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MEDICARE PRESCRIPTION DRUG BENEFIT

Final Rules Provide Flexibility for Retiree Health Plans

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On January 28, the Centers for Medicare and Medicaid Services (CMS) published a final regulation implementing the new Medicare prescription drug benefit authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The final regulation resolves a number of significant outstanding issues, including the requirements for the 28% tax-free retiree drug subsidy. CMS is expected to issue further guidance this spring on issues important to employers.

Medicare Prescription Drug Benefit

The MMA establishes an optional outpatient prescription drug benefit (Medicare Part D) that will be available beginning January 1, 2006, to beneficiaries who are entitled to Medicare Part A or Part B. The prescription drug benefit will be provided through private prescription drug plans (PDPs) offering only drug benefits, or through Medicare Advantage plans (MA-PD plans) offering drug benefits and other Medicare-covered medical benefits. Beneficiaries who choose to enroll in Part D will pay a monthly premium that varies by plan. The Part D premium is expected to average $37 per month in 2006.

Part D provides a standard prescription drug benefit package with dollar limits that increase annually. The table below shows the 2006 dollar limits for a retiree enrolled in Part D who has no other drug coverage:

Medicare Prescription Drug Benefit for 2006			
Drug Expenses	Retiree Pays	Medicare Pays	Retiree Out-of-Pocket
First $250.00	100%	0%	$250.00
Next $2,000.00	25%	75%	$500.00
$2,250.00	← Initial Coverage Limit →		**$750.00**
Next $2,850.00	100%	0% (the “donut hole”)	$2,850.00
$5,100.00	← Catastrophic Coverage Threshold →		**$3,600.00**
All remaining expenses	5%	95%	variable

If the retiree’s “true out-of-pocket” (TrOOP) expenses reach $3,600, Part D provides a catastrophic benefit that generally pays 95% of all covered drug expenses above that limit. TrOOP expenses include the retiree’s deductible, co-payments, and payments above the initial limit, but do not include amounts reimbursed by insurance or by an employer health plan. A retiree with no other coverage would have to incur $5,100 in covered drug expenses to reach the catastrophic coverage threshold.

CMS has established geographic competitive regions for organizations offering Part D plans. There will be at least two approved plans (one of which must be a PDP) in each region, or CMS will establish a government-sponsored fallback plan in the region. PDPs and MA-PD plans are required to negotiate lower drug prices and pass cost savings on to their members. CMS estimates that competitive pricing and other cost-management techniques will result in cost savings of 15% initially, increasing to 23% within five years. PDPs and MA-PD plans will have flexibility to offer alternative plan designs, as long as their plans meet various tests of actuarial equivalence to the standard Part D package. PDPs and MA-PD plans also may offer enhanced coverage that supplements the standard Part D package. Amounts reimbursed by supplemental coverage will not be included in a retiree's TrOOP expenses.

Employer Cost-Saving Options

Employers that provide prescription drug benefits to Medicare-eligible retirees will have opportunities to realize savings as a result of the new Medicare prescription drug benefit. The final regulation describes the options for coordinating employer-provided drug benefits with the new Part D benefit:

- **Pay Primary and Receive a Direct Subsidy** - Employer prescription drug plans can continue to provide primary coverage for those Medicare-eligible retirees (and their spouses and dependents) who do not enroll in Part D. The employer can receive a tax-free subsidy directly from Medicare for these individuals. The subsidy equals 28% of the plan's covered drug expenses (including amounts paid by the retiree) between annual dollar limits ($250 and $5,000 in 2006). CMS estimates that the average value of this subsidy will be $668 per beneficiary in 2006. Because the subsidy is tax-free, it will be equivalent to a taxable payment of $1,028 per beneficiary for companies that pay tax at the maximum rate.

- **Sponsor a Prescription Drug Plan** - An employer can sponsor a Part D PDP if the employer meets the qualification standards either on its own or with a business partner. Payments by an employer-sponsored PDP plan will not be eligible for the 28% retiree drug subsidy; but an employer-sponsored PDP (like other PDPs and MA-PD plans) will receive Part D premium subsidies from CMS, as well as reinsurance subsidies for retirees who reach the catastrophic coverage limit. Although PDPs ordinarily are required to accept all Part D-eligible individuals in a region, an employer can apply to CMS for a waiver that will permit the employer to limit enrollment in its PDP to the employer's own Medicare-eligible retirees. CMS published additional guidance concerning these waivers on its website on February 11. An employer that wishes to sponsor a PDP must submit a notice of intent by ***March 23, 2005,*** and must file a formal application by ***April 18, 2005.***

- **Pay Secondary With No Direct Subsidy** - An employer can provide secondary prescription drug coverage that "wraps around" Part D coverage for its retirees who enroll in Part D, the same arrangement that most employers currently use to coordinate retiree health coverage with Medicare Parts A and B. Secondary payments will not qualify for the 28% retiree drug subsidy; but the primary payments under Part D will cover a significant portion of drug costs. Any benefits the employer's plan pays—for example, covered drug expenses above the Part D initial limit ($2,250 in 2006)—will not count toward the $3,600 "true out-of-pocket" expenses that the retiree must incur in order to qualify for catastrophic coverage under Part D.

- **Contract With an Existing Medicare Advantage Plan or PDP** - An employer can contract with an MA-PD plan or PDP established by an independent organization in order to provide Part D drug benefits on a group basis to the employer's eligible retirees. Since CMS has designated 34 geographic regions for PDP plans and has permitted MA-PD plans to operate on a county-by-county basis, a large

employer might have to contract with a number of Part D plans in order to cover the areas where the employer's retirees are concentrated. Nevertheless, an employer that wishes to provide a "wrap-around" prescription drug benefit might find it easier to coordinate payments if the employer contracts with a single entity to provide both Part D coverage and supplemental coverage to the employer's retirees in a given region.

- **Pay Retirees' Part D Premiums** - Instead of (or in addition to) contracting with a Part D plan or providing "wrap-around" secondary coverage, an employer may pay all or part of the Part D premium for the employer's Medicare-eligible retirees. CMS estimates that the average monthly Part D premium will be $37 in 2006, but the actual amount will vary by Part D plan.

- **Eliminate Prescription Drug Coverage** - To the extent permitted under existing plan documents and collective bargaining agreements, an employer can eliminate its own prescription drug coverage and allow Medicare-eligible retirees to receive prescription drug benefits solely from Part D. At present, however, it is unclear whether employers may eliminate or reduce prescription drug coverage for Medicare-eligible retirees while continuing to offer full prescription drug coverage to retirees who are not yet eligible for Medicare. Although the EEOC has approved a final rule affirming that the Age Discrimination in Employment Act does not prohibit an employer from reducing or terminating health coverage when a retiree reaches Medicare eligibility, retiree advocacy groups have sued to enjoin the EEOC from issuing the final rule.

Requirements For The 28% Tax-Free Subsidy

Under the relatively lenient standard adopted in the final regulation, many employer prescription drug programs will be able to qualify for the 28% tax-free subsidy. This option is particularly attractive to employers that offer prescription drug benefits to union-represented employees, since it allows the employer to receive a financial benefit from Part D without negotiating changes in its existing program.

Demonstrating Actuarial Equivalence. In order to qualify for the 28% retiree drug subsidy, an employer must demonstrate that its prescription drug plan is "actuarially equivalent" to the Part D standard benefit package. The final regulation adopts a two-part test to determine actuarial equivalence:

- ***Gross Value Test*:** The first part of the test is satisfied if the expected value of the plan's benefit payments is at least equal to the expected payments for the same beneficiaries under the Part D standard benefit package. The value of the payments is based on claims experience, regardless of whether the payments under the plan are financed by employer or employee contributions.

- ***Net Value Test*:** The second part of the test compares the value of the plan's benefit payments financed solely by the employer with the net value of the Part D standard benefit package. In performing this test, the employer is permitted to reduce the value of the Part D benefit by the expected monthly beneficiary premiums under Part D to determine the net value of the Part D standard benefit package.

The final regulation gives employers substantial flexibility in applying the actuarial equivalence test:

- ***Applying the Test to the Entire Plan or to Each Benefit Option*:** If a group health plan offers more than one prescription drug benefit option (defined as a particular benefit design, category of benefits, or cost-sharing arrangement), the employer may choose to apply the net value test either to the plan as a whole or separately to each benefit option. This provision is helpful to a plan that provides different prescription drug coverage and contribution levels to different groups of retirees under a single plan: it

permits the employer to demonstrate actuarial equivalence for the plan as a whole even though the benefits provided to certain groups of retirees might not satisfy the net value test, or (conversely) to show that particular options are actuarially equivalent even if the plan as a whole is not. Regardless of which approach the employer chooses for the net value test, however, the employer must demonstrate that each benefit option separately satisfies the gross value test.

- ***Applying the Test to Combined Medical and Drug Plans:*** Most employers offer prescription drug coverage as part of an integrated health plan that also provides medical benefits (and sometimes dental or vision coverage as well), with a single retiree contribution for the integrated health package. For many integrated plans, the question whether they will pass or fail the net value test depends on the extent to which retiree contributions are allocated to the prescription drug benefit rather than to the other benefits provided under the plan. The final regulation gives the employer complete flexibility to allocate retiree contributions in any way it chooses. Accordingly, an employer may allocate the retiree contribution entirely to non-drug benefits, up to the full value of those benefits, before any portion of the contribution reduces the net value of the prescription drug benefit. This flexibility is particularly important to companies that have capped the employer contribution toward the overall cost of retiree health coverage: as the cost of coverage rises and the retiree contribution increases, the employer may attribute its share of the cost entirely to the plan's prescription drug coverage, extending the period during which the plan will be able to satisfy the net value test.

- ***Taking Account of Part D Enrollment.*** An employer may claim the subsidy only for an eligible individual who does not actually enroll in Part D. Although an employer may not prohibit its retirees from enrolling in Part D, the employer may provide that a retiree becomes ineligible for the employer's group health plan if the retiree enrolls in Part D. Alternatively, if the employer elects to provide secondary coverage to retirees who enroll in Part D, the employer may reduce the net value of Part D coverage to take into account the value of the employer's supplemental coverage, an approach that might make it easier for the employer to demonstrate actuarial equivalence and claim the subsidy for retirees who do not enroll in Part D.

Applying for the Subsidy. An employer must apply for the subsidy at least 90 days before the beginning of the plan year: employers that wish to receive the subsidy for 2006 must apply by ***September 30, 2005***. The application must include an actuary's certification that the plan satisfies the actuarial equivalence test. If the employer makes a material change in its prescription drug program during the year, the employer must provide an interim actuarial certification at least 90 days before implementing the change.

The application must identify each retiree, spouse, and dependent for whom the employer will seek the subsidy, and the employer must update this information each month as individuals join or leave the eligible group. Because preparing the application and obtaining the actuarial certification will require a significant amount of time, especially in the first year, employers that wish to apply for the subsidy should begin the application process well in advance of the deadline.

Calculating Eligible Costs. The 28% retiree drug subsidy is paid with respect to allowable costs for eligible retirees (and their eligible spouses and dependents). "Allowable costs" are gross drug costs (excluding administrative expenses) between specified dollar limits ($250 and $5,000 in 2006) paid by the employer plan or by the retiree, reduced by any discounts or drug manufacturer rebates the plan receives. In an insured plan, the subsidy is based on incurred claims rather than on premiums. The employer must provide cost data to enable CMS to calculate the subsidy, and must maintain detailed records of eligible costs, subject to audit by CMS, for six years after the year in which the cost was incurred.

Price Concessions. In determining allowable costs, employers must adjust for price concessions only if the concessions are attributable to actual drug costs: the preamble to the final regulation explains that employers do not have to take into account price concessions attributable to matters such as customer service performance standards or identification card delivery. In addition, the employer may ignore discounts or other price concessions that are passed through to the beneficiary and plan at the point of sale.

Fiscal Year Plans. The final regulation includes a number of special rules for plans that operate on a fiscal year rather than a calendar year basis. The employer may determine actuarial equivalence using the Part D standard benefit package in effect when the employer's plan year begins, provided that the employer submits the certification to CMS before (or no more than 60 days after) CMS publishes the new Part D standard benefit package for the upcoming year. The employer is permitted to calculate the gross retiree cost using the annual dollar limits for the calendar year in which the plan year ends. For the 2005-06 plan year, the employer must take into account claims incurred during the entire plan year to determine the gross retiree costs that fall within the annual dollar limits; but the employer will receive subsidy payments only for claims incurred on or after January 1, 2006. The employer may apply for the subsidy by the September 30, 2005, deadline, even if the employer's 2005-06 plan year has already begun.

Receiving Subsidy Payments. When an employer applies for the subsidy, it must elect to receive subsidy payments on a monthly, quarterly, or annual basis. If the employer elects to receive payments monthly or quarterly, it must submit estimated cost data each month or quarter, and it must reconcile the data within 15 months after the end of the plan year.

Coordinating Benefits To Provide Wrap-Around Coverage

Providing TrOOP Information to Part D Plans. The catastrophic benefit under Part D is triggered when a covered beneficiary's "true out-of-pocket" (TrOOP) expenses exceed a dollar threshold ($3,600 in 2006). Prescription drug expenses reimbursed by employer plans do not count toward a retiree's TrOOP threshold. Accordingly, in order to administer this provision, each Part D plan will need information on benefit payments made under employer-sponsored retiree health plans.

Coordinating Benefits at the Point of Sale. An employer that wishes to provide secondary coverage for retirees enrolled in Part D will face legal and administrative complications as it attempts to coordinate benefits at the point of sale, since the payments due from the retiree, the Part D plan, and the employer wrap-around plan all must be determined when the prescription is filled. Coordination of benefits will be particularly challenging in view of the fact that Part D plans are likely to have wide variations in formularies, cost-sharing requirements, and coverage management programs. It will also be necessary in some circumstances to resolve disputed benefit claims through parallel appeals under a Part D plan and under the employer's ERISA claim procedures.

CMS Role. CMS understands these challenges and is considering procuring a TrOOP coordinator to establish a single point of contact between primary and secondary payers at the point of sale. CMS also expects to expand its Medicare beneficiary database to help employers identify employees who are eligible for Part D. CMS expects to make its final decision regarding its strategy for facilitating coordination of benefits by July 1, 2005.

Requirements For Notice Of Creditable Coverage

Notice Requirement for Active and Retired Employees. To preserve the actuarial soundness of the Part D program, individuals who do not enroll during their initial period of eligibility will pay a financial penalty

in the form of higher monthly Part D premiums. This late-enrollment penalty will be waived for periods during which the individual receives comparable prescription drug coverage from another source, including an employer-sponsored retiree health plan. Employers that provide prescription drug benefits to Medicare-eligible individuals, whether retirees or active employees, will be required to determine whether the prescription drug coverage under each group health plan they sponsor is actuarially equivalent to Part D coverage, and to notify Medicare-eligible individuals and CMS of the results of this analysis. An employer must provide this notice even if it determines that its coverage is *not* comparable to Part D.

Gross Value Test for Actuarial Equivalence. An employer's prescription drug plan will be considered actuarially equivalent to Part D if the expected payments under the plan (regardless of whether they are financed by employer or employee contributions) on average will be at least equal to the expected payments under the Part D standard benefit package. The test must be applied to each benefit option under the plan, rather than to the plan as a whole. This test is the same as the gross value test used to determine actuarial equivalence for purposes of the 28% retiree drug subsidy. Accordingly, all employers that provide prescription drug coverage to Medicare-eligible individuals will have to perform the gross value test, even if the employer does not apply for the subsidy, and even if the employer does not provide prescription drug coverage to retirees. Employers are required to maintain documents showing the actuarial analysis and assumptions supporting the determination.

Timing of Notice. Employers must provide a notice of creditable coverage at the following times:

- Before the individual's initial enrollment period for the Part D program.
- Before the Part D open enrollment period, which begins on November 15th of each year.
- Before the effective date of the individual's enrollment in the employer's prescription drug coverage.
- At the time of any change that affects whether the employer's prescription drug coverage is creditable coverage.
- Upon request by the individual.

Including the Notice in the SPD. As long as the notice of creditable coverage is conspicuous, it may be included in other documents that are required to be distributed to active and retired Medicare-eligible employees, such as a summary plan description.

Rules for HSAs, FSAs, and HRAs

Treatment as TrOOP Expenses. Employees often pay health expenses through flexible spending accounts (FSAs) financed by payroll deduction or through employer-financed health reimbursement accounts (HRAs). In addition, MMA creates a new category of individual health savings accounts (HSAs), which can be funded by employers, employees, or both. Although drug expenses reimbursed by an employer-sponsored group health plan generally are not treated as "true out-of-pocket" expenses that count toward the catastrophic coverage threshold, the final regulation creates an exception for FSA and HSA reimbursements. CMS regards these accounts as "essentially analogous to a beneficiary's bank account." Accordingly, HSA and FSA reimbursements count as TrOOP expenses, even if the HSA is funded in whole or in part by employer contributions. In contrast, HRA reimbursements do not count as TrOOP expenses, since employees are not permitted to make contributions to HRAs.

Notice Requirement and Eligibility for Subsidy. FSAs, HRAs, and some HSAs (those maintained as ERISA welfare plans) are treated as group health plans for other purposes under the Part D regulation, including the requirement to provide notices of creditable coverage to Medicare-eligible individuals. For

purposes of the 28% retiree drug subsidy, it is unclear to what extent an employer will be able to demonstrate that these account-type arrangements are actuarially equivalent to Part D. The preamble to the final regulation acknowledges this issue and states that CMS intends to provide further guidance.

Issues On Which More Guidance Is Expected

Although the final regulation answers many significant questions, it also reserves a number of important issues for future guidance. CMS stated in the preamble to the final regulation that it expects to provide additional guidance relatively soon on the following issues of interest to employers:

Additional Guidance Concerning the 28% Retiree Drug Subsidy

- The methods for determining actuarial equivalence.
- The extent to which FSAs, HRAs, and other individual-account arrangements can be considered for the subsidy.
- Procedures and forms for applying for the subsidy.
- Procedures for obtaining an extension of the application deadline.
- The requirements for updating enrollment information during the year.

Additional Guidance Concerning Other Issues

- The conditions for issuing waivers to allow employers to establish PDPs for their retiree groups. (On February 11, 2005, CMS published guidance on Part D waivers for employer and union plans. The guidance is available on the CMS website; additional guidance is expected.)
- The availability of waivers allowing PDPs to serve employer plans in multiple geographic regions.
- Administrative procedures and mechanisms for coordinating benefits between Part D plans and employer plans that provide secondary coverage. (Expected by July 1, 2005.)
- Additional information concerning the form and timing of the notice of creditable coverage, including a sample notice.

For further information on the Medicare Part D prescription drug benefit, or to discuss employer strategies and options, please contact any of the following:

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