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American Federation of Labor and Congress of Industrial Organizations
Before the Senate Finance Committee
September 14, 2004

Thank you for the opportunity to offer our perspective on the proposed rules implementing the Medicare Prescription Drug Benefit. On behalf of the AFL-CIO's 13 million active members and more than 3 million retirees, I will focus my comments today on the regulations implementing the employer subsidy.

The changes in Medicare enacted last year will have enormous and far-reaching effects on the medical and prescription drug benefits provided to our nation's elderly and disabled. Roughly one in four Medicare beneficiaries currently receives prescription drug coverage from their former employer – representing the single largest source of such coverage for Medicare beneficiaries.

In enacting the employer options and subsidy, Congress sought to encourage employers to retain prescription drug benefits for their retirees. The preservation of employer-sponsored prescription drug benefits is clearly in the best interests of retirees and consistent with the fact that these benefits represent deferred wages over a lifetime of work. But it is also in the best interest of the Medicare program; sharing with employers the cost of prescription drug coverage for millions of beneficiaries better serves Medicare's financial health.

The provisions outlining employer options for continuing to provide prescription drug coverage are complex and represent mostly unchartered territory. While the statute was prescriptive in certain respects, it also left to the Administration broad authority to implement many of the provisions, particularly with regard to the employer subsidy. While the proposed rules published last month fail to provide clear guidance (and on some issues, no guidance at all) to employers and retirees on the options they will have and the standard employers must meet in order to qualify for the federal subsidy, our hope is that the final rules will do both.

Overall, we fully support the Department's objectives, as stated in the proposed regulations, "to take into account as much as possible the needs and concerns of plan sponsors, consistent with necessary assurances that Federal payments are accurate and in accordance with statutory requirements, that the interests of retiree-beneficiaries are protected, and that employers do not receive "windfalls" consisting of subsidy payments that are not passed on to beneficiaries."[1]

However, we have serious concerns that the proposed regulations may tilt too far in favor of the needs and concerns of plan sponsors and offer too few protections for the retirees whose coverage Congress has sought to preserve with this federal subsidy. While CMS Director Dr. McClellan has said the employer provisions will result in retirees spending

[1] 69 Fed. Reg. page 46737 (August 3, 2004)

less for prescription drugs and in some cases much less, we fear that the regulations potentially allow for even those retirees who retain coverage to be made worse off.

Already, we are seeing employers "book" the anticipated value of the subsidy they will receive as non-taxable income. A Wall Street Journal article published in March lists projected savings claimed by 18 large companies, ranging from $2 million to $1.4 billion. Yet we also know from recent contract negotiations and from published survey data that employers are pressing their retirees to pay a growing share of drugs costs each year.

As we continue our review and analysis of the proposed regulations, the AFL-CIO has three overarching areas of concern. First, the test for actuarial equivalence should not allow for significant cost shifting. In the proposed rules, CMS has outlined three options for determining actuarial equivalence. The "single prong" test would look only at the gross value of the benefit, regardless of financing. This test is totally unacceptable, since it would result in massive cost shifting, and in CMS's own words, would allow employers to contribute nothing yet still get the subsidy. The other two proposed tests – the "no windfall" test and the "two-prong" test – are preferable to the first test, since they take into consideration the amount the employer is paying toward coverage, yet both also have the potential to allow employers to shift costs to retirees and still receive the federal subsidy.

We understand the difficult calculation that CMS must make in establishing the actuarial equivalence standard – set the bar too high and employers may choose to drop coverage rather than meet the standard; set the bar too low and employers may interpret that as a signal to significantly reduce the coverage they now provide. To be consistent with the intent of the law, CMS must require employers to provide at least as much financing for retiree drug coverage as they will get from the subsidy. And in order to prevent employers from using the actuarial equivalence standard as an excuse to significantly reduce the coverage they now provide – even with the financial assistance of the subsidy – CMS must adopt and enforce strong retiree protections.

One such protection, and a key area of concern for us, would be to ensure the subsidy is used to preserve retiree benefits and not used simply to improve the employer's bottom line or for other non-health care uses. As you know, the statute does not include a maintenance of effort, or even maintenance of cost provision, nor did we advocate for such a requirement in the legislation. Until Congress enacts legislation that will meaningfully address crippling health care cost hikes, we believe such a position is untenable. However, the statute explicitly and directly ties the subsidy to the provision of prescription drug coverage, reflecting, we believe, Congress' intent that the subsidy be used to offset costs for both the employer and the retiree. Employers should demonstrate that the subsidy is allocated to health benefits according to the financing of those benefits. At a minimum, CMS must require employers to report to retirees and unions the value of the subsidy received, if the public is to have any ability to measure the effect of the subsidy on preserving retiree health benefits. To have much effect, such notices must be as contemporaneous as possible with the receipt of subsidy payments.

Finally, the regulations must include safeguards to ensure employer coverage meets the actuarial equivalence test in both design and practice, and in this area, we have several additional concerns. First, because the actuarial equivalence test is applied to the average of all retiree health plans offered by an employer, there is the potential for significant variation in the plans and, by extension, the use of different plan designs to encourage higher cost beneficiaries to enroll in Part D plans.

In addition, the plan is measured according to projected benefits as opposed to benefits received, when projections can clearly be unrealistic. For example, a plan sponsor may provide full coverage for prescription drugs for organ transplant patients, yet very limited coverage for drugs used to treat hypertension and diabetes. At the end of the plan year, actual spending on organ transplant drugs may be zero, while many more retirees required treatment for hypertension and diabetes. CMS has not outlined a process for reconciling the projected and actual spending, an important consideration to ensure appropriate use of the subsidy.

Despite these potential abuses, the proposed regulations do not include a process for retirees to challenge an employer's attestation that its plan is actuarially equivalent, nor does it require transparency in regard to plan sponsors' attestations or the underlying assumptions and projections. It would seem wise to include such requirements for transparency and attestation challenges in order to empower retirees and other interested parties to act as guardians of this new federal subsidy.

We have many other concerns in addition to these primary ones. They include holding retirees harmless from late enrollment penalties if their employer's actuarial equivalence attestation proves to be inaccurate. In addition, plan sponsors will be subject to unrealistic timeframes for designing a benefit, attesting to actuarial equivalence and notifying retirees of their plan options – all of which may occur without clear and final guidance from CMS or adequate information on the availability of commercial prescription drug or Medicare Advantage plans.

We would commend Dr. McClellan and the CMS staff for their outreach and willingness to discuss concerns of workers and their unions. We will be offering more detailed, written comments on the proposed regulations, as we seek to maximize the benefit for our members.

However, we continue to believe the law enacted last year did not go far enough in providing incentives for employers to retain retiree drug coverage. The True Out of Pocket provision has the effect of discriminating against beneficiaries with retiree health benefits and the employers who continue to provide them in the face of escalating health care costs. And the additional funds provided for the employer subsidy in the conference agreement -- $18 billion to make the subsidy tax-free – provided absolutely no additional benefit to non-taxable entities such as public sector employers and multi-employer plans that provide retiree health benefits.

At the same time, HMOs were provided billions of dollars in excessive overpayments in the legislation and beneficiaries were left with an inadequate benefit. While we appreciate the Department's efforts to limit the effect of this legislation on retiree coverage through regulation, the fact is that the True Out of Pocket definition in the law again favors private plans over retirees. Indeed, the fact that this legislation puts private plans' interests over that of retirees has manifested itself already - two years before the drug benefit is even implemented. Just last week, CMS announced the largest increase in the Part B premiums since the enactment of the program, which is largely a result of the provisions in this legislation. Our members, like the public at large, are saying this law needs to be overhauled, in order to put beneficiaries ahead of HMOs and drug companies.

Despite the limits of the legislation, the Administration has broad authority to implement the employer subsidy. Establishing the requirements employers must meet to qualify for the subsidy can either exacerbate or mitigate the harmful provisions of the underlying statute – making the number of retirees who are helped rather than hurt relatively better or worse. CMS has stated in the proposed regulations that the federal subsidy has the potential to stem the erosion of retiree health benefits. We believe this goal is laudable and we urge the Administration to issue final regulations that achieve that goal and address the concerns we have raised today