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Session 26 PD
The New Medicare Prescription Drug Benefit

Moderator: Judy L. Strachan

Panelists: Patrick J. Dunks
Mark R. White

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 products.

MS. JUDY L. STRACHAN: Patrick Dunks will be the first speaker. He is a consulting actuary with Milliman USA in Brookfield, Wis. His experience includes assisting many organizations with Medicare Advantage issues, from the initial stages of development through successfully managing the products. He has also assisted with medical cost estimates and projections, provider reimbursement strategies, product development, risk-sharing arrangements, provider negotiations, experience analysis, trend analysis, liability estimation, Medicaid contracting and e-health product development. He has advised HMOs, PPOs, hospitals, medical groups, PHOs, Blue Cross/Blue Shield plans and insurance companies.

Mark White will be the second speaker. He is a senior consulting actuary with Watson Wyatt Worldwide in Washington, D.C. He practices in the employer group benefits area with a particular emphasis on retiree medical benefits. He's a member of the American Academy of Actuaries Work Group on Actuarial Equivalence and is helping develop the Academy response to the proposed regulations for the Medicare Modernization Act.

Note: The chart(s) referred to in the text can be found at the end of the manuscript.

From listening to their backgrounds, you can probably tell that Pat will provide an overview and do an insurer's perspective on the new Medicare drug bill. Mark will be talking about the new Medicare drug bill from the employer's perspective.

MR. PATRICK J. DUNKS: The new prescription drug benefit came about in November; I think you've all heard of it by now. There has been a lot of political talk about it. First we're going to have an overview, in case any of you missed it or some of the elements of it. There have been a lot of misconceptions out there. If you haven't studied it, there's a chance that some of the information you have is probably not correct. If you have studied it, there's a chance that what you originally studied has changed six times since you studied it, and you're a little out of date there. So we'll go through that. I'm going to take a high level. We have a short amount of time, so we're not going to get into a lot of detail here, but we're going to try to understand what I see as the insurers and other folks in the environment are thinking. Mark is going to go over the employer perspective.

Medicare Part D, as it's called, is the new drug benefit. Prior to 2006 (right now and into 2005), all Medicare beneficiaries have the option to buy Medicare drug discount cards, which essentially are just what they say they are—the discount cards give them the opportunity to buy drugs at a discount. Vendors sold them or gave them away. When they sold them, they were allowed to charge a small administrative fee for them. Many of them gave them away trying to get business. There has been a lot of confusion out in the market, but generally seniors that have purchased them have been pretty happy because they are getting something off the cost of their drugs.

In 2006 everything changes. We move to a drug benefit plan. Medicare, for the first time, covers prescription drugs in a big way. Insurance coverage is available, and insurance companies need to prepare for the changes. We're going to be moving through a very fast time. From now until early June 2005, all of the insurers have to react to Medicare changes for prescription drugs. If they decide that they want to get in the market, they have to write their application. Come early June, they have to have their bids prepared. Guess what—the final regulations aren't out yet. The preliminary regulations were a big stack. For the final regulations, we know things are going to change, because the Centers for Medicare & Medicaid Services (CMS) tell us the preliminary rates were just shot out there in part to get reaction so they could change things. We're not exactly sure when the final regulations will be out. It's all going to happen very quickly. I wouldn't advise anyone in that particular business to schedule vacation.

Medicare designed a standard plan (we'll get to that design in a few minutes). Insurers will be able to offer equivalent benefits to the standard plan. A definition of "equivalent" right now is still floating. That's something they're working on determining. It's actuarially equivalent, but not necessarily in the sense that you'd usually think of it. They can offer richer plans, but they can't offer a benefit that's a lesser benefit than the Medicare standard plan.

Employers have several options. Mark will go into more detail. They can provide their existing benefit with a government subsidy, provided it meets certain criteria. They can try to coordinate their coverage with the Medicare benefit, which is troublesome if they might have two different pharmacy benefit managers (PBMs) trying to manage their benefit together with the Medicare part. The individual in their plan may pick an entirely different insurer, which may result in two PBMs, two different formulas and a whole administrative nightmare. Or employers could just drop coverage. This is sort of a one-shot deal. For employers with big retiree liabilities covering medical coverage over 65, drugs are typically the bulk of their liability out there if Medicare is primary. If they drop coverage, this is their big chance to say, "Hey, Medicare is providing it." They get out from under their liability, so a lot of them are going to look at that good and hard.

For beneficiaries without employer choice, they are all going to have the choice of at least two plans in the market. If there aren't two plans in the market, there are mechanisms in the law to create fallback plans. That is CMS' worst nightmare; they don't want it to get to that. Given the activity I see in the market, I don't see it happening. But everybody will have choice.

Chart 1 is our standard plan. How many of you would design something like this off the top of your head? Not even a group of actuaries would think of something like this. Here's the part that got them some votes or so they hoped—early coverage. This is the part between $250 and $2,250. These are 2006 values; they will be indexed going forward. There's 75 percent plan co-insurance. Medicare will pick up 75 percent of coverage and the beneficiary will have a 25 percent co-pay. That's all after that $250 deductible.

Then there's a so-called doughnut hole. I didn't draw the graph like a doughnut, but you could have. This is the part where the government realized it doesn't have endless resources and maybe the beneficiaries won't notice. There's catastrophic coverage above $5,100. This is indexed to the member out-of-pocket cost of $3,600, and it's important because if they have richer coverage than this, and they don't reach their out-of–pocket as soon, the government reinsurance doesn't kick in until they do reach the out-of-pocket. It has implications moving forward if somebody wants to offer a richer-than-standard plan. It pushes off the reinsurance, and in some ways they are almost paying twice for that extra benefit. This is because they are paying for the extra benefit and they're pushing the reinsurance off because members won't hit it as soon. It's sort of a double whammy. Then the beneficiary has some cost-sharing up here.

We see now in the Medicare Advantage market (or Medicare+Choice, if you're using the older term—Medicare Risk prior to that) that there are a lot of drug plans there with benefit limits. Those benefit limits are usually a cap on brand drugs. Those aren't going to work out here. Even some of the plans with higher co-pays may have trouble meeting actuarial equivalence on the catastrophic coverage. This is probably the coverage that people need most. You know we all understand

insurance. But this is also the coverage that back in the late 1980s Congress passed. They repealed that very shortly when the Medicare beneficiaries found out they had to pay a little bit for it, so they only could tack this on with a little bit. From the insurer's point of view, normally prescription drugs are very predictable for members. There's no way you would offer a stand-alone drug benefit and expect to ever be able to insure that because you'd be selected against and you couldn't win.

Milliman estimated a few months ago, when some of this came out, what we thought the values of these various pieces were in terms of annual cost (Chart 2). Remember that this is all without administrative cost, so if you try to tie it to the premiums that they're talking about, those premiums will include administrative cost. There's not a real mesh there. These are our estimates of costs.

Right now the message here is that the market is changing and it's changing fast. We have a market where currently a lot of Medicare beneficiaries don't have a drug benefit; looking forward, we expect very few not to have one. Now to get the drug benefit, Medicare beneficiaries are going to have to pay a premium that's estimated at about $35 in 2006. There are indications that due to a little actuarial snafu, the initial estimates were low in Washington. There are indications that it might be a little higher. They'll have the option of buying in. However, if they don't buy in right away, there's a very strong penalty for not doing that.

All private coverage, the Medicare Advantage (the new name for Medicare+Choice), gets moved on to Part D, because those carriers are required to include drug coverage with their benefit packages now. They have to have at least all the HMOs in the Medicare market. They have to have at least one coordinated care plan, which includes PPO. They have to have at least one benefit plan with a Medicare benefit at least as rich as the standard plan. They can offer other Medicare benefit packages without drugs as long as they have at least one at least as rich as the Medicare standard plan. They can't offer anything less. If they're going to offer drugs, it has to be at least the Medicare standard plan, or some equivalent of that.

Employers will move into this market. Some of them will insure it and some will get out of it. There will be different mechanisms. Mark is going to talk about that a lot. Other government coverages are going to maintain, although the Medicaid is actually going to slide up for dual-eligibles. Medicaid coverage is actually going to slide up into the Medicare program, and they are going to take some of the grants back from states. The states are going to get less money in essence to pay for the dual-eligible coverage of enrollees. Medigap plans with drugs are going away. There will be no new issues of those. So going forward, that coverage is going to go away.

We also see a big increase in expected spend. Provide coverage, and they will spend. For health actuaries, we all know that providing rich coverage means they'll really spend. The Medicare benefit coverage is in the ballpark of 50 percent coverage on average, but it's so goofy how it's aligned that with the doughnut hole,

different beneficiaries with different spends don't have a constant message about spending. It will be interesting. I can see seniors sitting down, figuring out $35 a month and comparing it to all the drugs they're currently on for the month, and they'll decide whether or not they should buy. If the decision is no, then they'll back up and say, "Oh, what's the penalty if I don't?" That is, provided they all understand it, which is going to be an enormous test. There's going to be all kinds of confusion.

Now I'm going to move into the insurer perspective. Why can the insurer think of doing this? There are a lot of insurers thinking about doing this—small insurers, relatively small, maybe regional players, statewide Blues plans, statewide other insurance companies and the big guys like the Uniteds and the Humanas. I don't know anything in particular. I'm not sharing anything they told me. But I just know, given the nature of the market (and I'm sort of an old dog in this market), they have to be thinking about this. There's too much money out here to be had for them not to be at least looking at it. I'm not going to say they're all going to leap, but there are a lot of them that are likely to leap.

We have about 40 million Medicare beneficiaries in 2006, and we all know that number is exploding going forward. Medicare is becoming a bigger and bigger piece of the health market, and these people are health insurers. It's what they do, so they are going to go where the market is. About 60 percent currently have some drug coverage. CMS has estimates out that 87 percent will pick up Part D coverage. It's a big leap in coverage. There are a lot of dollars in the system, so we've moved from a market of $60 billion to $88 billion in terms of insured drug spend. That's a big difference.

Why can an insurer think of doing this despite all the selection issues? The number one reason is that 74.5 percent of the expected cost of the benefit is going to be subsidized by the federal government. That's a big subsidy, so for the people deciding whether to get in or not, it really changes the equation. Only the very healthiest individuals are going to probably have a spend below what their premium would be. That really changes the dynamics of selection. It's not nearly as bad as if it were straight up like we would think.

When I first heard the federal government was thinking that insurers were going to buy into a drug benefit, I thought, "Oh, Congress is at it again. You know they're thinking 'build it and they will come.'" Insurers aren't stupid. They don't stay in business by insuring things that aren't insurable, not for long anyway. But somebody obviously talked to them. They have big subsidies in here. You saw the reinsurance piece back in the picture; once a member hits out-of-pocket threshold of $3,600, the government is going to kick in 80 percent of the cost. It's going to be an ongoing refund pass–through, and up front they're going to provide a big subsidy. Depending on a plan's experience, those subsidies will vary by plan, in particular because of the reinsurance.

What do beneficiaries pay? They're going to pay 25.5 percent of the expected cost. These are averages. The initial target premium is $35; we'll see what the answer is when it comes out. That's going to be adjusted. The process is going to be that come June all the prescription drug plans (PDPs) are going to bid for Medicare standard benefit. They're going to bid on a national average population. All those bids are going to go into the hopper, and CMS is going to compare them and do their magic. They're going to rank them. The high bids will be determined as those with all their costs above the benchmark, which CMS will determine based on the others—the benchmark will be in the middle. All the marginal premium for the high bidders is going to be added to the $35. It's going to hit right to the bottom line of the individuals enrolling, so there's going to be a strong disincentive to bid high because every dollar you bid high passes through right to the member.

This is going to vary by area. It's going to vary based on the supplemental benefits. If somebody wants to offer extra benefits, they can do that for extra premium. However, then you're getting into sort of a selection spiral with those marginal benefits. Remember, everything you bid above average goes right to the premium. Then you're in that same situation. A dollar of extra benefits on average, and they can compare. Is that extra dollar worth it versus somebody else's plan? Then you're setting yourself up for selection. What I think will probably happen is that we'll end up with sort of a two-tier market—those that are pretty close to the Medicare standard benefit (and this might happen over time because there will be a couple of people in the middle to start before they get killed and figure it out) and then there will be those people at the very high end. They'll have very high premiums, and they will attract people that are willing to pay anything. Those might be some niche players. You know there are people that write that kind of business now in the individual market.

One of the keys of this is that there are late enrollment penalties for Medicare members. If they don't enroll when they are first eligible for this Medicare benefit, they get a 1 percent premium penalty per month while they defer. If they don't have some qualifying drug coverage, which sort of deems them having alternate drug coverage that they were in on the insured program, then they're going to pay an enormous penalty over time. If they want to wait several years, their monthly premium is 1 percent per month. Their monthly premium for three years is going to go up an extra 36 percent. That's going to scare a lot of them into enrolling. Politically that may be hard to hold on to when they start complaining, but this program falls apart if you don't do that. Actuarially, it just doesn't work.

There are low-income subsidies for people who need them. One of the wild cards that we don't know much about is that CMS currently risk-adjusts the revenue when they pay an HMO for the Medicare Advantage program. They're phasing that to 100 percent. For all this drug spend, they're going to risk-adjust those premiums too. They have no idea what the risk adjuster is yet. Medicare hasn't collected prescription drug data because they don't cover it. They don't have a rich fee-for-service database on which to build the risk adjuster, which they did for the HMOs

and PPOs in the Medicare Advantage program. They have nothing. The person in charge of risk adjustment at CMS readily admits that what they'll come out with early is probably going to be pretty rough. It will probably be a few years by the time they collect data, analyze it and do all that. It's probably going to be a few years before they have a robust risk adjuster. That's one of the inherent risks in all this as an insurer. But given the level of subsidies, it might work. It certainly looks like it's worth looking at.

I said we're going to have a lot of market movement. The employers are probably going to keep moving away from this. It's just a matter of money. Remember that Medicare is providing the benefit, but they're farming out and bringing it to the private sector, unlike Medicare fee-for-service. The private sector is going to bid on this. It's competitive in the sense that the marginal premium hits the member, but it's not competitive in the sense that people get tossed out, like there are one or two winners. Everybody gets to play, but those that are high cost are going to play with very high premiums.

How can vendors participate? They can become a PDP. They can become the insurer in essence for this plan and be one of many PDPs for Medicare beneficiaries. They'll line up their benefits, their formularies, their whole works and their whole program, and they'll compete against everybody else. They'll be laid side by side, and come each fall the Medicare beneficiaries are going to be able to choose their PDP.

As I said, another way they can get in is to become a Medicare Advantage plan. There are a lot of insurers that are already Medicare Advantage plans; there are a whole bunch more looking at it very actively. There are some deadlines of applications February 1 and mid-March that are making folks like me very busy. I know there is a lot of activity because of that. People are looking at that option very strongly, and one of the things they'll have to do is put up a drug plan.

Another thing they can do is do administration for employers where employers have primary coverage, or they can offer a "wrap" plan. They can try to wrap around employer coverage. That's a way they can participate. Another thing they could probably do is work with Medicare Advantage plans who really don't want this risk in terms of reinsurance, and bring the program to them. It might be another opportunity.

Who do I think are the likely players? There are some large insurers with their own PBMs where frankly I'd be shocked if most of them didn't play this game, because they have these PBMs. PBMs typically don't like taking risk, but they work on volume. If you can get Medicare members in your drug plan, you want to put leverage on pharmacy suppliers. Medicare members matter. Commercial is nothing compared to Medicare. The PBMs understand that, and the insurers will understand it. Everybody knows that. There's going to be some competition in terms of offerings there. What drugs make the formularies? What drugs don't? There will be

some differences. There will be regional insurers; they'll probably talk to the PBM. There are PBMs out there (Caremark is one, and I can't remember the other one) where their CEOs came out months ago and said, "We're not taking risk on this program. That's not what we do." Their niche in this market is going to be doing all the backroom operations, and the PBMs are set up to do that. They'll be working with insurers and competing to actually get the insurers' business to send it to them. So there will be competition under that first layer.

Where might they distribute it? They might distribute it to Medicare Advantage Plans, employers or the individual sales market—there will be some that will go that route.

Some of the Medicare Advantage plans use their own PBMs and many will rent. I think I already covered that. I think we'll see more insurers getting in the Medicare Advantage market also, given the activity. Medicare is just exploding. If you look at numbers, the population is just exploding. If you're not really into this industry, one of the things they did with Medicare Advantage with the drug bill is that they added a lot of money to the pot. They used to have trend lines where the lower one is cost and revenue is the top. They would sort of cross out in the future, because trends of cost were going up more than trends in revenue. Revenue was going up 2 or 3 percent a year, and costs were going up more. Well, now they benchmarked the revenue trends to go up the same as the average national fee-for-service trends, so if you start with the model that works (they sort of move in unison), it really changes the model for Medicare Advantage. We'll see a lot of insurers look at that good and hard, provided they trust the federal government to keep its promise.

We also have a population that's aging that's used to all these choices in managed care. As working members of society age into Medicare, they're used to having the HMOs and PPOs more and more, so those become more and more viable options. There will be a lot of drug dealings with the Medicare Advantage plans also. There will be a lot of figuring out if Medicare Advantage plans offer one plan with drugs and one without. Is that going to help my selection? Remember for those folks their revenue is risk-adjusted now too. In this room we all know risk adjusters are not perfect, so that will create some interesting discussions there also.

I'd like to talk briefly about the ways to get in. One is the standard benefit. They can have alternative equivalent benefits, which probably mean actuarially equivalent, but it's not necessarily like you usually think of it. That's still a soft definition. There are a lot of subsidies. There's reinsurance, and there's health status risk adjustment, although we're not sure how good that will be. I don't think it will necessarily be bad. It probably will be in the right direction, but it might not be very refined to start.

For actuarial equivalence, the first thing is that your value in total has to be actuarially equivalent. That's probably the way you usually think of it. You take Benefit A and Benefit B, total up the per-member-per-month (PMPM) value and say,

"Is A bigger than B or are they the same?" If they're the same, you say they're actuarially equivalent. In the preliminary regulations they have this alternative thing, where actually you look at different segments of the drug benefit to say if they're actuarially equivalent. The deductible can't be any higher than $250. That's a really simple one.

The standard payment—the payments between $250 and $2,250 in drug spend—on average actuarially you have to provide as much coverage there. In that corridor you have to be actuarially equivalent. It's sort of the usual actuarial equivalence, but there are different slices and different corridors. Then when we get to the tail, the high-end coverage, we have to be actuarially equivalent out there, too. We cannot put any more on the member than we otherwise would. You can get in with alternate benefits, but you have to be actuarially equivalent or better. Because of selection, you probably have to be very cautious about getting too much better.

Whether we're going to see a lot of innovation in benefits or not is questionable, because of all these rules. Now it is very gray whether these rules will hold. We initially saw these on the employer side in the law, or we thought we did; when they came out with the regulations for the employer side, we didn't see this anymore. It appeared on the plan side. Previously the plan side was sort of the same stuff. They may roll this back as plans complain. They're asking for feedback, so we'll see what happens. Although it's in the law, I've seen funnier things happen with regulations. I'm often surprised.

Who do we think will get in besides the big carriers? I think some Medicare supplement carriers will. They are often in the business. They're with the Medicare beneficiaries; the beneficiaries already know their name. They sort of take risk without managing a whole bunch of it, so if they can find a way to hook up with the PBMs, they're some of the natural ones to take risk there, particularly those with a very strong market share in a given region.

All these bids are going to be on regions. That's something I failed to mention. When they bid, each PDP is going to have to bid for the entire region. A region could be a state or it could be a group of states. Those will be announced in late fall, which by the CMS calendar runs until December 20. December 20 still qualifies as late fall. That's how they are thinking. They are thinking middle to pushing late December. They're going to try to announce regions sooner, but I wouldn't hold my breath. That's assuming they hold to the schedule. They're required by law to do it by January 1, except there are no teeth in the law that say what happens to them if they don't. But they're getting a lot of feedback. I think the feedback is telling them to do states. A lot of that feedback is because of Medicare Advantage. It's also because most insurers are licensed state by state, and we're used to dealing with that state-by-state stuff. If you cut it differently, it would create all kinds of different issues. In the time window from when they announce the regions until your applications are due very shortly thereafter in March, I just can't see people getting things done quickly enough with anything other than states if they have to

create alliances with other organizations. It's just an enormous task.

The PBMs I think are going to be very active, but I think they're going to be very active in the background. They're going to love this volume business where somebody else takes the risk and they do the processing. This is what they do in the commercial market. A few years back, they got into taking a little bit of risk and they got burned a couple of times. They ran very fast from taking risk, so I don't expect them back. Medicare will be riskier.

MR. MARK R. WHITE: We're going to talk about the employer's side of it. There's a little bit of redundancy, as you might imagine, on the key provisions. I'll try to skip over some of that quickly and try to focus on how employers are doing with this from a strategic point of view as well.

We have the Medicare Part D benefit that we already talked about. The part that we didn't focus on too much is that there's a subsidy that is provided to employers who continue to sponsor a retiree medical plan that covers drug benefits. The subsidy is less than the subsidy that Medicare is willing to pay a health plan that provides a Medicare Part D benefit. That's the key factor here. The subsidy was established as a balancing item in the legislation, essentially. They had the $400 billion target, and in order to get to the $400 billion target, they knew they couldn't cover everybody, so they wanted the employer plans to stay in existence, take a smaller amount of money and continue to cover as many Medicare beneficiaries as possible. There's lots of subjectivity in the calculation that they did. It's one of the areas of difference between the estimate that the Congressional Budget Office (CBO) did, which hit $400 billion, and the estimate that the Office of the Actuary for CMS did, which was closer to $600 billion than $400 billion.

The subsidy is payable with a calculation that basically applies a 28 percent factor, which is just a random number that they pulled out, to the drug benefits that are provided between $250 and $5,000. Those are also being indexed. In order to receive the subsidy, the employer plan must be actuarially equivalent or better, but that's not defined.

Chart 3 is another way of looking at the plan. I wanted to focus primarily on the true out–of-pocket context, because it's very important for employer plans. If a Medicare beneficiary receives money from an employer plan or from an insured plan that is beyond the amount that's provided in the basic Part D benefit, then it defers the onset of the catastrophic coverage. If, for example, an employer had a plan that continued to pay 75 percent in this coverage gap, then the $5,100 would grow to $13,650 before the individual beneficiary has spent enough money (the $3,600 that they're required to spend) to trigger the catastrophic coverage. That's a big issue because it makes it very difficult to think about normal types of coordination. It's one of the more difficult aspects of coordination, but it also is a problem when we talk a little down the road about a concept called a private label PDP, where an employer might go to an insurer who offers a PDP and say, "I'd like

to offer private label PDP. Will you get the necessary waivers to do that for my population that covers multiple areas?" Well, if the benefit that I provide is actuarially equivalent on a more traditional basis, I'll get the full health plan subsidy, hopefully. But if it's richer than that again, that catastrophic benefit is deferred. We run into some problems because of this true out-of-pocket calculation.

In the regulations that are out there, there are basically five employer options that are discussed. One is receiving this 28 percent federal subsidy. The second is coordinating with Medicare, which is specifically addressed in the regulation. The third is this concept that I just alluded to—a private label PDP, where an employer would basically buy someone else's PDP as a shell, but call it a PDP for its own retirees. An employer could start its own PDP or Medicare Advantage plan, although that seems highly unlikely unless you're already in the business. The employer could reimburse premiums, which does not affect the Medicare subsidy because the health plan whose premiums are being reimbursed is now qualifying for a health plan subsidy. Premium reimbursement steps outside of the realm of this employer subsidization. There's no regulation proposed on that. That's not much different from what can be done today by an employer who would reimburse premium requirements for its retirees. We'll talk a lot about employer options, but the rules also apply to other types of plan sponsors like unions and trusts.

If you think about it from a health plan perspective looking at the employer marketplace, what are some of the roles that a health plan might have? One would be helping administer qualified employer plans. Another would be helping coordinate them. Now I would amend one of the comments that Pat made. When we're talking to our employer clients, we are telling them that they don't need a PBM anymore if they decide to coordinate because the PDP will be the primary plan. All they are going to be doing is exercising a financial adjustment. There's an information flow that's going to be necessary, and that flow would come from the PDP to the employer, where it would be adjudicated for the secondary benefits but taking for granted whatever the price was, whatever the formulary provisions, whatever the plan design was of the PDP that originally paid for the drugs. Then the employer, after deciding what its plan would pay, would send information back to the health plan. The health plan would then know how the employer's money is offsetting that true out-of-pocket calculation that we talked about. The problem is that it has to happen close to real time because the person might go in for another prescription the next day, and we need to know where that true of out-of-pocket calculation stands. It wouldn't be a problem if there were no employer involved because everything could be processed by the PDP, and they would know exactly where they stand.

This begs an issue: How are we going to accomplish this coordination? It's a big challenge. Medicare basically said, "We could do it, we could pay somebody else to do it, or everybody could do it on their own." That last alternative has potentially hundreds of PDPs across all these regions dealing with tens of thousands of employers potentially, although one would figure a lot would drop out of the

marketplace. It could be very complex to do it one-on-one. But Medicare also said, "If we do it, we don't have time to get it done before January 2006. Some sort of central clearinghouse could be used. If we pay somebody else to do it, we don't have the money yet allocated to do that."

None of the choices around coordination look all that attractive from a logistical point of view right now. Although from a financial point of view, it may be the best alternative for not-for-profit and governmental-type employers. If you're going to be in the PDP market anyway, as a risk-bearing entity, something that seems pretty exciting to me is to turn around and then charge a non-risk client, like an employer, a transaction-based fee in order to set the same thing up for them on a self-insured basis. You would have to get a whole bunch of waivers, and we'll talk about those in a minute, but it might be a way to put some relatively low-risk revenue on the back of the work that has been done to create the risk-bearing entities around the country.

Finally, creative solutions are developing to allow employer support to be made through financial support in ways that do not affect this true out-of-pocket calculation. I should say though, before we go much further, that employers are not limiting themselves to considering those options only. If you talk to employers right now, it's sort of minimalist, and they're looking at keeping their own plan, getting the subsidy, coordinating with Medicare—business-as-usual kinds of alternatives.

The next level over is the idea that you might do the private label PDP. Again, we try to keep our own employer plan more or less the same, but we do it through a PDP structure to try to improve the subsidization to a health plan level. A lot of employers are saying, "Should we be in the post-65 business? What kind of benefits should we offer? Maybe we should be doing accounts of some sort or something like that, because we might want to reallocate our support away elsewhere. Medicare Parts A and B already pretty much cover the catastrophic exposure on the medical side, and the drug side is taken care of now. So why are we in this business? We might move only to financial support, maybe paying the premiums from B and D and not doing much more than that. As long as we're looking at that, we should look at all pre- and post-65 benefits, because in most valuations the post-65 piece is the biggest chunk. Now that we're doing something to address that, why don't we just address the whole thing?" That leads to the concept of this potentially being an exit strategy where the employer is basically saying, "Because of Medicare reform we no longer have to be concerned about your expenses of medical care in retirement so much, so we are changing the whole deal."

There's a lot of discussion around this. If you look at it from an accounting perspective, there's a two-step dance going on. Initially we have to recognize what the financial accounting requirements are in terms of the impact of the law on the employers, assuming no change in their plans. That leads to the question: What's the change in the plans that is going to come from that? Typically employers are saying, "We'll recognize the impact on us. We'll assume we'll take the subsidy or

we'll assume that we'll coordinate. But we're looking at these other options, and maybe in the first half of 2005 or late 2005 or early 2006, we're going to announce something else to take the place of what we have." There's an initial gain that may occur because you assume you'll get the subsidy, but there may be a bigger gain that's going to come down the road for the employer once the substitution of some other strategy takes place.

This is a very important issue that I want to make sure that everyone understands. The federal subsidy for an employer is essentially flat. It's a function of whether you pass this actuarial equivalence test. If you do, we're going to pay some of your drug cost. It doesn't much matter how much you pass by, because the amount that we pay isn't a function of that. The amount we pay is a function of total drug spend, not the employer share. As a result, an employer who finds itself in a situation where it provides a rich benefit plan, because of the way the true out-of-pocket calculation works, will find that the health plan subsidy isn't that different from the employer plan subsidy, but the less rich of a plan it provides, the more likely that a health plan is going to get a big subsidy compared to what the employer plan can get. The really rich employer plans might as well take the subsidy, but when you're covering 50 or 60 percent of the drug cost, you may be better off trying to re-characterize the employer plan into a health plan environment to get the bigger subsidy. That may mean switching your support to a financial basis in some way, or the private label PDP concept might work here.

If you provide 40 percent or 30 percent support for the drug benefit, you'll fail the test, so there is no employer subsidy. It more or less forces you out of the business because you'll take what you will provide and do it as a financial support for the health plan that's getting the full health plan subsidy. The deck is stacked against employers keeping most of their plans because even though at some point there's sort of parity, the fact of the matter is that employers have been migrating down this curb for years now, and this concept that employers will say, "Oh gee, I can keep spending all this money," is kind of a false hope. In point of fact, it will probably be an environment much like we've had in the past, where employers continue to reduce their support for retiree drug benefits.

We'll move through a few other things. We saw some estimates before. In looking at the CMS 2006 estimates, it's instructive again to see the difference in what they are willing to pay an employer versus a health plan. The average federal subsidy that they have estimated for an employer is $611, but the average amount that they think they would pay in terms of support to a health plan is $1,231. It's roughly double, and an employer is not blind to this economic imbalance. An employer who coordinates with Medicare could get about $900 of the basic benefit. These numbers are pretty consistent with what we looked at before. Some employers are taxable, and they get a tax-free subsidy payment. That brings the subsidy payment up into that same $900 level. But if you're an employer with tax losses and a lot of the plans with the richest drug benefits, or you're a not-for-profit organization or governmental entity, getting $600 compared to getting $900 isn't

very attractive. The coordination method looks like the best method, yet we have this logistical problem that it may not be a very easy method with which to work. There's a big question yet about how this is all going to play out, particularly for those that would find coordination the most attractive method.

In order to receive the federal subsidy, you have to have a benefit level that's at least actuarially equivalent to the standard benefit. The good news for employers is that it appears traditional designs will be permissible, whereas the health plans we were just talking about work under all these ridiculous constraints about how the plan has to be built. That makes it extremely difficult to move very far away from that two-piece model, where you have the coverage, the gap and then the catastrophic coverage.

Employers should be able to design around that using a more traditional idea of actuarial equivalence. The subsidy more or less when you calculate it out is going to be worth about 20 percent of the drug spend for an employer, whereas the Medicare subsidy for Part D is about 40 percent of the drug spend. If you're in the tax-free group, then you get another 5, 6 or 7 percent.

Right now the proposed regulations have the employers stepping through a three-step process to get the subsidy. First, they have to perform a gross benefit test. That is a test to say: Are my benefits similar or better to Medicare Part D benefits regardless of any offsetting contribution? Then, one of the high number of possible anti-windfall rules is going to be performed. Finally, a subsidy payment calculation will happen. One of the things that is interesting here is that the proposed regulations go to great lengths to point out that these employers are now going to be in receipt of federal funds. I don't know about you, but usually when I hear about federal funds it's because somebody is not going to get their highway money because they built the school incorrectly. In other words, being in receipt of federal funds opens you up to federal leverage. They make a big point that the employers, as part of their filing, are going to have to acknowledge that they will be in receipt of federal funds.

The gross benefit test is an annual test. It's an aggregate plan test. It's going to compare the employer benefit value with Medicare Part D benefit value. The test would be performed in advance of the year on a projected basis, and the result of the test would be included in an "actuarial attestation," which is a new phrase for us all to learn. That will be part of an annual filing, which is filed 90 days before the beginning of the year. I think September 30 is the date they've set for this year.

The employer plan would pass if the benefit value is greater than Part D. In CMS estimation terms, that would be about $1,400, although it probably won't be a dollar threshold; it will be testing your database under both plans and comparing the two number thresholds. The aggregation is an interesting point, though. They've basically stated that all the plans of a plan sponsor need to be aggregated, which means that you might have different groups of retirees with different

contribution levels being aggregated for purposes of this test—different people with variant plan designs all carried by the same vendor. It's a little hard to say right now where this aggregation could occur. Probably union contracts would be tested separately. Possibly things with separate Schedule 5500s would be tested separately, but they haven't given much guidance on that issue. What is clear is that they don't regard contribution differences as being a reason for disaggregation.

Now let's talk about the windfall issue. The law was passed with that gross benefit test written into it. The first thing thought of was that the retiree-pay-all plans could get the subsidy because if the gross benefit is good enough, that passes that gross benefit test, even if the retirees are paying for it. Retiree contributions were not addressed anywhere in the Medicare Modernization Act or in the legislative history. They forgot about it entirely. The legislation was written in such a way that the actuarial equivalence concept didn't differentiate strongly between how it applied to health plans, on the one hand, and how it applied to employers on the other. The idea immediately popped out that this is more of a bonus for employers than we thought, because we could have these retiree plans. Well, immediately there was press coverage. There were letters from Congress to CMS saying, "No, no that's not what we had in mind." The proposed regulations include several ideas about how to prevent these windfalls for employers from occurring.

Interestingly, though, as they talk about them, they're saying in the proposed regulations (which read more like a discussion guide in this section than proposed regulations), "We're not even sure if this is legal, so tell us what you think." They did conclude, appropriately I think, that reliance on market forces with the gross benefit test as the only test would be unlikely to be successful. There are three types of anti-windfall rules that they talk about. One is that they might limit the payment that you get as an employer to the amount of your subsidies. If you provide an average of $300 to your retirees, you could only get $300 from the government. That would bring your cost down to zero, but a retiree-pay-all plan wouldn't get any dollars. That's one idea. Another is that the plan would fail the test if the average employer support were less than the subsidy or less than the after-tax subsidy. For a number like $611 or $900, if you didn't have at least that degree of support you couldn't get a subsidy. Another variation on the same theme is that you're not actuarially equivalent if you do not provide a level of support that is greater than what Medicare provides to the Medicare benefits. There you would look at the employer plan minus the retiree contributions and compare it to the Medicare Part D benefit minus the Part D beneficiary premiums. About 40 percent of the drug spend would meet that test. That's the most stringent of them all.

Somewhere or somehow they want to come up with an anti-windfall rule, although there's no legislative history supporting it. The reason is this concern over the retiree-pay-all plans (as the poster child). Many employers these days have some access-only people, some capped people and some other folks that are grandfathered. If you mix them all together, you could still pass. You could still be receiving a subsidy, therefore, for people that are capped or for people that are

access-only, as long as you pass on average. Within the big anti-windfall concept, there's still some exposure for little windfalls.

The second step is applying one of these rules, and we don't know which one they're going to come up with. The net benefit test is the most stringent of them. You do an aggregate test, and you compare the employer plan value less the contributions to the Medicare Part D less the Part D premiums. You would pass as long as you exceed that. You'd perform this test at the same time, and it would be part of your attestation filed in the fall prior to the beginning of the year. There are a lot more open questions about the details of this test because they can't figure which test they will do.

It's an interesting area. We're working now on comments in response to this, and it's a real can of worms, as you might imagine. Once you get through that, however, and you send in to the government your attestation and a list of your retirees, they say, "Okay, go." During the year you keep track of your expenditures. Chart 4 illustrates a simplified version of the calculation. You start out by looking at your gross point-of-sale spend. This is what it costs at the drug store and what it costs at mail order. For an individual spend between $250 and $5,000, you grab those claims. Then you adjust them downward for rebates and any other adjustments that are post–point–of–sale that might occur, which would reduce the cost. Say that you have rebates worth 2 percent. You'd scale the gross claims down by the 2 percent, allocating them into those dollars. That's why the allowable number is a little less than the gross number. Take that allowable number, still applying your thresholds, but now the thresholds have scaled down. They've drifted down by the same 2 percent, if you think about it. We're going to apply a 28 percent subsidy to the dollars between those thresholds. This is the amount of money that you get. It's roughly 20 percent of spend.

Now why they didn't just say 27 percent of that number I don't know, but it would have been a lot easier than having to deal with this. The rebates aren't known, at least under the current methodologies, until after the year is over. This creates a big timing problem in the subsidy calculation. The calculation, because it's based on actual data, is going to be based on actual data during the year, adjusted then at the end of the year. There's a big role for health plans in tracking, submitting and preserving after the fact all this data. In the end, this is going to be enforced by audit. Both the initial filing of the qualified plan status and the subsequent payment of the subsidy are going to be enforced on audit.

We can talk a little now about coordination. We've mentioned this several times. The big issue is the true out–of–pocket issue and the timing associated with that. In an example, the true out–of–pocket is $3,500. You could have someone with $7,000 of drug claims. The person has $2,000 paid by a coordinating plan and $1,500 paid by the Part D benefit (75 percent between $250 and $2,250 'is $1,500). They're still not triggering any catastrophic payment, so the individual is still not into that. If you're a health plan, this matters, because you would have

started having to pay out catastrophic coverage after $5,100. Some of what you would have had to pay you're not paying. At the same time, though, the subsidy that you would have gotten the 80 percent reimbursement for from the government, you're not getting. Now I like this deal where I don't pay 95 percent and I don't get 80 percent. I can make money on this deal. In general, the more coordination there is, the lower my cost. It should have some effect on the pricing associated with this product if you expect you're going to have a lot of coordination. It can help drive your beneficiary premium down a little, but it will be very complicated.

The other thing that proposed regulations introduced is the idea that employers might have to pay user fees because of how expensive all of this is going to be to coordinate. It doesn't go into any more detail than that really. The prospect of employers having to pay user fees to coordinate is not something that is going to make the method any more attractive.

The key, I think, is that the drug plan is going to have to control the drug administration. The employer is going to have to step out of the PBM business and step into a financing role. The PBM or regular third-party administrator (TPA) is probably going to be in a position to apply the employer plan design. It means, though, that certain types of plan designs don't make much sense anymore. In other words, the co-pay design, which is oriented toward the administrative side of things, doesn't fit so well anymore. Co-insurance design may well work better. A design with a deductible of $2,250 that escalates every year with the $2,250 might make a lot of sense, so that you don't even look at what the benefit structure is in that first basic benefit area.

We talked a little about the idea of a private label PDP. Here the key is going to be a waiver process, because practically the whole law has to be changed in order to facilitate this concept. CMS has indicated that they are pretty flexible on the waiver concept. While they haven't specifically talked about all these areas, there is at least a possibility that enough areas could be waived to facilitate this as an area offering a fairly attractive product. Again, the attractiveness is all based on the concept that if an employer could qualify for the health plan subsidy instead of the employer subsidy, it might make sense to do this. An employer, for example, might be able to offer a plan with straight 55 or 50 percent co-insurance across the board, still qualify actuarially and therefore offer a rational plan design, but with relatively full health plan reimbursement from the government.

What are some of the areas of waivers? One would be restricting the enrollment to the employer's' Medicare-eligible retirees and dependents, so you're no longer a public plan. Another is crossing the normal service areas to go where the retirees are. Next are access restrictions on the number of retail pharmacies and so on that are available. Those are going to be highly driven by the service areas, and, having stepped out of the service areas, you would find yourself failing those access restrictions. Plan design variations that are outside of the standard PDP structure

are another area. Premiums would be something that could be priced to each employer, and so you no longer would comply with premium rules that apply to health plans in general. If all these happen, this might work. If not all these happen, it won't work, because you need almost complete flexibility to move outside the realm of the law. It remains to be seen whether that will happen or not.

I'd like to wrap up this topic. Again, the roles that health plans are going to have in addressing the employer options are around administration. In administering the qualified employer plans, we want to be cognizant of the fact that we're going to have to preserve the records a long time, but these are transaction-based products doing this kind of service. That would be attractive. Administering the coordinating employer plan is again transaction–based, so that's attractive. The PDP role that we've already talked about and the private label role that stems off of that are, again, interesting options.

'The employers basically are being told they have to account for this even though the regulations don't define it. They are under a time constraint, because if they settle their accounting treatment before the end of the third quarter of this year, for those on a calendar-year basis, they can get retroactive credit back to the beginning of the year. They can get three months' worth of savings under FAS –106 if they do it by the third quarter. There are many employers who are doing what I call a two-step dance here, where they are recognizing the accounting savings associated with an assumption, such as taking the subsidy in the third quarter of this year (some even some did it in the second quarter of last year), and then they're still looking at their strategic options. They may announce a further change early next year, late next year or even into 2006.

Those changes, of course, would be plan amendments under FAS 106. They are making a distinction between what the Medicare Modernization Act is doing to us and our plans, and that's what we're recognizing now—'the subsidy. We don't have to change our plans to get the subsidy. What we're doing will come out of the plan amendment, and we'll trigger further adjustments in subsequent years.

The auditors are scrutinizing this kind of calculation and asking a number of questions, some of which have only estimated answers available. How is the actuarial equivalence being determined? There's a lot of good-faith estimation that's going on in the employer world right now. As I have seen the conversations take place, the auditors are recognizing that everyone is working without a full set of information. As long as there's a reasonable approach and reasonable documentation, most of the estimates are going through.

MS. STRACHAN: I''m beginning to look at all the reporting requirements and everything else for the employers and wondering why they would just not drop their coverage.

MR. WHITE: There are a couple of hard reasons why that more or less forces

employers' hands. Union contracts would be an example, or a past pattern of promises that they feel would be difficult for them to go back on. You use that most often with older groups of existing retirees that have been grandfathered under relatively rich promises. In those cases, maintaining the benefit plan, which is typically pretty rich and typically with fairly low contributions, makes the most sense and will likely be the strategy used for those closed groups Of older retirees, at least until the next bargaining cycle for the union plan.

MR. JOHN C. KELLY: This is a question for Patrick. I've read a couple of things that address this not as clearly as I would have liked. You said at one point Medicare supplement plans with prescription benefits will go away, and a few minutes later you said they wouldn't be sold anymore. I was curious whether existing people with those plans will be able to continue them after 2005 also. Would there be any kind of grandfathering?

MR. DUNKS: Existing people will be grandfathered. They can continue their policies. They won't be able to buy into Medicare Part D because you're not eligible for Medicare Part D if you have other coverage in terms of Medicare supplemental coverage, unless it's employer–based or that nature of the world. People already with those plans can keep them. However, they're going to get horribly expensive as people bail out, and financially it's going to be hard for those people to keep because the only people left are probably those that are going to use a lot of drugs. Those plans won't be sold going forward. There will be no new lives in there.

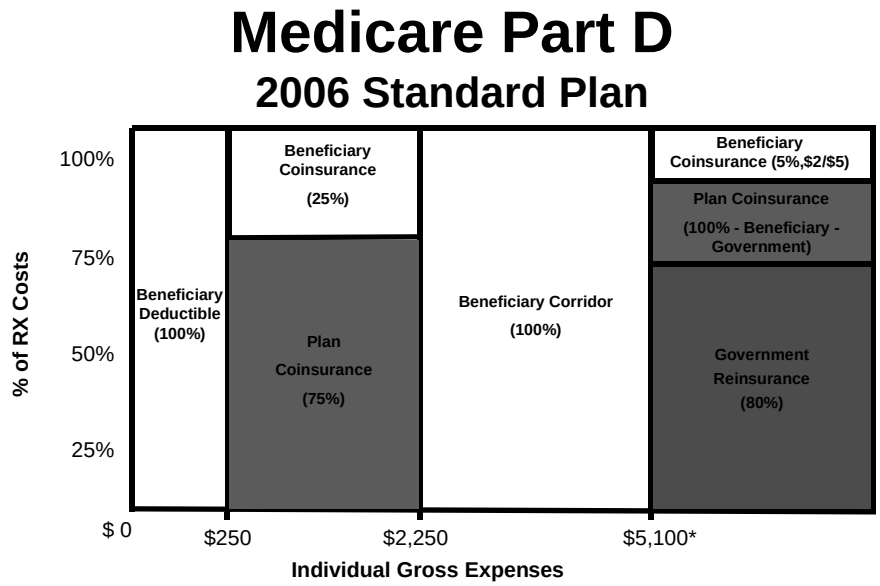
MS. STRACHAN: Pat, can you elaborate on the extra reporting requirements there might be for health plans that decide to become a PDP?

MR. DUNKS: I would expect that everything down to the database will need to be maintained. This is based on my experience in the Medicare Advantage world. – Right now, the federal government comes every third year to do audits for Medicare Advantage plans. When they come, they review the financial documents file, and they may ask for the claim database to build from there. It ties to their financials somehow to build that data up and show how that's consistent with what you relied on for your filing. They're going to ask you to keep all that detailed data for say seven years to go back and potentially audit. That's potentially a nightmare, Depending on the particular administration or the attitude of the administrators at that time. Honestly, I would say that depends in part on the election, because I've seen different administrations have completely different attitudes about these things in terms of working with people or not working with people.

The good news of all of it is that to date I''m not aware of Medicare Advantage plans that have gotten any significant fines because of findings. They've essentially been told to do better going forward. However, at some point there's going to be more money involved with the PDPs, and the Office of the Inspector General (OIG) does have authority here. Once it runs out of hospitals to go after in that industry, the OIG is probably going to be looking for the next place where it's going to find

some cash. The OIG isn't nearly as understanding as the people at CMS. I don't mean to criticize OIG, but it will look very hard for things. In many cases, it found real things. In other cases I might personally disagree with things the OIG has done.

Chart 1



The annual OOP threshold of $5,100 is based on beneficiary payment of $3,600 in cost sharing expense. Payments made by other benefit programs do not count toward the annual OOP expense.

Chart 2

Medicare Part D

Milliman 2006 Cost Estimate: Annual ($2,476)

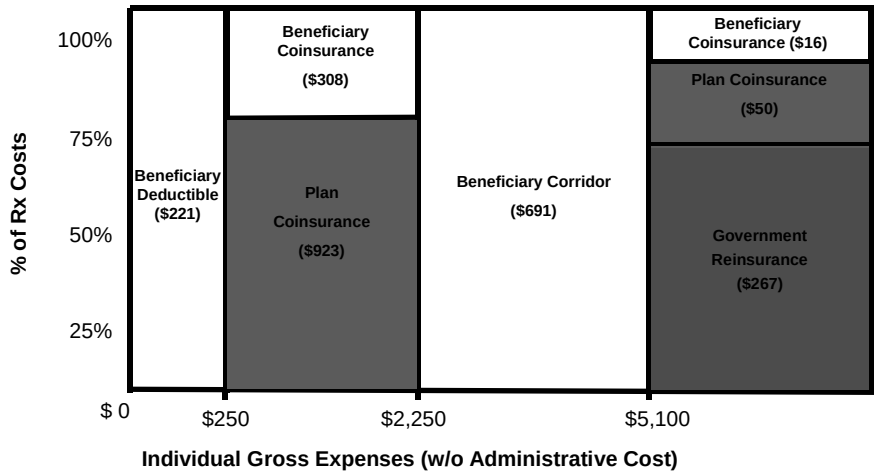


Chart 3

Part D Standard Benefit Provisions in 2006 (Indexed)

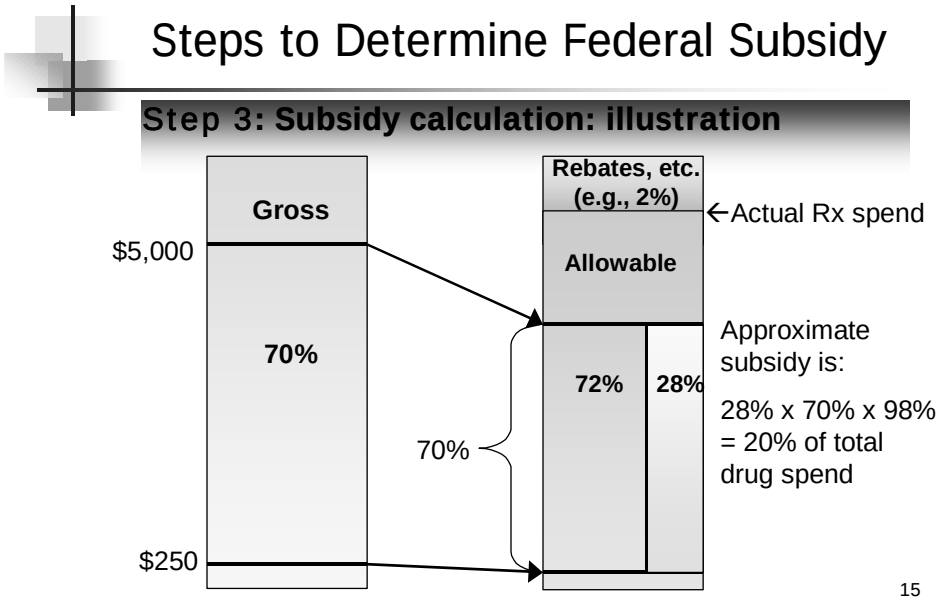
Average Monthly Premium	$35
"True" Out-of-Pocket[1]	$3,600

Annual Deductible	$0	$250	0%
Basic Benefit	$250	$2,250	75%
Coverage Gap	$2,250	$5,100[2]	0%
Catastrophic Coverage	$5,100[2]	No max	95%

[1] Catastrophic coverage begins after satisfaction of "true" out-of-pocket; only payments by the retiree and family members qualify – employer and insurance payments do not count.

[2] Assumes no 3rd party payments: $3,600 OOP = $250 + 25%*($2,250 - $250) + ($5,100 - $2,250).

Chart 4


Steps to Determine Federal Subsidy
Step 3: Subsidy calculation: illustration
Gross
$5,000
70%
$250
70%
Rebates, etc. (e.g., 2%)
←Actual Rx spend
Allowable
72%
28%
Approximate subsidy is:
28% x 70% x 98% = 20% of total drug spend
15