

Proposed Regulations for the New Medicare Rx Benefit

In August 2004, the Centers for Medicare and Medicaid Services (CMS) published proposed regulations implementing the new Medicare Part D outpatient prescription drug benefit.¹ Although the proposed regulations do not answer all of the questions plan sponsors have about the new law, they clearly define the options for providing benefits that either supplement, replace or coordinate with Part D benefits.

BACKGROUND ON PART D

Part D enrollment is voluntary for Medicare beneficiaries. An open enrollment period will be held every year, the first of which will be November 15, 2005 through May 15, 2006. Beneficiaries who want to enroll in a Part D program must choose either a private prescription drug plan (PDP) or a Medicare Advantage-prescription drug (MA-PD) plan.² The beneficiary would pay a monthly premium for the coverage (estimated at \$35.00 for 2006) and could switch plans on an annual basis. Beneficiaries who do not enroll in Part D, and who do not have other “creditable” prescription drug coverage, would be subject to a significant financial penalty for late enrollment.

¹ See The Segal Company’s January 2004 *Bulletin*, “Medicare Prescription Drug, Improvement, and Modernization Act of 2003,” for a summary of the law — which the CMS refers to as the Medicare Modernization Act (MMA) — that created Medicare Part D. That *Bulletin*, which includes information about the standard Part D benefit, including the deductible (\$250 in 2006, indexed) and the percentage of drug costs that Medicare will pick up (75 percent of covered costs up to \$2,250, indexed, and 95 percent of costs after the beneficiary pays \$3,600 out of pocket, indexed) is available on the following Web page: <http://www.segalco.com/publications/bulletins/jan04newMedicarelaw.pdf>

² MA-PD plans are either preferred provider organizations or Medicare health maintenance organizations (*i.e.*, today’s Medicare+Choice plans).

WHAT CMS PROPOSED: HIGHLIGHTS

Retiree Drug Subsidy

Employer-sponsored plans that provide an “actuarially equivalent”³ prescription drug benefit to Medicare beneficiaries will be eligible to receive a financial subsidy to help offset their costs. The subsidy is not a tax credit, but is a direct, non-taxable payment to plan sponsors (including private plans, collectively bargained plans, governmental plans, and church plans). The subsidy equals 28 percent of allowable covered Part D prescription drug claim costs actually paid for retired Medicare beneficiaries⁴ between \$250 and \$5,000 (indexed annually), and is estimated by the CMS to equate to an average of \$611 per beneficiary in 2006. Drug claim cost, as defined in the law, includes discounted ingredient cost, dispensing fees and rebates. It excludes administrative fees. Under the proposed rule, plan sponsors seeking the subsidy would have to:

- Apply for it *no later than 90 days prior to the beginning of the calendar year for which they are requesting the subsidy* (*i.e.*, by September 30, 2005 for January 2006).
- Submit an Actuarial Attestation of equivalency signed by a plan representative *and* a member of the American Academy of Actuaries,
- Submit data supporting the request for a subsidy (*e.g.*, names of retirees and demographic information that allows the CMS to coordinate coverage with Medicare), and
- Disclose to retirees whether their drug coverage is actuarially equivalent to Part D.

The CMS proposes several different methods for paying sponsors the subsidy, including monthly, on an estimated interim basis or annually. The CMS indicates that, although accounting for rebates might

³ “Actuarial equivalence” is discussed on the next page.

⁴ The subsidy is paid for each retiree and Medicare-eligible dependent who is eligible for, but not enrolled in, Part D.

be able to be done retroactively, it will expect rebates to be tracked in a significantly more detailed manner than is common in today's pharmacy administration structure. Requests for the subsidy would have to be accompanied by data showing the calculation of the amount due to the plan. The CMS will not require that plan sponsors submit individual claims data, but they must submit data regarding the amount of allowable costs incurred (the proposal requests comments as to whether to collect data in the aggregate or identified by each eligible individual).

Plan Options

Plan sponsors would have several options for coordinating coverage with the new Medicare Part D drug benefit, as summarized in the table below:

Plan Design Options	Medicare Subsidy?	Comments/Observations
Pay the Medicare Part D premium on behalf of a plan participant (or eligible dependent)	No	The Prescription Drug Plan (PDP) or Medicare Advantage-Prescription Drug (MA-PD) plan (not an employer-sponsored plan) would constitute retirees' primary coverage. The plan sponsor loses control of the plan design.
Provide "wrap-around" coverage for plan participants enrolled in a PDP or an MA-PD plan	No	This coverage would supplement the retirees' Part D coverage (e.g., assist with cost-sharing).
Provide retirees with "actuarially equivalent" (or better) drug coverage	Yes	The plan sponsor retains flexibility in benefit design and pharmacy access provisions. Medicare will pay the retiree drug subsidy to the plan sponsor.
Contract with a PDP or an MA-PD plan to provide coverage that is more generous than coverage offered under the standard Part D benefit	No	The plan sponsor may elect to subsidize the monthly beneficiary premium. A CMS waiver would be necessary.
Set up a PDP or an MA-PD plan, which could consist of drug coverage that is more generous than that offered under Medicare Part D	Yes	Direct and reinsurance* subsidies would be paid to the plan. The plan sponsor may elect to subsidize the monthly beneficiary premium. A CMS waiver would be necessary.

* "Reinsurance" refers to the government payment to Medicare Part D plans after an individual reaches his or her out-of-pocket maximum (i.e., after an individual's out-of-pocket expenditures total \$3,600, the Medicare Part D plan picks up 95 percent of costs).

Actuarial Equivalence

Contrary to expectations, the CMS did not detail a method of determining whether a retiree drug plan is "actuarially equivalent" to the Medicare standard benefit, but it did set forth goals to prevent employer "windfalls." The CMS suggests a two-prong test for calculating actuarial equivalence: (1) the "gross" value of the coverage and (2) the "net" value of the benefit without considering the financial contribution of the retiree. The CMS suggests that the plan's contribution would have to be at least \$611 in 2006 to qualify for the subsidy, but might have to be as high as approximately \$1,200 (the net value of the Part D benefit). The CMS proposes that a plan will be actuarially equivalent if the average actuarial value (over all participants) of retiree drug coverage under the plan is at least equal to the value of standard Part D coverage. Additional guidance is expected.

Other Issues

The CMS would place several other requirements on plan sponsors, including obligations to coordinate benefits with Medicare (e.g., enter into electronic

data-sharing arrangements), retain records for six years plus the year in which the subsidy was received (for audit purposes), assure that the privacy of data is protected in accordance with HIPAA, and that employers submit information regarding proposed changes in ownership (e.g., partnership changes, asset sales and mergers that create a new corporate body). In addition, the CMS would establish an appeals procedure for plans that are denied access to the subsidy.

The CMS will accept comments until October 4, 2004. It expects to release final regulations early in 2005.

Plan sponsors should rely on their attorneys for authoritative advice on the proposed MMA regulations.

Segal can be retained to work with plan sponsors and their attorneys to review the implications of the proposed regulations and prepare comments for the CMS.

★ SEGAL	
ATLANTA	678.306.3100
BOSTON	617.424.7300
CALGARY	403.692.2264
CHICAGO	312.984.8500
CLEVELAND	216.687.4400
DENVER	303.714.9900
HARTFORD	860.678.3000
HOUSTON	713.664.4654
LOS ANGELES	818.956.6700
MINNEAPOLIS	952.857.2480
NEW ORLEANS	504.483.0744
NEW YORK	212.251.5000
PHILADELPHIA	215.854.4017
PHOENIX	602.381.4000
PITTSBURGH	412.269.7771
SAN FRANCISCO	415.263.8200
SEATTLE	206.224.5628
TORONTO	416.961.3264
WASHINGTON	202.833.6400