



Testimony of  
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Subcommittee on Employer-Employee Relations

Hearing On

Examining Innovative Health Insurance Options for Workers & Employers

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Mr. Chairman and Members of the Subcommittee, thank you for the invitation to appear before you today to discuss the employer-sponsored retiree health care options available under the Medicare Prescription Drug, Improvement, and Modernization Act (or MMA for short).

My name is Frank McArdle, and I manage the Washington, D.C. Research Office of Hewitt Associates. Hewitt is a global human resources outsourcing and consulting firm with operations in 38 countries. We provide services to employers, employees, and retirees in the home states of all the Subcommittee members. Hewitt is headquartered in Lincolnshire, Illinois, and in addition has significant operations at U.S. offices in California, Connecticut, Florida, Georgia, Massachusetts, Minnesota, Missouri, Michigan, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Texas and Virginia.

As further background, Hewitt has worked in collaboration with The Henry J. Kaiser Family Foundation to conduct several detailed studies with respect to employer-provided retiree health benefits and their interaction with Medicare, all of which may be found at [www.kff.org](http://www.kff.org).

My task today is to describe the options available to employers under the MMA with respect to retiree health benefits. Before I do so, I would first like to place the MMA provisions in context relative to trends in the retiree health marketplace that preceded the new law.

### **Retiree Health Benefit Context Prior to the MMA**

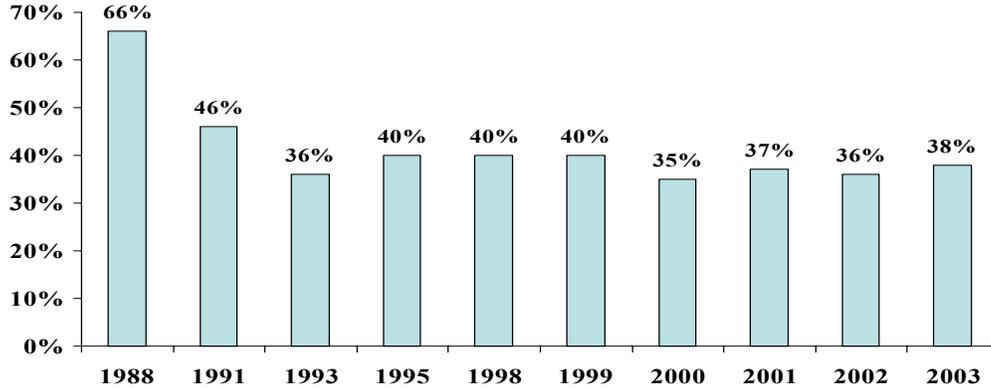
#### ***Retiree Health Benefits Have Been Eroding***

As this Subcommittee well knows, over the past 15 years, there has been a well-documented decline in the prevalence of employers sponsoring retiree health care plans (Chart 1). Even so, among the largest companies, i.e., those with 1,000 or more employees, a majority still provide retiree health care coverage (Chart 2). Typically, though not universally, these plans offer generous health benefits that have greater value than the Medicare benefits package, and will also provide greater value in terms of prescription drug benefits than under Medicare Part D, which as you well know becomes effective on January 1, 2006.<sup>1</sup>

## Chart 1

### Trends in Employer Retiree Health Coverage

Percentage of All Large Firms (200 or More Workers) Offering Retiree Health Benefits, 1988-2003

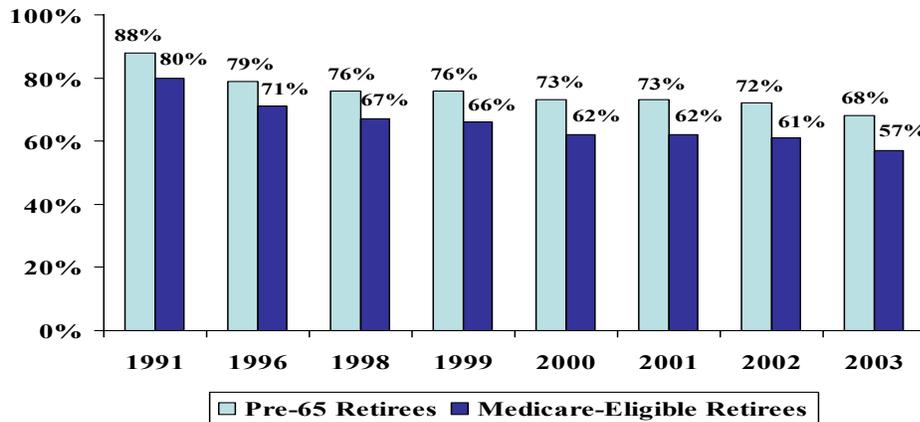


Source: Kaiser Family Foundation/HRET, Employer Health Benefits, 2003 Annual Survey.

## Chart 2

### Retiree Health Trends 1991-2003

Provision of Retiree Health Benefits by Employers with 1,000+ Employees, 1991-2003



Source: Hewitt Associates

These benefits are highly valued by retirees, for the following reasons:

- More than 3 million pre-65 retirees, or nearly six in ten retirees age 55-64, have retiree health benefits through an employer plan, which bridges the gap in coverage until Medicare eligibility is available at age 65. Absent such coverage, pre-65 retirees would have great difficulty in finding and affording coverage in the individual insurance market.
- About 12 million seniors, one in three, have supplemental Medicare coverage from their employer. Employer-provided retiree health plans are the largest source of prescription drug coverage for Medicare beneficiaries.

Therefore, the impact of Medicare reform on retirees with employer coverage was a top concern for Members of Congress, employers and retirees themselves.

### ***Rising Costs Are a Major Concern, Driving Changes in Plan Benefits***

Employers have made significant changes to their retiree health programs over the past several years under pressure to balance rising health costs with the organization's business needs, other benefits costs, and global competition.

Despite employers' concerted efforts to rein in their retiree health costs in recent years, the total cost (employer and retiree share) continues to rise rapidly.

- Among the 408 large private sector firms surveyed in the KFF/Hewitt retiree health survey, which have about 8.3 million employees and 3.6 million retirees, the total cost of providing retiree health coverage reached \$18.1 billion in 2002. The same companies estimated the total cost would rise by an average 13.7% between 2002 and 2003, which, if realized, would result in a 2003 total cost of more than \$20 billion.<sup>2</sup> Some individual firms have total retiree health costs reaching or exceeding \$1 billion.
- Among surveyed firms, retiree health costs represent more than a quarter of the total estimated cost of health coverage for active workers, retirees, and dependents. In addition, most of the large private companies offering retiree health plans tend to be more mature companies where there is already a ratio of only two workers per retiree, on average, which is what the worrisome average is projected to be for Social Security and the economy as a whole in about 25 years. Indeed, some of these companies have more retirees than active workers.
- These costs have become a substantial concern, with 92% of surveyed companies reporting that their firm's CEO is very (64%) or somewhat (28%) concerned about retiree health care costs. Some companies are finding that more of their global competitors do not provide retiree health coverage, putting them at a competitive disadvantage. In addition, retiree health benefits are only part of the employer's total employee benefit spending. For example, among large employers in a proprietary Hewitt database, all of the large companies offering retiree health care plans also offer a defined benefit pension plan or a defined contribution retirement plan; 77% offer a defined benefit plan; 76% provide a defined benefit plan and a defined contribution retirement plan; and 98% provide a defined contribution retirement plan.

### ***Retiree Health Plans Vary Significantly within Companies and across Firms***

Retiree health benefits vary significantly both within large multi-state companies and across firms. Differences are commonplace between pre-65 retiree coverage and post-65 coverage, in part because pre-65 retirees are often offered the same coverage as active employees, whereas post-65 retiree health plans are structured to coordinate with Medicare. Differences in the number and types of plan options are commonplace, as are differences in premiums and cost-sharing. In fact, there are so many differences within companies that for the purpose of collecting detailed data without overburdening the survey respondent, our surveys typically request detailed data only for the plan with the largest number of enrolled retirees.

To sum up, on the eve of enactment of the MMA:

- Employer-sponsored retiree health plans were providing coverage that was more generous than Medicare benefits and of great value to millions of both pre-65 and Medicare-eligible retirees;
- Retiree health coverage was continuing to erode;
- Double-digit cost increases were playing a major role in driving that erosion; and
- Retiree health plans varied widely, both within individual companies and across firms nationwide.

Each of these factors influenced the provisions related to employer-provided retiree health plans under the MMA.

### **Medicare Prescription Drug, Improvement, and Modernization Act**

As a way of encouraging employers to continue offering retiree health benefits, the MMA makes a range of new options available to employers. Reflecting the wide variations in plans and employer circumstances, this flexibility is intended to allow employers a choice among multiple options for supplementing Medicare benefits. These options fall into three broad categories, as follows:

1. Offering prescription drug benefits that are at least actuarially equivalent to what Medicare will provide under Part D, and receiving a subsidy from Medicare to compensate for a portion of that employer cost for retirees not enrolled in Part D.
2. Supplementing Medicare Part D prescription drug benefits, using several approaches for coordinating with Medicare benefits.
3. Becoming an employer-sponsored Prescription Drug Plan (PDP) or Medicare Advantage (MA) plan.

### ***Accepting the Subsidy for Offering Actuarially Equivalent Drug Benefits***

This option is probably the one that has generated the most discussion. Employers who provide retiree health prescription drug benefits that are at least actuarially equivalent to what Medicare will provide under Medicare Part D may be eligible for a direct subsidy from Medicare.

- The retiree is not enrolled in Part D and therefore no Part D premium is required.

- The subsidy is tax-free, and amounts to 28% of per retiree drug costs between \$250 and \$5,000 in 2006.

Note that this subsidy only partially compensates employers for providing prescription drug benefits that are at least as generous — if not more generous — than what Medicare would provide to a similarly situated retiree without employer coverage.

In sum, the subsidy offers partial compensation to the employer plan, saves money for Medicare,<sup>3</sup> and avoids disruption by allowing retirees to stay in their current employer plan and receive prescription drug benefits that are at least as generous, if not more generous, than under Medicare.

### ***Supplementing Medicare Part D Prescription Drug Benefits***

Under this set of options, the retiree enrolls in Part D and the employer plan supplements the benefits provided through Medicare Part D. This supplementation can be accomplished in multiple ways. For example:

- Employers may supplement or “wrap around” a stand-alone PDP or a MA plan. This kind of coordination can be complicated if the employer’s retirees are located throughout the country and enroll in dozens of different PDP or MA plans. It would be less complicated where an employer’s retirees are concentrated in a few areas.
- To avoid administrative complexity, an employer may also contract with a PDP or a MA plan on behalf of its retirees and negotiate additional benefits for the retirees in the PDP or MA plan.

### ***Becoming an Employer-Sponsored PDP or MA Plan***

In addition, the law provides the Secretary with waiver authority under which an employer may become a PDP or a MA plan and accept payments from Medicare as other PDP or MA plans would. Under this scenario:

- The retiree would be enrolled in a PDP or MA plan offered only to members of an employer group.
- The employer would seek a waiver from HHS to limit enrollment or make other changes.
- Medicare would pay the employer-sponsored PDP or MA only for Medicare coverage (standard or actuarially equivalent plan design).

### ***Other Possibilities***

Employers that may not be able to take advantage of one of the above options still have the flexibility to help retirees in other ways if they choose to. For example, the employer could make a contribution to assist retirees who are enrolled in Part D in one of several ways, including paying part of all of the Medicare Part D premium, or making a contribution available that the retiree can apply to the PDP or MA plan of the retiree’s choice. An employer may also sponsor an HSA account to encourage employees to accumulate an account balance over their working careers that they can use at age 65 to pay Part D premiums or to pay for other qualified health expenses or for long-term care.

## **Discussion**

### ***Choosing Among the Options***

At this stage, most employers have not made firm decisions as to which course they will take. It is still relatively early in the process. The attractiveness of each of the above options will vary by company based on a number of considerations, including:

- The company's existing retiree health plans and the utilization of prescription drugs by Medicare-eligible retirees in those plans;
- How much flexibility the company has to make changes in its program; and
- The company's overall financial situation and competitive position.

### ***Key Regulatory Decisions Pending***

In addition, employers' final decisions about which options to use with respect to Medicare will hinge on pending regulations, and the answers to some key questions, such as:

- How and when employers will be paid if they choose to offer actuarially equivalent drug benefits and accept the 28% subsidy?
- How employers will be required to demonstrate actuarial equivalence?
- How administratively burdensome the data generation and other requirements will be for the employer who wants to accept the 28% subsidy?
- How administratively burdensome it will be for an employer plan to wrap around Medicare Part D coverage, in terms of formularies and other related issues?
- How the fallback plans will work in regions where there is not a sufficient choice of at least two plans, one of which may be a PDP and the other a MA plan?

The Centers for Medicare & Medicaid Services (CMS) has been hard at work in terms of drafting these forthcoming regulations under a tight deadline, and they are to be commended for those efforts, especially since CMS is being asked to make detailed interpretations without the benefit of much guidance from the statutory language.

However, until the proposed rules are issued, perhaps in late June or early July, a considerable amount of uncertainty will remain concerning the key questions of payment and administrative burden.

Employers will also be looking to gauge how the marketplace will respond in terms of the emergence of the PDP, MA plans, and fallback plans. Pending CMS regulations may also have an influence on how such plans respond.

In my opinion, both the Administration and the Congress have an important role to play in the development of these forthcoming regulations. The task is to ensure that the administrative requirements associated with the different employer options will not be so great as to frustrate

congressional intent of encouraging employers to make use of these options and continue offering retiree health benefits.

### ***Tracking Future Employer Reactions***

As noted above, employer reactions to the new Medicare law are still being formulated. In the meantime, companies are trying to work through which of the options or which combination of options would best suit the needs of the organization and its retirees.

Reflecting the ongoing interest in this subject, the MMA has already mandated two General Accounting Office studies to examine trends in employment-based retiree health coverage, the options and incentives available under the MMA that may affect the provision of coverage, and how employers will be reacting to provisions of the MMA.

In attempting to sort out all these effects on retiree health plans, it will also be important, in my opinion, for policymakers to distinguish between continuation of trends that have already been firmly in place versus those that may be a new and direct response to the MMA. The KFF/Hewitt 2003 retiree health benefits survey is an excellent source of data, serving as a baseline of recent trends and future employer plans prior to enactment of the MMA. Of the many trends of interest, three are particularly noteworthy:

- Erosions in coverage were continuing on the eve of the MMA.
- 10% of surveyed employers said that they eliminated benefits for *future* retirees in the past year, these being mostly for new hires.
- Over the next three years, only 2% of employers said they are very or somewhat likely to terminate all subsidized health benefits for *current* retirees, whereas 20% said that they are very or somewhat likely to terminate subsidized benefits for *future* retirees.

Based upon Congressional Budget Office and Joint Committee on Taxation estimates,<sup>4</sup> the 28% employer plan subsidies are projected at \$71 billion between 2006 and 2013 along with a projected \$17.8 billion in tax benefits over that same period.

In approving these subsidies, the conferees noted that: "Absent this assistance, many more retirees will lose their employer-sponsored coverage." We agree with that conclusion.

Thank you, Mr. Chairman. I will be pleased to respond to any questions that you and the other Subcommittee Members may have.

## Notes

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<sup>1</sup> Frank B. McArdle, et al, “Large Firms’ Retiree Health Benefits Before Medicare Reform: 2003 Survey Results,” *Health Affairs* – Web Exclusive, January 14, 2004. <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.7v1>

<sup>2</sup> Frank McArdle, et al., *Retiree Benefits Now and in the Future: Findings from the Kaiser/Hewitt 2003 Survey on Retiree Health Benefits*, (Washington, Kaiser Family Foundation, 2004).

<sup>3</sup> Assuming an employer group with average utilization, Hewitt estimates that the 28% subsidy would be \$640 per retiree as opposed to a net Medicare cost for retirees without employer coverage that would otherwise be \$1,210 (74.5% of total cost), assuming the same group goes to a PDP and reflecting their experience (adjusted for expected behavioral change going to Medicare benefit levels) and 10% administrative expense load.

<sup>4</sup> Congressional Budget Office, letter to Sen. Don Nickles, November 20, 2003, Joint Committee on Taxation, “Estimated Revenue Effects of Certain Provisions Contained in the Conference Agreement for H.R. 1,” November 21, 2003.