September 2008

Issue Brief

Retiree Health Benefits After Medicare Part D: A Snapshot of Prescription Drug Coverage

Jon Gabel, Heidi Whitmore, and Jeremy Pickreign
National Opinion Research Center (NORC)

For more information about this study, please contact:

Jon Gabel
Senior Fellow
National Opinion Research Center (NORC)
E-mail gabel-jon@norc.org

ABSTRACT: Based on employers' responses to two national surveys, conducted in late 2005 and early 2007, fears that the Medicare Part D prescription drug benefit would "crowd out" existing retiree health benefits have not been realized. Employers have largely continued offering their prior benefits. The modest increases in the cost of prescription drug coverage over the past year might have contributed to this trend. However, most employers indicate that they will reconsider their current decision if the cost of coverage rises sharply or the Medicare Part D coverage becomes more comprehensive. A small but significant share of private employers reported they were planning to drop retiree coverage in the next two years for Medicare-eligible retirees, while others were planning to reduce coverage for new hires and active workers.

★ ★ ★ ★ ★

OVERVIEW

In enacting the Medicare Modernization Act of 2003, some members of Congress were concerned that the new prescription drug benefit under Medicare Part D would "crowd out" post-retirement employer-based health benefits. With drug coverage available through Medicare, it was feared, employers that previously offered retiree benefits might curtail or terminate drug benefits—or even end all coverage—for Medicare-eligible retirees. (Prior to 2003, approximately 12.4 million elderly beneficiaries, or about one of three elderly Medicare beneficiaries, received retiree health benefits from their former employer.[1]) To encourage

[1] Henry J. Kaiser Family Foundation, Analysis of 2002 Medicare Current Beneficiary Survey Cost and Use File. Historically, about 98 percent of elderly Medicare beneficiaries with retiree health benefits through employers had coverage for prescription drugs, and prescription drugs constituted 40 percent to 60 percent of claims expenses for this retiree coverage.

This and other Commonwealth Fund publications are online at www.commonwealthfund.org. To learn more about new publications when they become available, visit the Fund's Web site and register to receive e-mail alerts.

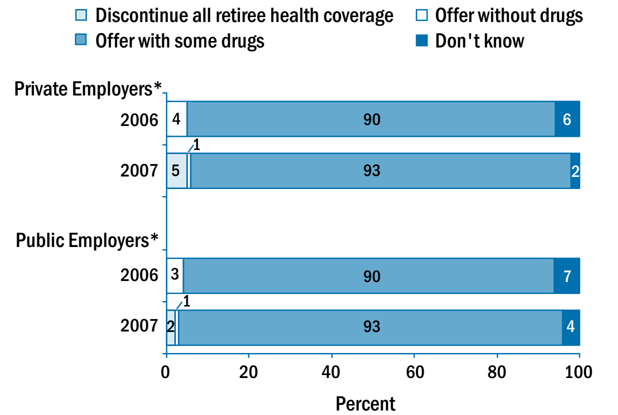
Commonwealth Fund pub. 1162
Vol. 46

employers to continue offering drug coverage, the legislation that created Part D stipulated that employers, or unions, that provide retirees with a "creditable" drug coverage plan—that is, at least actuarially equivalent to the standard Part D benefit—would receive a tax-free payment from Medicare equal to 28 percent of the cost of drug coverage.

Based on employers' responses to two national surveys we conducted, fears of a decline in retiree health benefits have not been realized, as employers have largely continued offering their prior benefits. Still, as we explain below, the future is far less certain: most employers indicate they will reconsider their current decision if the cost of coverage rises strongly or the Medicare Part D coverage becomes more comprehensive.

This issue brief summarizes findings from two national surveys of randomly selected public and private employers regarding the Part D prescription drug benefit provisions included in the Medicare Modernization Act of 2003. The first survey was conducted from October to December 2005, with complete interviews from 308 private firms and 270 public employers. We conducted the second survey from January to March 2007, completing interviews with 253 private firms and 407 public employers. See Methodology on page 6 for further details.

Figure 1. How Firms Offering Retiree Health Benefits with Prescription Drug Coverage to Medicare-Age Retirees Responded to the Medicare Modernization Act, 2007 vs. 2006



Note: No private firms of 1,000+ workers were surveyed in 2006.
* Distribution is significantly different between 2006 and 2007.
Sources: CMWF/NORC Survey of Retiree Health Benefits: 2007; CMWF/HSC Survey of Retiree Health Benefits: 2006.

SURVEY FINDINGS

Most employers retained retiree and prescription drug coverage, but there were more dropouts in the second year of Part D than in the first.

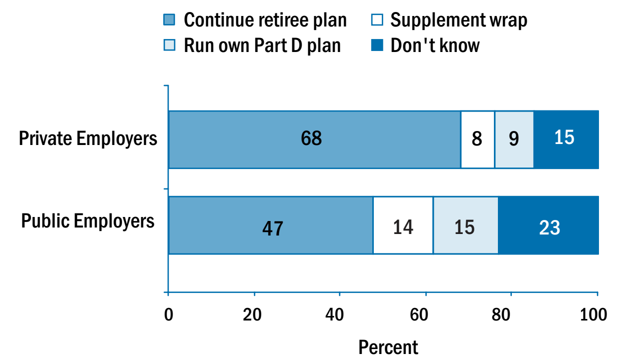
Among firms offering prescription drug benefits, less than 1 percent of public and private firms said they were dropping retiree coverage in the first year of the subsidy program (Figure 1). In the second year, however, 5 percent of private firms indicated they were dropping retiree coverage in 2007, and 1 percent were dropping prescription drug coverage. During the second year of the program, 2 percent of public employers were dropping all retiree health coverage, and 1 percent were dropping prescription drug benefits.

The majority of public and private employers continued to offer prescription drug benefits through retirement health benefit plans.

The MMA legislation allows employers three options for providing prescription drug benefits to Medicare-eligible retirees. The first option is to continue offering drug benefits through existing retirement plans, and receive a subsidy from the government for 28 percent of the firm's spending on the prescription drug benefit. The benefit package must be, at a minimum, actuarially equivalent to the Medicare Part D benefit. The second option allows employers to wrap benefits around the existing Part D plan. There is no subsidy from the government with this option, although the availability of subsidized basic coverage through Part D offsets costs that the employer might otherwise have borne. The third option is for the employer to operate its own Part D plan.

In 2007, for both public and private employers, the majority of firms continue to offer option one—providing drug benefits through an existing retiree health plan (Figure 2). Among employers able to identify the option chosen (that is, excluding those who responded "don't know"), 80 percent of private and 62 percent of public employers selected option one. Eleven percent of private employers and 20 percent of public employers chose to operate their own Part D plan.

Figure 2. Structure of Prescription Drug Coverage in Firms Offering Retiree Health Benefits with Some Drug Coverage, 2007

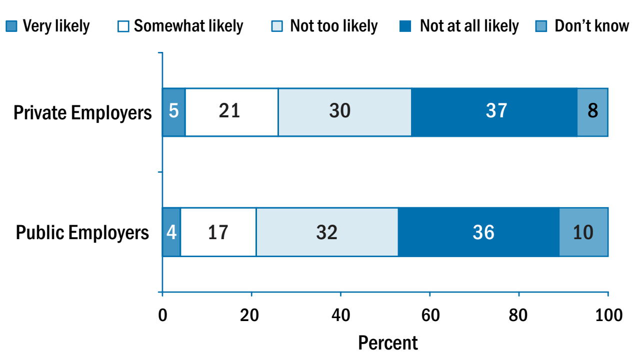


Source: CMWF/NORC Survey of Retiree Health Benefits: 2007.

When prompted about the possibility of rising costs and enhanced Part D benefits, many employers indicated that they were "very" or "somewhat likely" to change the design of their drug benefits.

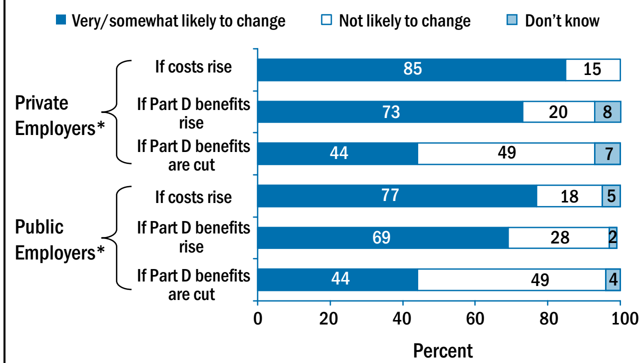
When asked, without any prompts, about the likelihood of altering the design of their prescription drug benefits in the next two years, only 26 percent of respondents from private firms and 21 percent of respondents from public employers indicated they were "very" or "somewhat likely" to make changes (Figure 3). But when asked what they would do if the cost of retiree health benefits continues to rise, 85 percent of private and 77 percent of public firms indicated they were "very" or "somewhat likely" to change their decision about the design of benefits (Figure 4). If Medicare were to offer more comprehensive Part D drug coverage, 73 percent of private and 69 percent of public employers are likely to change their decision. Fewer employers indicated they would be likely to change their decision if Part D benefits were reduced (44% of both private firms and public employers).

Figure 3. Likelihood That Firm Offering Health Benefits to Medicare-Age Retirees Will Change Its Response to Medicare Part D in Next Two Years



Source: CMWF/NORC Survey of Retiree Health Benefits: 2007.

Figure 4. Likelihood of Firm Changing Response to Medicare Part D If Program Changes Occur, 2007



* Tests found no significant distributions between public and private employers by response.
Source: CMWF/NORC Survey of Retiree Health Benefits: 2007.

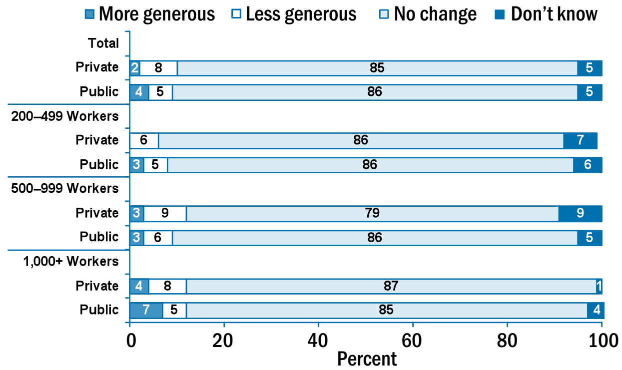
Most employers had not changed the generosity of their prescription drug coverage.

About 85 percent of public and private employers indicated that they had not changed the generosity of prescription drug coverage over the past year (Figure 5). Eight percent of private employers reported reducing and 2 percent indicated they increased the generosity of coverage. Corresponding figures for public employers were 6 percent and 4 percent. In the first year of Part D, more public and private firms reported they had increased the generosity of coverage rather than reduced it; meeting the requirement of actuarial comparability was likely a motivating factor in that increase.

Many state and local governments remained unfamiliar with new Government Accounting Standards Board (GASB) regulations, but governments familiar with the GASB rules showed concern about their effect on the cost of retiree coverage.

Beginning in 2008, local governments were required by GASB regulations to change from pay-as-you-go expensing of retiree benefits to accrual accounting.

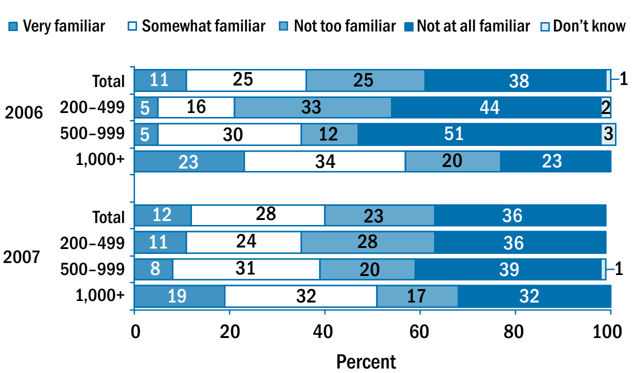
Figure 5. Percentage of Firms That Offer Retiree Health Benefits with Drug Coverage Who Report Change in Level of Generosity of Coverage for 2007 vs. 2006*



* Tests found no significant distributions between public and private employers by firm size.
Source: CMWF/NORC Survey of Retiree Health Benefits: 2007.

GASB may result in billions of dollars added to the balance sheets and income statements of state and local governments. In 2007, only 40 percent of public employers indicated they were either "very" or "somewhat familiar" with GASB, a figure only slightly larger than the 2006 figure of 36 percent (Figure 6). The percentage among large public employers with 1,000 or more workers declined from 57 percent to 51 percent. Among employers familiar with GASB, the percentage of employers "very" or "somewhat concerned" about the future financial impact of GASB remained essentially unchanged at 80 percent. Fifty-five percent of employers familiar with GASB had

Figure 6. Percentage of Public Employers That Are Familiar with GASB Regulations, 2007 vs. 2006

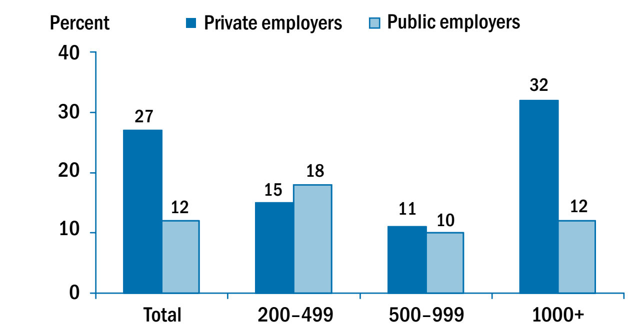


Note: Tests found no significantly different distributions between 2006 and 2007.
GASB = Government Accounting Standards Board.
Sources: CMWF/NORC Survey of Retiree Health Benefits: 2007; CMWF/HSC Survey of Retiree Health Benefits: 2006.

calculated the additional cost of retiree coverage, and the average cost was more than $1 billion for firms with more than 1,000 workers. Higher retiree contributions for the cost of coverage and higher patient cost-sharing are the most likely response of employers to the additional cost of coverage.

Nearly one-third of retirees receiving coverage from a private firm faced caps on their employer's contributions for coverage or payments for medical expenses. To limit the financial risk for retiree coverage, many employers have capped contributions for premiums or medical expenses. Twenty-seven percent of retirees obtaining health benefits from a private firm faced caps on their coverage in 2007, compared with 12 percent of retirees receiving their coverage from a public employer (Figure 7). Differences between private and public employers were most profound for firms with 1,000 or more workers, where 32 percent of employees faced caps in the private sector, but only 12 percent faced caps in the public sector.

Figure 7. Percentage of Retirees Receiving Benefits from Private and Public Employers That Have Capped Contributions for Spending for Medicare Retirees, 2007

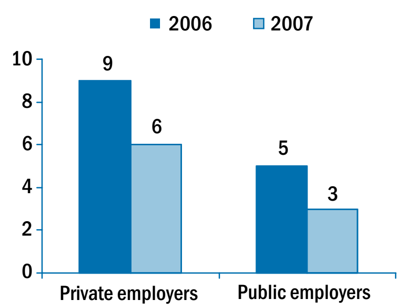


Note: Tests found no significantly different estimates between public and private employers by firm size.
Source: CMWF/NORC Survey of Retiree Health Benefits: 2007.

During the previous two years, the rate of increase in the cost of health benefits for Medicare-eligible retirees had moderated, but premiums had nearly doubled since 2000 and retiree contributions had tripled. As the rate of increase in claims expenses for prescription drugs has moderated over the past few years, increases in the cost of coverage for Medicare-age retirees has also moderated (Figure 8). In 2006, premiums increased 9 percent for private firms and 5 percent for public employers. In 2007, increases were 6 percent for private employers and 3 percent for public employers.

From a longer-term perspective, however, the cost of coverage has become increasingly expensive for both employers and employees—nearly doubling overall, and more than tripling for retirees since 2000. In 2007, the monthly cost of single coverage was $342 among private and $325 among public employers. Retirees' monthly contributions averaged $132, or about 40 percent of the cost of coverage. In contrast, in 2000 the average cost of coverage was $178, with retirees contributing 25 percent of the cost.

Figure 8. Percentage Change in Premiums for Single Coverage from One Year Ago for Medicare-Age Retirees in Largest Health Plan, 2007 vs. 2006

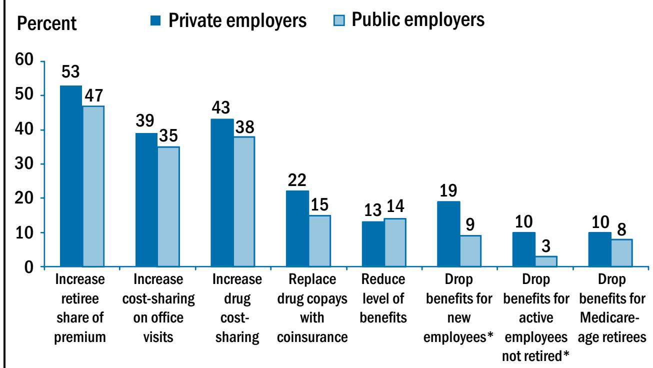


Note: No private firms of 1,000+ workers were surveyed in 2006.
Sources: CMWF/NORC Survey of Retiree Health Benefits: 2007; CMWF/HSC Survey of Retiree Health Benefits: 2006.

During the next two years, public and private employers planned to reduce the comprehensiveness of retiree coverage.

Planned changes (firms saying they were either "very" or "somewhat likely" to make a change) include increasing retirees' share of premiums (53% of private employers and 47% of public employers), increasing retiree cost-sharing for drugs (43% of private and 38% of public), and increasing cost-sharing for office visits (39% of private and 35% of public) (Figure 9). Some private firms indicated that the firm plans to drop health coverage for the Medicare-age retiree population (10%) or drop coverage for active workers not yet retired (10%) and reduce benefits (13%). When asked the same questions, figures were generally smaller for public employers than they were for private firms.

Figure 9. Very or Somewhat Likely Changes to Be Made to Retiree Health Benefit in Next Two Years



* Estimates are significantly different between public and private employers.
Source: CMWF/NORC Survey of Retiree Health Benefits: 2007.

CONCLUSION

The worst fears at the time of the passage of the Medicare Modernization Act of 2003 have not been realized. Rather than Part D "crowding out" prescription drug coverage, employers have largely continued offering their prior benefits. Modest increases in the cost of prescription drug coverage over the past year might have contributed to this trend.

But the future is far less certain. In our surveys, most employers indicated they would reconsider their decision if the cost of coverage rises strongly or the Medicare Part D coverage becomes more comprehensive. A small but significant share of private employers, meanwhile, planned to drop retiree coverage in the next two years for Medicare-eligible retirees; others planned to reduce coverage for new hires and active workers. Hence, the future of retiree coverage is uncertain.

Methodology

The Retiree Health Benefits Survey is a joint product of The Commonwealth Fund and the National Opinion Research Center (NORC). Researchers at NORC and the Fund developed the questionnaire and analyzed survey data, while National Research LLC administered the survey.

In the first year of the survey, we completed interviews with employee benefit managers from a random sample of 308 private and 270 public employers in firms that offer retiree health benefits. All private firms employed between 200 and 999 active workers. Interviews were conducted from October to December 2005. The sample was drawn from the Dun & Bradstreet list of employers and was designed to analyze private firms with 200 to 999 workers and public firms with 200 or more workers. The margin of error for responses among private employers (n = 308) is +/– 5.6 percent and among public employers (n = 270) is +/– 6.0 percent. Some exhibits do not sum to 100 percent due to rounding effects. The response rate was 27 percent for the entire survey.

In the second year of the survey, conducted from January to March 2007, we completed interviews with 253 private firms and 407 public employers. Private firms, unlike the first year of the survey, included firms with 1,000 or more workers. The response rate for the second year was 31 percent.

Many variables with missing information were identified as needing complete information within the database. To control for item non-response bias, missing values within these variables were imputed using either a distributional approach (continuous variables) or a hot-deck approach (categorical variables).

We used employer-based and employee-based weights to calculate statistics and extrapolate survey results. Calculation of the employer weight follows a common approach. First, the basic weight is determined, followed by a survey non-response adjustment. Finally, a post-stratification adjustment is applied. Retiree weights are calculated as the product of the employer weight and the number of retirees—Medicare-eligible or early retirees—in the firm.

About the Authors

Jon Gabel, M.A., is a senior fellow in the Washington, D.C., office of the National Opinion Research Center (NORC). Previously, he served as vice president of the Center for Studying Health System Change and vice president of health system studies at the Hospital Research and Educational Trust (HRET), director of the Center for Survey Research for KPMG Peat Marwick LLP, and director of research for the American Association of Health Plans and the Health Insurance Association of America. Mr. Gabel is the author of more than 100 published articles and serves on the editorial boards of a number of scholarly journals. He holds degrees in economics from the College of William and Mary and Arizona State University. He can be e-mailed at gabel-jon@norc.org.

Heidi Whitmore, M.P.P., is a health policy analyst with NORC's Health Policy and Evaluation department. Previously, she served as deputy director of health system studies at HRET, where she was responsible for studies and surveys that track changes in health benefits and the health care delivery system. Ms. Whitmore holds degrees in political science from Carleton College and a master's degree in public policy from Georgetown University. She can be e-mailed at whitmore-heidi@norc.org.

Jeremy D. Pickreign, M.S., is a senior research scientist with NORC's Health Policy and Evaluation department. Previously, he worked for HRET, serving as lead statistician for HRET's 2003 Survey of Employer-Sponsored Health Benefits. Mr. Pickreign also has worked at the National Rehabilitation Hospital Research Center and the Center for Studying Health System Change. He holds degrees in mathematics and statistics from the State University of New York at Albany. He can be e-mailed at pickreign-jeremy@norc.org.

Editorial support was provided by Chris Hollander.