



BENEFIT *Advisor*

In This Issue

In this sixth issue of the McGraw Wentworth Benefit Advisor for 2005, we continue our examination of Medicare Part D. This issue addresses the impact of Medicare Part D on retiree benefit plans. Organizations have a number of options to consider in regard to coordinating with Part D benefits. Each option has different cost implications as well as administrative concerns. We will review these options in depth and discuss the potential impact on your plan.

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.

“Retiree Health Plans: Medicare Part D”

The last McGraw Wentworth *Benefit Advisor* clarified Medicare Part D benefits, eligibility and plan requirements. Private vendors will deliver these benefits and they will need to meet extensive requirements to qualify as Prescription Drug Plans. Among these requirements are many provisions employers would like to see their pharmacy benefit managers offer, including full disclosure of discount information and auditing privileges on claims and rebates.



The Medicare regulations address in detail how plan sponsors that offer retiree prescription coverage today can coordinate with the Part D program. The government is encouraging organizations to continue offering retiree prescription drug coverage. One of the government’s key concerns has been the impact this benefit would have on retirees whose medical plans currently cover prescription drugs. Retirees feared their former employers would no longer cover prescription drugs or significantly cut benefits. The government shared this concern. It is estimated 30% of Medicare beneficiaries have outpatient prescription benefits under a retiree medical program. The government did not want to take primary liability for an expense that em-

ployers throughout the country are already covering.

With these concerns in mind, the Medicare Prescription Drug Improvement and Modernization Act offers organizations that sponsor retiree prescription benefits several options for working with Medicare Part D:

- Maintain a retiree prescription plan that is at least actuarially equivalent to Part D and qualify for a government subsidy.
- Provide a prescription benefit designed to pay secondary to Medicare Part D.
- Qualify to provide Medicare Part D as a qualified Prescription Drug Plan (PDP) for the plan’s retiree population.
- Eliminate coverage for outpatient prescription drugs under the retiree plan.

This *Advisor* examines each of these options in detail. Employers offering retiree prescription benefits will have to take action, regardless of which option they choose.

Maintain Actuarial Equivalent Benefits and Apply for Government Subsidy

The government will offer a tax-free subsidy to employers who maintain their retiree prescription drug coverage, provided the coverage is actuarially equivalent to the benefits the standard Medicare prescription plan provides. The final Medicare regulations explain the subsidy payment; however, employers still need more information. CMS is expected to release additional guidance over the next several months to clarify several aspects of the subsidy process.



The application must meet CMS requirements.

will allow the plan sponsor to disclose certain information to CMS. The information required will be the information CMS will need to manage the certification and subsidy process.

- To receive the subsidy, the plan sponsor must submit to CMS an

application signed by an authorized representative of the plan sponsor. The application must meet CMS requirements.

While these requirements seem simple, several have very involved steps.

Qualifying for a Subsidy

For employers to receive the federal retiree prescription drug coverage subsidy, their plans must meet specific criteria to be considered qualified prescription drug plans. The subsidy applies only to retirees; current employees over age 65 would not qualify. A qualified prescription drug plan means employment-based retiree health coverage that meets the following requirements:

- Actuarial certification that meets the requirements outlined in the next section.
- Covered Part D eligible individuals must receive creditable coverage notices.
- Records must be maintained and made available for audit as CMS specifies.
- A written agreement with the health plan insurer or with the group health plan that

Actuarial Attestation

The plan sponsor must certify that the actuarial value of the employer-sponsored drug plan is equal to or better than the actuarial value of the Medicare Part D prescription drug plan. The certification must include the following assurances:

- **Actuarial gross value of the plan sponsor's retiree drug coverage is equal or better than the standard Part D prescription coverage for the same plan year.** To determine gross value the plan sponsor:
 - Must use the actual claim experience and demographic data for Part D eligible retiree plan participants.
 - May use a CMS database if creditable data is not available because of plan size or other factors.
- May use other actuarial approaches CMS specifies as suitable alternatives.
- Should determine the gross value by calculating the gross value of the employer's plan design and comparing it to the value of the Medicare Part D standard program. If possible, the sponsor should use actual claim experience and demographic data to calculate the value.

- **Actuarial net value of the plan sponsor's retiree prescription drug coverage is equal to the actuarial net value of the standard Medicare Part D coverage for the same plan year.** To determine net value the plan sponsor may:
 - Subtract from gross value the expected premiums (or contributions) Part D eligible retirees (participant, eligible spouse and any dependents) pay for the current the plan.
 - Allocate a part of a retiree's contribution for prescription coverage in cases where the retiree makes a single contribution to cover both the medical and prescription plan. An actuary can determine how to calculate this amount.
 - Take the gross value determined in the previous step and subtract retiree premiums. To determine net value of the Medicare Part D benefits, the plan sponsor must subtract expected Medicare Part D benefit premiums from the gross value of the Medicare Part D standard plan.

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To determine the value of the Medicare plan, the plan sponsor can use the cost-sharing limits and out-of-pocket thresholds that will be in effect when the plan year starts.

The certification must be submitted no later than 60 days after the publication of Part D coverage limits for the upcoming plan year. Because this concept is difficult, the regulations include an example. If my plan year is from April 1 – March 31, the certification for the April 1, 2007, to March 31, 2008 plan year can use the 2007 coverage limits, cost sharing and so on; if the plan files the certification within 60 days of the publication of 2008 coverage limits. If the certification is filed after the 60 day limit, the 2008 limitations need to be used for certification of that plan year.

- Plan sponsors requesting a subsidy for several options must provide assurance for each benefit option separately.
- Plan sponsors must submit the certification annually at the time they apply for the subsidy or any other time CMS specifies. This certification must be submitted 90 days *before* they implement a material drug coverage change that affects the actuarial value.
- A qualified actuary who is a member of the Academy of Actuaries must certify and sign the attestation. The actuary must affirm the statement is true and accurate to the best of his or her knowledge. The actuary must also affirm that the informa-

tion being provided is done so to obtain federal funds.

Creditable Coverage

A plan sponsor must inform all Part D eligible participants enrolled in or seeking to enroll in the plan whether the coverage they have qualifies as creditable prescription coverage. **This requirement extends to all group health plans, not just retiree plans.** If your group health plan covers any Part D eligible participant, you must notify the Part D eligible participants, even those currently employed, that the benefits provided under the active employee group health plan qualify as creditable coverage.

Creditable coverage is prescription drug coverage that equals or exceeds the actuarial value of the standard Medicare Part D prescription plan. An actuary must certify that the coverage is creditable.

If a plan does not offer creditable coverage, it must disclose following key information to all Part D eligible participants:

- The coverage is not considered creditable.
- Individuals who do not enroll in Part D when they are initially eligible will have limited opportunities to enroll in Part D in the future.
- Individuals who do not enroll in Medicare Part D when they are initially eligible and do not have creditable coverage will have to pay a late enrollment penalty.

The notice of creditable coverage must be provided:

- Before the individual’s initial enrollment period for Medicare Part D for current enrollees.
- Before the effective date of coverage in a prescription plan and before any change in benefits that would affect the creditable coverage status.
- Before the Annual Coordinated Election period for Medicare Part D benefits that begins on November 15 each year.

The notice is necessary to ensure Medicare beneficiaries consider their current coverage before they decide to purchase Part D benefits. These



notices inform employees that they can enroll in Medicare Part D later than the initial eligibility date and late enrollment penalties will not be applied if they have creditable coverage.

Individuals who can show CMS that they were never told their prescription coverage was not creditable can apply to have their coverage con-

sidered creditable in order to waive any possible late enrollment penalty.

Audit of Records

The process for obtaining subsidy payments will be complicated and will require significant data transfers. Plan eligibility information and claim payments will need to be provided to CMS in order to calculate the subsidy amount. The audit requirement allows CMS access to the

information necessary to audit calculations and eligibility for subsidy payments.

Failure to allow access to pertinent records can result in non-payment of the subsidy or CMS recoupment of all or part of a subsidy payment.

Written Agreement

The written agreement is a formality that addresses the information that a health plan or a health plan insurer will need to provide to CMS in order to have the subsidy payment calculated. The information CMS will require, in most instances will be considered "protected health information" (PHI). The use of PHI is governed by the policies and procedures established by the covered entity, the group health plan. The written agreement will require the health plan insurer or group health plan to contractually commit to disclosing the required information to conduct the attestation and apply for the subsidy. Health plans need to make sure these activities are permitted by their privacy policies and procedures.

Applying for the Subsidy

The plan sponsor must apply for any subsidy in writing and include at least the following information:

- Employer tax ID number (if applicable).
- Sponsor name and address.
- Contact name and e-mail address.
- Actuarial certification that satisfies the standards specified in the previous section and any other supporting documents CMS may require for each applicable drug plan.

- A list of qualifying covered retirees (based on information the retirees provided when they enrolled). The list will need to include:

- Full name
- Health insurance claim number (HIC) or the Social Security number
- Date of birth
- Gender
- Relationship to retiree

The plan sponsor may enter into a voluntary data sharing agreement (VDSA) with CMS to meet this requirement.

- A signed sponsor agreement verifying the plan sponsor accepts and agrees to:

- Comply with the terms and conditions of eligibility for the subsidy payment set forth in these regulations and in any related CMS guidance.
- Acknowledge the information provided in the application is being provided to obtain federal funds.
- Require all subcontractors to acknowledge that information they submit is being used to obtain federal funds.
- Sign the agreement that acknowledges that the information submitted is correct to the best of the plan sponsor's knowledge.

The plan sponsor must apply for the subsidy no later than 90 days be-

fore the beginning of the plan year, unless the sponsor has filed a request for extension that is approved under the procedures CMS has established.

Payment of Subsidy

When a plan sponsor applies for a subsidy payment, CMS will compare the employer's retiree plan eligibility records with the Medicare Beneficiary database to determine whether any eligible individuals are also enrolled in Part D. If an individual is enrolled in Part D, the plan cannot receive a subsidy on that individual's claims. CMS will provide the results of this audit to the plan sponsor.



Once CMS determines the individual is qualified under the plan, the subsidy can be calculated. The subsidy is equal to 28% of the allowable retiree

prescription expenses. Allowable retiree expense means the gross covered retiree plan-related prescription drug costs actually paid (minus any manufacturer or pharmacy discounts, chargebacks, rebates, and similar price concessions). The allowable cost can be paid by the qualified retiree prescription drug plan or the qualified covered retiree (or on the qualified covered retiree's behalf). The subsidy is calculated on the drug cost that falls between the cost threshold and the cost limit. For 2006, the cost threshold is \$250 and the cost limit is \$5,000. The cost threshold and cost limit will be annually indexed in the same way as the Medicare Part B deductible.

CMS must receive accurate information in order to make subsidy payments. Although it allows plan sponsors to decide how often they will receive payments, CMS can restrict these options because of operational limitations. Sponsors may choose to receive subsidies:

- Monthly
- Quarterly
- Interim Annually (this frequency involves providing information on an annual basis but before all the rebates and price concessions are finalized)
- Annually

To receive payment, plan sponsors must submit the following information for each payment period:

- Qualifying retirees' drug costs incurred during the payment period.
- An estimate of the difference between the expected allowable retiree cost and the gross retiree prescription cost. Plan sponsors must calculate this amount using sound actuarial principles and historical plan data. This estimate is required in order to reflect rebates and other price concessions that may not have been apparent when the claim experience was submitted.
- Regardless of whether a plan sponsor elects monthly, quarterly or interim annual payments, the plan will also need to reconcile costs at year-end. The plan sponsor must submit to CMS within 15 months after the plan year ends (or later if CMS specifies)



the gross covered retiree plan-related prescription drug cost. In addition, the plan sponsor must provide actual rebate and price concession data for the plan year in question. If retiree prescription benefits are fully insured, a plan sponsor may determine gross plan costs based on the percentage of the premium the plan sponsor pays to provide the prescription coverage.

A plan can also request annual payments. In this situation, the plan sponsor elects a one-time final payment and waits to provide the claim data within 15 months after the plan year ends. The plan must subtract any applicable rebates or price concessions from the claim data. This approach will not require an official reconciliation calculation.

The plan sponsor (or its designee) must maintain the following records for six years after the plan year ends:

- Reports and working documents of actuaries who provided the attestation.
- All documentation of the cost incurred and other relevant information used to calculate subsidies.
- Any other record specified by CMS.

CMS may extend the six-year time limit if there is an ongoing investigation, ongoing litigation or an open investigation that would involve civil, administrative or criminal penalties.

CMS may issue guidance on maintaining records electronically.

Appeal Options

Plan sponsors may question and appeal any of the following initial subsidy determinations:

- The payment amount.
- The retiree prescription drug plan actuarial equivalence.
- Retiree qualifications.
- Anything else that affects subsidy eligibility or payment amount.

An initial determination will be binding. However, a plan sponsor may ask CMS to reconsider a determination by:

- Filing a written request within 15 days of the date of a notification of an adverse determination.
- Including the reasons why the plan sponsor disagrees with the initial determination. The request can include additional documentation to support the plan's argument.

CMS will review the subsidy calculation in light of the information provided and CMS will make a decision on the informal reconsideration request. CMS will notify the plan sponsor orally or electronically of their decision. The sponsor can request a written decision.

The effect of an informal reconsideration decision is final and binding, unless, a plan sponsor requests an informal hearing.

The result of an informal hearing is final and binding, unless the decision is reversed or modified by the administrator.

The plan sponsor may request an administrator review within 15 days of receiving the hearing officer's decision.

The Administrator has the power to review the officer's decision and has the ability to reverse the officer's decision. The administrator also has the ability to reopen a case subject to certain time limits:

- Within a year of the notice of determination for any reason.
- Within 4 years for good cause.

The Administrator must notify the plan sponsor in writing when the decision to reopen a case is made.

Design Benefit Option to Wrap-Around Medicare Coverage

The Medicare Secondary Payer provisions also apply to the Part D benefit. Just as retiree medical plans can be secondary to Medicare for Part A and Part B coverage, plans can be secondary to Part D as well.

If an organization is taking a wrap-around approach, many details should be considered:

- Retirees will need to enroll in Medicare Part D. The plan document will need to be amended to state that the plan will consider Medicare Part D to be the primary payer, even if the retiree is not covered by the Part D program.
- The plan should be designed to fill gaps in the standard Medicare benefit program.
- Wrapping the Medicare Part D plan will affect Medicare catastrophic coverage. Remember, the Medicare catastrophic benefit becomes effective when the Medicare beneficiary has incurred \$3,600 of *true* out-of-pocket cost. If a Medicare Part D beneficiary has no other coverage, the \$3,600 out-of-pocket maximum will be met when the individual has \$5,100 in covered prescription expenses in the calendar year. Any out-of-pocket expense a retiree health plan covers does not count toward meeting the \$3,600 true out-of-pocket maximum. This is a difficult

concept; the example below should help. In this example, the retiree plan is designed to coordinate with Medicare Part D to offer an overall benefit that pays 75% of the eligible prescription drug cost. If Medicare pays at least 75% of the cost, the retiree plan will not pay an additional benefit.

By coordinating on a secondary basis with Part D, employers will shift some of the initial retiree prescription cost to Medicare for payment; however, the point where Medicare will take over the majority of prescription drug expenditures will be delayed until the beneficiary meets the \$3,600 true out-of-pocket cost limit.

This approach may be most lucrative for employers who have low to moderate average annual retiree prescription costs. In evaluating this approach, organizations should consider the impact on retirees:

- Retirees will need to pay an estimated \$445 a year for the Medicare Part D benefit.

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Medicare Benefit	Prescription Expense	Covered by Part D	Covered by Retiree Plan		Beneficiary Pays	
			%	Dollars	%	Dollars
Annual Deductible	\$0-\$250	\$0	75%	\$188	25%	\$62
Initial Coverage Level	\$250.01 - \$2,250	\$1,500 (75%)	0%	\$0	25%	\$500
Coverage Gap	\$2,500.01 - \$14,400	\$0	75%	\$9,113	25%	\$3,038 Total: \$3,600
Catastrophic Coverage (\$3,600 true out-of-pocket max)	\$14,400.01	95% of remaining cost	Not covered	N/A	5%	No maximum

- Your organization's PBM will need to coordinate coverage with the local PDP sponsor. It is unclear whether this coordination will occur at the pharmacy or if beneficiaries will need to pay their portion of the prescriptions and apply for reimbursement from the employer plan. It seems that qualified PDPs may allow employers to purchase retiree wrap-around prescription plans and provide seamless coordination between Medicare Part D and the retiree health plan. However, no details on this type of coordinated plan have been released. Employers will need to work with local PDPs in each area their retirees are located. This may mean agreements with multiple PDPs depending on the distribution of covered retirees.
- If a seamless approach cannot be implemented, your organization should expect the coordination process to have a bumpy first year as administrative problems may arise from trying to coordinate at the point of pharmacy which is not standard operating procedure with benefit plans today.

Organizations considering this wrap-around approach should inform their retirees that they should enroll in Part D. In addition, the plan will need to inform CMS of any reimbursements made under a wrap-around plan design. Retirees who do not accurately disclose other coverage when they apply for Medicare Part D can be required to reimburse Medicare for any incorrect payment.

Qualify as a Qualified Prescription Drug Plan

Very large organizations where the administrative expense can be spread amongst a sizable retiree population may consider this option feasible. It is attractive because the employer will be treated just as any qualified PDP is treated. CMS will reimburse a portion of plan costs. The plan will accept a certain risk level in managing the prescription coverage, but the risk corridors are very favorable for the first two years of the plan benefit. In addition, the plan will receive stop loss protection because CMS underwrites 80% of losses that exceed the catastrophic coverage level.

However, this option will be exceptionally difficult to implement. In order to contract directly with CMS to become an approved PDP sponsor, the employer must meet all the requirements outlined in the previous *Benefit Advisor*. One of the most difficult requirements to meet is the requirement to be licensed as a risk-bearing entity in the states where retiree participants are located.

Eliminate Coverage for Outpatient Prescription Drugs

Organizations can discontinue retiree prescription coverage. Historically, employers provided the outpatient prescription benefit because Medicare did not cover these expenses. In fact, prescription benefits were always a key consideration in ending or reducing retiree benefits. Prescription expenses can

be sizeable and retirees find it difficult to secure alternate coverage.

Because Medicare now offers retiree prescription benefits, some employers may wish to drop this coverage altogether. Before discontinuing any retiree benefit, your organization should consult an attorney to determine whether your plan has appropriately reserved the right to do so. Your



organization should also consider the impact this decision may have on your retirees. The coverage Medicare offers is certainly not as comprehensive as most retiree plans and your

retirees' prescription costs share requirements will increase. Your organization may wish to consider funding the premium for Part D for retirees if you eliminate prescription coverage.

Action Steps

Employers that sponsor retiree medical plans will need to consider each of these options carefully. Before making any changes, every organization should consult an attorney to determine whether their plan language adequately reserves the right to change or terminate coverage.

If a retiree benefit plan is part of a union negotiated bargaining agreement, your organization needs to determine what options are available within the scope of these agreements.

Analyze the cost implications of each option. The cost implications will be two-fold. An organization needs to consider the actual im-

impact on the projected annual retiree plan cost as well as the impact on the FAS 106 valuations.

Each organization needs to consider each option's impact on its retirees:

- If an employer maintains the current benefit plan and decides to apply for the subsidy, the retiree impact will be minor. The employer will need to inform employees their coverage is considered creditable and explain that they do not need to elect Part D or pay the Part D premium.
- If an employer chooses to implement a Medicare wrap-around plan, the logistics of the process need to be considered. Will the retiree need to pay all non-covered expenses out of pocket and submit the claim for reimbursement? Will a vendor that offers a PDP in your region offer a wrap-around product that can be coordinated at the point of purchase? Will the PDP be able to accommodate your entire population based on their location?
- If an employer chooses to terminate prescription benefits, will retirees be offered any additional benefit? For example, an organization may choose to terminate retiree prescription coverage, but offer to pay Part D premiums for the retiree and any covered dependent.

Once you assess the impact of these options, review the administrative requirements:

- Applying for the subsidy will be a fairly intense administra-

tive process. Review the requirements and find out whether your current retiree prescription vendor will help you meet all the subsidy application requirements.

- Medicare wrap-around options could result in many administrative issues, especially if you attempt to coordinate benefits at the point of purchase with a PDP and a different retiree prescription plan vendor.

A retiree plan must take action before January 1, 2006, the date the Medicare Part D benefit takes effect.

To receive the subsidy, the employer will need to have an actuary perform the certification, distribute notices of creditable coverage and submit an application.

For the wrap-around approach, organizations should conduct detailed meetings with their plan vendors to determine what plan design options will be available. The organization will need to spearhead a campaign to inform retirees that they should apply for Medicare Part D and how the wrap-around benefits will be administered. In addition, if the change reduces benefits significantly, ERISA requires the health plan to inform

retirees within 60 days after the benefit change is adopted. Therefore, you must notify your retirees within 60 days of your final decision to provide wrap-around prescription benefits.

Finally, if your organization decides to end prescription benefits altogether; you must notify retirees of the benefit reduction within a reasonable time. If your plan eliminates prescription benefits, the ERISA notice requirements outline above apply. The decision to terminate these benefits is not likely to be taken well; it is very important to follow the appropriate ERISA timeframes for notifying retirees.

Survey data suggests many organizations that sponsor retiree medical plans are going to opt for the government subsidy for 2006. However, this commitment is not necessarily long term. It seems many plans want to see how the Medicare Part D benefit is launched and administered before they reduce benefits and take a secondary payment stance or terminate the benefits entirely.

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

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