

An hourglass-shaped graphic with a globe inside. The top bulb is dark blue, and the bottom bulb is light blue. The globe is centered in the narrow neck of the hourglass. The text is overlaid on the graphic.

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Medicare Drug Benefit: Retiree Provisions

Jennifer O'Sullivan, Domestic Social Policy Division

February 9, 2006

Abstract. This report provides a summary of the MMA provisions and an overview of the implementation requirements as outlined by the Centers for Medicare and Medicaid Services (CMS, the agency that administers the Medicare program). CMS issued final Part D regulations in January 20053 and has provided, on a periodic basis, supplemental guidance documents on its website.

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Medicare Drug Benefit: Retiree Provisions

Updated February 9, 2006

Jennifer O'Sullivan
Specialist in Social Legislation
Domestic Social Policy Division

<http://wikileaks.org/wiki/CRS-RL33041>

Medicare Drug Benefit: Retiree Provisions

Summary

On December 8, 2003, the President signed into law the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, P.L.108-173). The legislation created a new voluntary prescription drug benefit for Medicare beneficiaries under Medicare Part D. It went into effect January 1, 2006. Beneficiaries are able to purchase “standard coverage” or alternative coverage with actuarially equivalent benefits. Coverage is provided through private prescription drug plans (PDPs) or, for those enrolled in Medicare-Advantage (MA) plans, MA prescription drug (MA-PD) plans.

In recent years, employers have been cutting back on health benefits offered to their retirees. When MMA was being considered, there was concern that employers would use the enactment of a Medicare drug benefit as an excuse to further reduce retiree health benefits or drop such coverage entirely. In response, the legislation includes significant incentives for employers to continue to offer drug benefits to their Medicare-eligible retirees.

Specifically, MMA required the Secretary of the Department of Health and Human Services (HHS) to make special subsidy payments to employers or unions offering qualified retiree prescription drug coverage. Qualified plans are defined as those offering drug benefits at least actuarially equivalent to “standard coverage.” Subsidy payments are made on behalf of an individual covered under the retiree health plan who is entitled to enroll under a PDP or MA-PD plan but elects not to. In 2006, subsidy payments will equal 28% of a retiree’s gross drug costs between \$250 and \$5,000. (The dollar amounts will be adjusted annually by the percentage increase in Medicare per capita prescription drug costs.) Subsidy payments to employers and unions are not subject to federal tax.

Employers or unions may select an alternative option (instead of taking the subsidy) with respect to the new Part D. They may elect to pay a portion of the Part D premiums. They may also elect to provide enhanced coverage, though this has some financial consequences for the employer or union. Enhanced coverage may be provided through supplementary or “wrap around” benefits. Alternatively, employers or unions may contract with a PDP or MA-PD to offer the coverage. Finally, they may become a Part D plan sponsor themselves for their retirees.

In January 2006, the Secretary of HHS announced that close to 24 million Medicare beneficiaries had prescription drug coverage. This included 6.4 million persons in retiree plans receiving a subsidy. An additional 1 million retirees were in employer coverage that incorporated or supplemented Medicare’s coverage, and another 500,000 continued in plans with coverage at least as good as Medicare’s. An estimated 3.1 million beneficiaries were in TRICARE and the Federal Employees Health Benefits program (FEHB).

This report provides a summary of the MMA provisions and an overview of the implementation requirements. It will be updated as events warrant.

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Overview

On December 8, 2003, the President signed into law the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, P.L. 108-173). The legislation created a new voluntary prescription drug benefit for Medicare beneficiaries under Medicare Part D. It went into effect January 1, 2006. Beneficiaries are able to purchase “standard coverage” or alternative coverage with actuarially equivalent benefits. Coverage is provided through private prescription drug plans (PDPs) or, for those enrolled in Medicare-Advantage (MA) plans, MA prescription drug (MA-PD) plans. The program relies on these private plans to provide coverage and to bear some of the financial risks for drug costs, with the government covering the bulk of the risk to encourage participation. The plans determine payments and are expected to negotiate prices.¹

In recent years, employers have been cutting back on health benefits offered to their retirees.² When MMA was being considered, there was concern that employers would use the enactment of a Medicare drug benefit as an excuse to further reduce retiree health benefits or drop such coverage entirely. In response, the legislation included significant incentives for employers to continue to offer drug benefits to their Medicare-eligible retirees.

Specifically, MMA requires the Secretary of the Department of Health and Human Services (HHS) to make special subsidy payments to employers or unions offering qualified retiree prescription drug coverage. Qualified plans are defined as those offering drug benefits at least actuarially equivalent to “standard coverage.” Subsidy payments are made on behalf of an individual covered under the retiree health plan who is entitled to enroll under a PDP or MA-PD plan but elects not to. In 2006, subsidy payments equal 28% of a retiree’s gross drug costs between \$250 and \$5,000. (The dollar amounts will be adjusted annually by the percentage increase in Medicare per capita prescription drug costs.) Subsidy payments to employers and unions are not subject to federal tax.

It should be noted that employers may select an alternative option with respect to the new Part D. They may elect to pay a portion of the Part D premiums. They may also elect to provide enhanced coverage, though this has some financial

¹ See CRS Report RL31966, *Overview of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, by Jennifer O’Sullivan, Hinda Ripps Chaikind, Sibyl Tilson, Jennifer Boulanger, and Paulette Morgan.

² See CRS Report RL32944, *Health Insurance Coverage for Retirees*, by Hinda Ripps Chaikind and Fran Larkins.

consequences for employer or union sponsors. Enhanced coverage may be provided through supplementary or “wrap around” benefits. Alternatively, employers may contract with a PDP or MA-PD to offer the coverage. Finally, they may become a Part D plan sponsor themselves for their retirees. Most employers and unions offering drug benefits to retirees in 2005 elected the subsidy for 2006.

This report provides a summary of the MMA provisions and an overview of the implementation requirements as outlined by the Centers for Medicare and Medicaid Services (CMS, the agency that administers the Medicare program). CMS issued final Part D regulations in January 2005³ and has provided, on a periodic basis, supplemental guidance documents on its website.

Requirements for Employer/Union Subsidies

The employer/union subsidy is available to sponsors of qualified plans provided certain conditions are met. The plan itself must meet the definition of a qualified plan. The plan sponsor must submit an application to CMS on a timely basis. This application must include an actuary’s attestation that the plan meets the actuarial equivalence requirements. The plan sponsor must also meet certain administrative requirements.

Qualified Plans

MMA applies the employer/union subsidy provisions to qualified prescription drug plans.

Plan Requirements. A qualified plan is defined as employment-based retiree health coverage provided under a group health plan. Group health plans may include federal and state government plans, collectively bargained plans, and church plans. However, the Office of Personnel Management stated that plans offered under the Federal Employee Health Benefits (FEHB) program would not be applying for the subsidy.

A health reimbursement arrangement (HRA), may also qualify.^{4,5,6} HRAs are accounts, funded by an employer or union, which reimburse for medical expenses. Participants are credited up to a specified annual maximum dollar amount with unused

³ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, “Medicare Program: Medicare Prescription Drug Benefit,” *70 Federal Register* 4194, Jan. 28, 2005.

⁴ The arrangement will have to meet the definition of group health plan as specified in the Employee Retirement Income Security Act of 1974 (ERISA).

⁵ Other account arrangements such as a Health Savings Account and an Archer Medical Savings Account will not be considered as a qualified medical plan because contributions to the plan cannot be made once the individual is eligible for Medicare.

⁶ See CRS Report RS21573, *Tax-Advantaged Accounts for Health Care Expenses: Side-by-Side Comparison*, by Bob Lyke and Chris Peterson.

amounts carrying forward to subsequent coverage periods. HRAs, and other account based arrangements are often combined with high deductible health plans (HDHPs). Regardless of whether an account standing alone is a group health plan, the HDHP associated with that account can qualify as a group health plan if it is contributed to or otherwise established or maintained by an employer or union.

Qualifying Covered Retiree. Subsidies are linked to an individual's status as a *retired* participant in the qualified group health plan or as the Medicare-enrolled spouse or dependent of the retired participant. Thus, a sponsor offering qualified coverage for dependants will be able to claim coverage for a Part D eligible dependent of a retired participant, even if the retiree is under age 65 and not Part D eligible. However, the sponsor will not be able to claim coverage for a Part D eligible dependent of an active employee.

It should be noted that subsidies are only paid for qualifying retirees covered under the qualified employer plan, but *not* covered under Part D. Individual retirees may elect to enroll in Part D. However, that decision may have consequences. A recent survey of anticipated employer responses to the MMA provisions found that among large employers who expected to continue to offer drug coverage (and receive the subsidy), 41% said retirees who signed up for Part D would maintain employer-sponsored coverage, 31% said the retirees would lose prescription drug coverage only, and 29% said these retirees would lose both employer-sponsored medical and drug coverage. In addition, 44% of these employers stated that once an individual signed up for Part D they would not be allowed to enroll or re-enroll in the employer plan at a future date.⁷

Actuarial Equivalence

The sponsor of the plan must provide CMS with an attestation that the actuarial value of the retiree prescription drug coverage is at least equal to Part D standard coverage. The determination must be made using the methodology specified by CMS and be signed by a qualified actuary. The attestation must be provided annually.

Comparison to “Standard Coverage”. In order to determine actuarial equivalence, coverage under the retiree health plan is compared to “standard coverage” under Part D. In 2006, standard coverage has a \$250 deductible, 25% coinsurance for costs between \$251 and \$2,250, then no coverage until the beneficiary has true-out-of-pocket (TROOP) costs of \$3,600 (\$5,100 total drug spending). Once the beneficiary reaches the catastrophic level, or TROOP trigger, the program pays all costs except for the greater of: (1) \$2 for a generic or preferred multiple source drug and \$5 for other drugs; or (2) 5% coinsurance.

Calculation. Calculation of actuarial equivalence is determined according to a “two-prong test.” First, under the “*gross value test*,” the actuarial gross value of the

⁷ Kaiser Family Foundation and Hewitt, *Prospects for Retiree Health Benefits as Medicare Prescription Drug Coverage Begins - Findings from the Kaiser/Hewitt 2005 Survey on Retiree Health Benefits*; December 2005. [<http://www.kff.org/medicare/med120705pkg.cfm>].

retiree prescription drug coverage under the plan for the plan year must be at least equal to the actuarial gross value of standard coverage under Part D for the year in question. Second, under the “*net value test*,” the net value of the plan (taking into account expected premiums) must be at least equal to the actuarial net value of Part D standard coverage.

In general, gross value of coverage is determined using actual claims experience and demographic data for Part D eligibles who are in the sponsor’s plan; alternative approaches are permitted under certain conditions. The plan satisfies the gross value test if the total expected paid claims for beneficiaries under the sponsor’s plan will be at least equal to the total expected paid claims for the same beneficiaries under the defined standard Part D benefit.

The net value of coverage under the sponsor’s plan is determined by reducing the gross value of coverage by the expected premiums. Plan sponsors that charge a single premium for both drug and other medical coverage must allocate a portion of this premium to drug coverage. The plan’s net value is compared with the net value of standard coverage under Part D. The net value of standard Part D coverage is calculated by reducing the gross value by: (1) monthly beneficiary premiums expected to be paid for standard coverage; and (2) an amount reflecting the impact of sponsor-provided supplemental coverage on the value of standard coverage. (If the sponsor provides coverage that supplements standard coverage, this will delay the point at which retiree will qualify for catastrophic coverage because sponsor-paid costs will not count toward the TROOP trigger; this in turn decreases the value of that catastrophic coverage.)

Assurances related to the gross value test must be provided separately for each benefit option for which a sponsor is requesting a subsidy. Assurances related to the net value test may be provided in one of several ways. It may be applied separately for each benefit option, for a subset of benefit options that in the aggregate meet the test, or in the aggregate for all benefit options. For example, if a retiree group health plan has five separate options, all of which individually meet the gross value test, the plan could claim the subsidy for: (1) each of the options that separately meet the net value test; (2) all five options if they meet the net value test in the aggregate; or (3) a subset of the options if the subset meets the net value test in the aggregate.⁸

CMS notes that actuaries will have considerable flexibility in the use of simplified actuarial calculations, treatment of multiple benefit options, and allocation of premiums between drug and non-drug coverage. Further, once the actuarial equivalence standard is satisfied, plan sponsors will have full flexibility in plan benefit design.⁹

⁸ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Service, “Medicare Program; Medicare Prescription Drug Benefit; Interpretation,” 70 *Federal Register*, Mar. 21, 2005.

⁹ CMS, *The Retiree Drug Subsidy: Why Employers and Union Plan Sponsors Should Consider It*, Apr. 6, 2005, at [<http://www.cms.hhs.gov/medicarereform/pdbma/employer.asp>].

Notification to Retirees of “Creditable Coverage”. MMA imposes a premium penalty for persons who delay enrollment in a Part D plan after their initial enrollment period. The penalty is equal to 1% of the beneficiary’s Part D premium for each month of delayed enrollment. Thus, a one-year delay would result in a 12% surcharge.

However, there is an exception for persons who maintain *creditable coverage* through some other public or private source and then choose to enroll in Part D at a later date. Creditable coverage is defined as drug benefits whose actuarial value equals or exceeds that of standard coverage.

Sponsors of retiree plans are required to disclose whether their plan is creditable coverage. The disclosure must be made to all their retirees and their spouses and dependents who are both eligible to participate in the retiree health plan and who are eligible for Part D.

Administrative Requirements

Plan sponsors are required to submit applications containing information on the employer, plan, and individuals that the sponsor believes are qualifying covered retirees. A sponsor may satisfy the requirement relating to individual information by entering into a voluntary data sharing agreement with CMS. Once a full application has been submitted, CMS will match the name and identifying information on individuals with the Medicare Beneficiary Database to determine which retirees are Part D eligible individuals who are not enrolled in a Part D plan. The results will be provided to the sponsor.

In general, an application for a plan year must be submitted no later than 90 days prior to the beginning of the plan year. Applications had to be submitted by September 30, 2005 for plan years beginning in 2006.

Sponsors are required to provide information necessary to assure accurate subsidy payments. This includes electronic submission and periodic updating of enrollment information about retirees and dependents; electronic submission of aggregate data about drug costs; and reconciliation of costs at the end of the year.

Sponsors are required to maintain, and furnish to CMS or the Office of Inspector General upon request, certain records. These include reports and working documents of the actuaries who wrote the required attestation of actuarial equivalence and documentation of incurred costs and other information used to calculate the subsidy. Records must be retained for a minimum of six years after the expiration of the plan year in which the costs were incurred. A longer period is required in the event of investigation, litigation or negotiation involving civil, administrative, or criminal liability.

Subsidy Payments

As noted above, the MMA subsidy provisions were intended to counteract the erosion in employer-provided retiree health benefits. The subsidy is calculated based on gross plan-related drug costs that are actually paid (net any manufacturer or pharmacy discounts, chargebacks, rebates, and similar price concessions). The calculation includes drug payments made by the qualified retiree drug plan and those made by the covered retiree (or on the retiree's behalf). Gross costs include costs directly related to dispensing of the drugs but not administrative expenses.

In 2006, subsidy payments equal 28% of an individual's gross drug costs between \$250 (the cost threshold) and \$5,000 (the cost limit). The dollar amounts for the cost threshold and cost limit will be adjusted annually by the percentage increase in Medicare per capita prescription drug costs.

Subsidy payments may be made on a monthly, quarterly, or annual basis, as elected by the plan sponsor, unless CMS determines that these options must be restricted because of operational limitations.

MMA specifies that subsidy payments to plan sponsors are not subject to federal tax.

Other Options

Types of Options

Instead of taking the subsidy, an employer or union may choose another option for providing prescription drug coverage for their retirees. Under these options, the retiree is encouraged to sign up for Part D; the employer or union plan would then provide some additional assistance. The following are the major options available:

- *Payment of Part D Premiums.* Employers or union sponsors could choose to pay some or all of the Part D premiums for their Part D eligible retirees and eligible dependants.
- *Providing Supplemental Coverage.* Employers could set up their own separate plans that supplement or wrap around Part D coverage. These plans would coordinate with benefits offered by any PDP or MA-PD the beneficiary chooses. Health plans typically take this approach for services (such as hospital and physicians services), provided under Medicare Parts A and B.
- *Purchase of Enhanced Part D Benefit Through PDP or MA-PD.* An employer or union could elect to contract with a specific PDP or MA-PD plan to offer enhanced prescription drug benefits to retirees (and dependants) eligible for Medicare.
- *Become a PDP or MA-PD.* Alternatively, the retiree plan itself could apply to be a Part D plan for its retirees.

True Out-Of-Pocket (TROOP) Implications

If employers or unions elect to sponsor enhanced alternative coverage, or provide separate coverage that wraps around Part D, this will have financial consequences for them. As noted above, Part D enrollees with standard coverage must have \$3,600 in TROOP costs in 2006 before Part D catastrophic coverage begins. TROOP costs include only those payments paid by the individual, paid by another family member on behalf of the individual, paid on behalf of the individual under the low-income subsidy provisions, or under a state pharmaceutical assistance program.¹⁰ Insurance and other third party payments do not count toward TROOP. Thus, if an employer chooses to pay some of the Part D cost-sharing on behalf of its retirees, this would have the effect of delaying the point at which the Part D catastrophic coverage would begin. The employer could therefore end up paying some costs which would otherwise be covered under the catastrophic portion of the Part D benefit.

Employer/Union Sponsored Plans

Employers or unions that contract with a Part D plan to provide a customized package for their retirees, as well as those who elect to become a Part D plan themselves will have to meet Part D plan requirements. This means they will have to meet the applicable bidding requirements for PDPs or MA-PDs. However, both the law and subsequent CMS guidance¹¹ permits waivers from certain Part D requirements which would otherwise hinder the development and offering of such plans. The intention is to facilitate employer/union sponsors to offer these group plans.

Waivers. The following are some of the key waivers that have been identified:

- *Enrollment.* Plans may restrict enrollment solely to their retirees. Further, they do not have to meet otherwise applicable minimum enrollment standards.
- *Governmental Entity Requirements.* In general, governmental entities are not permitted to be PDP or MA-PD sponsors. However, this prohibition is waived for governmental entities applying to sponsor a PDP or MA-PD plan for their retirees, such as for state retirement funds and municipal and local government plans.

¹⁰ It should be noted that CMS final regulations state that distributions from health savings accounts, flexible savings accounts, and Archer medical savings accounts count toward TROOP. However, distributions from health reimbursement accounts do not count toward TROOP.

¹¹ For further guidance information, see (1) *Part D Waiver Guidance for Employer/Union Retiree Coverage*, Feb. 11, 2005; (2) *Additional Part D Waiver Guidance for Employer/Union Retiree Coverage*, Mar. 9, 2005; (3) *Additional Part D Waiver Guidance for Employer/Union Retiree Coverage*, Apr. 6, 2005; and (4) *2006 Part D Application Instructions for Employer Sponsored Retiree Group Plans (Employer/Union Direct Contractors and PDP/MA-PD/Cost Plan Sponsors Offering Employer/Union Retiree Group Plans)*, revised Apr. 19, 2005. All of these documents can be found at [<http://www.cms.hhs.gov/medicarereform/pdbma/employer.asp>].

- *Service Area Requirements for Direct Contracts.* In general, Part D plans can only cover beneficiaries in the service areas in which they operate. Under employer union *direct* contracts, coverage can be extended to all retirees, regardless of where they reside.
- *Service Area Requirements for PDPs Offering Customized Employer/Union-Only Group Plans.* To qualify for a waiver, the PDP must offer non-retiree coverage in the area where the largest portion of the employer/union's total number of employees/participants reside. Coverage may then be offered to all the employer/union retirees, regardless of where they reside. Otherwise, coverage is limited to retirees in the same region that the PDP offers non-retiree coverage.
- *Service Area Requirements for MA-PDs Offering Customized Employer/Union-Only Group Plans.* If a local MA-PD sponsor provides coverage to individuals in any part of a state, it can offer retiree-only coverage for an employer or union throughout the state. An MA organization offering a regional plan in a specified MA region may offer an employer/union sponsored MA-PD plan in any area within the MA region or throughout the region. CMS may, on a case by case basis, grant a waiver to permit a regional MA-PD to extend coverage to retirees living outside the area.¹²
- *State Licensure.* State licensure requirements may be waived for direct contracting plans. However, they are required to meet certain financial solvency standards. If the employer or union does not meet these specified standards, CMS may approve, on a case-by-case basis, waivers of the requirements provided the entity can demonstrate that (1) its fiscal soundness is commensurate with its financial risk; and (2) it can assure that claims for benefits will be covered.
- *Calendar Year Operation.* Part D plans are required to operate on a calendar year basis. Employer/union sponsored plans will be able to operate on a non-calendar year basis.
- *Pharmacy Access.* Plans will not be subject to the Part D retail pharmacy access standards. However, they will have to provide an attestation that the plan's networks are sufficient to meet the needs of its retiree population, including situations involving emergency access. Waivers of the mail-order only prohibition will not be granted.
- *Marketing/Beneficiary Communication Requirements.* CMS will waive specific Part D marketing/beneficiary communication requirements upon receipt of an attestation that the plans comply with alternative disclosure requirements (such as those applicable under ERISA).
- *Reporting Requirements.* In general, Part D plan sponsors are required to disclose certain information to CMS, enrollees, and the general public. For direct contracting plans only, information must

¹² For a discussion of local and regional MA plans, see CRS Report RL32618, *Medicare Advantage Payments*, by Hinda Ripps Chaikind and Paulette Morgan.

be disclosed to the extent required by other law (such as ERISA or securities law) or by contract.

Federal Payments to Plans. In general, federal payments to Part D plans include (1) a direct monthly per capita payment for each plan enrollee, which is labeled the direct subsidy payment (*not to be confused with subsidy payments to qualified retiree plans discussed earlier*); (2) catastrophic reinsurance payments equal to 80% of an individual's costs over the annual out-of-pocket threshold amount (the TROOP level); (3) risk corridor payments if a plan's losses exceed specified thresholds; and (4) subsidies for low-income enrollees.

CMS has established several payment modifications for employer/union plans, discussed below.

Per Capita Direct Subsidy Payments to Plans. Direct subsidy risk adjusted payments to employer/union plans will be based on the national benchmark amount rather than the bid submitted by the plan.

Catastrophic Reinsurance Payments. For most Part D plans, catastrophic payments will be made prospectively, with reconciliation adjustments at the end of the year. However, for employer/group plans, CMS will make the full reinsurance payment at the end of the year. CMS expects that since the employer/union plans will be providing enhanced benefits which do not count toward TROOP, the reinsurance trigger will be delayed and reinsurance payments will be small as a result.

Catastrophic reinsurance payments will not be available for non-calendar year plans. However these plans will still be required to provide catastrophic coverage.

Risk Corridor Payments. CMS guidance states that employer/union drug plans will forgo risk corridor payments. Risk corridors permit Part D plans to share both losses and gains with Medicare. Risk corridor payments were included in MMA to assist entities entering new markets in which they have no experience. CMS notes that employers/unions already have experience with their retiree population.

Low-Income Subsidies. In general, low-income subsidies will apply in the same manner they apply to other Part D plans.¹³ Low-income premium subsidies paid on behalf of an eligible retiree must first be used to reduce the portion of the monthly premium paid by the beneficiary with any remainder used to reduce the employer/union contribution.

CMS guidance states that if the premium subsidy amount is less than the beneficiary premium, the beneficiary should be informed of the premium impact of remaining in the employer plan versus enrolling as an individual in another Part D plan.

¹³ See CRS Report RL32902, *Medicare Prescription Drug Benefit: Low-Income Provisions*, by Jennifer O'Sullivan.

Beneficiary Payments. In general, Part D plans are required to charge a uniform premium for each beneficiary enrolled in the plan; this is the standard premium for basic coverage. The plan can charge 100% of the value of any supplemental coverage.

CMS will give employer/union plans flexibility in determining the amount they will subsidize for retirees, subject to certain conditions. Employer/union plans can subsidize different amounts for different classes, provided the classes are reasonable and are based on objective business criteria such as years of service, business location, or job category. This is in recognition of the fact that employers often acquire new employee groups as a result of business deals.

Premiums for employer/union plans cannot vary based on eligibility for the low-income subsidy. Further, enrollees cannot be charged more than the sum of the premium for standard Part D coverage plus 100% of the premium for supplemental coverage. Finally, the per capita direct subsidy payments from CMS to the employer/union Part D plan must first be passed through to the beneficiary to reduce the amount of the beneficiary premium.

Timing. In the fall of 2005, CMS signed contracts with employer/union direct contract plans. It also signed contracts with PDP and MA-PD plans with addenda for customized benefits for employer/union group applicants.

Impact of Provisions

Distribution of Beneficiaries

2006. When CMS issued the final Part D regulations in January 2005,¹⁴ it estimated that, in the absence of MMA, 11.4 million persons (28% of beneficiaries) would have employment-based retiree coverage (including unsubsidized coverage) in 2006. Of these, CMS estimated that 9.8 million persons (86%) would receive creditable drug coverage through an employer/union sponsored retiree plan that was eligible for the subsidy (though some employers, such as the federal government, would not apply for the subsidy). An estimated additional 0.4 million persons (3%) would receive coverage through a PDP or MA-PD plan with the employer/union offering enhanced benefits or providing wrap around or coordinated coverage. The remaining 1.3 million (11%) would enroll in a standard PDP or MA-PD; a portion of these persons will receive assistance with premium costs.

On January 17, 2006 the Department of Health and Human Services (HHS) released a press release on drug coverage.¹⁵ It estimated that nearly 24 million persons

¹⁴ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Medicare Program: Medicare Prescription Drug Benefit*; 70 *Federal Register* 4194, Jan. 28, 2005.

¹⁵ HHS, *Nearly 24 Million Medicare Beneficiaries Now Have Prescription Drug Coverage*, (continued...)

had drug coverage as of that date. The statistics include both those covered under Part D as well those persons who continued to have drug coverage through retiree plans. It estimated that 6.4 million persons were in retiree plans receiving a subsidy. About 1 million retirees were in employer coverage that incorporated or supplemented Medicare's coverage, and another 500,000 were continuing in plans with coverage at least as good as Medicare's). Approximately 3.1 million persons were receiving their drug benefits through TRICARE and the Federal Employees Health Benefits program (FEHB).

Subsequent Years. When CMS issued its January 2005 estimates, it suggested that the projected ratios would change over the five-year estimation period as some employers who elect the subsidy in 2006 transition to other options in later years. (See "Current Issues" discussion, below.) For 2010, CMS estimated a total of 11.8 million would have had coverage in the absence of MMA. Of these, an estimated 7.2 million (61%) would have assistance through a subsidy-eligible plan, 2.4 million (20%) would have enhanced or wrap around coverage and the remaining 2.3 million (19%) would enroll in a standard PDP or MA-PD.

Average Employer Savings

In the final Part D regulations,¹⁶ CMS estimated that the employer/union retiree drug subsidy payments would average \$668 per beneficiary in 2006. For employers with tax liability, this translates into a taxable per capita payment of \$891 for an employer in the 25% marginal tax category and \$1,028 for an employer with a 35% marginal rate. By comparison, the average indirect subsidy for employers/unions choosing to provide supplemental coverage was estimated to be about \$900 per person (excluding reinsurance payments which are expected to be low for this population because of the TROOP rules).

For employers/unions who cannot take advantage of the tax-free nature of the subsidy, such as state governments and non-profit corporations, one of the alternative options may appear more attractive than the subsidy. In its August 3, 2004 proposed rule-making, CMS estimated that 60% of beneficiaries over 65 receiving retiree health benefits were obtaining them from entities exempt from taxation.

Current Issues

In recent years, employers have been cutting back on health benefits offered to their retirees. When MMA was being considered, there was concern that employers would use the enactment of a Medicare drug benefit as an excuse to further reduce retiree health benefits or drop such coverage entirely. In response, the legislation includes significant incentives for employers to continue to offer drug benefits for their Medicare-eligible retirees. Most notably, the law both provides for a subsidy of

¹⁵ (...continued)
press release, at [<http://www.hhs.gov/news/press/2006pres/20060117.html>].

¹⁶ HHS, *70 Federal Register*, Jan. 28, 2005, op.cit.

a portion of retiree drug costs and exempts these subsidy payments from federal taxes. As noted, the legislation also offers other options to encourage employer/unions to continue to provide assistance to retirees.

CMS strongly encouraged employers/unions to take advantage of the subsidy rather than one of the other available options in 2006. It stated that it was generally a better option, because the value of the subsidy was generally expected to be larger, though the actual value of the assistance varies by a number of factors. Further, CMS established a streamlined application process for the subsidy.

Most large employers offering retiree health benefits in 2005 have taken the subsidy in 2006. Some plans may wish to avail themselves of other options; however it might take time to restructure their plans in light of the new Part D. A 2005 survey by Kaiser Family Foundation and Hewitt¹⁷ noted that its survey of 300 large private-sector firms with 1,000 or more employees showed that the majority of plan sponsors (82%) would seek the subsidy, at least in the first year. Fifteen percent said they were likely to supplement the benefit; and 2% said they intended to become a PDP. Eleven percent said they were likely to discontinue prescription drug coverage; of which 3% reported they were discontinuing both drug and other medical coverage.¹⁸ When asked which strategy they were most likely to pursue for their largest plan, 79% of surveyed employers (representing 89% of the age 65+ retirees in the largest plans), expected to take the subsidy in 2006.

The Kaiser/Hewitt study reported that many employers taking the subsidy in 2006 were likely to pursue additional cost control strategies. Thirty-six percent were very or somewhat likely to increase copayment or coinsurance charges; 21% were likely to require use of mail-orders for refills or maintenance drugs; 14% were likely to replace copayments with a coinsurance approach; 13% were likely to only cover the cost up to the level of the lowest-cost drug for a given condition; 8% were likely to impose deductibles specific to the drug benefit; 3% were likely to impose a cap on the drug benefit; and 2% were likely to cover generic drugs only.

Over time, many plans may face an additional consideration. It is not clear that employers will be able to continue to meet actuarial equivalence standards necessary to qualify for the subsidy. For a variety of reasons (including the Financial Accounting Standards Board (FASB) standards FAS 106)¹⁹ many employers are capping their contributions to future retiree health benefits. These amounts may fall below the level necessary to keep pace with the actuarial value of the Part D drug benefit.

¹⁷ Kaiser Family Foundation and Hewitt, *Prospects for Retiree Health Benefits as Medicare Prescription Drug Coverage Begins — Findings from the Kaiser/Hewitt 2005 Survey on Retiree Health Benefits*; Dec. 2005, at [<http://www.kff.org/medicare/med120705pkg.cfm>].

¹⁸ Some employers with multiple plans provided multiple responses. As a result the total exceeds 100%.

¹⁹ See CRS Report RL32944, *Health Insurance Coverage for Retirees*, by Hinda Ripps Chaikind and Fran Larkins.

Over time these considerations may become a bigger issue. As the baby boom generation ages into retirement, employers will continue to reexamine their contributions to health benefits for both current and future retirees. Some employers may elect to drop their contribution to retiree health benefits entirely while others may reduce their contributions for future retirees.

A key concern for policymakers is whether the MMA provisions will encourage employers to continue to provide retiree health coverage. It will be several years before we have a more complete picture of how employers have responded to the law's incentives. Further, whatever actions employers take should be viewed as part of the larger response to rapidly increasing health care costs, both for active workers and for retirees