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**REVISITING EMPLOYER PRESCRIPTION DRUG
PLANS FOR MEDICARE-ELIGIBLE RETIREES
IN THE MEDICARE PART D ERA**

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I. INTRODUCTION

For more than six decades, most Americans have accessed health care through employment-based health insurance. Since the 1960s, large employers have provided long-term employees with retiree benefits, and prescription drug coverage has been a standard feature for both active and retiree plans.¹ The development and entrenched nature of the employment-based system in the United States confounds simple explanation, but various arguments may be advanced both in favor and against continuing the current structure for active employees. Similar arguments apply to evaluating employment-based retiree health benefits although the presence of the Medicare safety net fundamentally affects that analysis for Medicare-eligible retirees. Historically, retiree prescription drug coverage occupied a unique place in the discussion of employment-based retiree benefits because Medicare excluded coverage for almost all prescription drug costs.² The passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)³ completely reshaped the discussion for employment-based retiree prescription drug plans by introducing primary prescription drug coverage for all Medicare-eligible beneficiaries through a new Medicare Part D beginning January 1, 2006.⁴ This fundamental change in Medicare raises significant questions for employers currently providing retiree prescription drug coverage as to whether they should continue such coverage in the Part D era.

This Article (1) provides background on the development and decline of employer-provided health insurance, with emphasis on retiree health insurance and prescription drug coverage, including an outline of key considerations in whether to continue the employ-

¹ See discussion *infra* Sections II.A, C & E.

² For an overview of Medicare and prescription drug coverage, see generally Thomas R. Oliver et al., *A Political History of Medicare and Prescription Drug Coverage*, 82 MILBANK Q. 283 (2004), available at <http://www.kff.org/medicare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=42275> (last visited Feb. 25, 2006).

³ Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (2003) [hereinafter Medicare Prescription Drug, Improvement, and Modernization Act].

⁴ See *id.*

ment-based system; (2) highlights the prescription drug challenge for the elderly in this country; (3) summarizes key features for employers of the MMA's prescription drug provisions; (4) reviews certain guidance issued by the Centers for Medicare & Medicaid Services (CMS) since passage of the MMA with respect to options for employer-sponsored retiree prescription drug coverage; (5) summarizes general employer reactions to the options; and (6) ends with an evaluation of how the MMA changes the analysis of whether to continue employment-based retiree prescription drug coverage after January 1, 2006. Although this evaluation generally concludes that public policy supports maintaining employer retiree prescription drug coverage and that the best choice for most employers in 2006—continuing existing plans and applying for the Medicare Part D employer subsidy—dovetails with the public policy argument, the Article also acknowledges that employer decisions after 2006 may well diverge from what public policy would suggest.

II. BACKGROUND

A. Development of the Employer-Sponsored Health Insurance System

American health insurance as it exists today has its origins in the late 1920s when a Dallas businessman laid the foundation for the Blue Cross organization by arranging for 1300 school teachers to pay for twenty-one days of future hospital care through small monthly payments to Baylor University Hospital.⁵ At about the same time, lumber and mining employers in the Pacific Northwest established what would become the Blue Shield system by arranging with local physicians to provide care for injured workers in return for a monthly fee from the employers.⁶ In the 1930s, President Franklin Roosevelt focused Social Security away from the issue of government-funded health benefits to sidestep political conflict with physicians,⁷ pushing health insurance completely into the private sector for the next thirty years. By 1939, nonprofit Blue Cross/Blue Shield plans offered limited hospital insurance coverage to

⁵ BLUECROSS BLUESHIELD ASS'N, BLUE BEGINNINGS, <http://www.bcbs.com/history/bluebeginnings.html> (last visited Feb. 25, 2006).

⁶ *Id.*

⁷ Charles P. Hall, Jr., *The Environment of Health Plans in the 1990s*, in *THE HANDBOOK OF EMPLOYEE BENEFITS* 75, 79–80 (Jerry S. Rosenbloom ed., 4th ed. 1996). See also COLIN GORDON, *DEAD ON ARRIVAL: THE POLITICS OF HEALTH CARE IN TWENTIETH-CENTURY AMERICA* 217 (2003).

three million Americans.⁸ A few commercial insurers offered similarly limited benefits.⁹ For example, Aetna began offering group health policies in 1936.¹⁰ Cigna entered the market in 1937.¹¹

Following the attack on Pearl Harbor and the United States' entry into World War II, Congress imposed wage and salary caps to control escalating labor costs.¹² Non-cash fringe benefits were exempted from the caps, however, allowing employers to use benefits such as health insurance as a way of attracting and retaining employees in a tight labor market.¹³ By the end of World War II, employer-provided benefits had become commonplace, and employees had grown to expect such packages as part of their overall compensation.¹⁴ After a number of administrative rulings and court cases in the mid-1940s confirmed that welfare benefits were subject to compulsory collective bargaining,¹⁵ unions began to advocate forcefully for the expansion of employer-provided benefits for their members.¹⁶ In the late 1940s, President Truman pushed briefly for a national health insurance program similar to those in other industrial nations,¹⁷ but employer-provided health insurance turned out to be entrenched.¹⁸ In 1950, the International Union, United Automobile, Aerospace and Agricultural Implement Workers of America (UAW) negotiated the first employer-paid health insurance program for members of its collective bargaining units at General Motors.¹⁹ By

⁸ BLUECROSS BLUESHIELD ASS'N, COVERING AMERICA, <http://www.bcbs.com/history/coveringamerica.html> (last visited Feb. 25, 2006).

⁹ Hall, *supra* note 7, at 80.

¹⁰ AETNA, AETNA HISTORY, <http://www.aetna.com/history> (last visited Feb. 25, 2006).

¹¹ CIGNA, COMPANY HISTORY, <http://www.cigna.com/general/about/history.html> (last visited Feb. 25, 2006).

¹² Hall, *supra* note 7, at 80; BLUECROSS BLUESHIELD ASS'N, TIMELINE: 1940s, <http://www.bcbs.com/history/timeline40.html> (last visited Feb. 25, 2006).

¹³ *Id.*

¹⁴ Hall, *supra* note 7, at 80.

¹⁵ See, e.g., *U.S. v. United Mine Workers*, 330 U.S. 258 (1947); *Inland Steel Co. v. NLRB*, 170 F.2d 247 (7th Cir. 1948).

¹⁶ Hall, *supra* note 7, at 90.

¹⁷ CTRS. FOR MEDICARE & MEDICAID SERVS. (CMS), HISTORY, <http://www.cms.hhs.gov/about/history/corningappa.asp> (last visited Feb. 25, 2006).

¹⁸ Hall, *supra* note 7, at 81.

¹⁹ Mike Hudson, *Soaring Big 3 Health Costs Set Up Standoff: UAW Resolves to Keep Generous Benefits*, DETROIT NEWS, July 28, 2003, at 1A.

1951, enrollment in the Blue Cross/Blue Shield plans reached sixty million.²⁰

Favorable tax treatment for employer-provided benefits also helped strengthen the position of health insurance as a standard employee benefit.²¹ Based on earlier wartime rulings by the Internal Revenue Service, the Internal Revenue Code of 1954 established that employer contributions to certain accident and health benefit plans for employees did not constitute taxable income to the employees.²² That exclusion continues today²³—a tax subsidy (technically referred to as a “tax expenditure”) estimated at \$9.6 billion in 1980,²⁴ \$106.72 billion in 2004,²⁵ and predicted to reach \$150.3 billion by 2009.²⁶

By the mid-1950s, almost seventy percent of Americans had private health insurance coverage.²⁷ The 1965 enactment of Medicare provided coverage for Americans aged sixty-five or older, but did not change the private employment-based system for younger Americans.²⁸ Some commentators in the early 1970s hoped that the passage of Medicare for retirees presaged the development of comprehensive national health insurance,²⁹ but this proved a false hope. Setting aside what by then constituted more than three decades of employee expectations of employment-based health insurance, the

²⁰ Jon R. Gabel, *Job-Based Health Insurance, 1977-1998: The Accidental System Under Scrutiny*, 18 HEALTH AFF., Nov.–Dec. 1999, at 62, 63, available at <http://content.healthaffairs.org> (last visited Feb. 25, 2006).

²¹ LEONARD E. BURMAN & JONATHAN GRUBER, URBAN-BROOKINGS TAX POL’Y CTR., TAX CREDITS FOR HEALTH INSURANCE (June 2005), http://www.taxpolicycenter.org/UploadedPDF/311189_IssuesOptions_11.pdf (last visited Feb. 25, 2006).

²² Melissa Thomasson, *Health Insurance in the United States*, <http://www.eh.net/encyclopedia/?article=thomasson.insurance.health.us> (last visited Feb. 25, 2006).

²³ 26 U.S.C. § 106 (2005).

²⁴ *The Effect of the Tax Laws on Health Insurance and Medical Costs: Hearing Before the H. Subcomm. on Oversight of the H. Comm. on Ways and Means and the Task Force on Tax Expenditures of the H. Comm. on the Budget*, 96th Cong. 1 (1979) (statement by Alice M. Rivlin, Director, Cong. Budget Office, available at <http://www.cbo.gov/ftpdocs/52xx/doc5228/doc25.pdf> (last visited Feb. 25, 2006)).

²⁵ EMP. BENEFIT RES. INST. (EBRI), TAX EXPENDITURES AND EMPLOYEE BENEFITS: AN UPDATE FROM THE FY 2005 BUDGET (Feb. 2004), <http://www.ebri.org/pdf/publications/facts/0204fact.pdf> (last visited Feb. 25, 2006).

²⁶ *Id.*

²⁷ BLUECROSS BLUESHIELD ASS’N, TIMELINE: 1950s, <http://www.bcbs.com/history/timeline/50.html> (last visited Feb. 25, 2006).

²⁸ The Social Security Act limits eligibility for Medicare to those age sixty-five and older and a few limited other categories of individuals. Social Security Act § 1811, 42 U.S.C. § 1395c (2005).

²⁹ Hall, *supra* note 7, at 83.

national consciousness did not perceive health insurance expenses in the early 1970s as a pressing problem for employers.³⁰ In 1977, 82.7% of employees were eligible for coverage from their employer.³¹ President Carter proposed a national health plan in 1979,³² but the idea quickly died.

Health care costs rose rapidly in the 1980s, leading to the introduction of managed care by mid-decade as employers struggled to continue providing insurance and control expenses.³³ By 1987, as health care costs continued to increase, 72.4% of American workers were eligible for employment-based health insurance.³⁴ President Clinton made universal national health care a top priority in the 1990s,³⁵ but the proposal failed. In 2001, even after a decade of widely publicized declines in employer coverage, 74% of all adults ages thirty-five to fifty-four and 66% of adults ages fifty-five to sixty-four still enjoyed employer-provided health insurance.³⁶ A 2003 survey indicated that the percentage of U.S. employers offering health benefits has remained relatively constant since 1996, from 59% in 1996 up to 69% in 2000 and down to 66% in 2003.³⁷ By 2005, with a struggling economy and constantly increasing health care costs, the percentage had dropped to 60%.³⁸ In general, larger firms

³⁰ See Michael S. Gordon, *Introduction to the Second Edition: ERISA in the 21st Century* in *EMPLOYEE BENEFITS LAW*, at lxiii (Steven J. Sacher et al. eds., 2d ed. 2000).

³¹ Gabel, *supra* note 20, at 66.

³² President James Carter, National Health Plan — Remarks Announcing Proposed Legislation (June 12, 1979), available at http://www.cms.hhs.gov/about/history/presidents/Carter_6_12_79.asp (last visited Feb. 25, 2006).

³³ *Frontline: The High Price of Health* (PBS television broadcast Apr. 14, 1998) (summary of Uwe Reinhardt, *Managed-Care Industry in Perspective* (1998), <http://www.pbs.org/wgbh/pages/frontline/shows/hmo/procon/hmoperspective.html> (last visited Feb. 25, 2006)).

³⁴ Gabel, *supra* note 20, at 66.

³⁵ President William Clinton, Address to a Joint Session of the Congress on Health Care Reform (Sept. 22, 1993), available at http://63.241.27.78/about/history/presidents/Clinton9_22_93.asp (last visited Feb. 25, 2006).

³⁶ *The Future of Retiree Health Benefits: Challenges and Options: Hearing Before the Subcomm. on Employer-Employee Relations of the H. Comm. on Educ. & the Workforce*, 106th Cong. (2001) (statement of Patricia Neuman, Vice President & Director, Medicare Pol'y Project, Henry J. Kaiser Fam. Found.), available at <http://www.kff.org/medicare/6010-index.cfm> (last visited Feb. 25, 2006) [hereinafter *Future of Retiree Health Benefits*].

³⁷ HENRY J. KAISER FAM. FOUND. AND HEALTH RES. & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2003 ANNUAL SURVEY 40 (2003), available at <http://www.kff.org/insurance/loader.cfm?url=/commonspot/security/getfile.cfm&PageId=20672> (last visited Feb. 25, 2006) [hereinafter KAISER/HRET 2003 SURVEY].

³⁸ HENRY J. KAISER FAM. FOUND. AND HEALTH RES. & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2005 ANNUAL SURVEY 14 (2005), available at <http://www.kff.org/insurance/7315/sections/upload/7375.pdf> (last visited Feb. 25, 2006) [hereinafter KAISER/HRET 2005 SURVEY].

are more likely to offer health coverage to employees.³⁹ In 2004, 99% of all firms with more than 200 employees offered some form of health benefits, as compared to 87% of companies with twenty-five to forty-nine employees, 74% of companies with ten to twenty-four employees, and only 52% of companies with three to nine employees.⁴⁰ In 2005, 98% of firms with 200 or more employees and 59% of firms with three to 199 workers offered some form of health benefits.⁴¹

B. Evaluating the Employer-Sponsored Health Insurance System

After almost seven decades of employer-sponsored health insurance coverage as the norm for American society, commentators sometimes refer to the arrangement as an “accidental” system,⁴² with all the idiosyncrasies and inconsistencies such terminology implies. Whether aptly so described or not, advocates of creating some form of government-managed universal health care typically do not analyze whether the employment-based system makes sense to maintain independently.⁴³ Instead, they focus on the problems facing those not covered by employer-provided health insurance and present health care as a basic right that should be guaranteed to all Americans.⁴⁴ For example, observing that the “greatest gap in our social security structure is the lack of adequate provision for the Nation’s health” and characterizing health as fundamental to American “ideals of freedom and equality,” President Truman in his 1948 State of the Union address noted that “most of our people cannot afford to pay for the care they need” and argued for a national health insurance system that would provide coverage to all citizens equally.⁴⁵ More than thirty years later, President Carter in 1979 similarly described access to health care as “a basic right for Americans,” and focused on the need for a national health plan to protect individuals

³⁹ See *id.*; HENRY J. KAISER FAM. FOUND. AND HEALTH RES. & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2004 SUMMARY OF FINDINGS 5 (2004), available at <http://www.kff.org/insurance/7148/loader.cfm?url=/commonspot/security/getfile.cfm&pageID=46287> (last visited Feb. 25, 2006) [hereinafter KAISER/HRET 2004 SUMMARY].

⁴⁰ KAISER/HRET 2004 SUMMARY, *supra* note 39, at 5.

⁴¹ KAISER/HRET 2005 SURVEY, *supra* note 38, at 13.

⁴² See, e.g., Gabel, *supra* note 20.

⁴³ See, e.g., Clinton, *supra* note 35.

⁴⁴ See, e.g., *id.*

⁴⁵ President Harry Truman, State of the Union Address (Jan. 7, 1948), available at <http://www.thisnation.com/library/sotu/1948ht.html> (last visited Feb. 25, 2006).

from the risk of financial ruin due to catastrophic illness as well as to provide comprehensive coverage to approximately at sixteen million low-income uninsured Americans.⁴⁶ A similar conception of health care as a fundamental right for Americans permeated President Clinton's 1993 universal health care proposal—what he proclaimed as “our most urgent priority, giving every American health security, health care that can never be taken away, health care that is always there.”⁴⁷ These pronouncements of health care as a basic right of all individuals implicitly reject treating health care as a privilege of economic and employment status, yet stop short of calling for the dismantling of the existing employment-based system. In any case, for a variety of political, social and economic reasons that lie well beyond the scope of this Article, all federal proposals for universal health care to date have been doomed while the employment-based system continues to lumber along.

This Article assumes that universal access to health care in the United States at least qualifies as a preferred social goal, if not a basic human right. This Article does not assume that the employment-based system necessarily provides the best mechanism for achieving that social goal. However, with regard to the limited question of how best to provide retiree prescription drug coverage in the post-MMA era, this Article does evaluate the employment-based system on the basis of a relatively narrow field of competing factors. These factors are discussed broadly in the remainder of this Section.

At least one historian has recently grouped explanations of the absence of a national American health care system into three competing theories: (1) American “popular or cultural faith in private solutions and a corresponding distrust of ‘radical’ political solutions,” (2) structural bias in American political systems against strong national political institutions and, by extension, against comprehensive reform on a national level, and (3) class politics that promote economic interests and disregard the working populace.⁴⁸ Each of these, if valid, might argue in favor of the employment-based system. For example, to the extent Americans pride themselves on individualism and private solutions to problems, private enterprise would inherently seem the preferred mechanism for providing health insurance. Similarly, if a bias against government so-

⁴⁶ Carter, *supra* note 32.

⁴⁷ Clinton, *supra* note 35.

⁴⁸ Gordon, *supra* note 30, at 3–7.

lutions agitates against national health insurance, in the absence of effective state regulation,⁴⁹ private employers may stand next in line as the logical institutions to inherit responsibility for health insurance coverage. Finally, if American culture does in fact glorify economic power over all else, with employers as the natural beneficiaries of that ideology, leaving the employment-based system alone may be the natural result of an overall value system entrenched in American society.

Other arguments in favor of the employment-based system also exist. For example, as long as the private sector continues to provide health insurance benefits to a significant portion of the populace, the government escapes financial responsibility for health care for the covered individuals. One may argue, of course, that in the absence of any universal government-funded health care system, the government is not actually saving money because it would not currently shoulder the cost of health care for most individuals in any case. This argument, however, seems disingenuous because individuals without health insurance still need health care and eventually will find their way into the public health charity care system if they have no other alternatives. At that point, their health care expenses do become taxpayer-funded. The more individuals who enjoy health insurance coverage through their employers, the fewer individuals will need such last-resort charity care, and this limits on a societal level the need for government expenditures for such care.

Another argument in favor of the employment-based system comes out of insurance principles. To the extent that any solution to providing health care involves an insurance-based system,⁵⁰ employer groups avoid adverse selection issues because they “exist[] for reasons other than the purchase of insurance.”⁵¹ In the absence of a government program that forces everyone into a risk pool, individual health insurance or even group health insurance programs for groups that have banded together solely because of a perceived need for health insurance create the classic adverse selection risk that insurers cannot afford to enable: The only people who will buy

⁴⁹ It should be noted that state power to regulate employee benefits, including health insurance, is extremely limited due to the preemptive impact of the Employee Retirement Income Security Act of 1974 (“ERISA”), which effectively exempts a self-insured employer plan from virtually all state regulation. 29 U.S.C. § 1144(a) (2000).

⁵⁰ Most major health care reform proposals have assumed that any long-term solution to achieving at least widespread access to health care will involve some type of insurance-based arrangements. *See, e.g.,* Truman, *supra* note 45; Clinton, *supra* note 35.

⁵¹ INST. OF MED., EMPLOYMENT AND HEALTH BENEFITS: A CONNECTION AT RISK 67 (Marilyn J. Field & Harold T. Shapiro, eds., 1993) [hereinafter EMPLOYMENT AND HEALTH BENEFITS].

insurance will be the ones who most need it. Employer programs, especially ones that cover all employees, naturally spread the risks across a broader range of people and bring healthy individuals into the pool who will pay (or have paid on their behalf) premiums in excess of what those healthy individuals will cost, offsetting the expenses of those who become ill and cost more than they contributed.

As compared to individual purchasers of health insurance, employers—particularly large ones—also have the benefit of leverage.⁵² Being able to negotiate with insurance companies from a position of economic strength means that an employer will typically be able to purchase insurance at a lower rate than an individual would be charged for the same product. Although a government health insurance program would obviously have even greater leverage, in the absence of such a program, employers may be the entities with the greatest bargaining strength and thus the greatest ability to obtain reasonably priced health insurance for large numbers of individuals. Admittedly, small employers may not enjoy much more bargaining strength than individuals, and, to the extent that the populace is employed more by small employers than large, the value of leverage may be limited in its application.

Retaining the employment-based health insurance system may also promote creativity and flexibility. Particularly in the absence of significant government regulation in this field, each employer can negotiate its own terms and conditions, and can develop innovative cost-control strategies.⁵³ For example, managed care in the late 1980s and early 1990s developed in large part out of large employers' efforts to control skyrocketing costs.⁵⁴ Although legitimate arguments may exist that employer cost control efforts, including managed care, do not always advance the quality of health care provided, anything that might rein in health care costs in the United States deserves some level of positive consideration.

Beyond cost control, the creativity and flexibility allowed by the employment-based system may actually serve certain groups of the population better than any one-size-fits-all national system would. An individual employer may tailor coverage to meet the needs of that employer's workforce in a way that no broad-based system could.⁵⁵ Such targeted coverage may well be more cost-ef-

⁵² *Id.* at 9.

⁵³ *Id.* at 9–10.

⁵⁴ See Reinhardt, *supra* note 33.

⁵⁵ EMPLOYMENT AND HEALTH BENEFITS, *supra* note 51, at 10.

fective because it may allocate premium dollars where they are truly needed rather than paying for certain types of coverage that are less important to a particular population.

Somewhat separate from the societal policy question of whether employers are objectively the best source of health insurance coverage for the working population is the question of why employers might choose to provide coverage for their own reasons. Currently, many employers may feel they have no other choice in light of employee expectations.⁵⁶ After decades of coverage, for an employer to not provide coverage might simply be unacceptable to their employees. For an employer with many similarly-situated competitors in a particular industry, virtually all of whom offer health insurance benefits to employees,⁵⁷ to fail to offer such benefits could place an employer at a distinct competitive disadvantage in recruiting and retaining qualified workers. Moreover, employers may perceive that employees remain healthier, more productive, and less likely to miss work due to sickness when employees have access to quality health care through an employer-sponsored health insurance benefit plan. In fact, employers increasingly have recognized that preventive health programs tend to lower overall health care costs.⁵⁸ Some employers may also be motivated simply by a paternalistic desire to protect and care for their employees.

Arguments rooted in fairness and equality tend to lie on the other side of both the societal benefits of continuing employment-based health insurance coverage and the reasons individual employers might want to provide such benefits. For example, although making health insurance primarily available through employment-based groups may avoid adverse selection on some levels, it also may encourage employers to select employees in part based on a perception of health.⁵⁹ After all, because employers shoulder much of the cost of the employment-based risk pools, employers want the healthiest—generally least expensive—employees in those pools.⁶⁰

⁵⁶ See discussion *supra* Section II.A regarding the development of employee expectations of employment-based health insurance.

⁵⁷ See KAISER/HRET 2004 SUMMARY, *supra* note 39, at Exhibit G.

⁵⁸ See, e.g., Julie Appleby, *Companies Step up Wellness Efforts*, USA TODAY, July 31, 2005, at 1A.

⁵⁹ The Americans with Disabilities Act attempts to limit the degree to which employers may make hiring decisions based on health factors. See, e.g., 42 U.S.C. § 12112(a) (2005). The Health Insurance Portability and Accountability Act also bars employer group health plans from basing eligibility to enroll in a group health plan on any one of a number of health-related factors. 29 U.S.C. § 1182(a)(1) (2002).

⁶⁰ See, e.g., Steven Greenhouse & Michael Barbaro, *Wal-Mart Memo Suggests Ways to Cut Employee Benefit Costs*, N.Y. TIMES, Oct. 26, 2005, at C1.

Because people who are seriously ill may also simply be too sick to be in the workforce, a natural self-selection of healthier people into employment-based health insurance may also exist. Moreover, employers may design benefits to avoid providing certain types of coverage that may be most needed by the sickest individuals.⁶¹ Federal law generally does not mandate coverage of any particular type of benefit; employers retain tremendous latitude to carve out certain types of coverage.⁶² The very creativity and flexibility that may be touted as a positive attribute of the employment-based system means that some employers may make choices that do not further overall societal goals of caring for the ill.

The employment-based system also does nothing for the unemployed. Although low unemployment presumably ranks with broad access to health care as a general societal goal, universal employment probably cannot occur, if for no other reason than individuals eventually age and most cannot continue working indefinitely. An employment-based health care system simply cannot meet the needs of an entire population. Even the leverage that employers enjoy in purchasing reduced-cost health insurance most likely benefits only larger employers. Not surprisingly, the percentage of employers offering health insurance drops precipitously as the size of the employer decreases.⁶³

In addition, a loudly lamented challenge of the employment-based system is its cost—both actual premium expenses and related administrative burdens.⁶⁴ Expecting employers to shoulder the financial burden for a perceived basic social need places employers in an unenviable financial position. Even employers who are providing health care benefits not merely due to a sense of historical or competitive necessity, but also out of a sincere concern for employee welfare, may find that health care costs threaten the viability of their businesses. As health care costs have increased, employers have increasingly struggled with providing employment-based health insurance benefits,⁶⁵ constantly searching for ways to reduce and control costs. In the past decade or so, this search has often targeted retiree health benefits, as discussed in the next two Sections.

⁶¹ EMPLOYMENT AND HEALTH BENEFITS, *supra* note 51, at 9.

⁶² See discussion of ERISA's preemption impact, *supra* note 49.

⁶³ See KAISER/HRET 2004 SUMMARY, *supra* note 39, at 5.

⁶⁴ See, e.g., Saul Friedman, *The Crumbling Obstacle to Universal Health Care*, NEWSDAY, Nov. 26, 2005, at B6.

⁶⁵ Cynthia Harrington, *Health Care Costs on the Rise*, J. OF ACCT., May 2003, <http://www.aicpa.org/pubs/jofa/may2003/harring.htm> (last visited Feb. 25, 2006).

C. Development of Employer-Sponsored Retiree Health Insurance

In the days before health care expenses dominated national news, and as employer-provided health insurance became commonplace for employees in the 1950s and 1960s, unions began to push employers to continue that insurance into retirement.⁶⁶ With health insurance costs relatively low, employers often viewed retiree health insurance as an easy bargaining chip to offer in union negotiations.⁶⁷ Still, by the 1960s, only 56% of Americans over age sixty-five enjoyed any form of health insurance,⁶⁸ employer-provided or otherwise. In 1962, only 21% of Americans age sixty-five or older had employer-sponsored health insurance coverage.⁶⁹ The limitations of the system became evident as the first retirees under the Social Security Act began to leave employment and found themselves unable to obtain affordable private medical insurance.⁷⁰ Eventually, Congress responded to the crisis by enacting Medicare in 1965 as Title XVIII of the Social Security Act.⁷¹

After the passage of Medicare, retiree health insurance, at least for Medicare-eligible retirees, tended to be fairly inexpensive as it provided primarily supplemental coverage to wrap around Medicare's generous benefits⁷²—with the glaring exception of prescription drug coverage, which generally was not provided by Medicare.⁷³ There were relatively few retirees as compared to the active population, and retirees often simply remained on the active plans.⁷⁴ Retiree medical plans also began to expand in the late 1960s

⁶⁶ PATRICIA H. BORN & ALICE M. ZAWACKI, U.S. CENSUS BUREAU, MANUFACTURING FIRMS' DECISIONS REGARDING RETIREE HEALTH INSURANCE (June 2003), available at <http://www.ces.census.gov/paper.php?paper=101680> (last visited Feb. 25, 2006).

⁶⁷ U.S. GEN. ACCT. OFFICE, RETIREE HEALTH PLANS: HEALTH BENEFITS NOT SECURE UNDER EMPLOYER-BASED SYSTEM, Report No. GAO/HRD-93-125 (July 1993), available at <http://www.gao.gov/cgi-bin/getrpt?HRD-93-125> (last visited Feb. 25, 2006) [hereinafter RETIREE HEALTH PLANS].

⁶⁸ Lynn Bailey, *An American Healthcare Primer*, THE S.C. NURSE, Oct.–Dec. 2003, http://www.findarticles.com/p/articles/mi_qa4103/is_200310/ai_n9306384 (last visited Feb. 25, 2006).

⁶⁹ ROLAND D. McDEVITT ET AL., WATSON WYATT WORLDWIDE, RETIREE HEALTH BENEFITS: TIME TO RESUSCITATE? 3 (2002), <http://www.americanbenefitscouncil.org/documents/w559.pdf> (last visited Feb. 25, 2006).

⁷⁰ Hall, *supra* note 7, at 82.

⁷¹ *Id.* See also Oliver et al., *supra* note 2, at 290–91. Title XVIII of the Social Security Act is codified beginning at 42 U.S.C. § 1395.

⁷² McDEVITT ET AL., *supra* note 69, at 3.

⁷³ See discussion *infra* Section II.E.

⁷⁴ McDEVITT ET AL., *supra* note 69, at 3.

due in part to the passage of the Age Discrimination in Employment Act in 1967 and other age discrimination prohibitions.⁷⁵ Employers found it safer to encourage older workers to retire by offering generous retirement packages, including retiree medical coverage, rather than risk the possibility of litigation over involuntary terminations.⁷⁶ Passage of the Employee Retirement Income Security Act of 1974 gave employers more design flexibility by generally exempting self-insured plans from state regulation.⁷⁷ Retirement coverage for pre-Medicare retirees expanded even further in the recession years of the 1970s and 1980s as employers enhanced early retirement programs to induce voluntary retirement, both to shrink workforces through attrition in difficult economic environments and to open positions for large numbers of baby boomers entering the workforce.⁷⁸ By the late 1980s, the majority of mid-size to large employers—including 66% of firms with 200 or more employees—offered some form of retiree health insurance.⁷⁹

However, despite a robust economy in the late 1980s and 1990s, the number of retiree medical plans dropped significantly.⁸⁰ The most significant drop came between 1988 and 1991, when there was a 20% decline in retiree health benefits offered by large employers (those with 200 or more employees).⁸¹ The percentage of large employers offering retiree health benefits to retirees over age sixty-five then declined from 80% in 1991 to only 66% in 1999.⁸² A 1999 survey of large employers found that 29% were “seriously considering” completely terminating retiree health coverage, 36% were considering cutting back on drug coverage, 51% were considering shifting to a defined contribution approach, and fully 83% were considering increasing costs to retirees.⁸³ In fact, over the following two years, 53% of all companies offering retiree health benefits increased

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ *Id.*; see also discussion of ERISA preemption, *supra* note 49.

⁷⁸ McDEVITT ET AL., *supra* note 69, at 4.

⁷⁹ HENRY J. KAISER FAM. FOUND., HEALTH RES. & EDUC. TRUST, & THE COMMONWEALTH FUND, EROSION OF PRIVATE HEALTH INSURANCE COVERAGE FOR RETIREES: FINDINGS FROM THE 2000 AND 2001 RETIREE HEALTH AND PRESCRIPTION DRUG COVERAGE SURVEY, figs. 1 & 2 (Apr. 2002), available at <http://www.kff.org/insurance/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14152> (last visited Feb. 25, 2006) [hereinafter KAISER/HRET 2000/2001 SURVEY].

⁸⁰ *Future of Retiree Health Benefits*, *supra* note 36.

⁸¹ KAISER/HRET 2003 SURVEY, *supra* note 37, at Exhibit 11.1.

⁸² *Future of Retiree Health Benefits*, *supra* note 36, at Exhibit 12.

⁸³ *Id.* at Exhibit 13.

retiree premiums.⁸⁴ Commentators at that time blamed the decline in the overall percentage of companies who sponsored retiree health plans on a combination of rising health care costs and the slowing economy, as well as on the fact that new companies typically were not implementing retiree programs in the first place.⁸⁵ Prognosticators in 2001 predicted continuing decline in employer-sponsored retiree plans due to both “rising health care costs and the downturn of the economy.”⁸⁶

By 2003, the downward trend overall for companies employing 200 or more people resulted in only 38% of such companies offering retiree health benefits in that year.⁸⁷ By 2004, the percentage again slipped slightly downward, this time to 36%,⁸⁸ but studies suggested that the downward trend might be ending: A 2004 study of large employers found that, while they might consider eliminating subsidized retiree benefits for new hires (and, in fact, 8% had already eliminated subsidized retiree benefits for future retirees hired after specified dates),⁸⁹ there was “virtually no interest” in terminating benefits for current retirees, and only 11% considered themselves “somewhat” or “very likely” to terminate subsidized benefits for future retirees.⁹⁰ On the other hand, by 2005, the numbers had slipped again. Only 33% of large firms offered health benefits to both active workers and retirees in 2005.⁹¹ Moreover, in 2003, retiree contributions for new retirees at least age sixty-five in the largest retiree plans of employers with at least 1,000 employees increased on average by 24%, to an average premium for retiree-only coverage of \$262 per month.⁹² In 2004, 19% of employers with 1,000 or more employees required payment by retirees sixty-five years or older of 100% of the premium cost; only 11% did not require retiree premium payments.⁹³ Furthermore, an overwhelming majority of large

⁸⁴ KAISER/HRET 2000/2001 SURVEY, *supra* note 79, at fig. 10.

⁸⁵ *Future of Retiree Health Benefits*, *supra* note 36, at 5.

⁸⁶ KAISER/HRET 2000/2001 SURVEY, *supra* note 79, at iv.

⁸⁷ KAISER/HRET 2003 SURVEY, *supra* note 37, at Exhibit 11.1.

⁸⁸ KAISER/HRET 2004 SUMMARY, *supra* note 39, at 5.

⁸⁹ HENRY J. KAISER FAM. FOUND. & HEWITT ASSOC., CURRENT TRENDS AND FUTURE OUTLOOK FOR RETIREE HEALTH BENEFITS: FINDINGS FROM THE KAISER/HEWITT 2004 SURVEY ON RETIREE HEALTH BENEFITS, Exhibit 27 (Dec. 2004), *available at* <http://www.kff.org/medicare/7194/loader.cfm?url=/commonspot/security/getfile.cfm&PageId=49752> (last visited Feb. 25, 2006) [hereinafter KAISER/HEWITT 2004 SURVEY FINDINGS].

⁹⁰ *Id.* at Exhibit 23.

⁹¹ KAISER/HRET 2005 SURVEY, *supra* note 38, at 18.

⁹² KAISER/HEWITT 2004 SURVEY FINDINGS, *supra* note 89, at Exhibit 10.

⁹³ *Id.* at Exhibit 12.

employers in 2004 considered themselves likely to make some sort of change to retiree health benefits that would increase the premium or other cost-sharing obligation for retirees.⁹⁴

In recent years, companies that continue to offer retiree health insurance tend to be larger. In 2003, only 10% of firms with fewer than 200 employees offered retiree health benefits, 32% of those with 200 to 999 employees offered such benefits, 48% of those with 1,000 to 4,999 employees provided retiree health insurance, and 54% of those with 5,000 or more employees provided retiree coverage.⁹⁵ Looking at the numbers from the beneficiary perspective, in 2003, of Medicare-eligible retirees with supplemental health benefits, 9% had worked for firms with fewer than 200 employees, 8% had worked for employers with 200 to 999 employees, 18% had worked for firms with 1,000 to 4,999 employees, and 65% retired from firms with 5,000 or more employees.⁹⁶ The availability of retiree health insurance also reflects an employer's unionized status. In 2003, 56% of firms with 200 or more employees who offered retiree health insurance were unionized.⁹⁷

D. Evaluating Employer-Sponsored Retiree Health Insurance

While the statistics in the preceding Section reveal a similar pattern to active employee health insurance coverage, in that larger employers tend to provide both active and retiree coverage far more than smaller employers,⁹⁸ employer-provided retiree health insurance clearly operates in a different environment than active employee health insurance. The fact that 98% of large employers in 2005 provided health insurance to active employees,⁹⁹ but only 33% of such large employers in the same year also offered retiree health insurance,¹⁰⁰ strongly suggests that employers do not perceive active employee and retiree populations the same. To some degree, this

⁹⁴ *Id.* at 35. Overall, 13% were considering shifting to a defined contribution approach, 18% were considering a shift to requiring retirees to pay 100% of the costs (and the employers were, in effect, merely providing access to health insurance), 51% thought they were "somewhat" or "very likely" to increase co-insurance or co-payments by retirees, and 85% anticipated being "somewhat" or "very likely" to increase retiree premium contributions. *Id.* at Exhibits 27 and 28.

⁹⁵ KAISER/HRET 2003 SURVEY, *supra* note 37, at Exhibit 11.2.

⁹⁶ KAISER/HRET 2000/2001 SURVEY, *supra* note 79, at fig. 4.

⁹⁷ KAISER/HRET 2003 SURVEY, *supra* note 37, at Exhibit 11.5.

⁹⁸ KAISER/HRET 2004 SUMMARY, *supra* note 39, at 5.

⁹⁹ KAISER/HRET 2005 SURVEY, *supra* note 38, at 13.

¹⁰⁰ *Id.* at 18.

may reflect less entrenched assumptions about employer responsibilities toward retirees than toward active employees. After all, retiree health insurance developed later than employer-provided insurance for active workers and, even in its infancy in the 1950s and 1960s, tended to be viewed as a relatively minor expense.¹⁰¹ Despite the later expansion of retiree health benefits, retiree health insurance never reached the pervasiveness of insurance for active employees, and the costs were historically dramatically lower, at least for Medicare-eligible retirees.¹⁰² On the government side, the enactment of Medicare suggests that American society has somehow classified the elderly in a different category than the rest of the populace and that, whatever the arguments as to whether universal access to health care for those under age sixty-five qualifies as a basic right or a preferred social goal, access to health care for the elderly is, in fact, a right in the United States—with the exception of prescription drug coverage before 2006. Medicare's passage also suggests that, if the social need is sufficiently pressing, American society can occasionally move beyond its ordinary preference for private solutions.

Taking into account the fundamentally different background that exists for retiree health benefits as a result of Medicare, evaluating the employment-based system for retiree health insurance based on the same factors applied earlier to active health insurance¹⁰³ should logically result in different conclusions. On the other hand, many of the general policy arguments in favor of maintaining employer-based retiree health insurance coverage resemble the arguments in favor of such coverage for active employees. For example, the more individuals covered by employment-based coverage, the fewer individuals are likely to need government-funded care. Retirees who are not eligible for Medicare (typically, early retirees who have not yet attained the age of sixty-five) appear indistinguishable from active employees with regard to the need for health insurance in that neither qualifies for a government-based safety net.¹⁰⁴ For Medicare-eligible retirees, however, employer health insurance—with the notable exception of retiree prescription drug coverage pre-

¹⁰¹ McDEVITT ET AL., *supra* note 69, at 3.

¹⁰² *Id.*

¹⁰³ *See supra* Section II.B.

¹⁰⁴ *See id.* for a discussion of the absence of a government-managed universal health care system in the United States. *See also Future of Retiree Health Benefits, supra* note 36, at Exhibit 13.

MMA—typically merely supplements Medicare,¹⁰⁵ and thus hardly would seem to relieve the government of any significant financial cost. To the extent that employer coverage provides greater preventative care, or that individuals may access health care more readily if they have employer coverage, perhaps employment-based retiree health benefits stave off more serious—and more expensive—health care problems and thus indirectly reduce the burden on Medicare. Such expense reduction for taxpayers may seem remote, however, in the context of Medicare-eligible retirees.

For retirees who are not yet eligible for Medicare, the issues are different. Losing employer coverage can be devastating, not dissimilar from the crisis that faces any uninsured individual in American society with health care needs, except that retirees may face a particularly daunting job market if they try to find new employment with health care coverage.¹⁰⁶ Many early retirees can neither afford to buy private insurance, if any is available—which it often is not if a retiree has any health problems—nor afford to pay for care directly,¹⁰⁷ yet they may not qualify for Medicaid. As a result, it is for the early retirees that the arguments for maintaining employer-sponsored benefits seem most urgent. Employers apparently recognize this distinction, providing retiree health benefits more often to pre-Medicare retirees than to those eligible for Medicare.¹⁰⁸ For example, in 2005, among employers with 200 or more employees who offered retiree health insurance, 94% provided such coverage for retirees who were not yet Medicare eligible, but only 81% provided such coverage for Medicare-eligible retirees.¹⁰⁹

From the insurance perspective, the fact that retirees' *raison d'être* as a separate health insurance risk pool is their prior employment relationship, not their need for health insurance, helps avoid adverse selection just as with active employee risk pools and without regard to whether individuals qualify for Medicare. Similarly, to the extent that an employer enjoys leverage in negotiating insurance rates (and acknowledging the limits of this leverage for smaller

¹⁰⁵ McDEVITT ET AL., *supra* note 69, at 3.

¹⁰⁶ *Future of Retiree Health Benefits*, *supra* note 36, at Exhibit 13.

¹⁰⁷ *Id.* at 2-4.

¹⁰⁸ KAISER/HRET 2000/2001 SURVEY, *supra* note 79, at fig. 2.

¹⁰⁹ KAISER/HRET 2005 SURVEY, *supra* note 38, at 19. These statistics have remained relatively constant. In 1999, 93% of larger employers (200 or more employees) offering retiree health benefits offered the benefits to pre-Medicare retirees as compared to 76% of such employers making the same offer to Medicare-eligible retirees. KAISER/HRET 2003 SURVEY, *supra* note 37, at Exhibit 11.3.

employers), that benefit applies equally to retiree (Medicare-eligible and otherwise) and active employee groups. The value of innovative cost-control strategies and flexible benefit design also applies to all employer-sponsored programs although employers may be more willing to apply more drastic cost-control techniques to retiree groups, especially Medicare-eligible groups for which the government has provided a significant health care safety net that does not exist for other groups. For example, almost all firms offering retiree health insurance also impose significant service requirements for an employee to qualify for the benefits.¹¹⁰ In 2001, firms with 3 to 199 employees on average required at least 13 years of service; firms with 200 or more employees on average required at least 10 years of service.¹¹¹ Similarly, employers typically require a higher level of cost-sharing from retirees than from employees.¹¹² For example, in 2001, retiree premiums tended to be \$20 per month more than premiums for active employees of the same company, and on average retirees with employer coverage tended to pay at least 26% of the overall premium costs as opposed to only 13% for active employees.¹¹³ Finally, to whatever degree employers experience altruistic concern for employee welfare, that paternalism should in theory extend to retirees as well as to current employees. However, employers may feel fewer obligations with regard to Medicare-eligible groups because of the Medicare safety net.

Significant differences in the analysis, however, do apply. Not only does employer-provided retiree health insurance occupy a weaker historical position than active employee health benefits, but two of the key motivating factors for employers in providing health insurance for employees largely vanish when the discussion shifts to retirees. First, employers do not compete against other employers for retirees, which means that the need to maintain competitive benefits commensurate with other similar employers does not exist. Although active employees may consider retiree benefit packages in making employment decisions, such long-term considerations may rank below other types of compensation, especially for younger

¹¹⁰ KAISER/HRET 2000/2001 SURVEY, *supra* note 79, at fig. 3.

¹¹¹ *Id.* These statistics reflect a dramatic increase from 1984 when only about 10% of companies offering retiree health insurance required more than five years of service for eligibility. Christian E. Weller & Jeffrey Wenger, *The Interaction between Health, Health Insurance and Retirement*, at 7, <http://www.nd.edu/~tghilard/Weller%20paper.htm> (last visited Feb. 25, 2006); McDEVITT ET AL., *supra* note 69, at 15.

¹¹² KAISER/HRET 2000/2001 SURVEY, *supra* note 79, at fig. 6.

¹¹³ *Id.*

workers. If older workers dominate a workforce, employers may perceive that terminating or reducing retiree health insurance would severely damage employee morale and retention, but such concern tends to be a feature of workplaces only in economic booms, not in times of economic uncertainty. Second, protecting employee health as a means to enhance productivity and reduce absenteeism obviously does not extend to retirees who, by definition, no longer contribute actively to the workplace. Without these two significant offsetting benefits for employers, the chief burden of maintaining retiree health insurance—the cost—may easily outweigh any general employer sense of obligation or paternalistic concern, particularly with regard to Medicare-eligible retirees.

The fact that retiree health insurance tends to be extremely expensive¹¹⁴ tips the scale even farther against an employer's maintaining retiree health benefits. For example, retiree health expenses in 2004 represented 29% of the total health care expense for large employers providing coverage to actives, retirees, and dependents.¹¹⁵ Moreover, the accounting treatment for retiree health insurance expenses makes them a particularly visible cost because Financial Accounting Standard (FAS) 106, "Employers' Accounting for Postretirement Benefits Other Than Pensions," requires employers to reflect the present value of future postretirement benefit liability on their current financial statements.¹¹⁶ In fact, commentators have generally blamed FAS 106, which became effective in 1993, for the dramatic drop in the number of retiree health insurance plans in the early 1990s.¹¹⁷ Even when large employers have not actually terminated retiree plans, in the wake of FAS 106 liability disclosure, many employers with at least 1,000 employees have reacted to rising costs and reporting obligations by capping their future retiree medical expenditures.¹¹⁸ Capping these expenses means that, once

¹¹⁴ Retiree health insurance costs have been attributed to a variety of factors, including the rising cost of medical care, the shifting ratio of retired to active workers, a trend of early retirement before Medicare eligibility, and Medicare's own cost control measures (which shift more cost to employer plans). See Stephen R. Miller et al., *Postretirement Medical Benefits Plans: An Analysis of Funding and Termination Issues*, 12 J. PENSION PLAN & COMPLIANCE 193, 193-94 (1986).

¹¹⁵ *Id.*

¹¹⁶ McDEVITT ET AL., *supra* note 69, at 10.

¹¹⁷ *Future of Retiree Health Benefits*, *supra* note 36, at 5.

¹¹⁸ A 2004 survey found that 54% of large firms surveyed had capped their contributions for retiree health care. KAISER/HEWITT 2004 SURVEY, *supra* note 76, at 9-11. The same survey found that, among firms with a cap on retiree health expenses, not only had 89% capped

medical costs rise above a certain level, retirees assume the cost burden.

Other employer-specific factors may also affect an employer's decision as to whether to maintain retiree health insurance. For example, many employers still have union contracts that require retiree health benefits,¹¹⁹ and it is unlikely that unions will relinquish this benefit in the foreseeable future. A number of large employers in 2004 noted that retiree health insurance had become "a focal point" in union negotiations and that retiree health expenses had been blamed as partially responsible for some company bankruptcy filings.¹²⁰ Some employers may otherwise be contractually bound to continue retiree health benefits, at least for current retirees.

The above discussion regarding general employment-based retiree health insurance applies equally to employer-sponsored retiree prescription drug coverage, with the key difference that, before 2006, the Medicare safety net simply did not exist for prescription drug expenses.¹²¹ The following Sections delve into how this distinction may change the analysis for employers.

E. Development of Employer-Sponsored Retiree Prescription Drug Coverage

In the mid-1960s, just as today, prescription drug costs posed a serious problem, representing almost 10% of national health spending,¹²² but relatively few private health insurance plans covered such costs, especially for retirees.¹²³ When plans did offer prescription drug coverage, employers imposed so many limits (co-insurance, high deductibles, and low maximums) that the coverage provided little assistance.¹²⁴ Despite these problems, cost concerns and the political wrangling over Medicare led to its enactment without any form of outpatient prescription drug coverage.¹²⁵

expenses for their largest retiree health plan for those age sixty-five or older, but 56% had already reached the cap and 27% expected to reach the cap within one to three years. *Id.*

¹¹⁹ KAISER/HRET 2003 SURVEY, *supra* note 37, at Exhibit 11.5.

¹²⁰ KAISER/HEWITT 2004 SURVEY, *supra* note 76, at V.

¹²¹ See generally Oliver et al., *supra* note 2.

¹²² *Id.* at 291.

¹²³ *Id.* at 293.

¹²⁴ *Id.*

¹²⁵ *Id.* at 294; Stephen H. Long, *Prescription Drugs and the Elderly: Issues and Options*, HEALTH AFF., Supplement 1994, at 157, 158, available at <http://content.healthaffairs.org/cgi/reprint/13/2/157.pdf> (last visited Feb. 25, 2006).

The Big Three automakers (General Motors, Chrysler, and Ford) introduced prescription drug plan coverage for union employees represented by the UAW in 1967.¹²⁶ By the late 1970s, most employer health insurance plans covered prescription drugs at some level.¹²⁷ However, such coverage typically fell under the major medical plan benefit and was not separately identified.¹²⁸ As a result, prescription drug benefits tended to be subject to the same deductibles and co-insurance as applied to general medical care.¹²⁹ By 1987, 92% of Medicare-aged individuals with employer-sponsored health insurance had retiree prescription drug coverage.¹³⁰ According to a 2001 survey, virtually all individuals with employer-sponsored retiree medical insurance received some level of prescription drug coverage through their former employer.¹³¹ In 2004, 98% of employer-sponsored retiree health plans provided prescription drug benefits.¹³² Overall, approximately one in three Medicare beneficiaries in 2004 enjoyed prescription drug coverage through an employer-sponsored retiree health plan.¹³³

Most employers in 2004 provided the drug benefit as part of the overall retiree health plan although about 5% had created a stand-alone prescription drug plan for retirees.¹³⁴ Of retiree plans in 2004 with the largest number of Medicare-eligible retirees, 58% subjected prescription drug benefits to the overall deductible and out-of-pocket spending limits applicable to medical benefits under the plan in general.¹³⁵ Another 27% set a separate annual drug deductible, ranging from \$25 to \$250 per year, with \$50 being the most common drug deductible.¹³⁶ Also in 2004, of the plans with the largest number of Medicare-eligible retirees, 18% imposed separate annual out-of-pocket maximums for pharmacy claims, with such maxi-

¹²⁶ See Hudson, *supra* note 19.

¹²⁷ Robert N. Frumkin, *Health Insurance Trends in Cost Control and Coverage*, MONTHLY LAB. REV., Sept. 1986, at 3, 7, available at <http://www.bls.gov/opub/mlr/1986/09/art1full.pdf> (last visited Feb. 25, 2006).

¹²⁸ U.S. DEP'T HEALTH & HUMAN SERVS., REPORT TO THE PRESIDENT: PRESCRIPTION DRUG COVERAGE, SPENDING, UTILIZATION, AND PRICES 11 (Apr. 2000), available at <http://aspe.hhs.gov/health/reports/drugstudy/C1.pdf> (last visited Feb. 25, 2006).

¹²⁹ *Id.*

¹³⁰ Long, *supra* note 125, at 160–61.

¹³¹ KAISER/HRET 2000/2001 SURVEY, *supra* note 79, at fig. 7.

¹³² KAISER/HEWITT 2004 SURVEY FINDINGS, *supra* note 89, at 27.

¹³³ *Id.*

¹³⁴ *Id.*

¹³⁵ *Id.*

¹³⁶ *Id.*

mums ranging from \$50 to \$5,000 (and the most common limit being \$1,500).¹³⁷ Only 9% of such plans imposed a separate cap on total covered drug expenses, and only 3% imposed separate prescription drug insurance premiums.¹³⁸

Employer-sponsored retiree prescription drug plans typically include a variety of cost control measures. For example, most retiree health plans apply different co-payment percentages to different types of drugs—i.e., generics, brand-name drugs without generic substitutes, and brand-name drugs with generic substitutes—to encourage use of less expensive alternatives.¹³⁹ Overall, in 2001, 52% of retiree health plans imposed at least two tiers of co-payments for prescription drugs, with 29% subject to two tiers (one for brand names and one for generics) and 23% subject to three tiers (one for generics, one for brand names with generic substitutes, and one for brand names without generic substitutes).¹⁴⁰ By 2004, 58% of all employees with employer-sponsored prescription drug coverage were subject to three-tiered cost-sharing structures, 4% had four or more tiers, 19% had two tiers for their largest plan covering Medicare-eligible retirees (one tier for generics, a second tier for all others), and 19% had the same co-payment/co-insurance structure for all types of drugs.¹⁴¹ Almost two-thirds (65%) of the plans covering the largest number of Medicare-eligible retirees in 2004 used pharmacy benefit managers (PBMs) to administer the plans and manage prescription drug costs.¹⁴²

Overall in 2004, of plans with a three-tiered cost structure, 68% required co-payments (where a retiree pays a fixed flat amount per prescription), 24% required co-insurance (where a retiree pays a specified percentage of the cost of a prescription), and 8% required both.¹⁴³ In the same year, for plans with both a three-tiered cost structure and a mail-order option, 85% required co-payments, 10% required co-insurance, but only 5% required both.¹⁴⁴ Also in 2004,

¹³⁷ KAISER/HEWITT 2004 SURVEY FINDINGS, *supra* note 89, at 27.

¹³⁸ *Id.*

¹³⁹ KAISER/HRET 2000/2001 SURVEY, *supra* note 79, at fig. 8.

¹⁴⁰ *Id.*

¹⁴¹ HENRY J. KAISER FAM. FOUND., PRESCRIPTION DRUG TRENDS (Oct. 2004), available at <http://www.kff.org/txdrugs/loader.cfm?url=commonspot/security/getfile.cfm&PageID=48305> (last visited Feb. 25, 2006) [hereinafter PRESCRIPTION DRUG TRENDS]; KAISER/HEWITT 2004 SURVEY FINDINGS, *supra* note 89, at 28.

¹⁴² KAISER/HEWITT 2004 SURVEY FINDINGS, *supra* note 89, at 27.

¹⁴³ *Id.* at 28.

¹⁴⁴ *Id.* at 27.

94% of large employer retiree health plans permitted use of either retail pharmacies or mail order for prescriptions (21% required mail order).¹⁴⁵ The median co-payments for retail pharmacy drugs (for plans with a three-tiered cost-sharing structure) ranged from \$10 for generics to \$20 for brand-name drugs included on the plan's formulary (preferred drug list) to \$35 for brand-name drugs not on the formulary; co-insurance rates at retail pharmacies were on average 20% for generic drugs, 25% for brand-name drugs included on the plan's formulary, and 40% for brand-name drugs not included on the plan's formulary.¹⁴⁶ Also for plans with a three-tiered cost-sharing structure that permitted mail-order drugs, the median co-payments for mail-order drugs (typically a ninety-day supply) ranged from \$20 for generics to \$40 for brand-name drugs included on the plan's formulary (preferred drug list) to \$70 for brand-name drugs not on the formulary; co-insurance amounts for such mail-order drugs tended to be the same as for retail pharmacy drug purchases.¹⁴⁷

F. Evaluating Employer-Sponsored Retiree Prescription Drug Coverage

To the extent that retiree prescription drug plans form an integral part of general retiree health insurance plans and do not exist separately, the analysis above as to why employers should or might wish to continue retiree health benefits generally applies equally to retiree prescription drug benefits.¹⁴⁸ As noted earlier, the key historical difference lies in the fact that, from 1965 through 2005, Medicare has not contained a general prescription drug benefit even for Medicare-eligible retirees even though some government-supported forms of prescription drug coverage—namely, Medigap policies and Medicare health maintenance organizations (HMOs)—have existed for a number of years.¹⁴⁹ In general, however, the coverage offered by supplemental Medigap policies and Medicare HMOs has rarely reached the same level as typical employer-provided coverage,¹⁵⁰ and both options have proved to be problematic for retirees.

¹⁴⁵ *Id.* at 28.

¹⁴⁶ *Id.*

¹⁴⁷ *Id.*

¹⁴⁸ See *supra* Section II.D.

¹⁴⁹ CMS, MEDICARE'S MILESTONES, Sept. 16, 2004, <http://www.cms.hhs.gov/about/history/mcaremil.asp> (last visited Feb. 25, 2006).

¹⁵⁰ *Future of Retiree Health Benefits*, *supra* note 36, at 4.

Medicare HMOs have often been unstable financially, often pulling out of markets and leaving enrollees without the anticipated supplemental benefits.¹⁵¹ Medigap policies—with limited and statutorily fixed supplemental benefit offerings—have been subject to premium increases that may have priced them out of range for many Medicare beneficiaries.¹⁵² Between 1999 and 2001, for example, premiums for Medigap policies covering some prescription drugs rose by more than 30%.¹⁵³

Without the Medicare safety net for outpatient prescription drugs, a Medicare-eligible retiree may look no different than an early retiree, other than perhaps being more likely to have significant prescription drug needs.¹⁵⁴ Furthermore, the rationales for maintaining or discontinuing employer-sponsored retiree prescription drug coverage parallel arguments for and against employer-provided general health insurance for retirees who are not yet Medicare eligible. The need for prescription drug coverage, however, may be even more urgent than the need for general health insurance due to how individuals react to prescription drug costs when they do not have prescription drug insurance.¹⁵⁵ As discussed below in more detail, high prescription drug costs tend to result in individuals' making cost-cutting choices that put health at risk.¹⁵⁶ For example, individuals without prescription drug coverage may delay or fail to fill prescriptions or skip dosages, exacerbating underlying health issues.¹⁵⁷ From a societal cost perspective, this tendency of individuals toward noncompliance with regard to prescription drugs means that, when such individuals eventually are forced to seek health care, they may be more ill and expensive to treat than they would have been had they followed prescription drug orders as directed.¹⁵⁸ This potential increased cost impact on society—in effect, a “common good” argument—may have been relatively remote from an individual employer's decision as to whether or not to maintain retiree prescription drug benefits. As a

¹⁵¹ *Id.* at 4–5.

¹⁵² *Id.* at 5.

¹⁵³ *Id.*

¹⁵⁴ See discussion *infra* Section III.B.

¹⁵⁵ *Id.*

¹⁵⁶ *Id.*

¹⁵⁷ Medicare Program; Medicare Prescription Drug Benefit, 70 Fed. Reg. 4194, 4474 (Jan. 28, 2005) (to be codified at 42 C.F.R. pts. 400, 403, 411, 417, and 423).

¹⁵⁸ See, e.g., UNIV. OF ARK. FOR MED. SCI., COMPLIANCE IN ELDERLY PATIENTS, <http://www.uams.edu/compliance/frmain.htm> (last visited Feb. 25, 2006).

result, its significance may easily be overlooked, but certainly its presence might have advocated in favor of maintaining employer coverage in the pre-MMA days.

Unfortunately, with prescription drug use increasing dramatically with age and with prescription drug expenses soaring, as discussed in more detail below,¹⁵⁹ employers weighing the immediate costs and benefits of the coverage might easily decide against coverage based solely on the financial impact. In fact, retiree prescription drug expenses may dwarf other retiree health insurance costs for employers, tipping the scale even farther against such coverage than might generally be the case for retiree health benefits. On the other hand, for Medicare-eligible retirees before 2006, just as with pre-Medicare-eligible retirees, the absence of a Medicare prescription drug safety net has meant that employers could not rely on the government to provide comparable coverage for retirees. Through 2005, this absence—at least for those employers motivated by altruistic concern for their retirees—may have balanced the scale slightly back in favor of maintaining prescription drug coverage. As noted above, employers have historically recognized a greater obligation to preserve retiree health benefits for those not yet Medicare-eligible.¹⁶⁰ Subsequent Sections of this article address how the passage of the MMA may change the analysis.

III. PRESCRIPTION DRUG CHALLENGE

A. Prescription Drug Expenses

In recent years, the cost of prescription drugs has been widely publicized as a major health crisis. In the decade from 1970 to 1980, prescription drug spending increased by an average of 8% per year.¹⁶¹ Over the next decade, it increased by an average of 13% per year.¹⁶² Annual drug spending increases in the 1990s and early 2000s ranged from 6% from 1992 to 1993 to a 20% increase from 1998 to 1999 and 15% from 2001 to 2002.¹⁶³ Overall, prescription drug spending quadrupled between 1990 and 2002, reaching \$162.4 billion in 2002.¹⁶⁴ The continuing spending increases have been attrib-

¹⁵⁹ See discussion *infra* Sections III.A & B.

¹⁶⁰ See *supra* Section II.D.

¹⁶¹ PRESCRIPTION DRUG TRENDS, *supra* note 141.

¹⁶² *Id.*

¹⁶³ *Id.*

¹⁶⁴ *Id.*

uted to three key factors: an increasing use of prescription drugs (estimated as responsible for 42% of the increase in drug spending from 1997 to 2002), a switch from older and less expensive drugs to expensive new drugs (estimated as responsible for 34% of the increase in drug spending over the same period), and an increase in manufacturer prices (estimated as responsible for the remaining 25% of the spending increase over the period).¹⁶⁵

In general, use of prescription drugs has been increasing per person over the past decade: The number of prescriptions bought between 1993 and 2003 increased from 2.0 billion to 3.4 billion (a 70% increase) while the U.S. population grew by only 13% over the same period.¹⁶⁶ Meanwhile, retail prescription drug prices increased an average of 7.4% per year from 1993 to 2003, reflecting both price increases by drug manufacturers and consumers switching to more expensive drugs.¹⁶⁷ The price increases far outstripped the rate of inflation over the same period—a mere 2.5%.¹⁶⁸

The trend of consumers switching to new and more expensive drugs is generally blamed, at least in part, on a tremendous increase in direct consumer advertising by drug manufacturers.¹⁶⁹ By 2003, the industry had increased its spending for consumer advertising to more than eight times what it had spent on such advertising in 1995.¹⁷⁰ The drug industry has also matched its advertising spending increases with increases in the prices of well-known brand-name drugs: For example, in early 2005, the top-selling drug for individuals age fifty or older was Fosamax.¹⁷¹ Merck increased the wholesale price for Fosamax 4.5% during the first quarter of 2005.¹⁷² In fact, for the first quarter of 2005, 110 of the 195 drugs most widely used by individuals age fifty or older experienced some level of price increases by drug manufacturers.¹⁷³ For a typical older American taking three prescription drugs each day, assuming manufacturer cost increases are passed through in full to consumers, brand-

¹⁶⁵ *Id.*

¹⁶⁶ PRESCRIPTION DRUG TRENDS, *supra* note 141.

¹⁶⁷ *Id.*

¹⁶⁸ *Id.*

¹⁶⁹ *Id.*

¹⁷⁰ *Id.*

¹⁷¹ AARP PUB. POL'Y INST., TRENDS IN MANUFACTURER PRICES OF BRAND NAME PRESCRIPTION DRUGS USED BY OLDER AMERICANS—FIRST QUARTER 2005 UPDATE 8 (2005), http://assets.aarp.org//rgcenter/health/dd121_drugprices.pdf (last visited Feb. 25, 2006).

¹⁷² *Id.*

¹⁷³ *Id.* at 6.

name prescription drugs cost on average \$144.15 more at the end of the first quarter of 2005 than a year earlier.¹⁷⁴ For the first half of 2005, prescription drug prices on average increased 5.5%.¹⁷⁵

Despite the price increases, between 2004 and 2013, U.S. drug spending is expected to continue to increase somewhat more slowly, at a rate of 10.7% per year.¹⁷⁶ This slowdown is anticipated because of a combination of factors, namely “fewer new drugs being introduced into the market, a reduction in direct-to-consumer advertising, the impending loss of patent protection for some leading drugs, new cost-sharing provisions in private insurance contracts, and a lower rate of price growth.”¹⁷⁷ The projection does not take into account potential increases resulting from the introduction of the Medicare Part D prescription drug benefit in 2006, which may improve access and in turn increase spending again.¹⁷⁸

B. Prescription Drugs and the Elderly

As health problems increase with age, so too does the use of health care services.¹⁷⁹ Adults ages sixty-five to seventy-four typically fill four times as many prescriptions as do adults younger than age forty-five and almost twice as many as adults ages forty-five and sixty-four.¹⁸⁰ This pattern assumes access to prescription drug insurance; a 2001 study of Medicare-eligible individuals in eight states, reflecting 42% of all U.S. adults ages sixty-five or older, found that 35% of such individuals without prescription drug insurance either did not fill a prescription or skipped dosages to extend an existing prescription.¹⁸¹ Of the surveyed Medicare-aged adults who had prescription drug coverage, only 18% engaged in such behavior.¹⁸² A 2003 survey found that 37% of uninsured individuals (whether Medicare-eligible or not) failed to fill a prescription because of cost while only 13% of those with insurance failed to do

¹⁷⁴ *Id.* at 4.

¹⁷⁵ HENRY J. KAISER FAM. FOUND., KAISER DAILY HEALTH POLICY REPORT: PRESCRIPTION DRUG PRICES INCREASED BY 5.5% IN FIRST HALF OF 2005, NEW RESEARCH INDICATES (Aug. 2, 2005) http://www.kaisernetwork.org/daily_reports/print_report.cfm?DR_ID=31776&dr_cat=3 (last visited Feb. 25, 2006).

¹⁷⁶ PRESCRIPTION DRUG TRENDS, *supra* note 141, at 2.

¹⁷⁷ *Id.*

¹⁷⁸ *Id.*

¹⁷⁹ *Future of Retiree Health Benefits*, *supra* note 36, at Exhibits 1 & 3.

¹⁸⁰ *Id.* at Exhibit 4.

¹⁸¹ PRESCRIPTION DRUG TRENDS, *supra* note 141, at 2.

¹⁸² *Id.*

so.¹⁸³ A 2001 study found that Medicare beneficiaries with five or more chronic conditions reported filling, on average, fifty prescriptions a year if they have prescription drug coverage, but only an average of thirty-eight prescriptions a year when they do not have such coverage.¹⁸⁴ Not surprisingly, an AARP survey found paying for prescription drugs posed a problem for 71% of Americans over age sixty-five, with 35% calling it a “major problem” and 36% calling it a “minor problem.”¹⁸⁵

Such actions as failing to fill prescriptions, skipping doses, and similar actions—all considered “medication noncompliance”—tend to exacerbate health problems and increase the need for additional medical care.¹⁸⁶ In fact, a 2002 study indicated that medication non-compliance often proves to be “a predictor of hospital admissions and emergency room visits.”¹⁸⁷ Despite such concerns, in the fall of 2001, 36% of all Medicare beneficiaries had no prescription drug coverage.¹⁸⁸

The single largest source of prescription drug coverage for Medicare beneficiaries was employer-sponsored retiree health plans, covering more than a third of all those at least age sixty-five, or about fourteen million individuals in 2001.¹⁸⁹ Other traditional sources of supplemental insurance have been Medigap policies, Medicaid, and Medicare HMOs.¹⁹⁰ Medigap policies and Medicare HMOs, however, have proved to be of limited value.¹⁹¹

IV. MMA AND PRESCRIPTION DRUG COVERAGE

Passage of the MMA fundamentally revised the contours of the retiree prescription drug coverage issue, both for individuals and for employers. The MMA introduces a new Medicare Part D that

¹⁸³ *Id.*

¹⁸⁴ Medicare Program; Medicare Prescription Drug Benefit, 70 Fed. Reg. 4194, 4474 (Jan. 28, 2005) (to be codified at 42 C.F.R. pts. 400, 403, 411, 417, and 423).

¹⁸⁵ AARP, RX WATCHDOG REPORT: FILLING THE PRESCRIPTION: WHAT ARE OLDER ADULTS LOOKING FOR? (July 2004), http://assets.aarp.org/www.aarp.org/_articles/legislative/watchdog_2.pdf (last visited Feb. 25, 2006).

¹⁸⁶ Medicare Program; Medicare Prescription Drug Benefit, 70 Fed. Reg. at 4474.

¹⁸⁷ *Id.*

¹⁸⁸ PRESCRIPTION DRUG TRENDS, *supra* note 141, at 2.

¹⁸⁹ KAISER/HRET 2000/2001 SURVEY, *supra* note 79, at iv.

¹⁹⁰ *Future of Retiree Health Benefits*, *supra* note 36, at Exhibit 11.

¹⁹¹ *Id.* at 4–5; *see also* discussion *supra* Section II.F.

will provide outpatient prescription drug coverage to Medicare-eligible beneficiaries beginning in 2006.¹⁹²

A. Medicare Part D Prescription Drug Coverage

In January 2006, Medicare beneficiaries became eligible to enroll in a new Medicare Part D and obtain outpatient prescription drug coverage for an average monthly premium of less than \$37.¹⁹³ Under the new Part D “standard” prescription drug coverage, enrolled Medicare beneficiaries will be required to pay for the first \$250 of their drug costs each year.¹⁹⁴ The \$250 annual deductible will increase each year after 2006 to reflect annual increases in average spending by Part D enrollees on covered Part D drugs.¹⁹⁵ After the annual deductible is satisfied, Medicare will pay 75% of an enrolled beneficiary’s allowed drug costs from \$250 to \$2,250 (for 2006), with the beneficiary remaining responsible for a 25% co-payment.¹⁹⁶ As with the annual deductible, the \$2,250 initial coverage limit will increase each year after 2006 to reflect annual increases in average spending by Part D enrollees on covered Part D drugs.¹⁹⁷ A prescription drug plan sponsor (including a Medicare Advantage organization) may apply a tiered co-payment structure (as is common in private sector plans), but such structure must result in a co-insurance structure that is actuarially equivalent to an “average expected payment” of 25% of the drug costs above the deductible.¹⁹⁸

Once a beneficiary has incurred a set amount of out-of-pocket costs (what CMS now calls “true out-of-pocket” expenses or “TrOOP”) for a year, Medicare will provide catastrophic coverage.¹⁹⁹ The out-of-pocket spending limit for 2006 is \$3,600; for subsequent

¹⁹² See Medicare Prescription Drug, Improvement, and Modernization Act, *supra* note 3.

¹⁹³ CMS, MEDICARE FACT SHEET: FINAL RULES IMPLEMENTING THE NEW MEDICARE LAW: A NEW PRESCRIPTION DRUG BENEFIT FOR ALL MEDICARE BENEFICIARIES, IMPROVEMENTS TO MEDICARE HEALTH PLANS AND ESTABLISHING OPTIONS FOR RETIREES (Jan. 21, 2005), <http://www.cms.hhs.gov/media/press/release.asp?Counter=1324> (last visited Feb. 25, 2006) [hereinafter FINAL RULES].

¹⁹⁴ Social Security Act § 1860D-2(b)(1)(A), 42 U.S.C. § 1395w-102(b)(1)(A) (2005).

¹⁹⁵ Social Security Act § 1860D-2(b)(1)(A)(ii), 42 U.S.C. § 1395w-102(b)(1)(A)(ii) (2005); Social Security Act § 1860D-2(b)(6), 42 U.S.C. § 1395w-102(b)(6) (2005).

¹⁹⁶ Social Security Act §§ 1860D-2(b)(2)-(3), 42 U.S.C. §§ 1395w-102(b)(2)-(3) (2005).

¹⁹⁷ Social Security Act § 1860D-2(b)(3)(A)(ii), 42 U.S.C. § 1395w-102(b)(3)(A)(ii) (2005); Social Security Act § 1860D-2(b)(6), 42 U.S.C. § 1395w-102(b)(6) (2005).

¹⁹⁸ Social Security Act § 1860D-2(b)(2), 42 U.S.C. § 1395w-102(b)(2) (2005).

¹⁹⁹ CMS, ISSUE PAPER #23: BENEFICIARIES AND TRUE OUT-OF-POCKET COSTS (TrOOP) (Jan. 21, 2005), http://www.cms.hhs.gov/medicareform/issuepapers/titleland2/files/issue_paper_23_-_beneficiaries_and_troop.pdf (last visited Feb. 25, 2006).

years, the \$3,600 will be adjusted—as with the annual deductible and the initial coverage limit—to reflect annual increases in average spending by Part D enrollees on covered Part D drugs.²⁰⁰ Medicare’s catastrophic coverage covers all allowed drug costs after the beneficiary pays the greater of 5% co-insurance or a co-payment of \$2 for generics and \$5 for other drugs (with the co-payments adjusted upward according to the same formula used to adjust the out-of-spending limit, the annual deductible and the initial coverage limit).²⁰¹ In most cases for 2006, the catastrophic coverage will apply after a beneficiary has incurred \$5,100 in allowed drug costs.²⁰²

In addition to the annual deductible and co-payments, beneficiaries will be responsible for 100% of their drug costs from the initial coverage limit (\$2,250 in 2006) until the TrOOP (out-of-pocket) limit (\$3,600 in 2006) is reached.²⁰³ This gap in which beneficiaries are solely responsible for costs is generally referred to as the “doughnut hole.”²⁰⁴ If a beneficiary is reimbursed by private insurance (including through an employer prescription drug plan) or other similar reimbursement, the reimbursed amounts do not count toward satisfying the deductible, nor are they considered in determining whether the beneficiary has incurred the doughnut hole costs.²⁰⁵ As a result, in order to receive the Medicare catastrophic coverage benefit, a beneficiary generally cannot escape a significant amount of out-of-pocket drug spending under a standard Part D prescription drug plan. One exception to this is that funds from a beneficiary’s own health care spending account, such as a flexible spending account or a health savings account, may be used to cover the doughnut hole and still count as TrOOP spending for purposes of reaching the catastrophic coverage threshold.²⁰⁶

A prescription drug plan sponsor may provide alternative prescription drug coverage as long as it provides benefits that CMS considers at least actuarially equivalent to the standard package and

²⁰⁰ Social Security Act § 1860D-2(b)(4)(B)(i), 42 U.S.C. § 1395w-102(b)(4)(B)(i) (2005); Social Security Act § 1860D-2(b)(6), 42 U.S.C. § 1395w-102(b)(6) (2005).

²⁰¹ Social Security Act § 1860D-2(b)(4)(A), 42 U.S.C. § 1395w-102(b)(4)(A); Social Security Act § 1860D-2(b)(6), 42 U.S.C. § 1395w-102(b)(6).

²⁰² See, e.g., VOLUNTEERS IN HEALTH CARE, MEDICARE PART D: THE BASICS (Aug. 10, 2005), <http://www.rxassist.org/docs/medicare-d-basics.pdf> (last visited Feb. 25, 2006) [hereinafter VOLUNTEERS].

²⁰³ Social Security Act § 1860D-2(b)(4), 42 U.S.C. § 1395w-102(b)(4) (2005).

²⁰⁴ VOLUNTEERS, *supra* note 202, at 3.

²⁰⁵ Social Security Act § 1860D-2(b)(4)(c)(ii), 42 U.S.C. § 1395w-102(b)(4)(c)(ii) (2005).

²⁰⁶ FINAL RULES, *supra* note 193, at 3.

as long as CMS approves the alternative design.²⁰⁷ To satisfy the actuarial equivalence requirement, not only must the plan provide total coverage that is actuarially equivalent to the standard package, but the unsubsidized portion of the alternative plan design must also be actuarially equivalent to the unsubsidized portion of the standard package.²⁰⁸ The maximum deductible under an alternative package cannot exceed the standard package deductible, and the alternative design must provide for payments of expenses up to the standard package initial coverage limit (and above the standard package deductible) that are at least equal to what Medicare would pay under the standard package.²⁰⁹ The alternative design must also provide the same level of catastrophic coverage as under the standard package.²¹⁰

A prescription drug plan sponsor may also provide supplemental coverage as long as the sponsor maintains the basic benefit package.²¹¹ Supplemental coverage may take the form of (1) reductions in the annual deductible or coinsurance limit or an increase in the initial coverage limit (or any combination of the preceding) as long as the overall effect is to increase the actuarial value of the benefit package above the actuarial value of the standard Part D prescription drug package; or (2) coverage of certain drugs that would be covered Part D drugs but for their exclusion from coverage under the Medicaid program²¹² (which excludes such drugs as fertility drugs, drugs used for cosmetic purposes, weight loss/gain drugs, and barbiturates).²¹³

Covered drugs under Part D generally include all prescription drugs that would be covered by Medicaid,²¹⁴ biological products, vaccines, insulin and medical supplies associated with the injection of insulin.²¹⁵ Drugs that are reimbursable under Medicare Part B or that would be excluded under Medicaid do not qualify for Part D coverage (but drugs covered under Part B will continue to be so

²⁰⁷ Social Security Act § 1860D-2(a)(1)(B), 42 U.S.C. § 1395w-102(a)(1)(B) (2005); Social Security Act § 1860D-2(c), 42 U.S.C. § 1395w-102(c) (2005).

²⁰⁸ Social Security Act § 1860D-2(c)(1), 42 U.S.C. § 1395w-102(c)(1) (2005).

²⁰⁹ Social Security Act §§ 1860D-2(c)(1)-(2), 42 U.S.C. §§ 1395w-102(c)(1)-(2) (2005).

²¹⁰ Social Security Act § 1860D-2(c)(3), 42 U.S.C. § 1395w-102(c)(3) (2005).

²¹¹ Social Security Act § 1860D-2(a)(2), 42 U.S.C. § 1395w-102(a)(2) (2005).

²¹² Social Security Act § 1860D-2(a)(2)(A), 42 U.S.C. § 1395w-102(a)(2)(A) (2005).

²¹³ Social Security Act § 1927(d)(2), 42 U.S.C. § 1396r-8(d)(2) (2005).

²¹⁴ Social Security Act § 1927(k)(2), 42 U.S.C. § 1396r-8(k)(2) (2005).

²¹⁵ Social Security Act § 1860D-2(e)(1), 42 U.S.C. § 1395w-102(e)(1) (2005).

covered).²¹⁶ Prescription drug plan sponsors may use formularies, but must include coverage of drugs within each “therapeutic category and class” of Part D drugs.²¹⁷ Under either the standard package or an alternative design, beneficiaries must be offered the same negotiated drug prices that apply to covered Part D drugs, even if the beneficiary is paying the full cost of such drugs due to an annual deductible or other cost-sharing obligation.²¹⁸

B. Medicare Part D Low-Income Assistance

When Medicare Part D prescription drug coverage begins in 2006, Medicare will also begin to provide prescription drug premium support and cost-sharing subsidies for certain low-income Medicare beneficiaries.²¹⁹ Three categories of low-income beneficiaries will qualify for federal assistance: (1) those with incomes below 150% of the federal poverty level²²⁰ and with limited assets (below \$10,000 for individuals, \$20,000 for couples);²²¹ (2) those with incomes below 135% of the federal poverty level and with limited assets (below \$6,000 for individuals, \$9,000 for couples),²²² and (3) those eligible for full Medicaid benefits as well as Medicare (the so-called “dual eligibles”).²²³ For Medicare beneficiaries below 150% of the poverty level, the MMA provides for a sliding-scale premium that varies with income,²²⁴ a \$50 annual deductible,²²⁵ 15% coinsurance up to \$5,100 in total drug costs,²²⁶ and limited co-payments af-

²¹⁶ Social Security Act § 1860D-2(e)(2), 42 U.S.C. § 1395w-102(e)(2) (2005).

²¹⁷ Social Security Act § 1860D-4(b)(3)(c), 42 U.S.C. § 1395w-104(b)(3)(c) (2005).

²¹⁸ Social Security Act § 1860D-2(d)(1), 42 U.S.C. § 1395w-102(d)(1) (2005).

²¹⁹ HENRY J. KAISER FAM. FOUND., LOW-INCOME ASSISTANCE UNDER THE MEDICARE DRUG BENEFIT (Sept. 2005), available at <http://www.kff.org/medicare/7327.cfm> (last visited Feb. 25, 2006); Social Security Act § 1860D-14, 42 U.S.C. § 1395w-114 (2005).

²²⁰ For 2005, the federal poverty level was \$9,570 for an individual and \$12,830 for a couple. Annual Update of the HHS Poverty Guidelines, 70 Fed. Reg. 8373 (Dep’t of Health and Human Servs. Feb. 18, 2005) (notice); Social Security Act § 1860D-14(a), 42 U.S.C. § 1395w-114(a) (2005).

²²¹ CMS, ISSUE PAPER #3: ADDITIONAL HELP TO THOSE WHO NEED IT MOST: THOSE WITH HIGH DRUG COSTS AND THOSE WITH LOW INCOMES (Jan. 21, 2005), available at <http://www.cms.hhs.gov/States/Downloads/MedicarePrescriptionDrugProgram&LimitedIncomeAssistance.pdf> (last visited Feb. 25, 2006) [hereinafter ISSUE PAPER #3].

²²² Social Security Act § 1860D-14(a)(1)(A), 42 U.S.C. § 1395w-114(a)(1)(A) (2005); ISSUE PAPER #3, *supra* note 221.

²²³ Social Security Act § 1860D-14(a)(3)(B)(v), 42 U.S.C. § 1395w-114(a)(3)(B)(v) (2005); FINAL RULES, *supra* note 193 (defining “dual eligible”).

²²⁴ Social Security Act § 1860D-14(a)(2)(A), 42 U.S.C. § 1395w-114(a)(2)(A) (2005).

²²⁵ Social Security Act § 1860D-14(a)(2)(B), 42 U.S.C. § 1395w-114(a)(2)(B) (2005).

²²⁶ Social Security Act § 1860D-14(a)(2)(D), 42 U.S.C. § 1395w-114(a)(2)(D) (2005).

ter the out-of-pocket \$3,600 threshold is met.²²⁷ For Medicare beneficiaries below 135% of the poverty level, the MMA provides for no premium (or a reduced premium in some cases),²²⁸ no deductible,²²⁹ limited co-payments up to the \$3,600 out-of-pocket threshold,²³⁰ and no co-payments once \$3,600 in out-of-pocket costs have been incurred.²³¹ Beginning in 2006, dual eligibles are exempt from Medicare Part D prescription drug plan premiums and deductible payments²³² and from any co-payment requirements after the first \$3,600 in out-of-pocket costs.²³³ Special additional provisions apply to dual eligibles.²³⁴

C. Medicare Part D Prescription Drug Plan Sponsor Requirements

In general, any insurer seeking to sponsor a Medicare Part D prescription drug plan beginning in 2006 must either satisfy the health insurer licensing requirements of the state in which it wishes to offer such a plan²³⁵ or qualify for a waiver of those requirements by the Department of Health and Human Services (HHS).²³⁶ The MMA provides two kinds of waivers. The first—a regional plan waiver—permits HHS to waive any particular state’s licensing requirement for a period of time for a prescription drug plan sponsor that is offering service to an entire region and is licensed in at least one state in the region.²³⁷ Under the second type of waiver, HHS must waive a state’s licensure requirements if a state takes certain actions, such as applying discriminatory criteria, or fails to act in a timely manner.²³⁸ Even with a waiver, a Medicare prescription drug

²²⁷ Social Security Act § 1860D-14(a)(2)(E), 42 U.S.C. § 1395w-114(a)(2)(E) (2005).
²²⁸ Social Security Act § 1860D-14(a)(1)(A), 42 U.S.C. § 1395w-114(a)(1)(A) (2005).
²²⁹ Social Security Act § 1860D-14(a)(1)(B), 42 U.S.C. § 1395w-114(a)(1)(B) (2005).
²³⁰ Social Security Act § 1860D-14(a)(1)(D)(iii), 42 U.S.C. § 1395w-114(a)(1)(D)(iii) (2005).
²³¹ Social Security Act § 1860D-14(a)(1)(E), 42 U.S.C. § 1395w-114(a)(1)(E) (2005).
²³² Social Security Act §§ 1860D-14(a)(1)(A)-(B), 42 U.S.C. §§ 1395w-114(a)(1)(A)-(B) (2005).
²³³ Social Security Act § 1860D-14(a)(1)(E), 42 U.S.C. § 1395w-114(a)(1)(E) (2005).
²³⁴ See, e.g., Social Security Act § 1860D-14(a)(1)(D), 42 U.S.C. § 1395w-114(a)(1)(D) (2005).
²³⁵ Social Security Act § 1860D-12(a)(1), 42 U.S.C. § 1395w-112(a)(1) (2005).
²³⁶ Social Security Act § 1860D-12(a)(1), 42 U.S.C. § 1395w-112(a)(1) (2005); Social Security Act § 1860D-12(c), 42 U.S.C. § 1395w-112(c) (2005).
²³⁷ Social Security Act § 1860D-12(c)(1)(B), 42 U.S.C. § 1395w-112(c)(1)(B) (2005); Social Security Act § 1858(d), 42 U.S.C. § 1395w-27a(d) (2005). The regional waiver provisions also apply to Medicare Advantage plans. Social Security Act § 1858(d), 42 U.S.C. § 1395w-27a(d) (2005).
²³⁸ Social Security Act § 1860D-12(c)(1), 42 U.S.C. § 1395w-112(c)(1) (2005); Social Security Act §§ 1855(a)(2)(B)-(D), 42 U.S.C. §§ 1395w-25(a)(2)(B)-(D) (2005).

plan sponsor must still satisfy solvency requirements established by HHS.²³⁹

The MMA also requires a prescription drug plan sponsor to follow certain enrollment, disenrollment, termination and change of enrollment rules, generally similar to those applicable to Medicare Advantage²⁴⁰ (previously Medicare+Choice) plans.²⁴¹ These rules include a requirement that the plan be open only to enrollees who reside within a geographic area served by the plan,²⁴² detailed provisions as to timing and duration of enrollment and disenrollment elections,²⁴³ and mandatory approval of all marketing materials by CMS.²⁴⁴ Medicare prescription drug plan sponsors must also permit Medicare beneficiaries to enroll during specified “special enrollment periods,” generally resulting from a beneficiary’s involuntary loss of “creditable prescription drug coverage” (coverage recognized as comparable to Part D prescription drug coverage).²⁴⁵

Medicare Part D prescription drug plan sponsors must not only disclose certain information, such as negotiated prices, to CMS in such manner as CMS determines,²⁴⁶ but must also provide significant annual disclosures to enrollees.²⁴⁷ The annual disclosures to enrollees must include information about access to covered drugs, how the plan’s drug formulary works (if the plan uses a formulary), and the enrollee’s cost-sharing obligations.²⁴⁸ Additional information, such as general coverage information, the plan’s utilization cost control processes, and grievance and appeal statistics, which must be provided to enrollees upon request.²⁴⁹ Specific information must be available to enrollees on a “timely basis” through a toll-free telephone number and in writing if requested.²⁵⁰ Plan sponsors must make available on an internet website any changes in plan for-

²³⁹ Social Security Act § 1860D-12(a)(3), 42 U.S.C. § 1395w-112(a)(3) (2005); Social Security Act §§ 1860D-12(d)(1)-(2), 42 U.S.C. §§ 1395w-112(d)(1)-(2) (2005).

²⁴⁰ Social Security Act § 1860D-1(b)(1), 42 U.S.C. § 1395w-101(b)(1) (2005).

²⁴¹ Medicare Prescription Drug, Improvement, and Modernization Act, *supra* note 3, at § 201(b).

²⁴² Social Security Act § 1851(b)(1)(A), 42 U.S.C. § 1395w-21(b)(1)(A) (2005).

²⁴³ Social Security Act §§ 1851(e)-(f), 42 U.S.C. §§ 1395w-21(e)-(f) (2005).

²⁴⁴ Social Security Act § 1851(h), 42 U.S.C. § 1395w-21(h) (2005).

²⁴⁵ Social Security Act § 1860D-1(b)(3), 42 U.S.C. § 1395w-101(b)(3) (2005).

²⁴⁶ Social Security Act § 1860D-2(d)(2), 42 U.S.C. § 1395w-102(d)(2) (2005).

²⁴⁷ Social Security Act § 1860D-4(a)(1)(A), 42 U.S.C. § 1395w-104(a)(1)(A) (2005).

²⁴⁸ Social Security Act § 1860D-4(a)(1)(B), 42 U.S.C. § 1395w-104(a)(1)(B) (2005).

²⁴⁹ Social Security Act § 1860D-4(a)(2), 42 U.S.C. § 1395w-104(a)(2) (2005); Social Security Act § 1852(c)(2), 42 U.S.C. § 1395w-22(c)(2) (2005).

²⁵⁰ Social Security Act § 1860D-4(a)(3)(A), 42 U.S.C. § 1395w-104(a)(3)(A) (2005).

mularies.²⁵¹ Plan sponsors must also provide enrollees with “easily understandable” explanations of benefits and notices of benefits that reflect the initial coverage limit and the out-of-pocket threshold for the applicable year.²⁵²

Additional requirements for Part D drug plan sponsors include a requirement that plans enlist a “sufficient number of pharmacies . . . to ensure convenient access” (other than through mail order).²⁵³ Plan sponsors must also issue a drug card or “other technology”—in accordance with standards established by CMS—to an enrollee to “assure access” to the drug plan’s negotiated prices.²⁵⁴ If a plan wants to use a formulary, a number of detailed rules apply to the development and adoption of the formulary. These rules include a requirement that the proposed formulary be reviewed by at least one practicing physician and one practicing pharmacist who are “independent and free of conflict” with regard to the plan sponsor and the plan and who have “expertise in the care of elderly or disabled persons.”²⁵⁵ Prescription drug plan sponsors must maintain a “cost-effective drug utilization management program”; a medication therapy management program; a program to control fraud, waste, and abuse; and “quality assurance measures and systems to reduce medication errors and adverse drug interactions and improve medication use.”²⁵⁶ Plan sponsors must also “provide meaningful procedures” for grievance resolution,²⁵⁷ and for claims determinations and appeals.²⁵⁸ Drug plan sponsors are also subject to periodic audit by CMS to protect against fraud and abuse.²⁵⁹

Assuming a prescription drug plan sponsor develops a plan that meets all of the above requirements, the sponsor must submit a bid to CMS, including, among other information, a description of the coverage the plan provides (including the deductible and cost-sharing requirements), the actuarial value of the coverage, and the service area for the plan.²⁶⁰ CMS will then review the bid and ap-

²⁵¹ Social Security Act § 1860D-4(a)(3)(B), 42 U.S.C. § 1395w-104(a)(3)(B) (2005).

²⁵² Social Security Act § 1860D-4(a)(4), 42 U.S.C. § 1395w-104(a)(4) (2005).

²⁵³ Social Security Act § 1860D-4(b)(1)(C), 42 U.S.C. § 1395w-104(b)(1)(C) (2005).

²⁵⁴ Social Security Act § 1860D-4(b)(2), 42 U.S.C. § 1395w-104(b)(2) (2005).

²⁵⁵ Social Security Act § 1860D-4(b)(3)(A)(ii), 42 U.S.C. § 1395w-104(b)(3)(A)(ii) (2005).

²⁵⁶ Social Security Act § 1860D-4(c)(1), 42 U.S.C. § 1395w-104(c)(1) (2005).

²⁵⁷ Social Security Act § 1860D-4(f), 42 U.S.C. § 1395w-104(f) (2005).

²⁵⁸ Social Security Act §§ 1860D-4(g)-(h), 42 U.S.C. §§ 1395w-104(g)-(h) (2005).

²⁵⁹ Social Security Act § 1860D-2(d)(3), 42 U.S.C. § 1395w-102(d)(3) (2005).

²⁶⁰ Social Security Act §§ 1860D-11(b)(1)-(2), 42 U.S.C. §§ 1395w-111(b)(1)-(2) (2005).

prove or disapprove the plan.²⁶¹ Among other factors, CMS must consider whether the plan design is “likely to substantially discourage enrollment by certain part D eligible individuals”²⁶² If the design results in such discouragement, CMS must disapprove the bid.²⁶³ If a bid is approved, the prescription drug plan sponsor must then enter into a contract with CMS before the sponsor may actually offer a Part D prescription drug plan.²⁶⁴

D. Medicare Advantage

In the pre-Part D era, one alternative for Medicare beneficiaries seeking supplemental coverage, particularly prescription drug coverage, was a private insurance approach, introduced in 1999 as “Medicare+Choice” or Medicare Part C and renamed by the MMA as “Medicare Advantage.”²⁶⁵ Medicare Advantage plans offer at least the same benefits as Medicare Parts A and B, but may also offer additional benefits to entice beneficiaries.²⁶⁶ Depending on the state, Medicare Advantage plans have included both Medicare HMOs and private fee-for-service plans under contract with Medicare.²⁶⁷ Medicare Advantage plans have generally been attractive to Medicare beneficiaries, but financial problems have resulted in a trend of Medicare Advantage insurers pulling out of markets across the country.²⁶⁸

In addition to changing the name, the MMA made a number of other changes intended to improve the Medicare Part C program and expand its availability, as well as coordinating Part C programs with the new Medicare Part D prescription drug coverage.²⁶⁹ Beginning in 2006, Medicare Advantage enrollees normally will receive their prescription drug coverage through their Medicare Advantage

²⁶¹ Social Security Act § 1860D-11(e)(1), 42 U.S.C. § 1395w-111(e)(1) (2005).

²⁶² Social Security Act § 1860D-11(e)(2)(D), 42 U.S.C. § 1395w-111(e)(2)(D) (2005).

²⁶³ *Id.*

²⁶⁴ Social Security Act § 1860D-12(b)(1), 42 U.S.C. § 1395w-112(b)(1) (2005).

²⁶⁵ Medicare Prescription Drug, Improvement, and Modernization Act, *supra* note 3, at § 201(b).

²⁶⁶ 42 C.F.R. §§ 422.101–102 (2003).

²⁶⁷ See, e.g., TEXAS DEP’T OF INS., MEDICARE ADVANTAGE PLANS FOR MEDICARE BENEFICIARIES (Aug. 2005), <http://www.tdi.state.tx.us/consumer/cbo36.html> (last visited Feb. 25, 2006).

²⁶⁸ See JOSE MONTEMAYOR, TEXAS DEP’T OF INS., OPTIONS FOR TEXANS WHO LOSE MEDICARE HMO COVERAGE, <http://www.tdi.state.tx.us/commish/columns/cc0999.doc> (last visited Feb. 25, 2006).

²⁶⁹ CMS, CHOICES FOR MEDICARE ADVANTAGE (Jan. 19, 2005), http://63.241.27.78/medicareform/pdbma/aiandocs/issue_paper_2_-_choices_for_maaian.pdf (last visited Feb. 25, 2006).

plans.²⁷⁰ In fact, as long as the Medicare Advantage plan in which a Medicare beneficiary is enrolled offers Part D prescription drug coverage, the enrolled individual may not separately enroll in another Part D prescription drug plan.²⁷¹ If, however, a Medicare beneficiary is enrolled in a Medicare Advantage private fee-for-service plan that does not include Part D prescription drug coverage, the individual may enroll in a separate prescription drug plan for Part D coverage.²⁷²

Provisions of the MMA applicable to prescription drug plan sponsors apply generally to Medicare Advantage plan sponsors that provide prescription drug coverage to their enrollees.²⁷³ Medicare Advantage plan sponsors must offer prescription drug coverage through at least one Medicare Advantage plan offered by the organization in any given area.²⁷⁴

E. Medicare Part D Employer Subsidies

The MMA provides tax-free subsidies for employer-sponsored retiree prescription drug plans offering prescription drug coverage that is at least equal to the actuarial value of the MMA's standard prescription drug coverage and that meets certain other requirements.²⁷⁵ During debate on the MMA, a key concern was that employer-sponsored retiree health plans might choose to reduce or eliminate prescription drug coverage for Medicare-eligible beneficiaries, accelerating the decline in employer-sponsored retiree health benefits.²⁷⁶ To offset this, the MMA included employer subsidies. If an employer-sponsored retiree prescription drug plan qualifies for the subsidy, the federal government will pay the sponsoring employer a subsidy equal to 28% of a qualifying enrollee's allowable annual prescription drug expenses from \$250 to \$5,000 (indexed after 2006), for a maximum annual subsidy of \$1,330 per enrollee.²⁷⁷ CMS estimates that the subsidy will average \$668 per beneficiary in

²⁷⁰ Social Security Act § 1860D-1(a)(1)(B)(i), 42 U.S.C. § 1395w-101(a)(1)(B)(i) (2005).

²⁷¹ Social Security Act § 1860D-1(a)(1)(B)(ii), 42 U.S.C. § 1395w-101(a)(1)(B)(ii) (2005).

²⁷² Social Security Act § 1860D-1(a)(1)(B)(iii), 42 U.S.C. § 1395w-101(a)(1)(B)(iii) (2005).

²⁷³ See, e.g., Social Security Act § 1860D-41(b), 42 U.S.C. § 1395w-151(b) (2005).

²⁷⁴ Social Security Act § 1860D-21(a)(1), 42 U.S.C. § 1395w-131(a)(1) (2005).

²⁷⁵ Social Security Act § 1860D-22(a)(2), 42 U.S.C. § 1395w-132(a)(2) (2005).

²⁷⁶ See generally HENRY J. KAISER FAM. FOUND. & HEWITT ASS'N, RETIREE HEALTH BENEFITS NOW AND IN THE FUTURE (Jan. 14, 2004), http://was4.hewitt.com/hewitt/resource/newsroom/pressrel/2004/01-14-04_report.pdf (last visited Feb. 25, 2006).

²⁷⁷ Social Security Act § 1860D-22(a)(3), 42 U.S.C. § 1395w-132(a)(3) (2005).

2006.²⁷⁸ The subsidy is payable only with respect to retirees who are not enrolled in Medicare Part D.²⁷⁹

Employer retiree health plans qualify for the MMA employer subsidy if they provide retiree prescription drug coverage that satisfies the MMA subsidy requirements.²⁸⁰ To receive the subsidies, employers must first ascertain whether their retiree prescription drug plans provide coverage that is at least actuarially equivalent in value to that provided under the standard MMA prescription drug package.²⁸¹ Most current employer-sponsored retiree prescription drug plans are believed to provide such coverage given the typical richness of such plans.²⁸² However, the MMA requires an annual attestation to HHS of such actuarial equivalence.²⁸³ The MMA also requires that employers maintain certain records to allow CMS to audit and provide oversight,²⁸⁴ and that employers notify all retirees, spouses, and dependents who are eligible for the retiree prescription drug plan as to whether coverage under the employee plan constitutes “creditable coverage” under the MMA.²⁸⁵ If the coverage is not “creditable,” retirees who subsequently enroll in a Medicare Part D prescription drug plan may be subject to late enrollment penalties.²⁸⁶

Although an employer will not receive the subsidy for a retiree who is both covered by the employer’s retiree prescription drug plan and enrolled in Medicare Part D, nothing in the MMA prevents such dual enrollment.²⁸⁷ In addition, nothing in the MMA prevents an employer-sponsored retiree health plan from paying for a retiree’s premium under a Medicare Part D prescription drug plan,

²⁷⁸ Medicare Program; Medicare Prescription Drug Benefit, 70 Fed. Reg. 4194, 4478 (Jan. 28, 2005) (to be codified at 42 C.F.R. pts. 400, 403, 411, 417, and 423).

²⁷⁹ MARK HAMELBERG, CMS, MMA TECHNICAL ASSISTANCE: EMPLOYER AND UNION GROUP ISSUES (May 19, 2005), http://www.healthactioncouncil.org/pdf/handouts/CMS_Mhamelburg_EmployerGroup.pdf (last visited Feb. 25, 2006).

²⁸⁰ Social Security Act § 1860D-22(a)(2), 42 U.S.C. § 1395w-132(c)(3) (2005).

²⁸¹ See, e.g., Greta E. Cowart, *Employer Sponsored Group Health Plan Changes in the Medicare Prescription Drug Improvement and Modernization Act of 2003*, A.L.I.—A.B.A. 413, 420 (Sept. 8, 2005).

²⁸² See, e.g., MELLON FIN. CORP., MELLON COMMENTS TO CMS ON MEDICARE REGULATIONS, HIGHLIGHTS OF OUR COMMENTS (Oct. 5, 2004), http://www.mellon.com/hris/pdf/fyi_10_05_04b.pdf (last visited Feb. 25, 2006).

²⁸³ Social Security Act § 1860D-22(a), 42 U.S.C. § 1395w-132(a) (2005).

²⁸⁴ Social Security Act § 1860D-22(a)(2)(B), 42 U.S.C. § 1395w-132(a)(2)(B) (2005).

²⁸⁵ Social Security Act § 1860D-22(a)(2)(C), 42 U.S.C. § 1395w-132(a)(2)(C) (2005).

²⁸⁶ Social Security Act § 1860D-13(b), 42 U.S.C. § 1395w-113(b) (2005).

²⁸⁷ Social Security Act § 1860D-22(a)(6), 42 U.S.C. § 1395w-132(a)(6) (2005).

from offering coverage under the retiree plan that is better than the standard Part D prescription drug package, or from providing supplemental coverage to Part D for retirees who are not enrolled in the employer's retiree prescription drug plan but are covered by Part D.²⁸⁸ The MMA specifies that employer retiree prescription drug plan design decisions do not need to reflect the Part D standard prescription drug package, as long as the overall design meets the actuarial equivalence requirements of the MMA (for employers who wish to qualify for the MMA subsidy).²⁸⁹

The MMA also permits CMS to waive certain Part D requirements for employer-sponsored prescription drug plans if the requirements "hinder the design of, the offering of, or the enrollment in such . . . plans."²⁹⁰ Even before the MMA, CMS had the "authority to waive or modify requirements that hinder the design of, the offering of, or the enrollment in Medicare Advantage plans by an employer" or labor union group.²⁹¹ The MMA simply extends this authority to cover prescription drug plans under Medicare Part D.²⁹² The waiver authority applies to contracts between employers and prescription drug plans or Medicare Advantage prescription drug plans, as well as to direct contracts between CMS and employers sponsoring their own prescription drug plans or Medicare Advantage prescription drug plans.²⁹³ The waiver authority allows CMS to authorize separate premiums for employer-sponsored retiree prescription drug plans and limitations of enrollment in such plans to the applicable employer's retirees and dependents.²⁹⁴

V. CMS GUIDANCE FOR EMPLOYERS ON IMPLEMENTATION OF THE MMA

Since the passage of the MMA, CMS has issued hundreds of pages of regulatory guidance aimed at explaining and facilitating implementation of Part D's prescription drug coverage provisions.²⁹⁵ Significant amounts of this guidance have focused directly

²⁸⁸ *Id.*

²⁸⁹ *Id.* at (D).

²⁹⁰ Social Security Act § 1860D-22(b), 42 U.S.C. § 1395w-132(b); Social Security Act § 1857(i), 42 U.S.C. § 1395w-27(i) (2005).

²⁹¹ HAMELBURG, *supra* note 279, at 14.

²⁹² *Id.* at 15.

²⁹³ *Id.*

²⁹⁴ Social Security Act § 1860D-22(b), 42 U.S.C. § 1395w-132(b) (2005).

²⁹⁵ See discussion *infra* Sections V.A & B.

on employer issues. In fact, CMS has stated that it “intend[s] to implement the drug benefit to permit and encourage a range of options for Medicare beneficiaries to augment the standard Medicare coverage [i]nclud[ing] facilitating coverage through employer plans”²⁹⁶

A. August 2004 Proposed Rule

CMS’ first major piece of guidance was a 231-page Proposed Rule issued in August 2004 that included 176 pages of comments preceding introduction of new regulations implementing Part D prescription drug coverage.²⁹⁷ CMS simultaneously issued a Proposed Rule implementing the Medicare Advantage program.²⁹⁸ The Part D Proposed Rule stated CMS’ policy goal of “reducing incentives for current employers, other insurers and government programs to reduce their current levels of coverage and replace that coverage with Part D wrap-around benefits”²⁹⁹

The Proposed Rule outlined several basic options for employers with retiree prescription drug plans. First, employers may continue to maintain their existing retiree prescription drug plan. If the plan provides drug benefits that are at least actuarially equivalent to the Part D standard prescription drug package, the employer will be eligible for the Part D employer subsidy to offset the employer’s costs.³⁰⁰ CMS noted that an employer who wants to qualify for the employer subsidy and also wants to provide retiree health insurance through a Medicare Advantage program can do so by selecting a Medicare Advantage program without a Part D drug benefit.³⁰¹ The employer then separately designs a drug benefit that provides coverage at least actuarially equivalent to the Part D standard drug benefit package, thereby qualifying for the subsidy, and then offers that coverage either directly or through a separate contract with a Medicare Advantage organization (which offers the alternative package as a private insurance option).³⁰²

²⁹⁶ Medicare Program; Medicare Prescription Drug Benefit, 69 Fed. Reg. 46,632, 46,633 (Aug. 3, 2004) (to be codified at 42 C.F.R. pts. 403, 411, 417, and 423).

²⁹⁷ *Id.* at 46,632–46,863.

²⁹⁸ Medicare Program; Establishment of the Medicare Advantage Program, 69 Fed. Reg. 46,866 (Aug. 3, 2004) (to be codified at 42 C.F.R. pts. 417 and 422).

²⁹⁹ Medicare Program; Medicare Prescription Drug Benefit, 69 Fed. Reg. at 46,650.

³⁰⁰ *Id.* at 46,698.

³⁰¹ *Id.*

³⁰² *Id.*

Employers can also provide supplemental or “wrap-around” coverage. In this model, an employer whose coverage doesn’t qualify for the Part D employer subsidy (because it is not sufficiently generous as to be actuarially equivalent to the Part D standard drug benefit package) uses the funds it previously directed toward some level of retiree prescription drug coverage to assist retirees with Part D costs not covered by Medicare (for example, the annual deductible and cost-sharing expenses).³⁰³ A similar alternative for employers is to pay all or part of the monthly Part D premium for retirees who enroll in Part D prescription drug plans or Medicare Advantage plans that include Part D prescription drug benefits.³⁰⁴

Finally, CMS suggested in the Proposed Rule that employers may offer a Part D prescription drug plan or Medicare Advantage prescription drug plan tailored specifically for their retirees, either through a contract with a third-party Part D prescription drug plan sponsor (or Medicare Advantage prescription drug plan sponsor) or directly under a CMS waiver.³⁰⁵ In either case, the employer’s costs will be reimbursed by Medicare to the extent Medicare covers the benefit package, just as with any other approved Part D prescription drug plan.³⁰⁶

CMS acknowledged in its comments to the Proposed Rule that any of the options that provide more generous benefits below the catastrophic coverage level than the basic Part D standard package will simply delay when Medicare’s catastrophic coverage becomes effective.³⁰⁷ A beneficiary still must incur the same level of out-of-pocket expenses before Medicare’s catastrophic coverage becomes effective, no matter what the option. For a retiree with relatively low prescription drug costs, having enhanced coverage as a result of an employer plan that provides either enhanced alternative coverage or wrap-around benefits will undoubtedly put that retiree in a better position than before Medicare Part D because the retiree’s expenses are subsidized by both the employer and Medicare. For a retiree with high prescription drug costs, the retiree is certainly not in a worse position by having the employer plan because his or her maximum exposure is still primarily the Medicare Part D out-of-pocket spending limit, plus the limited co-payments once Medicare

³⁰³ *Id.*

³⁰⁴ Medicare Program; Medicare Prescription Drug Benefit, 69 Fed. Reg. at 46,698–99.

³⁰⁵ *Id.* at 46,699.

³⁰⁶ *Id.*

³⁰⁷ *Id.* at 46,736.

catastrophic coverage is triggered. For the federal government, either employer option saves money because it lowers the government's reinsurance costs.³⁰⁸

The Proposed Rule also highlighted that the “[i]ntent of the MMA retiree prescription drug subsidy provisions is to slow the decline in employer-sponsored retiree insurance.”³⁰⁹ Overall, CMS has noted four “key policy objectives” with regard to the employer subsidy under the MMA: (1) “maximizing the number of retirees benefiting from the special retiree drug subsidy,” (2) “assuring that plan sponsors contribute to retiree drug coverage at least what Medicare pays on retirees’ behalf,” (3) “minimizing administrative burden while maximizing flexibility for employers and unions,” and (4) “remaining within budget estimates.”³¹⁰ In furtherance of at least the first goal, CMS stated that it intends “to make these subsidy payments as reasonably available to plan sponsors as possible.”³¹¹ Reflecting this approach, the Proposed Rule not only discussed in detail a range of alternative approaches under consideration, but also solicited comments on all aspects of Medicare Part D implementation.

B. January 2005 Final Rule

In late January 2005, after receiving 7,696 individual pieces of correspondence with comments on the Proposed Rule, CMS issued a Final Rule governing implementation of Medicare Part D.³¹² The Rule covers 391 pages, of which only sixty pages contain actual regulations. The remaining pages contain CMS’ extensive commentary, addressing the issues received during the comment period. Concurrent with publication of the Final Rule on Part D, CMS also issued its Final Rule on Medicare Advantage, a relatively minor 155 pages reflecting more than 1,000 comments received following publication of that Proposed Rule.³¹³

The Part D Final Rule begins its discussion of employer-sponsored retiree prescription drug coverage with two positive state-

³⁰⁸ *Id.*

³⁰⁹ Medicare Program; Medicare Prescription Drug Benefit, 69 Fed. Reg. at 46,737.

³¹⁰ HAMELBERG, *supra* note 279.

³¹¹ Medicare Program; Medicare Prescription Drug Benefit, 69 Fed. Reg. 46,632, 46,737 (Aug. 3, 2004) (to be codified at 42 C.F.R. pts. 403, 411, 417, and 423).

³¹² Medicare Program; Medicare Prescription Drug Benefit, 70 Fed. Reg. 4194, 4198 (Jan. 28, 2005) (to be codified at 42 C.F.R. pt. 423).

³¹³ Medicare Program; Establishment of the Medicare Advantage Program, 70 Fed. Reg. 4588 (Jan. 28, 2005) (to be codified at 42 C.F.R. pts. 417 and 422).

ments: (1) that the overall impact of employer coverage and Medicare Part D “will result in combined aggregate payments by employers/unions and Medicare for drug coverage on behalf of retirees that are significantly greater than they otherwise would have been without the enactment of the MMA” and (2) that Medicare Part D and the employer subsidy “represent a particularly important strengthening of health care coverage for future Medicare-eligible retirees,” the latter especially important in light of the “erosion in the availability and generosity of employment-based retiree coverage for future Medicare beneficiaries that has already been taking place.”³¹⁴ From that optimistic starting point, the Final Rule then discusses various aspects of the Part D subsidy for employer-sponsored retiree plans and other options available to employers. Underlying the discussion are the same four basic policy guidelines stated in the Proposed Rule, with some refinements in the first two guidelines: (1) “maximizing the number of Medicare-eligible retirees with high quality employer or union-provided retiree drug coverage, and maximizing the generosity of their coverage,” and (2) “avoiding financial windfalls in the retiree drug subsidy program by ensuring that plan sponsors contribute at least as much to retiree drug coverage as Medicare pays them as a subsidy.”³¹⁵

CMS lays out a more refined vision of employer options in the Final Rule than it had included in the Proposed Rule, presumably reflecting the effect of considerable outside input. In the Final Rule, CMS divides the employer options into two fundamentally different approaches. The first approach—to continue an employer’s existing retiree prescription drug plan and apply for the Medicare Part D subsidy—maintains the status quo for retirees, but gives employers a financial boost.³¹⁶ The second approach—to redesign an employer’s retiree coverage to coordinate with an approved new Medicare Part D prescription drug plan—throws the status quo to the wind and instead fully embraces the new Medicare program.³¹⁷ The first approach is relatively straightforward for employers whose existing plans provide coverage that is at least actuarially equivalent to the standard Medicare Part D package. The second approach,

³¹⁴ Medicare Program; Medicare Prescription Drug Benefit, 70 Fed. Reg. at 4476.

³¹⁵ *Id.*

³¹⁶ *Id.*

³¹⁷ *Id.* at 4477.

however, allows a variety of alternative implementation strategies.³¹⁸

CMS characterizes the second approach (coordinating with a Medicare Part D prescription drug plan) as a way for employers currently sponsoring retiree prescription drug plans to “provide additional drug coverage” by encouraging retirees to enroll in a new Medicare Part D plan and then by providing coverage “over and above the standard Part D benefit that maintains or exceeds the generosity of their current benefit designs.”³¹⁹ According to the Final Rule, an employer may provide the enhanced coverage by (1) contracting with a third-party Part D prescription drug plan to provide “enhanced benefits” to the employer’s retirees, (2) arranging for a third-party prescription drug plan provider (or Medicare Advantage organization) through a CMS waiver to “offer a customized plan that is exclusive to the employer[‘s] . . . retirees,” (3) directly offering a Part D prescription drug plan “that offers an enhanced benefit” to their retirees by becoming an approved Part D prescription drug plan sponsor, or (4) offering separate supplemental, wrap-around drug coverage that coordinates with a Part D plan.³²⁰ In addition, CMS notes that employers may also pay all or part of Medicare Part D premiums for their retirees.³²¹ Despite what appear to be close similarities between the various options, the Final Rule provides relatively little elaboration as to how the details of the different arrangements might work.

The Final Rule does, however, identify a number of factors that CMS believes will affect employers’ choices among the various options. First, CMS expects whether an employer is subject to federal income tax to significantly impact the value of the Part D employer subsidy for that employer.³²² As noted previously, CMS estimates that the subsidy will be worth on average \$668 per retiree without taking into account the tax-free nature of the subsidy.³²³ For a taxable employer, the nature of the subsidy increases its value to about \$891 per retiree for a corporation with a marginal tax rate of 25% and about \$1,028 per retiree for a corporation with a 35% marginal tax rate.³²⁴ Second, CMS expects whether or not an employer cur-

³¹⁸ *Id.*

³¹⁹ Medicare Program; Medicare Prescription Drug Benefit, 70 Fed. Reg. at 4477.

³²⁰ *Id.*

³²¹ *Id.*

³²² *Id.* at 4478.

³²³ *Id.*

³²⁴ Medicare Program; Medicare Prescription Drug Benefit, 70 Fed. Reg. at 4478.

rently uses a supplemental or wrap-around approach with Medicare Parts A and B and retiree health coverage to affect the employer's choice.³²⁵ CMS believes that employers who currently use a wrap-around approach with other parts of Medicare may prefer that approach with Part D.³²⁶ A third factor from CMS' perspective is whether an employer's existing retiree prescription drug package reaches the actuarially equivalent threshold to qualify for the Part D employer subsidy.³²⁷ An employer whose existing package was almost, but not quite, actuarially equivalent might choose to increase benefits just enough to qualify for the subsidy or instead switch to a wrap-around approach to maintain the same level of employer contribution (and, CMS hopes, provide a more generous overall benefit for retirees when the combined Part D and employer wrap-around coverage is taken into account).³²⁸

The Final Rule also acknowledges a number of additional factors raised by commentators responding to the Proposed Rule.³²⁹ These include: "the timeframe of CMS regulation and guidance; the degree of flexibility in the retiree drug subsidy program (for example, relating to the actuarial equivalence methodology, application process, plan sponsor and qualifying covered retiree definitions, payment methodology and frequency, and subsidy payment allocation requirements); the amount of flexibility in the waiver process for employer-sponsored [prescription drug plans and Medicare Advantage prescription drug plans]; the financial incentives and degree of administrative burden associated with the various options; the timely availability of feasible PDP and wrap-around options in the market; and employers and unions' own internal timeframes and processes required to make benefit design changes."³³⁰ Still additional concerns raised either by commentators or CMS include the cost of the actuarial attestation required to qualify for the subsidy,³³¹ the claims tracking requirements involved in ongoing qualification for the subsidy,³³² a Governmental Accounting Standards Board rule issued in 2004 that requires similar accounting by state and local

³²⁵ *Id.*

³²⁶ *Id.*

³²⁷ *Id.*

³²⁸ *Id.*

³²⁹ Medicare Program; Medicare Prescription Drug Benefit, 70 Fed. Reg. at 4479.

³³⁰ *Id.*

³³¹ *Id.*

³³² *Id.*

governments to what FAS 106 requires from private employers,³³³ and long-term economic and demographic trends (such as rising health care costs and increasing retiree populations as compared to active populations).³³⁴

Both the number and the range of factors that are expected to affect employer choices with respect to future retiree prescription drug coverage lead to CMS' observation in the Final Rule that "most employers and unions have not yet decided how they will respond to the options that are available to them under the Medicare drug benefit and retiree drug subsidy."³³⁵ CMS acknowledges that, while "early evidence suggests" that current retirees are likely to continue to receive some level of employer-provided prescription drug benefit, in the long run this may change.³³⁶ This may prove particularly true as drug costs continue to increase, as employers who have adopted caps on retiree health costs begin to approach those caps, and as the value of the Medicare Part D standard prescription drug package begins to equal or exceed the value of employer plans.³³⁷

The Final Rule also addresses a number of practical implementation issues with respect to which CMS had requested comment in the Proposed Rule. First, with respect to the determination of whether an employer's retiree prescription drug coverage is at least actuarially equivalent to the Part D standard benefit package (and thus qualifies for the Part D employer subsidy), CMS considered several alternative approaches to determining actuarial equivalence.³³⁸ The primary difference between the approaches was the degree to which the actuarial valuation would take into account retiree contributions toward the cost of coverage.³³⁹ In the Final Rule, CMS adopts a two-part actuarial equivalence test. First, an employer must pass a total or "gross" value test that evaluates whether the total value of the employer's benefit at least equals the value of the standard Medicare Part D benefit.³⁴⁰ Then, the employer must satisfy a "net" value test that again evaluates whether the total value of the employer's benefit at least equals the value of the standard Medicare Part D benefit, but then also takes into account the spon-

³³³ *Id.* at 4480.

³³⁴ Medicare Program; Medicare Prescription Drug Benefit, 70 Fed. Reg. at 4481–82.

³³⁵ *Id.* at 4480.

³³⁶ *Id.* at 4481.

³³⁷ *Id.*

³³⁸ Medicare Program; Medicare Prescription Drug Benefit, 69 Fed. Reg. at 46,741.

³³⁹ *See id.*

³⁴⁰ *See* HAMELBURG, *supra* note 279.

sor's contribution toward financing the employer benefit.³⁴¹ The "net" value test also considers the effect of an employer plan that supplements Medicare Part D coverage.³⁴² From CMS' perspective, the combined tests "minimize windfalls and present a good balance for both beneficiaries and plan sponsors."³⁴³

In addition to the actuarial equivalence issues, the Final Rule also specifies exactly what must be included in an employer's application to CMS for the employer Part D subsidy, including a significant amount of participant-specific information (such as full names, dates of birth, Social Security numbers, and relationship to the retired employee).³⁴⁴ An employer must provide this information each year no later than ninety days before the start of the next plan year (unless an extension request has been filed with and approved by CMS).³⁴⁵ This will require employers to complete all plan design changes well in advance of the annual deadline, and possibly to complete open enrollment by that date as well. This could significantly change timing of the planning process for most employers. Employers must also provide claims-related data each year, which may require end-of-year reconciliations.³⁴⁶ Although insured arrangements can be eligible for the subsidy, participating will require maintenance and provision of some employer-level data.³⁴⁷

C. Other CMS Guidance

In meetings with industry benefit experts, CMS in early and mid-2005 again outlined the same basic employer options as described in the Final Rule, then discussed reasons why an employer might choose one option over another.³⁴⁸ From CMS' perspective, employers may choose to retain current prescription drug plans for retirees and pursue the subsidy for a variety of reasons. Such a decision minimizes change, avoids the "lead time" required to redesign and roll-out a different program, avoids possible restrictions under existing contracts or collective bargaining agreements, and

³⁴¹ *Id.*

³⁴² *Id.*

³⁴³ *Id.*

³⁴⁴ Medicare Program; Medicare Prescription Drug Benefit, 70 Fed. Reg. at 4578.

³⁴⁵ *Id.*

³⁴⁶ See HAMELBURG, *supra* note 279.

³⁴⁷ *Id.*

³⁴⁸ *Id.*

gives an employer time to “see how the market evolves before committing to change.”³⁴⁹

On the other hand, CMS noted that some employers may wish to move toward supplemental (or wrap-around) coverage, especially those who will not enjoy the tax benefits of the subsidy (because they are tax-exempt or a governmental plan), or those who simply will not qualify for the subsidy because their plans fail to reach the actuarial equivalence threshold.³⁵⁰ Supplemental coverage can fill in the gaps where Medicare Part D does not provide coverage, which helps a retiree, and an employer benefits from the significant subsidy provided by the federal government through the costs covered by Medicare Part D.³⁵¹ CMS also observed that adopting a wrap-around coverage approach may also be easy for both employers and retirees to understand because it follows the model already in place for many employer-sponsored retiree plans that coordinate with traditional Medicare benefits.³⁵² Adopting a stand-alone plan also avoids issues of availability of national prescription drug plans or Medicare Advantage prescription drug plans, a key concern for large employers who may have retirees scattered across the United States.³⁵³ However, CMS stressed that supplemental coverage cannot count toward a beneficiary’s meeting the \$3,600 out-of-pocket spending limit before Part D catastrophic coverage becomes effective,³⁵⁴ which may limit the attractiveness of this option for some employers. Additional issues include coordination of benefits challenges for an employer who decides to implement a stand-alone supplemental plan.³⁵⁵ CMS indicated that it intends to assist employers with these challenges and is working “to facilitate effective coordination of benefits.”³⁵⁶

For some employers whose existing retiree prescription drug plans either fail to qualify for the Part D subsidy, or who will not realize any tax benefits from the subsidy, CMS believes that the waiver approach (i.e., becoming sponsor of an approved Medicare Part D prescription drug plan customized through a waiver for an individual employer’s retiree population) may be more appealing

³⁴⁹ *Id.*

³⁵⁰ *Id.*

³⁵¹ See HAMELBURG, *supra* note 279.

³⁵² *Id.*

³⁵³ *Id.*

³⁵⁴ *Id.*

³⁵⁵ *Id.*

³⁵⁶ See HAMELBURG, *supra* note 279.

than adopting a stand-alone supplemental plan because certain employers may prefer the “opportunity to provide [a] more integrated approach to drug and other health coverage . . . and avoid [the] operational challenges of stand-alone coordination of benefits.”³⁵⁷

For employers who choose to become prescription drug plan or Medicare Advantage prescription drug plan sponsors themselves, and then provide customized coverage directly pursuant to a CMS waiver, CMS has indicated that its review of waiver applications will consider three goals: (1) “providing sponsors with maximum flexibility and minimum administrative burden so they keep offering—and retirees can retain—high quality retiree prescription drug coverage,” (2) budget issues, and (3) “providing appropriate protections Medicare beneficiaries may expect from Part D benefits.”³⁵⁸ CMS has also independently issued a number of classes of waivers (in three separate pieces of guidance dated February 11, March 9, and April 6, all of 2005) that will automatically apply to direct contracts between employers and CMS, as well as waivers that will apply to employer plans that purchase benefits from other Part D plan sponsors.³⁵⁹ The waivers do not require individual applications to CMS by employers.³⁶⁰

Key waivers include (1) waiver of certain management and operational requirements under the MMA³⁶¹ for employers subject to ERISA fiduciary requirements or similar state or federal law standards,³⁶² (2) waiver of the actuarial equivalence test for alternative coverage for plans offered “exclusively to employer or union retirees,”³⁶³ (3) waiver of the state licensing requirement for an employer applying to become a prescription drug plan sponsor “solely for purposes of providing prescription drug coverage to its retirees;”³⁶⁴

³⁵⁷ *Id.*

³⁵⁸ *Id.*

³⁵⁹ CMS, ADDITIONAL PART D WAIVER GUIDANCE FOR EMPLOYER/UNION RETIREE COVERAGE (Mar. 9, 2005), <http://www.cms.hhs.gov/medicarerreform/pdbma/EmployerWaiverGuidance2.pdf> (last visited Feb. 25, 2006) [hereinafter MARCH WAIVER GUIDANCE].

³⁶⁰ *Id.*

³⁶¹ *Id.*

³⁶² *Id.* The waiver is intended to reflect the existence of other statutory oversight requirements and to “avoid imposing additional (and potentially conflicting) government oversight that may hinder employers and unions from considering direct Part D contracts with CMS” *Id.*

³⁶³ *Id.*

³⁶⁴ CMS, PART D WAIVER GUIDANCE FOR EMPLOYER/UNION RETIREE COVERAGE (Feb. 11, 2005), <http://www.cms.hhs.gov/medicarerreform/pdbma/EmployerWaiverGuidance.pdf> (last visited Feb. 25, 2006) [hereinafter FEBRUARY WAIVER GUIDANCE]. CMS still requires an

(4) waiver of certain pharmacy access requirements for employer plans and plans contracting directly with employer plans, subject to an attestation to CMS that “the plan’s networks are sufficient to meet the needs of its retiree population, including situations involving emergency access,”³⁶⁵ (5) waiver of Part D disclosure requirements for beneficiary communications and marketing materials, including requirements for prior CMS approval, in light of employer plan disclosure requirements under ERISA and other laws,³⁶⁶ (6) waiver of certain Part D cost reporting requirements (which mandate reporting of cost of operations and financial statements to CMS, enrollees, and the public at large) as long as “information regarding such arrangements [is] reported to enrollees and to the general public to the extent required by other law (including ERISA or securities laws) or by contract,”³⁶⁷ (7) waiver of Part D’s prohibition against state or local government sponsorship of Part D prescription drug plans for governmental entities that wish to sponsor a Part D prescription drug plan for their retirees,³⁶⁸ and (8) waiver of a Part D requirement that a Part D prescription drug plan accept any Medicare beneficiary who lives within the plan’s service area, but only beneficiaries who live within that area.³⁶⁹ The latter waiver allows an employer-sponsored Part D prescription drug plan to cover only the employer’s retirees, without regard to where they may reside.³⁷⁰

Since April of 2005, CMS has continued to issue guidance, organize conference calls, and generally assist employers in every way possible to encourage continuation of existing retiree prescription

employer to meet certain solvency and other standards. CMS has also provided for a waiver, on a case-by-case basis, of its own standards for an employer plan that can demonstrate “that its fiscal soundness is commensurate with its financial risk and that through other means the entity can assure that claims for benefits paid for by CMS and beneficiaries will be covered.” MARCH WAIVER GUIDANCE, *supra* note 359.

³⁶⁵ FEBRUARY WAIVER GUIDANCE, *supra* note 364. Medicare Part D generally prohibits a prescription drug plan from limiting coverage to mail order prescription drugs and requires a plan to offer “broad networks of retail pharmacies to provide convenient access to beneficiaries,” but CMS recognized that the pharmacy access requirements applicable to prescription drug plan sponsors in general may not be needed for employer plans, which already have an “interest in ensuring their retirees have adequate pharmacy access” and “may have only . . . small numbers of retirees concentrated in a local area within a large region.” *Id.*

³⁶⁶ *Id.*

³⁶⁷ *Id.* CMS explained that this waiver for employer plans was intended to “avoid imposing additional and possibly conflicting public disclosure obligations that would hinder the offering of employer . . . direct contract arrangements.” *Id.*

³⁶⁸ FEBRUARY WAIVER GUIDANCE, *supra* note 364.

³⁶⁹ *Id.*

³⁷⁰ *Id.*

drug plans.³⁷¹ For example, CMS argued that the subsidy has “highly flexible rules that permit employers . . . to continue providing drug coverage to their Medicare-eligible retirees at a lower cost while retaining their current plan designs.”³⁷² CMS also outlined what it called a “streamlined process” for employers to qualify for and receive the drug subsidy.³⁷³ CMS has also established a separate website specifically for employers interested in the retiree drug subsidy.³⁷⁴

VI. EMPLOYER REACTIONS

A February 2005 report by the Government Accountability Office (GAO) determined that many employers who currently offer retiree prescription drug coverage had yet to reach final decisions about what they will do following the January 2006 implementation of Medicare Part D.³⁷⁵ Most, however, expected to adopt the Part D employer subsidy approach at least for 2006.³⁷⁶ Employers who had previously established caps on retiree health liability generally expected to adopt some level of wrap-around coverage, and most employers planned to coordinate in some way with a Medicare Part D plan rather than to develop their own comprehensive plan.³⁷⁷ Overall, employers did not immediately expect to reduce their own retiree drug coverage, but believed that continuing health care cost increases could result in such reductions in the future.³⁷⁸ There was no evidence to suggest that any employer not currently offering retiree prescription drug coverage would become tempted to implement such coverage as a result of Medicare Part D.³⁷⁹

³⁷¹ See generally CMS, PRESCRIPTION DRUG PLANS, <http://www.cms.hhs.gov/pdps/> (last visited Feb. 25, 2006). See also CMS, TRAINING & USER GROUP INFORMATION, http://www.cms.hhs.gov/pdps/Trning_UsrGrpInfo.asp (last visited Feb. 25, 2006).

³⁷² CMS, THE RETIREE DRUG SUBSIDY: WHY EMPLOYERS AND UNION PLAN SPONSORS SHOULD CONSIDER IT, (Apr. 6, 2005), <http://www.cms.hhs.gov/medicarerereform/pdbma/RetireeDrugSubsidy4Emp04-06-05.pdf> (last visited Feb. 25, 2006).

³⁷³ *Id.*

³⁷⁴ See CMS, RETIREE DRUG SUBSIDY PROGRAM, <http://rds.cms.hhs.gov> (last visited Feb. 25, 2006).

³⁷⁵ U.S. GOVT. ACCT. OFFICE, REPORT NO. GAO-05-205: RETIREE HEALTH BENEFITS: OPTIONS FOR EMPLOYMENT-BASED PRESCRIPTION DRUG BENEFITS UNDER THE MEDICARE MODERNIZATION ACT (Feb. 2005), available at <http://www.gao.gov/new.items/d05205.pdf> (last visited Feb. 25, 2006).

³⁷⁶ *Id.*

³⁷⁷ *Id.*

³⁷⁸ *Id.*

³⁷⁹ *Id.*

The GAO findings match various industry reports on employer plans. For example, a 2005 survey by Deloitte Consulting found that 90% of employers currently offering retiree prescription drug coverage intended to continue some level of coverage following passage of Medicare Part D, and about 55% of those who intended to continue coverage either planned to apply for the Medicare Part D employer subsidy, or were “leaning” in that direction.³⁸⁰ Of the employers surveyed, 19% were either “leaning to” or had decided on wrap-around coverage.³⁸¹ Key factors for employers leaning toward applying for the Part D employer subsidy were the effect of their choice on their financial statements and the eligibility of the existing retiree plan for the subsidy, closely followed by the challenges of “communicating plan design changes to retirees.”³⁸² For employers leaning toward adopting some form of wrap-around coverage, the effect on the employers’ financial statements remained a primary concern, but was closely followed by concerns over administrative issues.³⁸³

Another 2005 report, this one by Chicago Consulting Actuaries, anticipated that most employers will choose the employer subsidy for 2006 “because it is the simplest to implement and involves the least change.”³⁸⁴ On the other hand, the report noted, the administrative hurdles to applying for the subsidy—such as the actuarial attestation, data collection and reporting requirements, and timing issues—may reduce the attractiveness of this option for some employers.³⁸⁵ For large employers with significant Medicare-eligible populations currently covered by employer-sponsored retiree prescription drug coverage, the report suggested that becoming a Part D prescription drug plan sponsor may be financially attractive, despite the considerable time and effort that will be involved in implementing such a decision.³⁸⁶ Employers who are attracted to this approach, but do not want to accept the administrative responsibili-

³⁸⁰ DELOITTE CONSULTING, EMPLOYER RESPONSE TO MEDICARE PART D PRESCRIPTION DRUGS—2005 SURVEY, http://www.deloitte.com/dtt/cda/doc/content/us_humancapita_medicare_survey.pdf (last visited Feb. 25, 2006).

³⁸¹ *Id.*

³⁸² *Id.*

³⁸³ *Id.*

³⁸⁴ CHICAGO CONSULTING ACTUARIES, INSIGHT: MEDICARE PART D LEGISLATION: EMPLOYER OPTIONS (Jan. 20, 2005), http://insight.chicagoconsultingactuaries.com/Insight/Documents/MedPartD_EmployerOptions.aspx (last visited Feb. 25, 2006) [hereinafter CHICAGO CONSULTING ACTUARIES].

³⁸⁵ *Id.*

³⁸⁶ *Id.*

ties, may decide to contract with third-party Part D prescription drug plan sponsors.³⁸⁷ The report noted, however, that there remains considerable uncertainty as to the mechanics of such arrangements, and that the availability of such arrangements in the market is still limited, prompting many employers to take a “wait and see” approach to this option.³⁸⁸ The report concluded what CMS and many other reports tend to leave unsaid: that it may be easier and more appealing for many employers to eliminate any form of direct retiree drug coverage and simply provide financial assistance to retirees to help cover Medicare Part D premiums.³⁸⁹

VII. EMPLOYER ALTERNATIVES AFTER THE MMA

For Medicare-eligible retirees, virtually all the factors that might cause an employer to make a choice in one direction or another with regard to retiree prescription drug coverage changed as a result of the MMA.³⁹⁰ Just as the initial passage of Medicare in the 1960s suggested that American society could set aside its general preference for private solutions when the social need (at the time Medicare passed, the need was for a general health care safety net for the elderly) became sufficiently pressing, so too does the passage of the MMA, with the creation of Medicare Part D, suggest that public concern over prescription drug costs for the elderly has finally trumped an entrenched bias against federal government intervention. The existence of Medicare Part D also removes much of the teeth from the most powerful public policy argument previously in favor of continued employer retiree prescription drug coverage—that no sufficient alternative existed for the vast majority of retirees.³⁹¹ Remembering the general assumption that access to care (including prescription drug coverage) is a preferred social goal in the United States,³⁹² and in the absence of any government-funded generally available alternative, employer-sponsored retiree prescription drug coverage in the pre-MMA days met a critical need.³⁹³ With

³⁸⁷ *Id.*

³⁸⁸ *Id.*

³⁸⁹ CHICAGO CONSULTING ACTUARIES, *supra* note 384.

³⁹⁰ Because Medicare Part D provides prescription drug coverage only for Medicare-eligible retirees, it does not impact the issues surrounding coverage for early retirees who are not Medicare-eligible.

³⁹¹ See discussion *supra* Section II.F.

³⁹² See discussion *supra* Section II.B.

³⁹³ See discussion *supra* Section II.F.

Medicare Part D in place, an arguably better and more widely available alternative exists.

The presence of the Medicare Part D prescription drug safety net also undercuts the financial “common good” argument that employer retiree prescription drug coverage should be maintained because, in the absence of a good alternative in the pre-MMA days, it was by far the best way to encourage medication compliance by retirees—and to avoid expensive health complications that result from medication noncompliance and that eventually increase society’s costs through higher Medicare expenses (or government-funded charity care for those not eligible for Medicare).³⁹⁴ On the other hand, a financial “common good” argument may still be made in favor of maintaining employer retiree drug plans to reduce the burden on Medicare. Medicare costs threaten to overwhelm the federal budget.³⁹⁵ The exact cost of adding prescription drug coverage to Medicare has provoked ongoing debate, but no one doubts that the added expense is massive.³⁹⁶ In fact, recent government budget figures project the cost for the drug benefit alone to be \$1.2 trillion over the next decade.³⁹⁷ Those numbers assume some level of continuing employer retiree prescription drug coverage. If employers were to significantly reduce or altogether stop their contributions toward retiree prescription drug coverage, the cost of the Medicare Part D program would necessarily increase. For example, assuming retirees do not elect Part D, an employer providing a retiree prescription drug plan with benefits that are actuarially equivalent to the standard Medicare Part D package will save the federal government the difference between the cost of that coverage and the cost of the 28% Part D subsidy. Given that one in three Medicare beneficiaries currently has some level of employer prescription drug coverage,³⁹⁸ and given the pervasive sense that many current employer plans provide coverage that is at least actuarially equivalent to

³⁹⁴ *Id.*

³⁹⁵ See, e.g., Tom Abate, *Medicare Faces Cost Crisis; Multitrillion-dollar Deficits Loom Over Federal Programs*, S.F. CHRON., Nov. 7, 2004, at B1, available at <http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2004/11/07/BUG0V9N54U1.DTL> (last visited Feb. 25, 2006).

³⁹⁶ Ceci Connolly & Mike Allen, *Medicare Drug Benefit May Cost \$1.2 Trillion*, WASH. POST, Feb. 9, 2005, at A1, available at <http://www.washingtonpost.com/wp-dyn/articles/A9328-2005Feb8.html> (last visited Feb. 25, 2006).

³⁹⁷ *Id.*

³⁹⁸ KAISER/HEWITT 2004 SURVEY FINDINGS, *supra* note 89, at 27.

Medicare Part D,³⁹⁹ any significant percentage of those beneficiaries moving from employer coverage to Part D could negatively impact the financial position of the Medicare program. In the long run, skyrocketing Medicare costs will result in either benefit cutbacks, increased taxes, or both.⁴⁰⁰ While such long-term risks may be somewhat remote for an individual employer to contemplate, their presence nonetheless advocates for maintaining employer plans.

When considering the financial benefit for Medicare of continuing employer retiree drug coverage, such coverage cannot be compared directly with general employer health insurance for Medicare-eligible retirees, at least not in the current environment. Other than prescription drug coverage, the vast majority of employer retiree health insurance for Medicare-eligible individuals currently wraps around or otherwise supplements Medicare.⁴⁰¹ As a result, the federal government generally carries the overwhelming majority of the financial burden for health care for such individuals without regard to whether they have employer-provided retiree health insurance or not. The same will not necessarily be the case with Medicare Part D and employer retiree prescription drug coverage because, at present, employer plans are an alternative, not a complement, to Part D. As long as employer retiree prescription drug plans remain an alternative, the government continues to escape a significant financial responsibility.

Taking a different perspective, one might suggest that shifting all prescription drug coverage to the government would lead to a more equitable sharing of costs across the tax base. Because large employers tend to be the only ones who still provide retiree health insurance with prescription drug coverage as a standard benefit, such employers disproportionately shoulder the burden of that coverage. If all retiree prescription drug coverage falls on Medicare, assuming that taxes eventually increase to balance the budget (as opposed to cutting back Medicare, which seems unlikely), the tax burden will be spread across the entire tax base. On some level, this will cause everyone, corporations and individuals alike, to share in the cost of prescription drug coverage for the elderly. On a practical

³⁹⁹ See, e.g., MELLON FIN. CORP., CMS FINAL MEDICARE REGULATIONS PROVIDE GUIDANCE ON THE EMPLOYER SUBSIDY (Jan. 28, 2005), available at http://www.mellon.com/hris/pdf/fyi_01_28_05.pdf (last visited Feb. 25, 2006).

⁴⁰⁰ Derek Hunter, *Medicare Drug Cost Estimates: What Congress Knows Now*, BACKGROUND, Apr. 28, 2005, at 7, available at <http://www.heritage.org/Research/HealthCare/bg1849.cfm> (last visited Feb. 25, 2006).

⁴⁰¹ McDEVITT ET AL., *supra* note 69, at 3.

level, however, any argument that relies on an assumption of increased taxes rarely fares well in the United States, and many Americans may not feel overly sympathetic toward large corporations.

Another argument in favor of shifting retiree prescription drug coverage entirely to the public sector and away from employment-based coverage also rests on fairly abstract fairness principles. Retiree prescription drug coverage, when provided in the private sector, can be arbitrary in design.⁴⁰² As noted before, because employers operate with little regulatory oversight of benefit design decisions, they enjoy almost unfettered flexibility in making coverage determinations.⁴⁰³ This leeway may encourage creativity, particularly in cost control strategies, and allow positive choices that are well-tailored to the needs of a specific employer's population; but it may also lead to seemingly unfair coverage decisions when one employer's coverage is compared to another employer's coverage. Moving coverage into the public sector means that everyone receives basically the same benefit. This may appeal to those who desire equality of treatment above all else.

Many of the other factors—such as market competitiveness, employee relations, employer altruism, or paternalism—that might previously have caused an employer to continue offering such coverage may also change as a result of Part D's existence. When no other reasonably attractive alternative existed, employees who did value retiree benefits might have been swayed in employment decisions by the presence of retiree prescription drug coverage.⁴⁰⁴ With Medicare Part D in place, an employee may perceive the value of retiree prescription drug benefits as less relevant than other compensation. This may be true even if, as many industry observers believe, current employer-provided coverage tends to be more generous than Part D.⁴⁰⁵ On the employer side, Part D may relieve an altruistic employer of a sense of moral obligation to preserve retiree health by maintaining retiree prescription drug coverage. Part D may instead free that employer to make financial decisions without the concern of leaving retirees in the lurch. Even where an employer has a contractual obligation to maintain retiree prescription drug coverage, exactly what that coverage looks like may change given the existence of Part D.

⁴⁰² See text accompanying *supra* notes 53–55.

⁴⁰³ See discussion of ERISA's preemptive impact, *supra* note 49.

⁴⁰⁴ See discussion *supra* Section II.F.

⁴⁰⁵ See, e.g., Milt Freudenheim & Robert Pear, *Retirees Must Weigh Company Coverage Against Medicare Plan*, N.Y. TIMES, Nov. 4, 2005, at C1.

In 2006, most employers may be expected to make few if any changes, but apply for the Part D subsidy assuming their retiree plans qualify.⁴⁰⁶ This option will appeal to retirees because it maintains the status quo for them. Presuming the retirees already understand their coverage, they can simply continue as they have before. The option holds some of the same appeal for employers. Implementing major employee benefit plan design changes requires long-term planning, dedicated personnel, and resources. Such changes, especially for larger employers, do not happen quickly or easily even when all factors lie within an employer's control. As discussed in more detail below, many Part D employer options remain filled with questions and uncertainties. Employers tend to prefer answers and some degree of certainty, especially before committing time and money to change. For such employers, staying with their existing retiree plans in 2006 avoids hidden pitfalls and gives them an additional year to consider alternatives before committing to a major plan redesign.

On the other hand, the employer subsidy option does have its own issues. As a preliminary matter, some plans may not actually qualify as actuarially equivalent even with CMS' efforts in the Final Rule to develop as accommodating a standard as possible.⁴⁰⁷ For plans that do not meet the standard, decisions should not be postponed for another year. In such cases, an employer should ascertain whether the value of the subsidy would be sufficient to justify the cost of improving the employer's plan to the level necessary to qualify for the subsidy. If not, the employer may want to consider one of the other options and evaluate whether converting the employer's current plan into some kind of supplemental coverage to Part D could provide retirees with a greater level of coverage at the same (or lower) cost to the employer.

Even if an employer's existing plan is actuarially equivalent to the standard Part D basic package and qualifies for the employer subsidy, the subsidy may be less valuable to a tax-exempt or governmental employer who will not enjoy any additional benefit from the tax-free nature of the subsidy. While such employers should still apply for the subsidy if their plans qualify and if they do not want to make any changes for 2006, they may have somewhat more incentive than taxable employers to go ahead and evaluate other

⁴⁰⁶ See discussion *supra* Section VI.

⁴⁰⁷ Medicare Program; Medicare Prescription Drug Benefit, 69 Fed. Reg. 46,632, 46,737 (Aug. 3, 2004) (to be codified at 42 C.F.R. pts. 403, 411, 417, and 423). See generally discussion *supra* Section V.

options. Taking into account the base 28% subsidy value, if such employers consider the overall employer cost of retiree drug coverage, and evaluate how their employer dollars might be best spent, they may be able to provide a better drug benefit package for their retirees with supplemental coverage. Of course, the same logic generally applies to all employer plan sponsors, but taxable entities will receive a noticeably greater benefit from the subsidy and may be more likely to defer consideration of other alternatives as a result.

All employers applying for the subsidy also face considerable expense and administrative headaches as they hire actuaries and establish new tracking and reporting processes to meet the requirements for the subsidy.⁴⁰⁸ Although CMS' express intent is to encourage employers to retain existing plans and apply for the subsidy, the recordkeeping and attestation requirements remain daunting.⁴⁰⁹ Moreover, employers face complicated employee communication and coordination issues. As noted above, the subsidy will not be paid to an employer for any retiree who enrolls in Part D, yet nothing in Part D prevents such dual enrollment in Part D and an employer plan.⁴¹⁰ Facing an avalanche of communications from every side, many retirees may become confused and enroll in both without even intending to do so. Tracking and sorting out these issues will require entirely new practices by employers, for which there is no current precedent. In addition, for some low-income retirees who qualify for the MMA's low-income assistance, Part D may be a much better package than anything the employer can offer.⁴¹¹ Employers may want to provide sufficient communications materials to these retirees to help them realize that, in fact, they should enroll in Medicare Part D, not the employer plan. If an employer fails to do so, the retiree or an irate family member most likely will realize eventually what the retiree should have done and may blame the employer. CMS tends to gloss over just how complicated and time-consuming handling such practical issues can be.

Even with the challenges described above, most employers seem likely to opt for the path of more clarity and relatively less work for 2006. That choice may not last long, however. Employers

⁴⁰⁸ See discussion *supra* Section V.

⁴⁰⁹ See, e.g., Social Security Act § 1860D-22(a), 42 U.S.C. § 1395w-132(a) (2005).

⁴¹⁰ Social Security Act § 1860D-22(a)(6), 42 U.S.C. § 1395w-132(a)(6) (2005).

⁴¹¹ See, e.g., HEWITT ASSOC., MEDICARE MODERNIZATION ACT: FINAL REGULATIONS MOVE EMPLOYERS CLOSER TO FINAL DECISIONS FOR 2006 (Feb. 2005), at 6, available at http://was4.hewitt.com/hewitt/resource/legislative_updates/united_states/medicare_final_regulations_rx.pdf (last visited Feb. 25, 2006); see also discussion *supra* Section II.E.

have been adding cost control measures to their retiree prescription drug plans for years. In 2001, for example, 72% of all employers with at least 200 employees and some form of retiree health plan expected to implement some form of cost-control measures in the next two years.⁴¹² Such measures may include techniques that limit the number of covered retirees, such as increasing service requirements for eligibility or simply eliminating eligibility for new hires, which does not affect coverage itself, and thus, will not affect qualifying for the subsidy. However, cost control measures may also include techniques such as increasing premiums, deductibles, co-insurance percentages, co-payments and out-of-pocket expense limits. Because any measure that shifts costs to employees necessarily lowers the employer's contribution to financing the benefit, and because an employer's cost is part of the actuarial equivalence determination,⁴¹³ such cost control measures will impact the determination of actuarial equivalence to the standard Part D package. As prescription drug costs and health care expenses in general continue to rise, employers will no doubt continue to seek ways to limit their exposure. They may be too busy qualifying for the subsidy in 2006 to devote much attention to traditional cost control measures, but in following years they may find their analyses altered by a desire to continue qualifying for the Part D subsidy. Because certain cost control measures will impact eligibility for the subsidy, those may become less favored techniques.

Instead, employers may find it preferable to continue to increase service requirements or to eliminate retiree health insurance for additional groups of future retirees so that the existing coverage remains unchanged and eligible for the subsidy for covered retirees. While these tactics protect current retirees and may be more palatable than an employer's sudden termination of an ongoing plan, constantly increasing service requirements or otherwise limiting eligibility for future retirees will eventually eliminate most employer retiree coverage as existing retirees die and few if any new retirees enter the plans. By 2001, many employers had already limited retiree health insurance to employees with at least ten to fifteen years of service who retired on or after age fifty-five⁴¹⁴ even though most

⁴¹² KAISER/HRET 2000/2001 SURVEY, *supra* note 79, at fig. 11; *See also* discussion *supra* Section II.E.

⁴¹³ *See, e.g.,* HAMELBERG, *supra* note 279.

⁴¹⁴ *Future of Retiree Health Benefits*, *supra* note 36, at 6.

younger workers today do not anticipate remaining employed with any single employer for such long periods of time.⁴¹⁵

For employers who take the Part D subsidy in 2006 and do not raise eligibility requirements or otherwise pursue cost control measures that operate as a back-door way of terminating retiree coverage, some cost control measures may still be needed. Unfortunately, most of these measures, which in some way tend to increase retiree cost-sharing obligations, will impact the actuarial valuation of the retiree plan's coverage.⁴¹⁶ For plans that currently provide coverage that exceeds the actuarially equivalent value of the Part D standard package, it may take some time before increasing retiree cost-sharing brings the value of the employer coverage down to the level of the Part D standard package. For other plans, any change could disqualify them for the Part D subsidy. In many cases, however, employers may not have a choice about imposing cost-sharing. As discussed earlier, many employers adopted caps on retiree health insurance costs as a reaction to the introduction of FAS 106 in the early 1990s.⁴¹⁷ As costs reach the caps, employers must take steps to avoid exceeding the caps, such as by passing expenses above the caps on to retirees. For these employers, once the caps are reached, if increased cost-sharing causes their plans to fail to qualify for the Part D subsidy, they will need to revisit their overall approach and consider other Part D options or find themselves in a much worse financial position. Even for employers who are not limited by caps on retiree health costs, rising prescription drug costs most likely will eventually trigger a review as to whether the employer can better use its retiree health care dollars by supplementing a Part D plan instead of maintaining its old plan. As an additional concern, once cost-sharing obligations reach too high a level, they begin to take coverage out of range for most retirees, much as though the employer had simply terminated the plan. Long before this level is reached, Part D coverage may be a better option for many individuals.

As employers move beyond the comparatively easy solution for 2006 of maintaining existing coverage and qualifying for the subsidy if available, the options become far less straightforward.⁴¹⁸

⁴¹⁵ See, e.g., Stephanie Armour, *Generation Y: They've Arrived at Work with a New Attitude*, USA TODAY, Nov. 8, 2005, available at http://www.usatoday.com/money/workplace/2005-11-06-gen-y_x.htm (last visited Feb. 25, 2006).

⁴¹⁶ See HAMELBERG, *supra* note 279.

⁴¹⁷ KAISER/HEWITT 2004 SURVEY FINDINGS, *supra* note 89, at 9–11.

⁴¹⁸ See discussion *supra* Section V.

If an employer remains wedded to its traditional plan design and wants to maintain a similar structure, it may find the option of becoming a Part D prescription drug plan sponsor (or Medicare Advantage plan sponsor) itself and offering alternative coverage through a waiver to be the most appealing alternative. As long as the alternative coverage is at least actuarially equivalent to the standard package, choosing this option gives an employer the opportunity to continue an integrated, customized program for its retirees. With the many group waivers already issued by CMS, most of the MMA requirements that would pose serious procedural problems for employers have already been eliminated. In addition, CMS appears committed to continuing along a path of supporting employer efforts under this option.⁴¹⁹ Retirees may also prefer this option because it avoids confusing coordination issues and because, if an employer generally follows a similar structure to the employer's previous plan design, they may find the new plan relatively easy to comprehend. On the other hand, becoming a Part D prescription drug plan sponsor still entails a great deal of time, money, and effort to implement, as well as a significant ongoing administrative and financial commitment from an employer.⁴²⁰ Once an employer steps beyond maintaining an existing plan, actually becoming a Part D prescription drug plan sponsor may be too much work for the perceived benefit.

In lieu of becoming a Part D prescription drug plan sponsor, the employer may contract with an existing Part D prescription drug plan sponsor or Medicare Advantage organization to provide a customized, alternative Part D prescription drug plan for the employer's retirees.⁴²¹ As with the employer's becoming a Part D prescription drug plan sponsor, this option relies on CMS' waiver authority.⁴²² For retirees, this option may feel indistinguishable from the employer's sponsoring the plan itself. From the employer side, contracting with a third party to provide such customized benefits could accomplish the employer's goals with far less hassle although not necessarily less cost. However, the success of this approach requires Part D prescription drug plan sponsors and Medicare Advantage organizations in the marketplace to be willing to provide such customized packages. Alternatively, an employer

⁴¹⁹ *Id.*

⁴²⁰ *Id.*

⁴²¹ Medicare Program; Medicare Prescription Drug Benefit, 70 Fed. Reg. 4194, 4477 (Jan. 28, 2005) (to be codified at 42 C.F.R. pt. 423).

⁴²² See HAMELBERG, *supra* note 279.

could contract with a Part D prescription drug plan sponsor or Medicare Advantage organization who has already developed an enhanced coverage option that meets the employer's needs. At present, however, either concept remains very new and quite possibly unduly expensive in the absence of market competition. Even if these options may in the long run attract employers who seek to provide enhanced or customized, integrated prescription drug coverage, most employers for now are not surprisingly taking a "wait and see" approach until the market settles.⁴²³

The "wait and see" approach may not appeal to employers whose current coverage does not qualify for the Part D subsidy. For these employers, their retiree prescription drug dollars may provide a better benefit for their retirees if used in a supplemental or wrap-around plan. As a result, coordinating with Medicare Part D as soon as possible will be a top priority, but one that may be filled with confusion in Part D's initial year. On the other hand, coordinating benefits with Medicare may be attractive to both employers and retirees who are already accustomed to coordinating general health benefits with Medicare Parts A and B. Familiarity with the general approach may make this option much less intimidating than it would otherwise be. Still, in an effort to avoid negotiating the complexities of a new Medicare system, employers may seek to purchase wrap-around coverage through third-party providers rather than establishing stand-alone plans. Because the marketplace has only begun to absorb what Medicare Part D means, employers may find themselves either forced to wait for options or forced to accept a provider without having the opportunity to consider alternatives. This may still be a better solution than retaining old coverage that fails to reach the actuarially equivalent threshold if the employer can cost effectively offer its retirees more generous coverage by combining supplemental coverage with a third-party Medicare Part D prescription drug plan.

If an employer provides truly limited retiree coverage, the best answer may be for the employer to terminate its own plan and, instead, direct its contributions toward covering its retirees' Medicare Part D premiums. This removes administrative hassles from the employer and may provide a better level of coverage for the retirees. Of course, as time passes and Medicare Part D premiums increase, the employer will be faced with a decision of whether to cap its premium payments or to absorb the increases.

⁴²³ See discussion *supra* Section VI.

Employers who do not want to continue retiree prescription drug coverage or any level of coordination with Medicare Part D, but still want to assist their retirees in some way, may consider making contributions to employee health savings accounts during employees' working lives. Amounts held in such accounts may be used to cover beneficiary out-of-pocket costs under Medicare Part D.⁴²⁴ However, contributions may not be made by Medicare-eligible beneficiaries,⁴²⁵ and that makes this an option only for future retirees.

VIII. CONCLUSION

It is tempting to evaluate the maintenance of any single employer's prescription drug plan for retirees in a vacuum and to look at the options for that employer in light solely of that employer's financial circumstances, competitive positioning, and internal culture. Those factors, along with a difficult economy with more people wanting work than available jobs, may cause many employers to see continuing prescription drug coverage as unnecessary for retirees who now have coverage available through Medicare. After all, the balance has been shifting away from retiree health care benefits in general for much of the past two decades. In addition, expanded Medicare coverage helps remove much of the pressing need for supplemental employer coverage for Medicare-eligible retirees. On the other hand, eliminating employer-provided retiree coverage would shift considerable additional drug costs to a Medicare system already strained almost to the breaking point. From a public policy perspective, this hardly seems a desired result.

Fortunately, at least among those employers who still provide retiree drug coverage, employer intentions currently support what seems a wise public policy. The real question, however, is what form employer coverage will take in the future. For 2006, the path for most employers seems clear, assuming they can qualify for the Part D employer subsidy and maintain their existing plans. After that point, which of the various options becomes most attractive to a specific employer will depend on numerous factors, including that employer's own cost constraints and culture. Most importantly, employers should consider what kinds of alternatives the drug plan marketplace has created for consideration. No one can predict yet

⁴²⁴ Medicare Program; Medicare Prescription Drug Benefit, 70 Fed. Reg., 4242.

⁴²⁵ 26 U.S.C. § 223 (2005).

what may be best in the future for any given employer, and no single solution seems likely to work for all. Unfortunately, unless the economic environment and prescription drug expense trends improve, financial concerns for individual employers may quickly outweigh any broader public policy arguments in favor of continuing employment-based retiree prescription drug coverage. This reality may eventually overshadow the promise of Part D prescription drug coverage.

