



Medicare Prescription Drug Benefits and Employer-Sponsored Retiree Medical Coverage

Statement of
Helen Darling
President
Washington Business Group on Health

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Mr. Chairman and members of the subcommittee, thank you for inviting me to appear before you this afternoon. I am Helen Darling, President of the Washington Business Group on Health (WBGH). Founded in 1974, WBGH is a national organization of 175 large employers dedicated to finding innovative and forward-thinking solutions to the nation's most important health care and health benefits issues. Our membership provides health care coverage for more than 40 million U.S. workers, retirees, and their families.

WBGH commends the Subcommittee for holding a hearing at this critical juncture as Congress has taken the first step toward providing outpatient prescription drug coverage for the Medicare population and is soon to convene the House – Senate conference on compromise legislation. WBGH believes that a Medicare prescription drug benefit is certainly long overdue and vitally important for seniors given the dramatic changes in medicine and health benefits in the private sector since 1965. Medicare beneficiaries deserve access to the same type of health care coverage options and benefits as other Americans. Comprehensive reform of the overall program is also necessary for the long-term financial survival of the Medicare program. Since employers and employees pay for Medicare through the payroll tax and other taxes, employers and today's active employees have a significant interest in the fiscal health and long term viability of the Medicare

program. WBGH and employers support comprehensive reform of the Medicare program to stabilize its financial condition and modernize its benefit and plan design. We owe all Americans a sense of security that they will have good health coverage during their later years and that their children and grandchildren won't be overburdened with taxes and benefit limitations because we didn't face these complex problems now. As part of Medicare reform, an outpatient prescription drug benefit should be included. It makes no sense that people who have the greatest need for prescription drugs have no coverage under Medicare. But, for this to be affordable now and in the long term, the Medicare program must promote and pay for appropriate use of health care services, including medications, that are proven to be cost-effective and enhance the quality and safety for Medicare beneficiaries. We will only find budgetary room for all of the new care that everyone hopes to have if we weed out unnecessary and less than appropriate medical treatments and prescription drugs.

Today, employers voluntarily provide prescription drug benefits to 12 million of the nation's Medicare beneficiaries. Employers are pleased that the framework for the new prescription drug benefit that Congress is considering would provide added flexibility for employers to coordinate with the Medicare program and allow employers to continue to use many of the private sector tools for innovation, patient safety and quality improvement.

My testimony today focuses on the following issues related to the Medicare changes that Congress is contemplating:

- The current state of employer-sponsored retiree health benefits,
- The effect of a Medicare prescription drug benefit on employers, and
- Employer views on Medicare reform

It is my hope that this testimony will help to clarify the facts, answer some questions, and dispel misconceptions surrounding employer-sponsored retiree medical benefits as you consider historic changes to the Medicare program in the coming weeks.

EMPLOYER- SPONSORED RETIREE-HEALTH BENEFITS

Employers provide health coverage, whether for active employees and their dependents or for retirees, on a voluntary basis either directly through self-insured plans or by purchasing coverage through a health plan or insurance company. The decision to provide health coverage, the level and scope of benefits, and the amount of funds that employers contribute to their health plans depend on a number of factors including the needs of employers' active and retired workforce, employers' needs to attract and retain the best talent, labor market conditions, economic conditions, company growth and profitability, and the costs of health and other benefits. Furthermore, changes in the way accounting rules treat the long-term costs of providing retiree health benefits have been a major factor in the employer decisions about retiree health coverage. For early retirees, those who are below age 65, some employer plans provide access to group health insurance that retirees

often have difficulty obtaining on their own. Retiree health insurance bridges the gap in coverage until Medicare eligibility. Employer plans assist one in three retirees age 65 and over by helping pay for benefits not covered by Medicare, such as prescription drugs. Nearly all employers that provide health benefits to age 65+ retirees –a shrinking group of employers--cover prescription drugs.

- **The Percentage of Employers Offering Retiree Medical Coverage Has Been Declining for Over 10 Years**

Annual increases in expenditures for health benefits, including prescription drug expenses, have been growing much faster than inflation for a number of years. Employers' costs for health care have increased 50% in the past five years and are expected to continue increasing by double digits for the near future. In the face of rising health care costs, large employers have been modifying retiree health plans to maintain coverage, but it is not an easy task. As a consequence of this and other factors, the percentage of large employers who offer retiree medical coverage has been falling for over a decade and is not a new phenomenon. According to data from Hewitt Associates,¹ the percentage of employers with more than 1000 employees offering health benefits to early retirees declined from 88% in 1991 to 72% in 2003. Similarly, the percentage of large employers with more than 1000 employees offering health benefits to post-65 retirees dropped from 80% in 1991 to 61% in 2003. Smaller employers are even less likely to offer health benefits to retirees.

¹ Hewitt Associates SpecBook TM database of approximately 1000 large employers with more than 1000 employees. *Washington Business Group on Health*

According to the Agency for Healthcare Research and Quality (AHRQ), only 22% of all private employers (irrespective of size) offered early retiree health benefits in 1997 and only 12% did so in 2000. The comparable percentage for Medicare-eligible retirees was 20% in 1997 and 11% in 2000.

Because of their cost pressures in a tough economy, those employers who continue to offer retiree health benefits are increasing the age and service requirements for eligibility, asking retirees to pay more, and reducing benefits.

- **Retiree Medical Benefits for Younger Workers, New Hires, and Future Hires Is Virtually Non-Existent**

Because of the rising cost of health benefits and other factors, a natural evolution has occurred in the marketplace that has practically eliminated retiree health benefits for future retirees. Outside of the government sector, very few employers are currently offering retiree health benefits to new hires and even fewer plan to offer such coverage for future hires. Furthermore, active employees, particularly those more recently hired are likely to have either no retiree health benefits or substantially reduced retiree health benefits compared to older employees and those who have been with their employer longer. While much of the discussion and concern in Congress has focused on current seniors in Medicare, 78% of them had some sort of supplemental coverage in 2000 according to

CMS, the majority with prescription drug coverage.² By contrast, a Medicare prescription drug benefit is more likely to be the only source of prescription drug coverage for future Medicare beneficiaries.

- **Employers Providing Retiree Health Benefits Often Have Multiple Plans**

Because employers have modified retiree health benefits over the years for different cohorts of retirees depending on when they retired, a single employer may have multiple plans. A recent survey of large employers conducted by PriceWaterhouse Coopers for The Business Roundtable found that employers surveyed had, on average, seven different retiree plans with a high of 140 plans within one company.³ These plans vary by premium charged, cost sharing, benefit designs, and geographic location.

- **Medicare Is the Primary Insurer for Retirees Age 65+**

Since its inception in 1965, Medicare has served as the primary insurer for people who qualify for Medicare upon reaching age 65, with employers who offer retiree health benefits supplementing Medicare benefits for eligible retirees. Medicare is only the secondary insurer to employer-sponsored coverage for people age 65 and over who are still working and for some people who are covered under a health care plan of their working spouse or who qualify for Medicare because of disability. This secondary coverage

² Medicare Current Beneficiary Survey, 2000, Office of Research, Development and Information, CMS

sponsored by employers is an enhanced benefit “(wrap around)”to Medicare, usually covering cost sharing requirements such as paying Medicare Part B premiums, and paying for benefits not covered by Medicare, notably prescription drugs.

When Medicare adds benefits or when a person turns 65, the benefits provided under a typical employer-sponsored retiree health plan are treated as supplemental to Medicare, both to avoid duplicative coverage and to provide the retiree with enhanced coverage beyond what is available under Medicare. Before age 65, the employer-sponsored coverage serves as the primary insurer for early retirees who are not Medicare eligible because they are younger than 65. However, when retirees turn 65, Medicare becomes the primary insurer and the employer coverage becomes secondary if the company offers it to Medicare eligibles.

POTENTIAL EFFECT ON EMPLOYER-SPONSORED RETIREE HEALTH BENEFITS

It is difficult to evaluate the effect of a Medicare prescription drug benefit on employers and Medicare-eligible retirees in employer plans given that the legislation is not yet final. Furthermore, the House and Senate versions differ, employer plans vary in design, employers operate within different constraints and consider different factors when making decisions about benefits, and they would likely evaluate their options differently.

³ PriceWaterhouse Coopers, Retiree Health Coverage Survey of Business Roundtable Member Companies, May 2003.

However, employers are generally very pleased with the flexibility that both the House and Senate bills offer employer-sponsored plans, which will make it easier to continue the voluntary offering of health benefits to retirees. Under both bills, employers may offer actuarially equivalent prescription benefits plus enhanced benefits beyond what Medicare covers and receive a federal subsidy, pay the prescription drug premium for retirees and provide enhanced benefits, elect Medicare Advantage and provide enhanced benefits, or provide enhanced benefits that wrap around the expanded Medicare benefit.

The following considerations are important to keep in mind when talking about any estimates of how employers are likely to respond to the availability of a Medicare prescription drug benefit and the continuing challenge of rising prescription drug costs:

- **Current Retirees with Employer Coverage Are Very Likely to Keep It**

The most common action taken by employers over the last decade has been to maintain retiree health coverage for current retirees and “grandfathered” future retirees but eliminate or reduce the future availability of similar benefits for those who are currently active employees and for new hires. It is likely that only a small percentage of employers will terminate coverage for current retirees.

- **The Percent of Employers Dropping Retiree Health Benefits Will Be No Greater than in the Absence of a Medicare Prescription Drug Benefit**

As stated earlier, the decline in employers offering retiree health benefits is an ongoing trend that will continue. However, we believe that with the establishment of a Medicare prescription drug benefit, this long term trend may be slower than it would have been in the absence of legislation because of the flexibility and new coverage options this legislation provides to employers that choose to assist their retirees in paying for health care costs. A Hewitt Associates survey of large employers for the Kaiser Family Foundation, estimated that only 18% of those currently offering retiree health benefits are likely to terminate coverage for future retirees if Congress enacts a Medicare prescription drug benefit. Conversely, Hewitt Associates estimated that 82% of large employers who currently offer retiree health benefits are likely to maintain coverage, wrap around the expanded Medicare benefit, or pay premiums for Medicare prescription drug coverage on behalf of their retirees.

MEDICARE REFORM

The motivation for Medicare reform is, and should be, more than financial. Medicare is modeled after indemnity insurance and the way health care was organized and financed in the 1960s. One of the glaring gaps is the absence of a prescription drug benefit.

Employers believe that America owes Medicare beneficiaries the financial and health

security that would be provided by an affordable, up-to-date Medicare program that delivers high quality care, including outpatient prescription drugs.

Yet clearly federal and societal resources are not infinite. As our society ages and health care costs generally rise, the Medicare program needs major structural reform to assure the financial soundness of the program for future generations. Mr. Chairman, WBGH and our employer members appreciate the very thoughtful leadership that you and many of your colleagues have shown regarding concern for the long-term viability of the Medicare program.

Employers are encouraged that both the House and the Senate bills would take significant initial steps in this direction through the creation of more competing private plan options through Medicare Advantage; other efforts to enhance the array of quality health plan choices for Medicare beneficiaries; and the addition of preventive services, disease management and chronic care coordination to manage high cost cases.

Employers have a significant stake in the financial viability and sustainability of the Medicare program. Employers and employees help pay for the Medicare program through the payroll tax and other taxes. In addition, Medicare competes not only with other spending priorities for a share of the federal budget, but also with private sector spending

for a share of the national economy and thus impacts overall economic conditions. In the future, as the Medicare population grows (because of increased longevity and greater numbers of older Americans) and health care utilization increases, Medicare spending and decisions affecting Medicare will have a greater effect on the overall economy. Employers therefore have an interest in the program's fiscal soundness and its ability to cover program expenses without an increase in taxes and without crowding out private sector investment dollars and consequently raising the cost of borrowing through higher interest rates for consumers and business.

In addition to enlistment of market forces and better management of beneficiaries with high cost, chronic conditions, Medicare must identify and deploy best practices in treatment and the use of technology in both the delivery and administration of health benefits to meet the challenges of rising health care costs. Many employers, including many of WBGH's members, are increasingly using the tools listed below as they make health plan purchasing decisions and manage health benefit programs to channel health care dollars where they are most appropriate. The most recent survey by WBGH and Watson Wyatt on employer health care trends found that companies that are aggressive value purchasers had significantly smaller increases in health care costs (e.g., 10% vs. 14% trend) compared to other employers.⁴

WBGH believes that it is critically important to assure that Medicare funds are used to purchase the highest value, most cost-effective care for beneficiaries and that the following tools should be adopted by the entire Medicare program as soon as possible:

- **Cover Only Safe, Appropriate Services and Treatments for Beneficiaries and Their Conditions**

Health care services, including prescription drugs, should be limited to the most cost-effective, medically and therapeutically appropriate services for the treatment of a beneficiary's injury, illness, or pregnancy. Medicare's framework should reflect a much higher standard than "a prescription written is a prescription covered or a service performed is a service covered."

By definition, cosmetic and discretionary prescriptions or those prescribed for treatment not approved by the Federal Food and Drug Administration should require substantial support for coverage approval.

- **Promote Effective Use of Health Care Services to Improve Outcomes and Value**

Prescription drugs are just one tool for improving health. Thus, a Medicare prescription drug benefit should be oriented toward patient-specific, medically appropriate, cost-

⁴ Eighth Annual Washington Business Group on Health/Watson Wyatt Survey Report, Spring 2003.
Washington Business Group on Health

effective prescribing and dispensing practices. Similarly, all health care services provided should be oriented toward patient-specific, medically appropriate, cost-effective treatment.

In the case of prescription drugs, Medicare should require the use of state-of-the-art management techniques, such as but not limited to, an electronic data infrastructure, beneficiary education and communication on pharmaceutical safety, therapeutic interchange, formularies, generic drug use where appropriate, drug interaction edits, accurate and efficient filling of prescriptions, prior authorization, utilization review, step therapy, health care management, physician education on appropriate prescribing and evidence-based medicine, dose optimization, mail order, pharmacy networks, and other steps to foster appropriate use.

- **Emphasize Quality Improvement and Patient Safety**

Medicare should utilize a consistent set of evidence-based, best practice standards for coverage to drive improvement in quality, safety and value. Coverage standards should encourage the use of care appropriate to the beneficiary's medical condition. Physicians and other health care providers and hospitals and other health care facilities who can demonstrably show better risk-adjusted health outcomes should be financially rewarded for their performance and beneficiaries should have incentives to use these higher quality providers and facilities.

Medicare should also require medical error reduction initiatives and safety process improvements for all health care services, including the dispensing of medications in both the inpatient and outpatient settings.

- **Share and Disclose Information to Promote Quality and Protect Patients**

Medicare should provide beneficiaries with access to user-friendly health care performance information from hospitals, physicians, other health care facilities and other health care professionals on safety, effectiveness, efficiency, and consumer experience. Medicare should also provide beneficiaries with information on and alternative therapies or medications. This information will help beneficiaries, their caregivers and their families make more informed decisions about their health care.

This concludes my testimony. I appreciate the opportunity to share the Washington Business Group on Health's perspective on this important issue, and I look forward to answering any questions that the Subcommittee may have.