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Medicare Modernization Act (MMA)—Changes to Employer Health Plans

Track: Health, Pension

Moderator: Frank R. Kopenski Jr.

Panelists: Frank R. Kopenski Jr.
George B. Wagoner

Summary: Panelists discuss the current implications of the Medicare Modernization Act on employer provided and employer sponsored health plans. Topics include plan options, federal subsidies and current experience. Attendees gain insight to the latest developments in the Medicare markets regarding the effect on health plans coordinated by employers for employees and retirees.

MR. FRANK R. KOPENSKI JR.: I'm a consultant with Milliman in the Milwaukee office. I'll be your moderator today. My colleague, George Wagoner, is from Mercer in the Richmond office. We'll be talking about the employer aspect of things. Mr. Wagoner will talk to you about some of the details of the Medicare Modernization Act as it affects employers, and then the two of us will serve as a panel to answer your questions at the end.

I'd like to start out by looking at the big picture. George will talk about a lot of the details, but it's important not to lose sight of the big picture for employers and the decision-making process that they will go through or have gone through if they were looking at this last year to put themselves in a good position for 2006. I'll talk about some of the questions that have come up from employers that I've spoken with over the last 18 months and some questions that retirees are asking. Then I'll talk to you a bit about the decision drivers. What are the drivers for the decision making by employers that we've seen in working with them?

Note: The chart(s) referred to in the text can be downloaded at:
http://handouts.soa.org/conted/cearchive/neworleans-june05/108_bk.pdf.

As far as the questions that employers are asking, obviously one of the big ones is, will you save money on Medicare-eligible retirees? Will there be some kind of saving there for you as you move forward, or will it be more costly? Will the administrative cost be more expensive and actually dip into the subsidies that you might get from the federal government with respect to the program? In addition, how can you maximize any available savings? To maximize savings, you already needed to be looking at this a while back so that you could take full advantage of investigating the different options that are available. To the extent that you wait until the last minute, you may wind up just taking something that's simple and easy to implement for 2006 and having to come back and look at the options available to you in 2007. Those employers who have taken the time to really look into their options early are in a much better position to make a decision that will maximize their savings.

What administrative changes will occur, and what will they cost? Certainly that's a question that depends on the organization and the characteristics of that organization. It's definite that there will be some additional administrative costs under these different programs as compared to the current operations. How will union-negotiated contracts be affected? It depends on whether the unions allow change for 2006 or whether they want the employer to keep the status quo. If it's beneficial to the union members, then potentially they'll change the contract. But because of union bargaining, sometimes that won't happen or there's just not enough time to do that. So, some of the options that are available when you have a union-negotiated situation just may not be possible to implement in 2006.

I've seen a number of employers, especially smaller employers, that think this is the perfect opportunity to exit the market. These are employers that don't provide coverage to the retirees on the pharmacy side, at least directly. They potentially provide some subsidy to them. But this is an opportunity for them to get out and have an excuse to do it. Additionally, as we move from the health side of the equation over to the employee benefits or the pension side of the equation, we hear many questions regarding the impact on the future retiree liability that's being held either by the public or private organizations. Certainly the private organizations that are accustomed to accruing for the future health care liabilities of the retirees are looking at an opportunity here to get some savings and to reduce their liability because of Part D. The public entities that are first starting to accrue for the future liabilities of the retirees are looking at this as potentially dampening how much they'll have to set aside.

Do your options change if you are a Chapter S Corporation? Yes, they change from the standpoint that some of the options are not as clear or as lucrative as they may have been if you were not an S Corporation. When you look and compare options, and George will talk about the different options, they start to get a little closer together when you're not a taxed entity.

What impact will this have on your retirees? That depends on the decision that you make. A number of organizations will maintain existing coverage, and to the retirees it'll look seamless. They won't really see any difference in their benefits going forward. Others who choose to drop coverage or take other initiatives will produce some kind of an impact on the retirees, but again it depends on the decision that you make. What impact will this have on our active members? That depends. If you have active members who are over 65, the benefit that's currently being provided still must be greater than or equal to the Part D benefit. That's an important thing to note, that this affects the active employees as well. To the extent that a premium is being paid and that premium is a combination of under 65 and over 65—and the benefit for the over 65 is changing—it can affect the composite premium that's being charged to the actives as well, or even the contribution that's being charged, to the extent that those are commingled.

What is the timetable? We're right in the middle of the timetable for the most part. The timetable began some time ago. Some of the opportunities and the options that were available are no longer available to employers. We're moving closer and closer to the September 30 deadline for making decisions on some of these options.

There's been a lot of emphasis on the programs, the insurers, the prescription drug and the Medicare Advantage Drug plan (MAPD) organizations, the employer, but there has not been a lot of talk about the retirees and what they're thinking. Certainly they're looking at this Medicare Part D benefit. It's fairly complicated, and they're trying to understand what that means. It may be less complicated when you currently have coverage from your employer and may be more complicated when you're a Medicare-eligible individual who doesn't have this kind of coverage and you're looking at whether you should purchase it. From the retiree's perspective, at least in the employer setting and looking at the benefits, it may affect them and it may not, depending on what the employer decision is.

Will your current coverage change, and, if so, will you lose benefits? Certainly if you're in a smaller employer setting, where you have a few retirees who may drop coverage and that would affect you, your benefit could be richer than the current Medicare Part D benefit, and as you go forward, that might change. From a cost perspective, at least, regarding the outlay that retirees are making, potentially they may be getting less but paying a lot less for it. From a financial perspective, they may be better off, even though they're losing some coverage. It may cost a lot less for them versus what they were paying before.

How much will it cost you for future prescription drug coverage? Again, it depends on what the employer does, what decision it makes. There are certainly a number of options out there, a number of choices that retirees can make. They don't need to continue to accept the coverage that they have with their employer. They can opt out and purchase the Medicare Part D benefit in the open market. Will they do that? I don't see a lot of people doing that. It depends on how rich their benefits are.

Let's talk about some of the drivers. When we look at the different options that are available out there, which George will get into in detail, often if you're dealing with an employer they want to know which option is best for them. They get right into the financial aspects of it. They start asking, "How much will it cost for this option, and how much will it cost for that option, and what impact is there on my retirees?" But you really need to take a step back and not get so caught up in the financial aspects. You need to look at it from a much higher perspective. These are the areas that I'll talk about briefly as to where you want to start. You need to make sure that you don't go into more detail than you need to with respect to how you make a decision about what you'll plan to do in 2006.

The number of retirees that you have is an important factor. If you currently have 100 or 150 retirees, your decision-making process probably will be quite a bit different than that of a large nationally based corporation that potentially has thousands of retirees. When I've talked with smaller employers, they are much more inclined to look at potentially dropping coverage at this point, whereas the larger employers just don't see that as an option. So, they're looking at some of the other things that are available to them.

It is also important to keep track of which employers are self-insured and which are fully insured. Of the options that are available, some are geared more toward the self-insured employers, and others are more geared to the fully insured. Then there are some that are geared to both. But when you look at the choices, often one or even two of them fall out just because of the size and whether you're self-insured or fully insured. It's important to make sure that you look at the drivers before you dig into all the numbers and make decisions at that level.

Another issue is union versus nonunion, which I briefly talked about. Depending on the contracting and negotiations, you may be limited in what you can do. Often, a union will not make changes to the contract midstream or midterm unless it's beneficial to the retirees. If you're tax-exempt, then certain options may look less appealing than they would if you were not tax-exempt, particularly the 28 percent federal employer subsidy. The difference between the options becomes a little less clear as you look at it from their perspective. There may not be a lot of difference between some of the options, just because of that fact.

Again, timing is important. If you wait until the last minute, you may wind up taking a choice that does not maximize your savings. It was not the best choice for you as an organization, but you needed to do it because you didn't get on board with this whole program early enough. We had a number of entities that were already looking into this in the middle of last year and are already in position to take advantage of what they want to do, or they already have made decisions about that. Other organizations are just now thinking about it and coming to the table, which doesn't give them a lot of time to make the decision.

The financial health of the employee benefits is a factor. If you're already bleeding from the financial consequences of providing health benefits, and you're already cutting back on your benefits—for example, you've already been capping your contribution to the retirees' health care costs—that will play into what you do going forward. If this is an opportunity to somehow stop the bleeding, again by dropping coverage or doing something that will provide some savings, then that's the direction that you'll go. You certainly won't enhance your benefits if you're already in a state of financial distress from this.

That's just an overview of some of the drivers and some of the important questions. As George moves into the details, keep in mind when you look at some of the options how those really appeal to organizations based on size, based on whether they're self-insured and other things.

MR. GEORGE B. WAGONER: First, I will give an introduction to Medicare. I'll make that very brief. Then I'll dig into what the employer options are under the Medicare Modernization Act. As you look at the Medicare Modernization Act and the Part D coverage, it's almost like you're looking at a picture while it's being painted. A fair amount of information is available. We know what the structure is. A lot of the faces and a lot of the landscape have been painted in, but there are some things that are being painted as we go forward. The Medicare Modernization Act itself has three key components that deal with Medicare. You have a new Part D coverage, you have a tax-free subsidy and you have enhancements for the Medicare Advantage plan that you've heard about. You also have the health savings accounts. You have a lot of information in the law and the final regulations that deal with these things, but there's a fair amount that we're still learning about as we go forward. We get guidance from the federal government almost every day.

As we look at the overview of the Medicare reform, again we have the basic structure of this painting. We know what Part D is. We know about the subsidy. With the regulations, some more of the picture was painted. We found out we had a two-pronged test for actuarial equivalence. We have additional guidance that's continuing to fill out the picture, but as with any picture, we're beginning to get some concerns about what the picture costs.

In the fourth quarter of 2003, the cost was $400 billion. By early 2004, it was $534 billion. Both of those numbers were for eight years. By early 2005, it was $724 billion for a 10-year period. People are beginning to talk about this picture and to ask, "Does it cost what we thought it would?" And then a final question arises because we aren't quite sure who will be selling this yet. The final decisions about carriers, health plans and pharmacy benefit managers (PBMs) haven’t been made. Those people had to send in their bids in June, but the Centers of Medicare and Medicaid Services (CMS) won’t make the selections about who will be a prescription drug plan (PDP) until September. We have a painting here, but we aren't totally sure who will be selling it. It's changing a little bit as we go forward, but we know a lot about it.

What we know you've heard about already. We have, on the right-hand side, the Part D benefits (Page 2, Slide 1). You start with a $250 deductible. The yellow is what the retiree pays. The green is what Medicare pays. An average premium of $37 a month is projected. That would cover a quarter of the cost. There are extra premiums if you have late enrollees. There are a number of things to make it easier for people to stay in the plan, such as premiums being deducted from Social Security and that type of thing. All the amounts are indexed. As you look at the coverage, the people who can offer creditable coverage include PDPs and MAPDs, and employers can offer creditable coverage in lieu of Part D and get a subsidy for this. You have 26 regions for PPOs and 34 regions for PDPs.

As you look at this from their point of view, every retiree is guaranteed to have at least two options for Part D coverage. At least one of them must be a PDP, and then there can be additional plans, either PDPs or MAPDs. As you heard today, 3,000 to 5,000 plans have been filed with Medicare. Some of these are filed by organizations that might file 100 or 200 separate plans, so we don't have that many different players. But there are an enormous number of choices out there, so certainly there's no need for any of the fallback plans that we're looking at. I saw a recent article that said there were 10 national PDPs or organizations that had filed to be PDPs nationally. As we learn more about them beyond just their press releases, it will be interesting to see what's out there. Some retirees will have additional options. They'll have the subsidized Part D coverage the employer provides in lieu of Part D. You could have a PDP or an MAPD, which the employer contracts with directly, or the employer could actually become a PDP or an MAPD themselves. They could set up their own plan. This coverage is optional. The retiree is not required to buy anything.

Let's take a look at the employer options under the Medicare Modernization Act. These are things Frank was talking about earlier. The first option, which certainly up to this point has seemed to be the most popular, is the employer subsidy. You can provide an actuarially equivalent prescription drug plan to get the federal subsidy. There are quite a number of options that involve using PDPs that offer the Part D benefits. As I mentioned earlier, we aren't sure who will be offering those, and we aren't sure at this point what the premiums will be. We know who's said that they're filing, but CMS has not yet issued the approvals. We don't have the actual premiums for these plans to compare them with what the employer cost is to really zero in on what the options are.

That being said, one key option is providing drug coverage that is secondary to Part D, which wraps around Part D and is chosen by the retiree. This is a self-funded type approach. Something that's very similar to that would be an insured approach, an enhanced benefit for which the insurance company would take the risk for a benefit better than the standard Part D and offer that. You could provide drug coverage and contract to enroll all of your retirees in a specific PDP. There are some waivers that I'll talk about that CMS allows that make this a very attractive option.

Of course, as I mentioned, you could become a PDP, but you can't do that for 2006 unless you made your filing already. You could do it for 2007.

FROM THE FLOOR: In another session, it was predicted that a lot of people will be applying for the 28 percent federal employer subsidy. . Do you have any take on that?

MR. WAGONER: That is certainly my take for the very reason that we don't really know who the Part D players will be right now. A lot of people that I'm talking with are saying, "I'll take the subsidy now. In 2007 or 2008, I'll be making my decision about what I'll be doing." I think you're exactly right, and the surveys show that. The anecdotal information shows that. It won't be too long before we actually know what's happening.

Another option that people don't talk about a lot is MAPDs. For a number of reasons, people are a little bit concerned about these, but they are legitimate options. You can contract with a specific MAPD or you can contribute to the cost of any MAPD. You could even become one if you wanted, although very few companies are trying to do that. The fourth general option is to simply drop coverage. That's nothing new. If you do that, you have the option of paying all, some or none of the premium.

As we look at the options, we're getting a better idea of what employers are planning to do as we move closer to January 1. What I'll describe here is just what Anna said. I'll describe what companies are doing now or what they're talking about doing, but bear in mind that these are decisions applicable to 2006. In 2007 or 2008, a lot of what I'm talking about could very well change, depending on what we find out about prescription drug plans. Today, two months ago and six months ago, the most common approach that employers were thinking about using was a subsidy. I call that option A, and I'll talk about that in a moment.

The second thing that companies are looking at is wrapping around or integrating with Part D coverage. Two months ago, it looked like most employers that were doing this were very concerned about the administrative hassle of having potentially 34, 40 or 100 different PDPs that they might have to wrap around with, if they wrap around any PDP the retiree gets. So, a lot of companies at that time—and it'll be interesting to see what happens as we go forward—were thinking about directing retirees to a specific employer-sponsored PDP, just so that they could simplify the administration.

The third major option is no company plan, and the fourth option is the MAPD. I'll talk about those four different things as we go through the options that employers have, and then we can come back to any of the other options in more detail—the employer becoming its own PDP, for example. In all the options, the employer can pay all, some or none of the cost, and the coverage is voluntary, as I mentioned previously.

Option A is to provide the actuarially equivalent plan and get a subsidy. Most of this was covered already in terms of what the employer gets, the level of the subsidy and that type of thing, so I'll pass over that fairly quickly. As you look at the subsidy, employers are delighted to see Part D coverage and the subsidy, because it reduces their Financial Accounting Standard (FAS) 106 cost. But there certainly are some administrative requirements that come with it, which Frank alluded to already. The regulations require that the annual application be filed by September 30, and guidance has already given an extra 30 days because of the difficulties that employers are finding in terms of getting Social Security numbers for spouses.

What you have to do in the application is provide an attestation for actuarial equivalence signed by a qualified actuary, as I'm sure all of you are very aware and are spending a lot of time on. As I mentioned, you have to list the eligible participants, including their Social Security numbers, and that is somewhat problematic for spouses for a lot of employers. You have to notify the Part D-eligible participants of creditable coverage status, both for people who are active and who are retired. Anybody who is eligible for Part D has to be notified of creditable coverage status, and this is something that is beyond just those that are having the subsidy.

I want to take a moment to explain this because it is something that has surprised a number of employers. You have to notify Part D-eligible participants. Someone is Part D-eligible if they're entitled to Part A and/or enrolled in Part B and if they live in an area where there is a PDP. Someone is entitled to Part A if they're over 65 and receiving monthly Social Security benefits, or under 65 and disabled and getting Social Security benefits. So it's fairly difficult for an employer to know exactly all of the people who work for it or the spouses of the people who work for it who are eligible for Part D coverage.

Rather than creating a database to figure that out, a lot of employers are looking at simply notifying all of their active employees about the creditable coverage status, which is part of what Frank was talking about. If you provide coverage that is not creditable, then you have to let anybody who's eligible for Part D know that so they have an opportunity to sign up for that Part D coverage. That's a significant requirement because that applies even if you don't offer retiree medical coverage at all. If you cover actives that are eligible for Part D, then you have to provide that information to them. This is something that affects everybody, and it's a fairly significant requirement .

The plan sponsor can elect to receive payment on a monthly, quarterly, interim annual, or an annual basis. The key point is the more frequently you want to get the money, the more frequently you have to report to CMS. Some of the additional things that you have to do if you want to get the subsidy are fairly straightforward. As you've heard a number of times, a subsidy goes only to those who aren't enrolled in Part D. The costs actually have to be paid by the plan.

Let me take a moment now to talk about actuarial equivalence. The regulations set up a two-pronged test: a gross test and net test. Both start using the actual participant experience, unless that experience isn't credible, in which case you can use the normalized data from CMS. You start with the total claims cost. You subtract copayments, deductibles and coinsurance, and what is left over is the gross employer payment value. As long as the amount on the left, the employer value, is greater than the amount on the right, you have creditable coverage out there. Each benefit option has to pass the gross test on its own, and a benefit option is defined as any particular design category of benefits or cost-sharing arrangement within a plan. You have lots of different plans that you have to test, but generally most of the plans that employers are offering are creditable.

However, there are a couple of exceptions that I think are important to think about. More and more people are moving to high-deductible health plans and consumer-directed health plans. If you look at one of these plans that doesn't have a health reimbursement account (HRA), then you certainly have the potential that the plan will not be creditable. That's something to consider if you're offering that plan to actives. Even if you don't offer retiree coverage, you do need to determine whether that plan is creditable coverage or not, and you do need to notify your employees whether it's creditable. That's a sticky part of the regulation to be concerned about, but other than the high-deductible health plans without an HRA or the many Med plans, virtually everything I've seen has been creditable coverage. That hasn't been a significant problem.

Moving beyond the gross coverage, we'll look at the net value. You start with what you had with the gross value test, the gross value of the employer contribution. From that, you subtract whatever the retiree contributions are, and as far as the employer plan is concerned, then you're through. What you have is the net plan value. As you look at the actuarial value of the Part D coverage, you start with the gross Part D coverage. You subtract the Part D premiums, but you have an additional item that you can subtract for those employers who also wrap around retirees that choose Part D coverage. If you want to get the subsidy generally, but your retirees don't take your coverage and they get Part D, and you wrap around that also, then you can make the true out of pocket (TrOOP) adjustment so you can get a lower value that you have to test and make it easier to pass the test. Again, as long as the net employer value is greater than the net Part D value, then you end up passing that test.

The second set of options is for retirees who purchase Part D. What we've talked about so far is the subsidy when people did not. Now we're talking about something for which there's no subsidy. Generally people will be wrapping around Part D, integrating with Part D or buying some type of enhanced benefit around Part D. As I mentioned earlier, I'll focus on the particular opportunity that employers have of working with a specific PDP so that you can reduce the administrative hassle. But all these things you can do, with extra administrative hassle, if you want in terms of integrating with any of the PDPs that your retirees might want to buy.

As you look at the options that you have, on a self-funded basis, you can either wrap around Part D or you can integrate Part D. Wrapping around Part D fills in the gaps for Part D, much like Medigap does for Parts A and B. As you integrate with Medicare, you reduce the plan benefits by the amounts payable under Part D, and you can do it whether or not the retirees are enrolled in Part D. This is very similar to the carveout that people do today for Parts A and B. Again, you have the option of paying all, some or none of the retiree premium.

Many employers that don't take the subsidy are gravitating toward using this wrap because it's something with which they're very familiar with Part A and B. But there are some very significant differences with medical coordination. Retirees have to enroll in two plans, the employer plan and Part D, rather than the one plan you would have for subsidy. As I mentioned already, CMS hasn't announced who the PDPs are yet, so you aren't sure whom you'll be working with at this point. The designs are likely to vary across the country if you don't contract with one PDP nationwide. Most prescription drug claims are adjudicated at point of sale, and it's not clear whether the support will be there. These are a number of the reasons that people are thinking about waiting a little while before they move on this and thinking about using a subsidy. The final thing is that coordination with Part D does expand the donut hole, so what you're doing is subsidizing the government, and that's distasteful to some employers.

What I've talked about so far in terms of wrapping and integrating with Part D is a self-funded approach, but you can also do this on an insured approach. You can buy what the regulations call enhanced benefits. These are simply benefits that are better than the standard Part D benefits. The donut hole will increase, just like it would if you wrapped around Part D, but it is another option.

Let's look at an example of what one of these wrap-around plans could be (Page 7, Slide 2). On the left, you see what we've already looked at, the Medicare Part D benefit. On the right-hand side, we see an example of what a wrapped benefit could be. The yellow is what Medicare pays. The blue is what the employer would pay. And the green is what the retiree would pay. From the retiree's point of view, this is a $250 deductible plan. Then they pay 25 percent coinsurance until you get to catastrophic coverage. You'll notice that the employer cost goes all the way up to $13,650. That's the increase of the donut hole, so that the retiree will pay an out-of-pocket cost of $3,600. As you look at this example, if you think of the blue and the yellow both as one benefit offered on an insured basis by a PDP, that could be an example of what an enhanced benefit would be. You would just simply buy that total benefit if a carrier were to offer something that rich.

Option C is a very straightforward option. You can terminate coverage. You can pay all, some or none of the Part D premium. If you do that, you could offer an HRA or other account-based approach. If you do that, those dollars don't count toward the true out-of-pocket. But if you look at the regulations, you could also offer a health savings account, a funding standard account (FSA) or a medical savings account

(MSA). If you offered those, the dollars paid would count toward TrOOP. Of course, you can only do an HSA pre-Medicare. For somebody who didn't save the money, that benefit's not available. But it's an additional option to be aware of.

As we have talked with and surveyed employers, we see a fairly small percentage that are indicating they'll drop coverage in 2006. Most of those who say they will drop it have said they'll pick up some of the Part D premium, at least initially. So, this is an option that, at least as you listen to the surveys, doesn't sound like it will be popular initially, but it'll be interesting to see what happens. This might be the type of thing that somebody doesn't want to put in the survey that they're planning to do.

FROM THE FLOOR: George, it seems to me that if it turns out with all these plans filing and employers having significant contribution, if there are a significant number of employees that have better options through buying Medicare Advantage plans than they have through the employer, that that's going to get really sticky and that this is going to become a much more attractive option, even though the Medicare Advantage plan is a higher premium.

MR. WAGONER: We'll talk about that in a minute. There are very significant opportunities with Medicare Advantage plans, even if it's short term, so that really could create some very significant issues for retirees and employers both. And that brings us to the next option.

The fourth option I want to talk about is contracting with MAPD for a sponsored plan. There are some nice waivers in the regulations from CMS and also some expansions of the Medicare Advantage plans. This could become a very attractive option, as Anna mentioned. The local plans are expanding. Regional plans are being added, although there's a question about whether many people will come to that party. Private fee-for-service plans seem to present some interesting options in rural areas. A lot of what I've heard from people who are offering Medicare Advantage plans indicates this is an area that people are thinking about relative to rural areas. There certainly could be some significant opportunities, as Anna mentioned, for employers in this area. Also, there's one other thing in the regulations. There is the potential for the MAPD plan to fill a portion of the donut hole with savings in Part A and B, but also have that count toward TrOOP. So, if people use that demonstration plan, that could be a potential advantage.

Past history has been problematic. There's been growth in the plans and enrollment in the past, but that's been followed by tight controls on reimbursement for Medicare and then reduction in plans and enrollment. That's a concern people have for the longer term. But putting those concerns aside, if you look at what you can save today and potentially in 2006, as Anna mentioned, it can be a very enticing opportunity, both for an employer and for a retiree. In Page 8, Slide 2, we've taken information from CMS as of July 2005 and arrayed it graphically on a map. This map shows where Medicare Advantage plans are offered today. We've shown it by

the premium. The red shows places where the lowest premium in the county is a zero-premium plan. With all the increases in reimbursements from Medicare, 56 percent of Medicare eligibles live in a county where they would have access to a zero-premium Medicare Advantage plan.

As you look at the next two colors below that, you get up to 81 percent of Medicare eligibles living in an area where they would have a premium of $70 or less per month as of 2005. So this, Anna, gets to your point. There are some really significant opportunities out there. A lot of retirees are paying a lot more than $70 a month right now for an employee program, so this can be an encouraging thing for people to look at.

In addition, note the two points on the upper left-hand side. Just looking at the comparison between Medicare Advantage plans in July 2004 to January 2005, 7 percent more Medicare eligibles have access to the Medicare Advantage plans, and 14 percent more have access to zero-premium plans. So, you have some significant opportunities out there potentially, at least in the short term, for Medicare Advantage coverage.

Page 8, Slide 3 gives you an idea about how the various Medicare Advantage plans move around the United States. The chart on the left shows HMOs. They're available to 64 percent of the Medicare eligibles, almost exclusively in major metropolitan areas, and 45 percent of the people have access to a zero-premium Medicare HMO. As you look at PPO plans, on the upper right-hand side, 31 percent of Medicare eligibles have access to those plans, and 18 percent of people get a zero-premium PPO at this point. The bottom left-hand side of the slide shows the private fee-for-service. Already 40 percent of Medicare eligibles have access to a private fee-for-service plan. Nine percent have a zero-premium plan. As I've talked with quite a number of carriers, I get the impression we'll see a fairly significant expansion here when the numbers are shown. I can envision the electoral maps with the last election and the red and the blue states, and it wouldn't surprise me to see the red states just about filled up with a private fee-for-service. That wasn't mentioned a lot in the earlier session, but it'll be interesting to see just exactly what happens with that coverage as it moves forward.

Some opportunities are probably worthwhile to look at, particularly in the short term. Why do I say "particularly in the short term?" Page 9, Slide 1 addresses that. The chart on the left-hand side shows the annual increase from December 1990 through December 2004 in both enrollees in Medicare Advantage plans and in the number of plans. You'll see the number of plans when the enrollees went up steadily in the latter part of the 1990s as the Medicare payments increased. We had increases of 25 percent or more four years in a row in terms of the Medicare enrollment.

As the government began controlling the cost, the number of plans went down, and the number of enrollees went down, and we saw that year by year until we got up

to 2003 to 2004. The chart on the right-hand side shows monthly changes from January 2000 to January 2005. For three years in a row, there were fairly significant drop-offs in January of each year as people moved away from Medicare Advantage plans. But in 2003, plans began to pick up. They saw the extra money that was out there. In 2004, members began to join more rapidly. The question is, will that continue?

The preliminary increase from the government payments for 2006 and 2005 is slightly more now than the 4 percent number that's shown there. The increase was 10.6 percent for 2004 and 7.1 percent for 2005. It's dropped to under 5 percent for 2006. The concern is that if it keeps going down, people might start changing the pricing, and this becomes not quite as beneficial an option as they thought it might be. The other thing that makes this somewhat of a concern in terms of the viability of the option is what we talked about earlier . Reimbursements are based on what the government calls a competitive bid, and plans below the benchmark have to give some savings back to the government. So, the impact of all of this from the pricing makes this a little bit uncertain in the long term.

I want to look at a comparison of these options in terms of what it means to an employer. Page 9, Slide 2 provides an example of some calculations we did for one employer. We've rounded things to protect the innocent. Let me start by looking at the columns that we have. First, we start with the current plan. Then we look at what happens if you go with a subsidy approach. That's the Option A. Then we look at the integration with Part D when the retiree pays the Part D premium. We look at the integration with Part D when the employer pays the Part D premium. And then we look at dropping coverage, with the employer paying the Part D premium. You'll note at the bottom that I didn't show Option D because that will be totally dependent on what the Medicare Advantage plan charges.

Starting on the first row, in this particular case the average employer per member per year expenditure for this group was around $2,100. Assuming a 35 percent tax bracket, there was a $735 tax deduction. The net employer cost after taxes was $1,365, and I've called this 100 percent of the current cost. As we look at Option A, we still have an employer cost of $2,100. We have the same deduction, but we also get the subsidy, the 28 percent of the amount from $250 to $5,000. For this particular group, it was $575 for the subsidy. That's not as large as CMS is estimating. Some would be a good bit different. The net employer cost after tax became $790, or 58 percent of what the coverage was originally.

As you move one step down, integrating with Part D, now the employer coverage is only $1,100 in terms of the cost. Medicare Part D paid about $1,000 of the cost. Now you have your tax deduction on a smaller amount, and $715 is your net after-tax cost. Assuming the employer doesn't pay any of the Part D premium, for this particular employer the cost is actually a little bit less than what it was for the subsidy, at 52 percent. If you add the Part D premium of $440, you do get to

deduct some, but now you come up with a number that's at 73 percent of the current number.

The key point for this example and for a number of them that we've run is that the wrap around brackets the subsidy, and whether it's more or less depends on what the employer pays in terms of Part D. That's not always the case, but that happens a good bit. The final thing on the slide is Part C. If the employer pays the $440 only, then he gets about an 80 percent reduction in the cost.

A Mercer survey several months ago began to show what organizations were thinking, and we have another survey that will be published in the next week or so. I will give you an idea of the direction of the new results. This particular survey showed that six months ago quite a lot of companies really didn't know what they were planning to do, but for those who did, the largest percentage planned to keep the subsidy. The next largest group planned to pay secondary with a wrap or integration. The third most common was dropping coverage.

More companies know what they're doing now, which is a good sign, but we're seeing the same type of a breakout that we saw before. There is still quite a number looking at subsidy. Probably even more are looking at subsidy now, for the reasons that Anna talked about earlier. They don't really know who the Part D carriers will be. We're still seeing a surprisingly low percentage of companies saying they'll drop coverage, and virtually all of them who say they will drop it also say they will pay some of the Part D premium. That should be encouraging for retirees at this point.

What are the next steps for employers? Doing nothing is really not an option. They need to be reviewing their retiree medical plans. They have a chance to take a fresh look at their total retirement strategy, if they want. There certainly are some additional compliance requirements for most, and some additional communications are needed. At the very minimum, companies should be communicating with the retirees to reduce the number of questions they get. If they want people to enroll in their own plan, they need to do a good bit more communication. For companies that are offering a subsidy or working with a Part D vendor, there will be additional vendor management and reporting and some extra administration and challenge, especially in benefits administration.

Finishing the plan portion of the presentation, Page 10, Slide 1 is a sample timeline of events. On the top, you have federal government and vendor key issues. On the bottom, you have plan sponsor key issues. I want to talk about three categories for plan sponsors. First, as you look at June, July and August, you see vendor decisions and retiree pricing completed. Employers need to be working on these things already if they're looking for the subsidy at all. The clock is ticking on this. Significant activity should be underway. Second, the federal subsidy application has to be filed soon. The regulation says September 30, but the guidance gives an additional 30 days. Before you get to the end of October, you must have filed if you

want to get the subsidy. Then the creditable coverage notices need to be sent out prior to open enrollment, which is November 15. That's another thing that's critical. That has to be done. As you look at the additional tasks for the federal government, CMS has to announce the plan selections in September, and that's a key. For the PDPs and MAPDs, the enrollment can begin on November 15. Frank, let me turn it back over to you, and we'll take questions.

MR. KOPENSKI: I have a couple of observations that I want to add before we open it up to specific questions that you have. When you look at the options for retirees in the marketplace, MAPD and PDP organizations that plan to provide qualified prescription drug coverage under Medicare Part D submitted their bids prior to June 6. Those bids were really in the individual open marketplace. They were not specific to employers. And the bids that were filed were, in many cases, either the standard Part D benefit or some minor enhancements to those benefits, such as taking away the deductible, changing the 25 percent coinsurance to three-tier copayments or providing generic coverage in the coverage gap between $2,250 and $5,100.

These same organizations that plan to provide a direct coverage to employers will again submit bids July 1. Those bids will be earmarked specifically for the employer. What they will generally file is, again, a standard Part D type benefit for the most part, because the PDPs and the MAPDs that will provide benefits in that marketplace are able to change the benefit that they submitted to CMS on July 1 or enhance that benefit to go along with whatever benefits the employer has. So, they can produce potentially hundreds of different plans off that single bid that they submit to CMS. CMS is not interested in them submitting all of those plans. That calculation of supplemental premium is really outside of the bid process. So they will come to market directly to different employers with benefits that are consistent with what they currently have.

A number of organizations have already been out there wooing employers all through this process. They've told them that they'll have a package of benefits available that they might want to elect going forward as opposed to what they're currently doing, which might be wrapping coverage around the Medicare A/B. Even though they may not know specifically what the premium is for the pharmacy, they've been in the employer's location and talking about the options that they have and trying to get people to come on board. It's important to note that in addition to the individual products that are out there, there will be the specific products for the employer.

Another thing to note is the organizations that have really taken the time to look at the different options and have said, "We'll maintain our existing coverage going forward, and we've looked at whether we qualify for the subsidy." Those entities have left the door open to check what the premium will be from the entities that are providing employer coverage later on. Even though they know that they're maintaining coverage and they can always use the subsidy path come September 30, they have not closed the door on the potential that the employer benefit

package being provided by a PDP or MAPD is not better than that subsidy. They're taking a wait-and-see approach, and saying, "We already know that we can get the subsidy, but now let's wait and see what those premiums are and see whether that's a better financial course for us."

Another thing with respect to wrapping coverage around your existing plan, most of the organizations or employers that I've talked to over the past six to 12 months have found that to be a fairly complex process. It's not the same as what they're doing with the Part A and Part B coverage, so they've steered away from that somewhat and looked at something a little simpler. There's been some talk that, potentially, that might be the best financial option. But until it becomes clear how you coordinate with these different vendors that would be providing the pharmacy benefit—maybe your current vendor has a particular formulary, and the other vendor that you're dealing with has a different formulary—you have a lot of different issues there. They're just not certain administratively whether it even makes sense to do that.

George and I had talked about the 28 percent subsidy, and I had earlier alluded to the fact that if you're a tax-exempt or an S Corporation, the subsidy takes on a slightly different meaning to you. We didn't really go into that in too much detail. But when you look at the federal employer subsidy, the 28 percent subsidy if you go that route and you qualify, that is basically tax-free. But in addition, the expense that you have for providing the pharmacy benefit is not reduced by that subsidy. It's not netted against that, so that's where the extra value comes in. If you're a tax-exempt organization, that extra value is really not there. So when you look at the opportunities, the 28 percent subsidy is not as appealing as it is when you're not an S Corporation.

Another important thing to note is for employers who have not done the homework and looked at these different options up to this point. You certainly do not want to wait until some time in September to determine that you don't actually qualify for the federal employer subsidy. It's pretty important if you're going that route that you know that you can do that and get the attestation and the certification from the actuary. You don't want to have the actuary come back to you on September 20 and tell you that you don't qualify, and then you have to determine what you will do. A number of employers will have to go to the last minute to determine exactly what will happen and make decisions. Those that have been more in touch with what's going on are already in a position to do that.

I'd like to open the discussion up to any questions that you have regarding the subject matter. Certainly we could talk at tremendous length and get into some dollar figures and dollar comparisons. George had a nice example there, and that can be interesting. I have some examples as well. But when you look at a particular example that may be applicable to only one of the employers that you looked at, you can give a false sense that it will be the same for others, and it's not true. You really have to look at each of them individually to determine financially what the

best option is for them and whether the same kinds of proportionate numbers come out from those analyses.

MR. ROY GOLDMAN: I'm with Mercy Health Plans. I have a question about how the reinsurance and the government work. In the example that you gave, you called it a wrapped plan. Suppose an MAPD offers that plan, and it's basically a $250 deductible and then it covers 75 percent up to $13,650. Does the health plan still get the reinsurance from the government, and does that kick in at the $13,650?

MR. KOPENSKI: That's right, Roy. The reinsurance kicks in later, so the richer your benefit plan is, really the less total subsidy that you're getting from the government. That has been difficult to grasp for a number of the employers, to recognize the fact that the $5,100 is really somewhat of a fictitious amount and that the key is that it's $3,600 out of the individual's pocket. So that fluctuates depending on the benefit plan that you have, and it's hard to visualize exactly where that stops and where the reinsurance kicks in.
MS. ANNA M. RAPPAPORT: Would either of you care to make any forecasts of where we might be in three to five years?

MR. KOPENSKI: Obviously, a lot of companies have rushed into this market who may not have been there before, and they're looking to generate significant membership. Whether or not they stay, it'll be interesting to see if CMS stays the course and continues to provide the subsidies or that drops off and these organizations start to fall by the wayside.

In addition, I think the big issue, at least in the open market or in the individual market, is the impact of all the Medicaid people that are coming over to the Medicare side, the dual eligibles, and what impact they will have on costs. Will that make it more difficult for some of these organizations to operate, not knowing really how those individuals spent before because they were under Medicaid? I think that'll be important. I would sense that you'll certainly have some organizations that came into this as a feeler to see whether they could make a go of it and make a profit out of it. If that doesn't materialize, then they'll move away from it. But obviously, the Medicare or the senior population is a tremendous market, and a number of organizations want to make sure that at least they get a piece of it if they can.

MR. WAGONER: I'll add one comment to that. I think the results of the next election will have an enormous impact on what happens. Somewhere in the middle of your three- to five-year period, we might have a complete change in the watershed, or we might not. I think that's the other thing to bear in mind.

FROM THE FLOOR: Do you mean the congressional elections coming up or the next presidential election?

MR. WAGONER: The next presidential election is what I was talking about. But if something happens in the congressional election that changes the power in Congress, then it will be sooner than the presidential election.

MS. GAIL M. LAWRENCE: I'd like you to comment on the small group marketplace. Do these employers know what needs to be done? Are there any small group carriers helping them make their decisions? And what do the small group carriers need to do?

MR. KOPENSKI: That's a good question. There are a lot of small groups out there. The question is whether they have significant retiree coverage and whether some of these options would even be available to them based on the contributions that are being made. I know that there are a number of TPAs that have been investigating whether they can do something on behalf of some of these organizations and what their options are. I've not had a lot of conversation with small group carriers about looking for specific assistance for these entities.

As I mentioned in the opening, it depends on how big you are. If you have, for example, 50 retirees or something less than 50 retirees, does it make a lot of sense when you look at the options that you have, to go through the administrative hassles or to bring in a consultant to do the certification on your benefit plan? When you take that administrative cost and spread it over that few people, does it really make sense to spend your money in that manner? I've have had a number of smaller organizations that wind up dropping coverage and providing a premium subsidy to the individual. Remember, the small group, if it is fully insured—which it probably is—is not really getting a good price in the market right now. When you look at dropping coverage and potentially paying something toward the Part D benefit, the individual may be getting a little bit less benefit, but the impact financially to them could be significant, because under the Part D program, you're getting about 74.5 percent subsidy. It's unlikely that the employer is contributing that much in a small group environment.

MS. RAPPAPORT: Can I add something there? It seems to me that since there are virtually no defined benefit pension plans in small employers that the likelihood that many of them are providing retiree health to begin with is pretty small. I would be very surprised to see many of them, if they are, do anything other than get out.

MR. KOPENSKI: Right.

MR. WAGONER: I'll add a comment or two. First, I need to say this is not an area that I spend time in, so these are comments from someone who's not knowledgeable about that particular marketplace. That being said, for the small percentage of companies that do offer retiree coverage, recognize that if you're taxed at a 35 percent tax rate, you have an increasing annuity starting at $1,000 per person for companies that do get a subsidy. So, if you have 50 or 100 retirees out there, and you think about this as $50,000 or $100,000 a year and increasing,

that's what you could afford. That could be a possibility to think through. The second thing is that MAPDs seem to be great benefits for the small employers out there. The third thing is, as you look at the benefits, if you change and subsidize the Part D premium and just paid the $37 a month or whatever as an employer, that's probably the best use of your funds, because you're buying $4 of benefits for every $1 that you spend. So, it wouldn't surprise me, if companies are offering coverage, that they would look at that. I know large employers are thinking of that also as the most efficient way to use their funds.

MR. KOPENSKI: Most of the entities that I've had to deal with have been of somewhat halfway decent size, or if they had 50 or 100 retirees, then they were choosing an option potentially to drop coverage or to purchase, as George said, one of these packages in the marketplace, a Medicare Advantage plan.

MR. LAWRENCE R. SMART: I'm with Aon Consulting. I have a question on the testing itself. You had mentioned that you'd use actual, unless it's not credible. Has the regulation defined what is credible, or are they leaving it up to us to define that?

MR. KOPENSKI: I have not seen where they drew a line as to what that is. I think that if you set it really high, then maybe you don't have to do as much work, because you don't have to get the information and go through all of it for particular smaller organizations. What we've probably done internally is set that limit at about 500. Does it really need to be that high? Maybe not, but when you look at the number of attestations that may have to be done and the amount of time to do them, you have to take some kind of a ground where you can actually help as many of these organizations as you can. Looking at the gross value test particularly, I've dealt with probably 30 or 35 organizations over the last six to 12 months. You can look at the plan and pretty much see that it's substantially better than the Medicare Part D benefit. So you really don't need to go through the seriatim calculation to figure that out. Even if you were to use an average or a normalized dataset, you probably won't be very far off in the fact that you have a huge difference between the two. If you have a contribution that's less than 50 percent and you don't have a big difference between the medical and the pharmacy so that you could actually just move it all over to pharmacy as a contribution, you can look at the contribution to get a sense of whether you'll have any issues there.

MR. WAGONER: I have a quick additional comment. I've not seen anything either relative to credibility, but one thing to think about, in addition to the size of the group, is the date of the data or how old the data is. I think Medicare's using 1998 data that they're projecting forward, for example. The longer you project, probably the more data you need to have to provide any hope of being credible. That's just an additional variable to think about.

MR. CARL B. WRIGHT: I'm with Humana. I have a couple of comments first. You've talked about the June 6 date and the July 1 date, but there was also a critical date of June 15 if you wanted to do group regional PPOs. If you haven't done them, you've missed it.

MR. KOPENSKI: Right.

MR. WRIGHT: Another thing that we discovered—and this has been around a while, but it came to light for us just before the June 6 deadline—is that for group plans, if you expect to be offering plans to non-calendar year groups, you have to do a separate filing. There's a penalty to the employer for that because a non-calendar year employer does not get reinsurance payments. That part of the cost then has to be charged to the employer, so it will increase his cost. Maybe the whole point there is to encourage those groups to move to calendar year.

The other thing is a comment and a question, and it revolves around this whole issue of active employees over 65 who are Medicare-eligible and their ability to participate or not participate in an HSA and the implications. At my prior employer, I developed a high-deductible health plan. It's my understanding that it's not eligibility that determines your ability to participate in an HSA. It's whether you enroll. And if you don't enroll, then presumably you can participate. There are some other issues associated with that, but the question that I have about what you both presented is, is there an issue for an active Medicare-eligible employee who chooses not to enroll and wants to be in an HSA? Are there implications for the drug coverage once they retire? Is there the possibility that they have to pay a penalty because the high-deductible health plan drug coverage, being subject to the same deductible as medical, doesn't meet the creditability test?

MR. KOPENSKI: I would say that is true, Carl. If they elect not to enroll in the Part D program and the consumer-driven product does not represent creditable coverage, then yes, they would be penalized when they did enter the market at a later point. To the extent that the consumer-driven product was creditable, then certainly they could enroll in that, and there's no future penalty to them.

MR. WRIGHT: Do you have any thoughts on what makes a high-deductible health plan where you have the integrated deductible a creditable drug coverage?

MR. KOPENSKI: I think the big issue with respect to the consumer-driven product is certainly what kind of an account it is—HRA, HSA, MSA—but also how you distribute the initial deductible to pharmacy and to medical. How do you split that up? I think that's the big issue. When you look at the information that has been put out there with respect to the consumer-driven products and how they relate to creditable coverage, I think it's been deficient. From what I've read, CMS has made a statement about it, but it really hasn't provided a lot of insight or guidance in how you treat those plans. I know that they put out some blanket information originally, and I have not really seen a lot of follow-up on that.

MR. WAGONER: I haven't seen a lot of follow-up either. If I describe a high-deductible health plan as something between a $1,000 and $2,000 deductible, and your drugs are subject to that same deductible, the only time I've seen those plans be creditable is when you have a decent health reimbursement arrangement attached to that. Those have come out creditable. If you have an HSA, for example, that doesn't count toward it. Without a health reimbursement arrangement, I haven't seen it work.

FROM THE FLOOR: For employers who are taking that 28 percent subsidy, what's your feeling around how many of those might be sharing part of that subsidy with their retirees, and does it differ between those who might have a capped cost commitment already for their retiree coverage and those who don't?

MR. KOPENSKI: That's a very good question. What do you do with it when you get it? How much of it do you pass on to the retiree? To be honest with you, I've had no discussions about what that employer will do with the money, whether they're going to provide additional coverage with it or whether they're going to take it all for themselves. I think that's yet to be determined. Most of the decision making has been about what option to take and has not moved down the line to, "What do we do with it, or how can we have some of that contribution then trickle down to the retiree?"

As opposed to the subsidy, which you just mentioned, if you look at purchasing a PD product in the marketplace, and the amount that you're paying in the way of premium is already subsidized through the process because the federal government pays for a portion of the premium, that amount of money has to then trickle down to the retiree. You can't increase the premium to offset the fact that you were getting this reduction and then charge that back to the retiree. There is some movement of the money down to the retiree in that setting, but there isn't anything that I've seen that is indicative of that having to happen under the 28 percent subsidy provision. George, have you?

MR. WAGONER: That is a question that we asked in the survey that I mentioned. While I can't give you the results—it'll be a couple weeks before it's published—I can at least tell you, out of three different things, the rank order of those. The largest percentage of companies said that they would keep the subsidy totally themselves and not share any. The second largest said they would share the subsidy. And the third largest said they would give all of the subsidy back to the retiree. The survey was about two weeks ago, and it'll be published in a couple weeks. To the extent that companies do what they say in the survey, few are giving it back.

FROM THE FLOOR: You talked about getting a waiver on behalf of an employer to offer a customized design. Could you give an example of that? Would that have anything to do with something like there's a co-pay involved? What would a customized design look like?

MR. KOPENSKI: If you look at the plans that are filed July 1 by these different entities, MAPD or PDP, they'll file the standard Part D benefit, but that's not what they'll sell you. They'll sell you something that is consistent with your current benefit plan or something potentially much richer than what they filed with CMS. That is a waiver benefit that they're allowed to do outside of the bid process. That would be potentially a three-tier co-pay design that's similar to what you're currently getting—nothing that even looks like the Medicare Part D benefit. There's no coverage gaps or anything like that. However, they most likely will go to the 5 percent or the greater of $2, $5 copayment above $5,100. It'll keep it similar to what you have, but then at $5,100 or at the point of reinsurance, they'll change back to the catastrophic coverage so that they don't create any violation of benefits at that point. You still need to maintain the catastrophic benefit. Even though you're providing a much richer benefit in aggregate, you still have to make sure that you're not cheating somebody on the back end.

MR. CHARLES F. LARIMER: I have a question on the net value test. As part of the net value test, you have to look at the employer contribution to the retiree premium. Suppose the employer is paying 50 percent of the combined medical and pharmacy premium. To pass this test, can you go back and somehow restate that as the employer's paying 100 percent of the pharmacy?

MR. KOPENSKI: Yes.

MR. LARIMER: You can make that shift?

MR. KOPENSKI: Yes, you can make that assumption.

MR. LARIMER: Good deal.

MR. KOPENSKI: You would think that under normal circumstances you would take the pharmacy cost and the medical cost and just say the pharmacy represents about half, and you'd split the contribution. But apparently CMS says you can do 100 percent/0 percent if you want in that allocation, which makes it fairly easy. If they're contributing anything of significance, but it's not 100 percent retiree pay, you can move things around to satisfy the test, for the most part. It's important to note that you can do that, because in many cases that is what gets you to being able to get the subsidy.

MR. WAGONER: I have a follow-up question on that. If in your substantive plan you've told your retirees that you're paying 80 percent of the cost and they're paying 20 percent—you specifically said that—do you need to change your substantive plan consistent with what you just said?

MR. KOPENSKI: If you've defined that you'll be providing something for medical and pharmacy, then yes. If it's in a plan document and it's in writing that you're providing this kind of contribution for each of the pieces, then you need to stick

with that. But there's not a lot of information about how that contribution is allocated in any of the plan documents that I've seen. But you are right, George. If there's something in writing that indicates that's the way you were doing it, then you need to stick with that. I think there's a lot of flexibility there because that's generally not in writing.