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Session 16PD
Recent Developments on the Medicare Modernization Act (MMA)

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Panelists: Dawn Helwig
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Summary: The new Medicare prescription drug legislation creates a number of issues for employers and managed-care plans. Employers must determine the impact of the legislation on their retiree prescription drug costs, evaluate options for plan design, and make decisions about how to reflect the effect of the legislation in their FAS 106 valuations. Managed-care plans need to review the effect of the legislation on plan design, statutory filings and financial reporting for their Medicare and Medicare Advantage products. Panelists discuss recent developments of the implementation of the Medicare Modernization Act (MMA): Medicare Advantage and competitive bidding; Medicare Part D—prescription drug coverage; Medicare actuarial equivalence; impact of MMA on Medicare Supplement plans; and direct Medigap effects of MMA. At the conclusion of this session, participants have insight into the latest developments in the Medicare market and understanding of the impact of the new Medicare prescription drug plan on plan design and accounting.

MS. DAWN HELWIG: In this session, we're going to talk about something other than valuation. This session actually has nothing directly to do with valuation, although, as I'm sure you'll agree as we go through, everything that's happening on the legislative side as far as MMA and its impact on Medicare Supplement, Medicare Advantage, etc., is going to have a lot of indirect effects on valuation issues.

Our three speakers are all going to be talking about the effects of the MMA on

NOTE: The chart(s) referred to in the text can be found at http://handouts.soa.org/conted/cearchive/valact05/016bk.pdf.

various aspects of the senior market, but our presentations are all different and distinct, because each of us is talking about a different aspect of the senior market. I'm going to be talking about the effect of the MMA on Medicare Supplement policies. Our next speaker will be Martin Hill from PricewaterhouseCoopers. He's going to be talking about the effect on Part D and employers. Our last speaker will be Don Zhang from WellCare, who will be talking about the effect of the MMA on Medicare Advantage policies.

I'm with the Chicago office of Milliman. I've been with Milliman for 19 years and have spent that time doing pretty much nothing but Medicare Supplement and long-term-care work. I've lived through a number of different variations and a number of changes in the regulations and the policies.

I want to give you a little bit of background for those of you that might not be as familiar with Medicare Supplement and the types of benefits that it covers. Starting in 1991, there was a regulation that standardized Medicare Supplement policies. Prior to that, there were some requirements as far as what basic benefits had to be covered, but starting in 1991, there was a specific set of 10 standardized plans that could be offered. All 10 of these standardized plans have to cover a core set of benefits. Plan A covers nothing but this core set of benefits, and then the other plans use a building block approach to add other benefits on top of this core set.

The core set of benefits that has to be covered includes the Part A hospital copayments. There are two different pieces of that: days 61 to 90, where one-quarter of the Part A deductible is required to be paid by the insured as a copay; and the reserve days 91 to 150, which require that one-half of the Part A deductible be paid by the insured at that point. Then the hospital excess days, days beyond the 150, have to be paid by the Medicare Supplement policy, and the 20 percent Part B coinsurance also has to be paid. These are the core benefits that are found in all 10 standardized plans.

Other than that, I'm going to list some of the optional benefits or building blocks are that are covered by the other plans. The Part A deductible is covered by pretty much every plan except for Plan A. The Part A deductible has just recently announced it's going to be going up to $952 for 2006. So basically, any plan other than Plan A will be picking up that $952.

The Part B deductible is covered under some plans and not under others. That deductible is going up. As part of MMA, it was slated for the first time to be something that would increase yearly with inflation. Before that, it had been at $100 for several years. It went to $110 for 2005, and it's scheduled to go to $124 for 2006. It's a pretty big hike, considering that it had been level as long as it was.

Skilled nursing facility copays are covered by a number of the plans. Those copays are equal to one-eighth of the Part A deductible. Part B charges made by a physician or an outpatient facility that are in excess of the Medicare allowable level

are covered under a couple of the plans. And foreign travel is covered under some.

A few other miscellaneous or optional benefits include the at-home recovery benefit, which covers up to $1,600 a year of expenses for short-term care, and preventive care, which covers up to $120 a year for various preventive services. The key benefits that have been most affected by the MMA are the prescription drug benefits, which are found in only three of the standardized plans. I want to go into a little bit of detail about what the benefits of these prescription drug options or policies are, because it will become important as we start talking about what the effects of the MMA have been and how these benefits compare to what's going to be covered under Part D in Medicare.

There are two different optional prescription drug benefits. The first is called the basic drug benefit. It is covered under Plans H and I. And then the extended benefit is covered under Plan J. The basic drug benefit pays 50 percent of prescription charges after a $250 deductible up until you accrue $2,750 of drug charges.

The extended prescription drug benefit pays also 50 percent after the $250 deductible, but it goes up to a prescription drug level of $6,250. So there's a $3,000 maximum on that benefit.

I know Marty will be getting into this more, but the Part D benefit that's going to go into effect in 2006 will pay 75 percent of drugs charges between $250 and $2,250. It pays approximately 95 percent of drugs after the person hits the $5,100 level.

One of the key things about the MMA is going to be whether the existing drug coverage that a person has is creditable, in other words, whether it is actuarially equivalent or better than the Part D benefit. This comparison is going to become important.

Helwig Slide 2, page 3 is a grid that shows what the various building blocks are and what each of the benefits is that goes into the 10 standardized plans right now. Again, as you can see, Plans H, I and J are the only ones that contain the prescription drug coverages.

Let's talk a little bit about some of the direct effects of the MMA on Medicare Supplement policies. First, the MMA is trying to encourage people to join Part D. They have made it very clear that there cannot be any Medigap policies with prescription drug coverage sold after January 1, 2006. They want to encourage people to buy Part D instead. In fact, there will be actually criminal and/or civil penalties for any company that continues to sell a Medicare Supplement plan with prescription drug coverage in it after Part D becomes effective.

That is not to say Plans H, I and J will go away. A company can still continue to sell plans H, I and J, but the prescription drug benefit has to be stripped out. If you go back to this grid, you can see that if you take out the prescription drug piece of H, I

and J, you still do have unique plans from the other 10 standardized ones. They're very similar to some of the other ones that are out there. Plan H becomes almost identical to Plan C, except that it doesn't cover the Part B deductible. Plan I becomes virtually identical to Plan G, except that it covers Part B excesses at 100 percent instead of 80 percent. Plan J is the only one that still stays unique, because Plan J covers every possible ancillary benefit that there is. So a company could continue to sell these three plans, but it needs to strip out the drug benefit starting in 2006.

One of the other direct effects of the MMA on Medigap policies is that two new plans are being introduced: Plans K and L. The purpose of these plans is to introduce more cost sharing for the insured. In particular, both of them will still continue to cover 100 percent of the core benefits—those hospital copays and excess days. But some of the extra benefits that are covered at 100 percent under the other plans will be covered to a lesser degree under Plans K and L. The Part A deductible will only be covered at 50 percent on Plan K. Skilled nursing facility copays, blood and the Part B coinsurance all are only going to be covered at 50 percent. The one exception to that is that they will continue to cover coinsurance on Part B services for preventive care. Again, they are trying to encourage people to get early care, but then also have a significant cost sharing aspect of this.

On Plan K, there will be a $4,000 out-of-pocket maximum in 2006 that will be indexed going forward. Plan L looks exactly like Plan K except that everything is covered at 75 percent instead of 50, and the out-of-pocket maximum is decreased to $2,000.

Under existing Medicare Supplement plans (and this is regardless of whether it's one of the 10 standardized plans sold after 1991 or an older pre-standardized plan), if a person opts to enroll in Part D, that existing Medicare Supplement plan that has prescription drug coverage has to have that prescription drug benefit stripped out of it, and the person is given a reduced premium. There's going to be a choice for them if they enroll early, and I'll get to that in a second. But you should note that a person can decide to not enroll in Part D, and then they can continue their Medicare Supplement coverage with prescription drug coverage. Nothing will change for those people.

If you go back and look at the benefit comparison that existed and consider the fact that the federal government is basically subsidizing the Part D plan by paying about 75 percent of the premium, you have to wonder why somebody would stick with some of the standardized plans. But there are some exceptions to that. There are some states that have standardized policies with very liberal drug benefits, and a person might be better off sticking with those. It will be a lot more expensive for them to do so, but they have that option. They can opt out of Part D or not enroll in it, and they can keep their Medicare Supplement plan as it is.

Those that do enroll in Part D will be given two choices if they enroll in the initial

enrollment plan, which is slated to go from November 15, 2005, through May 15, 2006. The first option is that they will be given a modified version of the Medigap policy with the drug coverage stripped out, and the premium has to be reduced proportionately for that. Or they are allowed, if they enroll during this open enrollment period and pick this option within 63 days after enrolling in Part D, to drop their Plan H, I or J and be guaranteed issuance in another plan that the company is willing to offer to them. The regulation says that companies at least have to offer Plans A, B, C, F, high-deductible F, K and L if they make those available. So there are going to be some implications to the choices that a person picks here, which we'll come back to in a little bit.

If they enroll in Part D and then wait beyond 63 days afterward, they no longer have the option of doing the guaranteed issue into one of the other plans. Their only choice at that point is to keep their Plan H, I or J with the prescription drug benefit stripped out.

The insurer has to notify all of its policyholders within 60 days before the Part D enrollment starts as to what their options are. There are a lot of states that have not even gotten geared up and gotten things passed. We're going to have a busy time in the next 60 days, for companies to get that in place, because the rate reductions on Plans H, I and J need to be filed, approved and ready to go by November 15, 2005.

As I stated, the policyholders have to be notified as to whether their current prescription drug coverage is creditable or not, which, loosely described, means whether it's actuarially equivalent to Part D. That has to happen within these 60 days prior to open enrollment starting. If it's determined that somebody's coverage is not creditable and they are informed of that, the implication is if they decide that they want to stay with their Medicare Supplement policy and not enroll in Part D and then decide later on that they do want to enroll in Part D, there are going to be some pretty significant late enrollment penalties. In particular, their Part D premium will be increased by 1 percent per month for every month that they enroll late. So somebody finding out that their coverage is not creditable and then sticking with their Medicare Supplement policy has some potential future implications.

The Centers for Medicare & Medicaid Services (CMS) have issued some standard language for notification. The standard language, if any of you have seen it, is two or three pages long. It's a pretty complicated document. There is definitely some concern in the industry that people are not necessarily going to read the whole thing and understand fully what's being said, and some of this creditability notification might get lost.

One important point to note, and I think it's something that's gotten buried and maybe hasn't gotten enough attention, is that these creditability notifications have to be sent to anybody who has any health coverage who is over 65. That includes major medical policies and hospital indemnity—anything where the person has

continued coverage past age 65. One of the things that I find interesting is that major medical policies are not required to strip out the prescription drug benefit. So you could, interestingly, have somebody enrolling in Part D and have a major medical policy with a prescription drug benefit. Consequently, they've gotten duplicative coverage, but that was not really addressed in the regulation.

It's pretty obvious, if you look at the benefits, that Plans H and I are clearly not creditable, and CMS has stated that as such. Based on our calculations, we don't think Plan J is creditable either, but CMS did leave that one open and said that a company can make that determination. I suppose it's possible that somebody's own data could indicate that it is, but I think that would be pretty unlikely.

We did a survey last spring of 25 Medicare Supplement carriers who sold policies that had prescription drug coverage in them. One of the things that came out of that survey is that at least half of those companies said that they had some pre-standardized business that they were determining was creditable. So this creditability issue is probably going to affect the older pre-standardized blocks more so than the current Plans H, I and J.

I want to talk a little bit about what some of the indirect effects of this regulation are on Plans H, I and J, particularly. Currently, Plans H, I and J have premiums that are significantly higher than their counterparts or the closest other similar coverage. That is because in the Medicare Supplement environment, not surprisingly, the people who choose Plans H, I and J are the less healthy insureds, so their morbidity on all of the benefits tends to be significantly higher than somebody who takes Plan C or Plan F, for example. If you go in and pull out the actuarial value of that prescription drug benefit and reduce the rates proportionately for that, you'll probably still have rates that will be quite a bit higher. For example, we said Plan H was very similar to Plan C. If you pull out the cost of the drug benefit, Plan H premiums are probably still going to be a lot higher than Plan C.

That creates a couple of issues. One issue is that, for any companies that want to continue selling Plans H, I and J, they're probably going to have very uncompetitive premiums compared to another company that decides it is now going to start selling Plans H, I and J without the drug benefit. A company cannot, according to the regulation, segment its rates and have a different set of rates for new business versus renewal unless you meet a number of conditions. So companies that want to continue selling these plans are probably going to look fairly uncompetitive compared to new entrants.

Secondly, for companies with a large proportion of their policyholders that have Plans H, I and J, if those people end up being presented with a rate reduction on Plan H, for example, that is a significantly higher premium than that company's premium for Plan C, they will likely opt within the 63 days to do the guaranteed issue conversion to the other plan that the company has. That will have some ramifications going forward on what the experience on those conversion plans is for

those companies. We can expect to see some higher trends on those and some worsening experience next year.

There is a Medicare Supplement Compliance Manual that gives the states some advice on how they should interpret the regulation. One of the things that the compliance manual added that is not in the regulation is that they are recommending that companies be required to segment their experience on Plans H, I and J with the drug benefit for the people that keep the drug benefit versus those that do not for both experience analysis and rate increase purposes.

Again, the survey that we did found that most companies are planning to just pull out the value of the drug benefit, even though that means that the remaining premium is worse or that the premium that is remaining is significantly higher than the corresponding plan, and that they won't do anything for the premiums on those other plans at this point. They'll wait to find out how many people do the conversion, how much worse the morbidity is and then do some catch-up next year in terms of a rate increase.

There are a number of additional complications that I won't get into here, but there were three states that were grandfathered in when the standardization happened back in 1991: Minnesota, Wisconsin and Massachusetts. All three of those states have an optional plan that has nearly full prescription drug coverage. In all three of those states, that option is clearly creditable, and it's going to create some other issues. In particular, it gets complicated in Massachusetts, because most people there did take the plan with the full drug benefits. When you pull those benefits out, the benefits are absolutely identical to the other plan, which has significantly lower premiums. How that is all going to shake out still remains to be seen.

There are a number of administrative complexities in how these drug plans will work and how the process will work. The company needs to get notification for all the people who are enrolling in Part D. There are questions as to what happens if the person just doesn't notify the company. How much work do you have to do to try to track them down? You're required to refund any premium that a person paid past the point in time when they enrolled in Part D. There are questions on how you do that. If a person paid a modal premium that took them past that date, do you have to refund that? How do you go about actually doing the conversions? Does an agent get involved? Do you take a new application? There are some companies that have left the market, so they don't have a policy for the person to convert into or they've changed their rating methodology. There are a lot of complications here. One of the other ones is that we have a lot of states that still have not passed the enabling the legislation, and this needs to be done very soon.

We've actually seen a lot of companies getting into Medicare Supplement in the last year or so, which hadn't happened for a while. But I think companies are starting to look at whether they view this as a core product for them or not. Companies that are in both Medicare Supplement and Medicare Advantage have a lot of

considerations because of the Medicare Advantage changes that are going on as far as how those two interact with each other.

The other thing that we've seen a lot of in this last year is many of the Medicare Supplement companies are starting to develop affiliations with pharmacy benefit managers (PBMs) that are going to be offering Part D, so that they can send their agents out and have them enroll the policyholder in Part D and sell them the Medicare Supplement product, and package the two of them together so the insured still gets one-stop shopping. With that, I'm going to turn it over to Marty.

MR. MARTY HILL: I'm with PricewaterhouseCoopers. I've been with the firm for about 10 years. My background has been mostly in employer consulting, mostly on retiree medical valuations. When the MMA hit late in 2003, it certainly worked itself into my day-to-day routine. That's almost exclusively what I am concerned with now—consulting with the employers and getting them ready for 2006.

We were involved in commenting on the draft regulations from CMS this past summer. A number of us were involved in actually reviewing the bids for the Medicare Advantage Prescription Drug (MAPD) plan and prescription drug plan (PDP). Is anybody in this room on the receiving end of any of those reviews? I see some hands. I guess we should have had some bulletproof glass up here. I want to let you know that we were just doing our jobs. Don't hold it against me. I was just a messenger. It wasn't my fault.

Anyway, I will be talking about Medicare Part D, the drug benefit, with an employer slant on it, talking about some of the employer options. This will naturally segue into the employer drug subsidy, which is the most popular option. I'm going to go through a little bit of the Part D basics for those of you who aren't too familiar with them, including some recent updates on Part D and what's been happening this past spring and summer. I'll go over the employer options, how they've responded to those options and focus on the retiree drug subsidy (RDS).

Medicare Part D is offered through the private sector. There are two acronyms to consider for Part D here. The stand-alone prescription-drug-only plan is called a PDP. If you're part of a Medicare Advantage plan, then that's an MAPD combined entity. There are various types of Part D coverage. One is the standard Part D design that Dawn briefly touched upon. There are alternative or actuarially equivalent plans that have slight variations on that plan design, but are roughly equivalent to it with a lot of rules about how you determine how they're equivalent. There's the enhanced alternative coverage, which lets you basically offer whatever benefit you want as long as it's at least as generous as the standard Part D. You have to separate it into the Part D section and the supplemental section. You put that together and that's enhanced alternative coverage. There's also wraparound coverage that's structured to fit around the standard Part D.

Part D is offered by a host of different entities: insurance carriers, PBMs and

hospitals. Even some employers were considering filing as PDPs for offering drug coverage to their retirees, though I don't know how many actually went through with it in the end. I'm not personally familiar with any. There were numerous requirements that were laid down for anybody who was offering a Part D plan, including formulary and retiree access, and they had to have a national PDP network set up, with certain exceptions. There are solvency requirements and licensing requirements. And as people asked more and more questions of new entities who were trying to get into the PDP business, CMS started granting various waivers that I believe held for 2006 with another round of consideration for 2007.

Then there is the bid review process, where anybody who wanted to file as a PDP or MAPD had to file this summer. There was a review process that happened after that. There will be a separate audit process that happens later on this year for some of those plans.

Next I'll get into the description of Part D. Hill Slide 3 is the chart I grew up with, so I kept it here. It's focusing on the retiree standpoint, the shaded section. The black sections are out-of-pocket spending. That's the more complicated way to view this. If you view it from what the plan is really covering, it's 75 percent of claims from $250 to $2,250, and 95 percent of claims after $5,100. This is the oversimplified version of what the standard Part D looks like.

If you get into some of the details, for instance, it's not really $5,100 in 2006. That's the overriding rule for the catastrophic coverage. It's really whenever the retiree hits $3,600 in true out-of-pocket (TrOOP) costs, which we'll get into in a second. Also, that catastrophic coverage of 95 percent is not really 95 percent. It's like the retiree pays the lesser of 5 percent or a $2/$5 copay system. And even then, as far as who's paying for what in that 95 percent, it's ultimately 15 percent from the plan and the other 80 percent is from the government in reinsurance payments.

I'll get into a little more detail on TrOOP spending. TrOOP has been a thorn in the side of those trying to price out the standard plan and to work with it, because it's somewhat of a moving target. Coverage changes once the total out-of-pocket spending is $3,600, so you necessarily have to track who is covering it for the retiree, whether it's the employer or whether they've enrolled in another plan and they're paying some of the benefits. It gets into benefit coordination issues.

TrOOP is the amount that they have to spend on just the Part D-covered drugs. It is an elusive list of what's a Part D-covered drug. It's not a Part B drug, which tends to relate to drugs administered in the hospital. There's also a short list of Part D-excluded drugs. The beneficiary has to pay a Part D premium. That premium payment doesn't count toward the TrOOP. According to the regulations, coverage by "insurance or otherwise, group health plan or other third party payer" does not count toward TrOOP. As far as the retiree spending accounts, health savings

accounts (HSAs) count toward TrOOP, but health reimbursement arrangements (HRAs) do not. The reason HRAs don't count is because those are employer dollars.

For the standard Part D plan, the coverage limits are all pre-indexed to go up with increases in drug costs. The Part D premium itself is 25.5 percent of covered claims, including administration and profit. If you read the definition in the regulations, it says 25.5 percent of the different amount, the bid amount with all these adjustments. And when you work out all the math, it basically comes down to 25.5 percent of just the part the plan covers, what the retiree sees.

The initial estimate by CMS was about $35 a month, $420 annually. After reviewing all of the bids and approving all of them, they computed a national average that was actually about $3 lower a month. That coverage chart that I showed you is only true for "normal" retirees. Those that are eligible for a low-income subsidy from the government don't pay all of those provisions. At the top of the list are those that are dual eligible with Medicaid and institutionalized individuals where at the end of the day they don't pay for anything out of their own pocket.

There's also the income and asset test, where if your income is below 150 percent of the federal poverty level, and you have assets below $10,000, you qualify for the low-income subsidy. I think that's the minimum, and it has a minimal amount of subsidy. There are actually various tiers defined by the government and various levels of the subsidy.

Another issue with the dual eligibles that's been a source of some consternation is that CMS intended to automatically enroll dual eligibles into a Part D plan because it's such a good deal for them. It has caused a little bit of backlash from employers who said, "Well, wait a minute. What if they're in my plan? I want them there so I can get the subsidy." But now I think they've backed away from that automatic enrollment for everybody, maybe just for those without the employer coverage.

I have some recent updates on the Part D perspective over the spring and summer. For this RDS for employers, CMS set up an RDS center in May of 2005. They set up a Web site as of June 1, 2005. For those of you who have been tracking the CMS Web site as it is related to Part D, it's gone through numerous changes. It still isn't quite there. But they segmented a whole site just for the RDS. The things for the PDP and MAPD were submitted on June 6. The review was substantially ended at the end of August or early September. There was a national conference held in Dallas in July 2005 to talk to employers about some of the administrative aspects of the RDS. They computed the national average Part D premium in a standard bid. That was released in early August. They released some guidance or some stats on the PDP premiums by region. CMS wanted to encourage a PDP player in every region in the country. We weren't sure how many takers they were going to get and, as it turns out, there were 16 to 23 different standalone PDP organizations to choose from. So they actually got quite a bit of participation. When the bids were submitted June 6, we found out from the inside that there were actually about twice

as many as CMS expected to receive. So when they mapped out with all of the companies they contracted with to review those bids because of the timeline, they were surprised to find they had twice as many as they expected. There's definitely lots of interest in playing in the Part D market.

I'll switch over to the various employer options. These options have been out and communicated ever since the end of May rollout. The most popular option is where the employers are actually encouraged by CMS to maintain the employer-provided drug coverage. As long as it's qualified and actuarially equivalent, they'll receive a 28 percent tax-free subsidy, roughly 28 percent of drug claims. Otherwise, the employers can supplement Part D. "Supplement" is probably a poor choice of words; I'd like to say "directly take advantage of" Part D. They can redesign their plans to wrap around the Part D coverage. They can contract with an organization offering a PDP or an MAPD, to offer their benefit design or a supplemented benefit design to Part D. Additionally, employers can actually file as a PDP themselves with some waiver benefits that others don't enjoy.

Of course, another option is that employers could eliminate the drug benefit altogether with somewhat of a clear conscience because at least there's some drug coverage out there now that there wasn't before. A variant on that is they could subsidize at least all or part of the Part D premium that the retirees would have to pay. And, of course, there's also the impact on the employer's Medigap HMOs and Medicare Advantage programs.

The response to all this is, first and foremost, even though when the MMA came out in late December 2003, the employers were required to reflect the impact on their financial statements, those that post the FAS 106 liability for retiree medical obligations, by the third quarter of 2004. So while a lot of the details weren't spelled out in the regulations on how to do actuarial equivalence and who would be eligible for what, everybody had to estimate something and book something. If you were PricewaterhouseCoopers, you had to audit that something. It made for a challenging year in 2004.

Once they got past that hump in 2004 and focused on what they were going to do in 2006, a large majority of them ultimately decided they were just going to play it safe for the moment. They were just going to keep their current plans. They had a decent estimate of what the subsidy is going to mean to them, and they'll wait and see what happens in 2007. Because CMS was fairly late in some of the details, they did a fantastic job of sifting through everything and getting the regulations out in time; supplemental information rolled out every month from all different aspects of this thing. But in the end, it caused employers to just want to wait and see how the market shakes out and not do anything too drastic. So that was the reason, I think, the majority of them selected the subsidy for 2006.

Some of them, unfortunately, decided to use Part D as a way to get out of providing retiree drugs and, some of them, out of the retiree medical business. Some of them

decided that they were going to offer a coverage that wraps around the standard Part D benefit. It's been challenging for them. We'll still see how that flows out this year, because the details on coordinating with other carriers, because of the TrOOP provisions, had a lot of organizations hesitant to showcase a product where they would just offer anybody wraparound coverage. So they've had to work through that to get ready for 2006. Some of them contracted with PDPs to offer coverage. Very few actually became PDPs themselves. And some of them have already made all their changes to the program and changed the plan documents and are biting their nails for 2006.

I want to switch to some of the illustrations of the different options (Hill Slide 10). In this first option, this is the employer plan as is, shown in a simplified chart. The darker section is the employer cost. It also shows the retiree out-of-pocket cost: copays, deductibles, what have you, and retiree contribution, the earmarked premium the employer charges them. That is the initial setup before the MMA. With the MMA, where they choose the employer subsidy, basically these don't move. From the retiree's perspective everything is the same, but now the employer gets some of this money back in the form of a subsidy.

This next option can be a logistical nightmare, but the idea is to wrap around the standard Part B. From the retiree's perspective, they're still paying the same out-of-pocket costs. It's almost as though they don't know they're in the Part D design. They are still charged the same contributions by the employer, but someone has to pay the Part D premium that goes along with enrolling in the standard Part B. That's usually the employer in these situations. What I call Medicare payments is on the chart, but it's really the part of the benefits covered by the Part D plan that they enrolled in. Of course, the key thing for employers is their cost and how these pieces compare to each other. It's been hard to nail down the details, especially early on in the year when they've been trying to make these key decisions.

The last option shows what it looks like when the employer is basically out of the picture, with the retiree paying the out-of-pocket costs associated with the standard Part D, including the amount paid by the plan and the Part D premium. The slide actually exaggerates a little bit of the aspect in comparing this third and fourth option. When the employer is wrapping around the standard Part D coverage, because of the TrOOP provisions, it's pulling away dollars from the table that would be provided by the government, the catastrophic coverage that hits the 95 percent coverage by the plan where 80 percent of that is from the government. At the end of the day, there are fewer government dollars on the table if you do this wraparound than if you had just gone with the standard Part D coverage. It's not quite such a pronounced difference as I have in the slide, but that is a consideration.

Since this is such a major topic this year with employers, I thought I'd talk a little bit about the RDS. It's provided to employers who sponsor drug coverage that is at least actuarially equivalent to the standard Part D Plan. "Actuarially equivalent" was

defined in the final regulations that came out in late January. Everybody was so eager to read those regulations. When they finally came out, they said there is additional guidance to follow. And the additional guidance only came out piece by piece. It's still not 100 percent there yet, but at least now finally everybody has a decent idea of that. Don't blame the SOA for not issuing anything on actuarial equivalence. They were waiting for the answer themselves.

The employers receive the subsidy for every qualifying covered retiree participating in their plan. Very recently, in the last couple of weeks, CMS finally came out with a special document clarifying exactly who these qualifying covered retirees are. They are retirees who are entitled to Part A or enrolled in Part B. They can't be enrolled in a PDP or an MAPD plan. If they are, then the employer is disqualified from getting a subsidy for them. Part of the challenge is they can't tell them not to enroll in a Part D plan. They could just encourage them not to. The retirees also have to, of course, be receiving coverage through the employer's PDP.

Part of the recent clarification is that it's based on the status as a retired participant under the plan. The regulations, I think, worded it as they had to be covered under the retiree plan. Sometimes it wasn't always clear what the active plan was versus a retiree plan. What do you do with disabled individuals? The rules were clarified at the time of the Medicare secondary payer rules. If you're disabled beyond six months, Medicare is primary and you're in and you could spin it as being a retired participant. Post-65 retirees and post-65 dependents of retirees are also qualifying covered retirees.

The retiree subsidy itself is 28 percent of allowable costs between $250 and $5,000. Allowable costs are the actual incurred claims costs, net of discounts and rebates, including the dispensing fee. It is not net of retiree out-of-pocket costs like copays and deductibles. You can only consider the Part D-eligible drugs. So that's part of the administrative issue that a lot of vendors are working through: when they're tallying these claims for the retirees, they have to keep track of which ones are Part D-eligible drugs. The subsidy was estimated in CMS to be about $668. I don't recall if I've seen an updated estimate from that, but, personally, I think it looks a little high. It's probably closer to the lower $600s.

I'm going to talk about the actuarial equivalence test. In order to determine whether a plan is actuarially equivalent to the standard Part D plan and thus to be able to have the employers say that they're eligible to receive the subsidy, you had to pass a gross value test and a net value test. Unfortunately, CMS redefined what gross value means. Gross value is really the allowed claims cost that I mentioned before, net of retiree copayments, deductibles, what have you. The gross value really is kind of a net value, in a sense. The first test is that on a gross basis it has to be at least equivalent to or better than the standard Part D. Then you have the net value test, which is if you net off any retiree contributions or premiums, how do the two compare? And that's how it was ultimately defined by CMS in the regulations.

Then you get into the definition of a plan and the different plan options, and that was also covered by guidance that was released in pieces. Basically, your top definition of a plan is however you filed it with the 5500 form using the COBRA definition. You can have benefit options defined under a plan where a lot of employers have different grandfather groups of retirees; those who retired prior to 1993 don't pay any contributions, but those that have retired after 1993 pay 50 percent or something. They're allowed to call those two groups two different plan options. Under the rules, every individual option that you determine in your configuration when you're trying to attest to actuarial equivalence has to pass the gross test, which you are allowed to combine for purposes of the net test.

There have been a lot of details coming out on actuarial equivalence. They have to be based on the employer's claims experience, if it's credible. That was a clarification that if you had enough retirees you couldn't just use a rating manual, you had to use the employer experience. There were limited safe harbors. I think the standard Part D plan is so different from a lot of employer plans that it was really hard to come up with some safe harbors that applied in a lot of cases. You can only recognize the value of the drugs covered by Part D, so when you looked at the employer experience you had to find a way to carve out the non-Part D drugs. You're allowed to include a utilization adjustment when using that data to calculate the value of the defined standard plan.

You can do a TrOOP adjustment to the value of a standard plan if the employer's plan is going to coordinate with those who elect Part D and stay in their plan. Employers have the flexibility of allocating contributions between medical and drug without it even being in the plan documents. That last provision helped a lot of employers pass this net test, because if they charged retirees 50 percent in contributions, they could allocate all those retiree contributions first on the medical side and the leftover piece to the drug side, thereby passing the net test.

As far as what's happening now with the RDS, employers are focused on completing this application. The application was due September 30, 2005, but you could get a one-month extension. Probably everybody in the country requested it, so CMS just declared that everybody gets a one-month extension. Employers are preparing their retiree list to submit with the application. They're trying to work out the details with their vendors. Can you do everything you have to do to comply with getting the subsidy? How much is it going to cost? They're trying to figure out what to say to the retirees.

For the vendors and carriers, they are finalizing all the service contracts. They are generating all the data for the actuaries like me who keep bugging them for better and more detailed data than they have in the past. They're trying to work through all the administrative items and data requirements themselves.

At CMS, they have been working nights and weekends for a year and a half now

processing applications, releasing additional guidance, looking at the retiree lists, trying to get their Web site to work and preparing a coordination of benefits center to go live on January 1, 2006 to handle these TrOOP provisions.

The retirees are soon going to get a flood of information. I think the plans can market directly to them as of October 1. Some of them have already received some information from CMS: basically the dual eligibles and some of the low-income-subsidy-eligible people, warning them about this, that it's probably going to be a good deal for them so to keep an eye out for it. Consequently, retirees, unfortunately, are probably largely confused at this point. With that, I will turn it over to Don.

MR. DON ZHANG: I'm with WellCare, a company that specializes in government-sponsored programs, so we only do Medicare and Medicaid. That's all we do. Before joining WellCare, I was with WellPoint, managing the department of actuarial functions supporting WellPoint's Medicaid business. So throughout the past 10 years as an actuary, most of my work was surrounded with Medicare and Medicaid products. That's all I know, and I hope I can bring some interesting observations about our products. The content of my presentation may be foreign to you, because most of you may be interested in the valuation aspect of the product or you are not health actuaries. Or you are health actuaries, but you are very familiar with the commercial products.

Here we're talking about a very special part of the health product: managed Medicare products. How many of you are familiar with this managed Medicare product concept? It looks like quite a few. Let me start with the definition of the managed Medicare product. This is a very interesting concept. The government has transferred risk to insurance carriers by paying the capitation dollar to insurance carriers so that the Medicare members will receive services from the insurance company. It's aimed to create a win-win-win situation for all three parties involved. The government itself will save some money, because it pays the capitation dollar based on 95 percent of the anticipated payment out of its own pocket, if it's on a fee-for-service basis. From the insurance company's perspective, of course, it's a product that can make money, so that is a good business opportunity. And from the members' perspective, they may receive richer benefits than they would have received from traditional Medicare. For example, they may get some drug benefits or hearing aids or lower copays. So it's a very good concept. But the product itself has evolved over time.

When I was with my first insurance company, working with Cigna, the product was called a Medicare Risk product. Later it became Medicare + Choice. Now it has become Medicare Advantage. So, what's new? Of course, MMA creates lots of job security for health care actuaries. But what's more important is it fundamentally changed the way the premium is determined, what benefits need to be covered and also the scope of members' choices. I'll go over some of those parts later on.

What I really want to talk about is something called the bidding process. Historically, we have had the so-called adjusted community rating proposal (ACRP) process. Essentially, you tell the government, "I anticipate you'll give me $500 a month. Out of this $500, how do I use the money to cover the benefits I promised to my members?" But at the same time, those justifications should be actuarially sum, and you have to leave some profit so that you show government that you are a company doing serious business. Then again, that profit margin cannot be excessive. So this is the so-called ACRP process. Of course, many companies do their own exercise and this becomes a ridiculous process. Remember, if you miss by a penny, you just cannot pass through.

In 2006, with MMA things have changed dramatically. Roughly speaking, again you calculate how much money you can get from the government on a monthly basis, say $700 or $800 for a particular member in a particular county. Then you tell the government how much money you spend to cover the basic Medicare fee-for-service and Medicare benefits, because you have to provide at least as rich benefits for the member as if they had gone through fee-for-service traditional Medicare. So that number would be much smaller than the total dollars you'd get: $500 versus $700. This is called a bid for what you think you can cover.

Now there's a difference between $700 and $500 ($200). Out of this $200, you can retain 75 percent of it, what we call a rebate, to provide whatever additional benefits you want to provide to members so that you can make your product competitive in the marketplace. The government takes the 25 percent back. So essentially, in my eyes, it's like a luxury or consumption tax. For every $3 you want to provide in additional benefits to a member, you have to pay $1 to the government. The government gets a shared savings out of this bidding process to fund their Part D dollars. So this is the first meaning of bidding.

There is another layer of bidding, talking about MAPD, a Medicare Advantage plan incorporated or integrated with a Part D plan. So you have another bidding for Part D. In bidding for Part D, you try to estimate what the national benchmark is or what your estimate of cost is. If there is uncertainty at the time you submit your overall bidding package, when all the bids are collected, the true national benchmark will be determined. At that time, you will see a difference between what you anticipated and the actual benchmark differences.

Now the fun starts. If you anticipated too much for the national benchmark and it's actually lower, that means that you have to cut your other benefit already submitted to balance that out. Or, on the other side, you cannot give additional benefits to the members. And they allow you a 50 cents leveraging to move around. So if a company hadn't thought about these consequences in a sophisticated enough manner, at the end you have a $3 difference you have to make up.

It's very difficult, because when you design a certain package of Medicare products, you really want to make sure you have a competitive advantage in certain markets

and that all benefits designed are well thought out. Any change such as a $5 copay on a primary care physician (PCP) fee or a $10 copay on a specialist will probably change the product picture. But then you still have the $3 to balance. So this has been a very hectic summer for most companies. I guess this is a lesson learned. You have to have some flexibility when you submit your first bid and anticipate there will be differences. That's why I wanted to pause here a little bit to talk about the bidding process. I think the old insurance companies are probably going to have difficulty understanding the bidding mechanics.

In 2004, a little more than 10 percent of the Medicare-eligible members were enrolled in HMO plans, and it is projected that about 30 percent will be in a managed care plan by 2009. As the population itself grows, as well as the penetrations, you will see roughly 10 million more members getting involved. These are business opportunities.

Let's look at the business opportunity. Roughly speaking, one Medicare member is equal to about four commercial members. The monthly premium is about $800 per month per member (PMPM), and we anticipate making about 6 percent or 5 percent profit margin. On an annual basis, you can make about $500 before tax for one Medicare member on average. So even if a block of business has about 100,000 members, with $500 annual profit, that will bring you $50 million. With 10 million members, there are five zeroes after that. So it is truly a place that you will see a lot of business opportunities. That's why I feel that more and more companies will get into that arena.

What are the considerations when you design that managed Medicare product? There are many things to think about. Do you get adequate premium in the area you want to service? What are the competitive situations in a certain region? The MMA provides many different types of plans that a member can choose from, from original traditional Medicare, to Medicaid supplemental product combined, to HMO and PPOs, and then we see something called a private fee-for-service and the special needs plans (SNPs).

I guess most of you know HMOs and PPOs, so I don't want to spend time talking about those. But there are two new products that are worthwhile to mention. One is called the SNP. The other is private fee-for-service. In the old days, Medicare was very strict regarding how you could design a product. You had to have a product on a county basis. You had to have a network broad enough to cover the member and service area, and you also could not discriminate against any type of member. If you had a product open to any senior, everybody could go.

In order to encourage innovative design, to service a very specific segment of a population, CMS allows you to have creativity in 2006 and beyond to create something called an SNP. You can identify members through special characteristics. One is their eligibility criteria (for example, some Medicare members are dual eligible for Medicare and Medicaid, the low-income seniors). You can have a plan

that services just those members. Or you can have a plan for members with certain chronic conditions, like chronic heart failure (CHF) members or diabetics, or a population with mental health problems. Also, you are allowed to have a plan that only has one or two facilities. You don't have to have the entire county or the whole network. So that adds a lot of interesting thoughts. What do you think about a company's competitive advantage? What are you good at? Do you want to do an SNP?

WellCare actually filed and got approved for two types of SNPs in 2006: a plan for fully dual eligible members and a plan for partial dual eligible members. We are thinking about doing more SNPs in the future.

The other plan is called private fee-for-service. Private fee-for-service is, of course, a private insurance plan. But also it's fee-for–service, so there seems to be no managed care aspect on it. Actually, it's kind of a hybrid plan. In many rural areas, you may not be able to get a network. Or in some areas, CMS intends to encourage more participation and more choices for members. So they pay you slightly more than what is needed to cover fee-for-service benefits, and this creates an arbitraging opportunity.

If you work as an actuary, you are smart enough and you look around the whole country to find out where you receive higher APCC CMS dollars to anticipate a claim cost for a member for fee-for-service. That, again, can offer you a profit margin. It also gives more benefits to the members. More importantly, this is the kind of product that does not need a network. All hospitals and doctors are deemed the providers. As a member, you are not restricted—you can select any hospital or any doctors. There are no PCPs. To a member, it's a good plan because you have the same access. You also receive richer benefits. And from an insurance company's perspective, you can make money if you are good at identifying these opportunities. All those benefits create a lot of interest in private fee-for–service.
In the past few years, a couple of companies have entered the market. They are looking at the low-end market. Mostly it's $0 plan, $9 plan. But I'm thinking that someday you probably want to have a very rich private fee-for-service plan providing the benefits that are equivalent to the traditional fee-for-service, plus the Medicare Supplement policy. I guess Medicare Advantage truly brings a lot of thinking to the insurance companies and the actuaries.

I want to talk about regional PPO plans. This is another interesting idea. This year they want you to introduce other managed care products. They divided the whole country into 26 divisions. They have a very, very difficult formula to calculate the anticipated premiums.

I was reading an article written by a couple of research scientists from Boston University and another one from the University of Minnesota. They were criticizing this regional PPO plan and its design. They said it's fundamentally deficient. They're saying that for a regional PPO plan you get average of premium across the entire

region, but then, because within the region you have certain companies with a chief accountant to provide the service, certain companies are more expensive companies to provide the services. If you use the average dollar to compete against the low-cost company, you'll have an advantage over those HMO plans.

But what really happened is that they don't understand how the premium is being determined. They don't understand the premium you get, or the difference between a true premium revenue dollar versus the bidding versus the benchmark dollar. They are only looking at the benchmark side of that. In reality, CMS actuaries have always thought about this kind of a game plan. So they designed another factor called intra-county, intra-service area rating. Basically, this factor will give you an additional adjustment—if you are in a lower county, then your premium will adjust down by the relative value for this low county to the regional average.

My point is not to introduce you to the regional PPO plan; I'm simply saying that the regulation itself is very sophisticated and complex. We, as actuaries, perform a very important function in an insurance company or as a consultant. We have to understand all the regulations and follow the most recent developments, and thus we can provide accurate and good advice to our clients. I just can't believe that those articles have been published. When a company CEO came to me, he said, "I'm very worried, because that means my HMOs cannot compete in those counties because those PPOs are there." It's not the case.

The last thing I want to talk about is the so-called risk adjustment methodology. I think actuaries will also be interested to hear this topic. In the past, in the beginning of the Medicare program, you were paid a premium based on where your member lived. So there were geographic differences. It also depended on the age and gender of the member. Along the way, people found out that the age and sex factors, especially for the senior populations, may not necessarily be good indicators of how much claims costs would be per member.

Since about 1998, there have been three or four different methodologies to try to use the historical claims experience to predict your future expenditures. All in all, they want you to design a perfect system such that you get compensated adequately. You don't design a product to discriminate against members that may have potentially high claim costs, because in the future you have a system that's perfect, and you will get compensated using a certain risk score. It's a very difficult task. So far, there's no such perfect system. Even with such a perfect system, the methodology itself has some fundamental flaws. For example, what if someone didn't have any claims next year? Theoretically, you aren’t supposed to get any dollars from CMS. But you would never design a system that has a risk score of zero, right? So you will get something from CMS, even if that person has been healthy and doesn't go into the hospital for five years. You will still get something. Of course, it's a zero dollar, zero balance game. On the high end, you still will never get enough money to compensate for a high-risk claimant.

With this 2003 MMA regulation, they want to move more and more of the premium payment through its risk adjustment premium methodology. In the past, it's been 100 percent demographically driven. Along the way, it becomes 25/75. I think in 2005 it was 50/50. In 2006, you work at 75 percent of premium that is risk-adjusted and 25 percent adjusted by demographics, and eventually you will be 100 percent adjusted by risk factors.

There is another challenge for insurance companies. All those risk factors are based upon the claims experience. It all depends on how that claims experience is being reported or submitted to CMS. What if you have lots of capitation providers? They get cap dollars. They don't even bother to have the medical records or submit claims, because it takes away the doctor's time. Then from CMS, we're outpatient heavy because we never receive any reports for medical history. Immediately a lot of companies tried to think of any revenue enhancement initiatives—what my company can do such that we submit as much accurate information as possible, or more relevant information as possible, that makes CMS believe I have a sick population.

The industry has responded, and I think there are lots of companies that, if you allow them to work, do a good job. Very recently, we received a notice from CMS saying that because every company submitted such an improved risk score data, they believe that they are going to overpay us in 2006. CMS does have something called risk-scaling or balancing factors. They anticipate at what kind of level you will report, then they adjust it back. Again, it's a revenue issue. But this year they found out that most companies have improved and they're way ahead of CMS. So CMS will be overpaying companies a little bit more in 2006. They said they will take it back in 2007 through 2009 or something like that. This is a very interesting thing to observe, and it also brings other business opportunities. There are smaller firms that just provide a service to improve your economic data quality.

But I think risk adjustment will continue to evolve, especially on the Part D side, the drug side. It will be 100 percent risk-adjusted even from day one for 2006. We still don't know how drug expenditures correlate with the medical side. There are lots of fuzzy parts, but we want to try to understand all those regulations and make sure that we're not falling behind.

Since we are talking about MAPD, my conclusion is that a new thing for 2006 is that if any managed Medicare company wants to provide a plan in that service area, they have to have at least one plan that provides an integrated drug benefit. That's why you have the MA side and the PD side. You have to put them all together. Most companies want to compete in local markets. If someone buys a stand-alone PDP plan, most likely that person will pay $20 or $30 for the premium. I believe for most managed care companies when they provide an MAPD Plan, they will design the product such that they will have a $0 premium for the PD side, so that they absorb the cost of the PDP side as part of the entire package. I think that this is a trend, and is also the reason a regional benchmark has been quoted down.

For example, in California they have lots of commercial carriers that have this MAPD plan. It provides $0 premium for this PD Plan. So the PD part of the premium is $0 and the weighted average will be lower. That is a consideration so if any company wants to compete in the future, you have to think about that part of the calculation.

FROM THE FLOOR: I have two questions for Marty on implementation. We're supposed to use the experience on Medicare-eligible population to determine whether it's creditable or not. What is being done when the information is not credible? Where are people going to find the data to do that?

My next question is about the fact that you had mentioned that it seems like most employers are choosing the subsidy route. That's probably, I imagine, very true for large or self-insured employers. But I wonder if you have any information as to what size employers that's going down to. Is there a lot of work for an employer to apply for the subsidy calculation, particularly for smaller or medium size insured plans, and do you know what they might be doing in that regard?

MR. HILL: To answer your first question, if you don't have enough data that's credible for the creditable coverage determination, you are allowed to use a rate manual or some normative database. It's just that CMS has clarified that if you have enough people so that your data is credible, and they're not about to define any credibility factors, then you have to use the employer data.

As far as your second question, I would say right now employers are certainly concerned about preparing themselves for the subsidy in 2006. It is a lot of work for certain key people for the employers, but they have a lot of work to do anyway. Every employer that has a retiree health plan out there needs to start communicating with its retirees to tell them what they're going to be doing in 2006 and what's going to happen to their coverage. To the extent they haven't worked out the details yet, they still have to do some kind of initial communication with some followup details later on.

As far as what types of employers are going for something other than the subsidy, I think that's somewhat driven by the need. If they really need to do something drastic to their plans, then this is the chance they've been waiting for. A lot of them have dropped the coverage. For those that can hold off and at least just go for the subsidy in 2006, I think another consideration in all this is that before you go through the process of amending your plan and communicating the amendment to all the retirees, you have to make sure you can offer it in 2006, and that's part of why a lot of employers have been hesitant on that. Certainly, if an employer has a union, then they usually can't drastically change their benefits. Their alternative is basically limited to getting the subsidy, because that's the one where basically they don't have to change the underlying coverage.

So it's not necessarily just the large employers. I think you have to be large enough

so that you have enough retirees to make it worth your while. If you only have five or 10 retirees out there, to go through the process of meeting with your vendor, making sure that they can handle everything, doing all your communications, getting the actuarial attestation down, might not be worth it.

FROM THE FLOOR: On the creditable coverage issue for active employees who are Medicare eligible, particularly those who are 65 and over and Part A eligible, do you still have to notify them even though they may not be eligible for subsidy?

MR. HILL: In general, we're advising our employer clients that there's a huge class of people to potentially send these creditable coverage notices to. If you have an active person who is post-65 and yet they're still covered under the active plan, they're still Medicare eligible and they ought to be provided a notice that says how their current coverage compares to Medicare Part D. If they get a certificate that says their current plan, their active plan is at least as generous, then they can enroll in Part D in the future without having this penalty on the premium that they pay. It's fairly challenging to try to spot all the people out there that are potentially Medicare eligible. What if you have a 40-year-old active who has a 66-year-old spouse? You have to make sure you hit the spouse with the creditable coverage notification. In general, it's better to play it safe on that front.