



BENEFIT *Advisor*

In This Issue

In this fifth issue of the McGrawWentworth Benefit Advisor for 2006, we discuss Medicare Part D. Medicare Part D launched effective January 1, 2006 and the initial enrollment period ended on May 15. Medicare Part D did have implementation issues that the government is still trying to correct.

New guidance was recently issued addressing indexed plan features for 2007 as well as clarifications to the notification requirements of Part D.

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 McGrawWentworth web site at www.mcgrawwentworth.com.

“Medicare Part D Today”

Medicare Part D, a landmark change in the Medicare program, launched on January 1, 2006. It offers Medicare beneficiaries a program to help pay for their outpatient prescription drugs.

The launch of Medicare Part D did not go as smoothly as the government would have liked. Most areas of the country had an overwhelming number of plan options available. Michigan alone has 41 plan options available for Part D coverage. Not only are there too many plan options, the plan designs are complicated and are not being communicated clearly.

This Advisor reviews Medicare Part D including:

- Overview of Medicare Part D in Practice
- Employers’ Reaction to Medicare Part D for 2007
- Medicare Part D Indexed Amounts for 2007
- New Creditable Coverage Notice Guidance

Although the dust has barely settled on the Medicare Part D launch, the government has just issued the 2007 indexed amounts and more guidance on creditable coverage notices. This Advisor provides the details you need to

keep your organization current on Medicare Part D.

Medicare Part D, In Practice

Medicare Part D adds a much needed outpatient prescription drug benefit to the Medicare program. This legislation was hotly debated because of the significant cost it adds to the already financially strapped Medicare program.

The federal law requires a minimum of two plan options

for all geographic regions throughout the country. In reality Medicare Part D offers many more plan options. Most Medicare beneficiaries have at least 30 options and some geographic regions have over 60 options available. Choice is usually a good thing; however, for many Medicare beneficiaries the choice of Medicare Part D plans is overwhelming.

A recent poll conducted by the *Washington Post* and ABC reveals most seniors feel the process for enrolling in a Part D plan is not difficult. They also indicate the plan is saving them money. According to the *Washington Post*, 29 million seniors have enrolled. On the other hand, the government indicates 8 to 14 million eligible Medicare beneficiaries have not en-



rolled. Many of these seniors say the Medicare Part D plan is either too complicated or too expensive.

One of the key concerns with Medicare Part D was that the plans would be delivered through private insurance carriers. The Department of Health and Human Services chose private sector involvement because the resulting competition should help keep drug costs in check.

The initial enrollment period for Medicare Part D ended on May 15. As of the end of April, the government was projecting 90% of Medicare eligible individuals would be covered by outpatient prescription drug coverage through Medicare Part D, a retiree health plan or a Medicare Advantage plan.



Some of the initial launch problems are getting resolved. Prescription Drug Plans (PDP) and the government are working on glitches in their electronic data transfers. CMS has identified a number of individuals enrolled in more than one PDP and it is working on correcting this situation.

The following are additional issues that will cause problems for many Medicare beneficiaries this year:

- Information on the medical management plans for PDPs

was not particularly clear. Certain medications require prior authorization, quantity limits, and step therapy protocols. Because these programs were not clearly explained, Medicare beneficiaries will have problems at the pharmacy if their medications are subject to these requirements.

- Plan information for many PDPs was very confusing. Many seniors do not understand the structure of the benefit program they selected.

In most cases, benefits will stop or be reduced when out-of-pocket costs combined with the plan's payments reach \$2,251. At that point, some plans

discontinue coverage in the "donut hole"; others reduce benefits and cover only generic drugs. This structure is not explained clearly in most plan materials. Seniors will be confused when they reach the \$2,251 threshold and their benefits are reduced.

- PDPs can change drugs covered on their formularies at any time. This would have created issues for seniors if a drug they were taking was dropped from their plan's formulary.

However, President Bush just approved an administrative amendment to the Medicare regulations to minimize the impact of any changes in a formulary. If a plan removes a drug from the formulary mid plan year, any covered beneficiary taking the drug must be "grandfathered" under the previous formulary until the end of the plan year. This allows the senior to continue receiving the drug as if it was on the formulary until the next open enrollment when the senior has the option of changing to another plan that covers the medication.

Because the government is aware that the sheer number of choices is difficult for seniors, it may reduce the number of plans each carrier can offer in a geographic region. Over the long term, the concern is that the risk cannot be effectively spread over so many plans throughout the country. The number of plans options should decrease over the next couple of years either through government action or attrition because plans with low enrollment will most likely not be profitable.

Medicare Part D is an important benefit to seniors throughout the country. The programs are still working through the problems that have arisen, but for the most part, Medicare beneficiaries are using the plans and seeing savings on their prescriptions. The government continues to review the delivery system for Medicare Part D benefits. Expect the government to make some changes to simplify the benefit plans and options over the next several years.

NOTABLE THOUGHTS

**AN EXPERT IS A MAN WHO HAS MADE ALL THE MISTAKES
WHICH CAN BE MADE IN A VERY NARROW FIELD.**

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Employers Reaction to Medicare Part D for 2007

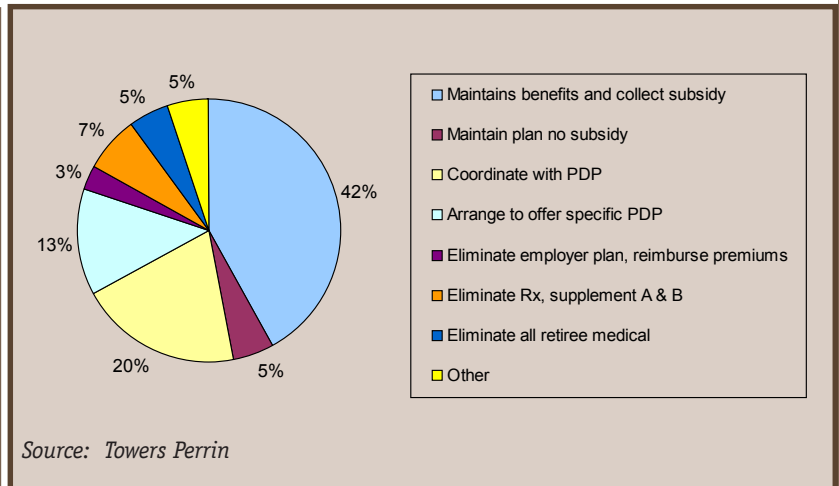
When Medicare Part D was passed, the government wanted to encourage employers to continue offering their retirees outpatient prescription drug coverage.

One incentive was a tax-free subsidy to cover part of the employers' costs. According to Towers Perrin, 65% of employers maintained their retiree prescription plan and applied for the subsidy in 2006. An additional 10% of employers maintained their benefit plans and chose not to apply for the subsidy.

It is generally believed most employers opted for the subsidy or maintained their benefits because the government did not release information on PDPs until very late in the year. Employers were unsure how the Medicare Part D benefits would look and were reluctant to make plan changes with so much uncertainty surrounding the Medicare Part D benefits.

Next year may be a very different story. According to Towers Perrin, far fewer employees will retain their retiree prescription benefits (see graph).

Far fewer employers plan to maintain retiree drug coverage for 2007. Interestingly, 20% plan to take a secondary stance to Medicare. This option may prove to be difficult unless some PDPs offer to administer the employer drug benefit plan secondary to Medicare Part D for retirees electing that vendor's Medicare Part D plan. However, no local Michigan plans are marketing plans capable of real-time coordination to pay secondary to Medicare Part D plans.



Over the next several years, fewer employers will offer retiree outpatient prescription drug coverage. The cost is substantial and with health care cost challenging so many organizations, Medicare Part D will make retiree drug coverage an attractive benefit to cut.

Medicare Part D Indexed Amounts for 2007

Part of the process to apply for a tax-free government subsidy of retiree prescription costs involves using an actuary to prove the retiree prescription drug coverage is equal to or better than the standard Medicare Part D plan design. CMS released guidelines for determining the value of employer provided benefits as they compare to Medicare Part D benefits. Recently, CMS updated the 2007 guidelines for the subsidy application.

The government paid subsidy is based on a percentage of each plan's claim utilization. The subsidy equals roughly 28% of prescription claims for Medicare Part D covered medications that fall between the cost threshold and cost limit.

The cost threshold and cost limit are as follows:

- Cost Threshold (2006) - \$250
Cost Limit (2006) - \$5,000
- Cost Threshold (2007) - \$265
Cost Limit (2007) - \$5,350

To calculate the 2007 subsidy, the 2007 limits will apply to the claims paid during the 2007 calendar year. For most plans, the 2007 amounts will also be used to calculate your actuarial attestations for retiree drug subsidy applications. A qualified actuary who is a member of the Academy of Actuaries must complete the attestations. For 2007, you must submit retiree drug subsidy applications by September 30, 2006.

Standard Medicare Part D Plan Design

Several parameters of the Medicare Part D standard benefit plan are also indexed. Remember, the government developed a standard plan design but allowed Medicare Part D carriers to choose either the standard plan design or an actuarially equivalent plan design. Although most carriers selected an actuarially equivalent plan design, some plans have deductibles and many plans change the coverage level once the initial out-of-pocket limit is reached.

The table to the right shows the standard plan design parameters for 2006 and 2007.

Once a beneficiary reaches the catastrophic coverage level, the beneficiary is responsible for the greater of 5% of drug cost or for 2007, a \$2.15 generic or \$5.35 brand name copay.

The 2007 adjusted Medicare Part D amounts have been released fairly early. These amounts will impact the required attestation tests for any plan applying for the subsidy.

In addition, these amounts should be used to determine if your group health plan offers creditable coverage. Creditable coverage is discussed in the next section.

These amounts may also impact the individual's Medicare Part D plan coverage. Even if a carrier did not choose the standard benefit plan design,



many of the plan designs offered include some aspects of the standard benefit plan design. Medicare Part D participants now have ample notice on 2007 plan option changes.

New Creditable Coverage Notice Guidance

CMS recently released new guidelines for the notice Medicare eligible participants must receive on the plan's creditable coverage status. The new rules are not significantly different from the rules set forth last May. However, they do clarify some gray areas.

	2006	2007
Annual Deductible (amount paid by beneficiary before benefits are payable)	\$250	\$265
Initial Coverage Limit (once deductible is met, plan pays 75% and beneficiary pays 25% until total prescription expense - paid by plan and beneficiary reaches initial coverage limit)	\$2,250	\$2,400
True Out-of-Pocket Maximum (Once the beneficiary has paid the true out-of-pocket cost, Medicare catastrophic coverage will pay the majority of prescription drug cost). The standard plan pays no part of expenses after initial coverage limit is met until the true Out-of-Pocket Maximum is reached.	\$3,600	\$3,850
Total Covered Medicare Part D Expenses before Catastrophic Coverage (providing the beneficiary has no coverage in addition to the Medicare Part D plan).	\$5,100	\$5,451.25

These notices must be provided:

- Within the 12 months before the Medicare Part D Annual Coordinated Election Period, sometimes referred to as the open enrollment period. The enrollment period lasts from November 15 through December 31 every year.
- Within the 12 months before an individual's initial enrollment period for Medicare Part D.
- Within the 12 months before the effective date of coverage under your plan for any Medicare eligible individual that applies for coverage.
- When your organization decides to discontinue offering prescription drug coverage or if your organization changes the drug benefit and it is no longer considered "creditable."
- When a beneficiary requests it.

If your organization notifies **all plan participants** annually, not just

Medicare eligible participants, that notice meets the notice requirement for anyone who becomes Medicare eligible during the plan year. This blanket notice is important because an employer may not know that a plan participant has become eligible for Medicare.

The new guidance also discussed the process group health plans could use to determine whether their plan is considered creditable. Plans have two options for determining creditable coverage status:

1. If a plan is applying for the Retiree Drug Subsidy and the plan passes the gross value test, the plan is considered creditable.
2. If a plan is not applying for the subsidy or is an active group health plan, the plan can pass the gross value test or use the simplified determination method.

The simplified determination method has not changed; however, the new guidance provides more detail on determining whether a plan has an integrated deductible. To meet the simplified determination requirements:

1. The plan must cover both brand name and generic prescriptions.
2. The plan must provide reasonable access to retail providers and optional mail order coverage.
3. The plan is designed to pay on average at least 60% of participants' prescription drug expenses.
4. The plan satisfies at least one of the following:
 - The prescription drug coverage has no annual benefit maximum or a maximum annual benefit payable of at least \$25,000.
 - The prescription drug coverage has an actuarial expectation that the amount payable by the plan will be at least \$2,000 for each Medicare eligible individual in 2006.

For simplified determination on a plan with an integrated deductible, the plan must meet requirements 1 through 3 listed above and have:

- No more than a \$250 deductible per calendar year.
- No annual benefit maximum for prescription drug benefits or if the plan has a maximum, it must be more than \$25,000.
- Have no less than a \$1 million combined lifetime maximum under the plan.

The new guidance defines an integrated plan as a plan combining the prescription drug benefit with other coverage the organization offers (including medical, dental or vision) and offering all the following provisions:

- A combined plan year deductible for all benefits the plan covers.
- A combined annual benefit maximum for all benefits the plan covers.
- A combined lifetime benefit maximum for all plan benefits.



Along with the new guidelines, CMS released three new creditable coverage model notices employers should use as of May 15, 2006:

1. Notice of Creditable Coverage
2. Notice of Non-Creditable Coverage
3. Personalized Notice

Although health plans need not use the models, they must ensure all notices contain the following content:

Creditable Coverage

- Statement that the health plan has determined the prescription drug coverage is creditable.
- The meaning of creditable coverage.
- Explanation of why creditable coverage is important, including a discussion of the consequences of a 63-day break in coverage.

The new notices included expanded discussions of the following:

- Right to a notice and when the beneficiary can expect a notice.

- Explanation of the beneficiary's various options with Medicare Part D and the impact on the beneficiary if he or she elects Medicare Part D.

For example, if a retiree elects Medicare Part D, will your plan cancel all retiree coverage or just the prescription portion? Will the beneficiary be able to re-enroll in your coverage later?

These issues should be discussed in your notice.

- Information on getting financial assistance to pay for Medicare Part D coverage if the beneficiary has limited income.

Non-Creditable Coverage

- Statement that health plan has determined the prescription drug coverage is not creditable.
- The meaning of creditable coverage.
- Explanation of limited opportunities to enroll in Medicare Part D.
- Explanation of why creditable coverage is important, including a discussion of the potential for a late enrollment penalty which will impact premiums paid.

The new notices included expanded discussions of the following:

- Right to a notice and when the beneficiary can expect a notice.

- Explanation of a beneficiary's various options with Medicare Part D and the impact on the beneficiary if Medicare Part D is elected. For example, if a retiree elects Medicare Part D, will your plan cancel all retiree coverage or just the prescription portion? Will the beneficiary be able to re-enroll in your coverage later? These issues should be discussed in your notice.
- Information on getting financial assistance to pay for Medicare Part D coverage if the beneficiary has limited income.

Personalized Notice

The Personalized Notice should be provided if a Medicare beneficiary requests one or it can be provided instead of the non-personalized notices discussed above. The Personalized Notice can be provided to PDPs to verify the status of a beneficiary's creditable coverage.



The Personalized Notice must contain the following:

- Beneficiary's first and last name.
- Beneficiary's social security number or health insurance claim number.
- Entity's name and contact information.
- Statement about the creditable coverage status – Is the plan's coverage creditable?
- The date ranges of the beneficiary's creditable coverage.

The government provided samples of all three notices. The model language can be found at www.mcwent.com/medicare/notices.htm.

Delivery Method

The government does state the form does not need to be delivered in a separate mailing. If the plan includes the notice with other materials, the following statement must appear prominently in at least a 14 point font, in a separate box, bolded or offset on the first page:

If you have Medicare or will become eligible for Medicare in the next 12 months, a new Federal law gives you more choices about your prescription drug coverage starting in 2006. Please see page ## for more details.

You can send a single notice to a Medicare covered employee and any Medicare eligible dependent covered under the plan and residing at the same address. If you are aware that a Medicare eligible dependent lives at a separate address, you must send a separate notice to that individual.

You can send a notice electronically only if the Medicare beneficiary has a way to access electronic information and the beneficiary affirmatively consents to electronic delivery. Before beneficiaries agree to receive this information electronically, they must be informed of the following:

- Their right to a paper copy.
- How to withdraw their consent.

- How to update their electronic address information with the plan.
- Hardware or software required to access the information.

In order to receive the information electronically, beneficiaries must send you their consent by e-mail and provide a valid e-mail address. If you send information electronically, the notice must also be posted on the company's website, if applicable, with a link to the full text of the disclosure notice.

What does this new guidance mean to your plan? You will need to amend your process to make sure you are providing the notice of creditable coverage when necessary. The best approach for most plans will be to include the notice information annually with any retiree or active plan materials. If you take this approach, the information must be provided before November 15 each year. If you provide this notice annually to all plan participants, it will satisfy the requirement to provide this information to individuals before their initial enrollment period in Medicare.

It makes sense to send the Personalized Notice to any Medicare beneficiary who loses coverage under your plan. This information will help ensure the former plan participant has the opportunity to enroll in a PDP in time to waive the late enrollment penalty.

Conclusion

As many expected, the launch of Medicare Part D was not without glitches and issues. PDPs and the government are working to resolve any problems related to the launch of the plan. Medicare Part D has given many seniors a much needed

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benefit: outpatient prescription drug coverage.

However, it has also brought them a few headaches with the complicated plan offerings and overwhelming number of options available throughout the country. As with any new benefit, it will take some time for seniors to become accustomed to their plans.

Employers that sponsor a retiree health plan also need to add Medicare Part D requirements to their "to-do" lists. They should review their strategy for working with Medicare Part D every year. These action steps should include:

1. Preparing for the subsidy application (if applicable).

These steps include:

- Engaging actuaries for gross/net value test. With the 2007 amounts available, the process can begin now.
- Complete the retiree drug subsidy application on-line and manage the adminis-



trative requirements for eligibility and claims.

2. Creditable coverage notices - creditable coverage applies to active and retiree plans:
 - Determine coverage status of plan.
 - Draft the appropriate notice (notice of creditable or not creditable coverage). Use the new model notice coverage produced by CMS. The language can be found at www.mcwent.com/medicarenotices.htm.
 - Establish a written procedure for

managing the notice process. A blanket notice annually will probably be the best approach for most organizations because it is not always

easy to identify your Medicare eligible individuals. Make sure to follow your procedures each year to meet your notice requirements.

3. Set an annual follow-up to complete the CMS required notice of creditable coverage.

An employer is required to make this disclosure annually to CMS. It must be done electronically.

For more information on this notice requirement, review our Special Alert at http://www.mcgrawwentworth.com/Special_Alert/2006/Special_Alert_Issue_1.pdf.

If you have any questions regarding Medicare Part D, please call your McGraw Wentworth Account Manager. **MW**

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