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Session #38 PD
What's New with Retiree Medical?

Track: Health and Pension

Moderator: Damian A. Birnstihl

Panelists: Corey N. Berger
Stephen Wood†

Summary: The Medicare Modernization Act has created numerous opportunities and as many questions for insurers as well as employers that provide retiree medical coverage. Panelists discuss such issues as:

- *Medicare Part D drug benefits and actuarial equivalence*
- *The future of Medicare Supplement*
- *New government accounting standards to be implemented in 2007*

Attendees gain a greater understanding of the imminent changes in this dynamic segment of the health insurance market.

MR. DAMIAN A. BIRNSTIHL: My name is Damian Birnstihl, and I am pleased to introduce our two speakers for today's session. First we have Corey Berger, senior consultant at Reden & Anders in the Atlanta office. Corey has been providing actuarial consulting services in the area of managed health care since 1993. His clients have included HMOs, physician groups, provider-sponsored health-care organizations, employers, other consulting organizations, the SOA and the Academy. Corey specializes in analyzing prescription drug claims to help forecast future trends and developing premium rates for prescription drug benefits for multiple clients. Corey has also worked extensively in the areas of managed health care pricing, capitation development, product development, contracting, reserve

†Stephen Wood, not a member of the sponsoring organizations, is the managing principal at Reden & Anders, Chicago, Ill.

Note: The chart(s) referred to in the text can be downloaded at http://handouts.soa.org/conted/cearchive/neworleans-june05/038_bk.pdf.

development and pharmacy pricing. Corey is a fellow of the SOA and a member of the Academy. He graduated from Washington University in St. Louis with a degree in mathematics and economics.

Our second speaker will be Stephen Wood. Steve is also with Reden & Anders, in the Chicago office. He is the managing principal and leads the senior market and individual market practices. Steve's work in the senior market dates to the mid-1980s, when he worked with hospitals to implement decision resources group payments by Medicare. Since that time, he has worked with most of the major insuring organizations serving the senior market to develop strategies, conduct new product feasibility assessments, improve performance and implement new strategies. Steve has extensive experience in managed care, governmental programs, senior markets and strategic consulting in the health insurance industry. His recent work includes Medicare Advantage feasibility assessment and implementation, disease management program and implementation and Medicare supplement product development, among many other things. In addition to his consulting experience, Steve held positions in capital finance at the American Hospital Association and as finance director and director of patient accounts at large medical group practices. Steve graduated from the University of Chicago and holds a master's degree from the Harris School of Public Policy at the University of Chicago. He edited and coauthored a book entitled "Implementing a Successful Medicare Managed Care Product." With that, I will turn it over to Corey Berger.

MR. COREY N. BERGER: The topic of this session is "What's New with Retiree Medical?" I am sure that to most of the people in this room, that topic basically means what is going on with the new Medicare prescription drug benefit. I am going to focus on that. I think Steve will focus on that a little bit and then have some other areas of discussion. I am going to go over what the Medicare prescription drug benefit is on the highest level and what it means to the overall market and then go into what some of the employer options are. For those of you who have gone through the Part D bidding process, this will all be background. For the rest of you, it might be new information or a slightly more detailed analysis of what the basic drug benefits are. Then I will go into what the different employer options are, some of which are no longer available for 2006 but could be something that you do for 2007. I think it is still worth going over them and then analyzing different options. I then will have some general conclusions.

What is the new Medicare prescription drug benefit? The Medicare Modernization Act, which was passed December 8, 2003, a date that will live in infamy, includes new voluntary coverage of prescription drugs. Nobody is required to enroll in this, although there are six to 12 million people whom nobody is sure that we have covered for drugs on Medicaid and who will automatically be enrolled into the new prescription drug benefit to minimize their disruption in coverage. Everybody else will either continue to receive some benefits through their employers or will have to proactively enroll into the new program.

Several options for Medicare-eligible subjects are to enroll in a stand-alone prescription drug plan (PDP), for which all the bids were filed on June 6. To enroll in a Medicare Advantage plan (MA-PD), the bids were filed on June 6 as well. Employers' unions have multiple options, including enrolling their members in either one of these two options, and then there are some other minor options. We will discuss those briefly.

Everyone has his own little format for the basic coverage under standard Part D. There is the $250 deductible, 25 percent member pay from $250 to $2,250 and allowed, and the allowable costs "donut hole," which Centers for Medicare and Medicaid Services (CMS) calls the coverage gap, and then there is catastrophic coverage. The general reason this benefit design came about was the desire to have catastrophic coverage for those people who truly had catastrophic drug claims combined with the socialistic aspect of Medicare, which is everybody gets something. The catastrophic coverage was for those who truly had a need, and then the $250 to $2,250 was so that everybody got something, and they had that $400 billion number that turned out not to be $400 billion,, and this is what it sold for. Therefore, nobody understands it. There will be a lot of alternative plan designs out there, some of which will get rid of the deductible, and some of which will be co-payments. To get truly comprehensive coverage, you will either have to enroll in an MA-PD if you are lucky enough to be an area that has rich enough revenue on the AB side of Medicare to cover drugs, or you will have to pay a supplemental premium, which gets into the adverse selection discussion, and I do not know if we will get into that in much detail.

Where are the costs in this? Our initial estimates of the total cost, including administrative for prescription drug coverage, was $225 to $255 per month per member (PMPM). If you assume a higher generic usage, that number goes down. The federal government is going to pay somewhere from $90 to $100, which includes 80 percent coverage of catastrophic. The estimate of the beneficiary premium was $30 to $40, but I think you will end up seeing plans out there that may have premiums as low as $15 for plans that encourage generic usage.

Again, for background, the plan design provided significant risk sharing between the government and plans that decided to offer these. The first is the risk-adjuster method, which CMS came up with based on medical diagnosis that gets applied to all individuals. If you enroll someone in a stand-alone PDP, it will calculate a risk score, and you will get paid your basic bid times that risk score. If you have 100,000 people, CMS will calculate 100,000 risk scores and calculate an average, and that is what your payment will be.

The reinsurance is the 80 percent of the catastrophic coverage that CMS is going to pay as a straight pass-through. It will pay a capitated amount monthly based on your bid and then do a reconciliation at the end of the year. Then there are risk corridors, which is more of an aggregate stop-loss. If you come up with a bid that is significantly too high or too low at the end of the year, there will be another

reconciliation after the reinsurance is reconciled and after the risk adjusters are applied. You will either get money back from the government or owe money back to the government, depending on where your actual costs fell relative to what you projected in your bid. Right now, CMS is in the process of evaluating all of the bids, because its goal is not to have people in the risk corridor. For anything that is a clear outlier, it will enter into negotiations with the plans that submitted the bids to try to get them to what CMS thinks is a more reasonable level.

Who has not heard of true out-of-pocket (TrOOP)? TrOOP is the acronym that CMS came up with that says certain dollars count toward a member's out-of-pocket and certain dollars do not. Everybody talks about $5,100 in allowed costs, and the real number that CMS is going to look at is the $3,600 in TrOOP, which is when member has spent $3,600 and becomes eligible for the catastrophic coverage. There are a number of items that count toward TrOOP, primarily what the member pays out-of-pocket or what charities pay, and then there is also an additional reimbursement from the government for people who are below a certain percentage of the federal income level. Those members get an additional benefit, and the dollars the government pays also count toward TrOOP. Any payments made by an employer or by a group health plan do not count toward TrOOP. In essence, if a member enrolls in a stand-alone PDP and the employer pays the cost sharing, the 25 percent, that pushes out the point at which an employee or retiree becomes eligible for the catastrophic coverage. There is an offset in what the government is going to pay in the reinsurance if the employer is filling in some of these coverage gaps.

I have a few things about employer options. Employers, like I said earlier, have multiple options. The first is potentially the simplest, which is to collect the after-tax subsidy from CMS. The legislature came up with this option to encourage employers to stay in the game. They said, "Here is an estimate of what we think beneficiaries would receive if they enrolled in a PDP, so we will pay you, the employer, approximately that amount." It is more or less a wash. I will go into that a little more.

The second option, and this is one that you had to have applied by April 18, was for employers to become their own PDP. Because tax-free organizations do not get any benefit from the after-tax subsidy, becoming their own PDP could have meant significantly more revenue on an after-tax basis. I think not a lot of tax-exempt organizations took advantage of that for 2006, but a lot more will do so for 2007 once they realize that the $600 or $700 dollars or $500 they get is part of the subsidy. They could be getting $700 or $800 by becoming their own PDP and have as much flexibility on the plan design as they currently employ.

The third option is to enroll people in a PDP or negotiate with a stand-alone PDP to continue to offer the same benefits, but these people are enrolled in a PDP, and you just have a coordination of benefits, which again would push out when people become eligible for the catastrophic coverage. A couple of minor options are to enroll people in a PDP and pay the Part D premium or to eliminate coverage

altogether.

The first option is the employer subsidy. To collect the subsidy, you have to pass two tests. The first is a gross value test, and the second is a net value test. The gross value test is making sure that on average the benefit design that you offer gives the same reimbursement to your members as standard Part D would. If the average benefit or the average payment for a member would $60 PMPM under standard Part D, your benefit design has to offer that same level of benefit.

The net value test looks at what the members are paying in premium versus what they would pay for a standard Part D plan. If you pass the gross value test and the members get about the same benefit as under standard Part D, and if member are going to pay a higher premium or higher part of the premium than they would under standard Part D, the employer is not eligible for the subsidy. The goal of these two tests is to avoid a windfall where the employer collects money but is providing less of a benefit for what the employees are paying than they would if they enrolled in standard Part D.

A couple of considerations for an employer that is considering collecting the subsidy include making sure that the benefit is at least as good as standard Part D. One note is that the benefit design it offers is not subject to the standard Part D plan design requirements. It does not have to have a deductible. It could conceivably have an annual maximum, although if it has an annual maximum that is likely to push it down in terms of passing the gross value test, because a large chunk of the benefit is the catastrophic coverage under standard Part D.

There is a question from the floor. If there is a combined medical and prescription drug premium that is charged to the employee, how do you allocate it? CMS gives you a broad flexibility in doing that allocation. In essence, you can say, "The total cost of what the member is getting is $300 PMPM. His contribution is $100, and we know that the medical is at least worth $100, so we will allocate all of the $100 to the medical." You just have to be able to do some justification of that allocation. In that example you could allocate it all to the medical. If it is $200, and the value of the medical is only $150, you could allocate only up to what the value of the medical is. That is what CMS's guidance has been on that.

FROM THE FLOOR: Is it your sense that most employers are already offering benefits greater than Part D or not?

MR. BERGER: Most are, although I have seen some other plan designs recently. If you think about what the average cost of the generic drug and the average cost of a brand drug are, with $25 for an average generic after discount and $100 for an average brand, CMS in the past couple of weeks released safe-harbor guidance. This guidance says that as long as you have a deductible that is less than $250 and a benefit that is at least 60 percent of the overall cost, it is a safe harbor. You have an annual maximum in excess of $25,000. If you look at a 15/50 co-payment

structure, that is pushing the limit of what would pass that safe harbor. I do not know that 15/50 plan designs are necessarily that uncommon. You know a 10/20 clearly would pass, but when you start getting into $40 and $50 co-payments for brand names, it becomes a little tougher to just say that it passes.

Is there anything else? The subsidy calculation is relatively straightforward. Once you have determined that you pass those two tests, there is an application that is due September 30, and my understanding is it is not a terribly difficult application to complete. There are a lot of attestations. Yes, we passed this test, yes we passed that test, we want our money, and we will do what we need to get our money.

The actual subsidy is 28 percent of the total spent by both the employer and the employee, between $250 and $5,000. The maximum subsidy if you take 28 percent times $4,750 would be $1,330 per individual. CMS has come out with an estimate of the average of about $600, but it depends on what the utilization of your plan is. Overall, our estimate of the value of the subsidy is about 20.5 percent of gross claims. Again, standard Part D is probably closer to a 40 percent or 50 percent benefit. When you start netting out the employee premium and then the after-tax value of this, in most cases it will be a wash. As I said earlier, for a tax-exempt organization it could mean a lot more money by getting it through a PDP, because you are getting some administration paid for and you do not have to pay the taxes.

I have a case study summary of the percentage of people that fall into each of these different buckets. Clearly the people over $5,000 will get the $1,330, and for the people between $250 and $5,000, you will have to calculate it. You can apply to get your subsidy payment as often as monthly, although you will have to submit a claims fee and an eligibility fee to CMS every month to get the money.

The second option was for an employer to become its own PDP. I probably already hammered this to death, but if you are tax-exempt, this is probably a better option. In particular, if you are either ASO or self-insured, you probably already have a relationship with a pharmacy benefit manager (PBM) that was doing the claims processing. A large chunk of what needs to be done to be a PDP is going to fall on the PBM, especially for an employer that will not have to do the marketing-type activities that a stand-alone PDP would.

I will quickly summarize some of what CMS provided to make this option reasonable for employers in terms of the delayed timeline. They basically pushed all of the deadlines back about a month from the normal PDPs. The waiver of state licensing requirements was relatively easy to get. They also allowed entities like labor organizations or state governments to become employer-sponsored PDPs, even though the legislation strictly prohibited state governments from becoming stand-alone PDPs and enrolling anybody who is Medicare eligible.

In terms of some of the other waivers that were available for the employers, I think this will probably be a bigger issue at the end of this year and early next year,

when employers are reevaluating their options and trying to determine whether they want to pursue this option for 2007.

There are a couple of items that make it slightly less attractive, including that there are no risks orders as for the stand-alone PDPs. The logic is that in most cases, the employers would have already known what their cost were going to be, so they could have done a better job of predicting their expenses. If it is a noncalendar-year plan, there is no government subsidy for the reinsurance, which might be a bigger deal than having no risk corridors. In any case, you do not get a capitated payment for the reinsurance on a monthly basis. There is only a reconciliation at the end of the year, which could have an impact on cash flow, but again, most of these employers were providing benefits and paying for them anyway, so it is not as big a deal as it would be for a stand-alone PDP.

They will receive low-income subsidy payments on a capitated basis. Then the payments are based on the national average bid as opposed to the actual employer bid and the way they calculate what the plan is going to get paid or what the employer would get paid versus the national average. The member premium is a little odd. I am still not sure I understand why they did it. Basically they take the plan bid and compare that with the national average bid to calculate the member premium and then pay the difference. In some ways, this provides an incentive to bid low.

FROM THE FLOOR: Do you have any sense of which employers are doing this?

MR. BERGER: There are not many. I know of two or three, but most of them were smaller entities that may not have had enough in employer contributions to qualify for the subsidy. If you look GM and the fact that right now it is not going to be paying any taxes because it is not making any money, take what it would get from the subsidy and multiply it by 50 percent more, and you may see GM doing something like this in 2007.

FROM THE FLOOR: You are talking 400,000 retirees times $200 a month, which is a lot of money. It will be a huge issue in 2007. People are going to figure this out, and many who probably work for benefits consulting firms will be pounding the pavement as they ought to be with employers.

FROM THE FLOOR: What does a "calendar-year plan" mean? Does that mean that there is a deductible that goes from July to July, as opposed to January to January?

MR. BERGER: The answer is the period from January 1 through December 31, when, like you said, deductibles are accumulated. I do not know how common it is to change premiums midyear but not change deductibles. It seems a little odd. I do not know whether you could change premiums midyear but keep the deductible accumulating throughout the calendar year. I am not sure how CMS would treat that. I think primarily it looks at it as a January 1 renewal date.

Again, one of the advantages, similar to the subsidy, is that employers can offer whatever benefit design they want and supplemental coverage as their only option and that would be what their bid is. I believe employers are waived in terms of having to offer the standard plan as a minimum benefit design. They can offer just one plan that mirrors what they were offering before.

The third option is to offer wraparound standard Part D coverage. With the standard Part D benefits, once you hit $3,600 under standard Part D, that is $5,100, and then members are eligible for the catastrophic benefit. If you have a benefit that is the same as the standard in the $250 deductible and the 25 percent member coinsurance, and then the employer pays 50 percent in the donut hole, members will not hit $3,600 in out-of-pocket until they hit $7,950 in total spend. That shrinks the value of the reinsurance, so if you are going to go to a PDP and buy this as supplemental coverage, not only are you going to get charged for this 50 percent in the coverage gap, but you also will get charged for the reduction in reinsurance that the PDP would have collected.

If you continue to 75 percent coverage all the way through the coverage gap, you do not hit catastrophic until the $13,650 in total allowed. With 80 percent overall coverage, you would not hit the $3,600 in TrOOP until $17,000.

What are the pros and cons of wraparound coverage? It may be that because of the government reinsurance payments, even if you do some supplemental coverage, the employer could pay less for comparable coverage than the value of the subsidy. You can also keep the same plan design; you are just pushing out that reinsurance. To know which would be better, you have to take a look at what the supplemental premium would be and what the employer is going to pay versus what it would collect from the subsidy.

Clearly the subsidy is a lot easier to do. You have to do this testing to determine which option is better. However, even if there is $1 PMPM, if you have 100,000 retirees, you are talking $1.2 million by taking one option versus the other.

FROM THE FLOOR: I have a problem with this concept of option 3 being looked at as a negative, and I think CMS is pushing it that way as well. I am confused as to why it is not so easy for an employer to go to a health plan that offers a PDP. It can fill the donut hole, get it the exact design it has, and there is no work on its part except all the administrative issues of the subsidy and all that. To me, this seems like the easiest action. I am missing what is there. There is no work on the employer's part. It hires a PDP, has done all the work and has all the systems in place.

MR. BERGER: When employers start looking at the different options, they may conclude that their costs are less by paying the base premium plus a supplemental premium versus the subsidy. It may just be a wash. It depends on what the benefit

design is, what the premium it would have to pay to the PDP is, and what it would get from the subsidy.

FROM THE FLOOR: When you say in general it is a wash, is it a wash when on the PDP side there is a donut hole, and you are getting the full value of the catastrophic coverage? Is that where CMS did that measurement?

MR. BERGER: I think when we looked at it, it was using a fairly rich benefit and continuing to collect the subsidy versus applying that same benefit to the Part D, not the standard coverage.

MR. STEPHEN WOOD: In your particular case, since you are not-for-profit, this weighs in slightly differently as well. You were not paying taxes on your products, either. It is a value proposition thing. I will talk about it in a little a while, but basically the employers are faced with how much it is going to cost to get this level of benefit delivered through one choice versus another, and by the way, they do not want to be in this game anyway. They do not want to be in health care; they would rather get out of it. They would rather give their retirees $500 a year to go buy their own. We will get to that.

MR. BERGER: This is an example of the type of analysis you would do to determine which option is better: PDP with supplemental coverage or the subsidy.

In summary, as Steve just said, current retiree strategies need to be reevaluated. I have a brief review of the three primary options. The subsidy is in some ways the least complex, although you could make an argument saying, "Here is $500; have fun." It is the least complex. However, then they did not buy a PDP and now have to pay late enrollment penalties and things like that. Employers' stand-alone PDP is probably the most complex but may offer the greatest benefits in terms of flexibility. A coordination of benefits wraparound might be a happy medium between the two.

MR. WOOD: I am Steve Wood and am also with Reden & Anders, but I spent two years at Towers Perrin, so I have a different perspective on employers and their ideas concerning retiree health. Most strategies from employers are like driving along a freeway, looking at the horizon, and then you see an exit ramp. Most employers have their signal, on and they are out of there. You have seen GM set the stage as well. I just did the math, and the math is $1 billion just for the subsidy versus the PDP number. When you are talking about a company like GM that has about 425,000 retirees, a $200 difference between subsidy and PDP for GM is $1 billion a year. It still provides benefits. This is just a vehicle for how it provides them.

You know that GM looks at that and says, "Dandy! We are saving $1 billion. By the way, we do not want to spend the other $8 billion on retiree health. We want to be out of here. How can we get our unions and the government to get us out of this?"

If you think about the employer's subsidy and the employer's ability to do a PDP or the employer's ability to buy a PDP, what is it? All of it is a huge bribe to employers to stay in the game. The reason is that 22 percent to 28 percent of all Medicare retirees continue to get employer wraparound retiree health coverage. If that 28 percent goes away next year, the $400 billion that the federal government set aside for Part D that is already gone is now totally gone. This is a huge deal for public policy as well as employers and all the rest in the game. This 28 percent is down; when I started working with employers and doing this at Towers about 15 years ago, the numbers were more like 50 percent and 60 percent. They have now leveled off. Now we have about a quarter of all of the retirees, or about 10 million of the roughly 40 million Medicare-eligible who have a group retiree benefit, and we have seen that flatten out. The employers that are left in that space are stuck there. The only way they are getting out is the way United Airlines got out, or Bethlehem Steel, or maybe GM, or others. You must declare bankruptcy. That is the only way to get out from under that burden, and that is a big deal.

Our job is to help employers figure out what the strategy is. How do they minimize their exposure? How do they maximize the benefit that they get from the federal government for paying for this program? By the way, they want a strategy so that, while they might be obligated to their current retirees and perhaps the ones that are retiring over the next five years, they will not be obligated to that 25-year-old who just signed on. There are a lot of strategies going on here.

In terms of the Medicare space, people tend to forget about employers. We discuss what the big fuss is about. It is about Medicare Advantage. Many of us spent long nights and weekends during the past month or so filing these bids. Fifteen percent of the Medicare-eligible population enrolled in MA-PD. Big deal. The deal is, employers represent twice that amount, and individual Medi-Gap is another 10 percent of that, 10 percent more than Medicare Advantage. You see that, in terms of group retirees, it is a huge deal, and it is a huge deal in terms of the bidding process, strategies and playoff among taking the subsidy, setting up your own PDP or buying it off the shelf from some PDP carrier.

The answers are not clear. What do employers need to know? First of all, they have to know the applicable accounting rules and how they affect their Part D decision, What do the accounting rules have to do with tax liability? Others have to do with Financial Accounting Standard 106 (FAS-106) liability. There are all sorts of proclivities for particular industries, as well. What are the regulations? How do I qualify for a subsidy? One of the big takeaways from getting the subsidy—and this scares the daylights out of employers when they begin to think about it—is who are you getting the money from? Do you think the federal government will say, "Here's the money; no sweat. You say I owe you $50 million? Here is the check." That is not what happens. This is auditable federal money.

Have you heard about the False Claims Act? Guess who is now going to be on the hook for the False Claims Act if you are a self-insured employer turning in claims to

the federal government? When employers begin to think about this, they might rather buy it from Highmark. You do not want to be liable for the False Claims Act among everything else. This is not a no-strings-attached deal when you are filing claims for your subsidy. It is federal money with all the fee bars and all the False Claims Act and other regulations that go along with getting federal money. Employers need to figure that out.

The other question on employers' minds has to do with getting burned on Medicare HMO. Ten years ago, they got all of their retirees to enroll in one of those HMOs. What happened to them? All the human resources vice presidents who advised their chief financial officers and CEOs that this was the greatest thing since sliced bread are not there anymore. The HMOs hit the skids and withdrew from the market, and all of a sudden all those retirees who gave up retiree wraparound plans and enrolled in one of those HMOs did not have an HMO to enroll in. They had to all be brought back into the plan. All those FAS-106 savings that were put on the books or taken off the books came back on the books.

Therefore, employers have a cynical attitude about the Medicare Advantage marketplace and in particular these weird things called PDPs. They did not exist last year, and they are not certain to exist next year. Why should they put their companies' and their own professional futures on the line buying something from somebody that may or may not offer that benefit or may or may not be around in two or three years? Your employers' horizons are not one or two years; they are 20 years. They want their retirees to take the gold watch when they're 65 or 63 or 57 years old and be gone. They never want to think about them again.

If financial obligations are bad from an employer's perspective, customer service to retirees is worse. They do not want to have to deal with these people. Retirees are no longer productive parts of the company. While they were, everything was fine, but they do not want to have to deal with retirees now and reenroll them in new plans.

How, then, is the marketplace going to develop? What will the employers do? We went through all this business with Corey, so let us go on to a Towers Perrin study. Somebody asked what employers are thinking of doing. Sixty percent of them said take the money and run. This is the subsidy route. They get 28 percent to the first $5,000 they spend. They want to get the money and go. Another 26 percent said maybe this is something that they can think about. Another 8 percent said, "All right, I am gone." By the way, does anybody know how much retiree health is tied up with pharmacy dollars?

Therefore pharmacy spends from an employer's perspective is its retiree health plan. The rest of it is just filling in the gaps and co-payments for Medicare, such as $900 a year for inpatient events, 20 percent on the professional side. That is chump change. Pharmacy is five or ten medicines a month, year in/year out, which is paying out the wazoo. There is a direct relationship where, the more impaired the

industry, the higher the medical spend is.

Industries such as steel, automobiles and old telecommunications companies have incredibly high spends on medical. They are the ones that are in the worst shape to fund it. This is the sort of dynamic. When they see an opportunity to book out of there, they will take it for $35 a month for a standard Part D. That is their idea.

Some are going to do other strategies, small slices of coordinating care and things like that. The fact of the matter is, for this coming year, virtually no employers are going to take and create their own PDP. That is not their space. They do not make health care. They are not going to start a PDP. However, think about the companies that have the turnkey for employers. They are out there now. One comes along, is a TPA and knows how to manage claims. This is seamless stuff. It has hooked up with the law firms, which will do all of the regulatory stuff, and GM will save $1 billion a year. Now we have something. These things will be moving through the employer's space. We are beginning to see some of them already emerged.

We have PBMs are all over the place. There was a huge response to the opportunity. Corey, do you think it is between 10 and 20 PDPs per region, which is about 18 more then most of us thought? Probably some will be PDPs, but benefit designs for certain. You have got a lot of activity out there.

FROM THE FLOOR: How many PDPs are there?

MR. WOOD: I think in some regions, between MA-PDs and PDPs, you will see 15.

FROM THE FLOOR: That is too low.

MR. WOOD: That is too low.

MR. BERGER: I think CMS received over 3,000 Part D bids. Some of those attached to MA-PDs, but I mean specifically, there were five bids per region.

MR. WOOD: That is 3,000 Part D bids. I know that Reden & Anders worked on about 1,000 of them. The response was overwhelming.

From an employer's perspective, there are a lot of vendors in this space, many of whom I have never heard of before. Some of them are Blue Cross plans, and I might think twice about those. They will sit on the sidelines and wait to let it shake out. However, there is a tremendous response, and there are all sorts of options out there.

The other deal is that employers themselves are not going to share the information with the federal government about getting the subsidy. You do not just get the subsidy. You must submit claims. You also have to submit all of your retirees and their dependants. You have to submit Social Security numbers, the names and

eligibility, the benefit design and all that to make sure that the benefit design meets the actuarial required coverage levels. These things are not necessarily what employers do. They will look to their PBMs. The PBMs are coming up with their cost structures. That is a cost of the subsidy. It is not just 28 percent net; that is 28 percent gross, not including all the administration costs, and not including all of the risk in terms of the regulatory and legal risk.

Now I am trashing subsidy. The reason that I am trashing subsidy is there are other alternatives that perhaps are easier for employers. The bottom line is, the federal government does not want employers to take PDP. The reason, as Corey outlined, is that PDP done right pays twice as much. The deal here is they have made some issues around the PDP for most employers. In fact, the employers that are most likely to get PDPs are ones that have calendar-year versus noncalendar-year benefit designs. Most municipalities mistakenly think they are on September 20 to October 1 or June 30 to July 1 or something vice versa. When you have an off-cycle benefit design in a calendar-year Part D product, we have a problem. There is no provision in the law that allows for accumulation of, for instance, counting toward TrOOP off cycle. You have a half of one calendar year and half of another calendar year constituting your group year. Try to figure that one out.

In fact, think about this. This is where it gets totally scary. On the TrOOP and on the subsidy, it is all back-end-loaded. Basically for TrOOP, you are not going to get to the coverage gap or the catastrophic until late in the year. What happens if you have a June 30 to July 1 year? You will never get to the end of the year. These kinds of issues are ongoing. We will all be collectively solving them over the next six months, so that by this time next year, all the employers will be ready to purchase their PDPs.

These are complex issues. Corey alluded to one of the things that we did, and my associate here, Kirk Twiss, who is a principal in the Chicago office, did this for one of the employers that we worked with. We did it, and this is an example of a comparison between taking the subsidy versus doing a PDP analysis. I cannot tell you how many times my telephone has rung in the past week. Just before I came down, I got a call from an employer saying, "We are not doing it this year; we could not get our act together. Next year should we take the subsidy or should we go PDP?" Our conventional response is, "We have to do the numbers, don't we?" This is ironic, but the sicker your retirees, the more attractive the PDP, right? If you have retirees who consistently blow through $5,000 in drug spend, how much of a subsidy do you get on the first dollar after $5,000? The answer is zip.

Say that you are a coal mine. You have all sorts of people with lung diseases, some of whom are covered by Medicare. Assume your average drug spend is $9,000, heaven forbid. You get $1,300. I could do much better putting them in a PDP in that situation. That is the extreme example, but you can see where the mix of employers' drug spend for the retirees has a great deal to do with whether the subsidy is good for them or not. You take all of their drug spend and stick it into the

various buckets that are the Part D product. You have your deductible on the first row, your coinsurance and your politically correct coverage gap. Then we have our catastrophic.

For this particular employer, if you were to flip its drug spend into a standard PDP design, it would come up with $80.14 for the pharmacy part; you add on the administrative, and by the way, you get the profit on your own population, which is a little bizarre. At any rate the total cost for this particular employer would be $94. Then you figure out what the member premium is, and by the way, this is illustrative and was built for an employer. Even human resource people could walk through the numbers and say, "Okay, logically I got from A to B to C to D to E." Under the subsidy (see Wood slide 14), the employer would have gotten $116.46. That is the calculation this particular employer did for us between the member cross-share and the employer subsidy. That compared to under the PDP factored in at $118. For this employer, $116 or $118 is not worth it. They may not choose to go down that route to do a PDP, because the subsidy for them does just as well.

There may be other reasons employers might want to buy. This assumes that they cannot buy this more cheaply from a PDP on the open market, or this may be more expensive than on the open market. We do not know those kinds of projects or those kinds of things. Here is the deal. The income tax makes the difference. In this case the income tax for this employer, which is a fairly profitable employer, was $22 a month. You see the difference between $160 and $180 is nominal, until you come up with $22 in income tax. If that employer was not profitable or was a not-for-profit, that's $22 a month.

Now I have a real difference, 22 times 12. You have worked through these numbers, and then you readjust them based upon whether you can buy something on the open market at a better price, from a Blue plan or some other stand-alone PDP or integrated with an MA-PD, and you say, "This is what I am going to do." That is the kind of thing, and you can whip through with the rebates and all the assumptions. It is not as simple as you take your subsidy this year; it is employer-specific. There are a lot of rules and strategies involved. The bottom line is employers want to be out of this altogether. The way that you meet their expectations is by quantifying what the spend is and perhaps transferring the risk away from the employer to a PDP or an MA-PD, and turning the benefit obligation into a financial obligation.

Then for instance, if you buy from a stand-alone PDP, you can say, "It cost $100 a month for this type of benefit design. That is how much we are buying on your behalf, Mr. or Ms. Retiree, and that is the quantified value. We are not giving you a benefit; we are giving you a financial protection." That feeds into the employer mindset. Do we have time for questions?

MR. LAWRENCE R. SMART: My question is on the data and on the testing itself. Doing the actuarial equivalence test, if you each have a credible enough group,

these data have not been broken out in the past. What is the standard on using a generic large model to do this testing or how far do you have to go to try to get the data to do this testing? The second part of that question is, When you file the data for the subsidy itself and come out with Social Security numbers, how do you get around the Health Insurance Portability and Accountability Act (HIPPA) rules?

MR. WOOD: I can deal with the second question, and Corey can deal with the first. When filing for the subsidy, the HIPPA privacy rules and the security rules apply, and it will be the standard transaction format. It will be an 820 format for the demographic information, that data feed will be transmitted to CMS via secure HIPPA compliant lines, and the claims themselves are going to be in a standard A37 format. By the way, employers, do you think they have the Social Security numbers of all the dependents? They do not, and they cannot get a subsidy unless they get that information, so it is not straightforward. There are big HIPPA issues, and presumably PBMs and their TPAs are going to be doing it for them for a fee.

MR. BERGER: I will add something to the submission, which is the reason that CMS is going to want Social Security numbers or Medicare numbers is so that they can make sure you are not enrolled in a PDP and collecting the subsidy. It will not be a lot of fun to tell the employers if you want the subsidy for this person, you have to give me a number to submit to CMS and say, "Map this against people that enrolled in PDPs." Once you do it the first time, it probably will not be as bad. The first time is.

To answer your first question, they do not have the data right now to do the testing, and they had better be thinking about how they will get the data because otherwise, they do not get a subsidy. Theoretically you could do the actuarial attestation based on a standard data set. If you cannot get the data but have 5,000 retirees, CMS may come back and say, "I do not know how picky they will be on that for the first go-around." They may say, "This is credible, with 5,000 people. Why did you do it on a standard data set instead of the actual data?" The bigger issue is going to be, if you do not have it now and cannot get National Drug Code level data, what are you going to do on January 1, when you want to get the subsidy to submit it to CMS?

FROM THE FLOOR: If you think about government experience in the pension area, it is perfectly possible that it will come back three years later and complain, or 10 years later and complain.

MR. WOOD: It will not only complain; it will come back 10 years later looking for reimbursement.

FROM THE FLOOR: I have one question about that. Going forward, you can change your procedures right now to start keeping track of it, but you have to look at historical data to cover the full year before to do that, which means you are already past that point where you have to keep track of it?

MR. BERGER: Right, and you hope to have something, but if you do not have anything on that group, I think you would put in the application that you relied on a standard data set because you did not have any data available from the client.

FROM THE FLOOR: Corey, you mentioned plans may be getting down to a $15 premium, and I know of one plan that had a release this week about the possible zero-dollar premium, but I do not know if that was a stand-alone PDP or not. Assuming that you are not just buying the business and taking a loss, you talked about generic usage. Do you have any insight as to strategies you can use to get down that low without meeting all the formulary requirements and the nondiscriminatory requirements?

MR. BERGER: They are primarily formulary, having a fairly restrictive formulary incentive for generic usage both through the formulary and through the benefit design. In answer to your question about the zero-dollar premium, that circulated internally. Was that real? I thought, either it has $65 bids that may or may not get through CMS, or it is assuming a national average premium, national average bid, which is $105 or $110, and I think the consensus that was worked through over the past couple of months is that it is probably going to be closer to $100 if not below $100. If you figure a $100 national bid and a $35 national premium to get to a member premium, to get to a zero you have to be at $65. I saw some bids that were low, but nothing that low. Therefore, without knowing where the national bid was going to be, you had no way of knowing, unless you were that low and thinking you were going to get through CMS tests. It seemed like a silly statement in my opinion.