, and dental coverage for any portion of your post-65 retiree population in the future?

Intend to Facilitate Individual Market Strategy in the Future

<table>
<thead>
<tr>
<th>Intend to Facilitate Individual Market Strategy in the Future</th>
<th>Exchange Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>No 39%</td>
<td>Single carrier exchange 4%</td>
</tr>
<tr>
<td>Yes 19%</td>
<td>Multi-carrier exchange 38%</td>
</tr>
<tr>
<td>Will consider in future 42%</td>
<td>Unsure of exchange strategy 58%</td>
</tr>
</tbody>
</table>

n=240 n=45

Of the plan sponsors currently leveraging individual market-based benefit sourcing strategies for Medicare-eligibles for all or a portion of their groups, Exhibits 17 through 20 outline the covered populations and key design features supporting these strategies.
Exhibit 17—Medicare Participant Individual Market-Based Strategies: Current Plan Sponsor Strategy—Populations Included

Which post-65 retiree populations are you including in your current individual Medicare retiree plan market strategy?

- 86% Both current and future retirees
- 2% Future retirees only
- 12% Current retirees only
- 1% Bargained retirees only
- 51% Both bargained and non-bargained/salaried retirees
- 48% Non-bargained/salaried retirees only

n=109

Exhibit 18—Medicare Participant Individual Market-Based Strategies: Current Plan Sponsor Strategy—Prevalence of HRAs

Many plan sponsors that facilitate guided access to the individual Medicare retiree plan market through an exchange provide a tax-effective subsidy through a health reimbursement arrangement (HRA) to reimburse all or a portion of retiree costs for individual coverage. Do you provide a subsidized HRA?

- Yes 75%
- No 25%

n=109
If you provide a subsidized HRA, which of the following characterize your current strategy?

- **HRA Strategy**
  - Closed (reimbursements for exchange-secured coverage only): 5.7%
  - Open (reimbursements for any individual plan enrollment): 94.3%

- **Subsidy Access/Payout Frequency**
  - Recurring (e.g., annual or “annuity based”): 43%
  - Lump-sum notional account at retirement: 12%
  - Other: 4%

- **Subsidy Strategy**
  - Age or service-linked: 56%
  - Same flat amount for all: 29%
  - Other: 15%

- **Subsidy Indexing**
  - No indexing: 8%
  - Indexed at company discretion: 30%
  - Indexed annually: 62%

- **Additional Subsidy for Spouse**
  - Yes: 8.7%
  - No: 91.3%

- **Single HRA Account per Retiree or Separate per Life**
  - Single account per retiree: 65%
  - Separate accounts per life: 35%

- **Eligible Expenses**
  - Premiums and all out-of-pocket expenses: 60%
  - Premiums only: 20%
  - Premiums and non-Rx out-of-pocket expenses: 20%

- **Savings Feature**
  - Allow carry-over of unusual credits: 76%
  - Do not allow carry-over: 24%

- **Interest Crediting on HRA**
  - No: 10%
  - Yes: 90%

- **Maximum Annual Reimbursement**
  - No, can use full account balance each year: 6%
  - Yes, with annual maximum less than full accumulated account: 94%

- **Support Contingent, Additional Medicare Part D “Donut Hole” Reimbursements, Over and Above Standard HRA Subsidies**
  - No: 68%
  - Yes, through the HRA strategy: 28%
  - Yes, through non-HRA after-tax cash reimbursements: 4%

- **Support Contingent, Additional Reimbursements Providing Some Level of Stop Loss in the 95% Part D Benefit Phase**
  - No: 68%
  - Yes, through the HRA strategy: 28%
  - Yes, through non-HRA after-tax cash reimbursements: 4%

n=82
If you provide a subsidized HRA, which of the following best describes the annual single life subsidy amount for your largest group of retirees in 2015?

<table>
<thead>
<tr>
<th>Annual HRA Amount</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under $500</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>$500 to $999</td>
<td>5</td>
<td>7%</td>
</tr>
<tr>
<td>$1,000 to $1,499</td>
<td>15</td>
<td>21%</td>
</tr>
<tr>
<td>$1,500 to $1,999</td>
<td>11</td>
<td>15%</td>
</tr>
<tr>
<td>$2,000 to $2,499</td>
<td>14</td>
<td>19%</td>
</tr>
<tr>
<td>$2,500 to $2,999</td>
<td>9</td>
<td>13%</td>
</tr>
<tr>
<td>$3,000 to $3,499</td>
<td>6</td>
<td>8%</td>
</tr>
<tr>
<td>Over $3,500</td>
<td>12</td>
<td>17%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>72</td>
<td>100%</td>
</tr>
</tbody>
</table>

n=72

Medicare Program Outlook

Driven by rising health care costs, funding deficits, and demographic changes, there have been a number of proposals recently considered at the federal level to address the Medicare program’s long-term financial challenges. The economy, federal budget deficits, and the political landscape will ultimately determine what types of changes are suggested and implemented, and the plan sponsor impact.

Plan sponsors need to understand the Medicare program changes under consideration including pure federal cost-shifting strategies, and begin positioning their programs to mitigate any potential unfavorable impact. Many plan sponsors will gravitate toward strategies that generally insulate them from the impact of changes to the Medicare program, such as individual market-based approaches.

Not surprisingly, Exhibit 21 shows that 91% of plan sponsors surveyed feel that tracking potential future changes in the Medicare program is at least somewhat important when setting a longer-term retiree health care strategy.
Exhibit 21—Tracking Potential Changes in the Medicare Program: Plan Sponsor Feedback

As you determine your longer-term retiree health care strategy, how important is it to understand the potential future changes in the Medicare program under consideration?

- 9% Not important
- 35% Somewhat important
- 56% Very important

n=349
A robust individual health insurance market for Medicare-eligible retirees has been in place since the introduction of the Medicare Part D program in 2006, but the market has been significantly enhanced due to the Medicare Part D and Medicare Advantage changes introduced by health care reform. Beneficiaries can choose from a wide variety of Medicare Advantage, Medigap, and individual Part D plans offered through a variety of health plans across the country, with very few enrollment restrictions. With limited exceptions, plans are guaranteed issue and guaranteed renewable without medical underwriting.

The 2014 introduction of state and federal health marketplaces has made the individual market more viable for pre-65 retiree populations. Employer interest will continue to grow as the new excise tax that goes into effect in 2018 renders some group plans less fiscally manageable for this population. Plan sponsors will generally start to migrate their pre-65 groups to individual market-based exchange-supported strategies in 2016. The individual market strategy is the optimal way to minimize or eliminate the cash and accounting excise tax risk for this group.

Plan sponsors interested in leveraging this individual market typically partner with an administrative coordinator or “exchange” platform to facilitate guided access to the individual market.

Aon Hewitt currently offers a robust health care exchange—the Aon Retiree Health Exchange™—for both pre-Medicare and Medicare-eligible retirees. This exchange supports individual market health insurance purchasing and value-added ongoing services. For plan sponsors, the individual market-based retiree health care exchange strategy has become a viable alternative to traditional group-based health care delivery.

Under this approach, the plan sponsor may offer a tax-effective defined contribution health care subsidy toward the purchase of individual coverage, which participants secure through the exchange. The exchange provides a variety of decision-support services to help participants choose the plan that’s right for them from among hundreds of competing plans offering significant value. The exchange serves as a centralized administrative platform designed to assist seniors in understanding, evaluating, and enrolling in the individual plan of their choice, and provides ongoing customer service and advocacy well after the enrollment process is complete.
Pre-Medicare Retiree Strategy

Health care reform introduces changes impacting pre-Medicare-eligible populations, including an excise tax on high-cost health plans, a variety of individual market reforms, an individual coverage mandate, the creation of state-sponsored health insurance exchanges, and federal health care subsidies for those who qualify. Additionally, reform introduced a short-term program to help support high-cost pre-Medicare retiree health claims before 2014 for those plan sponsors that applied and agreed to meet specific federal requirements.

Excise Tax
Beginning in 2018, a 40% excise tax will apply on the aggregate health plan cost in excess of specified federal dollar thresholds. This tax can impact active, pre-Medicare, and Medicare-eligible populations but because the cost of pre-Medicare health insurance is so high relative to active and Medicare-eligible populations, plan sponsors have been initially focused on the pre-Medicare population when attempting to understand the potential impact of the new tax.

Additionally, even though the tax does not take effect until 2018, plan sponsors must begin accounting for any material impact of the excise tax immediately under retiree welfare accounting standards. Some plan sponsors have already made changes to their retiree strategy simply to offset the immediate increase in accounting costs associated with this new tax, and others are expected to do so in the near future.

Exhibit 22 shows that many plan sponsors are currently leveraging high-deductible health plans (HDHPs) with health savings accounts (HSAs) to provide retirees with a lower-cost option while helping them save for their own health care costs in retirement.

Exhibit 23 shows that the most common approach sponsors anticipate using to mitigate the excise tax is to change plan features such as deductibles, copayments, and coinsurance. Moving to a defined contribution strategy and sourcing coverage through the state exchanges is also being viewed as a key option.
**Exhibit 22—Excise Tax Mitigation Strategies: HDHP/HSA Prevalence**

**Do you currently offer a health savings account (HSA) in conjunction with a high-deductible health plan (HDHP) to help current and/or future retirees save for their own health care costs in retirement?**

<table>
<thead>
<tr>
<th>Offer Retirees HSA/HDHP</th>
<th>Eligible Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Current retirees only</td>
</tr>
<tr>
<td>Yes</td>
<td>Current and future retirees</td>
</tr>
<tr>
<td></td>
<td>Future retirees/actives only</td>
</tr>
</tbody>
</table>

n=349  n=156

**Exhibit 23—Excise Tax Mitigation Strategies: HDHP/HSA Prevalence**

Which of the following long-term strategies are you favoring with respect to pre-65 retiree coverage to mitigate the excise tax?

- Changing plan features to reduce plan costs (e.g., managing deductibles, copays, coinsurance, etc., or utilizing an HSA/HDHP strategy): 18% #1 Ranking, 12% #2 Ranking, 2% #3 Ranking
- Sourcing coverage through the exchanges under a defined contribution approach: 8% #1 Ranking, 8% #2 Ranking, 7% #3 Ranking
- Changing retiree premium cost-sharing requirements: 3% #1 Ranking, 8% #2 Ranking, 8% #3 Ranking
- No changes to be made; current strategy adequately mitigates the excise cost: 7% #1 Ranking, 2% #2 Ranking, 3% #3 Ranking
- Eliminating pre-65 coverage in the employer plan altogether: 3% #1 Ranking, 2% #2 Ranking, 3% #3 Ranking
- No changes to be made; we will assume the additional cost: 1% #1 Ranking, 1% #2 Ranking, 2% #3 Ranking
- Other: 18% #1 Ranking

n=260
2014 Individual Market Reforms and Coverage Mandate
Reform introduced a variety of individual health insurance market reforms for 2014, including guaranteed-issue health care coverage without medical underwriting for federally prescribed benefit packages delivered through state-sponsored health care exchanges.

Pre-Medicare-eligible individuals (and families) can qualify for federal subsidies for state exchange-based coverage to reduce the cost of coverage. Subsidies are available to those with incomes less than four times the Federal Poverty Level, which varies by state and family size.

All U.S. citizens were required to have qualified coverage by 2014 or face a tax penalty. Pre-Medicare participants can satisfy the mandate by having qualified individual or group-based coverage.

State-Sponsored Health Insurance Exchanges and Federal Subsidies
Health care reform requires states to establish health insurance exchanges by 2014 to allow pre-Medicare-eligible citizens to access federally standardized individual health care coverage, with the following common characteristics:

- The exchanges must offer four “metallic” benefit levels, with varying overall actuarial benefit values—platinum (90%), gold (80%), silver (70%), and bronze (60%).
- Premiums are age-banded and the highest premium for a particular plan cannot exceed three times the lowest premium for that plan, which generally results in a subsidization of older participants by younger participants.
- Federal subsidies are available for individuals earning up to four times the Federal Poverty Level.

These new programs are designed to create a cost-effective individual market for pre-Medicare participants beginning in 2014 with very few, if any, barriers to purchasing coverage. As a result, many plan sponsors are likely to consider this new individual health insurance market as a viable pre-Medicare retiree benefit sourcing strategy in the near future.
Due to the newness of the public marketplaces, evolving implementation rules, deadlines, exemptions, and legal challenges, plan sponsors generally will not start to migrate to individual market-based exchange-supported strategies until at least 2016, assuming the market has stabilized.

Additionally, there is a range of near-term political, operational, legal, and economic uncertainties that need to be clarified before many plan sponsors will be comfortable sending retirees to the public marketplaces to secure coverage for the long term.

Plan sponsors can leverage the new public marketplaces in two fundamental ways. They can choose to eliminate the current group-based program and send retirees to the public marketplace on a full replacement basis, or they can make individual coverage on the public marketplace available as a formal alternative to the current group program, and facilitate evaluation and enrollment in that individual coverage.

Because of the newness of the market, Exhibit 24 shows that very few plan sponsors have chosen to directly leverage the new public marketplaces for 2015 to any extent.
Have you already decided to move any portion of your pre-65 retiree population to the state exchanges to secure coverage for 2015?

### Move Pre-65 Retirees to State Exchange?

#### Optional Strategy

- **No:** 91%
- **Yes:** 9%

<table>
<thead>
<tr>
<th>Eligible Populations</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current retirees only</td>
<td>16%</td>
</tr>
<tr>
<td>Current and future retirees</td>
<td>56%</td>
</tr>
<tr>
<td>Future retirees/actives</td>
<td>28%</td>
</tr>
</tbody>
</table>

n=349

### Full Replacement Strategy

- **No:** 94%
- **Yes:** 6%

<table>
<thead>
<tr>
<th>Eligible Populations</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current retirees only</td>
<td>14%</td>
</tr>
<tr>
<td>Current and future retirees</td>
<td>52%</td>
</tr>
<tr>
<td>Future retirees/actives</td>
<td>34%</td>
</tr>
</tbody>
</table>

n=349
Premium tax credit regulations indicate that if an individual enrolls in an employer-sponsored group health plan considered to provide Minimum Essential Coverage (MEC), he/she is not eligible for the premium tax credit offered through a public marketplace. Employer-sponsored health reimbursement arrangements (HRAs) are considered self-insured group health plans and appear to fall within the definition of an employer-sponsored MEC.

Therefore, implementing employer-sponsored HRAs that automatically enroll pre-Medicare retirees would preclude retirees from securing a federal subsidy on a state exchange, regardless of income. In order to maximize retiree federal subsidy opportunities, plan sponsors will generally make the HRA optional for retirees so they can determine whether to enroll in the HRA or opt out and secure the federal subsidy, if greater.

Exhibit 25 shows that, for the very few plan sponsors leveraging the public marketplaces in 2015 for pre-Medicare retirees, many are subsidizing the retiree to some extent—with an HRA the funding strategy of choice.
Exhibit 25—Subsidizing Retirees on the New Public Marketplaces in 2015

Have you already decided to provide any of the pre-65 retirees you are sending to the state exchanges to secure coverage with a company subsidy to support premiums, out-of-pocket cost reimbursements, or both?

<table>
<thead>
<tr>
<th>Subsidize State Exchanges?</th>
<th>Subsidy Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Optional Strategy</strong></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>75%</td>
<td>25%</td>
</tr>
<tr>
<td>n=32</td>
<td>n=8</td>
</tr>
<tr>
<td>100%</td>
<td>Through an HRA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Full Replacement Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
</tr>
<tr>
<td>57%</td>
</tr>
<tr>
<td>n=21</td>
</tr>
<tr>
<td>100%</td>
</tr>
</tbody>
</table>

With respect to the future, Exhibit 26 shows that many plan sponsors expect to change their pre-Medicare retiree strategy to leverage the new state exchanges in the future, but a significant number are also expected to continue to offer group coverage with no change in strategy. Assuming the market stabilizes, most plan sponsors interested in leveraging state exchanges will likely begin to do so in earnest beginning in 2016.
Exhibit 26—Pre-Medicare Participant Individual Market-Based Strategies: Initial Market Feedback

In light of the PPACA changes, which of the following long-term strategies are you favoring with respect to pre-65 retiree coverage?

Defined contribution strategy with individual market/state exchange-based benefit sourcing

- #1 Ranking: 18%
- #2 Ranking: 13%
- #3 Ranking: 4%

No anticipated change in strategy

- #1 Ranking: 17%
- #2 Ranking: 11%
- #3 Ranking: 6%

Eliminate pre-65 retiree coverage and subsidies altogether

- #1 Ranking: 5%
- #2 Ranking: 6%
- #3 Ranking: 17%

Other

- #1 Ranking: 1%
- #2 Ranking: 1%
- #3 Ranking: 6

n=228
Retiree Health Care Settlement Strategies

Settlement strategies allow a plan sponsor to fully or partially terminate its retiree medical program and eliminate the ongoing program cost and administrative commitment by providing a type of retiree benefit “buy-out.”

Although not common, settlements represent the purest retiree medical “exit strategy” and provide retirees with some level of benefit security, but typically less than what the plan sponsor was supporting on a going-concern basis.

Where applied, such strategies have been used by companies under significant financial duress or in bankruptcy proceedings to remove the retiree medical obligation from the balance sheet while still providing retirees with some level of benefit. These approaches may also be appealing in merger and acquisition scenarios so the new organization can eliminate the ongoing retiree medical program expense.

Settlements can take many forms. Also, there are a number of variables that impact whether a plan sponsor will seriously consider a settlement, the option chosen, the process followed, and the ultimate financial impact, including:

• Overall legacy benefit and bargaining commitments to retirees;
• Financial objectives, economic conditions, and interest rates;
• Accounting, cash flow, and tax implications; and
• Political and public relations implications.

Exhibit 27 shows the spectrum of general retiree medical settlement options and the key characteristics of each.
While not expected to be significant in number, a few plan sponsors will likely at least consider settlements in the future for a variety of reasons, including mitigating the impact of potential future U.S. social welfare program reforms.

Exhibit 28 shows feedback from surveyed plan sponsors concerning retiree medical settlements, and indicates that there is some plan sponsor interest in these strategies.
If the market environment could support a retiree medical settlement on a cost-effective basis, would you consider a retiree health care settlement strategy for all or a portion of your retiree group?

Exhibit 28—Retiree Health Care Settlement Strategies: Market Interest

- No: 26% (n=349)
- Yes: 25%
- Unsure: 49%
Plan sponsors are motivated by opportunities to reduce cost, risk, and administrative burden through specific strategies made possible under health care reform.

Though several key provisions in the new law take effect in the future, plan sponsors are generally not waiting to evaluate and refine their programs. Many are making changes now—or in the very near future—to realize immediate accounting savings while giving themselves and retirees time to understand and prepare for additional changes.

While the political environment will continue to focus on health care reform, the retiree health care marketplace will continue to evolve to facilitate strategies that benefit both plan sponsors and retirees, with a significant focus on individual market-based retiree health care sourcing strategies.

Additionally, with broader U.S. social welfare program reforms (Medicare, Medicaid, Social Security) likely on the horizon due to federal budget deficits and U.S. demographic changes, plan sponsors are looking for ways to mitigate any potential negative impact of such macroeconomic changes on their programs and ongoing costs. Many plan sponsors will find that health care reform-facilitated individual market strategies, which remove the sponsor from the intermediary role between its retirees and the Medicare program, will position them favorably for the inevitable broader social welfare program changes.

The anticipated future political and legislative activity and consistent, critical cost and health care challenges make this an unprecedented time in health care. The decisions plan sponsors make now—to review their retiree health care strategy and set a long-term direction—will have a profound impact. For both plan sponsors and retirees, new and emerging retiree health care strategies can provide superior benefit value at reduced costs.

Conclusions and Future Outlook
**Participant Profile**

**Exhibit 29—Participants by Industry**

<table>
<thead>
<tr>
<th>Industry</th>
<th>Number of Plan Sponsors</th>
<th>Number of Active Employees</th>
<th>Number of Pre-65 Retirees</th>
<th>Number of Post-65 Retirees</th>
<th>Number of Total Retirees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aerospace/Defense</td>
<td>7</td>
<td>338,869</td>
<td>36,959</td>
<td>249,253</td>
<td>286,212</td>
</tr>
<tr>
<td>Agriculture</td>
<td>1</td>
<td>2,800</td>
<td>57</td>
<td>165</td>
<td>222</td>
</tr>
<tr>
<td>Associations/Foundations</td>
<td>5</td>
<td>2,124</td>
<td>428</td>
<td>813</td>
<td>1,241</td>
</tr>
<tr>
<td>Automotive/Transport Manufacturing</td>
<td>11</td>
<td>125,567</td>
<td>40,853</td>
<td>75,587</td>
<td>116,440</td>
</tr>
<tr>
<td>Banking</td>
<td>3</td>
<td>24,500</td>
<td>157</td>
<td>1,150</td>
<td>1,307</td>
</tr>
<tr>
<td>Beverages</td>
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<td>7,571</td>
<td>285</td>
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<td>313</td>
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<tr>
<td>Business Services</td>
<td>5</td>
<td>148,140</td>
<td>14,291</td>
<td>42,169</td>
<td>56,460</td>
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<tr>
<td>Charitable Organizations</td>
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<td>27,281</td>
<td>248</td>
<td>1,863</td>
<td>2,111</td>
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<tr>
<td>Chemicals</td>
<td>10</td>
<td>69,163</td>
<td>9,495</td>
<td>18,864</td>
<td>28,359</td>
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<tr>
<td>Computer Hardware</td>
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<td>50,000</td>
<td>2,700</td>
<td>3,000</td>
<td>5,700</td>
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<tr>
<td>Computer Services</td>
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<td>6,337</td>
<td>896</td>
<td>296</td>
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<td>Conglomerate</td>
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<td>75,000</td>
<td>2,500</td>
<td>9,300</td>
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<tr>
<td>Construction</td>
<td>1</td>
<td>1,183</td>
<td>6</td>
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<td>33</td>
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<tr>
<td>Consumer Products Manufacturing</td>
<td>17</td>
<td>123,867</td>
<td>24,616</td>
<td>56,577</td>
<td>81,193</td>
</tr>
<tr>
<td>Districts and Authorities</td>
<td>2</td>
<td>12,430</td>
<td>480</td>
<td>286</td>
<td>766</td>
</tr>
<tr>
<td>Diversified Manufacturing</td>
<td>13</td>
<td>126,567</td>
<td>16,948</td>
<td>54,719</td>
<td>71,667</td>
</tr>
<tr>
<td>Diversified Nonmanufacturing</td>
<td>1</td>
<td>4,500</td>
<td>17</td>
<td>450</td>
<td>467</td>
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<tr>
<td>Education</td>
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<td>127,851</td>
<td>4,516</td>
<td>27,804</td>
<td>32,320</td>
</tr>
<tr>
<td>Electronics/Electrical</td>
<td>1</td>
<td>4,565</td>
<td>41</td>
<td>219</td>
<td>260</td>
</tr>
<tr>
<td>Energy</td>
<td>16</td>
<td>99,950</td>
<td>10,529</td>
<td>29,971</td>
<td>40,500</td>
</tr>
<tr>
<td>Entertainment/Comm/Publishing</td>
<td>1</td>
<td>2,600</td>
<td>80</td>
<td>100</td>
<td>180</td>
</tr>
<tr>
<td>Industry</td>
<td>Number of Plan Sponsors</td>
<td>Number of Active Employees</td>
<td>Number of Pre-65 Retirees</td>
<td>Number of Post-65 Retirees</td>
<td>Number of Total Retirees</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------</td>
<td>----------------------------</td>
<td>---------------------------</td>
<td>----------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Federal Government</td>
<td>4</td>
<td>31,133</td>
<td>11,719</td>
<td>29,805</td>
<td>41,524</td>
</tr>
<tr>
<td>Financial Services</td>
<td>17</td>
<td>168,557</td>
<td>5,655</td>
<td>26,747</td>
<td>32,402</td>
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<tr>
<td>Food</td>
<td>4</td>
<td>64,200</td>
<td>920</td>
<td>4,222</td>
<td>5,142</td>
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<td>Health Care</td>
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<td>353,045</td>
<td>4,761</td>
<td>12,898</td>
<td>17,659</td>
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<td>Industrial Manufacturing</td>
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<td>169,881</td>
<td>84,699</td>
<td>101,133</td>
<td>185,832</td>
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<td>Insurance</td>
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<td>268,865</td>
<td>19,343</td>
<td>60,628</td>
<td>79,971</td>
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<tr>
<td>Local Government</td>
<td>25</td>
<td>158,257</td>
<td>43,463</td>
<td>104,288</td>
<td>147,751</td>
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<tr>
<td>Media</td>
<td>1</td>
<td>5,000</td>
<td>800</td>
<td>700</td>
<td>1,500</td>
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<tr>
<td>Metals/Mining</td>
<td>4</td>
<td>34,427</td>
<td>7,817</td>
<td>47,151</td>
<td>54,968</td>
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<td>Pharmaceuticals</td>
<td>6</td>
<td>103,374</td>
<td>32,221</td>
<td>52,338</td>
<td>84,559</td>
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<tr>
<td>Public Higher Education</td>
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<td>212,012</td>
<td>14,074</td>
<td>27,662</td>
<td>41,736</td>
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<td>Public School System</td>
<td>7</td>
<td>72,434</td>
<td>5,758</td>
<td>14,780</td>
<td>20,538</td>
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<td>Retail</td>
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<td>446,500</td>
<td>2,750</td>
<td>4,331</td>
<td>7,081</td>
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<td>State Government</td>
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<td>1,075,640</td>
<td>243,135</td>
<td>596,684</td>
<td>839,819</td>
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<td>486,955</td>
<td>190,342</td>
<td>301,951</td>
<td>492,293</td>
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<td>Transportation</td>
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<td>29,950</td>
<td>4,617</td>
<td>6,927</td>
<td>11,544</td>
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<td>Transportation Services</td>
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<td>199,585</td>
<td>13,537</td>
<td>22,681</td>
<td>36,218</td>
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<td>Utilities</td>
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<td>179,803</td>
<td>55,113</td>
<td>104,557</td>
<td>159,670</td>
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<tr>
<td>Wholesale and Distribution</td>
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<td>44,164</td>
<td>228</td>
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<td>1,404</td>
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<tr>
<td>Private Other</td>
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<td>433,810</td>
<td>73,516</td>
<td>53,477</td>
<td>126,993</td>
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<td>Public Entities Other</td>
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<td>225,423</td>
<td>19,151</td>
<td>52,635</td>
<td>71,786</td>
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<tr>
<td><strong>Total Number of Survey Participants</strong></td>
<td>349</td>
<td>6,143,880</td>
<td>999,721</td>
<td>2,199,412</td>
<td>3,199,133</td>
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</tbody>
</table>
Nearly 40% of survey participants have 10,000 or more employees. The median number of U.S. employees is 6,525 and the average is 17,604. With regard to U.S. retirees, 56% of participants have 1,000 or more retirees, the median number is 1,350, and the average is 9,167.

### Total U.S. Employees

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1,000</td>
<td>14%</td>
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<tr>
<td>1,000–4,999</td>
<td>30%</td>
</tr>
<tr>
<td>5,000–9,999</td>
<td>19%</td>
</tr>
<tr>
<td>10,000–24,999</td>
<td>20%</td>
</tr>
<tr>
<td>25,000 or more</td>
<td>18%</td>
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</tbody>
</table>

### Total U.S. Retirees

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1,000</td>
<td>44%</td>
</tr>
<tr>
<td>1,000–4,999</td>
<td>29%</td>
</tr>
<tr>
<td>5,000–9,999</td>
<td>11%</td>
</tr>
<tr>
<td>10,000–24,999</td>
<td>8%</td>
</tr>
<tr>
<td>25,000 or more</td>
<td>8%</td>
</tr>
</tbody>
</table>
Contacts

For questions about this survey, contact:
Alesha Henley
Marketing Manager
Aon Hewitt
4 Overlook Point
Lincolnshire, IL 60069
+1.847.442.1995
alesha.henley@aonhewitt.com

For questions about the Aon Hewitt Retiree Health Care Sub-Practice or how Aon Hewitt can help support your retiree strategy needs, contact:
John V. Grosso, FSA, MAAA
Senior Vice President
Aon Hewitt
Health & Benefits Consulting Practice
45 Glover Avenue
Norwalk, CT 06850
+1.203.523.8416
john.grosso@aonhewitt.com

Aon Hewitt Retiree Health Care Sub-Practice

Retiree health care consulting is a core competency at Aon Hewitt, which goes well beyond simply valuing employer liabilities and focuses on retiree health care strategy, design, compliance, and cost management.

Aon Hewitt’s Retiree Health Care Sub-Practice is a dedicated team of health care and retirement actuaries, generalists, and specialists—including pharmacists and legal consultants—who are focused on retiree health care strategy innovation, market/vendor tracking, and client solution development.

This national team drives Aon Hewitt’s retiree strategy consulting for public and private employers, including the implications of health care reform, Medicare Part D, Early Retirement Reinsurance Program, Medicare Advantage, individual market strategy development, funding, and captives.

For questions about the Aon Retiree Health Exchange™, contact:
Michelle Futhey
National Market Leader
Aon Exchange Solutions
8182 Maryland Avenue
Clayton, MO 63105
+1.314.713.9268
michelle.futhey@aonhewitt.com

Aon Retiree Health Exchange™

As the market shifts toward individual market-based benefit sourcing, many employers are looking to leverage an exchange partner to help their retirees enroll in individual coverage. The Aon Retiree Health Exchange™ offers a trusted way for employers to transition retirees to the individual marketplace by providing expert one-on-one guidance and support to help them shop, compare, and enroll in the right plan for them.

The Aon Retiree Health Exchange features a broad range of insurance products to help retirees find quality coverage for every type of need: medical, prescription, vision, and dental. Our dedicated, licensed benefit advisors help retirees narrow down their choices to find the best option to meet their individual needs—providing unparalleled peace of mind and confidence to retirees and employers alike. The Aon Retiree Health Exchange is recommended by the National Council on Aging (NCOA), in part because of the lengths to which we go in helping retirees make informed choices and get the most out of their coverage.

Support doesn’t end at enrollment. Retirees have access to advocates who are engaged and accessible for as long as retirees own their coverage.
About Aon
Aon plc (NYSE:AON) is a leading global provider of risk management, insurance brokerage and reinsurance brokerage, and human resources solutions and outsourcing services. Through its more than 69,000 colleagues worldwide, Aon unites to empower results for clients in over 120 countries via innovative risk and people solutions. For further information on our capabilities and to learn how we empower results for clients, please visit:

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