



BENEFIT *Advisor*

In This Issue

In this fourth issue of the McGraw Wentworth Benefit Advisor for 2005, we will examine the Medicare Part D benefit. Medicare Part D is a voluntary program that will offer coverage for outpatient prescription drugs to Medicare beneficiaries. The program will be managed by private organizations.

We will discuss the benefits for Medicare Part D, including plan benefits, eligibility, cost and administrative issues. In the next issue, we will discuss the impact of this program on retiree medical benefit plans.

We welcome your comments and suggestions regarding this issue of our technical bulletin. For more information on this Benefit Advisor, please contact your Account Manager or visit the McGraw Wentworth web site at www.mcgrawwentworth.com.

“Medicare Part D”

The Department of Health and Human Services recently released the final regulations outlining Medicare Part D benefits. This landmark piece of legislation will have personal or professional impact on almost everyone.

The Part D program will add a voluntary outpatient prescription drug benefit to the Medicare program. However, the prescription benefits will not be delivered in the same way as Part A and Part B benefits. The government will not negotiate with pharmaceutical manufacturers and pharmacies directly, but instead will contract with private insurance carriers, pharmacy benefit managers and other organizations. Using private organizations to handle the prescription drug benefit has made administering Medicare Part D more complex.

Our next two Advisors explain the Medicare Part D benefits. This issue covers the details of the Part D program, including:

- Benefits
- Eligibility
- Prescription Drug Plans
- Part D Participant Communication
- Enhanced Benefit Options
- Part D Premiums
- Medical Care Management Programs

- Contractual and Performance Requirements

The next Advisor will explain how Medicare Part D affects retiree health plans.

Benefits

Private organizations will deliver Medicare Part D benefits. These organizations will need to meet all of the Centers for Medicare and Medicaid Services (CMS) formal requirements. CMS is requesting proposals to determine



which vendors it will approve to offer plans in specific geographic regions. CMS will choose at least two vendors in each region to offer prescription drug coverage. Because certain rural areas may not have two vendors available, CMS will offer a privately managed fallback plan. A vendor must submit a proposal either as a “Prescription Drug Plan” (PDP) vendor or a “fallback” plan vendor; it may not submit proposals for both.

CMS has set forth a standard benefit plan design. The PDP must offer the standard benefit structure or offer a plan that is the actuarial equivalent of the standard benefits. The standard benefits are outlined in the table at the top of the next page.

The \$3,600 potential out-of-pocket cost means the “true out-of-pocket” cost. Individuals will reach the catastrophic coverage level after paying \$3,600 out of their own pockets. When calculating the “true out of pocket costs”, CMS will not count any amount reimbursed from insurance coverage or any other plan arrangement. An individual must have paid at least \$3,600 in “true out-of-pocket cost” during the calendar year in order to qualify for catastrophic coverage.

While Medicare Part D will not cover all drugs, it will cover any of the following if used for a medically accepted indication:

- A prescription drug
- A biological product
- Insulin
- Syringes, needles, alcoholic swabs, and gauze for insulin injections
- A vaccine licensed under Section 351 of the Public Health Service Act

Each PDP can determine which drugs it will cover and which drugs it will place on its formulary. Certain drugs are not currently covered under the program; for example, erectile dysfunction drugs. However, drug manufacturers are currently lobbying to include them under Part D. If the PDP denies coverage for a specific drug, it must have an appeal procedure that follows CMS guidelines.

Part D coverage does not include any benefits for medications covered by Part A or Part B.

Eligibility

Medicare Part D will be a voluntary program and available for Medicare beneficiaries on January 1, 2006.

Individual Prescription Expense	Medicare Pays	Individual Pays
First \$250	\$0	\$250
Next \$251 - \$2,250	75% of cost (up to \$1,500)	25% of cost (up to \$500)
Next \$2,251 - \$5,100	\$0	\$2,850
Catastrophic Coverage \$5,101 +	95% of cost	Greater of 5% of cost or \$2 generic/\$5 brand name

The benefits are paid on a calendar year basis. Not counting premium payments, if an individual incurs at least \$5,100 for prescription drug expenses in a calendar year, the individual will pay **\$3,600**. However, expenses above \$5,100 will have minimum cost-share requirements.

The numbers in blue are indexed thresholds and will apply for 2006. These thresholds will be adjusted annually based on the projected rate of growth in per-capita spending in the Medicare population.

Individuals with incomes below 150% of the federal poverty level will receive cost-sharing subsidies based on income level.

To be eligible for Part D, individuals must be entitled to Part A or enrolled in Part B. Those entitled to Medicare Part A or Part B retroactively become eligible for Part D as of the month they receive notice they are entitled to Medicare benefits. They must reside in the service area of the Prescription Drug Plan available to them.

As with Part B, individuals will have an initial enrollment period. Individuals eligible for Part D by the end of February 2006 may enroll from November 15, 2005, through May 15, 2006. For individuals eligible on or after March 1, 2006, the enrollment period for Part B benefits applies. Therefore, Part D enrollment periods will be determined as follows:

- **Initial enrollment:** Begins 3 months before turning 65 and ends 3 months after turning 65.
- **General enrollment:** If an individual did not sign up when initially eligible, the general enrollment period lasts from January 1 through March 31 each year. If an individual signs up during the general enrollment period, coverage will be effective July 1 of that

year. There is a late enrollment penalty if an individual does not enroll when initially eligible.

- **Special enrollment:** A special enrollment period is available for individuals no longer covered as employees or dependents under an employer-sponsored group health plan. They can enroll in Part D with no premium penalties during the special enrollment period. The special enrollment period is the eight months following the earlier of the date coverage ends or employment ends.

Individuals must enroll to receive benefits under Part D. Different vendors will deliver benefits in different geographic regions, and these vendors will handle the enrollment process. Although the actual process has yet to be determined and most likely will vary among vendors, certain elements will be required:

- Applicants must complete the plan’s enrollment form and must authorize the exchange of

information between the plan vendor and the Department of Health and Human Services. Enrollment will not be accepted without this authorization.

- Part D enrollees must disclose any prescription reimbursement plans other than Part D, such as supplemental plans, retiree health plans, or any other third party arrangement. The applicant must also allow DHHS access to the payment information from any of these arrangements.
- PDP vendors must notify applicants promptly of a denial or an approval of coverage under the plan.



An individual may disenroll in the plan during the open enrollment period and elect coverage through another vendor. The PDP vendor must notify CMS of the disenrollment and must also have the disenrollment verified in writing.

A vendor may terminate PDP coverage under a number of circumstances:

- Premium is not paid on time.
- Individual no longer resides in the PDP's service area.
- The individual loses eligibility for Part D benefits.
- The PDP's contract with CMS is terminated.
- The individual materially misrepresents information regarding any third party reimbursements for out-of-pocket cost.

- The individual's disruptive behavior impairs the plan's ability to serve other plan members.
- The individual dies.

In these cases, the PDP vendor must notify the individual in writing of the disenrollment and follow CMS procedures for disenrolling plan participants.

Prescription Drug Plans

The government has established a number of geographic regions for PDP vendors. A vendor must submit a proposal to become a qualified PDP in one or more of the geographic regions. To be considered a PDP, a vendor must meet a number of criteria, including:

- **Pharmacy Access Requirements:** If the plan has a contract with a retail pharmacy network, the pharmacies must meet certain access requirements. In urban areas, at least 90% of enrollees must live within 2 miles of a network pharmacy. In suburban areas, at least 90% of enrollees must live within 5 miles of a network pharmacy. In rural areas, at least 70% of enrollees must live within 15 miles of a network pharmacy.
- **Preferred Pharmacy Incentives:** A PDP may offer incentives to use network pharmacies if the PDP offers coverage other than the defined standard plan. These incentives cannot have an impact on CMS payments.

- **Formulary Requirements:** If a PDP uses a formulary, a Pharmacy and Therapeutic (P & T) committee that meets CMS requirements must create the formulary and regularly review it. The formulary must meet the CMS requirements regarding the types and number of drugs available in each class and category. The formulary also must include the types of drugs Medicare Part D enrollees most commonly need. The formulary can be updated once a year or sooner for newly approved drugs or new therapeutic uses for medications.
- **Out of Network Access:** PDPs must cover prescriptions filled at out-of-network pharmacies when enrollees cannot be reasonably expected to obtain prescriptions at a network pharmacy. However, enrollees cannot use out-of-network pharmacies routinely.
- **Leveling the Playing Field:** A PDP sponsor must allow individuals to receive a 90-day supply of covered Part D drugs at any retail pharmacy in its network. The plan can require beneficiaries to pay any extra cost if they use a retail pharmacy instead of a mail order facility.
- **Risk-Bearing Entity:** The PDP must be licensed as a risk-bearing entity. There are exceptions that can be met in lieu of meeting state licensing requirements. This step is necessary because PDP vendors absorb some of the financial risk involved in managing the PDP. The final regulations set forth the risk that the PDP will be responsible for managing. For the first two years, the risk corridors are not particularly

aggressive because no claim data is available. However, as the PDP operates year over year, it is expected that with actual claim data, the PDP should be able to predict and managed cost more effectively. At that point, the risk corridors will be set at more aggressive levels.

- **Full Disclosure:** A PDP sponsor must disclose to CMS all prices negotiated with pharmaceutical manufacturers as well as all the prices passed through to Part D beneficiaries.
- **Audits:** PDP sponsors must agree to periodic audits of all their Part D financial statements and records.
- **Pharmacist Education:** A PDP must require preferred pharmacies to inform Part D enrollees of their prescription drug options. For example, the pharmacist must explain the difference between a requested drug and the lowest-priced generic equivalent drug available at the pharmacy.
- **Consumer Satisfaction Survey:** The PDP vendor will need to conduct periodic consumer satisfaction surveys according to CMS guidelines.



The PDP will need to meet these complicated guidelines to become an approved plan. PBMs may choose not to sponsor a PDP because they may not want to become "risk-bearing entities." However, PBMs may partner with a risk-bearing entity to become an approved plan.

Part D Participant Communication

Each PDP vendor must give current and potential Medicare Part D enrollees very specific, CMS approved marketing materials describing the plan, including:

- Information promoting the Part D plan.
- Information on enrollment or current plan coverage.
- Material explaining the Medicare Part D benefits and the rules that apply to Part D programs.
- Explanations of the medications the plan covers and any restrictions that may apply.

If CMS does not comment on the materials within a specified timeframe, a PDP plan sponsor may deem its marketing materials appropriate.

Once a beneficiary enrolls in a Medicare Part D plan, the PDP vendor must offer the following information in a manner that CMS approves:

- Individuals must receive detailed plan descriptions when they enroll and updates at least once a year. The descriptions must:
 - State the plan's service area.
 - Describe the plan's benefits, including conditions and limitations, premiums, cost-sharing (deductibles, coinsurance, copays, and so on) and any other applicable restrictions.
 - Present formulary information, including a list of

drugs on the plan's formulary, how the formulary is used, and the process for obtaining a drug not listed on the formulary.

- Explain how to access network pharmacies.
- Explain how to obtain out-of-network coverage information if a network pharmacy is not accessible.
- Include grievance procedures, coverage determinations and appeal procedures.
- Include quality assurance policies and procedures.
- Explain disenrollment rights.
- Explain the individual's rights to request additional information.
- The PDP sponsor must send participants a written Explanation of Benefits (EOB) every month in which a prescription is filled. The EOB must:
 - List payments made for each covered service or item.
 - Provide a year-to-date total amount of benefits provided as it applies to the deductible, the coverage limits, annual out-of-pocket thresholds, and year-to-date total of incurred costs, if possible.
 - State any changes the PDP is making to the formulary.

Additional information must be available through mechanisms CMS requires, including:

- A toll-free customer service call center staffed during normal business hours.

- An Internet website that provides:
 - The information outlined above.
 - The current formulary, updated monthly.
 - Information on any changes in the formulary with 60 days notice.
- Notices of any changes including contract issues, premiums, network providers, benefits, procedures or formulary changes.
- Changes in claim procedures or grievance process.

The PDP will be responsible for informing participants of these extensive requirements. These extensive communication requirements will help Part D beneficiaries understand their Part D benefit and how to use the plan appropriately.

Enhanced Benefit Options

A PDP may offer enhanced prescription drug benefits, providing it also offers standard benefits in that geographic region. Enhanced benefits can include:

- Covering drugs Part D specifically excludes.
- Reducing the annual deductible.
- Reducing cost-sharing requirements.
- Increasing the initial coverage limits.

If a PDP offers enhanced benefits, it can increase premiums to cover the projected increased costs. The PDP assumes full risk for any enhanced benefits it offers.

Part D Premiums

To determine the Part D premium, the government is currently requesting pricing proposals from various potential PDP vendors. While the monthly premium is expected to be approximately \$37 a month, it may vary by geographic region depending on how the bid amount compares with a national baseline premium amount.

Premiums may be higher if an individual enrolls late in Medicare Part D. Similar to Part B, the late enrollment penalty will be the greater of:

- An amount CMS determines is actuarially sound for each uncovered month for the period of eligibility.
- One percent of the base beneficiary premium for each uncovered month in the period of eligibility.

The late enrollment penalty will not apply if an individual has had continuous creditable coverage (such as coverage under a retiree health plan) and the individual enrolls as a special enrollee.

Low income beneficiaries may pay lower premiums.

The PDP sponsor will collect the premiums directly.

Medical Care Management Programs

Each PDP vendor must have programs to manage drug use, quality and medication therapy.

The programs to manage drug use must:

- Include incentives to reduce cost when medically appropriate.
- Maintain policies and systems to prevent over- and under-utilization of prescription drugs.
- Inform CMS of program performance.

The programs to assure quality must focus on reducing medication errors and adverse drug interactions:

- Network pharmacists must comply with the state's minimum pharmacy practice standards.
- Drug use protocols must screen for potential problems caused by duplicate drugs; age or gender-related contraindications; drug interactions; incorrect dosage or duration of therapy; drug allergy issues and clinical abuse or misuse.



The programs to manage drug therapy focus on the Part D disease management initiatives. It targets beneficiaries who:

- Have multiple chronic diseases.
- Take multiple Part D covered medications.
- Are likely to exceed a pre-determined annual prescription expense threshold specified by the Secretary of the Department of Health and Human Services. The threshold amount was not published in the final regulations.

This program aims to reduce the risk of adverse events by targeting medication non-compliance. The program must be developed with medical experts. The vendor must also be able to coordinate with other Medicare disease management initiatives.

Contractual and Performance Requirements

A PDP must agree to a number of requirements when entering into a contract with the government to deliver Part D benefits. The initial contract period will be 12 months.

The PDP must:

- Protect confidentiality and accuracy of enrollee records. It must abide by federal and state laws regarding confidentiality and disclosing medical records. The PDP sponsor must have internal policies to protect enrollee specific data and procedures to ensure the data is being used only to meet plan requirements.
- Take responsibility for administering the Part D program, including premium collection, claim payments, eligibility processing, and so on.
- Confirm that it will develop and administer grievance and appeal procedures meeting the CMS guidelines.
- Comply with all the reporting requirements that CMS requires to meet the calculations of risk adjustments.
- Provide required information for payments under the plan and participate in audits as necessary.

- Agree to submit a bid for the following year by the date CMS specifies.
- Allow claim adjudication at point of service.
- Have the ability to communicate electronically with CMS.
- Meet minimum CMS participation requirements.
- Maintain required records.

The extensive contractual requirements should ensure all vendors offer fairly consistent Part D benefit management.

Conclusion

Part D benefits seem simple enough; however, introducing private program management has made them more complex. While the basic requirements have been fleshed out, more specifics will come soon as CMS reviews the various vendor proposals and assigns PDP vendors to different geographic regions. In addition, it will be interesting to see how PDP vendors structure any enhanced benefit offerings.

Our next Advisor explains how these new benefits can affect your organization's retiree benefit plan. Employers will have several retiree benefit program choices:

- Maintain a retiree benefit program that is actuarially equivalent to Medicare Part D and qualify for a government subsidy of a percentage of the prescription plan's drug cost.
- Provide prescription coverage that supplements the Medicare benefit program.
- Qualify to provide Medicare Part D benefits as a PDP for the plan's retiree population.
- Eliminate retirees' prescription coverage.

This private delivery of a public benefit may also affect the pharmacy benefit marketplace. Many of the requirements to become a PDP are services employers have requested of their PBMs frequently. Services that include providing EOBs, disease management initiatives, full disclosure, access to records for audit purposes, and medical management protocols will hopefully become more prevalent in the private marketplace to help manage skyrocketing drug benefit costs.

If you have any questions, please contact your McGraw Wentworth Account Director. **MW**

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