

Retiree Health Plan Drug Benefits in Light of the New Medicare Drug Law

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Introduction

The recent trend of decreasing employer coverage for retiree health benefits will have major implications for the future viability of the Medicare program. This connection stems from the new tax-free subsidies for retiree plans in the Medicare Prescription Drug Improvement and Modernization Act of 2003 (Public Law 108-173), MMA. In passing the MMA, Congress intended to relieve the difficult situation that retiree plans are currently facing. This situation includes an increasing trend of higher out-of-pocket costs for those employees who have retired, less support from plan sponsors for both current and future retirees, and disappearing plans for those employees yet to retire. A number of factors have brought about this trend in retiree benefits. Those factors most directly responsible include the increasing cost of health coverage (though the trend has slowed down somewhat), increased competition among plans, certain changes in accounting practices among both private and public employers, and an aging population.

This aging population has and will continue to have an increasing need for employer-sponsored health plans as an important supplement to Medicare as its members begin to retire. The most recent data from the Medicare Current Beneficiary Survey shows that nearly a third (28%) of current non-institutionalized Medicare beneficiaries rely on supplemental coverage from retiree employer-sponsored plans. In fact, employer-sponsored retiree plans were the leading source of supplemental insurance (1). These supplemental benefits have been especially important in the area of prescription drugs. Though the MMA has provisions to explicitly provide benefits for prescription drugs, the main provisions for Medicare Part D (the drug benefit) will not emerge until 2006. These provisions will also include an employer subsidy to help provide support for those employer-sponsored retiree plans that maintain drug benefits at least actuarially equivalent to what will be offered in the new Medicare Part D. The process for making determinations of equivalency is currently the subject of a proposed rule from the Centers for Medicare and Medicaid Services (CMS).

The payments will be made as direct subsidies and through insurance. The MMA also provides for tax-free status to the funds employers receive if they maintain drug coverage for retirees once the Medicare drug benefit begins. Employers who maintain drug coverage could either enroll their beneficiaries in Part D or supplement the Part D benefits. Any third-party coverage for cost-sharing, however, does not count towards the beneficiary out-of-pocket limits. Those employers already providing benefits equal to Part D coverage (to beneficiaries who are eligible but not enrolled in Part D) will get paid for 28% of allowed drug coverage (not including the deductible) from \$250 up to \$5,000 per enrollee (indexed to growth for Part D drugs average per capita spending). The legislation also directs a study to be undertaken to study both the effects the MMA has on employer-based health coverage and other issues in employer-based retiree coverage.

Though intended to help support retiree benefits, many have expressed strong concern that the subsidy will influence employers to lower their benefits to just meet the actuarial criteria necessary for the subsidy. The Congressional Budget Office (CBO) projected subsidy spending to be \$71 billion between 2006 and 2013, not including \$17.8 billion in tax benefits. CBO initial estimates also predicted about a third of Medicare beneficiaries with retiree benefits could lose their benefits directly as a result of the legislation. This estimation stems from CBO's belief that some employers would see the Medicare employer drug subsidy as an opportunity to reduce the costs and risks associated with the drug plan and hence choose not to supplement the Part D benefit. To this

effect, CBO quoted research showing that a quarter of surveyed employers would take this approach should Part D include catastrophic coverage above \$4,000 (2). Also, supplemental plan assistance (for those plans with the subsidy) does not count towards the out-of-pocket limit for beneficiaries, which means they do not count towards catastrophic coverage. Hence, the supplemental payments will not receive federal reinsurance as is the case for out-of-pocket expenditures. This result makes it disadvantageous for employers to sponsor supplemental plans compared to sponsoring non-supplemental coverage. Whether or not retirement plans choose to go this route is solely up to the plan sponsors: the employers. There are no provisions in the MMA to make sure plan sponsors do not lower their benefits. However, it is important to note that the trend of decreasing benefits and rising retiree contributions was already present before the MMA. And it is more likely that the underlying factors for this trend will continue to be more influential than the impact of the MMA.

Retiree Benefit Erosion

Employer-sponsored retiree health care has shown a general decline in recent years and shows signs of continued worsening. For example, the percentage of employers offering health coverage for their retirees has declined since 1988 from 66 percent to 38 percent in 2003 (3). To examine the components of this erosion, the Kaiser Family Foundation in conjunction with Hewitt Associates conducted a survey of firms covering nearly a third of the approximately 12 million nonfederal retirees in employer-sponsored health plans. This survey, conducted between passage of the House/Senate Medicare bill (June 27, 2003) and passage of the final conference agreement (November 25, 2003), basically presented a snapshot of what employers were offering in retiree health plans prior to the Medicare subsidy taking effect.

Retiree Health Plan Structures

According to the Kaiser/Hewitt study, over half (55 percent) of firms currently offer their retirees a choice of two plans, while the remaining 45 percent only offer one plan. Common health plan types include indemnity and managed indemnity (the most often offered for Medicare retirees). Other plan types include Medicare+Choice (which will become Medicare Advantage under the new MMA), and other managed care choices including HMOs and PPOs. Employers use these plans primarily as either “carve-outs” or in a fully coordinated fashion with Medicare. If an employer chooses to “carve-out” the benefit (43 percent take this approach), the plan calculates the total cost of the benefit, subtracts the Medicare portion and passes the difference on to the retiree, who is still required to pay the employer plan’s deductible and cost sharing. The full coordination approach (used by 27 percent of firms) involves calculating the total charges for health care, subtracting the Medicare contribution, and the employer paying the difference. This method basically covers everything for retirees (no out-of-pocket expenses) (3).

Private Sector Employer Reaction to Rising Health Costs

The Kaiser/Hewitt study also showed that retiree health costs increased 13.7 percent in 2003 to reach a total of \$20.6 billion (up from \$18.1 billion in 2002). In the firms surveyed, 92 percent of chief executive officers expressed concern

over the matter of retiree health benefit costs. The reaction to this concern has been not only to shift more of the cost, but also to start placing limits, or caps, on expenditures. Some firms have begun to follow this practice (46 percent), and more firms plan on doing so in the future. Of those firms with caps on 65 and older retiree health expenditures, over half (52 percent) have reported hitting their cap (another 27 percent reported probably hitting their cap in the next one to three years). Furthermore, two thirds of firms who use or will use caps reported they held or intend to hold steadily to the cap (3).

In addition to caps, employers take other measures to streamline their retiree health care costs in terms of plan structure. For example, for the 93 percent of firms that offer drug benefits, those benefits generally do not fall under a separate deductible. However, over a quarter of firms surveyed (26 percent) use a separate deductible, and 8 percent of the largest firms also impose a separate limit on drug benefits. Fortunately, less than 1 percent of surveyed firms have recently eliminated drug coverage entirely. Employer-sponsored drug plans are increasingly beginning to look to three-tier cost-sharing arrangements along with prior-authorization requirements and therapeutic interchange rules. Also, more firms are beginning to require “step therapy,” where low-cost treatment is used before moving onto more expensive medication (3).

Although employer-sponsored retiree health plans have had several structural options at their disposal that they are increasingly beginning to use, the bluntest is to increase beneficiary contributions. This option has been more common than other more drastic measures like eliminating retiree coverage entirely for future employees: only 10 percent of firms surveyed. Increased contributions have manifested themselves in the form of raised premiums, higher percentage cost-sharing, and increased contributions for dependent coverage. Increased cost-sharing for retirees often accompanies increased cost-sharing for current employees. PriceWaterhouseCoopers obtained survey information indicating that 86 percent of surveyed companies are requiring employees to make a greater contribution to their health care benefits (4). In following this practice, 72 percent said they have raised their deductibles, 71 percent have increased co-payments for drugs, and 69 percent raised the co-payments for generics (the presumably less expensive drugs) (3). A survey by the Commonwealth Fund also shows 33 percent of companies increased employees’ co-payments or coinsurance in 2002, 31 percent increased their employees’ share of premiums, and 25 percent raised deductibles (4). These data show how the sting employers are feeling from increased health care costs is being transferred to their employees, which helps provide a precedent for the cost-shift to their retirees.

Recently, despite the consistent increases from year to year, medical cost trends have begun to at least slow down. In 2002, health care spending per privately insured American rose 9.5 percent (slightly smaller than the 10 percent rise in 2001), but spending increases actually dipped to a 7.4 increase in 2003. Despite the rising costs of prescription drugs, pharmaceuticals actually experienced the greatest deceleration (from 13.2 to 9.1 percent). Deceleration also occurred in employer health premiums (5).

Despite the decreases in acceleration, experts say not to expect any real decreases in premium costs. Wall Street analysts have pointed to increased clout by insurance companies (a market that experienced greater consolidation over recent years) as a major reason for insurance companies to hold their ground. Analysis by leaders in the private health care world also predicts the unprecedented sophistication the insurance industry exercises places it at a distinct advantage over those who will try to negotiate with them in the future. As long

as this case holds true, the future of retiree care will most likely continue its trend of cost-shifting and structural price controls (6).

The Kaiser/Hewitt survey reports that most of the changes that firms predict will involve higher retiree contributions and cost-sharing for their plans. It found that 86 percent of surveyed firms claim that it is somewhat or very likely that they will increase retiree contributions to premiums in the next three years. The cost-sharing increases predicted by employers include deductibles, physician visit co-payments, out-of-pocket limits, hospital co-payments, and retiree co-insurance. In addition, half of surveyed employers are planning to switch from fixed co-payments to co-insurance for their retiree population for prescription drugs. Also, separate deductibles as well as caps or decreases in annual drug benefits will become more prevalent. Cost-controls will probably also include more prior authorization requirements, requirements for therapeutic interchange, and step therapy (3).

These measures will in all likelihood contribute to the general erosion of retiree benefits, leaving many retirees at greater risk of having inadequate financial protection for health care costs. For example, a study conducted by Hewitt Associates finds that for employees who retire at age 65 with no employer subsidy for health costs, medical care will cost annually 20 percent of pre-retirement income. Hewitt predicts that workers will need to acquire enough funds to provide an annual income on par with about 85 to 95 percent of their pre-retirement income. Pre-Medicare beneficiaries are expected to have an even more difficult time (7).

Accounting Practice Change Effects in Private and Public Retiree Plans

The measures employers are taking for their retiree health plans also emerged as a result of changed accounting practices for retiree health plans which highlighted retiree costs. . The Financial Accounting Standards Board (FASB) in the early 1990s issued FAS 106 switching away from accounting practices where retiree expenses (annual pension benefit obligation [APBO]) were reported in the period when they were spent for an employer's retirees. Instead, FAS 106 calculated costs as the current employee earned time in his or her plan. This change was necessary as current funding for retiree plans was becoming inadequate. The balance sheet then reflected how liable a company would be not only for present but for future expenditures for these persons. Such liability has definite implications for stockholder values, an industry tremendously driven by speculation.

The government (particularly state and local) tends to follow guidance from the Governmental Accounting Standards Board (GASB) when calculating their post-employment benefits (OPEB). The GASB has decided to follow a model closer to that espoused by the FASB, but there may be differences. For example, while the effect on private firms, coupled with increasing health care costs, seems to have been definite erosion in health benefits for retirees, the public sector might not mirror the experience as closely. For one, the actual effect of FAS 106, by itself, is somewhat in doubt. Also, stock market values often hinge on what a company reports yearly. State and local governments are not publicly traded, easing the pressure. Plus, state governments tend to be larger with more clout to use in negotiating with insurers. This leverage provides more stability in retiree benefit plans long term. For example, premium sharing has been stable over the last ten years. This stability, even if it is for just one cost-sharing dimension, has remained despite the rising health costs that have battered private-sector retiree plans into decreasing retiree benefits. An

increasingly aging population could hinder the situation, though. For example, in 1996, the ratio of active employees to retired personnel in large public pension plans for state workers was 2.8 to 1, but fell to 2.4 to 1 in 2002 (8).

Both FASB and GASB guidance will help to foster greater generational equality between current retirees and future retirees. This greater equality stems from the fact that current tax-payers will now be paying more into the retirement system when pre-funding their plans supporting not only the current generation of Medicare retirees, but also their own plans as well. The equity between generations of employees and retirees has become a larger issue as recent guidance (published in the Federal Register June 28, 2004) from the Equal Employment Opportunity Commission (the EEOC) has reversed its policy concerning the Age Discrimination in Employment Act (ADEA), now supporting the elimination of benefits for Medicare-eligible retirees (9). The EEOC decision stems from the difficulty that plans were experiencing in maintaining mandated parity between Medicare and non-Medicare eligible retirees. Having the option of eliminating coverage for Medicare-eligible retirees will reflect more positively on private sector balance sheets should firms pursue this option.

In May of 2004, the FASB issued new guidance for addressing the MMA and accounting for the employer subsidy. Their guidance took effect on June 15, 2004 and applied only to single-employer defined benefit postretirement health care plans for which (1) the employer has decided that the drug benefits in the plan are “actuarially equivalent” and thus qualify for subsidy funds under the MMA and (2) the estimated subsidy will offset or reduce the employer’s portion of costs of post-retirement drug coverage. According to the guidance, the subsidy will be used as an actuarial gain for APBOs in current periods. Hence, the current benefit will be considered as a gain against future expenditures for current workers. Guidance from FASB also clarified accounting procedures a company would need to follow to increase their plan’s status for Part D. Conversely, the procedures for lowering a health plan’s status were described as well (10).

For the categories of private sector employers mentioned, an employer sponsor can only meet those requirements if they are able to satisfactorily calculate what the effect of the subsidy will be on their plans. This effect may be difficult to see since the level of future participation will largely be determined by factors external to company plans (e.g. the number of Medicare regions or what Medicare + Advantage options a retiree chooses). For those unable to calculate the magnitude, the guidance does not specify that the subsidy needs to be reported, at least until the effect can be determined. However, the company does need to report its awareness of the MMA subsidy and that the APBO does not reflect the subsidy difference. Hence, even for those employers who do not report the numerical difference on their financial statements, stockholders can still get an idea that the APBO is somewhat exaggerated in a positive direction.

Even though FASB provided some guidance for single sponsors of retiree health plans, the board did not cover what would happen in the case of multiple sponsors. Furthermore, and of more public policy significance, the guidance did not mention what procedures to follow if the subsidy was greater than the employee contribution to the plan. This matter is of more public policy significance, because an employer whose contribution was out-matched by the subsidy would experience a financial gain. CMS is taking steps to address this issue in their proposed rule discussed further below. The private and public sector also need further guidance on what plan requirements need to be met in order for a plan to meet the actuarial equivalence standard that Part D requires. CMS has also provided some options to consider for this question as well as subsidy options for employers.

MMA Subsidy Issues

Beneficiary Concerns

A number of groups have expressed concerns over what the new MMA could mean for retiree plans. Some believe that because plans only have to meet a minimum equivalency standard for the Part D subsidy, there is a realistic possibility that plan sponsors will start to lower standards to qualify. Consequently, there has been some pressure on Congress to mandate that employers sustain current benefit sponsorship to qualify for the subsidy.

Some congressional critics of the MMA have expressed concerns that the increases in Part B and Part D premiums will eat into the cost-of-living adjustments (COLAs) that act as the current limit for Part B increases deducted from a retiree's social security check (11). The Part D legislation does not have this "hold-harmless" provision in place. Seniors are hence running an increased risk of having premium raises deplete more of their savings. It is important to note that the COLA is intended to help adjust for the price rises in non-medical goods and services. Hence, even if the "hold-harmless" provisions do not cut savings directly, they will still have to pay for the costs of other price increases made more difficult by increasing premiums. MMA supporters have claimed that any premium increases from the MMA's Part D represent what retirees are paying already for drugs. Critics have also expressed concern about the MMA not allowing retiree health plan expenditures to count towards the catastrophic limit. Also, they have decried the high discrepancy between the percent of subsidy to employers (28 percent of allowable drug costs) and that granted to Medicare Advantage Prescription Drug Plans (73 percent of typical plan costs). To secure these subsidies, however, Medicare Advantage plans must submit certain bids to meet benchmarks that the Secretary determines. The MMA does not require employer sponsored plans to meet any such criteria. The private sector will have to meet other criteria to receive the subsidy from the MMA program, and CMS has begun to outline what those criteria will be.

CMS Proposed Rule

On July 26, 2004, CMS released its proposed rule for distributing funds to employers for the MMA subsidy to their retiree plans. A final version of the rule is scheduled for release in early 2005. In the proposed rule, CMS maintained that it intends to make funding attractive to employers and beneficial to the retirees. CMS attributes decreasing levels of retiree benefits to rising health costs, increasing numbers of retirees, and new accounting rules. The subsidy is projected to provide on average \$611 per beneficiary. The tax-free status raises the value to \$855 at the average corporate marginal tax rates and \$940 at the 35 percent marginal tax rates which many large firms pay. For beneficiaries to take part, CMS has released three different options for participation (12).

In the most direct option, the federal government would provide the 28 percent subsidy and reinsurance subsidies directly to the employer for qualified drug costs as long as the employer's plan meets the actuarial standards necessary to be considered a Part D plan. Also, beneficiaries could opt to get drug coverage through a private coordinated-care health plan available only to a firm's retirees, which would mean that the plan receives the subsidy. Employers and unions who provide "wrap around" coverage (supplemental benefits) could receive subsidy payments and reinsurance from payments to the employer or union. To facilitate this process, CMS is issuing guidance on waiver processes so Prescription Drug Plans or Medicare Advantage Drug Plans can more easily

be offered to employers. If an employer stops providing coverage, the beneficiary will be able to enroll in a Medicare Part D program with no late enrollment penalty. In financing all of these options, the catastrophic provisions available to retirees without employer-sponsored plans are still available to those with retiree plans. However, the costs that the employer pays will not count towards the out-of-pocket limit for beneficiaries.

In determining the payments, CMS will consider only the gross costs for the plan as the basis for the 28 percent subsidy. Only costs falling between the \$250 and \$5,000 range can qualify for subsidy payments. Any costs directly associated with the dispensing of a prescription drug will count as gross costs. Expenses such as administrative costs, discounts, charge-backs, rebates, and other price deals that PBM's or other negotiators are able to obtain from drug suppliers will not count in the gross cost estimate. Often, these rebates occur after a payment is made to the pharmacy, and hence further adjustment is needed.

CMS has a concern that, in certain instances, plan sponsors will take lower administrative costs or accept services equal to or below fair market value in exchange for all or some of the rebate. To address this concern, CMS plans to monitor these transactions very closely to make sure that charge costs are not exaggerated. Hence, CMS proposes to require that all rebates passed through to the plan sponsor and retiree be subtracted when calculating cost. To further accurately gauge how a rebate affects a sponsor's expenditures, CMS will propose that the rebates be allocated (calculated) as the basis of percentage as opposed to covered lives. The plan would consider the bulk discount and divide that up on a weighted basis of drug usage (heavier users are assigned more of the discount) to more accurately gauge how the savings are truly distributed. To capture these figures, CMS is asking for commentary on whether annual retroactive payments or other more frequent intervals are best for receiving/reconciling payment for the subsidy. Furthermore, CMS is considering methods whereby firms would estimate the reductions in gross cost from charge-backs (etc.), and CMS would then reduce the subsidy by this amount with any reconciliation necessary to follow later. Following such a method may be a hindrance to cash flow that could have significant policy implications for physicians who are awaiting their reimbursement for services.

It is important to note that CMS is attempting to scrutinize these transactions carefully, because in addition to getting employers to participate CMS is trying very hard to avoid any "windfalls" for employers who may seek to recover the difference in their expenditures and the MMA subsidy. For example, in determining what cost to reimburse, even after subtracting all the charge-backs how will CMS know that they are addressing a cost paid by employers and not employees (to whom the subsidy does not directly go)?

To just reimburse the allowable cost, CMS would basically use a "one-prong" criterion for actuarial equivalency. The "one-prong" would mean that CMS would only use the drug benefit's absolute cost (that Part D will cover for employer plans) and pay employers accordingly. Aggressive negotiating practices would attempt to reduce the share of costs going to employees, but CMS believes monitoring transactions carefully, though an administratively difficult task, would be necessary to make sure employers weren't keeping the difference in payments. CMS believes the "one prong" could be narrowed by limiting the amount of the drug subsidy so that it only just covered the employer's expenses to avoid a profit, effectively adding a second prong to CMS's criteria. One "prong" is whether the benefit's whole cost is in the MMA range, and the second "prong" is how much of that whole cost the employer is actually paying. Despite the

simple implementation, there are some concerns on legal authority. CMS is also concerned about legal authority with respect to the “two prong” approach where the employer contribution would be subtracted from claims payments and act as the basis for actuarial equivalence.

CMS believes this equivalence could act as a threshold that should at least equal what Medicare would have paid in retiree subsidies on average (approximately \$611 in 2006). However, CMS is once more worried about legal authority, in addition to policy concerns (should there be a financial floor in basing its decisions on equivalence?). Alternatively, CMS could impose a higher threshold more similar to what Medicare would pay out after the beneficiary contribution. The policy question arises when one considers where to move the threshold. If the threshold is too high (closer to the Medicare payout), some plans may not want to participate (though most plans offer more generous benefits than Part D). Nevertheless, more plan sponsors will shove their retirees into Part D instead of participating. Too low of a threshold will take away funding incentives.

Employers have yet to form a significant response to, at the time of this document, the recent release from CMS. Initial reaction expresses a desire for as much administration as possible to be done through the actual health plan (which the MMA does allow) and other third party administrators to avoid paperwork. However, in shifting the administrative burden to third party administrators for handling issues related to the subsidy, plan sponsors want to shield themselves from any legal liability that may result.

In doing so, a look at the Employee Retirement Income Security Act of 1974 (ERISA) may be necessary, as that law is the current legislative shield certain firms are using against liability claims from beneficiaries. CMS will rely upon third party administrators, who are more familiar with confidential employee/retiree data than employers, to follow privacy and security procedures necessary to protect the identity of retirees when transferring information to CMS for subsidy funds. Should the administrator not follow procedure and allow a retiree’s information to be compromised, a cause of action will emerge, and legal decisions could be made on the basis of whatever policy CMS sets regarding employer-liability. The CMS proposed rule does not address this point, but there may be commentary on it that could lead to guidance in the final rule.

Conclusion

The increased cost sharing that retirees have increasingly had to shoulder shows no signs of letting up as current employee health costs also continue to strain employer budgets. More aggressive cost controls also represent a trend that will most likely continue. There is concern that employers are dropping health benefit coverage for retirees. The changing accounting practices adopted by the private and public sectors highlight the problem of rising costs and have created additional pressures for employers to cutback on health benefits for retirees. The MMA subsidy raises a number of concerns and administrative questions for policymakers.

Recommendations

1. *ACP should closely monitor the implementation of the employer subsidy provisions in the MMA to assure subsidies are adequate to encourage employers not to discontinue or reduce coverage.*

In College policy on buy-ins into the FEBHP, ACP has supported minimizing incentives for employers to drop health insurance coverage by allowing a premium subsidy to be applied to the employee's share of the health insurance premium for employer-based insurance in order to maintain a role for employer-based health insurance. College policy on buying into the FEBHP further advocates against the creation of incentives for employers who already provide coverage for their employees to drop that coverage. The MMA effectively contributes funds to an employee's Part D/retiree plan, and it is important that the implementation follows ACP's intention, maintaining employer participation. Though Congress has intended the employer subsidy in the MMA to assist in maintaining or improving employee drug benefits for retired persons, there are still logistic concerns that could change whether or not employers will take advantage. For example, as CBO has noted, the prohibition of employer expenditures as counting towards the out-of-pocket threshold limits the attractiveness of supplemental drug plans. Furthermore, in determining the costs to reimburse, CMS will need to set the threshold at a level where plans will want to participate, but not at a reduced level. Although healthcare expenditures play more of a role than the MMA, the drug law's implementation still has a chance to meet Congress's original goal and relieve the pressure that employers are feeling to reduce their retiree plans for current and future beneficiaries.

2. *Incentives should be sufficient to encourage employers who do not currently provide coverage to do so.*

Accounting standards have highlighted the expenditures that employers will have to face in the future for their retirees, and some employers have taken notice by dropping current retirees and ending future retiree plans for their current employees. To help address this trend and keep in spirit with College precedent of advocating participation incentives for employers buying into the FEBHP, the federal government should make sure the subsidy authorized by the MMA compares favorably with what employers need to keep their retiree plans going. In examining this issue, it is important to consider the discrepancy between subsidies for employer-sponsored retiree plans and those going to Medicare Advantage plans. Though employer-sponsored plans do not have to meet the bidding requirements, Congress may want to reconsider and design some criteria that would enable employer-sponsored retiree plans to receive funding more on par with what Medicare Advantage plans receive. By doing so, employer-sponsored retiree plans will more closely parallel the private sector improvement the MMA espouses while likely increasing the number of employers with retiree drug plans.

3. Protection should be provided for retirees and employees who lose existing coverage.

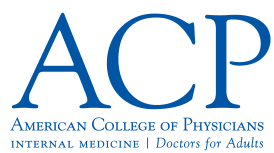
The MMA allows retirees to sign up for Part D coverage without a late enrollment penalty should an employer no longer sponsor coverage. Furthermore, CMS proposed rules suggest 90 day notices and other measures to make sure retirees have the time and support necessary to maintain their coverage before signing up for Part D coverage. It is important that CMS implements these mechanisms in a manner that makes sure retirees get the information they need on all transitioning activities and other changes that may occur in their health plans. For example, the supplemental coverage that may no longer be available will need a replacement, and CMS should make sure retirees know what their options are. By making sure beneficiaries know the choices available should their retiree plan no longer provide care, CMS can help ensure continuous coverage.

4. MMA implementation should avoid providing funds that go to employer “wind-falls” and not to employer drug costs.

CMS has a valid concern that employers could keep funds from the subsidy and shift the difference to employees. Some in the private sector have claimed aggressive negotiating practices like collective bargaining and more complete information on the union and employee side should stem this effect. Disseminating this information is in keeping with College policy regarding employer expenditures on health care: ACP encourages all employers to provide their employees and retirees with short, clear statements of the employers' contributions for each employee's health coverage. An effect in windfalls would presumably occur because unions and other employee representatives would try to stop as much cost going to employees as possible. These practices have not, however, halted the increases in cost-sharing that have occurred over the last decade, and as prices for healthcare rise, they are not likely to do so in the future. Hence, CMS will need an actuarial standard that is fair to both the employers sponsoring the benefit and the retirees whom the benefit serves. In doing so, the subsidy will meet Congress's intention helping retiree plans that America will continue to need.

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