# THE ERISA INDUSTRY COMMITTEE (ERIC)

***Representing the Employee Benefits Interests of America's Largest Employers***

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May 27, 2004

Mark B. McClellan, M.D., Ph.D.
Administrator, Centers for Medicare and Medicaid Services
U. S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington D.C. 20201

RE: Request for Guidance Concerning Implementation of the Medicare Modernization Act

Dear Administrator McClellan:

Attached for your consideration is a request for guidance concerning issues related to implementation of the new Medicare prescription drug benefit. The issues were identified by member companies participating on our Medicare Implementation Task Force, who look forward to working with you and your staff to develop the guidance needed.

The ERISA Industry Committee (ERIC) is a nonprofit association committed to the advancement of the employee retirement, health and other benefit plans of America's largest employers. ERIC's members provide comprehensive retirement, health care coverage, and other economic security benefits directly to some 25 million active and retired workers and their families. ERIC has a strong interest in proposals affecting its members' ability to deliver those benefits, their cost and effectiveness, and the role of those benefits in the American economy.

If you would like to schedule a meeting or conference call to discuss the request for guidance, please contact Edwina Rogers, ERIC's Vice President, Health Policy, or Anthony Knettel, ERIC's Senior Health Policy Advisor, at 202-789-1400.

Sincerely,

[ signed ]

Mark J. Ugoretz
President

# THE ERISA INDUSTRY COMMITTEE
# REQUEST FOR GUIDANCE CONCERNING
# IMPLEMENTATION OF THE MEDICARE MODERNIZATION ACT

## 1. Actuarial Equivalence and Related Issues

### A. Adequate notice of the actuarial value, and methods and processes necessary to determine actuarial equivalence, of the Medicare standard prescription drug benefit.

ERIC members typically begin planning their health plan changes a year in advance of the plan year in which those changes will take effect. Since knowing whether a plan's prescription drug coverage is actuarially equivalent to the Medicare standard benefit is now integral to this planning process, it is essential that plan sponsors have adequate notice of the actuarial value against which they are benchmarking their plans for each plan year, as well as the methods and processes to be used in determining actuarial equivalence. *ERIC urges the Secretary to publish the projected value of the Medicare standard prescription drug benefit, and any new or revised methods and processes for determining actuarial equivalence, not later than April 1 of the year prior to the year for which the value, methods and processes will be used.*

### B. Treatment of health plans not operating on a calendar year basis.

A number of employer-sponsored health plans do not operate on a calendar year basis (*e.g.*, the plan year coincides with the plan sponsor's fiscal year instead). It would be extremely disruptive to such plans if they were required to make mid-year plan amendments to maintain their actuarial equivalence whenever the value of the Medicare standard benefit is revised. To ensure that non-calendar year plans have adequate notice of changes in the value of the Medicare standard prescription drug benefit, *ERIC urges the Secretary to promulgate guidance permitting non-calendar year plans to use as their benchmark for a given plan year the latest Medicare value in effect not less than 270 days prior to the first day of that plan year.*

### C. No recalculation required when neither Medicare standard benefit nor employer plan design[1] have changed.

ERIC does not expect the experience of employer-provided plans to diverge sufficiently from that of the Medicare standard prescription drug benefit to warrant annual recalculation of actuarial equivalence in the absence of a material change to either the employer plan or the Medicare standard benefit. Therefore, *ERIC urges the Secretary to clarify that once actuarial equivalence is established, no further actuarial equivalence calculations are required until either the Medicare standard benefit or the employer's plan design is materially modified.*

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[1] The term "plan design" used here and throughout this document is intended to encompass both benefit design and share of contribution to total plan costs.

**D. "Safe harbor" plan designs.**

Several ERIC members have expressed strong interest in the establishment of "safe harbor" plan designs as a means of eliminating the need to perform actuarial equivalence calculations. For example, any actuarially equivalent plan design offered by a Prescription Drug Plan as an alternative to the standard prescription drug benefit under Part D could reasonably qualify as such a "safe harbor" plan design. Additional design-based safe harbors might also be appropriate. *ERIC urges the Secretary to create a process for establishing these or similar "safe harbors."*

**E. Appropriate actuarial processes and methods.**

The statute gives the Secretary broad discretion to define the processes and methods to be used in determining the actuarial equivalence of employer-sponsored coverage to standard prescription drug coverage. Given the multiplicity of coverages typically offered by major employers to retirees and dependents, as well as the wide range of circumstances faced by different employers, *ERIC urges the Secretary to adopt flexible processes and methods that avoid unnecessary complexity in the actuarial calculations required, in recognition of the variety of plan design and administrative structures and provisions*.

ERIC members have identified several different methods that might reasonably be used to determine actuarial equivalence. For example, a "premium expense" approach would permit employers that provide coverage through an insurance policy or contract to attest that the employer's share of the premium paid for such insured coverage is equal to or greater than the published value of the standard benefit without requiring further formal actuarial calculations. Under an alternative "rate book" approach, the Secretary would publish an actuarial value for the standard prescription drug benefit based on standardized population and utilization assumptions and employers would apply these same standardized assumptions to their own plan designs in order to make the actuarial equivalence determination. Finally, an "actual experience" approach would permit employers to apply their actual plan demographics and utilization experience to both the standard prescription drug benefit and the employer's retiree health plans when making the actuarial equivalence determination.

Our discussions suggest that each of these approaches has advantages and/or disadvantages depending on a particular employer's circumstances, and that no one approach is clearly most appropriate for all employers under all circumstances. *Therefore, ERIC urges the Secretary to include each of the "premium expense," "rate book" and "actual experience" approaches among the permissible processes and methods for determining actuarial equivalence.*

**F. Actuarial equivalence determination in cases of multiple plans, multiple benefit formulas within a single plan, and plans using service-related retiree premium contributions.**

As a result of mergers and acquisitions, separate bargained and salaried plans, or separate plans maintained for different lines of business or different groups of retirees depending on date of retirement, many ERIC member companies sponsor multiple retiree health plans covering

distinct populations. Even in cases where there is a single plan, there may be multiple classes of retirees in the plan with different levels of coverage as a result of accumulated benefit changes over time (*e.g.*, certain participants were grandfathered when benefit changes were implemented). In addition, a significant number of ERIC members have adopted service-related premium formulas for their retiree health plans that result in a range of retiree premium contributions under the plan.[2]

ERIC believes that the statute was intended to require actuarial equivalence in the aggregate, not actuarial equivalence for each plan participant. Not only is the latter overwhelmingly burdensome to calculate (especially in the situations described above), but it is unnecessary to protect participants' interests given the fact that each retiree has the right to enroll in the Medicare Part D benefit rather than their employer-provided coverage if Medicare provides them with superior coverage based on their own personal circumstances.

Depending on the particular levels of coverage offered, some of an employer's plans (or classes of retiree coverage within a plan) may meet or exceed the actuarial equivalence standard while other plans (or classes of retiree coverage) do not. *ERIC urges the Secretary to clarify that an employer plan will be treated as actuarially equivalent if it is actuarial equivalent in the aggregate even though one or more classes of retiree coverage within the plan are not actuarially equivalent when calculated in isolation*. In addition, in cases where one or more classes of retiree coverage within a plan are actuarially equivalent but the plan in the aggregate is not, *the Secretary should clarify that employers may choose to calculate actuarial equivalence separately for these classes of retiree coverage in order to ensure they are eligible for the subsidy even though the remaining classes of retiree coverage under the plan are not eligible for the subsidy*.

**G. Actuarial equivalence determination in cases of integrated plans.**

Many ERIC members provide retiree health coverage that does not impose separate deductibles, out-of-pocket limits, premiums or other cost-sharing features on prescription drugs. There are compelling health policy reasons for doing so,[3] and the processes and methods for determining actuarial equivalence ought not dictate plan design by effectively requiring employers to adopt separate deductibles, out-of-pocket limits, premium contributions or other cost-sharing for prescription drugs in order to meet the actuarial equivalence standard. Therefore, *ERIC urges*

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[2] As an illustration, the formula might assign each retiree points based on the sum of his/her age at retirement and years of service, requiring no premium contribution for retirees with 85 or more points, a 25 percent premium contribution for retirees with 75-84 points, and a 50 percent premium contribution for retirees with 74 or fewer points. In this example, the result is a plan with three classes of retirees (*i.e.*, those with no premium share, those with a 25 percent premium share, and those with a 50 percent premium share). Under some plan designs, however, each retiree's service-related premium contribution is calculated individually as a function of age and years of service. In these cases there is no defined number of classes of retirees, but a range of possible premium contributions that can change from year to year depending on the characteristics of the participants that enter and leave the retiree health plan.

[3] For example, research has shown that increased cost-sharing for prescription drugs can cause patients with chronic illnesses to reduce or stop taking medications, which increases costs over the long term as their illness becomes less well managed.

*the Secretary to clarify that use of an integrated plan design does not prevent a plan from demonstrating actuarial equivalence by permitting employers to determine and utilize a reasonable methodology for allocating a portion of integrated deductibles, out-of-pocket limits, premium contributions and other cost-sharing features of the plan to prescription drug coverage for purposes of making the actuarial equivalence calculation.*

**H. Actuarial equivalence determination in case of plans with other common design features.**

A number of major employers have adopted formularies, incentives for generic drug substitution, mandatory mail order, and similar techniques to promote greater efficiency in their prescription drug plans. The processes and methods for determining actuarial equivalence ought not dictate plan design by effectively requiring employers to forego such design and administration features in order to meet the actuarial equivalence standard. Therefore, *ERIC urges the Secretary to clarify that the value of benefits provided through these and similar plan features, which are not part of the Medicare standard prescription drug benefit design, may be included in employers' actuarial equivalence calculations.*

**I. Notice of actuarial equivalence for late enrollment relief.**

ERIC members are concerned that the Secretary will mistakenly view the purpose of this notice to be providing individual retirees with the information they need to determine whether they are better off enrolling in Medicare or their employer's retiree health coverage and require that individualized notices be provided to retirees when they reach Medicare eligibility age. Actuarial equivalence is not the appropriate basis for individuals to make enrollment decisions because the relative value of Medicare vis-a-vis employer-provided coverage to them will depend on their personal health needs and utilization, which will not be reflected in the actuarial equivalence calculation. Therefore, there is no reason to require employers to provide individualized notices to retirees when they reach Medicare eligibility age.

Instead, the purpose of this notice is to provide relief from otherwise applicable Medicare late enrollment penalties meant to discourage "gaming."[4] This purpose can be satisfied without imposing unreasonable burdens on employers by permitting them to incorporate the notice in open enrollment materials, or in disclosure documents required by ERISA, particularly in the course of notifying plan participants of a material modification of the plan that results in the plan no longer being actuarially equivalent. Since most plan changes are implemented and communicated in conjunction with annual open enrollment periods, employers should be permitted to provide a general notice of the plan's actuarial status at this time without having to generate personalized notices.[5] Therefore, *ERIC urges the Secretary to clarify that the notice*

[4] I.e., discouraging individuals with low health risks from enrolling in less generous but cheaper coverage when they are healthy, then enrolling in more generous Medicare coverage when they get sick.

[5] Some ERIC member companies permit retirees to change plans throughout the year, and therefore do not have an open enrollment period; in this case provision of an annual notice in conjunction with some other retiree communication would be an appropriate alternative.

*requirement can be satisfied with a general notice provided in conjunction with open enrollment materials or other required disclosure documents and need not be provided based on each retiree's individual circumstances*.

**2. Subsidy and Related Issues**

**A. Employers' ability to determine which of its retirees have (and have not) enrolled in Medicare Part D.**

Despite an employer's intent to provide prescription drug coverage to retirees in lieu of Medicare Part D coverage, some retirees will mistakenly enroll in both employer-provided coverage and Part D and others who choose to enroll in Part D rather than their employer's coverage (which they have the right to do) will forget to notify their employer of the decision to switch coverage, with the result that vendors accidentally submit claims under the wrong coverage. Given the checkered history of the Medicare Secondary Payor (MSP) program and the problematic operation of the current voluntary data match program, it is in the interest of both employers and CMS to make sure employers have appropriate means to minimize enrollment errors and detect inappropriate prescription drug claims as soon as possible before they are compounded by erroneous subsidy payments.

The best way to address this need is for CMS to make available to all employers real-time, HIPAA-compatible, electronic means of determining whether an individual is enrolled in Medicare Part D. *Until CMS establishes a standards-compliant electronic enrollment verification system, ERIC urges the Secretary to clarify that employers may:*

*(1) make a condition of eligibility to enroll in the employer plan that the retiree has not enrolled in Medicare Part D;*
*(2) require retirees to indicate whether they are enrolled in Medicare Part D at the time they seek enroll in employer-provided retiree health coverage;*
*(3) require retirees to notify the employer when they enroll in Medicare Part D at a subsequent point in time; and*
*(4) rely on such retiree attestations for purposes of meeting the employer subsidy requirements.*

**B. The preferred timing of the subsidy calculation and payment.**

Given the difficulty in maintaining and coordinating the enrollment and claims records needed to calculate the subsidy, voluntary arrangements between employers and their vendors to put in place information systems that calculate the subsidy amount at the point of service may provide both the most economical and the most accurate means of determining the subsidy amount, submitting the amount to CMS and receiving reimbursement. Although ERIC does not believe the statute forecloses such an approach, *we urge the Secretary to provide guidance authorizing voluntary point of service determination of the subsidy amount.*

In the absence of real-time point of service determination of the subsidy amount, cash flow will have a significant impact on the level of benefits employers will be able to sustain; if employers must wait a significant length of time after expenses have been incurred to receive subsidy

payments, they will be less willing to continue to assume that financial burden. Therefore, *ERIC urges the Secretary to authorize periodic subsidy payments based on prospective estimates of expenses to be incurred, to be paid within 60 days of submission by an employer, with subsequent reconciliation based on actual expenses incurred*, as the best means to ensure cash flow is not an obstacle to employers continuing to offer coverage.

**C. The preferred form of subsidy payment.**

Several policy makers have suggested that it may be feasible to implement subsidy payment through tax offsets rather than cash transfers. While most ERIC members have expressed a preference for cash transfers, several have expressed interest in tax offsets. Therefore, *ERIC urges the Secretary to consider tax offsets as an optional alternative to a cash transfer subsidy payment mechanism*.

**D. Assignment of subsidy payment to plan vendors in order to reduce plan premiums.**

As noted above, cash flow is likely to have a significant impact on an employer's willingness to continue offering coverage. Some employers may wish to enter into contractual agreements with their vendors to assign their subsidy payments to the vendor in exchange for a lower up-front premium payment. *ERIC urges the Secretary to clarify that subsidy payments will be made by electronic funds transfer to the account designated by the employer, including directly to the employer's vendor(s) if that is the arrangement agreed to by the parties*.

**3. Wrap-around Coverage and Related Issues**

**Ability of Part D prescription drug plans (PDPs) to offer group only PDPs with supplemental benefits.**

The Act authorizes PDP sponsors to offer PDPs with supplemental benefits. It is unclear whether such plans can be offered only on a group basis or whether they would be required to be offered to all eligible individuals in a region. In addition, it is unclear whether the PDP sponsor would be allowed to vary the premiums for a particular plan design for different groups due to differences in expected claims utilization based on factors such as actual claims experience or the demographic make-up of the group. In order to maximize the ability of employers to offer seamless wraparound coverage in conjunction with Part D PDP coverage, *ERIC urges the Secretary to clarify that PDPs can design and sponsor plans with supplemental benefits that are only offered on a group basis, and the decision to offer a particular plan design and the premium to be charged for that plan design can be determined on a group by group basis.*