Returning Retirees:

Considerations for Health Plan Fiduciaries

by | **Paul Catenacci**

Returning retirees can help ease labor shortages, but multiemployer health plan trustees must be aware of the compliance and administrative implications created when a retiree comes off the sidelines.

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Retirees returning to work raise a variety of plan design and compliance considerations for trustees of multiemployer health plans. This includes compliance with Medicare Secondary Payer (MSP) rules, how to treat incoming employer contributions for the retiree, possible reinstatement of working retirees to active coverage as well as whether the return to work affects service requirements applicable to retiree coverage when the retiree stops working.

This article will explore these topics and discuss the fiduciary and compliance considerations they present for health plan fiduciaries.

Plugging the Labor Gap

The need for workers has been a recurring theme for just about every industry since the ending of the restrictions put in place due to the COVID-19 pandemic. Yet, perhaps nowhere is the need more acute than in the building and construction industry. An aging population of tradespeople, combined with the backlog of work created by the pandemic as well as new developments driven by government programs and funding, has resulted in many unions and employers turning to retirees to ease temporary or extended labor shortages.

Returning retirees bring not only extra pairs of hands but also years of experience performing and supervising work and crews of workers. They can also serve as an invaluable training and mentoring resource to the next generation of tradespeople who are starting their careers. But their return raises legal, plan design and operational issues for health plans that require consideration and ongoing monitoring by plan trustees.

takeaways

- As a result of the backlog of work created by the pandemic as well as new developments driven by government programs and funding, many unions in the building and construction trades are turning to retirees to ease temporary or extended labor shortages.
- When a retiree returns to work, it raises legal, plan design and operational considerations for multiemployer health plans.
- One question that plan trustees must consider is where to direct employer health plan contributions. Some plans direct them to the good of the plan, use them to offset eligibility premiums paid by the retiree or refund them to the retiree.
- The number of hours retirees work will affect their return to retired status and the application of Medicare Secondary Payer rules.
- Health plan design considerations include how to treat hour banks and service requirements for retiree health coverage.

Keeping Their Pensions

When retirees return to work, boards of trustees, as well as the retirees themselves, often inquire first about whether the working retirees will continue to receive their pension benefit. Retirees are generally restricted by the defined benefit (DB) plan rules in the number of hours per month they can work while still collecting their pension benefits. This can be low, 40 hours per month in some cases; so if there is a desire to bring retirees back into the workforce, the DB plan trustees will need to consider changes to their "suspension of benefit" rules. This situation requires clear and open communication between the boards of trustees for the health and pension plans in situations where the board makeup is not the same—But the inquiry does not end there.

Trustees of health plans must also consider how retirees returning to work will impact their plans. Considerations are explored in detail as follows.

Incoming Contributions for Retirees—Who Keeps the Money?

When a retiree goes back to work, their employer will be required to remit contributions to the health plan for the hours they work. Absent existing plan rules on this topic, plans will have to set rules to determine who gets to keep that money. There is no right or wrong answer to this question, so each plan will have to decide what works best for that particular plan. For example, some plans direct the contributions to the financial benefit of the plan overall, which means that the retiree (if covered by a retiree health plan) will continue making the monthly premium payment they were making before they came back to work. Other plans may decide to use the employer contributions to benefit the working retiree by offsetting the eligibility premium paid by the retiree with any excess going to the benefit of the plan. Still others may refund the contributions to the retiree, return the retiree to active status or adopt a mix of these options.

Determining which option is best will vary from plan to plan, and like any other decision, designing these rules is a fiduciary function under the Employee Retirement Income Security Act (ERISA). When deciding on a prudent design, health plan trustees must determine what is in the best interest

of the plan and its participants, and this will require the balancing of many factors. For instance, health plan trustees should first consider the financial health of their plan—Is the plan deficit spending or low on cash reserves? In those situations, trustees may well decide that the plan needs this money for the good of the plan, particularly when the retiree is also receiving a DB pension benefit while working. On the other hand, plans in a stable or strong funding position may take a different approach and decide to give the retiree all or a portion of the benefit of the contributions as an additional enticement to come off the bench and go back to work.

Regardless of which way a plan chooses to go, the rules should be clearly laid out in the plan's governing documents; understood by the board of trustees, the salaried plan administrator or third-party administrator (TPA); and clearly communicated to plan participants in a written notice.

Keep a Close Eye on Medicare Retirees

How many hours retirees will work is another issue that trustees must consider. They should ensure that those hours are being tracked and determine what classification the retiree will be given under the plan while they are working. This is critically important for Medicare-eligible retirees, due to MSP rules.[1]

The MSP rules prevent plans from "taking into account" a participant's eligibility for Medicare when determining eligibility for coverage. This generally results in Medicare paying *secondary* whenever an employee is eligible to receive health insurance coverage as a result of working.[2] These rules will apply to most multiemployer plans, since all it takes is a single contributing employer to the plan to have employed 100 full-time or part-time employees on 50% or more of its regular business days during the previous calendar year to trigger their application.[3] In instances where a plan insures its Medicare retirees and self-funds the claims for everyone else, the MSP rules can result in a complete shifting of the claims risk for the working Medicare retiree from Medicare back to the self-funded asset pool of a health plan.

To better understand the MSP rules, let's take a closer look at how the rules work in practice. In a nutshell, this prohibition[4] means what it says—A plan cannot consider a participant's eligibility for Medicare in its plan design by taking actions such as:

- Failing to pay primary benefits
- Making Medicare-eligible participants wait longer for coverage to begin
- Charging Medicare-eligible participants higher premiums
- Imposing limitations on benefits for the Medicare-entitled individual that do not apply to others enrolled in the plan. Examples of such limitations include providing less comprehensive health care coverage, excluding benefits, reducing benefits, charging higher deductibles or coinsurance, providing for lower annual or lifetime benefit limits, or being more restrictive on preexisting condition exclusions.[5]

Accordingly, if a Medicare-eligible retiree who is receiving coverage from the plan's Medicare program works sufficient hours to become an active participant in the plan, the retiree would have to be treated as an active participant under the plan at least for purposes of coordination with Medicare.[6] This means at a minimum that the plan—not Medicare—has to pay first, resulting in a shift of primary liability for the claims that the working retiree (and any dependent) incurs.

Moreover, in some settings, the shifting of claims risk can be more dramatic. In recent years, the structure of Medicare and associated subsidies has driven many plans that cover Medicare retirees to adopt fully insured group Medicare Advantage (MA) plans. When a retiree comes back to work and works enough hours to become an active participant in the plan once again, that retiree must move off the MA plan and back onto the active plan. Not only does this result in a complete shift of the claims risk, it also creates an administrative load for the plan since the administrator must track the hours of the working retiree and ensure that they are moved off the MA plan and put back onto the active plan. Health plan trustees should discuss with their plan professionals how this shifting of risk may impact the plan. For self-funded plans in particular, the trustees need to review the potential impact on stop-loss coverage.

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Another way in which the MSP rules play a role is how Medicare views extended eligibility. Active participants typically have a way to accumulate eligibility for use when work is slow or when the participant may be laid off. Most plans refer to this mechanism as an "hour bank," but different terms may also be used. Plan rules on these banks vary widely, so trustees will need to carefully review the rules in place that affect all participants. If a returning retiree is restored to active status, they would start to accumulate extended eligibility once again. This is very important to consider because Medicare considers banked hours or extended eligibility to be a form of retention of employment rights.[7] In other words, Medicare views extended coverage rights or banked hours as equivalent to a retiree still being actively employed. As a result, if a plan permits or requires a retiree to exhaust accumulated eligibility or banked hours before being required to start paying for retiree coverage, Medicare will pay *secondary* during the period that the banked hours are being exhausted. Consequently, a plan's bank exhaustion feature will operate to extend the period that the active pool bears the risk of claims for Medicare-eligible working retirees after their return to work is over.

But the plan is not alone in being impacted by the way the MSP rules affect working Medicare-eligible retirees. The retiree also will be impacted by moving from one plan of benefits to another. In many cases, the cost-sharing requirements (copays, deductibles and coinsurance), as well as the network and prescription drug coverage, are unlikely to be the same under each plan. Therefore, welfare plan trustees should ensure that retirees are well-informed about how their coverage may change should they choose to return to work. Non-Medicare retirees who are moving from a retiree health plan to active coverage also should be informed of the potential for such changes.

Additional Fiduciary and Plan Design Considerations

Navigating the MSP rules and deciding how to allocate the incoming contributions are not the only fiduciary considerations for welfare plan trustees. Unlike pension plan trustees, health plan trustees have wide latitude to set eligibility rules. Typically, eligi-

Returning Retiree Checklist

Health plans should make sure to address the following issues related to returning retirees:

- ❑ **Treatment of health plan contributions.** Absent existing rules, the plan must set rules governing treatment of employer health plan contributions made on behalf of the returning retiree. Options range from directing the contributions to the benefit of the plan to refunding the contributions to the retiree. Plans may tinker with novel approaches as well, such as crafting broadly applicable rules that apply equally to all plan participants (for example, adopting a uniform rule on treatment of contributions for working retirees in excess of what is needed for eligibility), not just those who are eligible for Medicare, in an effort to manage risk and ease plan administration.
- ❑ **Compliance with MSP rules.** The salaried administrator or TPA should keep a close eye on the hours being worked and how the plan is coordinating coverage on claims for participants with coverage under Medicare.
- ❑ **Shifting of claims risk.** Discuss with plan professionals how the shifting of retirees from Medicare to active coverage will affect the plans as well as stop-loss coverage.
- ❑ **Retirees who return to active status and retire once again.** Issues include:
  - **Banked hours:** If the plan provides for the use of banked hours before retiree premiums are due, any accumulated banked hours must be exhausted before Medicare begins or returns to paying primary. To accelerate this process, plans may consider applying the active rate for coverage rather than subsidized retiree rates against banked hours. They may also adjust hour bank balances when the contribution rate increases.
  - **Service requirements for retiree health coverage:** Plan documents should be clear about whether the return to work will reset any service requirements that apply to eligibility for retiree health coverage. Most commonly a short stint will not reset the clock, but plan trustees might think differently about longer periods of work, especially if the retiree continues to work after the expiration of a pension plan's lifting of benefit suspension rules.

bility for retiree coverage is earned through service. These service-based rules often require the active participants to have a certain number of years of service or hours worked to qualify for retiree coverage. Many plans also require the active participant to have worked a certain number of hours in the years or months directly preceding the participant's retirement. These rules are meant to ensure that retired participants have a working history with the plan, as opposed to departing for the majority of their working years, only to resume working just before retirement, seeking to secure subsidized retiree coverage from the plan.

Health plan trustees should clarify how these service rules will apply to retirees who regain active status in order to avoid administrative confusion, unintended loss of coverage or both. In addition, many plans provide a host of other ancillary benefits such as death benefits, accidental death and disability (AD&D), and loss of time (or short-term disability) benefits. Trustees must address whether working retirees are entitled to some, all or none of these benefits when designing return-to-work rules.

Conclusion

As discussed previously, when employers and unions are faced with a temporary or even extended shortage of labor, retirees bring more than just extra pairs of steady hands. Their experience can be an invaluable resource, and the hours they will work will generate dollars not only for health plans but also pension, training, supplemental unemployment and other affiliated fringe benefit plans. But their return to work does not come without some legal and administrative considerations. These considerations, even the shifting of claims risk, are highly unlikely to outweigh the gains and the absolute need to ensure that jobs are properly staffed. However, they nonetheless must be considered in order to meet ERISA's fiduciary obligations and to ensure that the return-to-work process for retirees begins—and ends—smoothly for everyone involved.

bio

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Plan design governing returning retirees should be studied thoroughly and undertaken in close consultation with plan professionals. Any plan design changes should be documented in writing and clearly communicated to all plan participants to meet applicable notice obligations under ERISA and to ensure compliance with MSP rules.

Even if the plan has existing rules on this topic, revisiting them occasionally is a prudent and worthwhile exercise. It is also a good idea to periodically remind working retirees of these rules. Annual mailings, such as those sent during open enrollment, represent a good opportunity to reinforce that returning to work is not as simple as dusting off the tool belt from the garage.

Endnotes

1. The Medicare Secondary Payer rules apply in other situations in addition to when persons return to work, such as when a person is diagnosed with end-stage renal disease. This article, however, will discuss the application of these rules only to retirees coming back to work in covered employment.
2. 42 CFR 411.104(c).
3. 42 CFR 411.100.
4. 42 CFR 411.108(a)(1)-(11).
5. See 42 CFR 411.108(a)(1)-(11) for comprehensive list of prohibited actions.
6. 42 CFR 411.104(c)(1).
7. 42 CFR 411.104(b)(3).