

May 2007

# RETIREE HEALTH BENEFITS

## Majority of Sponsors Continued to Offer Prescription Drug Coverage and Chose the Retiree Drug Subsidy





Highlights of [GAO-07-572](#), 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 resulted in options for sponsors of employment-based prescription drug benefits, such as a federal subsidy payment—the retiree drug subsidy (RDS)—when sponsors provide benefits meeting certain MMA requirements to Medicare-eligible retirees. The MMA required GAO to conduct two studies on trends in employment-based retiree health coverage and the MMA options available to sponsors. The first study, *Retiree Health Benefits: Options for Employment-Based Prescription Drug Benefits under the Medicare Modernization Act* ([GAO-05-205](#)), was published February 14, 2005. In this second study, GAO determined which MMA prescription drug coverage options sponsors selected, the factors they considered in selecting these options, and the effect these decisions may have on the provision of employment-based health benefits for retirees.

GAO identified options that sponsors selected using data from employer benefit surveys and the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicare. To obtain sponsors' views about the factors they considered and the effects of their decisions, GAO also interviewed private and public sector sponsors and experts.

[www.gao.gov/cgi-bin/getrpt?GAO-07-572](http://www.gao.gov/cgi-bin/getrpt?GAO-07-572).

To view the full product, including the scope and methodology, click on the link above. For more information, contact John E. Dicken at (202) 512-7119 or [dickenj@gao.gov](mailto:dickenj@gao.gov).

## RETIREE HEALTH BENEFITS

### Majority of Sponsors Continued to Offer Prescription Drug Coverage and Chose the Retiree Drug Subsidy

#### What GAO Found

According to survey data GAO reviewed, a majority of retiree health benefit sponsors reported that for 2006 they continued to offer prescription drug coverage and accepted the RDS. However, the size of the reported majority differed across the surveys. For example, one survey of private sector sponsors with 1,000 or more employees found that 82 percent of these sponsors accepted the RDS for 2006. Another survey of private and public sponsors found that 51 percent of surveyed sponsors with 500 or more employees accepted the RDS for 2006. Data from CMS showed that more than 3,900 sponsors, representing about 7 million retirees, were approved for the RDS for 2006. According to the surveys GAO reviewed, much smaller percentages of sponsors reported selecting other MMA options for 2006. For 2007, according to one survey, 78 percent of surveyed employers reported that they planned to apply for the RDS for that year. CMS data showed that about 3,600 sponsors were approved for the RDS for 2007.

Public and private sponsors GAO interviewed reported considering a variety of factors when selecting MMA prescription drug coverage options, including whether they could offer the same retiree health benefits they offered prior to the MMA and their ability to save on costs. In general, in order to implement most MMA options, sponsors would likely have to change the prescription drug benefits they offer. For example, sponsors that offer their own Medicare Part D plan must generally meet all CMS requirements for Part D plans, such as providing coverage for specific categories of prescription drugs. In contrast, sponsors that select the RDS option can offer the same retiree health benefits they offered prior to the MMA, as long as a sponsor's coverage remains at least actuarially equivalent to the standard Part D benefit. When deciding which, if any, options to pursue, public sponsors were affected by some factors that did not affect private sponsors.

In the short term, sponsors' decisions regarding the MMA options appear to have resulted in benefits remaining relatively unchanged, in part because a majority of surveyed sponsors reported that they continued to offer prescription drug benefits and accepted the RDS the first 2 years the RDS was offered. Over the longer term, the effect of sponsors' decisions about the MMA options is unclear. For example, some experts GAO interviewed indicated that the MMA may extend the amount of time that sponsors offer benefits without reducing coverage, while other experts said the availability of the Medicare Part D benefit may make it more likely that sponsors will stop offering prescription drug benefits for retirees. In addition, it is unclear to what extent sponsors will continue to select the same MMA option in the future. To the extent that sponsors that have accepted the RDS select other MMA options, sponsors' provision of retiree health benefits may change.

In commenting on a draft of this report, CMS and four experts agreed with the report's findings.

---

# Contents

---

<b>Letter</b>		<b>1</b>
	Results in Brief	5
	Background	6
	Majority of Sponsors Reported Continuing to Offer Prescription Drug Coverage and Accepting the RDS	12
	Sponsors Considered a Variety of Factors When Selecting MMA Prescription Drug Coverage Options	16
	In the Short Term, Sponsors' Decisions Regarding MMA Options Resulted in Benefits Remaining Relatively Unchanged, but over the Longer Term the Effect Is Unclear	23
	Agency and Other External Comments	25
<b>Appendix I</b>	<b>Information on Employment-Based Retiree Health Coverage, Updated since GAO's 2005 Report</b>	<b>29</b>
<b>Appendix II</b>	<b>Alternative Approaches to Providing Retiree Health Coverage Suggested by Sponsors and Experts</b>	<b>39</b>
<b>Appendix III</b>	<b>Scope and Methodology</b>	<b>44</b>
<b>Appendix IV</b>	<b>Comments from the Centers for Medicare &amp; Medicaid Services</b>	<b>53</b>
<b>Appendix V</b>	<b>GAO Contact and Staff Acknowledgments</b>	<b>57</b>
<b>Tables</b>		
	Table 1: Number and Percentage of Sponsors Approved for the RDS, and Percentage of Retirees Affected, by Sponsor Type, for 2006 and 2007	15
	Table 2: Alternative Approaches to Providing Employment-Based Retiree Health Coverage Described by Sponsors and Experts	40

---

## Figures

Figure 1: Mercer Survey Results—Percentage of Employers with 500 or More Employees Offering Health Benefits to Medicare-Eligible Retirees, 1993–2006	30
Figure 2: Kaiser/HRET Survey Results—Percentage of Employers with 200 or More Employees Offering Health Benefits to All Retirees and to Medicare-Eligible Retirees, 1991–2006	32
Figure 3: Percentage of Medicare-Eligible Retirees and Their Insured Dependents with Employment-Based Health Benefits, by Age Group, 1995–2005	35

---

## Abbreviations

CMS	Centers for Medicare & Medicaid Services
CPS	Current Population Survey
FEHBP	Federal Employees Health Benefits Program
GASB	Governmental Accounting Standards Board
HRA	health reimbursement arrangement
HRET	Health Research and Educational Trust
HSA	health savings account
MA-PD	Medicare Advantage prescription drug
MCBS	Medicare Current Beneficiary Survey
MEPS	Medical Expenditure Panel Survey
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MSA	medical savings account
OPM	Office of Personnel Management
PDP	prescription drug plan
RDS	retiree drug subsidy
VEBA	voluntary employees' beneficiary association

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

May 31, 2007

### Congressional Committees

Before 2006, Medicare, the federal program that finances health care benefits for nearly 43 million elderly and disabled beneficiaries, did not generally provide coverage for outpatient prescription drugs. If Medicare beneficiaries had such coverage at all, it was typically obtained outside of the program—for example, through policies with drug coverage that supplemented Medicare or through Medicaid. In particular, Medicare beneficiaries who were retired could enroll in health plans with prescription drug coverage offered through former employers or other employment-based groups, such as unions. To help Medicare beneficiaries with increasing prescription drug costs and encourage employment-based health care coverage, especially for prescription drug coverage for retirees, Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Among its provisions, the MMA established an outpatient prescription drug benefit, known as Medicare Part D, beginning January 1, 2006.<sup>1</sup> The MMA also resulted in various options to encourage retiree health benefit sponsors<sup>2</sup> to offer prescription drug benefits to retired Medicare beneficiaries.

Specifically, among the options resulting from the MMA, which in this report we refer to as MMA options, sponsors can

- offer health plans for retirees that provide comprehensive prescription drug coverage, which retirees can use in lieu of Medicare Part D; sponsors with plans that offer prescription drug benefits meeting certain MMA requirements will receive a federal subsidy payment, known as the retiree drug subsidy (RDS);

---

<sup>1</sup>Pub. L. No. 108-173, §101, 117 Stat. 2066, 2071-2152.

<sup>2</sup>In this report, we use the term sponsor to refer to a sponsor of employment-based retiree group health coverage, including private sector employers; public sector employers (federal, state, or local governments); sponsors of church plans; and sponsors of plans (including multiemployer plans) offered under collectively bargained agreements. In some instances, when reporting data from surveys of various sponsors, we use the term employer instead of sponsor to describe a specific subset of sponsors.

- 
- offer health plans for retirees that supplement—or “wrap around”—retirees’ Part D prescription drug benefit;
  - offer their own Medicare Part D plan;
  - contract with private plans that provide Medicare Part D benefits; or
  - pay for some or all of the Part D premiums for their eligible retirees.

The MMA required that we conduct two studies on trends in employment-based retiree health coverage and the MMA options sponsors selected for providing employment-based prescription drug coverage for retirees.<sup>3</sup> In our first study, published in 2005, we reported that the percentage of employers offering retiree health coverage had declined beginning in the early 1990s but had leveled off by the early 2000s.<sup>4</sup> We also reported that many sponsors had not made final decisions about which MMA prescription drug options they would choose for their Medicare-eligible retirees,<sup>5</sup> although many sponsors were considering accepting the RDS as a primary option. In this study, we are reporting on (1) which MMA prescription drug coverage options sponsors selected, (2) the factors they considered in selecting these options, and (3) the effect these decisions may have on sponsors’ provision of employment-based health benefits for retirees. The MMA also required us to report information on employment-based retiree health coverage, including information updated since our first study. We are including this information in appendix I. In addition, the MMA required us to describe alternative approaches for the provision of employment-based retiree health coverage that sponsors and others say may help maintain, expand, or improve upon retiree health coverage. We are including this information in appendix II.

To determine which MMA prescription drug coverage options sponsors selected, we reviewed survey data collected by benefit consulting firms on the options that sponsors reported selecting for 2006 and the options that

---

<sup>3</sup>MMA, §111, 117 Stat. 2174-2176.

<sup>4</sup>See GAO, *Retiree Health Benefits: Options for Employment-Based Prescription Drug Benefits under the Medicare Modernization Act*, [GAO-05-205](#) (Washington, D.C.: Feb. 14, 2005).

<sup>5</sup>For this report, we specify when information is for Medicare-eligible retirees (primarily those aged 65 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 reported that they planned to select for 2007. The surveys we reviewed included a survey conducted by Mercer Health & Benefits of employers—including large employers, defined as those with at least 500 employees—that offered employment-based health benefits. The Mercer survey, which was based on a random sample of private and public employers, can be projected nationwide.<sup>6</sup> We also reviewed data from a survey conducted by the Kaiser Family Foundation and Hewitt Associates for a nonrandom sample of large private sector employers—those with 1,000 or more employees.<sup>7</sup> We also reviewed one survey of multiemployer plans<sup>8</sup> and one survey of state and local public sector sponsors conducted by The Segal Company.<sup>9</sup> The data from the surveys provided us with information on sponsors' reported selections for 2006 and their plans pertaining to the MMA options for 2007. In addition, we obtained and analyzed data on the number and characteristics of sponsors that were approved for the RDS for these 2 years. We obtained these data from the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicare and that is responsible for implementing and administering the RDS program.

To describe both the factors that sponsors considered in selecting the MMA options and the effect that sponsors' decisions about the MMA options may have on the provision of health benefits for retirees, we relied on the Mercer and Kaiser/Hewitt surveys of private and public sector

---

<sup>6</sup>Mercer Health & Benefits, *National Survey of Employer-Sponsored Health Plans: 2006 Survey Report* (New York, N.Y.: Mercer Health & Benefits, LLC, 2007).

<sup>7</sup>Frank McArdle, Amy Atchison, and Dale Yamamoto, Hewitt Associates; and Michelle Kitchman Strollo and Tricia Neuman, The Kaiser Family Foundation, *Retiree Health Benefits Examined: Findings from the Kaiser/Hewitt 2006 Survey on Retiree Health Benefits* (Menlo Park, Calif.: The Henry J. Kaiser Family Foundation; Lincolnshire, Ill.: Hewitt Associates, December 2006).

<sup>8</sup>A 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 the Secretary of Labor may prescribe by regulation. 29 U.S.C. § 1002(37) (2000).

<sup>9</sup>The Segal Company, *Results of the Segal Survey of Multiemployer Health Funds' Response to the Initial Availability of Medicare Part D Coverage* (New York, N.Y.: Spring 2006), and *Results of the Segal Medicare Part D Survey of Public Sector Plans* (New York, N.Y.: Summer 2006).

---

employers.<sup>10</sup> We reviewed documents from the literature, including CMS documents, on the factors that sponsors may consider in selecting the MMA options. We also interviewed officials from 13 of the 15 private and public sponsors of retiree health benefits that we reported on in 2005, including the Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits Program (FEHBP).<sup>11</sup> We also interviewed 2 sponsors that chose to offer their own Medicare Part D plan in 2006 instead of implementing the RDS or another MMA option. We did not interview these sponsors for our 2005 report. In addition, we interviewed several experts on sponsors' decisions regarding the MMA options, including experts from five firms providing benefit consulting services primarily for large public and private sector sponsors; six organizations, including one representing unions, one representing multiemployer plans, two representing large employers, and two representing health plans; one professional organization for actuaries; and other research organizations. In our interviews with sponsor officials and experts, we asked open-ended questions about the factors sponsors considered in making decisions about the MMA options for 2006 and future years, as well as the effect of these decisions on the provision of health benefits for retirees. Because we asked the officials and experts we interviewed open-ended questions, the frequency of our interviewees' responses is not comparable. Therefore, we report interviewees' responses without reporting the total number of officials or experts associated with each response.

We assessed the reliability of the data from the employer benefit surveys, CMS, and three large federal surveys and determined that the data were sufficiently reliable for the purposes of our study. (App. III provides more detailed information on our methodology.) We performed our work from April 2006 through May 2007 in accordance with generally accepted government auditing standards.

---

<sup>10</sup>Mercer Health & Benefits, *National Survey of Employer-Sponsored Health Plans: 2005 Survey Report* (New York, N.Y.: Mercer Health & Benefits, LLC, 2006), and Kaiser/Hewitt, *Retiree Health Benefits Examined: Findings from the Kaiser/Hewitt 2006 Survey on Retiree Health Benefits*.

<sup>11</sup>In addition to OPM, the 13 sponsors included 10 Fortune 500 employers and two state retirement systems.



---

## Results in Brief

According to survey data we reviewed, a majority of retiree health benefit sponsors reported that for 2006 they continued to offer prescription drug coverage and accepted the RDS. However, the size of the reported majority differed across the surveys. For example, the 2006 Kaiser/Hewitt survey of private sector employers with 1,000 or more employees found that 82 percent of these employers continued to offer prescription drug coverage and accepted the RDS for 2006. Another survey, the 2006 Mercer survey of private and public employers, found that 51 percent of surveyed employers with 500 or more employees continued to offer prescription drug coverage and accepted the RDS for 2006. Data from CMS showed that more than 3,900 sponsors, representing about 7 million retirees, were approved for the RDS for 2006. According to the surveys we reviewed, much smaller percentages of sponsors reported selecting other MMA options. For example, the percentage of sponsors that reported offering supplemental, or “wrap-around,” coverage ranged from 0 to 13 percent across the surveys. For 2007, according to the Kaiser/Hewitt survey, 78 percent of surveyed employers reported that they planned to apply for the RDS for that year. CMS data showed that about 3,600 sponsors were approved for the RDS for 2007.

Public and private sponsors we interviewed reported considering a variety of factors when selecting MMA prescription drug coverage options, including whether they could offer the same retiree health benefits they offered prior to the MMA and their ability to save on costs. In general, in order to implement most MMA options other than the RDS, sponsors would likely have to change the prescription drug benefits they offer. For example, sponsors that offer their own Medicare Part D plan must generally meet all CMS requirements for Part D plans, such as providing coverage for specific categories of prescription drugs. In contrast, sponsors that select the RDS option are able to offer the same retiree health benefits they offered prior to the MMA, as long as a sponsor’s coverage remains at least actuarially equivalent to the standard Part D benefit. Most sponsors we interviewed told us that the ability to offer the same retiree health benefits they offered prior to the MMA was an advantage of the RDS. Sponsors also reported that when selecting an MMA option, they considered how the RDS and the other MMA options would affect their ability to save on costs.

While, in the short term, sponsors’ decisions regarding the various MMA options appear to have resulted in the provision of retiree health benefits remaining relatively unchanged, the effect over the longer term is unclear. The short-term effect of sponsors’ decisions appears to have resulted in benefits remaining relatively unchanged, in part because a majority of

---

surveyed sponsors reported that they continued to offer prescription drug benefits and accepted the RDS for the first 2 years the RDS was offered. In addition, according to the 2005 Mercer survey, 72 percent of respondents reported that their decisions about the MMA options would have no effect on their ability to provide retiree health coverage. Similarly, many sponsors we interviewed told us that they did not make changes to their retiree health benefits—including decreasing coverage—in direct response to their decisions in selecting MMA options. Over the longer term, some experts we interviewed indicated that the MMA may extend the amount of time that sponsors offer benefits without reducing coverage. Other experts said that it was possible the availability of the Medicare Part D benefit may make it more likely that sponsors will stop offering prescription drug benefits for retirees. In addition, it is unclear to what extent sponsors will continue to select the same MMA option in the future. If sponsors that have accepted the RDS thus far select other MMA options in subsequent years, their future provision of retiree health benefits may change.

In commenting on a draft of this report, CMS and four experts agreed with the report's findings.

---

## Background

For retirees aged 65 and older, Medicare is typically the primary source of health insurance coverage. Medicare covers nearly 43 million beneficiaries. The program covers hospital care as well as physician office visits and outpatient services and, effective January 1, 2006, prescription drugs.

---

## Private Supplemental Insurance for Medicare Beneficiaries

Medicare beneficiaries may rely on private retiree health coverage through former employment or through individually purchased Medicare supplemental insurance (known as Medigap) to cover some or all of the costs Medicare does not cover, such as deductibles, copayments, and coinsurance. For 2004, the most recent data available, the Medicare Current Beneficiary Survey (MCBS) found that about one-third of Medicare-eligible beneficiaries obtained supplemental coverage from a former employer or union.<sup>12</sup> Employment-based retiree health benefits are typically offered as a voluntary benefit to retirees, thereby giving sponsors

---

<sup>12</sup>Other sources of supplemental coverage for Medicare-eligible beneficiaries may include individually purchased coverage or Medicaid. Some Medicare-eligible beneficiaries have a combination of employment-based and individually purchased coverage.

---

of these benefits the option of decreasing or eliminating benefits. However, some sponsors may be prevented from making immediate changes to coverage because of union contracts, for example. Benefit surveys have found that the percentage of employers offering retiree health benefits has decreased, beginning in the early 1990s. For example, according to a series of surveys conducted by Mercer, the percentage of employers with 500 or more employees offering health insurance to Medicare-eligible retirees declined from 44 percent in 1993 to 29 percent in 2006, although this trend had leveled off from 2001 through 2006.<sup>13</sup> (See app. I for more information on employment-based retiree health coverage.)

Sponsors typically integrate their retiree health benefits with Medicare once retirees reach age 65, with Medicare as the primary payer and the sponsor as the secondary payer. Several types of integration occur between sponsors and Medicare. For example, some sponsors coordinate through a carve out approach, in which the sponsor 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 sponsors is full coordination of benefits, in 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.

The provision of employment-based retiree health benefits may vary depending on a variety of factors, including whether the sponsor is in the private or public sector, and by industry type. The 2006 Kaiser Family Foundation and Health Research and Educational Trust (HRET) survey, for example, showed that 82 percent of state and local government employers with 200 or more employees offered coverage to retirees, compared with 35 percent of employers with 200 or more employees across all employer industries that offered coverage to retirees.<sup>14</sup> Coverage can also differ between retirees under age 65 and those eligible for

---

<sup>13</sup>See, for example, Mercer Health & Benefits, *National Survey of Employer-Sponsored Health Plans: 2006 Survey Report*.

<sup>14</sup>Gary Claxton and others, Kaiser Family Foundation; Samantha Hawkins, HRET; and Jeremy Pickreign, Heidi Whitmore, and Jon Gabel, Center for Studying Health System Change, *Employer Health Benefits: 2006 Annual Survey* (Menlo Park, Calif.: The Henry J. Kaiser Family Foundation; Chicago, Ill.: HRET, 2006).

---

Medicare, although sponsors often cover both groups of retirees. For example, some sponsors offer retirees under age 65 a preferred provider organization plan but offer a fee-for-service plan for retirees eligible for Medicare. While the provision of employment-based retiree health benefits varies by employer size, plan type, industry, and whether retirees are Medicare-eligible, these benefits almost always include coverage of prescription drugs.

---

## The MMA Prescription Drug Benefit

MMA created a prescription drug benefit for beneficiaries, called Medicare Part D, which became effective January 1, 2006. This voluntary benefit is available to all Medicare beneficiaries and is the first comprehensive prescription drug benefit ever offered under the Medicare program.<sup>15</sup> In January 2007 (the most recent data available) CMS reported that approximately 39 million beneficiaries were receiving prescription drug coverage from a combination of Medicare Part D, employment-based coverage, and other sources, such as the Department of Veterans Affairs.<sup>16</sup>

The drug benefit is offered primarily through two types of private plans created as a result of the MMA: stand-alone prescription drug plans (PDP) that supplement fee-for-service Medicare, and Medicare Advantage prescription drug (MA-PD) plans, such as coordinated care plans, that

---

<sup>15</sup>Enrollment in the program is voluntary for most beneficiaries, except dual eligibles—low-income Medicare beneficiaries who also qualify for full Medicaid benefits. All dual eligibles were automatically enrolled in a Medicare Part D plan by December 31, 2005, to ensure that these beneficiaries continued to have prescription drug coverage when their Medicaid coverage ended on December 31, 2005. However, these individuals had the option to opt out of the Medicare Part D benefit.

<sup>16</sup>Specifically, a January 30, 2007, CMS press release reported that these Medicare beneficiaries, totaling approximately 39 million, received prescription drug coverage through the following sources: Medicare prescription drug plans or Medicare Advantage prescription drug plans (nearly 24 million); sponsors approved for the RDS (7 million); federal retiree programs, such as FEHBP or TRICARE, the Department of Defense's health system (3 million); and other sources, such as the Department of Veterans Affairs (5 million).

---

cover drugs and other Medicare benefits.<sup>17</sup> To be in operation for 2006, prospective PDPs and MA-PD plans had to apply by March 2005 and were approved in September 2005. At a minimum, these plans were required to offer the standard Medicare Part D benefit or alternative coverage that was at least equal in value.<sup>18</sup> According to the Kaiser Family Foundation, plans approved for 2006 often varied from the standard Part D benefit in benefit design and covered drugs. For example, although the standard Part D benefit had a \$250 deductible for 2006, Kaiser reported that 58 percent of PDPs and 79 percent of MA-PD plans approved for 2006 had no deductible requirement. In 2007, a total of 1,875 PDPs are offered nationally across 34 PDP regions.

The standard Medicare Part D benefit in 2007 has a \$265 deductible (up from \$250 in 2006) and 25 percent coinsurance up to an initial coverage limit of \$2,400 in total drug costs (\$2,250 in 2006), followed by a coverage gap in which enrollees pay 100 percent of their drug costs until they have spent \$3,850 out of pocket (\$3,600 in 2006). Thereafter, the plan pays approximately 95 percent of total drug costs. The standard benefit amounts are set to increase annually by the rate of per capita Part D spending growth. Assistance with drug benefit premiums and cost-sharing is available for certain low-income beneficiaries.

---

## Options Available to Sponsors under Medicare Part D

The MMA resulted in several options for sponsors of employment-based retiree health plans to provide prescription drug coverage to Medicare-eligible retirees. These options are as follows:

*Retiree Drug Subsidy (RDS).* Sponsors with plans ending in 2007 that offer prescription drug coverage that is actuarially equivalent to that under Part D can receive a federal tax-free subsidy equal to 28 percent of the

---

<sup>17</sup>The 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 health maintenance organizations and other types of health plans, such as preferred provider organizations, 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 preferred provider organizations. MMA § 221, 117 Stat. 2180-93.

<sup>18</sup>Plans could also offer enhanced benefits.

---

allowable gross retiree prescription drug costs<sup>19</sup> over \$265 (up from \$250 for plans ending in 2006) through \$5,350 (up from \$5,000 for plans ending in 2006), with a maximum subsidy of \$1,423 per beneficiary for each individual eligible for Part D who is enrolled in the employment-based plan instead of Part D. Actuarial equivalence, which is attested to by a qualified actuary, is intended to certify that a retiree health benefit sponsor's coverage is at least as generous as the standard Part D coverage.<sup>20</sup> Sponsors must demonstrate actuarial equivalence to qualify for the RDS, and sponsors will only receive the RDS for those Medicare beneficiaries who do not enroll in the Part D benefit. Sponsors may opt to receive RDS payments on a monthly, quarterly, or annual basis.

In order to receive the RDS, sponsors must apply to and receive approval from CMS. For 2007 and subsequent years, sponsors are required to apply for the RDS no later than 90 days prior to the beginning of the plan year.<sup>21</sup> For example, sponsors that applied for a calendar year 2007 plan would have had to apply no later than midnight on October 2, 2006. Additional steps involved in applying for and receiving the RDS include

- submitting a qualified actuary's attestation that the plan meets the RDS actuarial equivalence standard;

---

<sup>19</sup> Allowable costs are nonadministrative costs actually paid for any prescription drugs that would be covered under the Part D benefit, net of any discounts, rebates, and similar price concessions.

<sup>20</sup> To demonstrate actuarial equivalence sponsors must satisfy a two-prong test. The first prong is a gross value test, in which the expected amount of paid claims for Medicare beneficiaries in the sponsor's plan must be at least equal to the expected amount of paid claims for the same beneficiaries under Part D standard coverage. The second prong is a net value test, which takes into account the impact of retiree contributions to the plan, as well as the impact that sponsors' supplemental coverage, if provided, has on the value of the standard Part D benefit.

<sup>21</sup> Sponsors can also request an automatic 30-day extension of this deadline.

- 
- certifying that the creditable coverage status of the plan has been or will be disclosed to plan participants and CMS;<sup>22</sup>
  - electronically submitting and periodically updating enrollment information about retirees and dependents; and
  - electronically submitting aggregate data about drug costs incurred and reconciling costs at year-end.

*Provide Supplemental Coverage.* Sponsors can set up their own separate plans that supplement, or wrap around, Part D coverage.

*Apply to Offer Own PDP or MA-PD Plan.* Sponsors can apply to CMS to offer their own PDP or MA-PD plan for retirees.<sup>23</sup> CMS has waived or modified Part D requirements added by the MMA that hinder the design of, the offering of, or the enrollment in a Part D plan offered by a sponsor. For example, CMS has issued guidance that allows sponsors to limit coverage to retirees only, whereas other Part D plans must offer coverage to all eligible individuals residing within a certain location.

*Contract with a PDP or MA-PD Plan.* Sponsors can contract with a PDP or MA-PD plan to offer the standard Part D prescription drug benefits or enhanced benefits to the sponsors' retirees who are eligible for Medicare. For example, an enhanced benefit could allow retirees to pay a lower deductible or lower copayment than the standard Part D benefit requires. As with the previous MMA option, CMS has waived or modified Part D requirements that hinder the design of, the offering of, or the enrollment in these types of arrangements.

*Payment of Part D Premiums.* Sponsors can pay for some or all of the Part D premiums for their eligible retirees.

---

<sup>22</sup>With certain exceptions, sponsors must disclose to all of their Medicare-eligible retirees whether their prescription drug coverage is considered "creditable" as compared to the Part D benefit. To be creditable, the expected amount of paid claims under the sponsor's drug coverage generally must be at least equal to the expected amount of paid claims under the standard Part D benefit. A Part D eligible individual must pay a late enrollment penalty if there is a continuous period of 63 days or longer during which the individual was not covered under any creditable prescription drug coverage. This disclosure can be incorporated into other plan communications and is required to be sent to retirees prior to certain events, such as the first day of the Part D annual enrollment period.

<sup>23</sup>Others have referred to this option as "becoming a PDP or MA-PD plan."

---

## Majority of Sponsors Reported Continuing to Offer Prescription Drug Coverage and Accepting the RDS

According to survey data we reviewed, the majority of surveyed retiree health benefit sponsors reported that they continued to offer prescription drug coverage and accepted the RDS for 2006. Survey data also indicated that much smaller percentages of sponsors took other MMA options—such as offering supplemental, or wrap-around, prescription drug coverage or contracting with a PDP or MA-PD plan.

---

## Majority of Sponsors Reported Accepting the RDS

According to survey data we reviewed, the majority of surveyed sponsors reported that they continued to offer prescription drug coverage and accepted the RDS for plans ending in 2006. However, the size of the reported majority differed across the surveys. For example, the 2006 Kaiser/Hewitt survey, which surveyed private sector employers that offered retiree health benefits and had 1,000 or more employees, found that 82 percent of these employers accepted the RDS for 2006.<sup>24</sup> In contrast, the 2006 Mercer survey found that 51 percent of surveyed private and public employers that offered retiree health benefits and had 500 or more employees continued to offer prescription drug coverage and accepted the RDS for 2006.<sup>25</sup> Another survey of state and local public sector sponsors that offered retiree health benefits found that 79 percent reported accepting the RDS for 2006.<sup>26</sup> Similarly, a survey of multiemployer plan sponsors that offered retiree health benefits found that 71 percent reported accepting the RDS for 2006.<sup>27</sup>

According to representatives from both Kaiser/Hewitt and Mercer, the percentages of surveyed employers that reported accepting the RDS—82 percent and 51 percent, respectively—may be different because the employers surveyed differed in size between the two surveys. According to the 2005 Mercer survey, smaller employers may have such a limited number of Medicare-eligible retirees that they do not believe the RDS would be worth the cost and administrative burden associated with

---

<sup>24</sup>Kaiser/Hewitt, *Retiree Health Benefits Examined: Findings from the Kaiser/Hewitt 2006 Survey on Retiree Health Benefits*.

<sup>25</sup>Mercer Health & Benefits, *National Survey of Employer-Sponsored Health Plans: 2006 Survey Report*.

<sup>26</sup>Segal, *Results of the Segal Medicare Part D Survey of Public Sector Plans*.

<sup>27</sup>Segal, *Results of the Segal Survey of Multiemployer Health Funds' Response to the Initial Availability of Medicare Part D Coverage*.



---

applying for the RDS.<sup>28</sup> Furthermore, experts we interviewed told us that a minimum of 50 to 100 retirees is needed to make it worthwhile for employers to apply for the RDS.<sup>29</sup>

Data from CMS show that more than 3,900 sponsors, representing approximately 7 million retirees, were approved for the RDS for 2006.<sup>30</sup> The number of retirees represented by sponsors that year ranged widely, from 1 to 444,818, with a median of 174 retirees. According to CMS data, commercial and government sponsors<sup>31</sup> made up approximately 70 percent of sponsors approved for the RDS and represented approximately 90 percent of retirees covered by the RDS for 2006. Nonprofit, religious, and union sponsors made up the remaining approximately 30 percent of sponsors and approximately 10 percent of retirees covered by the RDS for 2006.

For 2007, the Kaiser/Hewitt survey reported that the majority of surveyed employers planned to take the RDS. Specifically, 78 percent of surveyed private sector employers that offered retiree health benefits and had 1,000 or more employees planned to take the RDS for 2007—compared with 82 percent that took the RDS for 2006. CMS preliminary data for 2007 showed that the number of sponsors approved for the RDS decreased

---

<sup>28</sup>Mercer Health & Benefits, *National Survey of Employer-Sponsored Health Plans: 2005 Survey Report*. In its survey results, Mercer reported that larger employers were more likely than smaller employers offering retiree health benefits to take the RDS for 2006. For example, 30 percent of employers with 500 to 999 employees planned to take the RDS for 2006, while 61 percent of employers with 5,000 to 9,999 employees planned to take the RDS for 2006.

<sup>29</sup>According to CMS data, about 78 percent of sponsors that were approved for the RDS for 2007 represented more than 50 retirees and about 63 percent of sponsors that were approved for the RDS for 2007 represented more than 100 retirees.

<sup>30</sup>According to CMS officials, these approximately 7 million retirees represent the number of retirees covered by the RDS as of June 11, 2006, and may include retirees enrolled in plans approved for the RDS for 2007. As a result, these 7 million retirees are not necessarily linked to the 3,900 sponsors approved for the RDS for 2006. According to CMS officials, the RDS program has no current business or operational need to calculate the unique number of retirees linked to the number of sponsors that were approved for the RDS for plans ending in 2006, and therefore CMS has not expended the RDS system development resources it has to code its system to allow for this calculation.

<sup>31</sup>The sponsor categories “commercial” and “government” are used by CMS on the RDS application and are self-reported by applicants.

---

somewhat from 2006, to about 3,600 sponsors.<sup>32</sup> CMS officials indicated that the decrease in the number of sponsors between 2006 and 2007 could be explained by a combination of several factors, including mergers by sponsors offering retiree health benefits, differences in the time of year when data were extracted,<sup>33</sup> and the movement of some sponsors from the RDS to other MMA options. According to CMS data, in 2007 the number of retirees represented by sponsors approved for the RDS continued to show a wide range as in 2006, from 1 to 196,840, with a median of 169 retirees. The percentage of sponsors approved for the RDS by sponsor type, such as commercial or government, remained relatively consistent from 2006 to 2007. (See table 1.)

---

<sup>32</sup>As was the case with 2006 data, CMS did not provide a unique number of retirees linked to the number of sponsors that were approved for the RDS for plans ending in 2007. However, in January 2007, CMS published a press release that again reported that approximately 7 million Medicare-eligible retirees received coverage through sponsors approved for the RDS.

<sup>33</sup>CMS officials told us that because the 2006 data were compiled late in the year (September), most of the technical difficulties sponsors experienced had been resolved by that time and their applications had been approved, and therefore the approved application total by that time of the year was close to the final total for the year. In contrast, the preliminary 2007 approved application data were compiled early in the year (February) when some sponsors, especially those participating in the RDS program for the first time, were still experiencing technical difficulties, and therefore their applications had not yet been approved.

**Table 1: Number and Percentage of Sponsors Approved for the RDS, and Percentage of Retirees Affected, by Sponsor Type, for 2006 and 2007**

Sponsor type <sup>c</sup>	2006 <sup>a</sup>		2007 <sup>b</sup>	
	Number of sponsors (percentage) <sup>d</sup>	Percentage of retirees <sup>e</sup>	Number of sponsors (percentage) <sup>d</sup>	Percentage of retirees <sup>e</sup>
Commercial	1,433 (36)	58	1,287 (36)	53
Government	1,307 (33)	30	1,220 (34)	33
Nonprofit	566 (14)	5	515 (14)	5
Religious	107 (3)	1	93 (3)	1
Union	526 (13)	6	492 (14)	8
<b>Total (100%)</b>	<b>3,939</b>		<b>3,607</b>	

Source: GAO analysis of CMS data.

<sup>a</sup>Data on the characteristics of sponsors that were approved for the RDS for 2006 are based on all complete applications that were accepted by CMS for the RDS as of September 11, 2006.

<sup>b</sup>Preliminary data on the characteristics of sponsors that were approved for the RDS for 2007 are based on all complete applications that were accepted by CMS for the RDS as of February 16, 2007.

<sup>c</sup>Sponsor types are self-reported on the RDS application using the categories listed in the table.

<sup>d</sup>Percentages do not add to 100 because of rounding.

<sup>e</sup>This percentage is based on the number of retirees covered by plans whose sponsors were approved for the RDS. We only report percentages of retirees because CMS data by sponsor type double counts certain types of retirees, such as those who have duplicate coverage and those who switch plans midyear. CMS did not provide a unique number of retirees linked to the number of sponsors that were approved for the RDS for plans ending in 2006 and 2007. According to CMS officials, the RDS program has no current business or operational need to calculate the unique number of retirees linked to the number of sponsors that were approved for the RDS for plans ending in 2006 and 2007 and therefore CMS has not expended the RDS system development resources it has to code its system to allow for this calculation.

### Smaller Percentages of Sponsors Reported Selecting MMA Options Other than the RDS

All of the surveys we reviewed reported much smaller percentages of sponsors taking MMA options other than the RDS for 2006. In these surveys, the percentage of sponsors that reported offering supplemental, or “wrap-around,” prescription drug coverage in 2006 ranged from 0 to 13 percent. For example, the Mercer survey of private and public employers that offered retiree health benefits and had 500 or more employees reported that 13 percent offered supplemental coverage in 2006. Similarly, among the surveys we reviewed, the percentage of sponsors that reported contracting with a PDP or MA-PD plan ranged from 3 percent to 7 percent. For example, the Kaiser/Hewitt survey reported that 3 percent of surveyed private sector employers that offered retiree health benefits and had 1,000 or more employees contracted with a PDP or MA-PD plan in 2006. In addition, CMS reported that few sponsors applied to offer their own PDP or MA-PD plan for 2006 and 2007. Specifically, CMS

---

reported that for the 2006 and 2007 contract years, there were 10 approved sponsors that offered their own PDP and none that offered their own MA-PD plan.

---

## Sponsors Considered a Variety of Factors When Selecting MMA Prescription Drug Coverage Options

Public and private sponsors we interviewed reported considering a variety of factors when selecting MMA prescription drug coverage options. Sponsors cited factors such as whether they could offer the same retiree health benefits they offered prior to the MMA, their ability to save on costs, the ease of explaining the option to retirees, the administrative requirements associated with each option, and the extent of information available on the options. When making decisions about which, if any, MMA option to pursue, public sponsors we interviewed were affected by some factors that private sponsors did not face.

---

## Sponsors Considered Ability to Offer the Same Retiree Health Benefits

Sponsors we interviewed told us that when selecting an MMA prescription drug coverage option, they considered the extent to which they would be able to continue to offer the same retiree health benefits they had offered before implementing the MMA option. In general, in order to implement most MMA options other than the RDS, sponsors would likely have to change the prescription drug benefits they offer. For example, sponsors that offer their own PDP or MA-PD plan must generally meet all CMS requirements for Part D plans,<sup>34</sup> such as including specific categories of prescription drugs on their formularies.<sup>35</sup> One sponsor we interviewed also told us that it did not consider the option of paying Part D premiums because that option alone would result in a reduction in the level of prescription drug coverage offered to retirees, compared with coverage

---

<sup>34</sup>CMS has issued guidance for multiple MMA options to waive or modify Part D requirements added by the MMA that hinder the design of, the offering of, or the enrollment in an employer- or union-sponsored Part D retiree plan (including a PDP or MA-PD plan). For example, sponsors that contract with CMS to offer their own PDP or MA-PD plan can limit coverage to retirees only, while other Part D plans must offer coverage to all individuals who reside in one or more specified regions. According to CMS, the guidance was needed to ensure that certain MMA options, such as a sponsor's option to contract with or offer its own PDP, are viable options for sponsors seeking to retain high-quality retiree coverage.

<sup>35</sup>A formulary is a preferred list of drug products that typically limits the number of drugs available within a therapeutic class for purposes of drug purchasing, dispensing, reimbursement, or for all three purposes. According to CMS, the Part D formulary must include at least two drugs in each approved drug category and class (unless only one drug is available for a particular category or class), regardless of the classification system used.

---

offered through the sponsor. In contrast, sponsors that select the RDS option are able to offer the same retiree health benefits they offered prior to the MMA, as long as a sponsor's coverage remains at least as generous as the standard Part D benefit, thus meeting the actuarial equivalence standard to qualify for the RDS.<sup>36</sup> In addition, the final rule implementing the MMA prescription drug benefit that was published in January 2005 gave sponsors flexibility in terms of how they could meet the actuarial equivalence standard.<sup>37</sup> Some of the sponsors and experts we interviewed credited this flexibility with allowing sponsors to meet actuarial equivalence without having to change the retiree health benefits they offered. For example, one sponsor told us that it was able to combine multiple benefit options to meet actuarial equivalence, which allowed the sponsor to collect the RDS for most retirees—including those paying the full cost of their coverage—without making changes to the benefits offered. Prior to the final rule, this sponsor did not plan on collecting the RDS for the group of retirees paying the full cost of coverage because the coverage would not have met the actuarial equivalence standard on its own. Most sponsors we interviewed told us that the ability to offer the same retiree health benefits they offered prior to the MMA was an advantage of the RDS. In addition, experts we interviewed reported that some sponsors are unable to change the benefits they offer in the short

---

<sup>36</sup>According to a 2005 Kaiser/Hewitt survey on retiree health benefits, 94 percent of surveyed employers indicated that their 2005 benefits had an actuarial value that was equal to or greater than the standard Medicare prescription drug benefit for 2006. See Frank McArdle, Amy Atchison, and Dale Yamamoto, Hewitt Associates; and Michelle Kitchman Strollo and Tricia Neuman, The Kaiser Family Foundation, *Prospects for Retiree Health Benefits as Medicare Prescription Drug Coverage Begins: Findings from the Kaiser/Hewitt 2005 Survey on Retiree Health Benefits* (Menlo Park, Calif.: The Henry J. Kaiser Family Foundation; Lincolnshire, Ill.: Hewitt Associates, December 2005).

<sup>37</sup>As we stated earlier, each health benefit option offered by sponsors has to pass both a gross and a net value test to meet actuarial equivalence. The final rule gave sponsors with multiple benefit options the ability to aggregate benefit options to pass the net test or to pass the net test separately for each benefit option. 70 Fed. Reg. 4194, 4579 (Jan. 28, 2005) (codified at 42 C.F.R. §884 (d)(5)(iv)). As a result, sponsors that have benefit options that would not be able to meet the actuarial equivalence standard on their own can aggregate these options with other benefit options that are more generous than the standard Part D benefit, which may allow sponsors to collect the RDS for all of the options. In addition, sponsors that include both medical and drug coverage and have a single premium for this coverage have the discretion and flexibility to allocate a portion of the premium to the drug coverage for the purpose of the net value test of actuarial attestation. 70 Fed. Reg. 4579 (codified at 42 C.F.R. §884 (d)(ii)(B)). For example, a sponsor of an integrated medical and drug plan that has a premium of \$30 can attribute a small portion of that amount to drug coverage when it does the calculations for the net value test. Experts we interviewed told us that this flexibility was helpful to sponsors in meeting the actuarial equivalence standard.

---

term because union contracts prevent them from doing so, thus making the RDS the only MMA option for which they likely would qualify.

---

### Sponsors Considered Their Ability to Save on Costs

Sponsors reported that when selecting an MMA option, they considered how the various options would affect their ability to save on costs. While all of the MMA prescription drug coverage options may provide sponsors with an opportunity for cost savings, the amount of savings may vary based on a sponsor's tax status. For example, in guidance to employers, CMS estimated that the average cost savings to a sponsor that offers its own PDP or MA-PD plan for 2006 would be close to \$900 per participating retiree, and the average tax-free payment for sponsors that took the RDS would be \$668 per participating retiree. Because RDS payments are tax-exempt, CMS estimates indicate that the relative value of savings from the RDS as compared with savings from offering a PDP or MA-PD plan would be greater for private, tax-paying sponsors than it would be for public, non-tax-paying sponsors.

In addition, some sponsors said they considered the trade-off between the cost savings associated with the different MMA options and the effect the options would have on the prescription drug benefits sponsors would be able to offer. For example, depending on their tax status, some sponsors might save more money by taking the RDS, while others might save more by offering or contracting with a PDP or MA-PD plan. However, as previously discussed, while most MMA options likely require a change of benefits, the RDS allows sponsors to continue offering the benefits they offered prior to the implementation of the MMA as long as the benefit is at least actuarially equivalent to the Part D benefit. In one case, a sponsor we interviewed reported that it chose the RDS, even though the sponsor could have reduced costs by choosing one of the other MMA options. As one expert explained, the RDS allows sponsors to save money without significantly changing their retiree health plans.

---

### Sponsors Considered the Ease of Explaining MMA Options to Retirees

Sponsors also reported considering how easy it would be to explain an option to retirees. In particular, sponsors we interviewed told us that they considered how benefit changes made as a result of implementing the various MMA options would complicate communications with retirees. For example, one sponsor we interviewed indicated that a disadvantage of some MMA options was that they would require a great effort to communicate changes to retirees, who range in age from 50 to 105 and who might find benefit changes difficult to understand. Conversely, sponsors that take the RDS are able to preserve their benefit structure and

---

may find it easier to communicate this option to retirees, according to CMS.

In addition, depending on the option they choose, sponsors have to meet different MMA requirements for communicating information about the options to retirees. For example, sponsors that take the RDS are required to explain how their prescription drug coverage compares to the Medicare Part D benefit.<sup>38</sup> In contrast, sponsors that offer their own PDP or MA-PD plan are required to meet more strict CMS communication requirements on Part D plans—such as developing and sending more detailed information about prescription drug coverage to retirees.<sup>39</sup>

---

### Sponsors Considered the Administrative Requirements Associated with Each MMA Option

According to CMS and the experts and sponsors we interviewed, each option has different administrative requirements—some of which take up a considerable amount of time and resources, so sponsors also considered these requirements when selecting an option. For example, according to CMS, sponsors that offer their own PDP or MA-PD plan are required to calculate “true out-of-pocket” costs<sup>40</sup> and adjust premiums for low-income

---

<sup>38</sup>With certain exceptions, sponsors that provide prescription drug coverage to Medicare Part D-eligible individuals must disclose to retirees whether the coverage is or is not “creditable prescription drug coverage” (i.e., the coverage would be able to pass the gross benefit test used in calculating actuarial equivalence).

<sup>39</sup>Among other CMS communication requirements, sponsors that offer their own PDP or MA-PD plan are required to send retirees certain marketing-related communications, such as the Annual Notice of Change, Summary of Benefits, and Evidence of Coverage. The Annual Notice of Change explains changes that a PDP or MA-PD plan has made to its coverage from the previous year. The Summary of Benefits provides benefit design details. The Evidence of Coverage explains the rights, benefits, and responsibilities of plan members.

<sup>40</sup>Part D enrollees with standard coverage must have \$3,850 in true out-of-pocket costs in 2007 before Part D catastrophic coverage begins. True out-of-pocket costs include only those payments made by the individual; made by another person (which may include another family member, individual, corporation, or charity) on behalf of the individual; made on behalf of the individual under the low-income subsidy provisions; or made under a state pharmaceutical assistance program. Payments by insurance, a group health plan, a government-funded health program, or other third-party payment arrangement, such as those from employers and other retiree health benefit sponsors, do not count toward this limit.

---

retirees,<sup>41</sup> among other administrative requirements. One sponsor we interviewed that offered its own PDP for 2006 indicated that it took 11 full-time employees and 13 part-time employees over 15,000 hours to implement the PDP.<sup>42</sup> Conversely, according to CMS, sponsors that take the RDS are not required to calculate true out-of-pocket costs, adjust premiums for low-income retirees, or meet many of the other administrative requirements required of other options. Some sponsors we interviewed told us that the RDS would be administratively easy or easier than other MMA options, although many reported some first-year implementation issues, such as issues in submitting a list of eligible retirees to CMS, which made administration of the RDS more difficult than originally anticipated.<sup>43</sup>

---

<sup>41</sup>Sponsors that contract with or become a PDP or MA-PD are required to adjust premiums for retirees eligible for the low-income subsidy. For most beneficiaries entitled to the low-income subsidy, CMS pays the beneficiary's premium (up to the low-income premium subsidy amount). CMS requires that the low-income premium subsidy first be used to reduce the portion of the monthly beneficiary premium paid for by the beneficiary, with any remainder then used to reduce the employer's premium contribution. For example, if, under the terms of the retiree plan, the beneficiary is responsible for paying \$20 of a \$40 monthly premium with the employer paying the remaining \$20, a monthly low-income premium subsidy of \$35 would be used first to reduce the beneficiary's liability to \$0 and then to reduce the employer's liability from \$20 to \$5.

<sup>42</sup>This sponsor told us that these additional resources were needed to address a number of issues related to offering its own PDP, such as researching and keeping up with CMS guidance in a timely manner. This sponsor, however, also said that most of the issues had been resolved for 2007.

<sup>43</sup>For example, sponsors applying for the RDS must submit a retiree file to CMS that contains data about the retirees for whom a sponsor has applied for the subsidy and that CMS uses to determine whether the submitted retirees are eligible for the subsidy. Several sponsors we interviewed told us they experienced difficulties when they submitted the retiree file, such as having some of their submitted retirees rejected by CMS without an explanation for why this occurred. According to one sponsor, retirees were rejected for reasons such as an incorrect Social Security number or a name misspelling, and it was the responsibility of the sponsor to determine why the retirees were rejected. Another sponsor we interviewed had difficulty with the online application, indicating that it was slow and nonintuitive. Several of the sponsors we interviewed expected that these implementation issues would be fixed by the second year of the RDS. Other RDS-related administrative issues, such as difficulties in determining whether a drug should be submitted for reimbursement under Medicare Part B or Medicare Part D, may be longer lasting. According to the 2006 Kaiser/Hewitt survey, the operational and administrative issues associated with the RDS were among the reasons some employers cited for not planning to take the RDS in the future.



---

## Sponsors Considered the Extent of Available Information Regarding MMA Options

Sponsors also reported that the extent of available information regarding the MMA options at the time they needed to make decisions was a factor they considered in selecting an option. CMS did not approve PDP and MA-PD plans until September 2005—the same month in which sponsors had to apply for the RDS for plans ending in 2006.<sup>44</sup> Some sponsors we interviewed reported that they did not have enough information about the PDP and MA-PD plan options at the time they had to make their decision for 2006. For example, one sponsor we interviewed that took the RDS told us that there were too many unknowns at the time it had to make its decision for 2006 and that if the sponsor wanted to make changes to its retiree health benefits, it would need to provide a transition period for retirees in order to prepare them for plan changes. In addition, according to the 2005 Mercer survey, the timing of the plan and rate information available from health plans in the Medicare market was a key factor that led many employers to seek the RDS or to delay taking any action for 2006.

When selecting an option for 2007, sponsors we interviewed continued to have concerns about the extent of the information available about the PDP and MA-PD plans. For example, one sponsor we interviewed told us that while there was better information available when it had to make its decision for 2007 compared with 2006, the sponsor still did not have a full year's worth of data on PDPs when it had to make its decision. As the markets for PDPs and MA-PD plans mature and more detailed information becomes available, the availability of information on the various MMA prescription drug coverage options may become less of a factor in future years. According to one expert we interviewed, when employers are making their decisions for 2008, there should be a full year of information on the MMA prescription drug coverage options so that sponsors will be able to make more fully informed decisions.

---

## Public Sponsors May Have to Consider Unique Factors

When making decisions about which, if any, MMA option to pursue, public sponsors may have to consider some factors that private sponsors do not. For example, some public sponsors may be influenced at the state level to

---

<sup>44</sup>After CMS published its final rule implementing the MMA prescription drug benefit, in January 2005, the various companies that planned to issue private PDPs began to assess the feasibility of entering the market and what products they should offer, but most of these companies focused on signing up individual beneficiaries for Part D rather than on developing the alternative employer options created by the MMA, such as contracting with employers to offer a PDP or MA-PD plan. See Dale H. Yamamoto, "What Comes After the Retiree Drug Subsidy?" *Benefits Quarterly*, vol. 22, no. 3 (2006).

---

either offer health insurance or choose a certain MMA option. One public sponsor we interviewed was directed by the budget committee of its state legislature to take the RDS in 2007 even though the sponsor—a state retirement system—had concluded that contracting with a PDP would allow the sponsor to decrease premiums for the state, contracting agencies, and some enrollees; decrease prescription drug copayments for enrollees; or both. As we stated earlier in this report, CMS estimates indicate that the relative value of savings from the tax-free RDS, as compared with savings from offering a PDP or MA-PD plan, for example, would be greater for private, tax-paying sponsors than it would be for public, non-tax-paying sponsors. In addition, OPM, which administers FEHBP, opted to continue offering prescription drug coverage to retirees without taking the RDS or any of the other MMA options. We reported previously that OPM officials told us OPM did not apply for the RDS for FEHBP because they said the intent of the RDS was to encourage sponsors to continue offering prescription drug coverage to enrolled Medicare beneficiaries, which all FEHBP plans were already doing.<sup>45</sup> As such, OPM officials told us, the government would be subsidizing itself to provide coverage for prescription drugs to Medicare-eligible federal employees and retirees.

---

<sup>45</sup>In a recent report, we discussed the potential effect of the RDS on FEHBP premiums. Specifically, we reported that “plan officials differed on whether the subsidy would have affected growth in FEHBP premiums in 2006 had OPM applied for the subsidy and used it to mitigate premium growth. Most plan officials we interviewed stated that the subsidy would have had a small effect on premium growth. Officials from two large plans with higher-than-average shares of retirees stated that the subsidy would have lowered their plans’ premium growth—officials from one plan claimed by at least 3.5 to 4 percentage points for their plan. We estimated that the subsidy would have lowered the growth in premiums across all FEHBP plans for 2006 by more than 2 percentage points on average, from 6.4 percent to about 4 percent.” See GAO, *Federal Employees Health Benefits Program: Premium Growth Has Recently Slowed, and Varies among Participating Plans*, [GAO-07-141](#) (Washington, D.C.: Dec. 22, 2006).

---

---

## In the Short Term, Sponsors' Decisions Regarding MMA Options Resulted in Benefits Remaining Relatively Unchanged, but over the Longer Term the Effect Is Unclear

Sponsors' decisions regarding the various MMA options appear to have resulted in the provision of retiree health benefits remaining relatively unchanged in the short term, although the effect over the longer term on the provision of health benefits to retirees is unclear. The short-term effect of sponsors' decisions appears to have resulted in benefits remaining relatively unchanged, in part because the majority of sponsors continued to offer prescription drug benefits and accepted the RDS during the first 2 years this option was offered. In addition, according to the 2005 Mercer survey, 72 percent of employers with 500 or more employees reported that the MMA options would have no effect on their ability to provide retiree health coverage. Similarly, many sponsors we interviewed told us that they did not make changes to their retiree health benefits—including decreasing coverage—in direct response to the MMA. Only one of the sponsors we interviewed that selected the RDS for 2006 reported making any changes to its benefits to meet the RDS actuarial equivalence standard. This sponsor told us it eliminated one of its plans that did not meet CMS's actuarial equivalence standard for the RDS, but the sponsor said it moved all affected Medicare-eligible retirees into coverage that did qualify for the RDS. In addition, some sponsors we interviewed told us that they shared part of the subsidy they received from accepting the RDS with retirees by reducing retiree premiums. Furthermore, the 2005 Mercer survey reported that only 3 percent of employers with 500 or more employees indicated they were likely to terminate drug coverage for Medicare-eligible retirees—rather than choosing one of the MMA options—in response to the availability of the Part D prescription drug benefit.

While, in the short term, sponsors' decisions regarding the MMA options resulted in benefits remaining relatively unchanged, the effect over the longer term of sponsors' decisions on the provision of employment-based retiree health benefits is unclear. Experts we interviewed differed in their assessments of what the effect is likely to be over the longer term. In particular, some experts we interviewed indicated that the MMA may extend the amount of time that sponsors offer benefits without reducing coverage. Furthermore, one sponsor we interviewed indicated that the RDS increased the number of years that its retiree health benefits program would be solvent. On the other hand, other experts said that it was possible that the availability of the Medicare Part D benefit may make it more likely that sponsors will stop offering prescription drug benefits for retirees. Nearly all experts we interviewed told us that it was unlikely that an employer or other potential sponsor that did not offer retiree prescription drug coverage prior to the MMA would begin sponsoring these benefits in response to the new options resulting from the MMA.

---

According to experts, employers are not planning to improve or expand retiree health coverage and do not want the additional financial liability of providing these benefits.

Furthermore, it is unclear to what extent sponsors will continue to select the same MMA option in the future. For example, the 2006 Kaiser/Hewitt survey reported that of those respondents that accepted the RDS for 2006, only 54 percent said they were very or somewhat likely to accept the RDS for 2010. Furthermore, 25 percent said they did not know whether they would accept the RDS for 2010. Most of the sponsors that we interviewed that took the RDS for 2006 and planned to take the RDS for 2007 said they were unsure which option they would be taking for 2008. The 2006 Kaiser/Hewitt survey also reported that employers that are unlikely to take the RDS in the future are considering a number of other MMA options, including contracting with a PDP to offer enhanced coverage.<sup>46</sup> To the extent that sponsors that have accepted the RDS select other MMA options in subsequent years, sponsors' provision of retiree health benefits may change.

In addition to the MMA options, a host of other long-standing factors may affect a sponsor's provision of health benefits to retirees. These include the existence of union contracts that may require the provision of certain health benefits, increasing costs for health care, the degree of industry competition, and the strength of sponsors' financial conditions. For example, in 2005 we reported that sponsors that negotiated retiree health benefits with unions might not have as much flexibility to change these benefits prior to negotiations.<sup>47</sup> Sponsors we interviewed also cited the competitiveness of the industry as another factor that affected retiree

---

<sup>46</sup>Sponsors we interviewed told us that they were considering alternative options other than the RDS for the future, such as offering MA-PD plans—which may have lower premiums than sponsors' current plans. Some sponsors also told us they may be forced to move away from the RDS in the future because limits on their contributions to retiree health plans jeopardize their ability to meet CMS's actuarial equivalence standard for the RDS. For public sponsors, experts we interviewed told us that requirements published in June 2006 by the Governmental Accounting Standards Board (GASB) that limit the ability of public sector sponsors to account for future RDS payments on their financial statements may affect the long-term MMA options selected by public sponsors. See GASB Technical Bulletin No. 2006-1, *Accounting and Financial Reporting by Employers for Payments from the Federal Government Pursuant to the Retiree Drug Subsidy Provisions of Medicare Part D* (Norwalk, Conn.: GASB, June 30, 2006).

<sup>47</sup>[GAO-05-205](#).

---

coverage, with one sponsor stating that it strove to have benefit packages that were in line with the overall market as well as the specific industry.

---

## Agency and Other External Comments

We provided a draft of this report to CMS and experts on retiree health benefits at the Employee Benefit Research Institute, Hewitt Associates, Mercer Health & Benefits, and the National Opinion Research Center.<sup>48</sup>

In its written comments on a draft of this report, CMS stated that the report provided an excellent summary of available information concerning the choices sponsors made among MMA options. (CMS's comments are included in app. IV.)

CMS agreed with the finding that the majority of sponsors reported continuing to offer prescription drug coverage and accepting the RDS for 2006, with smaller percentages of sponsors reporting selecting other MMA options. In commenting on the draft report's identification of several factors that may have contributed to the differences in the surveys' reported percentages of employers accepting the RDS for 2006, CMS suggested an additional factor that may have contributed to the differences in the survey finding. Specifically, CMS said that some of the surveys reported what sponsors said they intended to do or were considering doing at the time of the survey, and it was possible that a portion ultimately decided not to pursue those options. However, both the 2006 Kaiser/Hewitt survey—which reported that 82 percent of surveyed employers accepted the RDS for 2006—and the 2006 Mercer survey—which reported that 51 percent of surveyed employers accepted the RDS for 2006—were reporting decisions surveyed employers said they had already made, not what they planned to do. Therefore, it is not likely this factor would explain the difference in the survey results. CMS also agreed with the draft report's related finding regarding the number of sponsors participating in the RDS program. CMS suggested that we identify the 2007 data as preliminary, since it was compiled in February. We have made this clarification to the final report.

CMS stated that it agreed with the report's second finding, that sponsors considered a variety of factors when selecting which MMA prescription drug coverage options to pursue, with one clarification. The draft report

---

<sup>48</sup>The researcher with the National Opinion Research Center who reviewed our report is also an author of the 2006 Kaiser/HRET survey.

---

stated that, in general, in order to implement most MMA options other than the RDS, sponsors would likely have to change the prescription drug benefits they offer. CMS stated that the report did not fully acknowledge that CMS has used its statutory waiver authority for several MMA options to afford flexibility in benefit design, and as a result, MMA options may require minimal (if any) adjustments to premiums, cost-sharing, and other primary elements of benefit design. The draft report did describe CMS's authority to waive or modify Part D requirements added by the MMA that hinder the design of, offering of, or enrollment in certain employer- or union-sponsored Part D retiree plans. In response to CMS's comments, we have included additional information clarifying that CMS has waived or modified Part D requirements for multiple MMA options. However, while CMS has used this waiver authority, our report notes that sponsors may still need to make changes to benefits—such as changing the drugs included on their formularies—and, according to sponsors we interviewed, any changes to benefits can complicate communications with retirees.

CMS also agreed with the draft report's finding that in the short term sponsors' decisions regarding MMA options resulted in benefits remaining relatively unchanged, but over the longer term the effect is unclear. However, CMS stated that the examples of differing experts' assessments of the likely effect over the longer term lacked sufficient context to be included in the findings. CMS also stated that there was no indication in the finding of the preponderance of expert opinion in favor of one or the other point of view. Our report states that the effect over the longer term is unclear and that experts we interviewed differed in their assessments of what the effect was likely to be. The report describes both the opinions of experts who said the MMA may extend the amount of time that sponsors offer benefits without reducing coverage and those who said the Medicare Part D benefit may make it more likely that sponsors will stop offering prescription drug benefits for retirees, and there was not a preponderance of opinion for either perspective.

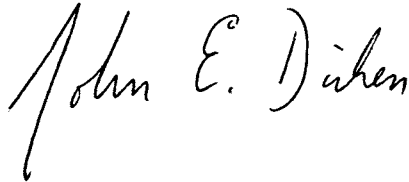
The experts who reviewed the draft report generally indicated that the report provided an accurate portrayal of employment-based retiree health benefits and sponsors' decisions about the options available under the MMA.

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

---

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

If you or your staffs have any questions about this report, please contact me at (202) 512-7119 or [dickenj@gao.gov](mailto:dickenj@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix V.

A handwritten signature in black ink that reads "John E. Dicken". The signature is written in a cursive style with a large initial 'J' and 'D'.

John E. Dicken  
Director, Health Care

---

*List of Committees*

The Honorable Max Baucus  
Chairman

The Honorable Charles E. Grassley  
Ranking Member  
Committee on Finance  
United States Senate

The Honorable Edward M. Kennedy  
Chairman

The Honorable Michael B. Enzi  
Ranking Member  
Committee on Health, Education, Labor, and Pensions  
United States Senate

The Honorable George Miller  
Chairman

The Honorable Howard P. "Buck" McKeon  
Ranking Member  
Committee on Education and Labor  
House of Representatives

The Honorable John D. Dingell  
Chairman

The Honorable Joe Barton  
Ranking Member  
Committee on Energy and Commerce  
House of Representatives

The Honorable Charles B. Rangel  
Chairman

The Honorable Jim McCrery  
Ranking Member  
Committee on Ways and Means  
House of Representatives



---

# Appendix I: Information on Employment-Based Retiree Health Coverage, Updated since GAO's 2005 Report

---

This appendix describes information on employment-based retiree health coverage since the initial mandated GAO study, published in 2005.<sup>1</sup> We reported in 2005 that the long-term decline in employment-based retiree health coverage had leveled off, and retirees were paying an increasing share of the costs. We reported that the percentage of employers offering health benefits to retirees, including those who are Medicare-eligible, had decreased beginning in the early 1990s, but had leveled off by the early 2000s. This leveling off has continued since the initial mandated study. We also reported in 2005 that the percentage of Medicare-eligible retirees aged 65 and older with employment-based coverage remained relatively consistent from 1995 through 2003. Since issuance of our 2005 report, we received data for 2004 and 2005 showing that the overall percentage remained relatively consistent from 2003 through 2005 at about 31 percent, although some modest changes occurred within specific age cohorts. Sponsors continued to respond to increasing costs by implementing strategies that required retirees to pay more for coverage and thus contributed to a gradual erosion of the value and availability of benefits. For example, one employer benefit survey reported that over half of surveyed employers reported increases in retiree contributions to premiums between 2005 and 2006.

---

## Employer Benefit Surveys Showed a Decline, then a Leveling Off, in Share of Employers Offering Health Benefits to Retirees; New Data Showed Continuation of Leveling-Off Trend

According to surveys of sponsors of retiree health benefits, the percentage of employers offering health benefits to retirees declined beginning in the early 1990s and then remained relatively stable by the early 2000s through 2005. In our 2005 report, we reported that a series of surveys conducted by Mercer Human Resource Consulting indicated that the percentage of employers with 500 or more employees offering health insurance to retirees who are eligible for Medicare<sup>2</sup> declined from 1993 to 2001, although this decline had leveled off from 2001 through 2004. Data obtained after the publication of our 2005 report showed that this leveling-off trend continued, with approximately 29 percent of employers with 500 or more employees offering the benefits to Medicare-eligible retirees in 2006.<sup>3</sup> (See fig. 1.)

---

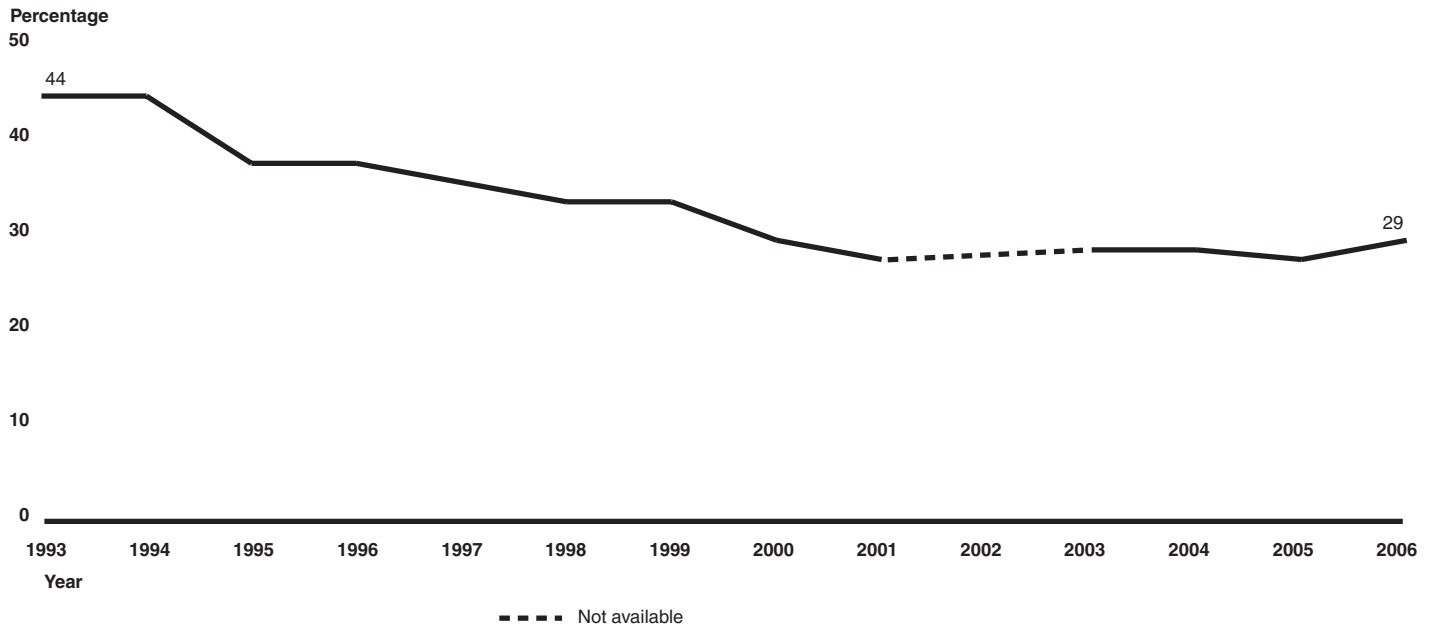
<sup>1</sup>See GAO, *Retiree Health Benefits: Options for Employment-Based Prescription Drug Benefits under the Medicare Modernization Act*, [GAO-05-205](#) (Washington, D.C.: Feb. 14, 2005).

<sup>2</sup>Medicare-eligible generally refers to retirees aged 65 and over.

<sup>3</sup>See Mercer Health & Benefits, *National Survey of Employer-Sponsored Health Plans: 2006 Survey Report* (New York, N.Y.: Mercer Health & Benefits, LLC, 2007). Mercer Health & Benefits is a business of Mercer Human Resource Consulting.

**Appendix I: Information on Employment-Based Retiree Health Coverage, Updated since GAO's 2005 Report**

**Figure 1: Mercer Survey Results—Percentage of Employers with 500 or More Employees Offering Health Benefits to Medicare-Eligible Retirees, 1993–2006**



Sources: GAO analysis of Mercer Health & Benefits; Mercer Human Resource Consulting; William M. Mercer, Incorporated; and Foster Higgins data.

Note: Based on employer benefit surveys from 1993 through 2006. 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.

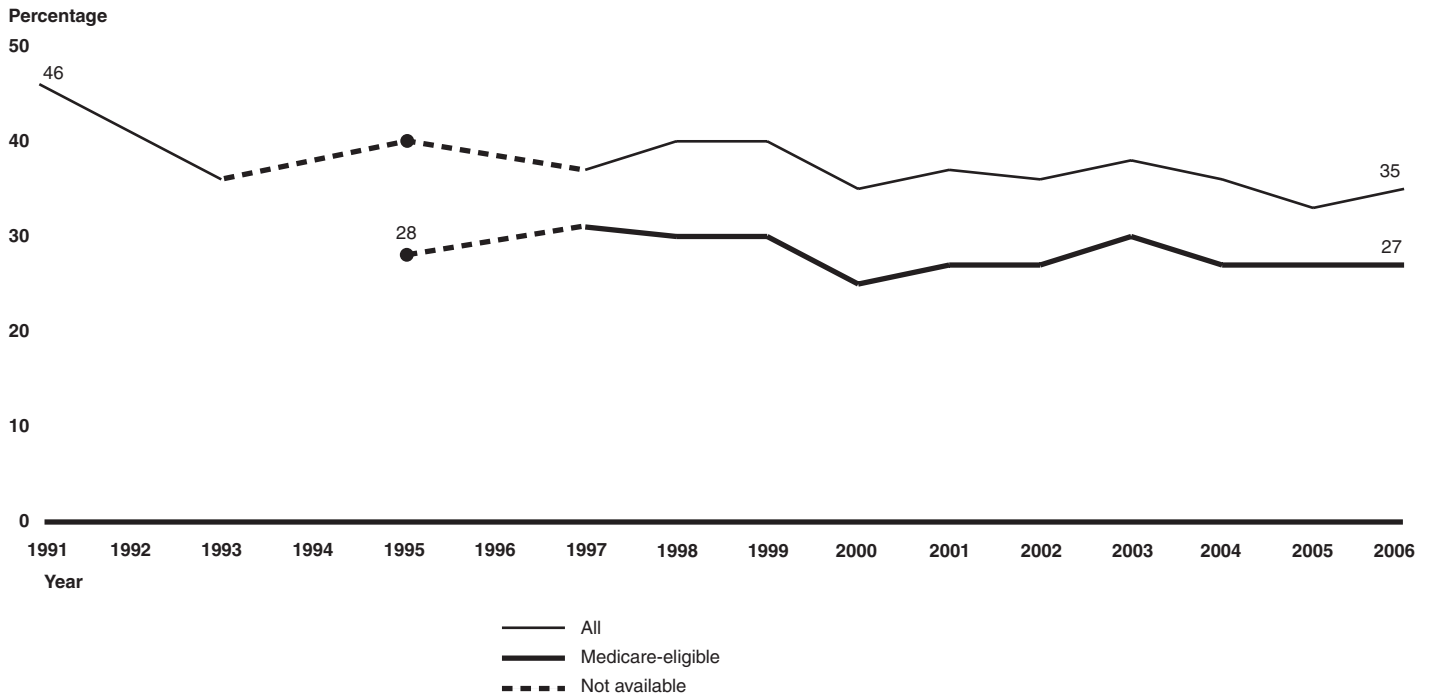
We also reported in our 2005 report that a series of surveys conducted by the Kaiser Family Foundation and Health Research and Educational Trust (HRET) estimated that the percentage of employers with 200 or more employees offering retiree health coverage decreased from 46 percent in 1991 to 36 percent in 1993. This decline leveled off from 1993 through 2004, with approximately 36 percent of employers with 200 or more employees offering coverage to these groups in 2004.<sup>4</sup> Data obtained after our 2005 report showed that this trend continued. According to the Kaiser/HRET survey, approximately 33 percent and 35 percent of employers with 200 or more employees offered retiree health benefits in 2005 and 2006, respectively. For Medicare-eligible retirees specifically, the percentage of employers reporting that they offered health benefits to this group has generally not changed since our 2005 report, in which we reported that 27 percent of employers with 200 or more employees offered coverage, according to Kaiser/HRET. (See fig. 2.)

---

<sup>4</sup>Gary Claxton and others, Kaiser Family Foundation; Samantha Hawkins, HRET; and Jeremy Pickreign, Heidi Whitmore, and Jon Gabel, Center for Studying Health System Change, *Employer Health Benefits: 2006 Annual Survey* (Menlo Park, Calif.: The Henry J. Kaiser Family Foundation; Chicago, Ill.: HRET, 2006).

**Appendix I: Information on Employment-Based Retiree Health Coverage, Updated since GAO's 2005 Report**

**Figure 2: Kaiser/HRET Survey Results—Percentage of Employers with 200 or More Employees Offering Health Benefits to All Retirees and to Medicare-Eligible Retirees, 1991–2006**



Sources: GAO analysis of Kaiser/HRET and KPMG Peat Marwick data.

Notes: Based on KPMG Peat Marwick surveys from 1991 through 1998 and Kaiser/HRET surveys from 1999 through 2006. 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.

For retirees under age 65, we reported in our 2005 report that coverage showed a steady decline from 1993, when 50 percent of employers with 500 or more employees offered coverage to this group of retirees, to 2001, although this percentage generally leveled off from 2001 through 2004.<sup>5</sup> New data reported by Mercer showed that 39 percent of employers with 500 or more employees offered coverage to these retirees in 2006.

The survey data we reviewed for our current report indicated that some types of employers are more likely to provide health benefits to retirees than others. Data on retiree health coverage showed that larger employers, for example, are more likely than smaller employers to offer coverage to retirees, including Medicare-eligible retirees. The 2006 Mercer survey reported that 56 percent of employers with 20,000 or more employees offered coverage to Medicare-eligible retirees, compared with about 22 percent of employers with 500 to 999 employees. The 2006 Kaiser/HRET survey also showed that 54 percent of employers with 5,000 or more employees offered health benefits to retirees, while 35 percent of employers with 200 or more employees offered health benefits to retirees. For smaller employers in the Kaiser/HRET survey—those with 3 to 199 employees—approximately 9 percent offered retiree health benefits. These data are similar to the data reported in our 2005 report, although the percentage of employers with 5,000 or more employees offering health benefits to retirees is slightly lower than in previous surveys.

In addition, employers with a union presence continued to be more likely to offer retiree health coverage than employers without a union presence. For example, in the 2006 Kaiser/HRET survey, among employers with 200 or more employees, 50 percent of those employers that had union employees offered health coverage to retirees, compared with 27 percent without union employees.

According to federal and employer benefit surveys, certain industries continued to be more likely to offer retiree health coverage than others. For example, the most recent Agency for Healthcare Research and Quality's Medical Expenditure Panel Survey (MEPS) data showed that approximately 88 percent of state entities offered health insurance for retirees aged 65 and older.<sup>6</sup> In addition, new data released from Kaiser/HRET in 2006 showed that 82 percent of state and local government

---

<sup>5</sup>Data based on Mercer surveys from 1993 through 2004.

<sup>6</sup>MEPS data are for 2004.

employers with 200 or more employees offered coverage to retirees.<sup>7</sup> Furthermore, these data are similar to the data reported in our 2005 report. Recent data released by Kaiser/HRET continued to list the transportation/communication/utility industry as the second likeliest industry, after government, to offer health benefits to its retirees, with 52 percent of all employers with 200 or more employees in this industry sector offering health benefits to their retirees.<sup>8</sup> This survey also continued to show, as we reported in 2005, that the industries least likely to offer coverage were health care and retail, with 15 percent and 11 percent, respectively, of employers with 200 or more employees in these industry sectors offering retiree health benefits.

---

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

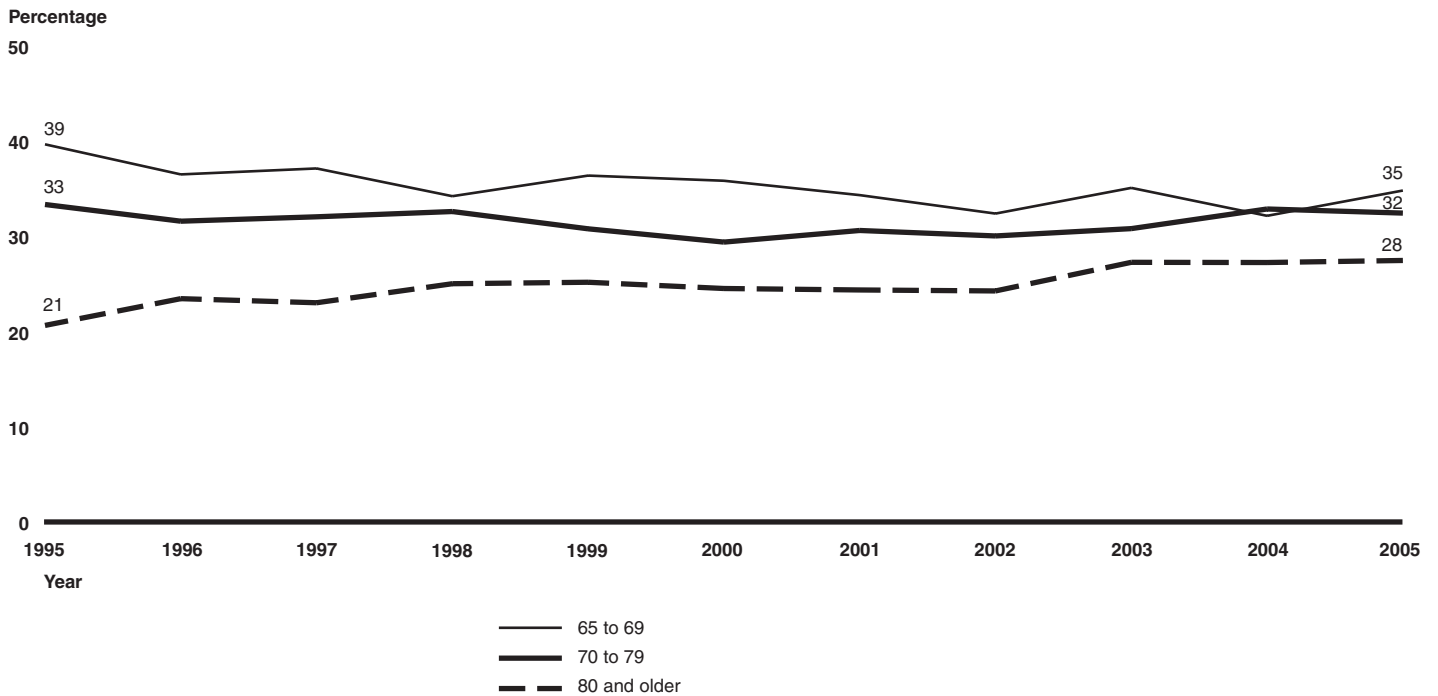
In our 2005 report, we stated that the overall percentage of Medicare-eligible retirees and their insured dependents aged 65 and older obtaining employment-based health benefits through a former employer remained relatively consistent from 1995 through 2003, based on data from the U.S. Census Bureau's Current Population Survey (CPS). Since issuance of that report, we received subsequent data for 2004 and 2005 showing that the overall percentage remained relatively consistent from 2003 through 2005, although some modest changes occurred within specific age cohorts (see fig. 3).

---

<sup>7</sup>As we reported in 2005, there continues to be a concern that standards adopted by the Governmental Accounting Standards Board (GASB) in 2004, which affect the reporting of postretirement benefit obligations, may put new pressures on public sector funding of retiree health care benefits. The 2005 Mercer survey reported that although the GASB changes do not require sponsors to fund health plan liabilities, it is possible that the changes will prompt a decline in coverage in the public sector. GASB Statement No. 43: *Financial Reporting for Postemployment Benefit Plans other than Pension Plans* (Norwalk, Conn.: GASB, April 2004) and GASB Statement No. 45: *Accounting and Financial Reporting by Employers for Postemployment Benefits other than Pensions* (Norwalk, Conn.: GASB, June 2004). The standards are effective in three phases, depending on a public sector entity's total annual revenues. For the largest employers, the effective date for Statements No. 43 and No. 45 began in the first period after December 15, 2005, and December 15, 2006, respectively.

<sup>8</sup>Kaiser/HRET, *Employer Health Benefits: 2006 Annual Survey*.

**Figure 3: Percentage of Medicare-Eligible Retirees and Their Insured Dependents with Employment-Based Health Benefits, by Age Group, 1995–2005**



Source: GAO analysis of CPS data.

Notes: Based on the March CPS Supplement from 1996 through 2002 and the Annual Social and Economic Supplement to the CPS from 2003 through 2006. 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. Differences for ages 65 to 69 and age 80 and older are statistically significant.

As noted in Census Bureau press release dated March 23, 2007, the Census Bureau will be revising the historical health insurance coverage estimates from the CPS due to an identified programming error. According to the Census Bureau, the impact of the required revisions is small—the original and revised estimates for 2004 and 2005 differ by less than 1 percent—and the Census Bureau’s assessment is that the impact of the required revisions is relatively constant from one year to the next.

According to our analysis of CPS data, for those aged 65 and older, approximately 32 percent had coverage in 1995 and approximately 31 percent had coverage in 2005 (no change from last report). Medicare-eligible retirees and their insured dependents for two groups—those aged 65 through 69 and those aged 80 and older—continued to show approximately the same modest decline and increase, respectively, in the percentage with employment-based health coverage. For those aged

70 through 79, the modest decline reported in our initial report was no longer statistically significant.<sup>9</sup>

---

## Employer Strategies Implemented to Mitigate Increased Costs of Providing Coverage Continued to Require Greater Retiree Contribution

According to employer benefit surveys and our interviews with sponsors and experts, sponsors have continued to rely on various strategies, as we noted in our 2005 report, for mitigating the increasing costs of providing health benefits to retirees that have contributed to a gradual erosion of the value and availability of health benefits. These strategies included the same strategies identified in our 2005 report: restricting retirees' eligibility for health benefits; limiting sponsors' contributions to retirees' health benefits; and increasing retirees' copayments, coinsurance, and premiums.

---

## Sponsors Have Limited Retirees' Eligibility for Benefits

Employers participating in the 2006 Kaiser/Hewitt Associates survey reported that between 2005 and 2006 they limited retiree eligibility for health benefits by restricting eligibility to certain groups of retirees and by increasing age, years of service, or both, needed to be eligible for such benefits. For example, according to 2006 Kaiser/Hewitt survey data, 11 percent of employers that currently offer retiree health benefits reported that they would not provide future employer-subsidized health benefits to a particular group of individuals, such as those hired after January 1, 2006, if they retire under the age of 65.<sup>10</sup> Nine percent of the surveyed employers reported that they would not provide future employer-subsidized health benefits to a particular group of individuals if they retire at age 65 or older. In addition, 4 percent of surveyed employers reported that they raised the age requirements, years of service requirements, or both, for retiree health benefit eligibility for retirees under the age of 65, and 2 percent made such changes for retirees at age 65 or older. Similarly, one sponsor we interviewed told us about changes the sponsor had made to coverage for future retirees since our 2005 report. This sponsor told us

---

<sup>9</sup>In our 2005 report, we reported a modest decline for those aged 70 through 79 from 1995 through 2003 (33 percent in 1995; 31 percent in 2003) that was statistically significant. When updated with the 2005 CPS data, the change from 1995 to 2005 was no longer statistically significant.

<sup>10</sup>In the survey, nearly half of the employers that terminated subsidized coverage for future retirees indicated that they provide a form of access-only coverage—where retirees have the option to buy into a health plan at a group rate, but without any financial assistance from a sponsor.



about coverage beginning January 1, 2007, in which future retirees will have the option to receive a lump sum of money that can then be used to purchase coverage in the individual market at the time of retirement.

---

### Sponsors Have Limited Their Contributions to Retirees' Health Benefits

Data from the 2006 Mercer survey showed that 20 percent of employers with 500 or more employees have implemented limits—often referred to as caps—on contributions to retirees' health benefits. The survey data also showed that an additional 8 percent of such employers were considering such caps. Caps were most common among the employers in the Mercer study with the largest number of employees; 47 percent of employers with 20,000 or more employees had implemented caps and 4 percent were considering implementing caps. Data from the 2006 Kaiser/Hewitt survey showed that 50 percent of employers with 1,000 or more employees reported having capped contributions to the health benefits for Medicare-eligible retirees. Of these employers, 61 percent reported hitting the cap and another 20 percent expected to hit the cap within the next 1 to 3 years. One sponsor we interviewed with financial caps in place but not yet reached told us that sponsors generally have two options once they reach these spending limits: (1) negotiate plan design changes to bring spending under the limits or (2) pass costs on to retirees through higher premiums.

---

### Sponsors Have Increased Retirees' Copayments, Coinsurance, and Premiums

More than one-fourth of employers participating in the 2006 Kaiser/Hewitt survey reported that between 2005 and 2006 they increased required out-of-pocket contributions from retirees and increased the use of other cost-sharing strategies. In addition, some of these strategies were intended to address the costs of providing prescription drug coverage to retirees.<sup>11</sup> For example, according to the 2006 Kaiser/Hewitt survey, 25 percent of employers raised copayments or coinsurance for prescription drugs for retirees aged 65 and older, and 10 percent of employers replaced fixed dollar copayments for prescription drugs with coinsurance, which can

---

<sup>11</sup>In 2005 we reported that, according to 2001 Medicare Current Beneficiary Survey (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. See [GAO-05-205](#). In 2004, these costs accounted for 52 percent of all health care expenditures for these beneficiaries, based on MCBS data.

increase retirees' out-of-pocket expenses as the total cost of the benefit rises.<sup>12</sup>

More than one-half of employers in the 2006 Kaiser/Hewitt survey also reported that between 2005 and 2006 they increased retiree contributions to health care premiums for retirees aged 65 and older.<sup>13</sup> However, the survey reported a lower rate of increase in the amount that retirees aged 65 and older contributed to premiums as compared to the amount that retirees under age 65 contributed to premiums, which the survey largely attributed to the Medicare Part D program. Sponsors we interviewed also told us that they had increased retiree premiums to compensate for the trend in increasing health care costs.<sup>14</sup> For example, one public sponsor told us that premiums for its coverage designed for active workers and retirees under the age of 65 increased 9 percent for 2005 and 2006. Finally, according to the 2006 Mercer survey, about 41 percent of retiree health plans for employers with 500 or more employees required Medicare-eligible retirees to pay the full cost of their employment-based health benefits plan.<sup>15</sup>

---

<sup>12</sup>Coinsurance requires beneficiaries to pay a percentage of benefit costs as opposed to a fixed amount, such as a copayment.

<sup>13</sup>In a previous survey, Kaiser/Hewitt also reported how the increase in retiree contributions to premiums compared to the rate of increase for total health care premium costs. In the 2005 Kaiser/Hewitt survey, 42 percent of surveyed employers with 1,000 or more employees increased retiree premiums for retirees aged 65 or older at a rate that was higher than the reported increase in total premium costs, suggesting an increase in the share of premiums these retirees were required to pay. However, the survey researchers noted that this subgroup of employers tended to require retirees to contribute a lower share of premiums than other surveyed employers in that year. Comparable information is not reported in the 2006 Kaiser/Hewitt survey.

<sup>14</sup>Benefit surveys also reported increased health care costs for retirees. The 2006 Kaiser/Hewitt survey reported that the total cost of providing health benefits to all retirees for surveyed employers increased, on average, by an estimated 6.8 percent between 2005 and 2006. Respondents to the 2006 Mercer survey were asked about their retiree costs for both 2005 and 2006, and Mercer used this information to estimate an average annual cost increase of approximately 2.6 percent per Medicare-eligible retiree from 2005 to 2006. Because of the low response rate for this part of the survey, these results are not projectable nationwide and should be viewed only as a general indicator of retiree medical plan cost.

<sup>15</sup>Data reflect retiree contributions for health plans for retiree-only coverage.

---

# Appendix II: Alternative Approaches to Providing Retiree Health Coverage Suggested by Sponsors and Experts

---

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required GAO to describe both (1) alternative approaches to providing employment-based retiree health coverage suggested by retiree health benefit sponsors and (2) recommendations by sponsors and other experts for improving and expanding such coverage. In this appendix we present a range of alternative approaches to providing employment-based retiree health coverage and options for expanding and improving these alternative approaches, as described by retiree health benefit sponsors and experts we interviewed. To obtain this information, we interviewed officials from 15 private and public sponsors of retiree health benefits and several experts on areas relating to the provision of employment-based retiree health coverage, including five benefit consulting firms; six organizations, including one representing unions, one representing multiemployer plans, two representing large employers, and two representing health plans; one professional organization for actuaries; and other research organizations. The alternative approaches we describe are not intended to be a comprehensive list but rather represent the approaches that were mentioned by the sponsors and experts we spoke with.

Many of the alternative approaches to providing employment-based retiree health coverage that were described to us rely on tax advantages that provide an incentive for a sponsor, an employee, or both to set aside funds for future health care needs. Some of these tax-advantaged approaches are made available as part of consumer-directed health plans, which usually consist of a savings account—such as a health savings account (HSA) or health reimbursement arrangement (HRA)—and a health plan with a high deductible. In addition to consumer-directed health plans, there are other tax-advantaged accounts and trusts that do not require enrollment in a high-deductible health plan, such as a voluntary employees' beneficiary association (VEBA). Some sponsors and experts described a third category of arrangement, generally without tax advantages, that assists sponsors in providing retiree health care coverage, such as establishing savings accounts that provide a sponsor's match to the employee's contribution. Although there is no requirement that retiree health benefit sponsors prefund their retiree health benefit plans, many of the approaches sponsors and experts described are prefunded vehicles—wherein the sponsor directly contributes, rather than earmarks, dedicated funds to an account or trust. The alternative approaches these sponsors and experts described are listed in table 2.

**Appendix II: Alternative Approaches to  
Providing Retiree Health Coverage Suggested  
by Sponsors and Experts**

**Table 2: Alternative Approaches to Providing Employment-Based Retiree Health Coverage Described by Sponsors and Experts**

<b>Approach</b>	<b>Funding/tax advantage status</b>	<b>Details</b>
<b>Consumer-directed health plans</b>		
Health savings account (HSA)	Prefunded/tax advantaged	<ul style="list-style-type: none"> <li>Allows limited individual (tax-deductible) or sponsor-based (tax-exempt) contributions; however, Medicare enrollees are not eligible to make contributions.</li> <li>Requires a minimum deductible amount and a maximum limit on enrollee out-of-pocket spending.</li> <li>Allows tax-free withdrawals for qualifying medical expenses.</li> <li>Is portable from job to job.</li> </ul>
Health reimbursement arrangement <sup>a</sup> (HRA)	Not prefunded <sup>b</sup> /tax advantaged	<ul style="list-style-type: none"> <li>Allows sponsors to establish accounts that are not prefunded; however, individuals are not eligible to make contributions.</li> <li>Distributions for medical care expenses are tax-free.</li> <li>Provides that sponsors' credits to an HRA may accumulate tax-free on an annual basis.</li> <li>Places no limit on contributions.</li> <li>Is not required to be portable from job to job.</li> </ul>
Medical savings account (MSA)	Prefunded/tax advantaged	<ul style="list-style-type: none"> <li>Was designed for small businesses (with 50 or fewer employees) and the self-employed.</li> <li>Allows limited individual (tax-deductible) or sponsor-based (tax-exempt) contributions, but not both in the same year.</li> <li>Is portable from job to job.</li> </ul>
<b>Other tax-advantaged arrangements</b>		
Retiree medical account	Not prefunded <sup>b</sup> /tax advantaged	<ul style="list-style-type: none"> <li>Allows sponsors to establish accounts that are not prefunded to track dollars that will be available for an employee to spend on health benefits in retirement.</li> <li>Allows individual contributions on an after-tax basis.</li> <li>Distributions for retiree health benefits are tax-free.</li> <li>Is dedicated exclusively to the use of medical expenses during retirement.</li> </ul>
Voluntary employees' beneficiary association (VEBA)	Prefunded/tax advantaged	<ul style="list-style-type: none"> <li>Employs a trust to fund certain benefit plans.</li> <li>Must be based on voluntary membership.</li> <li>Allows limited sponsor contributions, which are tax-deductible.</li> <li>Allows the tax-free withdrawal of funds by retirees for qualifying health care expenses.</li> </ul>
Section 420 transfer/401(h) subaccount	Prefunded/tax advantaged	<ul style="list-style-type: none"> <li>Permits the transfer of excess pension assets of an overfunded defined benefit plan (the "Section 420 transfer") into a 401(h) subaccount for the payment of retiree health benefits.</li> <li>Has certain restrictions to the subaccount relative to the size and method of the defined benefit plan. Medical benefits, together with life insurance benefits, must be subordinate to the defined plan's retirement benefits.</li> </ul>

**Appendix II: Alternative Approaches to  
Providing Retiree Health Coverage Suggested  
by Sponsors and Experts**

<b>Approach</b>	<b>Funding/tax advantage status</b>	<b>Details</b>
<b>Sponsor/industry arrangements<sup>c</sup></b>		
Employer-sponsored savings account	Prefunded/tax advantaged	<ul style="list-style-type: none"> <li>• Specifies a sponsor-provided match (e.g., dollar-for-dollar) to an employee contribution.</li> <li>• Is available upon retirement to pay for retiree medical premiums.</li> <li>• Earnings and sponsor match are not taxed upon withdrawal.</li> </ul>
Purchasing coalition	Not prefunded/not tax advantaged	<ul style="list-style-type: none"> <li>• Used to increase leverage in the marketplace to gain better prices for both active and retired employees of certain trades.</li> </ul>
Premium reimbursement	Not prefunded/not tax advantaged	<ul style="list-style-type: none"> <li>• Provides capped premium reimbursement to retirees who purchase health care coverage outside of the sponsor's plan.</li> </ul>

Source: GAO interviews with retiree health benefit sponsors and other experts.

<sup>a</sup>Although HRAs are usually combined with a high-deductible health insurance plan, this is not required.

<sup>b</sup>These accounts are generally set up as notional accounts, which means they do not require prefunding, although sponsors may choose to do so.

<sup>c</sup>The details of these arrangements were provided by sponsors and experts we interviewed. The specific details of these arrangements may vary across sponsors.

In addition to describing examples of the alternative approaches to traditional employment-based retiree health coverage, sponsors and experts we interviewed provided a variety of recommendations for improving and expanding these approaches. For example, some sponsors and experts recommended permitting tax-advantaged contributions by Medicare-eligible retirees to HSAs and allowing stand-alone HSAs that do not require an accompanying high-deductible health plan.<sup>1</sup> Another expert also suggested increasing the maximum annual contribution that is currently allowed for an HSA and expanding the ability of retirees to use HSA funds to pay for health insurance premiums.<sup>2</sup> One sponsor we interviewed highlighted the increased portability of an HSA as a factor in

<sup>1</sup>Under current law, ongoing contributions to HSAs must be accompanied by active enrollment in a high-deductible health plan.

<sup>2</sup>The Health Opportunity Patient Empowerment Act of 2006 makes several adjustments to federal policy regarding HSAs. First, the annual deductible limit on contributions to HSAs was repealed. Second, individuals can now make a onetime transfer of funds from their HRA or flexible spending account (an annual employer-sponsored “use-it-or-lose-it” fund for medical expenses not covered by health insurance) to their HSA. However, the contribution must be made prior to 2012. Finally, individuals can now also make a onetime transfer of funds from retirement accounts such as individual retirement accounts, subject to certain penalties, taxes, and limitations, to their HSA. Pub. L. No. 109-432, §§ 302, 303, 307, 120 Stat. 2922, 2948, 2949, 2951.

the sponsor's decision to stop offering an HRA at the end of 2006 and to begin instead to offer an HSA option for early retirees and active workers. In addition, according to one expert we interviewed, because sponsors are not required to make unused HRA balances available to employees when they change jobs, individuals may have an incentive to spend down accumulated funds.<sup>3</sup> Several sponsors and other experts also suggested creating additional tax-advantaged arrangements for retiree health benefit sponsors. For example, one expert suggested allowing the tax-free transfer of funds from individual tax-preferred vehicles—such as 401(k) retirement accounts—and pensions to pay for health care costs, including health care premiums.

Overall, a majority of the sponsors we interviewed indicated that sponsors are willing to use or consider alternative approaches, such as the ones described above, to assist retirees with their future health care needs without increasing their costs. Indeed, one sponsor indicated that it would support anything that would expand its ability to offer and fund retiree health coverage, such as additional subsidies or favorable tax treatment. Moreover, one expert indicated that alternative approaches such as HSAs offer a level of predictability that allows sponsors to sustain their retiree benefit packages. One reason for this predictability is that contributions by the sponsor in many of these alternative approaches are limited to a defined contribution.

Most alternatives that sponsors and experts described in our interviews were established (or are currently under consideration) for active employees to use for current and future expenses rather than for those who are currently retired. For example, among the alternative approaches described, few of the sponsors we interviewed indicated that they make such approaches available to current retirees. Specifically, only one sponsor we interviewed told us that it makes consumer-directed health plans available to current retirees.<sup>4</sup> Seven sponsors told us that their current use (or consideration) of consumer-directed health plans is targeted to active employees for current and future health care costs. Two

---

<sup>3</sup>Currently, employers are not required to make unused HRA balances available to employees upon job separation.

<sup>4</sup>According to the 2006 Kaiser/Hewitt survey on retiree health benefits, 10 percent of those surveyed among large private sector employers (defined as those with 1,000 or more employees) offering retiree health benefits offered retirees under age 65 an account-based retiree health plan such as an HSA or HRA in 2006, whereas fewer (3 percent) did so for retirees aged 65 and older.

---

**Appendix II: Alternative Approaches to  
Providing Retiree Health Coverage Suggested  
by Sponsors and Experts**

---

experts we interviewed, however, noted flaws with using consumer-directed health plans as adequate savings mechanisms for retiree health care costs because this approach assumes that active employees will not need the account funds for current health care expenses. Similarly, one sponsor noted that because many of the alternative approaches are geared toward active employees, they were less likely to be effective solutions for retiree health care needs.

---

# Appendix III: Scope and Methodology

---

This appendix describes in detail the scope and methodology used to address the three report objectives—(1) which MMA prescription drug coverage options sponsors selected, (2) the factors they considered in selecting these options, and (3) the effect these decisions may have on sponsors' provision of employment-based health benefits for retirees. It also addresses the mandated update on employment-based retiree health coverage since our 2005 report (reported in app. I) and sponsors' and others' views on alternative approaches for the provision of employment-based retiree health coverage that may help maintain, expand, or improve retiree health coverage (reported in app. II). Because some of the methodologies apply to more than one objective or appendix, we have organized this appendix by data source. Specifically, this appendix briefly describes the methodologies by objective and then discusses (1) surveys of employment-based health benefits, (2) federal surveys, (3) data from the Centers for Medicare & Medicaid Services (CMS), and (4) interviews with sponsors and other experts.

---

## Methodology by Objective

To determine which MMA prescription drug coverage options sponsors selected, we reviewed data from four surveys collected by three benefit consulting firms on the options that sponsors reported selecting for 2006 and the options that sponsors reported that they planned to select for 2007. One survey is an annual survey of employer health benefits, including private and public sector employers, conducted since the early 1990s through 2006, and one is a private sector survey on retiree health benefits conducted in 2006. We obtained and analyzed data provided by CMS on the number and characteristics of sponsors that were approved for the retiree drug subsidy (RDS) for plans ending in 2006 and 2007. To describe the factors that sponsors considered in selecting the MMA options and the effect their decisions about the options may have on the provision of benefits for retirees, we relied on two of the employer benefit surveys and reviewed documents from the literature on the factors that sponsors may consider in selecting the MMA options. We also interviewed private and public sponsors and experts on sponsors' decisions regarding the MMA options and employment-based retiree health benefits, including benefit consultants and officials at health plans, groups representing large employers, and other organizations.

To update information on employment-based retiree health coverage since our 2005 report, we reviewed data from employer benefit surveys and data from three large federal surveys that contained information either on Medicare beneficiaries or on the percentage of public sector employers that offer retiree health benefits. We also obtained this information in our



interviews with sponsors and experts. 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. To describe alternative approaches for the provision of employment-based retiree health coverage, we reviewed data from several of the same sources used to address the other report objectives, including employer benefit surveys, reports and analyses from the literature, and interviews with sponsors and experts.

---

## Surveys of Employment-Based Health Benefits

We relied on data from annual surveys of employment-based health benefit plans. Kaiser/HRET and Mercer 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 2006.<sup>1</sup> We also used data from a survey focused solely on retiree health benefits that Kaiser/Hewitt conducted in 2006. 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. We also reviewed two 2006 surveys by The Segal Company. The first represented a nonrandom sample of multiemployer plans from a range of industries and geographic regions; the second collected data from a nonrandom sample of public sponsors that offered prescription drug coverage to Medicare-eligible retirees.

---

## 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*.<sup>2</sup> Kaiser/HRET selects a random sample from a Dun & Bradstreet list of

---

<sup>1</sup>Year-to-year fluctuations 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.

<sup>2</sup>Kaiser/HRET has been conducting the survey of small and large employers beginning in 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 sampled only large employers in 1991, 1992, 1994, and 1997 and sampled both large and small employers in 1993, 1995, 1996, and 1998.

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 2006 and published in September 2006—2,122 employers responded to the full survey, giving the survey a 48 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 1,037 employers, or cumulatively about 72 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*.<sup>3</sup> 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. For the 2006 survey, which was published in 2007, Mercer mailed questionnaires to employers with 500 or more employees in July 2006 along with instructions for accessing a Web-based version of the survey instrument, another option for participation. Employers with fewer than 500 employees, which, according to Mercer, historically have been less likely to respond using a paper questionnaire, were contacted by phone only. Telephone follow-up was conducted with employers with 500 or more employees in the random sample and some mail and Web respondents were contacted by phone to clear up inconsistent or incomplete data. A total of 2,136 employers responded to the complete survey, yielding a response rate of 24 percent. By using statistical weights, Mercer projects its results nationwide and for four

---

<sup>3</sup>Foster Higgins, which later merged with Mercer Human Resource Consulting, began conducting the survey in 1986. Mercer Health & Benefits, a business of Mercer Human Resource Consulting, conducted the 2005 and 2006 surveys.

geographic regions.<sup>4</sup> 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 2006 Kaiser/Hewitt study—*Retiree Health Benefits Examined: Findings from the Kaiser/Hewitt 2006 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 databases, which list private sector employers potentially offering retiree health benefits. Kaiser/Hewitt conducted the survey online from June through October 2006 and obtained data from 302 large (1,000 or more employees) employers. Its results were published in December 2006. According to the survey, these employers represented 36 percent of all Fortune 100 companies and 22 percent of all Fortune 500 companies. They accounted for more than one quarter of the Fortune 100 companies with the largest retiree health liability in 2005. Because the sample is nonrandom and does not include the same sample of companies and plans each year, survey results for 2006 cannot be compared with results from prior years.

---

Segal

We reviewed two nonrandom surveys conducted and published by The Segal Company in 2006 that report on responses by non-private-sector sponsors to the availability of prescription drug coverage under Medicare Part D. The first survey, which was published in spring 2006, was based on data collected in January and February 2006 from a nonrandom sample of 273 multiemployer plans that provided prescription drug coverage to

---

<sup>4</sup>However, the 2006 Mercer report stated that the average annual cost increase data cited for Medicare-eligible retirees are not projectable.

Medicare-eligible retirees.<sup>5</sup> The 273 multiemployer plans that participated in the survey are Segal clients and, according to Segal, represented a range of industries and geographic regions. The second survey, which was published in summer 2006, was conducted by Segal in conjunction with the Public Sector HealthCare Roundtable, a national coalition of public sector health care purchasers.<sup>6</sup> This survey was based on data collected in May 2006 from a nonrandom sample of 109 public sponsors, including state and local sponsors, 82 of which offered prescription drug coverage to Medicare-eligible retirees.

---

## 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 CPS, conducted by the U.S. Census Bureau for the Bureau of Labor Statistics. 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 Beneficiary Survey (MCBS), sponsored by 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

---

<sup>5</sup>A 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 the Secretary of Labor may prescribe by regulation. 29 U.S.C. § 1002(37) (2000).

<sup>6</sup>According to the survey, the goal of the Public Sector HealthCare Roundtable is to represent the interests of the public sector during the formulation and debate of federal health care reform initiatives.

to insurance.<sup>7</sup> The survey is based on a sample designed to represent a cross section of the nation's civilian noninstitutionalized population. In the 2006 CPS Annual Supplement, about 83,800 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 2006 CPS Annual Supplement was about 83 percent. 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 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 that 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.<sup>8</sup> The survey also

---

<sup>7</sup>See [www.census.gov/hhes/www/income/p60\\_231sa.pdf](http://www.census.gov/hhes/www/income/p60_231sa.pdf) (downloaded Apr. 3, 2007) 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 2006.

<sup>8</sup>See <http://www.cms.hhs.gov/apps/mcbs/Overview.asp> (downloaded Feb. 21, 2007) for additional information.

relates coverage to payment sources. 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. We used the 2004 MCBS Cost and Use file, the most current data available, to determine the percentage of Medicare-eligible beneficiaries obtaining supplemental coverage from a former employer or union. We also used the MCBS data to determine the percentage of all health care expenditures for retired Medicare beneficiaries paid by employment-based insurance for prescription drug expenditures.

---

## Medical Expenditure Panel Survey

MEPS consists of four surveys and is designed to provide nationally representative data on health care use and expenditures for U.S. civilian noninstitutionalized individuals.<sup>9</sup> We used data from one of the surveys, the MEPS Insurance Component, to identify the percentage of state entities that offered retiree health benefits in 2004. 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 samples provide a nationally representative sample of employers. The target size of the list sample is approximately 40,000 employers each year.

---

## CMS Data

We analyzed data provided by CMS on the number and characteristics of sponsors approved for the RDS for plans ending in 2006 and of sponsors approved for the RDS for plans ending in 2007. The data include selected variables from applications that were approved for the RDS. For plans ending in 2006, the CMS data are current as of September 11, 2006; for plans ending in 2007, the CMS data are current as of February 16, 2007. Based on conversations with CMS and data reliability checks that we performed, we have determined that these data were sufficiently reliable for our purposes.

---

<sup>9</sup>See [http://www.meps.ahrq.gov/mepsweb/about\\_meps/survey\\_back.jsp](http://www.meps.ahrq.gov/mepsweb/about_meps/survey_back.jsp) (downloaded Apr. 4, 2007) for additional information.

---

## Interviews with Sponsors and Experts

To learn more about retiree health benefit trends, the factors that sponsors considered in selecting the MMA options, the effect that sponsors' decisions about the MMA options may have on the provision of health benefits for retirees, and alternative approaches for the provision of employment-based retiree health coverage, we interviewed 13 of the 15 private and public sector sponsors of employment-based retiree health benefits that we interviewed for the initial mandated study published in 2005.<sup>10</sup> In our 2005 study, we interviewed officials of 12 Fortune 500 employers that provided retiree health benefits; the Office of Personnel Management, which administers the Federal Employees Health Benefits Program; and two state retirement systems. To select the 12 Fortune 500 employers in our 2005 study, we judgmentally selected 10 employers from a stratified random sample of 50 Fortune 500 employers. We 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 financial statement, and union presence when making our selection. We also interviewed officials at two additional Fortune 500 employers at the recommendation of a benefit consultant. In our 2005 study, 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. For our current study, we also interviewed 2 sponsors that chose to offer their own Medicare Part D plans instead of implementing the RDS or another MMA option. These sponsors were not interviewed for our 2005 report.

To obtain broader-based information about retiree health benefit trends, MMA options, and alternative approaches for the provision of employment-based retiree health coverage, we interviewed benefit consultants and other experts at several other organizations. Specifically, we interviewed representatives of five 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

---

<sup>10</sup>See [GAO-05-205](#). Two private sector employers that participated in the 2005 study declined to be interviewed for this study.

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 consulting services to multiemployer plans. We also interviewed officials from the American Academy of Actuaries, America's Health Insurance Plans and its members, AARP, the American Benefits Council, the BlueCross BlueShield Association and its members, the Employee Benefit Research Institute, the National Business Group on Health, and the National Coordinating Committee for Multiemployer Plans. Finally, we reviewed other available literature on retiree health benefit trends, factors affecting sponsors' decisions about the MMA options, and alternative approaches for the provision of employment-based retiree health coverage.



# Appendix IV: Comments from the Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator  
Washington, DC 20201

**DATE:** MAY - 3 2007

**TO:** John E. Dicken  
Director, Health Care  
Government Accountability Office

**FROM:** Leslie V. Norwalk, Esq.  
Acting Administrator  
Centers for Medicare & Medicaid Services

**SUBJECT:** Government Accountability Office (GAO) Draft Report: RETIREE HEALTH BENEFITS: Majority of Sponsors Chose the Retiree Drug Subsidy and Continued to Offer Prescription Drug Coverage (GAO-07-572)

Thank you for the opportunity to review and comment on the GAO Draft Report referenced above. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required the GAO to conduct two studies on trends in employment-based retiree health coverage. This draft report is the second of those studies. In this study the GAO determined: which MMA options made available to private and public retiree drug plan sponsors were selected by plan sponsors; the factors plan sponsors considered in selecting these options; and the effect these decisions may have on the provision of employment-based health benefits for Medicare-eligible retirees.

We appreciate the GAO's thorough review of these important issues. In general, the draft report provides an excellent summary of available information concerning the choices plan sponsors made among MMA options. We appreciate the hard work of the GAO staff and their thoughtful consideration of our previous comments provided during the preparation of the draft report.

At the time the MMA was enacted, many expressed concern that creation of the Medicare drug benefit would cause employers to terminate employment-based retiree drug coverage. As a direct result of the successful implementation of the RDS program and other MMA Part D employer options, fears that MMA would accelerate the loss of employment-based retiree drug coverage were unfounded.

Implementation of the MMA options in the short time frame provided by the statute posed extraordinary challenges for CMS, including how to design a Retiree Drug Subsidy (RDS) program that could effectively and securely interact with the wide range of benefit plan designs and information systems used by plan sponsors and their vendors. Despite these many challenges, by partnering with plan sponsors and their vendors, benefits experts, and many other stakeholders, CMS successfully launched its online RDS application process in the summer of 2005, followed by successful implementation of

Page 2 - John E. Dicken

electronic drug cost and payment request submissions in 2006 and payment reconciliation earlier this year.

While the report understandably focuses primarily on the RDS, which is the dominant plan sponsor choice to date, CMS' achievement in implementing the MMA Part D employer group options identified in the draft report, most notably the Part D employer/union-only group waiver plan (EGWP) program, was no less remarkable. EGWPs can be used by plan sponsors to offer supplemental coverage that is integrated with Medicare products. By using its statutory authority to waive or modify requirements that hinder the design of, the offering of, or the enrollment in these products, CMS successfully implemented the Part D EGWP application, bid and contracting processes. In doing so, CMS not only issued a series of waivers it determined necessary for the initial establishment and implementation of the program but also reviewed and acted upon numerous individual waiver requests from entities seeking to offer, sponsor or administer a Part D EGWP in order to remove obstacles related to providing this integrated coverage.

Given the daunting task of designing, establishing and implementing the RDS and EGWP programs to meet the needs of diverse private and public employment-based retiree drug plans, the results achieved by CMS and documented in the GAO report far exceeded expectations. While program participation statistics cited in the report and elsewhere are impressive in their own right – thousands of participating plan sponsors providing prescription drug coverage through all the MMA options to an overall total of nearly 9 million Medicare-eligible retirees – the achievement is all the more remarkable in light of the heterogeneous nature of plan sponsors' and vendors' benefit programs.

With respect to the specific findings in the GAO draft report, the Centers for Medicare & Medicaid Services (CMS) agrees with the first draft report finding that the majority of sponsors continued to offer prescription drug coverage and accepted the Retiree Drug Subsidy (RDS) for plans year ending in 2006, with much smaller percentages of sponsors reported selecting the other available MMA options. With respect to the draft report's observation that the size of the reported majority actually choosing the RDS option differed across plan sponsor surveys, the draft report findings identified several factors that may have contributed to these differences. An additional factor CMS would like to highlight is that some of the surveys reported what plan sponsors said they intended or were considering doing at the time of the survey. As the RDS participation levels demonstrate, of those reportedly considering other options, a portion ultimately decided not to pursue those options. CMS also agrees with the draft report's related finding regarding the number of plan sponsors participating in the RDS program, with one clarification. The data for 2006 was compiled in September. In contrast, the data for 2007 was compiled in February and thus should be considered and identified as a *preliminary* rather than a final tabulation of RDS plan sponsor participation for 2007.

CMS agrees with the second draft report finding that plan sponsors considered a variety of factors when selecting which MMA prescription drug coverage option to pursue, with one clarification. The draft finding states that "in order to implement most MMA options

Page 3 - John E. Dicken

other than the RDS, sponsors would likely have to change the prescription drug benefits they offer.” With respect to the issue of benefit design changes, the report does not fully acknowledge that for several MMA options (e.g., plan sponsors that choose to offer their own Medicare Part D plan or purchase customized coverage by contracting with a Medicare Part D plan), CMS has utilized its statutory waiver authority to afford the utmost flexibility in benefit design (and in many other regards, including the mechanisms for communicating to retirees about these benefits). As a result, these other MMA options may require minimal (if any) adjustments to premiums, cost sharing and other primary elements of benefit design. We are concerned that readers could misunderstand this finding and mistakenly conclude that a plan sponsor choosing any MMA option other than the RDS is likely to cause most retirees to experience a change in retiree drug benefits. As we have noted above, because of the flexible manner in which CMS has implemented other MMA options, it is likely that selecting these other options may result in minimal benefit design changes. Moreover, as the findings demonstrate, the vast majority of retirees in 2006 and 2007 are covered by RDS plans that did not require any changes in benefits.

CMS agrees with the third draft report finding that, in the short term, sponsors’ decisions regarding MMA options resulted in benefits remaining relatively unchanged, but over the longer term the effect is unclear. However, CMS is concerned that the examples of contrasting expert opinions included in this draft finding lack sufficient context to be appropriate for inclusion in the report’s draft findings. Moreover, there is no indication in the draft finding of the preponderance of expert opinion in favor of one or the other point of view. While the cited expert opinions may be appropriate to include in the appendix discussing interviews and expert opinions, we are concerned about the appearance of elevating opinions to the status of findings by including them in the findings sections of the report. The inclusion of these opinions in the report findings also may create the mistaken impression that GAO has analyzed and/or validated the opinions being expressed concerning a particular MMA option.

In conclusion, the Medicare prescription drug benefit program and the RDS program represent important sources of financial support that can help private and public employer and union plan sponsors continue to provide high quality drug coverage for their retirees. While RDS has proven to be the most popular approach to date, CMS continues to promote and support the other MMA options which allow employers to utilize Part D and/or Medicare Advantage (MA) plans in instances where they may be better suited to the needs of some plan sponsors. CMS has provided maximum flexibility, consistent with its statutory authority, in the RDS program and the various Medicare Part D and MA employer and union group plan options made available by the MMA. CMS continues to reach out to employer and union plan sponsors to ensure they are informed about the host of MMA options for providing coverage. The findings in the draft report validate our efforts to make these programs accessible and workable for plan sponsors in order to increase the likelihood that these sources of financial support will improve the short and long term prospects for retiree drug coverage, enhancing both its quality and security.

---

**Appendix IV: Comments from the Centers  
for Medicare & Medicaid Services**

Page 4 - John E. Dicken

Thank you again for your efforts to study this matter and for the opportunity to review and comment on the draft report. Attached are our technical comments on the draft report which are included for your consideration.

Attachment

---

# Appendix V: GAO Contact and Staff Acknowledgments

---

## Contact

John E. Dicken, (202) 512-7119 or [dickenj@gao.gov](mailto:dickenj@gao.gov)

---

## Acknowledgments

In addition to the contact named above, Kristi A. Peterson, Assistant Director; George Bogart; Kevin Dietz; Laura Sutton Elsberg; Kristin Friday; Gregory Giusto; Elizabeth T. Morrison; Giao N. Nguyen; 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](http://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](http://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](http://www.gao.gov/fraudnet/fraudnet.htm)

E-mail: [fraudnet@gao.gov](mailto:fraudnet@gao.gov)

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

---

## Congressional Relations

Gloria Jarmon, Managing Director, [JarmonG@gao.gov](mailto: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](mailto:AndersonP1@gao.gov) (202) 512-4800  
U.S. Government Accountability Office, 441 G Street NW, Room 7149  
Washington, D.C. 20548