

February 2005

RETIREE HEALTH BENEFITS

Options for Employment-Based Prescription Drug Benefits under the Medicare Modernization Act





Highlights of [GAO-05-205](#), a report to congressional committees

Why GAO Did This Study

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) created a prescription drug benefit for beneficiaries, called Medicare part D, beginning in January 2006. The MMA included incentives for sponsors of employment-based retiree health plans to offer prescription drug benefits to Medicare-eligible retirees, such as a federal subsidy when sponsors provide benefits meeting certain MMA requirements. Plan sponsors cannot receive a subsidy for retired Medicare beneficiaries who enroll in part D. In response to an MMA mandate, GAO determined (1) the trends in employment-based retiree health coverage prior to the MMA and (2) which MMA prescription drug options plan sponsors said they would pursue and the effect these options might have on retiree health benefits.

GAO identified trends using data from federal and private sector surveys of employers' health benefit plans and financial statements of 50 randomly selected Fortune 500 employers. Where data for Medicare-eligible retirees were not available, GAO reported data for all retirees, including Medicare-eligible retirees. To obtain plan sponsors' views about options they were likely to pursue, GAO reviewed the 50 employers' financial reports and interviewed benefit consultants; private and public sector plan sponsors, including the Office of Personnel Management for federal employees' health benefits; and other experts.

www.gao.gov/cgi-bin/getrpt?GAO-05-205.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen at (202) 512-7118.

RETIREE HEALTH BENEFITS

Options for Employment-Based Prescription Drug Benefits under the Medicare Modernization Act

What GAO Found

A long-term decline in the percentage of employers offering retiree health coverage has leveled off in recent years, but retirees face an increasing share of costs, eligibility restrictions, and benefit changes that contribute to an overall erosion in the value and availability of coverage. Although the percentages and time frames differed, two employer benefit surveys showed that the percentage of employers offering health coverage to retirees has declined since the early 1990s; this trend, however, has leveled off. The cost to provide retiree health coverage, including coverage for Medicare-eligible retirees, has increased significantly: one employer benefit survey cited double-digit increases each year from 2000 through 2003. Prescription drugs for Medicare-eligible retirees constituted a large share of retiree health costs. Employers and other plan sponsors have used various strategies to limit overall benefit cost growth that included increasing retiree cost sharing and premiums, restricting eligibility for benefits, placing financial caps on health care expenditures, and revising prescription drug benefits.

Many plan sponsors had not made final decisions about which MMA prescription drug options they would choose for their Medicare-eligible retirees at the time of GAO's review. Specifically, 13 of the 15 private and public plan sponsors GAO interviewed were undecided for some or all retirees. However, most plan sponsors interviewed had chosen the federal subsidy option for some or all retirees or were considering the subsidy as one of several options. Alternatively, some plan sponsors that had set caps on their retiree health benefit obligations were considering supplementing (known as "wrapping around") the new Medicare prescription drug benefit for some or all retirees rather than providing their own comprehensive prescription drug coverage in lieu of the Medicare drug benefit. Also, some plan sponsors and benefit consultants said they were waiting to see how the market for other MMA options, such as Medicare Advantage plans, develops. About two-thirds of financial statements GAO reviewed for Fortune 500 employers reporting obligations for retiree health benefits had begun to reflect reduced obligations resulting from the MMA options. While plan sponsors contacted said they did not anticipate reducing their drug coverage in view of new coverage offered through the MMA, increasing health care costs might cause them to do so in the future. Benefit consultants and other experts interviewed said that the MMA was not likely to induce employers to begin to provide prescription drug coverage or to supplement the Medicare drug benefit if they had not previously offered retiree health coverage.

In commenting on a draft of this report, the Centers for Medicare & Medicaid Services and four experts generally agreed with the report's findings. The Office of Personnel Management indicated that it has not made final decisions about which MMA prescription drug option it would choose for the Federal Employees Health Benefits Program, but it does not expect to choose the subsidy option.

Contents

Letter		1
	Results in Brief	4
	Background	6
	Long-term Decline in Employment-Based Retiree Health Coverage Has Leveled Off, with Retirees Paying an Increasing Share of the Costs	13
	Employers and Plan Sponsors Considering MMA Options for Prescription Drug Coverage, Often Considering Subsidy as Primary Option for Some or All Medicare-Eligible Retirees	31
	Concluding Observations	46
	Agency and Other External Comments	46
Appendix I	Scope and Methodology	50
	Surveys of Employment-Based Health Benefits	50
	Federal Surveys	52
	Financial Data from Fortune 500 Employers	55
	Interviews with Benefit Consultants, Plan Sponsors, and Others	56
Appendix II	Comments from the Centers for Medicare & Medicaid Services	59
Appendix III	Comments from the Office of Personnel Management	61
Appendix IV	GAO Contact and Staff Acknowledgments	62
	GAO Contact	62
	Acknowledgments	62
Tables		
	Table 1: Status of Decisions by 15 Private and Public Sector Plan Sponsors Interviewed regarding the MMA Subsidy Option for Prescription Drug Coverage	33
	Table 2: Actions Taken in Response to the MMA by 50 Randomly Selected Fortune 500 Employers, Most as of the Quarter Ending September 30, 2004	42

Figures

Figure 1: Medicare Part D Standard Prescription Drug Benefit	10
Figure 2: Mercer Survey Results—Percentage of Employers with 500 or More Employees Offering Health Benefits to Medicare-Eligible Retirees, 1993-2004	15
Figure 3: Kaiser/HRET Survey Results—Percentage of Employers with 200 or More Employees Offering Health Benefits to All Retirees and to Medicare-Eligible Retirees, 1991-2004	16
Figure 4: Percentage of Medicare-Eligible Retirees and Their Insured Dependents with Employment-Based Health Benefits, by Age Group, 1995-2003	20
Figure 5: Under the MMA Subsidy Option, the Portion of Retired Medicare Beneficiaries' Prescription Drug Expenditures Paid by Employment-Based Coverage and Paid Out-of-Pocket Eligible for Subsidy, Estimate for 2006	36

Abbreviations

CMS	Centers for Medicare & Medicaid Services
CPS	Current Population Survey
EEOC	Equal Employment Opportunity Commission
FAS	Financial Accounting Standards
FASB	Financial Accounting Standards Board
FEHBP	Federal Employees Health Benefits Program
GASB	Governmental Accounting Standards Board
HMO	health maintenance organization
HRET	Health Research and Educational Trust
HSA	health savings account
MEPS	Medical Expenditure Panel Survey
MCBS	Medicare Current Beneficiary Survey
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
OPM	Office of Personnel Management
PPO	preferred provider organization
SEC	Securities and Exchange Commission

This is a work of the U.S. government and is not subject to copyright protection in the United States. It may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.



United States Government Accountability Office
Washington, DC 20548

February 14, 2005

Congressional Committees

As prescription drug costs have continued to increase, many retired senior citizens face significant out-of-pocket costs for prescription drugs. Because the Medicare program as originally designed did not cover outpatient prescription drugs, many beneficiaries relied on other sources to cover the costs of drugs. About a third of all retired Medicare beneficiaries obtained supplementary health benefits through plans sponsored by former employers or other employment-based groups, and most of these plans covered prescription drugs. However, most retired Medicare beneficiaries, including those with employment-based health plans, still relied to varying degrees on their own financial resources to pay for prescription drugs. More broadly, there has been concern in recent years about a long-term decline in the availability of employment-based retiree health coverage.¹ To help senior citizens with increasing prescription drug costs and encourage employment-based retiree health coverage, especially for prescription drugs, Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) in December 2003 that among other things, created a new prescription drug benefit as part D of the Medicare program.² The Medicare part D benefit begins in January 2006. The MMA also established various options and incentives to encourage sponsors of employment-based retiree health plans to offer prescription drug benefits to retired Medicare beneficiaries.

Once the Medicare drug benefit is available in 2006, employers and other sponsors of health coverage will have several options to provide prescription drug benefits to Medicare-eligible retirees. To encourage plan sponsors to offer prescription drug coverage to retired Medicare

¹See, for example, Frank McArdle, Amy Atchison, and Dale Yamamoto, Hewitt Associates; and Michelle Kitchman and Tricia Neuman, The Kaiser Family Foundation, *Current Trends and Future Outlook for Retiree Health Benefits: Findings from the Kaiser/Hewitt 2004 Survey on Retiree Health Benefits* (Menlo Park, Calif., and Lincolnshire, Ill.: The Henry J. Kaiser Family Foundation, December 2004), and GAO, *Retiree Health Benefits: Employer-Sponsored Benefits May Be Vulnerable to Further Erosion*, [GAO-01-374](#) (Washington, D.C.: May 1, 2001).

²Pub. L. No. 108-173, sec. 101, §§ 1860D-1-1860D-42, 117 Stat. 2066, 2071–2152 (to be codified at 42 U.S.C. §§ 1395w-101–1395w-152).

beneficiaries—which they generally do on a voluntary basis—the MMA established a federal subsidy payment for plan sponsors that offer comprehensive drug benefits meeting certain MMA requirements.^{3,4} Subsidy payments will be available for each retiree who chooses to enroll in the sponsor’s plan in lieu of enrolling in part D. Alternatively, plan sponsors can provide coverage that supplements (wraps around) the retiree’s Medicare part D prescription drug benefit and forgo eligibility for the subsidy. Plan sponsors also have several other options for providing prescription drug coverage to retired Medicare beneficiaries under the MMA, such as contracting with private plans that provide standard or enhanced Medicare part D prescription drug benefits.

The MMA required that we conduct a study documenting trends in employment-based retiree health coverage prior to the enactment of the MMA, including coverage provided under the Federal Employees Health Benefits Program (FEHBP),⁵ and the options and incentives available through the MMA that could affect the voluntary provision of employment-based retiree health benefits.⁶ As discussed with the committees of jurisdiction, this report addresses the following questions:

- What were the trends in employment-based retiree health coverage, particularly for Medicare-eligible retirees, prior to the MMA?

³“Plan sponsor” refers to a sponsor of employment-based retiree group health coverage, including private sector employers and public sector employers, including federal, state, or local governments; sponsors of church plans; and sponsors of plans offered under collectively bargained agreements.

⁴MMA sec. 101, § 1860D-22, 117 Stat. 2125-28. The subsidy will be available to employment-based group health plans regulated under the Employee Retirement Income Security Act of 1974 (29 U.S.C. §§ 1001 et seq. (2000)) as well as to federal government and other public sector plans and church plans.

⁵The federal government, through FEHBP, is the nation’s largest purchaser of employment-based health benefits. All active and retired federal workers and their dependents are eligible to enroll in health plans offered through FEHBP. For 2005, 11 nationwide fee-for-service plans, some of which are available only to certain federal retirees and most of which offer a preferred provider organization (PPO), will be participating in FEHBP. While federal retirees also have more than 260 health maintenance organization (HMO), point-of-service, consumer-driven, and high-deductible health plan options, the number available varies by state.

⁶MMA § 111, 117 Stat 2175-76. The MMA also required that we conduct a second study after the implementation of the Medicare drug benefit, following up on trends and the options selected.

-
- Which MMA prescription drug coverage options do plan sponsors say they are likely to pursue and what effect will these options likely have on health benefits for Medicare-eligible retirees?

To identify trends in employment-based retiree health coverage and expenditures, we reviewed data from several sources, including (1) three private sector surveys of employers' health benefit plans nationwide, two of which covered both private and public sector employers and have been conducted annually for more than a decade; (2) three large federal surveys, which contained information on public sector employers' retiree health benefit offer rates, retired Medicare beneficiaries covered by employment-based health coverage from 1995 through 2003, and retired Medicare beneficiaries' prescription drug expenditures, respectively; (3) financial statements that 50 randomly selected Fortune 500 employers filed with the Securities and Exchange Commission (SEC) reporting their anticipated obligations for retiree health benefits;⁷ and (4) studies, reports, and analyses from the literature on retirees' health benefits. To supplement these sources and to obtain more in-depth information, we interviewed officials at (1) 6 firms providing benefit consulting services primarily for large public and private sector employers; (2) 12 Fortune 500 employers that sponsored retiree health benefit plans;⁸ (3) 3 public sector sponsors of retiree health benefits, including the Office of Personnel Management (OPM), which administers FEHBP; (4) 1 association representing unions and 1 representing multiemployer plans that sponsor retiree health benefit plans for unionized workers;⁹ (5) 2 associations representing small to midsized employers; (6) 4 trade organizations, including those representing large employers; and (7) 1 professional

⁷"Obligations" are incurred during employees' active service and refer to projected costs that employers will likely pay in the future for retirees.

⁸Ten of the 12 Fortune 500 employers we interviewed were selected from the 50 randomly selected Fortune 500 employers whose financial statements we reviewed; the other 2 Fortune 500 employers we interviewed were selected prior to our review of financial statements on the basis of recommendations by a benefit consultant.

⁹A multiemployer plan is a pension, health, or other employee benefit plan to which more than one employer is required to contribute; that is maintained under one or more collective bargaining agreements between one or more employee organizations, such as a union, and more than one employer; and that satisfies such other requirements as the Secretary of Labor may prescribe by regulation. 29 U.S.C. § 1002(37) (2000). They are common in industries that typically include smaller employers and have a mobile workforce, such as construction, trucking, and communications. A multiemployer plan's board of trustees, which has equal representation from labor and management, as opposed to an individual employer or union, controls the design and financing of the plan.

organization for actuaries. We focused on trends particularly affecting Medicare-eligible retirees, but in some cases when information specific to Medicare-eligible beneficiaries was not available, we reported on trends affecting all retirees, including those who were under age 65 and those who were eligible for Medicare.¹⁰ To determine which MMA prescription drug coverage options plan sponsors said they would likely pursue and what effect these options might have on retiree health benefits, we relied primarily on our review of the annual and quarterly financial statements that 50 Fortune 500 employers filed with the SEC and on our interviews with benefit consultants, private and public sector sponsors of employment-based retiree health benefit plans, and other experts. We also interviewed officials at the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicare, to obtain information on MMA prescription drug options for plan sponsors. We assessed the reliability of the data from the three employer benefit nationwide surveys and three large federal surveys and determined that the data were sufficiently reliable for the purposes of our study. (App. I provides more detailed information on our methodology.) We performed our work from April 2004 through February 2005 in accordance with generally accepted government auditing standards.

Results in Brief

A long-term decline in the percentage of employers offering retiree health coverage has leveled off in recent years, with retirees shouldering a steadily increasing share of costs and facing additional constraints on eligibility and benefits. Although the percentages and time frames differed, two employer benefit surveys showed that the percentage of employers that offer health coverage to retirees has declined since the early 1990s, but this trend has leveled off in recent years. For example, one survey found that the percentage of employers with at least 500 employees offering coverage to Medicare-eligible retirees declined from about 44 percent in 1993 to 27 percent in 2001, then remained relatively stable through 2004. Meanwhile, the cost for employers and other plan sponsors to provide health coverage to retirees, including Medicare-eligible retirees, has increased significantly, with one employer benefit survey reporting double-digit increases each year from 2000 through 2003. Prescription drugs represent a large share of these increases and a large share of plan

¹⁰For this report, we specify when information is for Medicare-eligible retirees (primarily those aged 65 years or older) and when it is for retirees under the age of 65. If information is not specific to Medicare-eligible retirees or to those under the age of 65, we use the term retirees to refer to those that may be Medicare-eligible, under 65, or both.

sponsors' overall health coverage costs for Medicare-eligible retirees. Employers and other plan sponsors have used various strategies to limit overall benefit cost growth, usually requiring retirees to pay more for coverage and thus contributing to an overall erosion in the value and availability of coverage. Cost-cutting strategies have included increasing retiree cost sharing; restricting eligibility for benefits, including eliminating coverage for future retirees; and redesigning prescription drug benefits to encourage the use of lower-cost drugs. Public sector sponsors' measures to cut costs have mirrored those in the private sector, with one major difference: they generally have not eliminated coverage for future retirees.

Many employers and other plan sponsors had not made final decisions about which MMA drug coverage options they would choose for their Medicare-eligible retirees at the time of our review. Although they were in various stages of decision making, 13 of the 15 plan sponsors we interviewed were undecided with respect to some or all of their retirees. However, most plan sponsors we interviewed were considering the federal subsidy as the primary option in their deliberations—2 had chosen the subsidy option for all of their retirees; 10 had chosen the subsidy option for some of their retirees or were considering it as one of their options; and 3, including OPM for FEHBP, said that they would not or did not expect to choose the subsidy option. Where plan sponsors had set financial caps on their retiree health benefit obligations, they often were considering offering benefits that would wrap around Medicare's drug benefit for all of their retirees or for those retirees whose benefits would not qualify for the subsidy. Plan sponsors would offer coverage wrapping around Medicare part D rather than providing their own comprehensive prescription drug coverage in lieu of the Medicare drug benefit. Also, some plan sponsors and benefit consultants said they were waiting to see how the market for other MMA options, such as private health plans offered through the Medicare Advantage program, developed before they made final decisions. About two-thirds of the financial statements we reviewed from a sample of Fortune 500 employers reporting obligations for retiree health benefits had begun to reflect reduced obligations for retiree health benefits from the federal subsidy or other options, whereas the remainder had not reflected any changes as a result of the MMA. Generally, in response to our questions about the effects of the MMA on their retiree drug coverage, plan sponsors said that they did not anticipate immediately reducing the current drug coverage they provided for Medicare-eligible retirees but that increasing health care costs might cause them to reduce coverage in the future. Benefit consultants and other experts we interviewed said that the MMA was not likely to induce employers that did

not already offer prescription drug coverage to retirees to begin to provide such coverage or to supplement the Medicare drug benefit but that each employer would have to make this decision while considering its own financial and business strategy.

In commenting on a draft of this report, CMS and four experts generally agreed with the report's findings. In its written comments, CMS confirmed that many plan sponsors are still considering their options under the MMA. Having just released its final rule, CMS stated that it intends to provide additional guidance and continue conducting outreach and education efforts on the options for retirees' prescription drug coverage available to plan sponsors. While at the time of our interviews OPM officials indicated that the agency was considering the federal subsidy for FEHBP, OPM indicated in its written comments on a draft of this report that it does not expect to choose the federal subsidy option, and we revised the report accordingly.

Background

For retirees aged 65 or older, Medicare is typically the primary source of health insurance coverage. Medicare covered about 41 million beneficiaries as of July 2003. The program covers hospital care as well as doctor visits and outpatient services but has never covered most outpatient prescription drugs.

Medicare and Supplemental Coverage before Implementation of Medicare Drug Benefit

Under traditional Medicare, eligible individuals may apply for part A, which helps pay for care in hospitals and some limited skilled nursing facility, hospice, and home health care, and may purchase part B, which helps pay for doctors, outpatient hospital care, and other similar services. Depending on where they live, individuals may have the option of obtaining traditional Medicare coverage (on a fee-for-service basis) or coverage from a managed care or other private plan offered through the Medicare Advantage program.¹¹ Many beneficiaries have been attracted to

¹¹The MMA created the Medicare Advantage program to replace the Medicare+Choice program (MMA § 201, 117 Stat. 2176). Medicare+Choice was established in the Balanced Budget Act of 1997 (Pub. L. No. 105-33, sec. 4001, §§ 1851-1859, 111 Stat. 251, 275-327 (codified at 42 U.S.C. §§ 1395w-21-1395w-28)) to expand Medicare beneficiaries' health plan options and encourage wider availability of HMOs and other types of health plans, such as PPOs, as an alternative to traditional fee-for-service. H.R. Conf. Rep. No. 108-391, at 524 (2003). While retaining many of the same provisions in Medicare+Choice, including the eligibility, enrollment, grievance, and appeals provisions, Medicare Advantage provides additional features, such as increased payment rates and a new option for Medicare beneficiaries—regional PPOs. MMA § 221, 117 Stat. 2180-93.

these plans because they typically have lower out-of-pocket costs than fee-for-service plans and offer services not covered by traditional Medicare prior to the MMA, such as routine physical examinations and most outpatient prescription drugs.¹² Nearly 4.7 million Medicare beneficiaries were enrolled in a local Medicare Advantage plan as of July 2004.

To cover some or all of the costs Medicare does not cover, such as deductibles, copayments, and coinsurance, Medicare beneficiaries may rely on private retiree health coverage through former employment or through individually purchased Medicare supplemental insurance (known as Medigap).^{13, 14} For example, for 2001, the Medicare Current Beneficiary Survey (MCBS) found that about three-fourths of Medicare-eligible beneficiaries obtained supplemental coverage from the following sources: a former employer or union (29 percent); individually purchased coverage, including Medigap policies (27 percent); both employment-based and individually purchased coverage (7 percent); or Medicaid (13 percent).¹⁵ About 24 percent had Medicare-only coverage.

¹²For Medicare beneficiaries who purchase part B coverage on or after January 1, 2005, Medicare will cover a one-time preventive physical exam within the first 6 months that the beneficiary is enrolled in part B. MMA sec. 601, § 1861 (s)(2) and (ww), 117 Stat. 2303-24 (to be codified at 42 U.S.C. § 1395x(s)(2) and (ww)).

¹³Medigap is a privately purchased health insurance policy that supplements Medicare by paying for some of the health care costs not covered by Medicare. 42 U.S.C. 1395ss (2000). Medicare beneficiaries can purchase 1 of 10 standardized Medigap benefit packages. Three of the 10 standardized Medigap benefit packages offer limited prescription drug benefits, paying 50 percent of drug charges up to either \$1,250 per year or \$3,000 per year after the beneficiary pays a \$250 deductible. New Medigap plans sold after January 1, 2006, will no longer include prescription drug benefits. MMA sec. 104(a)(1), § 1882(v)(1), 117 Stat. 2161 (to be codified at 42 U.S.C. § 1395ss(v)(1)).

¹⁴Health plans typically require enrollees to pay a portion of the cost of their medical care. These cost sharing arrangements include deductibles, which are fixed payments enrollees are required to make before coverage applies; copayments, which are fixed payments enrollees are required to make at the time benefits or services are received; and coinsurance, which is a percentage of the cost of benefits or services that the enrollee is responsible for paying directly to the provider.

¹⁵Low-income Medicare beneficiaries may qualify for assistance from Medicaid, a joint federal-state program that covers health care services for certain individuals with low incomes and resources. 42 U.S.C. § 1396 et seq. (2000). For Medicare beneficiaries qualifying for full Medicaid benefits, known as “dual eligible” individuals, state Medicaid programs pay for Medicare’s part A and part B cost sharing requirements up to the Medicaid payment rate as well as for services that are not generally covered by Medicare, including prescription drugs.

Employers generally offer health benefits to retirees on a voluntary basis.¹⁶ While these benefits vary by employer, they almost always include prescription drugs and often cover both retirees under age 65 as well as those eligible for Medicare. However, coverage can vary between these groups of retirees. For example, premiums are often lower for those aged 65 and over because Medicare pays for certain costs, and cost sharing requirements, which can make retirees more sensitive to the costs of care, may differ.¹⁷ Plan types may also differ based on Medicare eligibility. For example, some employers offer retirees under age 65 a preferred provider organization (PPO) plan but offer a fee-for-service plan for retirees eligible for Medicare. Regardless of the type of plan offered, retirees who have employment-based coverage generally have a choice of more than one plan.

Plan sponsors typically coordinate their retiree health benefits with Medicare once retirees reach age 65, with Medicare as the primary payer and the plan sponsor as the secondary payer. Several types of coordination occur between plan sponsors and Medicare. For example, some plan sponsors coordinate through a carveout approach, in which the plan calculates its normal benefit and then subtracts (or carves out) the Medicare benefit, generally leaving the retiree with out-of-pocket costs comparable to having the employment-based plan without Medicare. Another approach used by plan sponsors is full coordination of benefits, in

¹⁶Since World War II, many employers have voluntarily sponsored health insurance as a benefit to employees for purposes of recruitment and retention and some have also offered these benefits to their retirees. The federal tax code provides incentives for employers to offer health benefits because qualified employer contributions do not count as taxable income to employees and may be deducted from the employer's income for tax purposes. 26 U.S.C. §§ 106(a) and 419(a), respectively (2000). Requirements for most employment-based health plans for workers or retirees are prescribed by the Employee Retirement Income Security Act of 1974, which gives employers considerable flexibility to manage the cost, design, and extent of health care benefits they provide. 29 U.S.C. §§ 1001 et seq. (2000).

¹⁷In 2000, a federal court held that an employer providing Medicare-eligible retirees a health benefit that is different from that offered to other retirees constitutes age discrimination unless, under an exception established by regulation, the health benefits provided by both the employer and Medicare are equal to, or cost the employer as much as, the health benefit provided to other retirees. *Erie County Retirees Ass'n v. County of Erie*, 220 F.3d 193 (3d Cir. 2000), *cert. denied*, 532 U.S. 913 (2001). The Equal Employment Opportunity Commission (EEOC) published a proposed rule on July 14, 2003, that would establish an additional exception under which altering, reducing, or eliminating health benefits when retirees are eligible for Medicare would not constitute age discrimination. 68 *Fed. Reg.* 41,542. During a public meeting on April 22, 2004, EEOC voted to approve the final rule, but before it becomes final, it must be published in the *Federal Register*.

which the plan pays the difference between the total health care charges and the Medicare reimbursement amount, often providing retirees complete coverage and protection from out-of-pocket costs.¹⁸ According to one employer benefit survey, carveout is the most common type of coordination used by employers that sponsor retiree health plans.¹⁹

The MMA Established a New Prescription Drug Benefit for Medicare Beneficiaries

In January 2006, Medicare will begin offering beneficiaries outpatient prescription drug coverage through a new Medicare part D. Medicare beneficiaries who choose to enroll for this voluntary benefit will have some of their prescription drug expenditures covered by prescription drug plans authorized by the MMA.²⁰ In addition to paying a premium—estimated initially to be about \$35 per month (\$420 per year)—beneficiaries must meet other out-of-pocket expense requirements:

- a \$250 deductible;
- 25 percent of their next \$2,000 in prescription drug expenditures; and
- 100 percent of the next \$2,850 in prescription drug expenditures, a coverage gap often referred to as the Medicare part D benefit “doughnut hole.”

Medicare beneficiaries must therefore pay \$3,600 out-of-pocket for prescription drugs in 2006 before part D catastrophic coverage begins. Part D catastrophic coverage pays most drug costs once total costs exceed \$5,100, with beneficiaries paying either the greater of a \$2 copayment for each generic drug and \$5 copayment for other drugs, or 5 percent coinsurance. Only prescription drug costs paid by the part D enrollee or by another person or certain charitable organizations or state pharmaceutical assistance programs on behalf of the enrollee, rather than by a plan

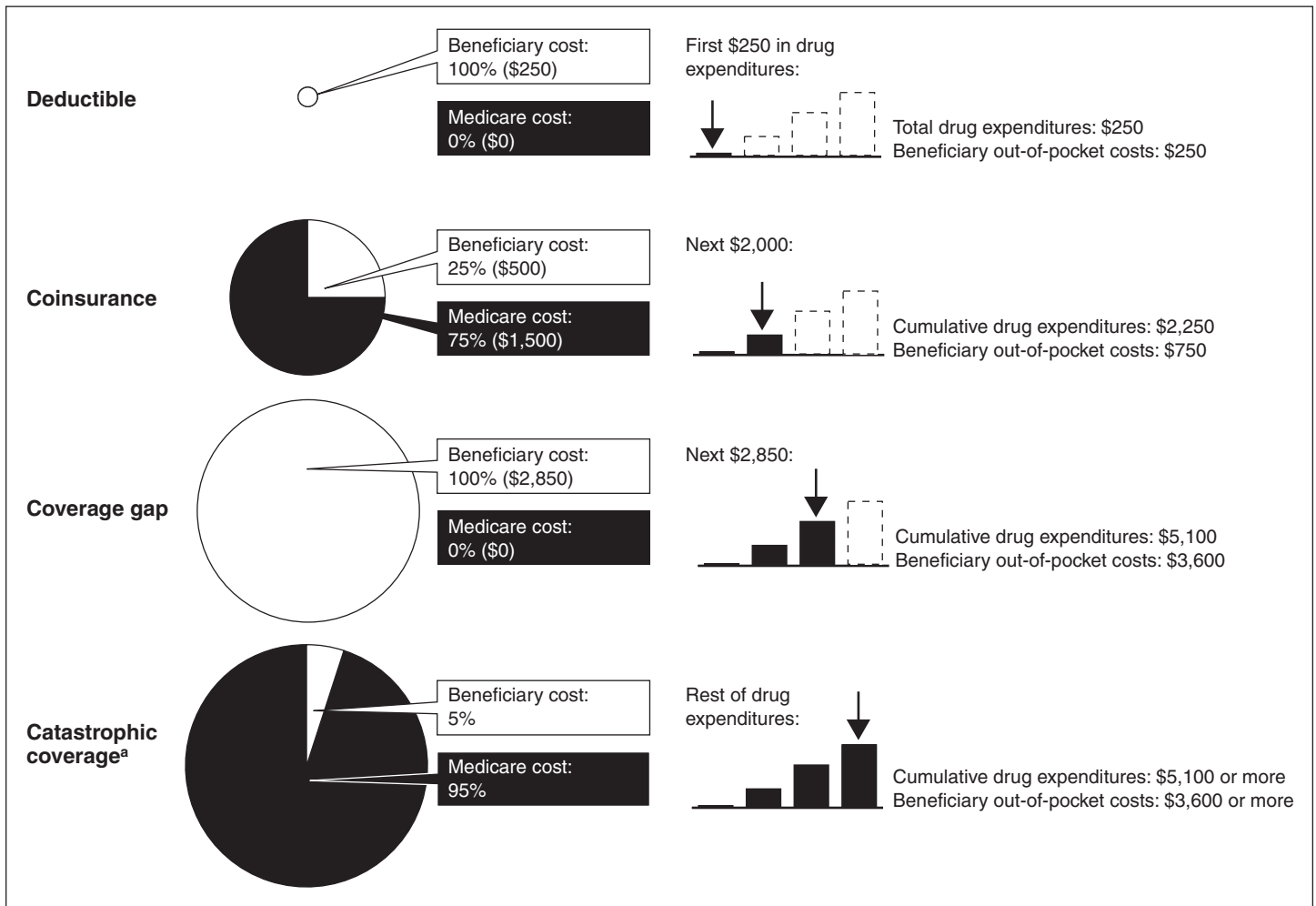
¹⁸Different coordination approaches can result in different costs for plan sponsors and retirees. For example, consider an individual with total health care costs of \$10,000 and retiree health benefits paying (without Medicare) \$8,500 of these costs. Under full coordination of benefits, if Medicare paid \$8,000, the plan payment would be \$2,000, and the retiree would have no out-of-pocket costs. In a carveout, if Medicare paid \$8,000, the plan payment would be \$500, and the retiree would pay \$1,500 out-of-pocket. See Frank B. McArdle and Dale H. Yamamoto, Hewitt Associates LLC, for the Kaiser Medicare Policy Project, *Retiree Health Trends and Implications of Possible Medicare Reforms* (Washington, D.C.: The Henry J. Kaiser Family Foundation, September 1997).

¹⁹*Kaiser/Hewitt 2004 Survey on Retiree Health Benefits.*

²⁰The initial enrollment period for Medicare part D will run from November 15, 2005, to May 15, 2006. MMA secs. 101 and 102, §§ 1860D-1(b)(2)(A) and 1851(e)(3)(B)(iii), 117 Stat. 2073 and 2152 (to be codified at 42 U.S.C. §§ 1395w-101(b)(2)(A) and 1395w-21(e)(3)(B)(iii)).

sponsor, are considered in determining a beneficiary's true out-of-pocket costs. (See fig. 1.)

Figure 1: Medicare Part D Standard Prescription Drug Benefit



Source: GAO analysis of the MMA.

^aIf a \$2 copayment for generic drugs and a \$5 copayment for other drugs is greater than the 5 percent coinsurance, the beneficiary is required to pay the copayment.

After the part D benefit becomes effective in January 2006, Medicare beneficiaries will be able to receive prescription drug coverage in several ways, such as the following:

-
- Beneficiaries covered through the traditional fee-for-service Medicare program will be able to enroll in privately sponsored prescription drug plans that contract with CMS to receive their drug benefits.
 - Beneficiaries enrolled in Medicare Advantage plans providing part D prescription drug benefits will receive all of their health care services, including part D benefits, through their Medicare Advantage plan.²¹
 - Beneficiaries will be able to continue to receive prescription drug benefits from other sources, such as an employment-based plan, if the plan sponsor chooses to provide prescription drug coverage to Medicare-eligible retirees.

The MMA Provides Plan Sponsors Options and Incentives for Providing Prescription Drug Coverage

The MMA creates options and incentives for a current or a potential sponsor of an employment-based retiree health plan to provide prescription drug coverage to Medicare-eligible retirees. Options for plan sponsors under the MMA include the following:

- Offer retirees comprehensive prescription drug coverage through an employment-based plan in lieu of Medicare part D prescription drug coverage. Under this option, a sponsor of a plan with prescription drug coverage actuarially equivalent²² to that under part D will receive an incentive to maintain coverage through a federal tax-free subsidy equal to 28 percent of the allowable gross retiree prescription drug costs over \$250 through \$5,000 (maximum \$1,330 per beneficiary) for each individual eligible for part D who is enrolled in the employment-based plan. For 2006, CMS estimated that the average annual subsidy would be \$668 per beneficiary.²³ In order to qualify for this subsidy, however, a plan sponsor

²¹MMA sec. 101, § 1860D-21, 117 Stat. 2122 (to be codified at 42 U.S.C. § 1395w-131). Medicare Advantage plans will be required to offer basic drug coverage starting in 2006. They may also offer additional drug benefits for an increased cost. A beneficiary enrolled in a Medicare Advantage plan generally will receive prescription drug coverage through that plan and may not enroll in a part D prescription drug plan.

²²Specifically, when applying for the subsidy, the plan sponsor will have to provide an attestation that the actuarial value of its prescription drug benefits available to Medicare-eligible retirees is at least equivalent to the actuarial value of the standard part D benefit. MMA sec. 101, § 1822D-12(a)(2)(A), 117 Stat. 2125, (to be codified at 42 U.S.C. § 1395w-132(a)(2)(A)).

²³70 *Fed. Reg.* 4,194, 4,462 (Jan. 28, 2005). For a plan sponsor in the 35 percent tax bracket, this would be the equivalent of receiving taxable income of \$1,028. In the case of a private employer, this amount would be in addition to the employer's savings resulting from the deductibility of qualified plan contributions from taxable income. 26 U.S.C. § 419 (2000). However, CMS estimated that at least 60 percent of retirees receiving employment-based prescription drug coverage do so through plan sponsors that are exempt from federal income taxes—for example, state and local governments or not-for-profit corporations.

must attest that the actuarial value of prescription drug coverage under the plan is at least equal to the actuarial value of standard Medicare part D prescription drug coverage.²⁴ Furthermore, a plan sponsor will receive a subsidy only for those Medicare beneficiaries who do not enroll in the Medicare part D benefit.

- Offer prescription drug coverage that supplements (“wraps around”) the part D benefit, as health plans commonly do for hospital and physician services under Medicare parts A and B.
- Pay all or part of the monthly premium for any of the prescription drug plans or Medicare Advantage plans in which Medicare-eligible retirees (and dependents) choose to enroll.
- Contract with a prescription drug plan or Medicare Advantage plan to provide the standard part D prescription drug benefit or enhanced benefits to the plan sponsor’s retirees who are Medicare-eligible (equivalent to offering a fully insured benefit) or become a prescription drug plan or Medicare Advantage plan (equivalent to offering a self-insured benefit).²⁵

Plan sponsors also have other options. As has always been the case, plan sponsors could stop providing any type of subsidized health care coverage, including prescription drugs, to Medicare-eligible retirees and their dependents. While they are not available for current Medicare beneficiaries, the MMA also authorized the use of health savings accounts (HSA) to which employers and active workers and retirees not eligible for Medicare can contribute to cover future health care costs.²⁶ This option could provide a means for employees who are not offered employment-based retiree health coverage to save money for health coverage when they retire.

On August 3, 2004, CMS published a proposed rule for implementing the Medicare part D prescription drug provisions of the MMA, and the comment period closed October 4, 2004.²⁷ The proposed rule provided a preliminary overview of how CMS intended to implement the MMA, including the subsidy and other options. On January 28, 2005, CMS

²⁴70 *Fed. Reg.* 4,407.

²⁵MMA sec. 101, § 1822D-22(b), 117 Stat. 2127 (to be codified at 42 U.S.C. § 1395w-132(b)).

²⁶MMA sec. 1201, § 223, 117 Stat. 2469-79 (to be codified at 26 U.S.C. § 223). Amounts contributed to HSAs will receive preferential income tax treatment.

²⁷69 *Fed. Reg.* 46,632.

published a final rule implementing the MMA.²⁸ CMS also indicated that it will provide further guidance relating to the subsidy for plan sponsors providing retiree drug coverage.

Long-term Decline in Employment-Based Retiree Health Coverage Has Levelled Off, with Retirees Paying an Increasing Share of the Costs

The percentage of employers offering health benefits to retirees, including those who are Medicare-eligible, has decreased since the early 1990s, according to employer benefit surveys, but offer rates have leveled off in recent years. At about the same time, the percentage of Medicare-eligible retirees aged 65 and older with employment-based coverage has remained relatively consistent. Meanwhile, employment-based retiree health plans experienced increased costs to provide coverage, with one employer benefit survey citing double-digit annual average increases from 2000 through 2003. Financial statements we reviewed for a random sample of 50 Fortune 500 employers showed that over 90 percent of the employers that offered retiree health coverage had increased postretirement benefit obligations from 2001 through 2003. Private and public plan sponsors, including those that provide coverage for Medicare-eligible retirees, have responded to increasing costs by implementing strategies that require these retirees to pay more for coverage and thus contribute to a gradual erosion of the value and availability of benefits.

Employer Benefit Surveys Show Decrease in Share of Employers Offering Health Benefits to Retirees, but Trend Has Levelled Off in Recent Years

Employer benefit surveys reported that the percentage of employers offering health benefits to retirees has decreased since the early 1990s; however, these offer rates have remained relatively stable in recent years. A series of surveys conducted by Mercer Human Resource Consulting indicated that the portion of employers with 500 or more employees offering health insurance to Medicare-eligible retirees declined from 44 percent in 1993 to 27 percent in 2001, and leveled off from 2001 through 2004, with approximately 28 percent offering the benefits to Medicare-eligible retirees in 2004 (see fig. 2).²⁹ A second series of surveys conducted by the Kaiser Family Foundation and Health Research and Educational Trust (Kaiser/HRET) estimated that the percentage of employers with 200 or more employees offering retiree health coverage—for those Medicare-

²⁸70 *Fed. Reg.* 4,194. In its written comments, CMS indicated that it released this final rule on January 21, 2005.

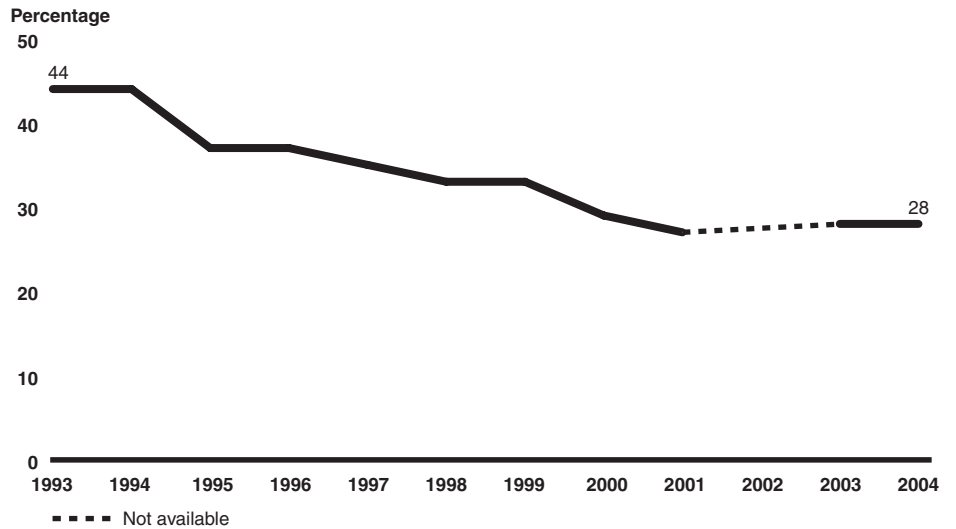
²⁹See, for example, Mercer Human Resource Consulting, *National Survey of Employer-Sponsored Health Plans 2004* (forthcoming).

eligible or those under age 65 or both³⁰—decreased from 46 percent in 1991 to 36 percent in 1993 and then leveled off from 1993 through 2004, with approximately 36 percent of employers with 200 or more employees offering retiree health benefits to these groups in 2004 (see fig. 3).³¹ For Medicare-eligible retirees specifically, the percentage of employers in the Kaiser/HRET survey offering coverage fluctuated from 1995 to 2004, but differed by only 1 percentage point in 1995 (the earliest data available) and 2004, with 28 and 27 percent of employers, respectively, offering coverage in these 2 years. Coverage for early retirees, those under age 65, has also been significantly affected since the early 1990s. For example, the Mercer surveys showed a steady decline in employers with 500 or more employees offering coverage to this population from 50 percent in 1993 to 34 percent in 2001, although this percentage has generally leveled off since 2001.

³⁰Unless otherwise specified, the percentage of employers in the Kaiser/HRET study that offer retiree health benefits may include employers that offer health benefits to Medicare-eligible retirees, retirees under age 65, or both.

³¹Gary Claxton and others, The Kaiser Family Foundation; and Jon Gabel and others, Health Research and Educational Trust, *Employer Health Benefits 2004 Annual Survey* (Menlo Park, Calif., and Chicago, Ill.: The Henry J. Kaiser Family Foundation, 2004), <http://www.kff.org/insurance/7148/index.cfm> (downloaded Dec. 8, 2004).

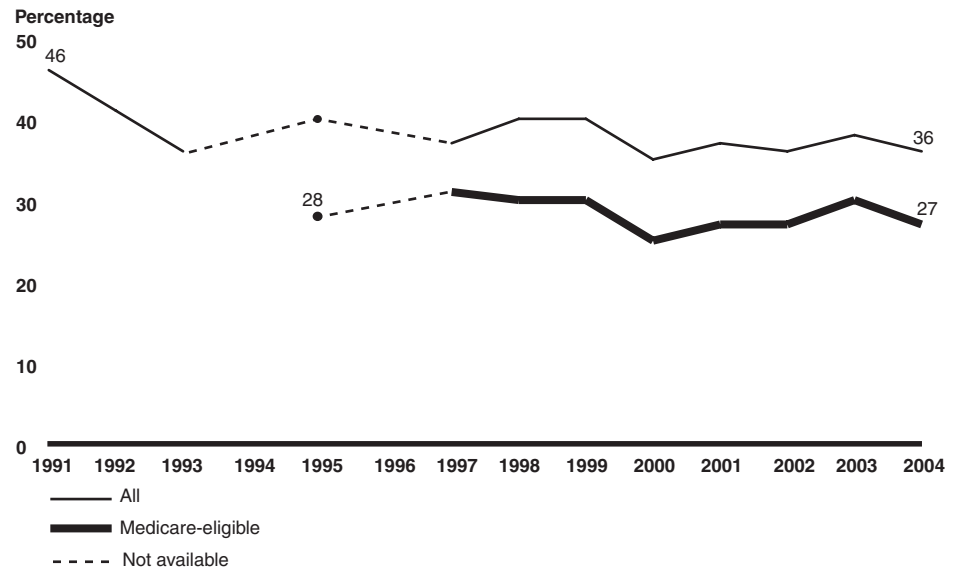
Figure 2: Mercer Survey Results—Percentage of Employers with 500 or More Employees Offering Health Benefits to Medicare-Eligible Retirees, 1993-2004



Sources: Mercer Human Resource Consulting; William M. Mercer, Incorporated; and Foster Higgins.

Notes: Based on employer benefit surveys from 1993 through 2004. The Mercer data include employers that offer coverage on a continuing basis to newly hired employees as well as employers that may limit coverage to individuals who were hired or who retired before a specified year. The dotted line from 2001 to 2003 indicates that comparable 2002 data were not available because of a wording change on the 2002 survey questionnaire. In 2003, Mercer modified the survey questionnaire again to make the data comparable to prior years (except 2002). Thus, consistent with the Mercer 2003 survey, we have excluded data for 2002. Although Mercer provided us with the 2004 data, the comprehensive 2004 annual report will not be available until March 2005.

Figure 3: Kaiser/HRET Survey Results—Percentage of Employers with 200 or More Employees Offering Health Benefits to All Retirees and to Medicare-Eligible Retirees, 1991-2004



Sources: Kaiser/HRET and KPMG Peat Marwick.

Notes: Based on KPMG Peat Marwick surveys from 1991 through 1998 and Kaiser/HRET surveys from 1999 through 2004. The data for “all” retirees may include employers that offer health benefits to Medicare-eligible retirees, retirees under age 65, or both. Data for all retirees were unavailable for 1994 and 1996. Data for Medicare-eligible retirees were unavailable from 1991 through 1994 and for 1996.

In 2003, Kaiser/HRET made changes to its survey methodology that resulted in adjustments to some of the estimates reported in prior-year reports. The differences resulting from these adjustments for the retiree health benefits data were not statistically different.

Employer benefit consultants and the 15 private and public sector plan sponsors that we interviewed consistently cited a general erosion in health benefits for all retirees, including those who are Medicare-eligible, but some officials we interviewed also told us that plan sponsors that could eliminate benefits had already done so, which is consistent with the period of leveling off shown in the Mercer and Kaiser/HRET surveys. For example, although the provision of health benefits for all retirees by employers is generally voluntary, officials we interviewed noted that employers that continue to offer retiree health benefits may be limited in their ability to decrease benefits further because of existing contracts with unions, which are generally negotiated every 3 to 5 years. According to the 15 private and public sector plan sponsors and employer benefit consultants that we interviewed, many plan sponsors have restricted coverage for future retirees—including those who are Medicare-eligible—

but have continued to offer benefits to existing retirees, which would also contribute to a leveling off of these rates.

Large employers are more likely than small employers to offer retiree health coverage, including coverage for Medicare-eligible retirees. For example, Kaiser/HRET data for 2004 showed that 36 percent of employers with 200 or more employees offered health benefits to retirees compared to approximately 5 percent of employers with 3 to 199 employees. Within the Mercer and Kaiser/HRET definitions of large employers (at least 500 and at least 200 employees, respectively), those with the greatest numbers of employees were the most likely to sponsor health benefits for retirees. For example, Kaiser/HRET reported that approximately 60 percent of employers with 5,000 or more employees offered health benefits in 2004 to retirees compared to about 31 percent of employers with 200 to 999 employees. Based on the 2003 Mercer survey, 63 percent of employers with 20,000 or more employees offered coverage specifically to Medicare-eligible retirees compared to 23 percent of employers with 500 to 999 employees.³²

In addition, employers with a union presence were more likely to offer retiree health coverage than those employers without a union presence. According to the 2004 Kaiser/HRET survey, among employers with 200 or more employees, 60 percent of these employers with union employees offered health coverage to retirees compared to 22 percent of these employers without union employees.

The provision of retiree health coverage also varies between the private and public sector and by industry type. For example, employers in the public sector were more likely than employers in the private sector to offer coverage to retirees, including those who are Medicare-eligible. All federal government retirees—Medicare-eligible and those under age 65—are generally eligible for FEHBP health benefits and pay the same premiums as active federal workers for the same benefits, including

³²Mercer Human Resource Consulting, *National Survey of Employer-Sponsored Health Plans: 2003 Survey Report* (New York, N.Y.: Mercer Human Resource Consulting, Inc., 2004).

prescription drugs.³³ State plan sponsors also typically have higher offer rates than private sector employers for retirees. For example, the 2004 Kaiser/HRET study showed that 77 percent of state and local government employers with 200 or more employees offered coverage to retirees compared with the average offer rate of 36 percent across all employer industries. For retirees aged 65 and older, Medical Expenditure Panel Survey (MEPS) data for 2002 indicated that approximately 86 percent of state entities offered health insurance to this group of retirees.³⁴ After government employers, according to the 2004 Kaiser/HRET study, the industry sector with the next highest percentage offering retiree coverage was transportation/communication/utility, with 53 percent of all employers in this industry sector (200 or more employees) offering health benefits to their retirees in 2004. The industry sectors in this survey least likely to offer coverage were health care and retail, with 22 percent and 10 percent, respectively, of employers (200 or more employees) in these industry sectors offering retiree health benefits.

Percentage of Medicare-Eligible Retirees with Employment-Based Health Coverage Remained Consistent

The overall percentage of Medicare-eligible retirees and their insured dependents aged 65 and older obtaining employment-based health benefits through a former employer has remained relatively consistent from 1995 through 2003, based on data from the U.S. Census Bureau's Current Population Survey (CPS). According to our analysis of CPS data, the percentage of Medicare-eligible retirees aged 65 and older with employment-based health coverage and their insured dependents was

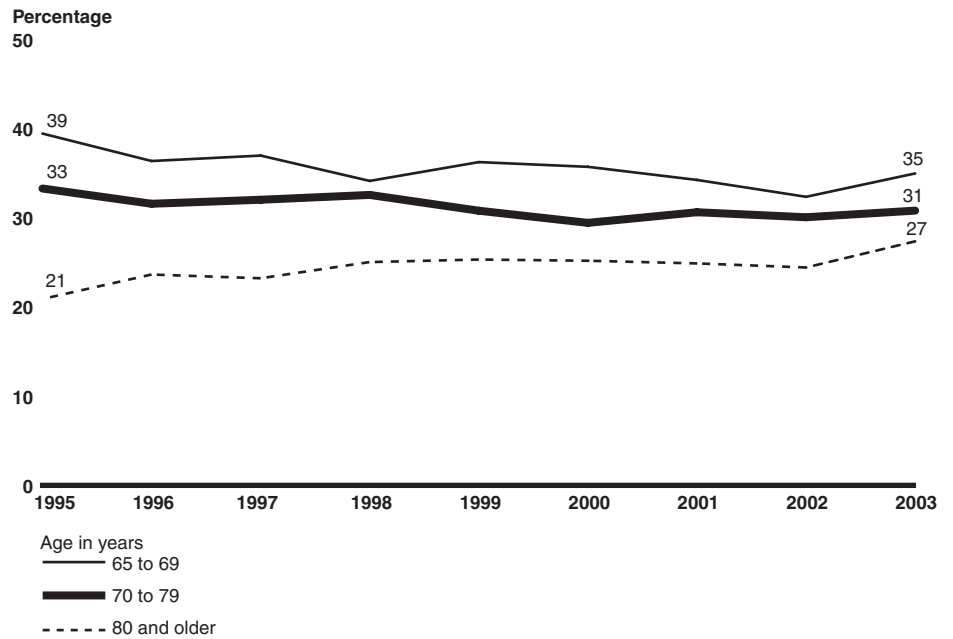
³³To qualify, a federal retiree must have been continuously enrolled (or covered as a family member) in any FEHBP plan(s) for the 5 years of service immediately before retirement begins, or for the full period(s) of service since the first opportunity to enroll (if less than 5 years). 5 U.S.C. § 8905(b) (2000). When a federal retiree covered by Medicare uses health care, the bill for the care is sent first to Medicare, which pays for covered care according to its payment rules and then the bill is sent to the FEHBP plan, as secondary payer, which pays for care covered under its policy that is not covered by Medicare. In 2003, OPM reported that about 2.6 million people (including spouses, dependents, and survivors) received benefits through retirees who were enrolled in FEHBP. Of this group, approximately 1.7 million were Medicare beneficiaries.

³⁴This percentage had increased from about 69 percent in 1998. MEPS also reported for both 1998 and 2000 that about 80 percent of full-time employees at large public sector employers (1,000 or more employees) worked where health insurance was offered to retirees aged 65 and older.

approximately 32 percent in 1995 and 31 percent in 2003.³⁵ Among Medicare-eligible retirees and their insured dependents aged 65 through 69 and aged 70 through 79, there was a modest decline in the percentage with employment-based health coverage from 1995 through 2003, but a modest increase among Medicare-eligible retirees and their insured dependents aged 80 and over (see fig. 4). The modest decline among those aged 65 through 69 and aged 70 through 79 relative to all Medicare-eligible retirees aged 65 and over may be because plan sponsors are more likely to reduce benefits for future or recent retirees than for all retirees. Thus, the effect of changes that plan sponsors have made to their retiree health benefits may take additional time to be evident in the percentage of current retirees receiving employment-based health benefits.

³⁵These percentages include retirees aged 65 or over with employment-based health coverage from a former employer or union as well as the insured dependents of these individuals who are also Medicare-eligible retirees aged 65 or over and who have employment-based health coverage, such as spouses.

Figure 4: Percentage of Medicare-Eligible Retirees and Their Insured Dependents with Employment-Based Health Benefits, by Age Group, 1995-2003



Source: GAO analysis of March CPS Supplement and Annual Social and Economic Supplement to the CPS.

Notes: Based on the March CPS Supplement from 1996 through 2002 and the Annual Social and Economic Supplement to the CPS from 2003 through 2004. The age categories for insured dependents are based on the age of the actual individual, not the primary policyholder. For example, an 80-year-old insured dependent is counted as 80 years of age regardless of the age of the primary policyholder. All differences by age group comparing 1995 to 2003 CPS data are statistically significant.

Faced with Increasing Costs, Plan Sponsors Have Implemented Various Cost-Cutting Strategies, Which Often Require Retirees to Pay More for Coverage

Retiree health costs continue to increase for many plan sponsors of retiree health coverage, including those that provide coverage to Medicare-eligible retirees. Our analysis of financial statements filed with the SEC by a sample of 50 Fortune 500 employers pointed to increases—some 50 percent or higher—in employers’ obligations for postretirement benefit obligations from 2001 through 2003. Employer benefit surveys and our interviews with officials from 15 private and public plan sponsors have also cited increased retiree health costs. These increases often have prompted plan sponsors to attempt to contain cost growth to provide coverage in a variety of ways, including requiring greater cost sharing from retirees.

Increasing Cost of Providing Retiree Health and Prescription Drug Coverage

The cost of providing retiree health coverage—and prescription drug costs in particular—is increasing for many plan sponsors. Financial statements filed with the SEC by 50 randomly selected Fortune 500 employers showed that over 90 percent of the 38 employers that reported postretirement benefit obligations from 2001 through 2003 had an increase in these obligations during this period.³⁶ About 20 percent of these 38—8 employers—had an increase in their obligations above 50 percent, while one-third of these 38—13 employers—had an increase of between 25 and 50 percent from 2001 through 2003. During this same period, the Bureau of Labor Statistics estimated that the Consumer Price Index, which reports prices for all consumer items, increased 5.3 percent, a 1.8 percent average annual rate of increase. Over 80 percent of the 38 employers that reported postretirement benefit obligations from 2001 through 2003 had a change in their postretirement benefit obligations that exceeded the Consumer Price Index increase of 5.3 percent for all consumer items from 2001 through 2003.³⁷

Data from employer benefit surveys also showed increased costs for plan sponsors for roughly the same period. For example, a survey conducted in 2004 by the Kaiser Family Foundation and Hewitt Associates reported that the total cost of providing health benefits to all retirees for employers surveyed (1,000 or more employees) rose rapidly between 2003 and 2004, with an estimated average annual increase of nearly 13 percent.³⁸ Mercer data projections by employers for 2003 also showed an average annual cost increase of approximately 11 percent from 2002 for Medicare-eligible retirees from—\$2,702 to \$3,003—the fourth straight year of double digit increases. (For active employees, employers in the Mercer survey reported

³⁶The postretirement benefit obligations included retiree health benefits and other postretirement benefits, but not pensions. One employer in our sample of 50 Fortune 500 employers that sponsor health coverage for retirees is not included in this analysis because it did not report postretirement benefit obligations for 2001 and 2003.

³⁷The Consumer Price Index for medical care increased by 13.1 percent from 2001 through 2003, an average annual increase of 4.3 percent.

³⁸*Kaiser/Hewitt 2004 Survey on Retiree Health Benefits*. The data in this report reflect the responses of 333 private sector employers with 1,000 or more employees that offered health benefits to retirees at the time of the survey. Because the sample in this study is nonrandom, its results cannot be compared to data from prior Kaiser/Hewitt surveys.

a 10 percent increase in 2003 in the average total health benefit cost from 2002.³⁹⁾

The cost for public sector plan sponsors to provide retiree health coverage, both for Medicare-eligible retirees and those under age 65, is also increasing. For example, one public sector plan sponsor we interviewed reported that retiree health care costs had doubled in a 6-year period, from \$440 million in 1998 to over \$900 million in 2003, with an average annual cost in 2004 of \$3,542 per Medicare-eligible retiree, compared to \$1,822 per Medicare-eligible retiree in 1998. For FEHBP, as set in statute, the federal government pays 72 percent of the weighted average premium of all health benefit plans participating in FEHBP but no more than 75 percent of any health benefit plan's premium.⁴⁰ Thus, retirees and active workers pay approximately 28 percent of their plan premiums—a share that has not changed since it became effective in January 1999.⁴¹ While the percentage of plan premiums contributed by the government has remained constant in recent years, the actual rates have increased over time. In December 2002, we reported that health insurance premiums for FEHBP plans had increased on average about 6 percent per year from 1991 through 2002.⁴² According to OPM, average FEHBP premiums increased by 11 percent in 2003, about 11 percent in 2004, and about 8 percent for 2005.

Prescription drug benefits represent a large share of plan sponsors' retiree health costs, particularly for Medicare-eligible retirees. In 2002, prescription drug costs were cited as a key driver of increases in employment-based retiree health costs and were estimated to be typically 50 to 80 percent of an employer's total health care costs for Medicare-

³⁹Mercer noted that the 10 percent increase in the average total health benefit cost for active employees was less than the previous annual increase of 14.7 percent that occurred between 2001 and 2002 and likely reflected steps taken by employers to cut costs, such as changing plan design to increase employee out-of-pocket costs, reducing covered services, and dropping costly plans. Costs reported for active employees and retirees include both employer and employee/retiree shares.

⁴⁰5 U.S.C. § 8906(b)(1) and (2) (2000).

⁴¹The Balanced Budget Act of 1997 authorized the current formula for calculating the federal government's share of FEHBP premiums, effective January 1999. Pub. L. No. 105-33, § 7002, 111 Stat. 251, 662.

⁴²See GAO, *Federal Employees' Health Plans: Premium Growth and OPM's Role in Negotiating Benefits*, [GAO-03-236](#) (Washington, D.C.: Dec. 31, 2002).

Private Sector Plan Sponsors' Cost-Cutting Strategies

eligible retirees.⁴³ According to 2001 MCBS data, prescription drug expenditures for retired Medicare beneficiaries that were paid by employment-based insurance accounted for 45 percent of all health care expenditures for these beneficiaries. Three Fortune 500 employers we interviewed reported that prescription drug costs for Medicare-eligible retirees and their dependents ranged from approximately 56 to 64 percent of their total estimated annual cost of providing health benefits for this same population.

Faced with increasing costs, private sector plan sponsors have implemented certain strategies to reduce these obligations that often require retirees to pay more for coverage and contribute to a general erosion in the value and availability of health coverage for retirees. For example, many plan sponsors have increased cost sharing through increased copayments, coinsurance, and premium shares; restricted eligibility for benefits based on retirement or hiring date; implemented financial caps or other limits on plan sponsors' contributions to coverage; and made changes to prescription drug benefits, such as creating tiered benefit structures and increasing retiree out-of-pocket contributions. These cost-cutting strategies are not new—in 2001 we reported that employers had implemented similar mechanisms designed to control retiree health care expenditures.⁴⁴ However, according to private plan sponsors we interviewed, the share of costs paid by retirees is increasingly affected as the plan sponsors reach and enforce financial caps and other limits they had set. While these strategies are intended to limit the increase in plan sponsor obligations, the information provided by employer benefit surveys and the plan sponsors and consultants we interviewed did not specify the magnitude of any decrease in plan sponsors' costs for retiree health benefits that could be attributed to these changes.

Increasing Retirees' Cost Sharing. One strategy that plan sponsors have adopted to limit their obligations for retiree health costs is increasing the share of costs for which the retiree is responsible. For example, employers have increased retiree copayments and coinsurance. When asked about changes made “in the past year,” Kaiser/Hewitt reported that

⁴³ Anna Rappaport and Derek Guyton, Mercer Human Resource Consulting, *Retirees and Focused Prescription Drug Programs* (New York, N.Y.: Apr. 18, 2002), <http://www.mercerhr.com/knowledgecenter/reportssummary.jhtml?idContent=1011310> (downloaded Dec. 29, 2004).

⁴⁴ [GAO-01-374](#).

nearly half of its surveyed private employers (1,000 employees or more) had increased cost sharing.⁴⁵ The majority of employers in the Kaiser/Hewitt study reported that they expected to make similar increases “for the 2005 plan year,” with 51 percent indicating they were very or somewhat likely to increase retiree coinsurance or copayments. These increases are consistent with the changes cited in our interviews with private employers and with officials we interviewed at other organizations, including benefit consulting firms and an organization representing unions. For example,

- one employer we interviewed reported cost sharing increases for all retirees every year since 1993;
- another employer we interviewed introduced a mix of coinsurance and copayment requirements in January 2004 to address rising health care costs and make retirees more aware of the cost of the benefits they received; and
- a third employer we interviewed that had historically paid approximately 90 percent of total retiree health care costs was planning to increase the share of costs borne by retirees who had retired prior to 1994 from approximately 10 percent to 20 percent of health care costs by January 1, 2006.

Increasing Premiums. Increased contributions by retirees to health care premiums is another area where plan sponsors have continued to make changes to control their health care expenditures. Kaiser/Hewitt data showed that 79 percent of surveyed employers had increased retiree contributions to premiums in the past year, and 85 percent reported that they were very or somewhat likely to increase these contributions for the 2005 plan year. Retiree contributions for new retirees aged 65 and over increased, on average, 24 percent from 2003 to 2004, according to the Kaiser/Hewitt study. The Mercer 2003 study reported that employers varied retiree premium contributions, with Medicare-eligible retirees paying on average about 38 percent of plan premiums when the cost was shared between the employer and the retiree, an increase of approximately 4 percentage points since 1999.⁴⁶ Four of the 12 Fortune 500

⁴⁵The survey was conducted from May through September 2004. Unless specifically noted, the data reported by Kaiser/Hewitt regarding the changes made by employers “in the past year” and the changes that employers expect to make “for the 2005 plan year” were not specific to Medicare-eligible retirees or retirees under age 65.

⁴⁶Data reported for retiree-only coverage. The Mercer survey sample also included some government agencies.

plan sponsors we interviewed also reported changes to premiums. For example, one plan sponsor made a change in 2004 to increase premiums for all individuals retiring after January 1, 2004, consistent with increases in premiums for active workers, whereas previously retirees kept the same premiums for life. Officials we interviewed representing unions and their members also cited increased premiums for many retired union workers.

Some employers are also beginning to offer access-only coverage to some or all retirees, in which employers allow retirees to buy into a health plan at the group rate, but without any financial assistance from the employer. For example, according to 2003 Mercer data, about 37 percent of retiree health plans for employers with 500 or more employees required Medicare-eligible retirees to pay the full cost of the employment-based plan. Thirteen percent of the Kaiser/Hewitt employers reported making a change in the past year to provide access-only coverage to retirees, with retirees paying 100 percent of the costs. A supplement to the 2004 Kaiser/HRET survey examined the percentage of Medicare-eligible retirees with access-only coverage and found that 5 percent of Medicare-eligible individuals who are retired from employers with 200 or more employees that offer retiree health benefits had such coverage.⁴⁷ While 5 of the 12 Fortune 500 plan sponsors we interviewed had implemented access-only coverage, 1 of these plan sponsors had implemented this level of coverage for all of its retirees in the early 1990s in response to health care costs. The other 4 plan sponsors had implemented the access-only change at a later date, implementing it for some or all employees ranging from those hired after January 1, 1995, to those retiring on or after January 1, 2007.

Reducing Benefits for Future Retirees. Implementing access-only coverage is often part of a broader movement by plan sponsors to restrict eligibility or offer reduced benefits for employees who are hired or retire after a certain date. In December 2004, Kaiser/Hewitt reported that 8 percent of surveyed employers (with 1,000 or more employees) said they had made a change “in the past year” to eliminate their subsidized health benefits for future retirees, typically for those hired after a specific date. Of the 12 Fortune 500 plan sponsors we interviewed, 5 plan sponsors had eliminated retiree health coverage for some or all individuals hired after a certain date, ranging from January 1, 1993, to January 1, 2003, while 4 of

⁴⁷“Retiree Health Benefits, 2004: The Medicare Payment Advisory Commission’s Supplement to the Kaiser/HRET Survey of Employer-Sponsored Health Benefits” (public meeting sponsored by the Medicare Payment Advisory Commission, Ronald Reagan Building, Washington, D.C., Nov. 16, 2004).

the 5 plan sponsors that had switched to providing access-only coverage did so for some or all of their future retirees. Some plan sponsors said that they generally avoided making changes for current retirees rather than for future retirees, who may be in a position to make other arrangements. In addition, plan sponsors generally tried to minimize the disruption when making changes for those already in retirement. For example, one Fortune 500 plan sponsor we interviewed carried 15 separate health plans for several years that had accumulated as the result of grandfathering in current coverage levels for existing retirees. It was only in 2003 that the company consolidated the 15 plans into 3 plans and instituted changes affecting both existing and some future retirees. Plan sponsors that have either eliminated coverage or created access-only plans for some or all retirees generally reported that recruitment had not been affected. One plan sponsor we interviewed, however, noted that current employees' retirement planning could be affected, as some employees might stay longer with the company because they could not afford to retire. This sentiment is consistent with data reported in Mercer's 2003 annual survey of employer-sponsored health plans showing that retirees tended to delay retirement when their employers did not sponsor retiree medical plans.

Introducing and Enforcing Financial Caps. In 2001, we reported that some employers had established caps and other limits on expenditures for retiree health benefits, but it was not clear at that time how employers would ensure that spending did not exceed the caps and how coverage would be affected.⁴⁸ Employers began to implement caps in response to rising retiree health costs and to accounting changes introduced in the early 1990s when the Financial Accounting Standards Board (FASB) adopted Financial Accounting Standards (FAS) 106, requiring employers to report annually on the obligation represented by the promise to provide retiree health benefits to current and future retirees.⁴⁹ The 2003 annual survey of employer-sponsored health plans conducted by Mercer shows

⁴⁸GAO-01-374.

⁴⁹FAS 106, *Employers' Accounting for Postretirement Benefits Other Than Pensions*, required employers to report accrued retiree medical obligations beginning with plan years starting after December 15, 1992 (implementation for some employers began after December 15, 1994). By capping employer premium contributions above the then-current levels, employers could substantially reduce their obligations and still shield retirees from large premium increases. Some employers have said that FAS 106 requirements were a reason for reducing retiree health benefits. While FAS 106 did not affect an employer's cash flow, there was concern that listing this future obligation could affect companies' stock prices because the reporting of projected retiree health care costs affects the overall statement of financial profitability.

that 18 percent of employers with 500 or more employees have implemented caps, while an additional 10 percent of such employers were considering them. Caps were most common among the employers with the largest number of employees in the Mercer study (20,000 or more employees); 33 percent of such employers had implemented these limits on overall spending and 9 percent were considering them. Similarly, 54 percent of employers with 1,000 or more employees offering retiree coverage in the 2004 Kaiser/Hewitt employer survey reported having capped contributions. Ninety percent of employers in the Kaiser/Hewitt study that have hit caps or anticipated hitting caps in the next year reported that they intended to enforce them or already had.

Of the 12 Fortune 500 plan sponsors we interviewed, 8 had implemented capped contributions or other limits on retiree health spending. For example, 1 plan sponsor reported monthly caps of \$217 per person for nonunionized retirees under age 65 and \$51 per person for nonunionized Medicare-eligible retirees. Another plan sponsor provided fixed company health care credits for its retirees under age 65 (unionized and nonunionized) in which an individual could receive up to \$3,750 to apply to the plan sponsor's estimate for health care costs for a retiree under age 65. While many plan sponsors had implemented these types of limits, they varied as to whether all groups of retirees were affected and whether the caps had been reached and thus enforced. For example, 2 of the 12 Fortune 500 plan sponsors we interviewed had capped benefits for some individuals depending on the individual's date of retirement (typically more recent retirees were affected), and in some cases the caps varied by whether retirees were part of a union or former employees of an acquired company. The plan sponsors we interviewed whose retiree health benefit costs had reached the caps generally were enforcing them. For example, one plan sponsor required some retirees—both Medicare-eligible and those under age 65—to pay a portion of premiums for the first time after the plan's costs reached the cap in 2002. However, implementing and enforcing caps can be an issue in union negotiations. One plan sponsor we interviewed had opted in the past to negotiate benefit changes with unions to delay hitting the caps, but now expects to hit and enforce the caps by 2007. Another plan sponsor, while enforcing the financial caps for retiree health benefits, has agreed in some union negotiations to give retirees an additional contribution toward health care expenses that effectively offsets the premium increases triggered by reaching the caps. A few plan sponsors and benefit consultants we interviewed noted that employers are more likely today to enforce caps than to raise them. For example, the 2003 Kaiser/Hewitt study stated that there is some concern that auditors

will question the effectiveness of a cap if there is a pattern of continually raising it once costs approach the set limit.

Implementing Changes to Prescription Drug Benefit Design. Given the sensitivity of retiree health benefits to prescription drug costs, many plan sponsors have made changes to prescription drug benefits. The primary mechanisms cited by the 2004 Kaiser/Hewitt employer benefit survey and benefit consultants and the 12 Fortune 500 plan sponsors we interviewed included increasing copayments; switching from copayments to coinsurance; and implementing tiered benefit structures in which generic drugs, formulary/preferred drugs, and nonformulary/nonpreferred drugs are subject to different retiree copayment and coinsurance rates. Over half of the employers in the 2004 Kaiser/Hewitt study reported having increased copayments or coinsurance for prescription drugs in the past year, and 15 percent had replaced fixed-dollar copayments with coinsurance in the past year. Over half of the plan sponsors offered a three-tiered benefit structure, and among plans with this design, about two-thirds require copayments and nearly one-fourth required coinsurance for retail pharmacy purchases. In addition, about one-fourth of the Kaiser/Hewitt-surveyed employers had instituted a three-tiered drug plan in the past year to save money.

The 12 Fortune 500 plan sponsors we interviewed echoed these types of changes in their prescription drug benefit for retirees within the last 5 years. For example, 3 plan sponsors had instituted retiree coinsurance requirements, which can make retirees more price conscious because the retiree out-of-pocket cost is higher for more expensive drugs than for less expensive drugs. One plan sponsor reported it had increased drug copayments for retirees. Several of the 12 Fortune 500 plan sponsors we interviewed already had tiered benefits in place. One plan sponsor had implemented a three-tiered structure as well as mandatory use of a mail-order pharmacy for some prescription drugs. Another plan sponsor reported it planned to implement “step-therapy” in January 2005, in which retirees would have to demonstrate the ineffectiveness of a lower-cost generic drug before receiving coverage for a higher cost brand-name drug. Officials we interviewed representing unions and their members noted similar prescription drug trends for many former union workers.

Public Sector Plan Sponsors’ Cost-Cutting Strategies

While public sector plan sponsors generally offer more coverage than those in the private sector, these plan sponsors are also starting to implement cost-cutting mechanisms similar to those implemented in the private sector, with one major exception—they generally are not eliminating retiree health benefits for future retirees. For example, in

December 2002, we reported that FEHBP plans had implemented some benefit reductions for all enrollees—mostly by increasing enrollee cost sharing.⁵⁰ We reported that three large fee-for-service plans had increased or introduced cost sharing features such as copayments or coinsurance for prescription drugs and deductibles for other services.⁵¹ OPM officials informed us that FEHBP plans have implemented cost-containment strategies relating to prescription drugs, such as three-tiered cost sharing, comparable to private sector employers. However, OPM does not implement cost-containment strategies for retirees that do not also affect active workers.

Similarly, other public sector plan sponsors, such as state governments, are starting to reduce benefit levels and implement cost-cutting mechanisms, including changes to prescription drug benefits. However, eliminating retiree health benefits entirely for current or future retirees does not appear to be as prevalent in the public sector as the private sector. For example, a 2003 survey conducted by the Segal Company, a benefit consulting firm specializing in the public sector, reported that no state plan sponsor in its survey was considering eliminating retiree health coverage as a cost-containment strategy.⁵² A 2003 study prepared by Georgetown University for the Kaiser Family Foundation that collected survey data from 43 states and the District of Columbia also found that no state government had terminated subsidized health benefits for current or future retirees and no state government was planning to do so.⁵³ However, the Georgetown study found that 24 of these states reported increased cost sharing in the past 2 years, while 13 had increased retiree premium shares in the past 2 years. A study released by AARP in July 2004 on state government retiree health benefits found that 11 states required Medicare-

⁵⁰[GAO-03-236](#).

⁵¹In 1990, OPM required all FEHBP plans to provide prescription drug coverage.

⁵²The Segal Company, *2003 Segal State Health Benefits Survey: Medical Benefits for Employees and Retirees* (n.p.: The Segal Group, Inc., 2003), <http://www.segalco.com/government/pub-govt.cfm?ID=458> (downloaded Dec. 2, 2004). Segal surveyed all 50 states after collecting information available on state Web sites and requesting enrollment packages from each state. Thirty-nine states provided their enrollment packages and 34 states completed all or portions of the survey questionnaire. According to the report, the survey covers more than 80 percent of total state health plan enrollment, representing more than 3 million employees and retirees.

⁵³Jack Hoadley, Health Policy Institute, Georgetown University, *How States Are Responding to the Challenge of Financing Health Care for Retirees* (Menlo Park, Calif.: The Henry J. Kaiser Family Foundation, September 2003).

eligible retirees to pay the full amount of the premium.⁵⁴ Almost all of the states in the Georgetown study cited prescription drugs as the most important driver behind the growth in state retiree health spending and, as a result, have taken specific steps to manage these costs, such as increasing cost sharing and implementing tiered benefit structures. The majority of states in the AARP study had three-tiered copayment benefits. One public sector plan sponsor we interviewed is proposing significant changes to keep its retiree health benefits fund solvent that would vary the employer's contribution toward retiree health care costs on the basis of the retiree's age and years of service, rather than paying the full cost of coverage for those meeting the minimum age and service requirements.

Benefit consultants and officials from other organizations we interviewed noted new pressures on public sector funding of retiree health care benefits as a result of standards adopted in 2004 by the Governmental Accounting Standards Board (GASB) that affect the reporting of postretirement benefit obligations for many public sector sponsors of employment-based retiree health coverage.⁵⁵ Similar to FAS 106 for private sector employers, the new standards require public sector plan sponsors, including state governments, to accrue the costs of postretirement health care benefits during the years of service as opposed to reporting these costs on a pay-as-you-go basis. However, the GASB standards are not identical to those in the private sector, and the July 2004 AARP study noted that it is unclear whether the experience of FAS 106—and its frequently cited impact on the decrease in employment-based retiree health coverage—would directly translate to the public sector. While the study stated that the new GASB standards might encourage state governments to reduce retiree health benefit programs in order to reduce

⁵⁴Stan Wisniewski and Lorel Wisniewski, *State Government Retiree Health Benefits: Current Status and Potential Impact of New Accounting Standards* (Workplace Economics, Inc., commissioned by the AARP Public Policy Institute) (Washington D.C.: AARP, July 2004), http://research.aarp.org/health/2004_08_benefits.html (downloaded July 29, 2004).

⁵⁵Statement No. 43, *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans*, and Statement No. 45, *Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions*. The requirements apply to all public sector plans that cover postemployment benefits (other than pensions) and the sponsoring entities, such as public employee retirement systems, public colleges, and hospitals. The standards are effective in three phases based on a public sector entity's total annual revenues. For Statement No. 43, the largest employers begin in the first period after December 15, 2005, and the smallest employers begin 2 years later. For Statement No. 45, the largest employers begin in the first period after December 15, 2006, and the smallest employers begin 2 years later.

obligations, it also noted that these standards alone were not likely to cause major program changes. Regardless, benefit consultants and other officials we interviewed cited notable implications for public sector employers. For example, large unfunded obligations can affect bond ratings in the public sector, which affect these public sector entities' ability to borrow money. One benefit consultant told us that its public sector clients are raising issues such as plan design, cost, financing, and the possible reduction of retiree health benefits in light of the new GASB standards. The provision of retiree health benefits in the public sector may also be affected by other factors, such as state budget deficits and state political pressures.

Employers and Plan Sponsors Considering MMA Options for Prescription Drug Coverage, Often Considering Subsidy as Primary Option for Some or All Medicare-Eligible Retirees

At the time of our review, many employers and plan sponsors said they had not decided which MMA options they would implement for their Medicare-eligible retirees, but the primary option many sponsors were considering was the subsidy. Ten of the 15 plan sponsors we interviewed said that while undecided, they were considering the federal subsidy option for some or all of their Medicare-eligible retirees, while 2 other plan sponsors had chosen the subsidy option for all their Medicare-eligible retirees. Four plan sponsors we interviewed were concerned that because their benefits already had reached or soon would reach the caps they had set on their retiree health benefit obligations, they would be ineligible for the subsidy and therefore said that redesigning their benefits to wrap around Medicare would be prudent. In our random sample of 50 Fortune 500 employers, most that reported obligations for retiree health benefits indicated that they would choose the federal subsidy or other options, but others had not reported their final MMA decisions on their financial statements filed with the SEC as of November 2004. In addition, 2 plan sponsors we interviewed were considering Medicare Advantage plans, but these plan sponsors were waiting to see how the market for these developed. While plan sponsors generally expected to continue to maintain coverage levels for their retirees as they considered their MMA options, they acknowledged that cost pressures could cause them to reevaluate their benefits. If employers were not already providing prescription drug benefits to retirees, most benefit consultants and other experts we interviewed said that the MMA was not likely to prompt employers to begin providing coverage or supplementing the Medicare benefits.

Plan Sponsors We Interviewed Were Considering MMA Options for Prescription Drug Coverage, but Few Had Made Final Decisions

The 15 private and public sector sponsors of retiree health benefit plans we interviewed were considering their MMA options for prescription drug coverage, but few had decided which MMA options they would choose for all their Medicare-eligible retirees. Of the 15 plan sponsors we interviewed, 12 were Fortune 500 private sector employers. Two of the 12 had made a decision for all of their Medicare-eligible retirees, and 10 said they had not yet made their final decisions for some or all of their retirees and were assessing the implications associated with the MMA options. Officials from the three public sector sponsors of health benefit plans we interviewed—the federal government and two state retirement systems—said they were considering their options. Both private and public sector plan sponsors told us they anticipated making their final decisions by early 2005. In addition, officials we interviewed representing multiemployer plans told us that most multiemployer plans had not focused on the MMA options to the same extent as single-employer private sector plan sponsors, and therefore most were undecided about the options they would implement. As part of their deliberations, plan sponsors were considering several MMA options, including the federal subsidy option if they decided to provide their own prescription drug benefits for Medicare-eligible retirees; coordinating with part D by wrapping their prescription drug benefits around the Medicare part D benefit, thus providing secondary coverage; and several other options. In some cases, plan sponsors were considering implementing a combination of options for different groups of Medicare-eligible retirees.

The Federal Subsidy

Ten of the 15 private and public sector sponsors of employment-based retiree health benefits that we interviewed were considering the 28 percent federal subsidy for prescription drug costs for some, if not all, Medicare-eligible retirees, although they were in different stages of the decision-making process at the time of our interviews. Two private sector sponsors had chosen the subsidy option for all of their Medicare-eligible retirees. Three of the private and public sector sponsors, including OPM for FEHBP, said they would not or did not expect to choose the subsidy option.⁵⁶ (See table 1.)

⁵⁶Several recent surveys have also found that the subsidy is the primary option employers are considering. Kaiser/Hewitt reported that 58 percent of employers said they expected to choose the subsidy option for prescription drug benefits in their largest plans; Kaiser/HRET reported that about half of employers surveyed in early 2004 were likely to choose the subsidy option; and Mercer reported that about 40 percent of plan sponsors would apply for the subsidy. Each of the surveys also found that some employers remained undecided about which MMA option they would select for prescription drug coverage.

Table 1: Status of Decisions by 15 Private and Public Sector Plan Sponsors Interviewed regarding the MMA Subsidy Option for Prescription Drug Coverage

MMA subsidy option	Number choosing or considering MMA subsidy option	
	Private sector Fortune 500 sponsors	Public sector sponsors
Subsidy		
Choosing the subsidy option for all Medicare-eligible retirees	2	0
Choosing the subsidy option for some Medicare-eligible retirees and considering other options for other Medicare-eligible retirees	3	0
Considering the subsidy option	5	2
No subsidy		
Not choosing the subsidy option for any Medicare-eligible retirees	2	1 ^a
Total	12	3

Source: GAO.

Note: Based on information from 15 sponsors of retiree health benefit plans in the private and public sectors.

^aOPM said it did not expect to choose the subsidy option for FEHBP.

Retiree health benefit plan designs and other circumstances affected plan sponsors' decisions regarding the subsidy. In particular, whether a plan sponsor had implemented financial caps on retiree health benefit expenditures played a major role in the decision-making process.⁵⁷ In addition, plan sponsors that negotiated retiree health benefits with unions said that they did not have as much flexibility to change these benefits prior to negotiations. Three of the private sector plan sponsors we interviewed said they would choose the subsidy option only for some of their Medicare-eligible retirees because of capped benefits, the role of unions, or both, as described in the following:

- One of the three plan sponsors capped health benefits for workers who retired after a specific date, so it offered richer uncapped benefits to those who retired before that date. This sponsor determined that the uncapped

⁵⁷Caps on benefits could cause an employer's prescription drug plan to have less value on an actuarial basis than the standard part D benefit and not qualify for the subsidy option.

benefits would be actuarially equivalent. Therefore, this plan sponsor said it would choose the subsidy option for the uncapped benefits but was not certain that the capped benefits would be actuarially equivalent for purposes of the subsidy.

- Another of these sponsors offered many different prescription drug plan designs to retirees with collectively bargained benefits (union retirees) and those without collectively bargained benefits.⁵⁸ This sponsor chose the subsidy option for all plans that met the actuarial equivalence test. The sponsor's plans that were not likely to meet the actuarial equivalence test typically had financial caps.
- The third sponsor said it was fairly certain it would choose the subsidy option for its collectively bargained retiree prescription drug benefits. While both the collectively bargained and noncollectively bargained retiree benefits were capped, the unions had renegotiated higher capped amounts for the collectively bargained benefits. The next negotiation session with the primary union was scheduled for July 2006, thereby making it difficult to make changes to these benefits other than accepting the subsidy in the interim. The caps for the retirees with noncollectively bargained benefits would be reached sooner and were less likely to be actuarially equivalent. Therefore, this sponsor said it was considering other options for the retirees with noncollectively bargained benefits.

Although they had not made any final decisions on the MMA options at the time of our interviews, 5 of the 12 private sector Fortune 500 sponsors of employment-based health benefit plans we interviewed were considering the subsidy option. Two of these 5 plan sponsors said they were likely to apply for the subsidy for their Medicare retirees. Of the 2, 1—whose employees were partially unionized and that had not capped any of its retiree health benefits—said it did not “strongly consider” any other options during its deliberations. The other of the 2 sponsors expected to apply for the subsidy for all of the prescription drug plans for Medicare-eligible retirees that met the actuarial equivalence test. At the time of our interviews, 3 of these 5 plan sponsors said they either needed additional information from CMS regarding actuarial equivalence or needed more time before they could make their final decisions about the subsidy option.

⁵⁸This plan sponsor obtained different plans through acquisitions. Also, the plan sponsor negotiated about 80 to 90 contracts with about 20 different unions. However, not all the plans provide retiree health benefits. In most cases, the plan sponsor could not change the retiree health benefits without renegotiating with the unions. Taking collectively bargained and noncollectively bargained retiree health benefits together, the plan sponsor had about 100 different prescription drug plans. Some of the retiree prescription drug plans had capped benefits amounts.

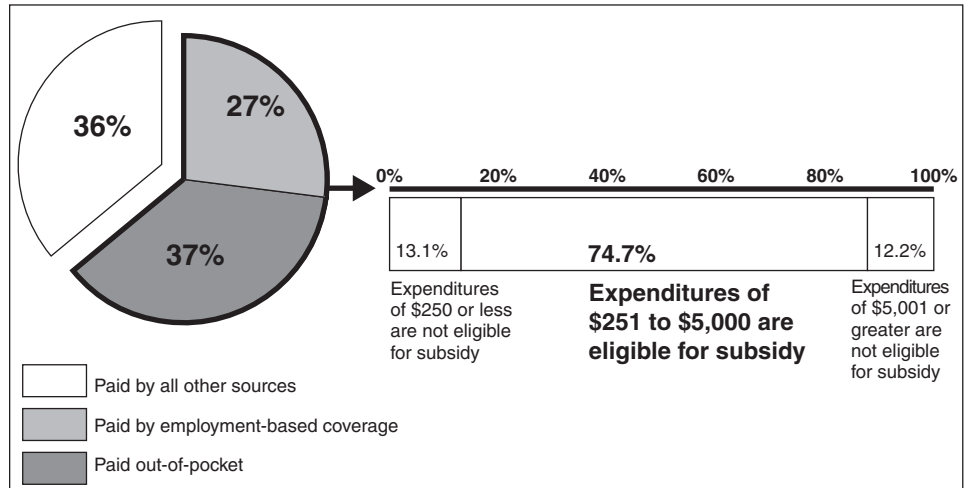
Two large state sponsors of health benefits for Medicare-eligible retirees were considering the subsidy option along with others. OPM had not made any decisions at the time of our interview, but in written comments on a draft of this report it indicated that it did not expect to choose the federal subsidy for FEHBP.

The subsidy option offers plan sponsors several advantages. Cost savings associated with the subsidy played a major role in the plan sponsors' decision-making process. Several benefit consultants and plan sponsors we interviewed stressed the importance of cost savings when considering the MMA options. Most of the plan sponsors we interviewed considered the savings associated with the subsidy to be an advantage. For example, one plan sponsor estimated that it would reduce its accumulated postretirement benefit obligations by about \$161 million just by choosing the subsidy option for one group of its Medicare-eligible retirees.

Some plan sponsors and benefit consultants we interviewed said that most of the prescription drug expenditures for Medicare-eligible retirees would be eligible for the subsidy because most retirees incurred costs from \$251 through \$5,000, the range eligible for the subsidy as defined in the MMA. While Medicare-eligible retirees' prescription drug expenditures could be paid by several different sources, employment-based coverage accounted for about 27 percent of total expenditures in 2001, while out-of-pocket payments accounted for about 37 percent, according to our analysis of MCBS. According to our projections of the estimated amount of Medicare-eligible retirees' total prescription drug expenditures that employment-based plans would pay for and that beneficiaries would pay out-of-pocket in 2006, most of the expenditures from employment-based coverage and from out-of-pocket—about 75 percent—could be eligible for the subsidy (see fig. 5).⁵⁹

⁵⁹Also, when only considering Medicare-eligible retirees' prescription drug costs covered by employment-based plans, our analysis showed that about 76 percent of these expenditures are projected to be \$251 through \$5,000, the range eligible for the subsidy in 2006.

Figure 5: Under the MMA Subsidy Option, the Portion of Retired Medicare Beneficiaries' Prescription Drug Expenditures Paid by Employment-Based Coverage and Paid Out-of-Pocket Eligible for Subsidy, Estimate for 2006



Source: GAO analysis of MCBS data.

Note: MCBS data for 2001 inflated to 2006 using CMS's National Health Care Expenditures Projections.

Preserving the benefits the plan sponsors currently provide and retaining the control over and flexibility of the benefits were also cited as advantages to choosing the subsidy option. Benefit consultants, plan sponsors, and others we interviewed said that it would be easier for beneficiaries if the benefits offered did not change. Choosing the subsidy option also gave plan sponsors the ability to maintain control over the benefits and their costs. In addition, preserving their current benefits allowed plan sponsors time to see how other MMA options would play out in the marketplace. For some plan sponsors, these advantages made the subsidy the easiest, most seamless, and least risky option to pursue.

Several benefit consultants we interviewed said that to receive the subsidy, sponsors of employment-based retiree health plans would have to fulfill certain administrative reporting and record keeping requirements, as identified by CMS. For example, sponsors will have to apply for the subsidy no later than 90 days prior to the start of the calendar year,⁶⁰ including providing an attestation regarding actuarial equivalence. Each

⁶⁰70 *Fed. Reg.* 4,410. A plan sponsor would have to apply by September 30, 2005, to receive the subsidy for 2006.

application must include the names of all people enrolled in the sponsor's drug plan to ensure that a sponsor is not receiving a subsidy for an individual who is enrolled in a part D prescription drug plan or a Medicare Advantage plan. The plan sponsor must also notify Medicare-eligible retirees and their spouses and dependents whether their retiree health plan provides "creditable coverage"—that is, generally whether the expected amount of paid claims under the plan sponsor's prescription drug coverage is at least equal to that of the expected amount of paid claims under the standard part D coverage. This notice is important because retirees who do not enroll in part D when first eligible will be charged a penalty for late enrollment if they enroll after finding that their previous employment-based coverage did not meet CMS's creditable coverage criteria.⁶¹ A special enrollment period will be provided, however, without a late enrollment penalty, when there is an involuntary loss of creditable coverage because, for example, an employer eliminates or reduces coverage.⁶² All plan sponsors choosing the subsidy will have to document prescription drug costs that fall within the MMA's eligibility criteria.

Although several benefit consultants saw the potential administrative requirements as a disadvantage of the subsidy, most of the plan sponsors we interviewed were not concerned about the subsidy's proposed administrative requirements. For example, one plan sponsor told us it was less concerned about how it would manage the subsidy's administrative requirements than about how it would manage relations with retirees if it changed prescription drug benefits under other MMA options. At the time of our interviews, however, some plan sponsors said they were not fully aware of or had not considered all of the administrative requirements.

Besides cost savings, ease for retirees, and administrative requirements, plan sponsors we interviewed said they also considered other factors when making decisions about the subsidy. For example, plan sponsors considered as part of their decision-making process possible negative press, potential for lawsuits, relations and communications with Medicare-eligible retirees, benefit equity between Medicare-eligible retirees and retirees not yet eligible for Medicare, future union negotiations, hiring and

⁶¹MMA sec. 101, §1860D-13(b), 117 Stat. 2104-06 (to be codified at 42 U.S.C. § 1395w-113(b)).

⁶²MMA sec. 101, § 1860D-1(b)(3) and (6), 117 Stat. 2073-74 and 2374-75 (to be codified at 42 U.S.C. §§ 1395w-101(b)(3) and (6)).

retention of workers, marketplace competition, and uncertainty about CMS rules.

Wrapping Retiree Drug Benefits around Medicare Part D

One alternative to choosing the federal subsidy option for plan sponsors that provide prescription drug coverage to Medicare-eligible retirees is the option of coordinating with part D by wrapping their benefits around the new Medicare part D benefit by covering some drug costs not paid by Medicare. Plan sponsors would offer coverage wrapping around Medicare part D rather than providing their own comprehensive prescription drug coverage. Prescription drug costs not covered by Medicare part D that plan sponsors could cover might include the \$250 deductible or the retirees' costs within the coverage gap (i.e., the doughnut hole) until the Medicare catastrophic coverage begins paying for most drug costs. Several plan sponsors we interviewed said they were considering this option for Medicare-eligible retirees along with the subsidy and other options as part of their overall MMA deliberations. For example, one plan sponsor said it was considering wrapping its drug benefits around the part D benefit as its primary option for all its Medicare-eligible retirees because it had set financial caps on its retiree health benefit obligations that would eventually render it ineligible for the subsidy. Three other plan sponsors told us they were considering wrapping their prescription drug benefits around the part D benefit for those Medicare-eligible retirees for whom they could not qualify to receive the federal subsidy. Furthermore, OPM officials said that wrapping prescription drug benefits around the part D benefit could be more complex for the federal government than for employers in the private sector because, in contrast to many large private sector employers, FEHBP does not provide different benefits for active workers and for retirees.

Some plan sponsors and benefit consultants we interviewed expected that wrapping prescription drug benefits offered to Medicare-eligible retirees around the new Medicare part D benefit would provide several advantages. For example, some benefit consultants said that this option could save more money than the subsidy. However, they said plan sponsors would have to do a cost/benefit analysis to make this determination. Also, plan sponsors could continue to provide the same level of benefits to Medicare-eligible retirees in coordination with the Medicare part D coverage, thereby maintaining benefit continuity. Conceptually, sponsors of employment-based health benefit plans and benefit consultants generally viewed the option to wrap prescription drug benefits around the part D benefit as being similar to how most now coordinate other benefits with Medicare parts A and B. Some sponsors we interviewed planned to rely on their pharmacy benefit managers, benefit

consultants, and others for assistance in administering the benefit. However, plan sponsors and benefit consultants we interviewed were waiting to learn more from CMS about how the benefit coordination would operate. As a result, at the time of our interviews, employers and others had questions about how prescription drug benefit designs would wrap around the Medicare part D benefit.

Wrapping benefits around the Medicare part D benefit also could present some administrative and other challenges for plan sponsors. Two benefit consultants we interviewed told us that wrapping benefits around the different Medicare part D plans, such as Medicare Advantage or a private prescription drug plan, in which retirees might enroll could add to the administrative complexity. Also, according to one benefit consultant and CMS officials, while coordinating with the Medicare program can be a fairly straightforward task for part A and B services, part D coordination might be more difficult because each Medicare-eligible retiree's true out-of-pocket costs must be determined. Part D requires that Medicare beneficiaries must have \$3,600 in out-of-pocket expenses for covered drugs in 2006 before federal catastrophic coverage begins.⁶³ Generally, beneficiaries' expenses reimbursed by other sources such as employment-based plans are not counted. This can become complicated for plan sponsors that have different copayment and coinsurance requirements for different groups of retirees.

Another possible challenge for plan sponsors in wrapping around Medicare part D coverage is financial. Plans sponsors that supplement the Medicare part D benefit could spend thousands of dollars for each retiree before the Medicare catastrophic coverage begins. Two plan sponsors and several benefit consultants were concerned about how employment-based drug benefits that wrap around the Medicare part D benefit would affect the out-of-pocket payment requirements for beneficiaries. For example, if a plan sponsor covered 75 percent of a Medicare-eligible retiree's expenditures within the coverage gap (i.e., the doughnut hole) the plan sponsor would have to spend \$8,550 before the retiree reached \$3,600 in out-of-pocket expenditures as required by the MMA. Specifically, under this wraparound scenario,

⁶³MMA sec. 101, § 1860D-2(b)(4)(B), 117 Stat. 2077-78 (to be codified at 42 U.S.C. § 1394w-102(b)(4)(B)).

-
- the Medicare-eligible retiree would spend \$3,600 out-of-pocket—\$250 for the part D deductible, \$500 in coinsurance for the next \$2,000 in expenditures, and \$2,850 for the expenses not covered by Medicare;
 - Medicare would spend \$1,500—75 percent of the next \$2,000 in expenditures after the deductible is met; and
 - the plan sponsor would spend \$8,550.

This would require a total of \$13,650 in expenditures from all sources before the retiree would reach the amount—that is, combined Medicare and beneficiary expenditures equal to \$5,100—at which Medicare part D catastrophic coverage would begin.

Other Options

Under the MMA, sponsors of employment-based health benefit plans for Medicare-eligible retirees have several other options. For example, plan sponsors could contract with privately marketed prescription drug plans and Medicare Advantage plans to cover the part D benefit, or they could become prescription drug plans or Medicare Advantage plans.⁶⁴ In addition, while not allowed for current Medicare-eligible retirees, plan sponsors could establish HSAs for their active workers, who could use these benefits when they retire.

Several benefit consultants told us their clients might consider these other MMA options, and some plan sponsors we interviewed were doing so. For example, four benefit consultants we interviewed said that Medicare Advantage plans could offer advantages to plan sponsors. Two of these benefit consultants said that having Medicare-eligible retirees enroll in Medicare Advantage plans would shift the financial risk away from the plan sponsor to the Medicare Advantage plan. The other two said that Medicare Advantage plans could help to reduce costs, and they also believed that having Medicare-eligible retirees enroll in these plans could help reduce administrative burdens associated with the Medicare part D benefit. Two benefit consultants noted that these plans might not be available in all parts of the country, but others said that increased federal reimbursement rates established as part of the MMA might cause more private plans to enter this market in the future. In addition, two benefit consultants commented that their clients might be more interested in Medicare Advantage once the market for these plans is established. During our interviews, some Fortune 500 plan sponsors generally discussed Medicare Advantage plans as an option they might consider. While several

⁶⁴MMA sec. 101, § 1860D-22(b), 117 Stat. 2125 (to be codified at 42. U.S.C. § 1395w-132(b)).

plan sponsors said that none of their Medicare retirees were enrolled in a health maintenance organization (HMO), two said that HMOs might be a viable option in the future as long as managed care plans continued to participate in the Medicare program. One plan sponsor considered Medicare Advantage plans as an option during its deliberations but determined that based on its past experience with Medicare+Choice, it did not provide many savings.

One benefit consultant we interviewed said that plan sponsors might be reluctant to form their own Medicare Advantage plans because many HMOs left the Medicare+Choice program in the past. However, new options that had not yet been offered under the Medicare Advantage program might also be attractive to employers with retirees living all across the country. CMS officials said that they are currently developing the waivers that plan sponsors would need to form their own Medicare Advantage plans.

The MMA also established HSAs, which receive preferential tax treatment, that are used in conjunction with high deductible health insurance plans.⁶⁵ The HSA can be used to pay for qualified medical expenses not covered by insurance or other reimbursements. Although HSAs cannot be set up to fund health benefits for current Medicare-eligible retirees, they can be a savings vehicle for workers to pay the cost of their health care coverage when they retire. However, some benefit experts said it is unlikely that enough money would accumulate in these accounts for retirees, especially for older workers, to benefit substantially from them.⁶⁶ Six of the 15 plan sponsors we interviewed said they were exploring how HSAs would integrate into their overall benefit programs or were considering them for the future.

⁶⁵MMA § 1201, § 223, 117 Stat. 2469-79 (to be codified at 26 U.S.C. § 223). While employers, employees, or both can set up and contribute to these accounts, employees own the accounts. In general, individuals making contributions can deduct the lesser of the deductible or up to \$2,650 for self-only coverage or \$5,250 for family coverage from federal taxes in 2005. Any funds remaining in an HSA at the end of the year can be carried over to the next year.

⁶⁶According to the Employee Benefit Research Institute, HSAs will be of limited benefit to people who are already 55 years of age or older because they would not produce enough savings to substantially offset retiree health expenses. See Paul Fronstin and Dallas Salisbury, *Health Care Expenses in Retirement and the Use of Health Savings Accounts*, Issue Brief No. 271 (Washington, D.C.: Employee Benefit Research Institute, July 2004).

Most Plan Sponsors in Our Sample Reported MMA-Related Changes on Recent Financial Statements, While a Third Were Considering MMA Options

According to financial statements filed with the SEC as of November 2004, most of the Fortune 500 employers we reviewed that reported postretirement benefit obligations⁶⁷ (27 of 39) reflected the effect of the MMA options on these obligations.⁶⁸ For example, 3 of these plan sponsors each reported reductions in accumulated obligations of over \$100 million. The other 12 employers did not report on their MMA decisions in these financial statements. (See table 2.)

Table 2: Actions Taken in Response to the MMA by 50 Randomly Selected Fortune 500 Employers, Most as of the Quarter Ending September 30, 2004

Action	Number of employers
Employers reporting postretirement benefits	
Addressed impact of the MMA on postretirement benefit obligations	27
Did not address impact of the MMA on postretirement benefit obligations	12 ^a
Subtotal	39
Employers not reporting postretirement benefits or not filing statements	
Did not report postretirement benefits on annual or quarterly financial statements	8
Did not file annual or quarterly financial statements with the SEC	3 ^b
Subtotal	11
Total	50

Source: GAO.

Notes: Based on analysis of annual (10-K) and quarterly (10-Q) financial statements Fortune 500 employers filed with the SEC. The 50 employers represent a randomly selected group of employers from the Fortune 500 list for 2003. Most of these employers' fiscal years ended in December 2003, so their most recent quarterly financial statement covered the period ending September 30, 2004.

^aOne of the 39 employers that sponsored retiree health benefit plans addressed the MMA but did not provide complete information on postretirement benefit obligation amounts.

^bThree of the 50 randomly selected employers were private, not publicly traded, employers and were not required to file annual 10-K or quarterly 10-Q financial statements with the SEC.

⁶⁷Publicly traded companies account for their postretirement benefit obligations in their financial statements. The postretirement benefit obligations we refer to here include obligations for retiree health benefits and other retiree benefits, such as life insurance, but not for pensions (which are separately reported). This information is included in the annual (10-K) and quarterly (10-Q) financial statements they file with the SEC.

⁶⁸At the time of our analysis, most of these employers' fiscal years ended in December 2003, so their most recent quarterly financial statement covered the period ending in September 2004, which most filed in November 2004. A few employers had already reflected changes in obligations as a result of the MMA in prior annual or quarterly filings with the SEC.

Thirteen of the 27 plan sponsors that reflected the effect of the MMA options reported they would be choosing the subsidy option, which reduces their postretirement benefit obligations and other expenditures. However, even among these 13 plan sponsors, 3 reported that they would be choosing the subsidy option for some but not all of their retirees. They had not reported what options they would pursue for the remaining retirees. While the remaining 14 plan sponsors addressed the MMA options in their financial statements, their MMA decisions for Medicare-eligible retirees were not as clear. These plan sponsors generally reported that the MMA options either reduced their postretirement benefit obligations or that the changes they made because of the MMA were not expected to have a material impact on their postretirement benefit obligations.⁶⁹

Twelve of the 39 employers that reported sponsoring retiree health benefit plans and having postretirement benefit obligations did not report on their MMA decisions in financial statements filed as of November 2004. One of these 12 plan sponsors reported that it had determined that its prescription drug benefits were not actuarially equivalent to the Medicare part D benefit and could not take advantage of the subsidy option. This plan sponsor reported that it was evaluating the impact of other MMA options. The remaining 11 plan sponsors did not report on the impact of the MMA on their postretirement obligations; 4 of these 11 plan sponsors did not expect any changes they made to be material.

⁶⁹In May 2004, FASB issued guidance regarding how employers that sponsor postretirement health benefit plans were to account for the effects of the MMA—FASB Staff Position FAS 106-2, *Accounting and Disclosure Requirements Related to the Medicare Prescription Drug, Improvement and Modernization Act of 2003*. Under this guidance, employers were required to report the effect of the MMA on their retiree health benefit obligations for the first interim or annual period that began after June 15, 2004. However, if employers could not determine the effect of the MMA, they could reconsider the impact periodically.

Sponsors of Retiree Health Benefit Plans We Interviewed Unlikely to Reduce Current Drug Benefits for Medicare Retirees in Response to the MMA

In interviews, sponsors of health plans that included prescription drug benefits for Medicare-eligible retirees told us they did not expect to reduce these benefits in response to the new Medicare part D benefit and the MMA options. Although one benefit consultant said that some of his clients might consider reducing benefits in response to the MMA, plan sponsors we interviewed that were considering choosing the subsidy option said they did not expect to reduce their benefits in response to the MMA, even though some could do so and still qualify for the subsidy.⁷⁰ Plan sponsors considering wrapping their benefits around the Medicare part D benefit were focused on wrapping benefits in a way that would maintain, not restrict, the current level of benefits. According to a benefit consultant, many employers who sponsored retiree health benefit plans supplemented Medicare parts A and B with additional benefits and might also do so for Medicare part D. However, plan sponsors change benefits for different reasons. Even though they said they were not considering a reduction in prescription drug benefits in response to the MMA, some plan sponsors and benefit consultants said that ongoing cost pressures prompt plan sponsors to constantly review and, if necessary, adjust their benefits for future retirees.

Two of the 12 private sector employers that sponsored retiree health benefits told us that during their deliberations on the MMA options they had considered, but dismissed, elimination of some or all retiree prescription drug benefits as one of several options. One of these plan sponsors said eliminating prescription drug coverage would not be realistic, especially with collectively bargained benefits. The other plan sponsor said it was easier to continue to provide the benefits to this declining population—it no longer offered retiree health benefits to new hires—than to contend with the negative press and relations with current retirees and active workers.

None of the three public sector sponsors of health benefits for Medicare-eligible retirees we interviewed expected to reduce or eliminate prescription drug benefits in response to the MMA options. OPM officials said that they did not plan to decrease or eliminate any prescription drug coverage for Medicare-eligible retirees in response to the MMA. These officials, who administer health benefits for federal employees and

⁷⁰In the *Kaiser/Hewitt 2004 Survey on Retiree Health Benefits*, 85 percent of the employers who planned to choose the subsidy said they would likely retain current benefit levels, 7 percent would modify benefits to match the standard part D benefit, and 8 percent did not know about possible changes in their benefits.

retirees, noted that eliminating prescription drug benefits would not be a politically realistic option. An official at a public sector plan that provides health benefits to Medicare-eligible retirees in one state said that the state also was not planning to reduce its benefits in response to the MMA. However, the state had already planned to make extensive changes to its benefits in response to rising health care costs about a year before Congress passed the MMA, and eliminating or further reducing benefits for public sector retirees was not an option currently being considered.

The MMA Is Not Likely to Induce Employers Not Already Offering Retiree Health Coverage to Begin Doing So

Few employers, if any, that were not sponsoring retiree prescription drug benefits were expected to begin sponsoring them in response to the MMA. Benefit consultants and experts we interviewed consistently agreed that it was doubtful that an employer would want to assume new benefit obligations for retiree health or prescription drugs if it did not already do so, regardless of the MMA options. Furthermore, the availability of Medicare's prescription drug benefits in 2006 might give employers more of an incentive not to start to provide these benefits because prescription drug benefits would be available without the employer's participation. Ultimately, benefit consultants and experts told us this decision would vary by employer. An employer's particular financial, business, and competitive situation could affect the employer's decision to provide any new benefits or to provide supplemental coverage—pay the part D premium, cover out-of-pocket expenses, or consider a Medicare Advantage plan as an option—to Medicare-eligible retirees in response to the MMA.

According to officials at organizations representing small and midsized employers and other experts, the MMA is not likely to encourage such employers to add to their operating costs by beginning to offer retiree health benefits or supplementing the prescription drug benefits available through Medicare part D. These employers are more concerned about providing health benefits to active workers rather than to retirees. However, as with large employers, employers' specific circumstances drive their business and benefit decisions. Therefore, according to these officials, while there may be isolated individual employers that might begin to provide retiree health benefits or prescription drug coverage supplementing the benefits established by the MMA, they would likely be the exception rather than the rule.

Concluding Observations

The provision of employment-based retiree health benefits for Medicare beneficiaries continues to be an issue for evaluation and change with employers and other plan sponsors even as they begin to choose options available as a result of the Medicare drug benefit enacted as part of the MMA. The long-term decline in the percentage of employers offering retiree health benefits to Medicare-eligible individuals has leveled off in recent years. Plan sponsors have continued to modify their requirements for eligibility, benefits, and cost sharing in an effort to contain cost growth. As employers and other plan sponsors choose options as provided under the MMA, they likely will continue to face rising health care costs, particularly for prescription drugs, that will increase their obligations for retiree health benefits. The Medicare drug benefit is expected to provide some insulation from these cost increases for plans that qualify and employers that receive a subsidy for a portion of their drug expenditures or that choose to allow Medicare to bear primary responsibility for these costs for Medicare-eligible retirees. Nonetheless, even after employers select a particular option in response to the Medicare drug benefit, it is likely that they will continue to reshape their retiree health benefits in response to cost pressures, as they have for the last decade. However, few employers not already offering retiree health or prescription drug coverage are likely to begin doing so as a result of the options available under the MMA.

Agency and Other External Comments

We provided a draft of this report to CMS, OPM, and experts on retiree health benefits at the Employee Benefits Research Institute, Health Research and Educational Trust, Hewitt Associates, and Mercer Human Resource Consulting.

In its written comments, CMS generally agreed with our findings. CMS stated that the new Medicare drug benefit and the subsidy can help plan sponsors continue to provide drug coverage to Medicare-eligible retirees. Consistent with our finding that plan sponsors intend to continue offering prescription drug benefits, CMS cited a survey released in January 2005 that indicated that most plan sponsors intended to continue offering prescription drug coverage after the Medicare part D benefit begins. CMS confirmed that many plan sponsors are still considering their options under the MMA. CMS also indicated that some employers may reevaluate their retiree benefits and that some plan sponsors may begin to offer prescription drug benefits. In its comments, CMS noted that it had recently released its final rule implementing the Medicare part D benefit and plan sponsor options. CMS also noted that it plans to provide additional guidance to respond to issues raised by comments on the proposed rule,

including guidance on actuarial equivalence. CMS acknowledged that plan sponsors need to have timely guidance because of the complexity of the process, and CMS intends to continue to conduct outreach and education efforts on the options for retirees' prescription drug coverage available to plan sponsors. (CMS's comments are reprinted in app. II.)

In its written comments, OPM highlighted its role in limiting premium increases while continuing to provide the same level of health insurance coverage at the same premium rates for retirees that it provides to active federal employees. While at the time of our interviews OPM officials indicated that OPM was considering the federal subsidy for FEHBP, in its written comments the agency said that it does not expect to choose the federal subsidy option. We revised the report to reflect that OPM does not expect to choose the subsidy option. (OPM's comments are reprinted in app. III.)

The experts who reviewed the draft report generally indicated that the report provided a comprehensive and accurate portrayal of employment-based retiree health benefits and prescription drug benefits under the MMA. Two of the experts noted that while they concurred that the percentage of employers offering retiree health benefits has leveled off in recent years, this finding may understate the impact of other changes that reduce the extent of retiree health benefits. They highlighted other changes, as we cited in the draft report, such as reduced eligibility for future retirees, increased cost sharing and premium contributions, and financial caps. We agree that as noted in the report, these changes contribute to an overall erosion in the value and availability of retiree health benefits.

CMS and several of these experts also provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the Administrator of CMS, the Director of OPM, and interested congressional committees. We will also provide copies to others on request. In addition, this report is available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staffs have any questions about this report, please contact me at (202) 512-7118. Another contact and staff acknowledgments are listed in appendix IV.

Kathryn G. Allen

Kathryn G. Allen
Director, Health Care—Medicaid
and Private Health Insurance Issues

List of Committees

The Honorable Charles E. Grassley
Chairman
The Honorable Max Baucus
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable Michael B. Enzi
Chairman
The Honorable Edward M. Kennedy
Ranking Minority Member
Committee on Health, Education, Labor,
and Pensions
United States Senate

The Honorable John A. Boehner
Chairman
The Honorable George Miller
Ranking Minority Member
Committee on Education and
the Workforce
House of Representatives

The Honorable Joe Barton
Chairman
The Honorable John D. Dingell
Ranking Minority Member
Committee on Energy and Commerce
House of Representatives

The Honorable William M. Thomas
Chairman
The Honorable Charles B. Rangel
Ranking Minority Member
Committee on Ways and Means
House of Representatives

Appendix I: Scope and Methodology

To identify trends in employment-based retiree health benefits, we analyzed data from (1) two annual private sector surveys of employer health benefits conducted since the early 1990s through 2004, (2) one private sector survey on retiree health benefits conducted in 2004, and (3) three surveys conducted by the federal government that included information on Medicare beneficiaries and employment-based health benefits. We also reviewed financial data for fiscal years 2001 through 2003 that a sample of Fortune 500 employers submitted to the Securities and Exchange Commission (SEC) to identify changes in large employers' retiree health benefit obligations. To supplement the trend and financial data and to identify which options for prescription drug coverage provided under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) sponsors of employment-based retiree health benefits said they planned to implement, we interviewed benefit consultants, private and public sector sponsors of employment-based retiree health benefits, officials at associations and groups representing large and small employers and others. In addition, we reviewed studies and literature addressing retiree health benefits. We conducted our work from April 2004 through February 2005 in accordance with generally accepted government auditing standards.

Surveys of Employment-Based Health Benefits

We relied on data from two annual surveys of employment-based health benefit plans. The Kaiser Family Foundation and the Health Research and Educational Trust (Kaiser/HRET) and Mercer Human Resource Consulting each conduct an annual survey of employment-based health benefits, including a section on retiree health benefits. Each survey has been conducted for at least the past decade, including 2004.¹ We also used data from a survey focused solely on 2004 retiree health benefits that the Kaiser Family Foundation and Hewitt Associates (Kaiser/Hewitt) conducted in 2004. For each of these surveys of employment-based benefits, we reviewed the survey instruments and discussed the data's reliability with the sponsors' researchers and determined that the data were sufficiently reliable for our purposes.

¹Year-to-year fluctuations or gradual changes in these employer benefit survey results need to be interpreted with caution. These surveys are based on random samples designed to be representative of a broader employer population and are used widely but may not have the precision needed to distinguish small changes in coverage from year to year because of their response rates and the number of firms surveyed.

Kaiser/HRET

Since 1999, Kaiser/HRET has surveyed a sample of employers each year through telephone interviews with human resource and benefits managers and published the results in its annual report—*Employer Health Benefits*.² Kaiser/HRET selects a random sample from a Dun & Bradstreet list of private and public sector employers with three or more employees, stratified by industry and employer size. It attempts to repeat interviews with some of the same employers that responded in prior years. For the most recently completed annual survey, conducted from January to May 2004, 1,925 employers completed the full survey, giving the survey a 50 percent response rate. In addition, Kaiser/HRET asked at least one question of all employers it contacted—“Does your company offer or contribute to a health insurance program as a benefit to your employees?”—to which an additional 1,092 employers, or cumulatively about 78 percent of the sample, responded. By using statistical weights, Kaiser/HRET is able to project its results nationwide. Kaiser/HRET uses the following definitions for employer size: (1) small—3 to 199 employees—and (2) large—200 and more employees. In some cases, Kaiser/HRET reported information for additional categories of small and large employer sizes.

Mercer

Since 1993, Mercer has surveyed a stratified random sample of employers each year through mail questionnaires and telephone interviews and published the results in its annual report—*National Survey of Employer-Sponsored Health Plans*.³ Mercer selects a random sample of private sector employers from a Dun & Bradstreet database, stratified into eight categories, and randomly selects public sector employers—state, county, and local governments—from the Census of Governments. The random sample of private sector and government employers represents employers with 10 or more employees. Mercer conducts the survey by telephone for employers with from 10 to 499 employees and mails questionnaires to employers with 500 or more employees. Mercer’s database contains information from 2,981 employers who sponsor health plans. By using statistical weights, Mercer projects its results nationwide and for four

²Kaiser/HRET has been conducting the survey of small and large employers since 1999. From 1991 through 1998, KPMG Peat Marwick conducted the survey using the same instrument. However, data for all sizes of employers are not available for all years. For example, KPMG Peat Marwick only sampled large employers in 1991, 1992, 1994, and 1997 and sampled both large and small employers in 1993, 1995, 1996, and 1998.

³Foster Higgins, which later merged with Mercer Human Resource Consulting, began conducting the survey in 1986.

geographic regions.⁴ The Mercer survey report contains information for large employers—500 or more employees—and for categories of large employers with certain numbers of employees as well as information for small employers (fewer than 500 employees). We have excluded from our analysis Mercer’s 2002 data on the percentage of employers that offer retiree health plans because Mercer stated in its 2003 survey report that the 2002 data were not comparable to data collected in other years because of a wording change on the 2002 survey questionnaire. In 2003, Mercer modified the survey questionnaire again to make the data comparable to prior years (except 2002).

Kaiser/Hewitt

The Kaiser/Hewitt study—*Current Trends and Future Outlook for Retiree Health Benefits: Findings from the Kaiser/Hewitt 2004 Survey on Retiree Health Benefits*—is based on a nonrandom sample of employers because there is no database that identifies all private sector employers offering retiree health benefits from which a random sample could be drawn. Kaiser/Hewitt used previous Hewitt survey respondents and its proprietary client database—a list of private sector employers potentially offering retiree health benefits. Kaiser/Hewitt conducted the survey online from May 2004 through September 2004 and obtained data from 333 large (1,000 or more employees) employers. According to information provided by Hewitt, these employers included about one-third of the 100 Fortune 500 companies with the largest retiree health obligations in 2003. Because the sample is nonrandom and does not include the same sample of companies and plans each year, survey results for 2004 cannot be compared to results from prior years.

Federal Surveys

We analyzed three federal surveys containing information either on Medicare beneficiaries or on the percentage of public sector employers that offer retiree health benefits. We obtained information on retired Medicare beneficiaries’ sources of health benefits coverage, including former employers and unions, from the Current Population Survey (CPS), conducted by the U.S. Census Bureau. We obtained data on the sources of coverage for all health care expenditures and for prescription drug expenditures for retired Medicare beneficiaries from the Medicare Current

⁴However, the 2003 Mercer report states that the average annual cost increase data cited for Medicare-eligible retirees are not projectable beyond a group of 158 total employers that were able to provide cost information for both 2002 and 2003.

Beneficiary Survey (MCBS), sponsored by the Centers for Medicare & Medicaid Services (CMS). We obtained data on the percentage of public sector employers that offer retiree health benefits from the Medical Expenditure Panel Survey (MEPS), sponsored by the Agency for Healthcare Research and Quality. Each of these federal surveys is widely used for policy research, and we reviewed documentation on the surveys to determine that they were sufficiently reliable for our purposes.

Current Population Survey

We analyzed the Annual Supplement of the CPS for information on the demographic characteristics of Medicare-eligible retirees and their access to insurance.⁵ The survey is based on a sample designed to represent a cross section of the nation's civilian noninstitutionalized population. In 2004, about 84,500 households were included in the sample for the survey, a significant increase in sample size from about 60,000 households prior to 2002. The total response rate for the 2004 CPS Annual Supplement was about 84 percent. Because the CPS is based on a sample, any estimates derived from the survey are subject to sampling errors. A sampling error indicates how closely the results from a particular sample would be reproduced if a complete count of the population were taken with the same measurement methods. To minimize the chances of citing differences that could be attributable to sampling errors, we present only those differences that were statistically significant at the 95 percent confidence level.

The CPS asked whether a respondent was covered by employer- or union-sponsored, Medicare, Medicaid, private individual, or certain other types of health insurance in the last year. The CPS questions that we used for employment status, such as whether an individual is retired, are similar to the questions on insurance status. Respondents were considered employed if they worked at all in the previous year and not employed only if they did not work at all during the previous year.

The CPS asked whether individuals had been provided employment-based insurance "in their own name" or as dependents of other policyholders. We selected Medicare-eligible retirees aged 65 and older who had employment-based health insurance coverage in their own names because

⁵See <http://www.census.gov/hhes/www/hlthins/hlthin03.html> (downloaded Dec. 22, 2004) for additional information. We analyzed data from the March CPS Supplement from 1996 through 2002 and the Annual Social and Economic Supplement to the CPS from 2003 through 2004.

this coverage could most directly be considered health coverage from a former employer. For these individuals, we also identified any retired Medicare-eligible dependents aged 65 or older, such as a spouse, who were linked to this policy. We used two criteria to determine that these policies were linked to the primary policyholder: (1) the dependent lived in the same household and had the same family type as the primary policyholder and (2) the dependent had employment-based health insurance coverage that was “not in his or her own name.”

Medicare Current Beneficiary Survey

MCBS is a nationally representative sample of Medicare beneficiaries sponsored by CMS.⁶ The survey is designed to determine for Medicare beneficiaries (1) expenditures and payment sources for all health care services, including noncovered services, and (2) all types of health insurance coverage. The survey also relates coverage to payment sources. The sample represents 16,315 Medicare beneficiaries from CMS’s enrollment files who are interviewed three times a year at 4-month intervals. The complete interview cycle for a respondent consists of 12 interviews over 4 years. Response rates for initial interviews ranged from about 85 to 89 percent. After completing a first interview, individuals had a response rate of 95 percent or more in subsequent interviews. Interview data are linked to Medicare claims and other administrative data, and sample data are weighted so that results can be projected to the entire Medicare population.

The MCBS Cost and Use file links Medicare claims to survey-reported events and provides expenditure and payment source data on all health care services, including those not covered by Medicare. Therefore, this file contains data on Medicare beneficiaries’ expenditures and sources of coverage for prescription drugs. Among other items, the prescription drug data include the following payment source categories: Medicare, Medicaid, health maintenance organizations (HMO), Medicare HMO, employment-based insurance, individually purchased insurance, unknown, out-of-pocket, discounts, and other.

We analyzed prescription drug expenditure data for retired Medicare beneficiaries aged 65 and older who had employment-based health coverage in 2001, the most current data available at the time we did our

⁶See <http://www.cms.hhs.gov/MCBS/Overview.asp> (downloaded Dec. 22, 2004) for additional information.

analysis. We extrapolated these data to 2006—when the Medicare part D benefit begins—using projections based on National Health Care Expenditures per capita data developed by CMS to provide estimates of prescription drug expenditures paid by employment-based insurance or paid out-of-pocket for retired Medicare beneficiaries with employment-based insurance. We did not make adjustments to reflect significant changes in payment sources for prescription drug coverage once the Medicare part D benefit begins in 2006. For employers that elect to continue covering prescription drugs, these projections provide an estimate of the share of these prescription drug expenditures covered that could be eligible for the MMA subsidy.

Medical Expenditure Panel Survey

MEPS, sponsored by the Agency for Healthcare Research and Quality, consists of four surveys and is designed to provide nationally representative data on health care use and expenditures for U.S. civilian noninstitutionalized individuals.⁷ We used data from the MEPS Insurance Component, one of the four surveys, to identify the percentage of state entities that offered retiree health benefits in 1998 and 2002. Insurance Component data are collected through two samples. The first, known as the “household sample,” is a sample of employers and other insurance providers (such as unions and insurance companies) that were identified by respondents in the MEPS Household Component, another of the four surveys, as their source of health insurance. The second sample, known as the “list sample,” is drawn from separate lists of private and public employers. The combined surveys provide a nationally representative sample of employers. The target size of the list sample is approximately 40,000 employers each year. The response rate for the public sector MEPS Insurance Component was about 88 percent in 2002.

Financial Data from Fortune 500 Employers

We reviewed selected financial data for a stratified random sample of 2003 Fortune 500 employers, which is a list of the U.S. corporations with the highest annual revenues. First, we stratified the Fortune 500 list into five groups of 100 in descending order of revenues.⁸ We then randomly selected 10 Fortune 500 employers from each of the five groups, for a total of 50 employers. To identify the 50 employers’ postretirement benefit

⁷See <http://www.meps.ahrq.gov/default.htm> (downloaded Dec. 22, 2004) for additional information.

⁸See “The 500 Largest U.S. Corporations,” *Fortune*, vol. 149, no. 7 (2004).

obligations,⁹ we reviewed the annual financial statements (Form 10-K) that these employers submitted to the SEC.¹⁰ We reviewed the Form 10-K that each employer submitted for its most recent fiscal year, ending in 2003 or early in 2004.¹¹ Then, to identify each employer's postretirement benefit obligations for the two previous fiscal years, we reviewed the Form 10-K filed in either 2002 or 2003. To identify the types of changes these employers planned to make to their postretirement benefits in light of the MMA, we reviewed the latest quarterly financial statements (Form 10-Q) that employers submitted to the SEC, most as of November 2004.¹²

Interviews with Benefit Consultants, Plan Sponsors, and Others

We interviewed representatives of six large employer benefit consulting firms. Benefit consultants help their clients, which include private sector employers, public sector employers, or both, develop and implement human resource programs, including retiree health benefit plans. While most of these benefit consulting firms' clients were large Fortune 500 or Fortune 1,000 employers, some also had smaller employers as clients. One benefit consulting firm that we interviewed, in particular, provided actuarial, employee benefit, and other services to a range of public sector clients, including state and local governments, statewide retirement systems and health plans, and federal government agencies. It also provided human resources services to multiemployer plans.

To learn more about retiree health benefit trends and MMA options from large private sector plan sponsors, we interviewed 12 Fortune 500 employers that provided retiree health benefits. From the stratified random sample of 50 Fortune 500 employers selected for a financial data review, we judgmentally selected 10 employers for interviews. We

⁹Postretirement benefit obligations included retiree health and other postretirement benefits, but not pensions.

¹⁰See <http://www.sec.gov/edgar.shtml> (downloaded Dec. 22, 2004) for additional information. Information, including revenues and obligations, reported to the SEC reflect employers' worldwide operations.

¹¹Forty-seven of the 50 employers we reviewed submitted Forms 10-K to the SEC. Thirty-eight of these employers had fiscal years that ended in December 2003. Of the remaining employers, 5 employers had fiscal years that ended earlier in 2003 and 4 had fiscal years that ended in either January or February 2004.

¹²Generally, companies had to file their Forms 10-Q 45 days after the end of each quarter for fiscal years that ended on or after December 15, 2002, and before December 15, 2004. Most of the quarterly statements we reviewed covered the quarter ending in September 2004.

interviewed at least 1 employer from each of the five groups of 100 Fortune 500 employers that were stratified on the basis of annual revenues. In addition to considering revenues, where data were available, we considered each employer's industry, number of employees, postretirement benefit obligations, preliminary MMA option decision as reported on its annual Form 10-K, and union presence when making our selection. We also interviewed officials at two additional Fortune 500 employers at the recommendation of a benefit consultant.

While small and mid-sized employers are less likely than large employers to offer retiree health benefits, we also assessed small and mid-sized employers' preliminary reactions to the MMA options. We relied primarily on discussions with officials at two organizations representing the interests of small and mid-sized employers—the National Federation of Independent Business and the United States Chamber of Commerce—and benefit consultants.

To learn more about retiree health benefit trends and MMA options at public sector plan sponsors, we interviewed officials at the Office of Personnel Management (OPM), two state retirement systems, and one association. OPM administers the Federal Employees Health Benefits Program—the country's largest employment-based health plan. We judgmentally selected two large states' retiree health benefits systems on the basis of a review of selected state data and referrals from a benefit consultant that works with public sector clients. We also interviewed officials at the National Conference on Public Employee Retirement Systems and reviewed available studies on retiree health benefits in the public sector.¹³

¹³See Jack Hoadley, Health Policy Institute, Georgetown University, *How States Are Responding to the Challenge of Financing Health Care for Retirees* (Menlo Park, Calif.: The Henry J. Kaiser Family Foundation, September 2003). Responses to this study were provided by 43 states and the District of Columbia. These state retirement systems had about 1.8 million retirees and dependents, approximately three-fourths of whom were Medicare-eligible. See also Stan Wisniewski and Lorel Wisniewski, *State Government Retiree Health Benefits: Current Status and Potential Impact of New Accounting Standards* (Workplace Economics, Inc., commissioned by the AARP Public Policy Institute) (Washington, D.C.: AARP, July 2004). The AARP Public Policy Institute commissioned Workplace Economics to conduct research on retiree health benefits in state governments. Workplace Economics analyzed information in its proprietary database on benefits provided to state government employees in all 50 states (excluding the District of Columbia, which is not part of the state government database). Workplace Economics also analyzed state governments' annual financial reports as part of this study.

To obtain broader-based information about retiree health benefit trends and MMA options, we interviewed officials at several other groups and associations. Specifically, we interviewed the President of the National Business Group on Health and the Director of the Health Research and Education Program of the Employee Benefit Research Institute to obtain more information about large private sector employers. We also interviewed officials from the American Academy of Actuaries, the Kaiser Family Foundation, the American Federation of Labor and Congress of Industrial Organizations, and the National Coordinating Committee for Multiemployer Plans. Finally, we reviewed other available literature on retiree health benefit trends, cost-containment strategies, and plan sponsors' likely responses to MMA options.

Appendix II: Comments from the Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JAN 28 2005

TO: Kathryn G. Allen
Director, Health Care—Medicaid
and Private Health Insurance Issues
Government Accountability Office

FROM: Mark B. McClellan, M.D., Ph.D.
Administrator

A handwritten signature in black ink, appearing to read "Mark McClellan".

SUBJECT: Government Accountability Office's (GAO) Draft Report: *RETIREE HEALTH BENEFITS: Options for Employment-Based Prescription Drug Benefits Under the Medicare Modernization Act* (GAO-05-205)

Thank you for the opportunity to review and comment on the GAO's draft report entitled, *RETIREE HEALTH BENEFITS: Options for Employment-Based Prescription Drug Benefits Under the Medicare Modernization Act* (GAO-05-205). The report examines the trends in employment-based retiree health coverage prior to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA); which MMA prescription drug options plan sponsors say they will likely use; and what effect these options will likely have on health benefits for Medicare-eligible retirees.

The Centers for Medicare & Medicaid Services (CMS) agrees with the report findings that the recent trend in employment-based prescription drug benefits shows those benefits to be declining in the value and availability of coverage. As the report indicates, employment-based retiree health insurance has been an important source of drug coverage for many Medicare beneficiaries. However, for well over a decade, the availability and generosity of employment-based retiree health coverage has been eroding, particularly for future retirees. As prescription drug costs have risen, employers have been shifting more of those costs to their retirees, and many employers have ceased offering retiree health coverage altogether.

The Medicare prescription drug benefit and the retiree drug subsidy represent additional funding sources that can help employers and unions continue to provide high quality drug coverage for their retirees. Employer and union plan sponsors and beneficiaries will have multiple options for enhancing retiree coverage through new resources available through Medicare. We anticipate that this new funding will generally improve support for retiree drug coverage, enhancing both its quality and security. We are pleased that the GAO report confirms that the retiree drug subsidy provisions of the MMA will directly assist employers in retaining retiree health benefits. We also would like to bring to your

Page 2 – Kathryn G. Allen

attention a recent survey by Deloitte Consulting LLP, released after your study was concluded, that shows 90 percent of employers offering their retirees prescription drug coverage intend to continue offering drug coverage after the new Medicare Part D drug coverage is available in 2006, which is consistent with your findings.

The report states that it is unlikely that the MMA will induce employers to begin to provide prescription drug coverage or to supplement the Medicare drug benefit if they had not previously offered retiree health coverage. However, the report also indicates (and our own discussions with stakeholders confirm) that many plan sponsors are still considering the potential impact of the various MMA prescription drug options. Employers are often encouraged to review and consider total retirement costs for their retirees, and we believe some may re-think certain aspects of their overall retirement benefit package – and even begin offering prescription drug coverage to retirees -- once Federal subsidy dollars become available under these various options beginning in January 2006.

On January 21, 2005, we released a final regulation that implements the Part D prescription drug benefit and the retiree drug subsidy. Based on the valuable comments and input we received on the proposed policies, this final rule reflects our four objectives: maximizing the number of retirees benefiting from the retiree drug subsidy; avoiding windfalls; minimizing administrative burden; and not exceeding budget estimates. In addition to the policies set forth in the final rule, CMS is planning to issue guidance on a range of issues for which commenters indicated additional direction would be helpful. For example, we plan to provide guidance on the actuarial equivalence standard and the process of attesting to actuarial equivalence, the application process, and the streamlined approach CMS plans to use in implementing the employer waivers.

We respect plan sponsors' need to have guidance on the retiree drug subsidy and other employer and union options as soon as possible due to the complexity and timing of the process. In addition to issuing this final rule and other guidance as quickly as possible, CMS will continue to conduct outreach to various groups to educate the stakeholders on the requirements for applying for the retiree drug subsidy and taking advantage of the other options that are available to employers and unions for continuing to provide assistance with their Medicare-eligible retirees' drug costs.

Thank you again for the opportunity to review and comment on the draft report.

Appendix III: Comments from the Office of Personnel Management



OFFICE OF THE DIRECTOR

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-1000

January 28, 2005

Ms. Kathryn G. Allen
Director, Health Care—Medicaid
and Private Health Insurance Issues
U.S. Government Accountability Office
Washington, DC 20548

Dear Ms. Allen:

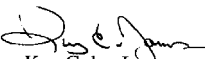
Thank you for the opportunity to respond to the proposed report entitled *RETIREE HEALTH BENEFITS: Options for Employment-Based Prescription drug Benefits Under the Medicare Modernization Act* (GAO-05-205).

The Office of Personnel Management (OPM) is justifiably proud of its stewardship for the Federal Employees Health Benefits Program (FEHBP). As your report points out, through tough negotiations with the participating health plans, OPM was successful in holding down premium increases this year to only 7.9 percent. This accomplishment was achieved, as your report also acknowledges, while continuing to provide the same level of health insurance coverage at the same premium rates for retirees and their families as available to Federal employees.

The Medicare Modernization Act (MMA) will make available to all Medicare beneficiaries a benefit that FEHBP members, including Medicare-eligible members, have enjoyed for years: a comprehensive prescription drug benefit. The MMA, in fact, requires health plan sponsors, including the Federal Government, and its agent for the FEHBP, OPM, to decide how to coordinate existing prescription drug benefits with the drug benefits that will be available beginning in 2006 under Medicare Part D. The proposed GAO report incorrectly indicates that the FEHBP would most likely receive the Federal subsidy payment provided for by the MMA. At this time, we do not expect to participate in the employer subsidy.

I appreciate the opportunity to provide this response. If you have any questions, please contact Richard B. Lowe, 202-606-1000.

Sincerely,


Kay Coles James
Director

CON 131-64-4
September 2001

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

John E. Dicken, (202) 512-7043

Acknowledgments

Laura Sutton Elsberg, Joseph A. Petko, Kevin Dietz, Elizabeth T. Morrison, and Suzanne Worth made key contributions to this report.

GAO's Mission

The Government Accountability Office, the audit, evaluation and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's Web site (www.gao.gov). Each weekday, GAO posts newly released reports, testimony, and correspondence on its Web site. To have GAO e-mail you a list of newly posted products every afternoon, go to www.gao.gov and select "Subscribe to Updates."

Order by Mail or Phone

The first copy of each printed report is free. Additional copies are \$2 each. A check or money order should be made out to the Superintendent of Documents. GAO also accepts VISA and Mastercard. Orders for 100 or more copies mailed to a single address are discounted 25 percent. Orders should be sent to:

U.S. Government Accountability Office
441 G Street NW, Room LM
Washington, D.C. 20548

To order by Phone: Voice: (202) 512-6000
TDD: (202) 512-2537
Fax: (202) 512-6061

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Web site: www.gao.gov/fraudnet/fraudnet.htm

E-mail: fraudnet@gao.gov

Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Gloria Jarmon, Managing Director, JarmonG@gao.gov (202) 512-4400
U.S. Government Accountability Office, 441 G Street NW, Room 7125
Washington, D.C. 20548

Public Affairs

Paul Anderson, Managing Director, AndersonP1@gao.gov (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, D.C. 20548