CHEIRON CLIENT ADVISORY

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Deadlines Near for Key Decisions on Retiree Drug Benefit Strategy

Plan Sponsors that provide drug benefits to retirees have some important decisions to make soon in light of upcoming deadlines imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). The "MMA" provides prescription drug benefits for all eligible participants effective January 1, 2006.

Summary of Key CMS Dates*

December 8, 2003	Benefit Announced
August 3, 2004	Initial Regulation
January 24, 2005	Final Regulations for Actuarial Equivalence Released
February 18, 2005	Final Regulations for PDP and MA-PD
March 23, 2005	Notice of Intent to Become a PDP Due
April 6, 2005	Waiver Guidance Released
April 8, 2005	Actuarial Equivalence Guidance Released
June 6, 2005	MA-PD/PDP Applications Due
August 3, 2005	Forms for Plan/Trust Subsidy Available
August 3, 2005	Amount of MA-PD/PDP/Part D Premiums to be Released
September 14, 2005	MA-PD/PDP Approvals Made
September 30, 2005	Request for Plan Sponsor Subsidy Due for Plan Years Ending in 2006
October 1–15, 2005	CMS Mailing to Eligible Participants Containing Benefit and Cost Information
November 15, 2005 to May 15, 2006	Eligible Individuals can Enroll in Part D

*CMS continues to regularly change the dates. These are as of 3/15/05.

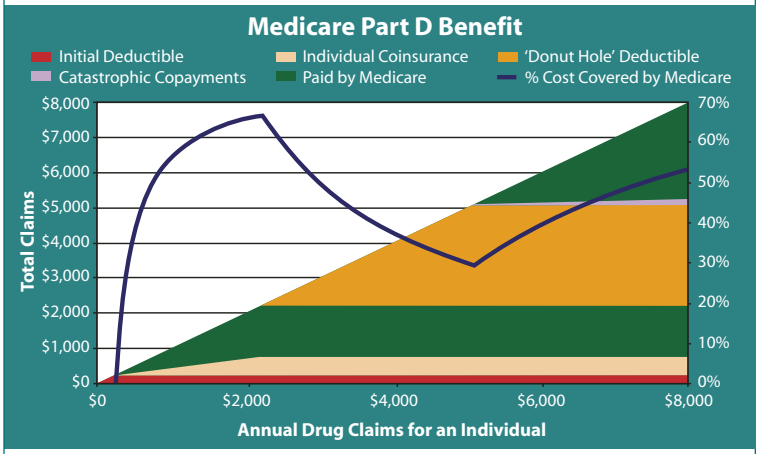
Plan Sponsors have several options under MMA that could effectively reduce the cost of their retiree drug benefit programs. This Client Advisory reviews the basic provisions of the law and recent enabling regulations as they impact Plan Sponsors and then outlines the choices you face. The Advisory also organizes critical information from the Plan Sponsors'/Trustees' perspective.

The new prescription drug benefit is referred to as Medicare Part D and is administered by the Centers for Medicare and Medicaid Services (CMS). The first clue that this was going to be complex was the benefit structure itself. Eleven months later the regulations finally started to be released. There are literally thousands of pages of regulations. No one can make it simple.

What Benefits will Medicare Part D Provide?

Medicare Part D will begin on January 1, 2006. The base benefit is shown in the graph below. What Medicare pays for in 2006 is shown in green and will be:

- 75% of an individual participant's prescription drug costs, once the costs have reached a $250 deductible, and until the participant's prescription drug costs reach $2,250.
- 95% or everything over a $2 generic and $5 brand copay, once the individual has personally spent $3,600 on prescription drugs, regardless of how high the individual participant's prescription drug costs are. If the participant is paying all the drug costs out-of-pocket, the 95% benefit occurs when total drug spending (all costs less rebates) reaches $5,100.



All of the above amounts are indexed with drug inflation. For example, if drug costs increase 10%, the $250 deductible will become $275 in 2007.

In addition to the base benefit described above, participants will be able to choose from competing Prescription Drug Plans (PDPs) and Medicare Advantage - Prescription Drug (MA-PD) plans.

Anyone with Medicare Part A or B is eligible for Medicare Part D if he/she enrolls in Part D. The initial enrollment for participants currently eligible for Medicare begins November 15, 2005 and ends May 15, 2006. Future Medicare participants will be eligible to enroll upon becoming eligible for Part A or B.

On August 3, 2005, the exact premium is expected to be announced. CMS estimates it will be around $37 per month for the 2006 base plan. Premiums for other PDPs or MA-PD plans could be higher or lower, depending on the bid submitted by the plan. Current estimates say that the range could be as wide as from $7 to $50. Anyone who does not enroll immediately after becoming eligible is subject to a late enrollment penalty of 1% of the base premium per month. That is, if a participant waits six months and the base premium is $37, the late enrollment penalty is $2.22 per month (6 x 1% x $37). The penalty will be waived for late enrollees who are in another plan (e.g., employer-sponsored).

It is also possible for employers to sponsor a PDP or MA-PD plan themselves, in essence creating a self-insured PDP. Currently, however, the process is very involved and expensive with a lot of regulations to be plausible for nearly all except the largest Plan Sponsors. There are signs that this will change, and it has the potential to be a viable option in the future.

What Options do Plan Sponsors Have?

For Plan Sponsors who want to provide comparable benefits under Medicare Part D to what they currently provide, there are three basic options available. The back page of this Advisory summarizes the options. Below we describe each option and what Plan Sponsors must do. In the table on this page we show a sample comparison of savings a Plan Sponsor could achieve on the Medicare Pharmacy Claims Cost assuming an average retiree and plan drug spending of $2,370.

Option 1: Subsidy The MMA provides a subsidy to employers and other Plan Sponsors whose benefits are actuarially equivalent to or better than the basic Medicare Part D benefit.

The subsidy is tax free (even to corporations) and is 28% of total drug costs between $250 and $5,000 per person. For example, if a retiree has $1,250 in total drug costs, the subsidy would be $280 (the excess of $1,250 over $250 times 28%). CMS estimates the average subsidy will be about $668 per retiree. It is important to note that this represents total drug costs - before subtracting retiree copays but after rebates. Also, actual drug claims need to be submitted to CMS, so it will take some time for the subsidy to be paid.

Sample Saving Estimates for Plan Sponsors

Retirees Currently Pay 20% of Total Drug Cost

	% Saved	Claim Costs Per Retiree in 2006
Current Plan	—	$2,370
Option 1	28%	$1,700
Option 2*	26%	$1,740
Option 3	42%	$1,360

*Assumes the Plan pays for Medicare Part D Premium.

To qualify for the subsidy, a Member of the American Academy of Actuaries is required to attest that your Plan is actuarially equivalent (or better). However, the required filing forms for actuarial attestation will not be available until as late as August 3, 2005. The January 24, 2005 regulations explained that plans must pass two tests:

(i) **Actuarial gross value** of the plan for the plan year is at least equal to the actuarial gross value of the defined standard prescription drug coverage. The gross value is the value of the benefits provided by the plan, ignoring any contributions.

(ii) **Actuarial net value** of the plan for the plan year is at least equal to the actuarial net value of the defined standard prescription drug coverage. The net value is the gross value of the benefits less retiree contributions.

All plans must pass the gross value test individually; however, if a retiree has a choice of plans, the plans may be combined to pass the net value test. Also note that just because one retiree group does not pass, doesn't mean that the whole plan fails. For example, if a plan requires retirees with less than ten years of service to pay 75% and those with more than ten years of service to pay 25% of the prescription drug cost then the plan may be able to get the subsidy for the retirees with the 25% contribution, even if the 75% contribution does not qualify.

Plan Sponsors must apply for the subsidy annually and applications must be submitted 90 days before the start of the plan year. For plan years ending in 2006, all applications must be submitted by September 30, 2005. Therefore, a plan with a plan year ending March 31, for example, must file by September 30, 2005 for the period of January 1 through March 31, 2006 and must file again by December 31, 2005 for the plan year beginning April 1, 2006.

Finally, Plan Sponsors CANNOT get a subsidy from CMS on a person who signs up for Medicare Part D, so Plan Sponsors who choose this option must actively communicate to retirees NOT to sign up for Part D.

Option 2: Supplement Plan Sponsors can provide supplemental benefits to Medicare Part D. The plan would be changed to pay what it would normally pay less what Medicare pays, similar to what many plans do with regard to Medicare payments for Parts A & B. To the participant the benefit would be similar (or quite possibly identical) to their current benefit. They simply get reimbursed from both the plan and CMS.

However, the supplement would prevent or greatly postpone the reaching of the 95% reimbursement level because, under most current plan designs, participants rarely spend $3,600 on prescription drug costs. For example, if the plan covered 85% of prescription drug costs, then the total prescription drug expenses for an individual participant would have to be over $24,000 before the 95% reimbursement from Medicare would begin.

Under this option, the Plan Sponsor would need to communicate that participants MUST enroll in Part D. Either the plan or the participant can pay the Part D premium. If the retiree pays the Part D premium out-of-pocket, then the Plan Sponsor's savings is generally more than the subsidy. If the Plan Sponsor pays the premium (or reduces the retiree's contributions by the Part D premium amount) then the savings would be similar to the savings available with the subsidy, if the plan qualifies. However, a Plan Sponsor's specific plan design, tax status, geographic location, and drug usage can impact whether Option 1 or 2 is most beneficial. As stated earlier, it is not anticipated that the exact amount of the Part D premium will be known until August 3 and the current estimates for the range of premiums varies by geographic location anywhere from $7 to $50.

Any supplemental or wrap around benefits that are sold by PDPs or MA-PDs have to be approved actuarial equivalent benefit designs. Preliminarily, we expect there to be 2 or 3 forthcoming. Except for a few demonstration programs for individuals without employer coverage, all plans will be subject to the same requirement that retirees must pay $3,600 in "true" out-of-pocket expenses in order for CMS to reimburse at the 95% level.

Option 3: Creative Design For some Plan Sponsors, it would probably be in their best interest to change the benefit design to take full advantage of Medicare. For illustrative purposes, consider a plan where the benefits are exactly actuarially equivalent to Medicare. The expected cost of such a plan might be around $1,700 per retiree, depending upon the administrative costs. The Plan Sponsor could apply for the subsidy and receive the estimated $668 per retiree, reducing its costs to $1,032 per retiree. Instead, it could abandon its current plan and just pay for its retirees' enrollment in Part D at an estimated cost of $440 per year, saving nearly $600 per retiree.

That same concept can be applied to plans that are even more generous than Medicare. Consider that most Medicare participants do spend in some way via contributions, deductibles, coinsurance, and copays over $3,600 per year. For many sponsors, changing the plan design so that the drug benefit is the Part D benefit and any benefit reduction is compensated by reducing retirees' medical out-of-pocket and/or their retiree contributions would likely result in Plan Sponsors saving significantly more than Options 1 & 2.

Conclusion

For Plan Sponsors who are satisfied with their current drug program and who want to wait and see how the market develops, we recommend taking the subsidy if they qualify (Option 1). For those who want to maximize savings, we suggest they consider changing the plan design to maximize savings (Option 3). There is a lot of money at stake for both the Plan Sponsors and the retirees. Careful consideration of the options is well worth most Plan Sponsors' time.

Your Cheiron consultant can assist you as you evaluate the costs and benefits of the various alternative strategies for responding to the MMA, including the provisions regarding Medicare Advantage programs and Healthcare Savings Accounts (HSAs). For more information, please contact John Colberg or Karen Mallett at (877)-CHEIRON or email us at MMAhelp@cheiron.us.

Cheiron is a full-service actuarial consulting firm assisting corporations, public employers and Taft-Hartley plans manage their benefit plans proactively to achieve strategic objectives and safeguard the interests of plan participants and beneficiaries.

Summary of Plan Sponsors' Alternative Responses to Medicare Drug Benefit Law

Alternative	Key Points	Pros	Cons	Bottom Line
Option 1: Subsidy	• Tax-free benefit equal to 28% of total drug costs between $250 and $5,000 per person.	• Worth an estimated $668 per retiree. • Tax free to corporations.	• Plan Sponsors must apply each year. • Retirees must not enroll in Part D. • Benefit must be equal or better than Medicare Part D benefits. • Requires actuarial certification.	• Good starting option for Plan Sponsors waiting to see how market develops.
Option 2: Supplement PDP	• The plan would be changed to pay what it would normally pay less what Medicare pays. • Retiree benefit would be similar (or identical) to their current benefit.	• If the retiree pays the Part D premium out-of-pocket, then the Plan Sponsor's savings is generally more than the subsidy.	• The supplement would prevent or greatly postpone reaching the 95% reimbursement level. • Plan Sponsors must communicate that participants MUST enroll in Part D. • Administrative costs for wrap around.	• Plan Sponsors' specific plan design, tax status, geographic location, and drug usage can impact whether Option 1 or 2 is most beneficial.
Option 3: Redesign	• Plan Sponsors can purchase a Medicare approved benefit card from a qualified PDP provider or MA-PD provider.	• Removes the burden of claims administration and integrating with Medicare or requesting the subsidy from the Plan Sponsors.	• Significant changes to benefit design may be required; could change individual retirees' out-of-pocket costs. • Plan Sponsors must communicate that participants MUST enroll in Part D.	• Best chance for savings for Plan Sponsors willing/able to change benefits.