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It's Time for Plan Sponsors to Reassess Their Options Under Part D

BY TROY FILIPEK AND GREG GYSBERG

Following the passage of new healthcare reform legislation earlier this year (55 PBD, 3/24/10; 37 BPR 699, 3/30/10) several plan sponsors asked Milliman to evaluate the impact of the legislation on their retiree prescription drug plans and help them determine the optimal option for providing Medicare retiree drug coverage going forward. The significant changes to Part D resulting from healthcare reform are presented below, along with a case study illustrating these impacts to plan sponsors.

An optimal strategy will vary according to the current situation of each plan sponsor and its goals in providing coverage into the future. However, one important conclusion remains constant—plan sponsors may miss savings opportunities by assuming that their current approaches are optimal. With some healthcare legislation already taking effect in 2011, plan sponsors should reconsider their options for retiree prescription drug coverage now.

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Healthcare Reform Impact

Healthcare reform's primary intention is not to change the landscape of retiree prescription drug coverage for plan sponsors, but several of its new provisions affect the relative value of the options (discussed below) available to them. These include:

- eliminating the tax exemption for the Retiree Drug Subsidy (RDS),
- closing the Part D coverage gap, and
- increasing Part D premiums for certain high-income beneficiaries.

Eliminating the tax deductibility of the RDS is a significant change that makes this program much less attractive to taxable entities. This change comes into effect in 2013, but plans are required to immediately reflect the change in their financial statements. This made the provision one of the first in the healthcare reform bills to have a significant impact on plan sponsors' current strategies for providing prescription drug benefits.

Closing the coverage gap—defined in 2011 as amounts between $2,840 in allowed drug expenditures and $4,550 in member cost-sharing or true out-of-pocket (TrOOP) costs—is likely to have the greatest impact on plan sponsors because of how the Centers for Medicare and Medicaid Services (CMS) will administer these changes. The coverage gap will eventually be closed through several changes to the Part D program. The changes impact the available plan sponsor options differently, as discussed below.

 ISSN

Pharmaceutical Manufacturer 50 Percent Discount (Pharma Discount)

This is the most significant change for plan year 2011. For non-low-income members, pharmaceutical manufacturers are reimbursing 50 percent of allowed cost after any Part D enhanced benefits (and net of dispensing fees) for brand-name drugs in the coverage gap. In the individual marketplace, this represents a significant benefit enhancement on almost all plans.

However, in the employer group market, this change is of lesser consequence because it does not apply to RDS plans and because most employer group waiver plans (EGWP) provide enhanced coverage on brand-name prescriptions in the coverage gap. Hence, for EGWPs, the Pharma Discount would merely reduce the current member cost sharing by half. EGWP sponsors should therefore consider doubling the cost sharing on brand-name prescriptions in the coverage gap to keep the benefit the same as it was and collect the savings from the discounts.

The secondary wraparound option gains the most from this new provision. CMS specified that the Pharma Discount will not be net of any payments made by a carrier secondary to a Medicare primary plan. This means plan sponsors can provide a rich benefit and maximize the value of the Pharma Discount and associated government reinsurance (if the plan runs on a calendar year basis) through a defined standard (DS) or equivalent Part D primary plan and a secondary wraparound benefit.

Additional Medicare DS coverage in the coverage gap and slower increase in TrOOP

The DS benefit has been changed to provide a small layer of benefits for generic drugs in the coverage gap in 2011 and another layer of benefits for brand-name drugs (in addition to the Pharma Discount) in 2013. The benefit increase is gradual: the 7 percent generic coverage in 2011 increases to 75 percent in 2020 and brand-name coverage increases to 25 percent in 2020.

For some EGWPs, this will require providing richer benefits. In most cases, though, EGWPs already provide full coverage in the coverage gap and are not affected. However, for plans providing benefits close to equivalent to DS, they will need to improve coverage going forward.

At this time, regulations specify that the equivalence tests required to qualify for RDS are not affected by the additional DS coverage in the coverage gap. Therefore, RDS plans should not be immediately impacted. The government is partially funding the closing of the gap through subsidies to EGWPs, though, while the RDS is not changing in value. This puts the RDS option at an inherent disadvantage, as does the loss of the RDS tax exemption in 2013.

This change also provides savings for secondary wraparound plans that provide coverage in the coverage gap as the share that will be covered by the primary Medicare plan will have to increase in the future to match the DS coverage.

The adjustment to TrOOP increases is much less significant than the Pharma Discount and additional DS coverage in the coverage gap. Because TrOOP is increasing more slowly than the other parameters, the value of DS coverage increases annually. The impacts will be similar directionally to those identified with the additional DS coverage above but will have a smaller effect.

The Part D premium increase on high-income beneficiaries is designed similarly to the Part B program. Members with income exceeding the Part B thresholds ($85,000 for individuals) will have to pay additional premiums for coverage to offset a lower government subsidy. CMS announced that it would collect the additional premium directly from Social Security checks and thus the plan sponsor will not be affected unless they wish to cover the high-income surcharge through some form of reimbursement to the member. In this case, the plan sponsor would face increased costs and new administrative challenges relative to the current premium structure that is not income-based. This change affects individual and group Part D plans, but not RDS plans.

Medicare's Prescription Drug Options

In general, the options available to plan sponsors have not changed, but the new provisions impact each option's value in significantly different ways. Understanding these new provisions is essential to making an informed decision, as many of these provisions go into effect as early as fiscal year 2011.

The RDS option was created under the Medicare Modernization Act of 2003 to encourage plan sponsors to continue offering prescription drug coverage to Medicare-eligible retirees. To date, this approach has been by far the most popular, deemed the path of least resistance by many in the industry because it allows a plan to keep its benefit options while receiving government contributions. However, with recent changes from the reform legislation, other existing options that have not received as much attention may be more attractive than a sponsor's current option.

As was the case before reform legislation, however, the optimal choice depends on the plan sponsor's current drug benefit plan(s), the number of covered Medicare retirees, the plan sponsor's tax status, the way the plan sponsor shares premium costs with retirees, the sponsor's goals in providing drug benefits to retirees, and the effect on post-retirement benefit accounting in the financial statements. The other options besides RDS are:

- providing secondary wraparound coverage for a Part D plan (and possibly paying the member's premium for the underlying Part D coverage),
- purchasing group coverage or contracting directly with CMS under an EGWP, and
- dropping prescription drug coverage for Medicare-eligible retirees (and possibly paying the member's premium for individual Part D coverage).

Exploring Alternatives to RDS: A Case Study

One client, a white-collar private corporation covering roughly 500 retiree and dependent lives, requested that Milliman review its retiree prescription drug coverage options under Medicare Part D in order to make an optimal decision in light of recent health care reform changes. Working collaboratively with the client, Milliman reviewed its current RDS strategy, as well as all other available options, weighing both financial and administrative concerns while considering the organization's present and future plan goals.

  ISSN

For this organization, terminating its current prescription drug coverage for Medicare-eligibles produced the most favorable financial results (see the table below). This was the most financially favorable option because it maximized the payment from the government and met the client's goal of transferring the risk for this uncapped liability.

However, in addition to focusing on the quantitative results, the client also had qualitative factors to consider in making an optimal decision for its retirees. Terminating its current prescription drug coverage posed too drastic a change and was not feasible for the client.

In light of these qualitative factors, providing a secondary wraparound plan and paying the retiree premium for an underlying DS EGWP was the optimal option for the client. This option enabled the client to replicate its current benefit structure without significant adjustments while reducing its current liability. The main driver reducing the plan's liability for the secondary wraparound plan was the Pharma Discount.

Another advantage of the secondary wraparound option in comparison to the RDS option was the certainty of the cost reduction. The Pharma Discount is not dependent on passing any equivalence tests. However, the RDS is contingent upon the client continuing to offer a benefit design at least as good as the DS Part D plan design, as well as sufficient funding relative to Medicare.

If the client needed to increase member contributions in the future, these RDS restrictions would limit the client's freedom to do so. Because the secondary wraparound option has no restrictions on member contributions, the client will receive the Pharma Discount while retaining the freedom to increase member contributions in the future as needed.

One additional consideration Milliman discussed with the client is the higher administrative costs associated with EGWPs and secondary wraparound plans compared with RDS. The additional complexity involved with administering a secondary wraparound plan combined with the extra marketing and educational material necessary to describe the shift to its members increased administrative costs. However, since the Pharma Discount more than offset the increased administrative costs, the client was willing to take on the increased administrative responsibilities inherent with secondary wraparound plans.

Conclusion

As a result of Milliman's analysis, the client was able to explore a variety of options for offering pharmacy coverage to its Medicare-eligible retirees. Based upon both the quantitative and qualitative results, the client was able to select the option (secondary wraparound) that matched both its current benefits and its long-term goals. This was not the client's expected optimal approach when we started the project and thus they benefitted from an assumption that their current approach was not necessarily optimal.

Client ABC
Projected Benefit Option Comparison - Annual Cost Per Member
January 2011 - December 2011 Coverage Period

Projected 2011 Cost Components	Prior to Healthcare Reform - Pay Primary (RDS)	Post Healthcare Reform - Pay Primary (RDS)	Pay Secondary1 (Coordinate)	Drop Coverage and Pay Part D Premiums for Standard Coverage	Purchase Insured Coverage through a PDP (EGWP)
Total Prescription Drug Cost	$2,250	$2,250	$2,250	$0	$2,250
Less: Member Cost Sharing	($700)	($700)	($600)	$0	($600)
Less: Pharma Discount	N/A	N/A	($250)	N/A	($50)
Less: Federal Reinsurance	$0	$0	($100)	$0	$0
Plan Liability for Primary Coverage	$1,550	$1,550	$850	$0	$1,600
Plan Liability for Secondary Coverage	N/A	N/A	$450	N/A	N/A
Plus: Administration	$50	$50	$100	$0	$100
Plus: Part D Member Premium [2]	NA	NA	$384 [4]	$384 [4]	$0
Subtotal: Total Cost Before Subsidy	$1,600	$1,600	$934	$384	$1,700
Less: Federal Subsidy [2]	($450)	($450)	N/A	N/A	($450) [5]
Less: RDS Tax Advantage [3]	($250)	$0	N/A	N/A	N/A
Total Plan Sponsor Cost After Subsidy	$900	$1,150	$934	$384	$1,250

[1] Assumes the client ensures retiree cost sharing is no more than the cost sharing under the client's current plan.

[2] Premium and subsidy values are not adjusted to reflect the premium increase for high-income beneficiaries introduced under healthcare reform.

[3] The subsidy is currently worth more to tax-paying entities because it is free of federal taxes. However, this will change under healthcare reform legislation beginning in 2013, and this change must be reflected immediately in financial statements.

[4] Assumes Medicare eligible retirees will be able to purchase Standard Part D coverage (which was lower than the client's proposed coverage) for $384 in the marketplace, or $32 per month. However, because the premium will vary by plan, the actual premium may be more or less than estimated.

[5] Equal to the subsidy received by the PDP. Uses the nationwide average Part D bid of $87.05, the nationwide average member premium of $32.34, and an average risk factor of 0.826.

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