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# Medicare Part D: Planning for the Future!

Presented by:  
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Thursday, March 2, 2006

# Agenda

- Introductions
- Rocky Rollout? Marketplace Response
- Collecting the Subsidy in 2006
- Employer Options for 2007 and Beyond
- Final Tips: Communication Considerations

Please submit questions through the "Ask a Question" button on the webcast player or by emailing Adabelle Cohen at [adabelle.cohen@buckconsultants.com](mailto:adabelle.cohen@buckconsultants.com)

# Rocky Rollout? Marketplace Response

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## Rocky Rollout Affected Part D's Credibility

- Overload on choice: 52 plan options in some locales
- CMS phones on overload; 400,000+ calls in a single day
- Paperwork failed to keep up (in part due to allowing enrollment up to the last day of each month)
  - Worst problem: 6.2 million low-income and disabled enrollees auto-transferred from Medicaid to a Part D plan
  - Pharmacists on hold for hours to verify eligibility, while CMS computers crashed; pharmacist help line staffing was raised from 150 to 4,500
  - Instead of \$3 to \$5 fees, charged \$50 to \$100 or more; many retirees had to walk away
  - 20 states told pharmacies to fill orders and bill the state

# Headlines Told the Human Impact of the Confusion

## *Medicare Drug Plan Leaves Out Supplies*

**The benefit covers home IV medication but not the implements and care needed to administer it.**

New York Times Staff Writer

January 27, 2006 WASHINGTON — The new Medicare drug program is denying supplies that seriously ill patients need to administer intravenous antibiotics and other medications at home. As a result, some patients are being referred to nursing homes, and others have had to go into hospitals.

## Or Not So Rocky? Contrasting Viewpoints

“The 4.7% voluntary enrollment rate ‘compares miserably’ with the 93% voluntary rate achieved when Medicare was launched in 1966.”

Robert M. Hayes  
Medicare Rights Center

“The enrollment numbers are ‘encouraging news’ and demonstrate that the retiree drug subsidy program is allowing most employers to continue to provide valuable benefits for retirees in 2006.”

John J. Castellani  
President, Business Roundtable

## What's the Story on the Skepticism?

- **Complex design and donut hole:** *“Like the horse designed by committee, which ended up as a camel,”* as Part D provides drug coverage with *“a beginning and end, but no middle”*
- **Belated recognition of the complexity:** *“A wild, wild, West free-for-all...”* (Sen. Baucus, D-Mont.)
- **After a February 22<sup>nd</sup> town hall with seniors:** *“There’s real deep anger and hostility...more than just bugs and start-up snafus. There’s some real structural problems.”* (Sen. Levin, D-Mich.)
- **Distrust:** Many stories of seniors where math showed Part D should be cheaper, but who feared trusting the government and letting go of employer plan coverage
- **Enrollment:** CMS predicted 39.1 million by year-end; then adjusted expectation to 28-30 million
- **Result:** Employers’ retirees have been watching the confusion

## Report Card: MMA Program Availability

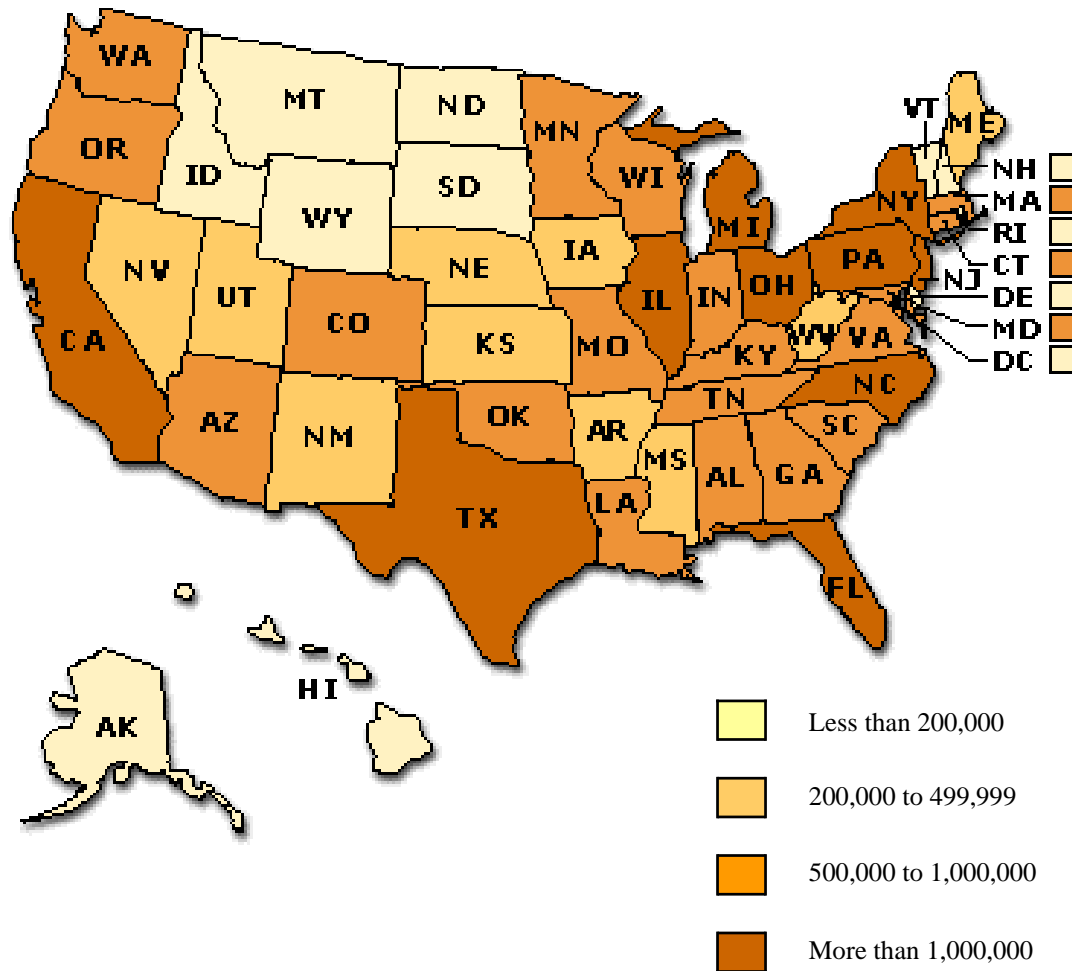
- Each state has from 27 to 52 PDPs, including Medicare Advantage plans, available to the general Medicare-eligible population
- Puerto Rico has no PDP or MA plans
- Enrollment has met Federal expectations, according to HHS Secretary Mike Leavitt (December 2005)
- 11 million retirees have maintained employer- or union-sponsored coverage for prescription drugs
- Monthly premium levels are competitive and better than expected

# Breakdown: Part D Enrollments as of February 2006

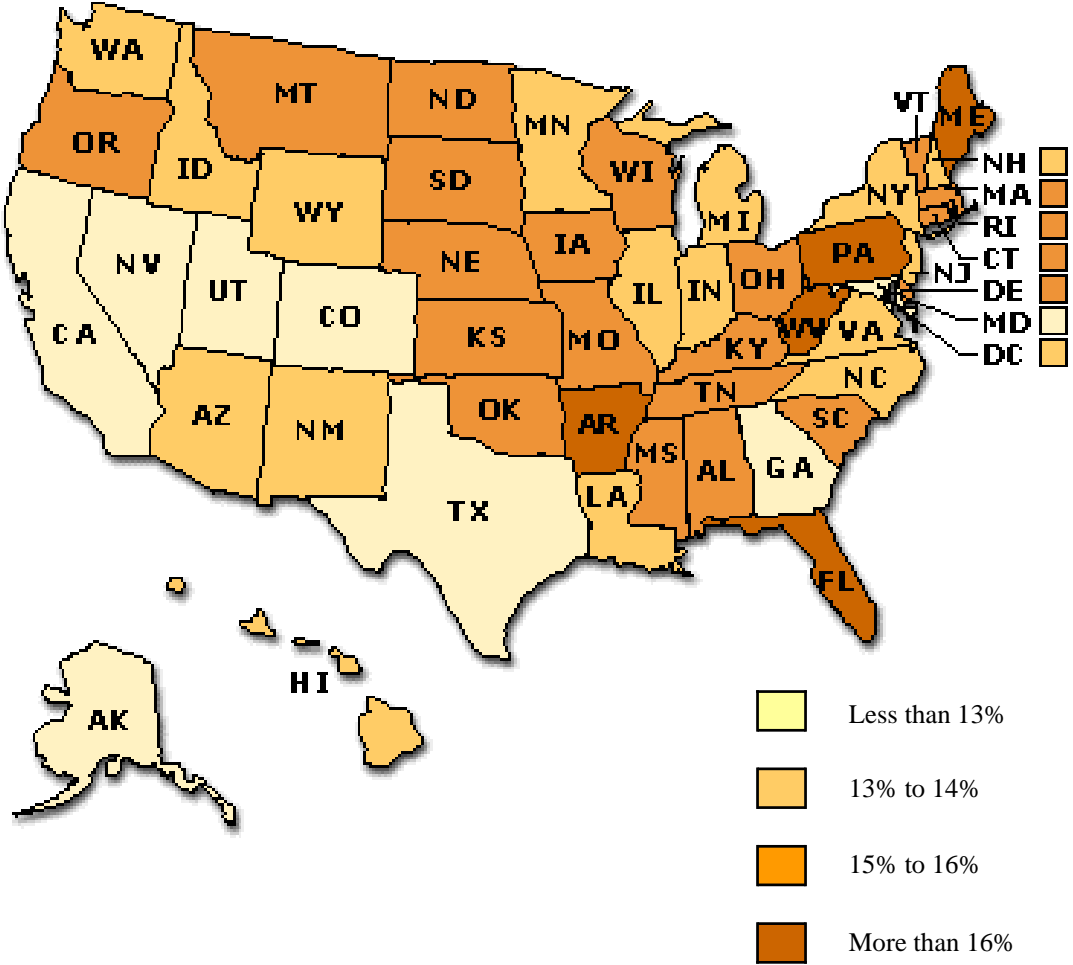
Enrollees out of potential total population of 42,000,000:

■ Nearly 25 million enrollees	
– Prescription Drug Plan (PDP)	5,400,000
– Medicare/Medicaid	6,200,000
– Medicare Advantage plans	4,400,000
– Retiree Direct Subsidy	5,900,000
– Tri-Care/FEHB	3,100,000
<b>Total MMA Part D Participants</b>	<b>25,000,000</b>

# Total Number of Medicare Beneficiaries



# Medicare Enrollment as a Percent of Population



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# Collecting the Subsidy in 2006

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# Likelihood of Continuing to Collect Employer Subsidy

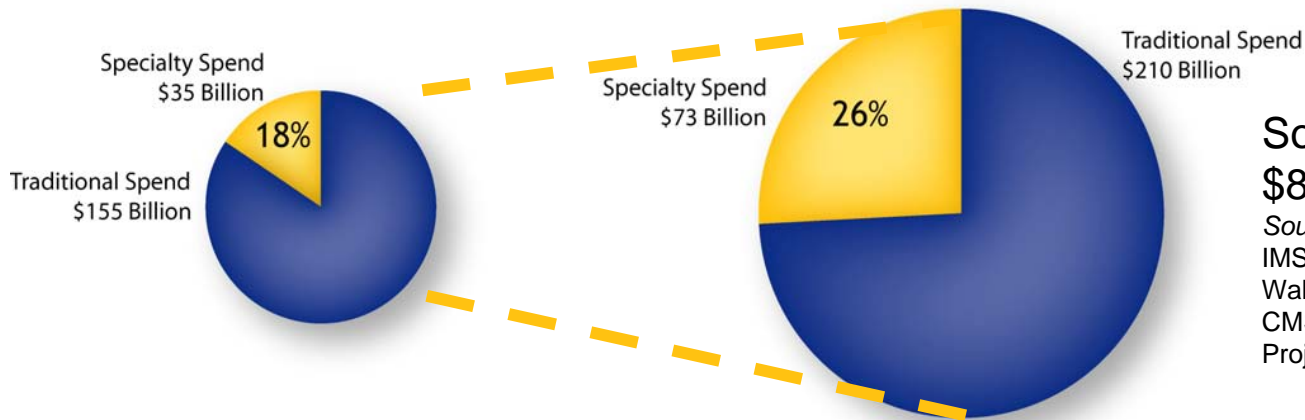
## Market Changes

- \$48 to \$50 billion of brand name prescription drug sales in the USA are going generic within approximately 42 months
- The average generic prescription costs under \$25, versus the average brand name prescription cost of \$100 or more for a one-month supply
- The deductible and allowed expense corridors for the MMA Part D subsidy payments to employers will be indexed annually
- The 28% allowable subsidy payment MAY cover smaller percentages of prescription drug expenses for employers in coming years

# Likelihood of Continuing to Collect Employer Subsidy

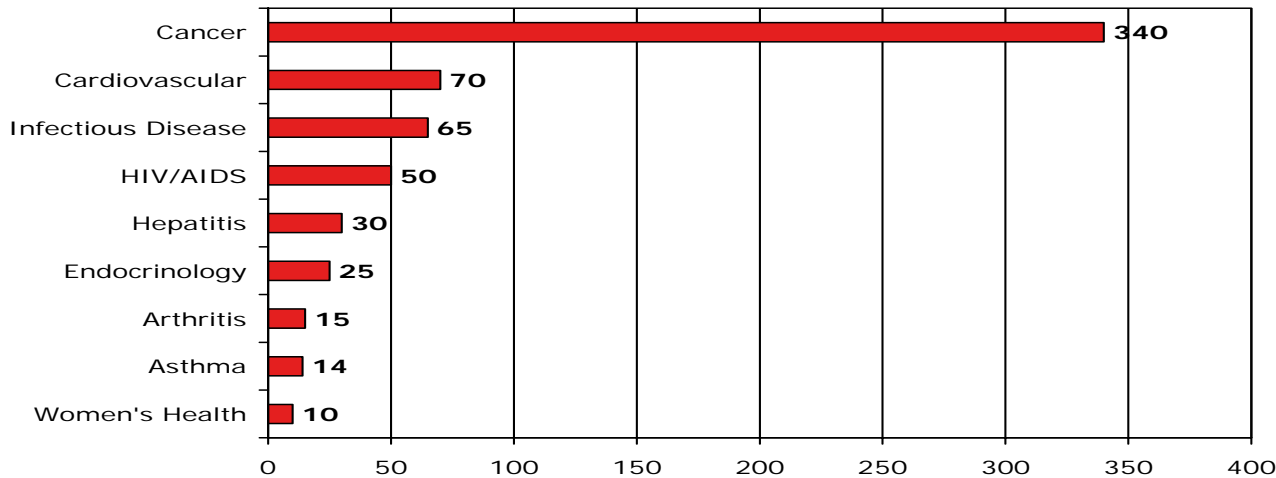
Medication	Indication	Scheduled Generic Introduction	Avg. Rx Cost	Comments
Pravachol	High Blood Cholesterol	April 06	\$146.45	Generic may allow step therapy
Zocor	High Blood Cholesterol	June 06	\$135.93	No generic defense; dramatic decrease in cost expected
Zoloft	Depression	June 06	\$90.65	Generic may allow step therapy
Wellbutrin XL	Depression	August 06	\$111.74	Generic may allow step therapy
Norvasc	High Blood Pressure/ Heart Disease	January 07	\$62.68	Will create generic class at low cost
Ambien	Sleep	April 07	\$87.21	CR version available to extend patent life
Imitrex	Migraine	June 07	\$251.86	Generic may allow step therapy
Lamisil	Anti-fungal	June 07	\$255.23	OTC topical available
Zyrtec	Allergies	December 07	\$60.44	May move OTC (Allegra also)

# Likelihood of Continuing to Collect Employer Subsidy



Some estimates suggest \$87 billion in 2008 sales

Sources:  
IMS Data through November 2004  
Wall Street Equity Research, 2004  
CMS National Healthcare Expenditure Projection: 2003-2013



Over 600 Biological and Specialty medications in the pipeline

Sources:  
Raymond James & Associates, Industry Report  
PhRMA, International Federation of Pharmaceutical Wholesalers & Biotech Industry Organization

# Product Mix: Disease Prevalence Model

Example of 10,000-Life Commercial Group (\$11.50 PMPM):

Disease State	National Prevalence	Commercial Prevalence	Est. Avg. Annual Spend Per Patient	Number Of Member Lives	Estimated Annual Client Spend
Rheumatoid Arthritis	0.926%	0.074%	\$13,800	7	\$ 96,600
Multiple Sclerosis	0.137%	0.078%	\$14,400	8	\$ 115,200
Psoriasis (moderate to severe)	0.512%	0.110%	\$13,500	11	\$ 148,500
Hepatitis C	0.735%	0.034%	\$25,000	3	\$ 75,000
Growth Hormone	0.018%	0.007%	\$31,200	1	\$ 31,200
IVIG	NA	0.007%	\$25,000	1	\$ 25,000
Asthma (severe)	0.517%	0.005%	\$18,000	11	\$ 198,000
RSV	NA	0.067%	\$18,000	7	\$ 126,000
Oncology (all)	0.467%	0.230%	\$25,000	23	\$ 575,000
<b>TOTAL</b>				<b>72</b>	<b>\$1,390,500</b>

## Product Mix: Observations

- More generic product introductions will save money and impact subsidy payments
- Increased biologicals entering the marketplace will potentially add Rx claims expense above the subsidy reimbursement amount
- New pharmaceutical delivery technology will become increasingly available
- The lines between medical and pharmaceutical expenses (Medicare Part B & D) will continue to blur
- Collecting the subsidy as a cost-effective method of participating in Part D activity should be reviewed

# Performing Due Diligence for Subsidy Collection:

## Why?

- To minimize consequences of errors in Retiree Drug Subsidy (RDS) data submission
- Streamline RDS administrative oversight
  - Minimize risk of errors in subsidy submissions
  - Maximize subsidy reimbursements to Plan Sponsors
- Potentially simplify new RDS roles and responsibilities
- Medical and pharmacy claims data integration of Part B versus Part D drugs for reporting purposes
- Audits vendors on an ongoing basis

# Minimum Due Diligence Support Services

## Compliance

- Part of a total comprehensive compliance plan
- Actuarial attestations reviewed
- HIPAA privacy requirements reviewed
- Account Representative and Account Manager verifications of responsibility

## Audit

### Eligibility

- Only Medicare-eligible individuals in the US submitted for subsidy
- Exclude retirees opting for Part D programs (MA-PD or PDP)

### Claims

- Proper application of rebates according to CMS rules
- Only Part D-covered prescriptions
- Not duplicative of Part B drugs
- 100% of claims validated for pricing

## Data Storage

- Comprehensive, auditable data retrievable according to CMS rules and regulations
- Easy to access and report as needed
- Available for CMS review for required 7 years
- Guaranteed access even with changes in PBM, carrier or TPA administrators

# Minimum Due Diligence Support Services: What One Client Has Done

## Situation:

- Excess of 1,000 retirees (Medicare eligible)
- Single PBM vendor
- Multiple medical vendors
- Needed help on collecting/managing the subsidy

## Needs:

- Manage eligibility file
- Verify/audit pricing and subsidy calculations
- Reconcile changes
- Maintain knowledge of CMS rules and regulations
- Data storage and retrieval availability

# Minimum Due Diligence Support Services: What One Client Has Done

## Solution:

- Independent data aggregator to store, audit and verify integrated medical and Rx claims
- Review 100% RDS subsidy calculations
- Eligibility verification and “clean-up”
- Reformatting as required for submission
- Accountable resource with experience

## Results:

- Peace of mind
- Complete compliance plan for management



# Employer Options for 2007 and Beyond

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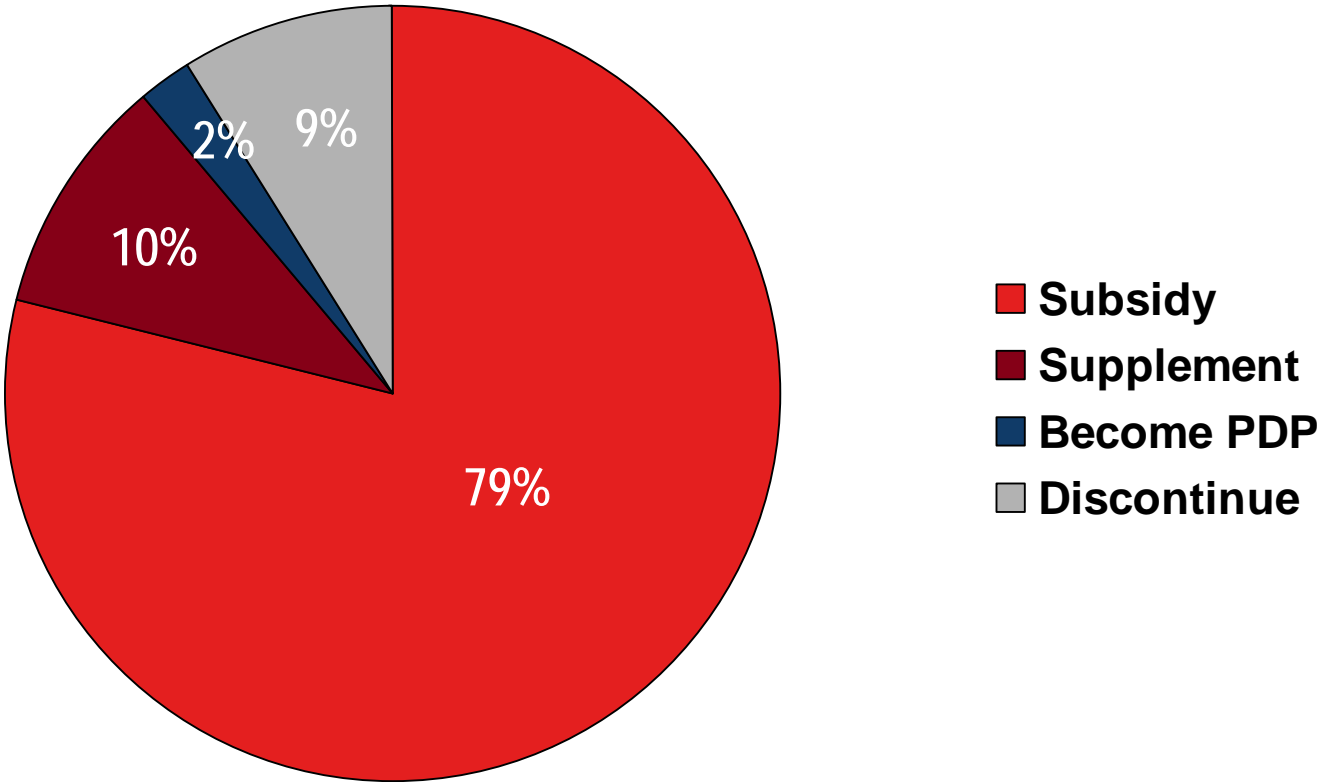
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## Polling Question #1

What was your 2006 strategy for your largest group of Medicare retirees?

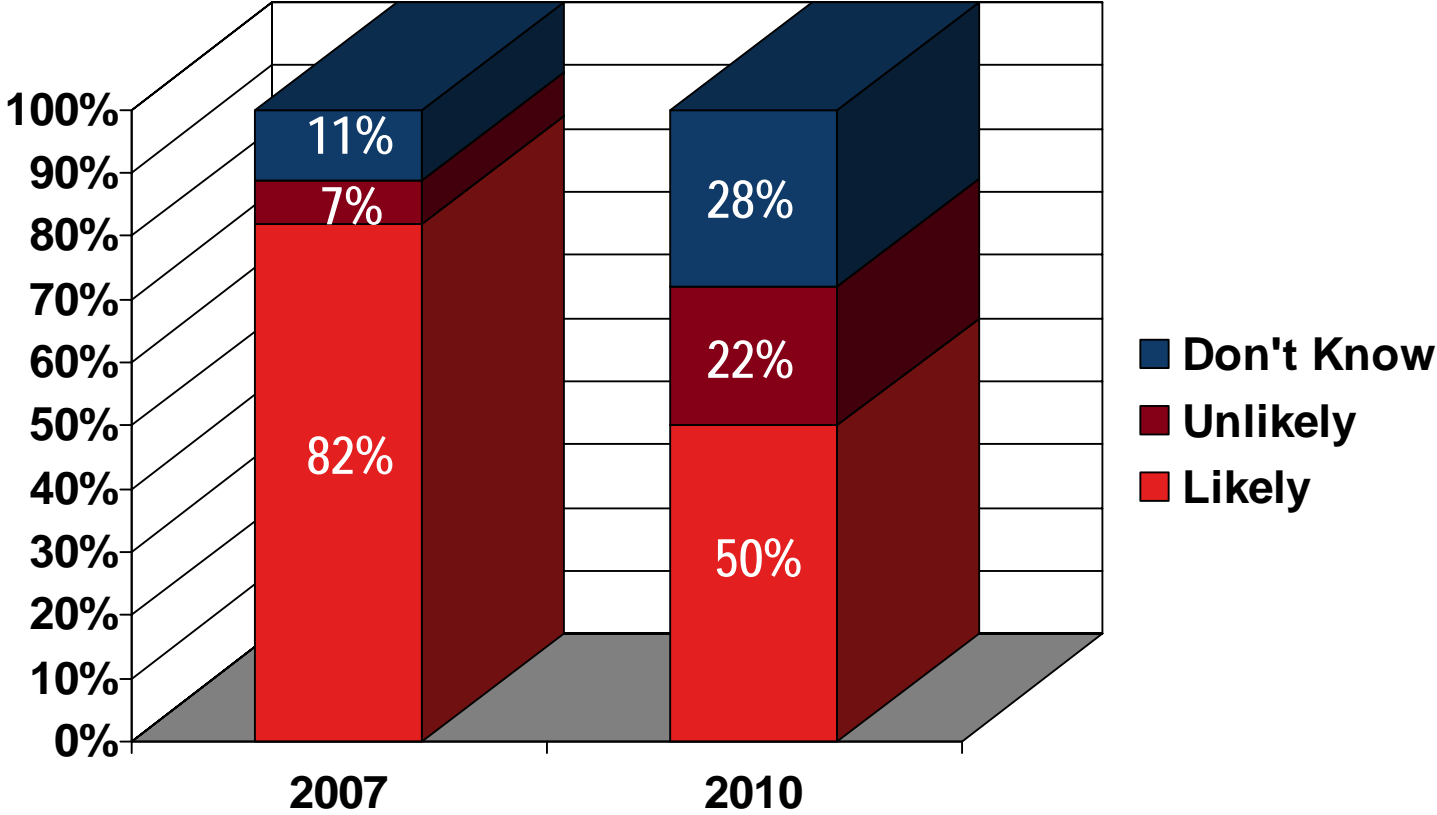
- a. Collecting subsidy
- b. Continued coverage wrapping around Part D
- c. Contracted with a PDP
- d. Directly sponsored a PDP
- e. Discontinued retiree prescription coverage

# Marketplace Response: Employer Strategies for 2006



Kaiser/Hewitt 2005 Survey on Retiree Health Benefits

# Likelihood of Continuing to Collect Employer Subsidy



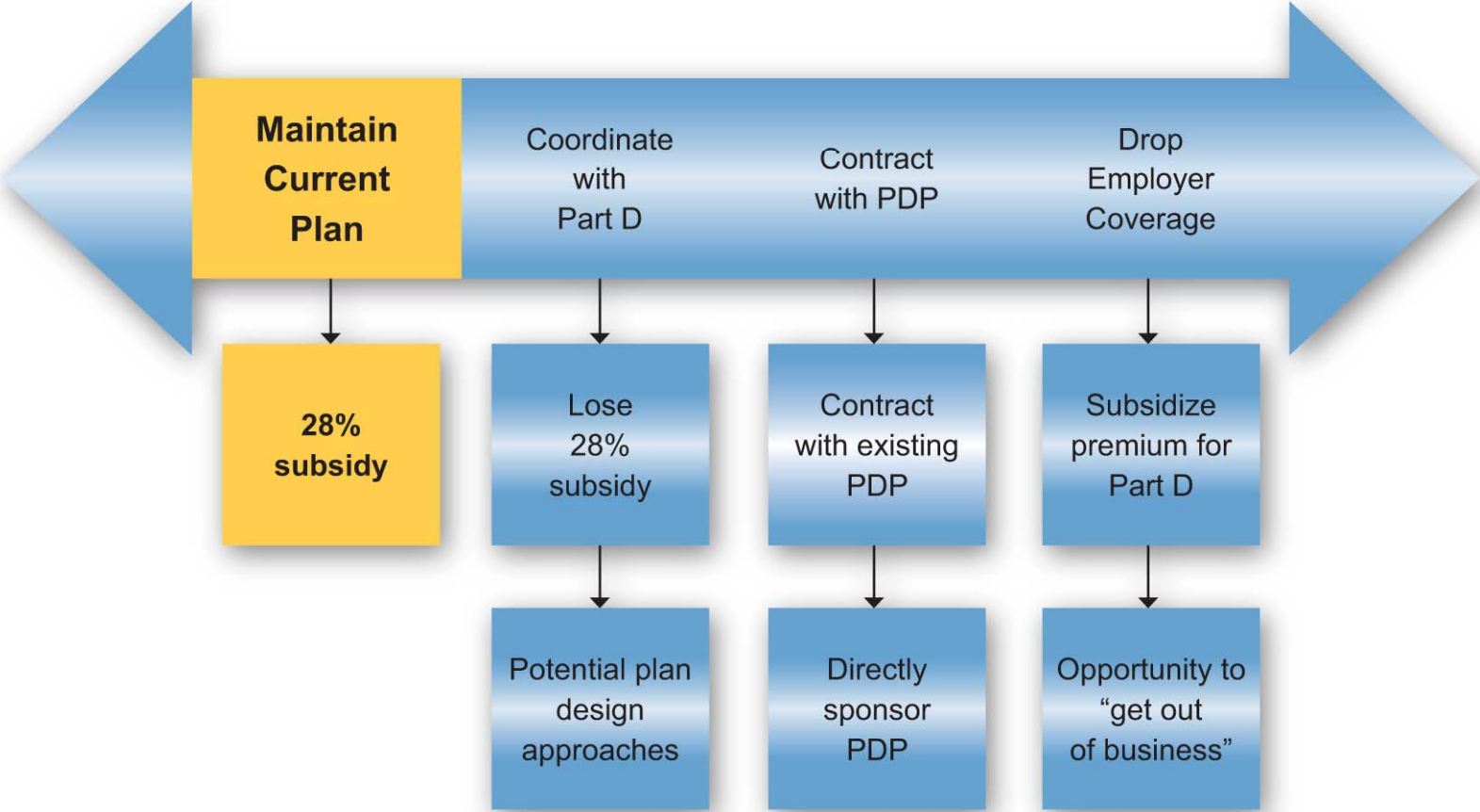
Kaiser/Hewitt 2005 Survey on Retiree Health Benefits

## Polling Question #2

For those of you who are collecting the subsidy in 2006, how many expect to continue to collect the subsidy for 2007?

- a. Likely
- b. Unlikely
- c. Not sure

# Employer Options



# Subsidy

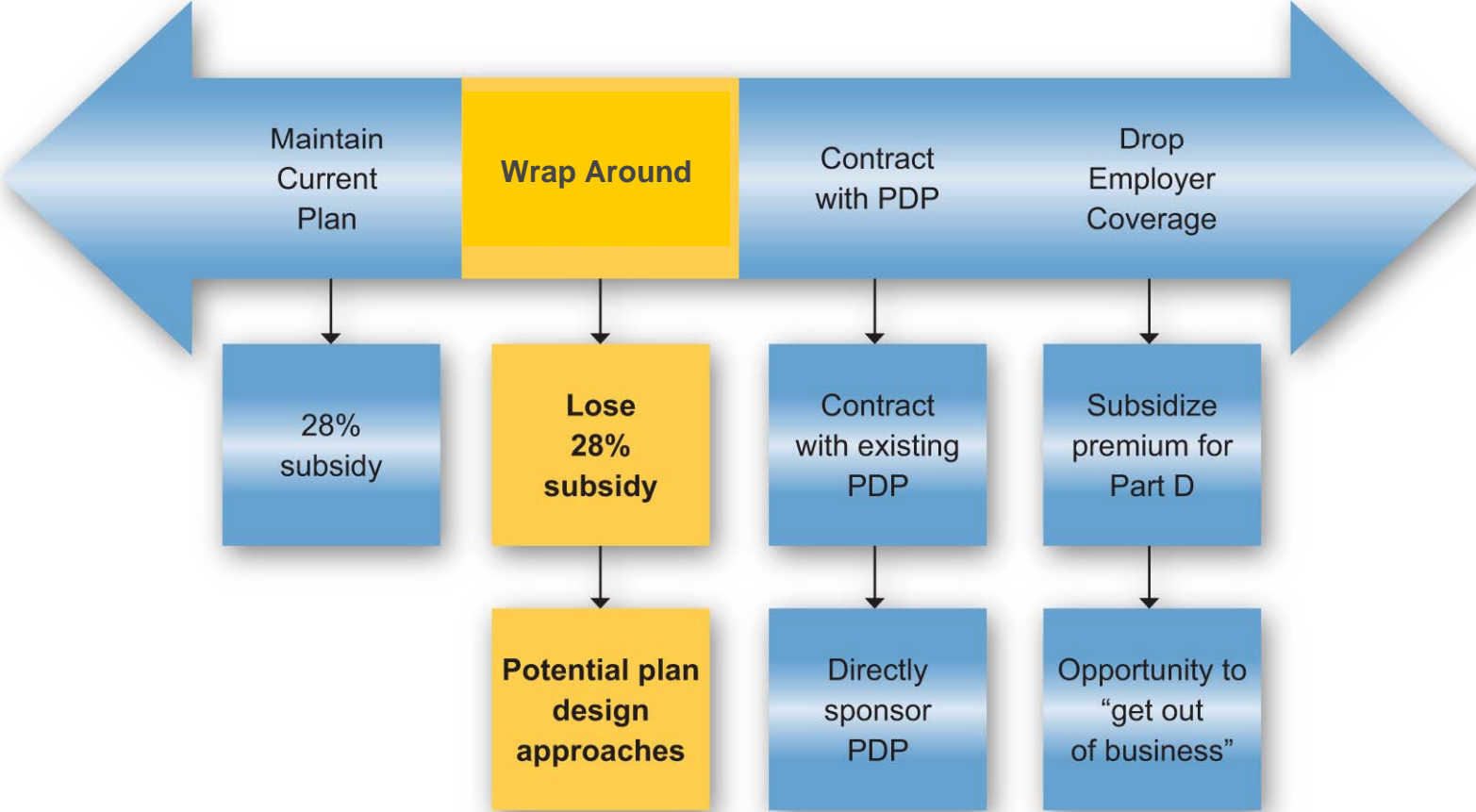
## Advantages

- Least amount of administrative, financial and regulatory uncertainty
- Retains greatest flexibility in the short-term
- No major plan design or vendor modifications required
- Least disruption to retirees
- Simplest required communications
- Subsidy payments are tax-exempt
- Subsidy payments increase with trend

## Disadvantages

- Requires additional annual recordkeeping and reporting
- Requires annual determination of actuarial equivalence
- May be greater savings from other approaches, particularly for governmentals and non-profits

# Employer Options



# Wrap Around

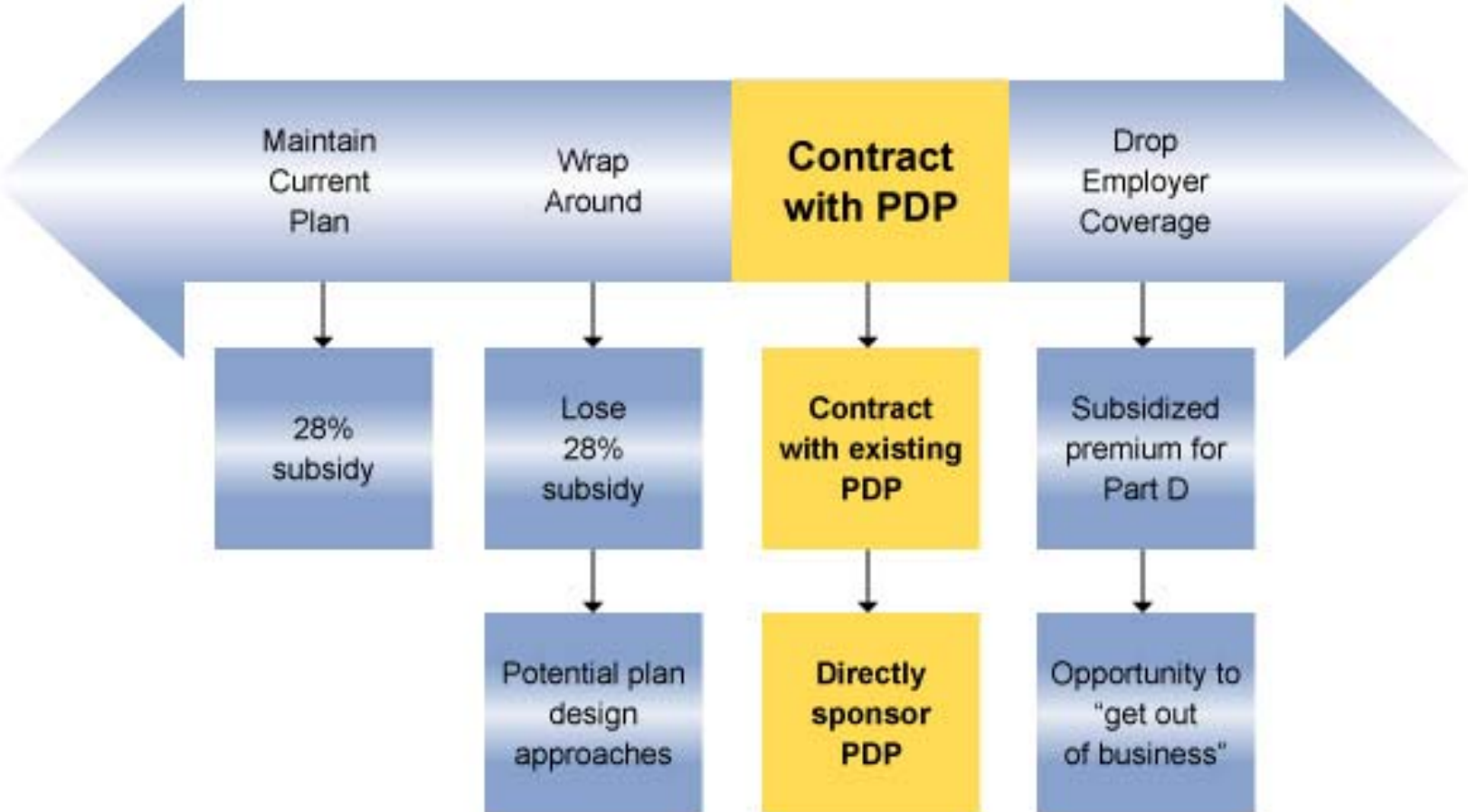
## Advantages

- Similar to employer COB with Medicare Part A and B
- Retiree Rx benefit from Part D and employer combined remains the same reducing disruption
- Employer financially benefits from enhanced Part D benefits for low income
- No actuarial attestation, certificates of creditable coverage or CMS reporting
- Strategy not dependent on national PDP option(s)

## Disadvantages

- Potentially complex claims administration
- Inconsistencies in plan terms between PDP and employer plan could lead to retiree confusion (e.g., formularies, days' supply, copays, etc.)
- Employer secondary obligation varies depending on richness of PDP the retiree selects
- Significant retiree communications required to help retirees make choice and enroll in a PDP
- May offer greater savings than other approaches

# Employer Options



# Employer Contract with Single PDP

## Advantages

- No actuarial attestation, certificates of creditable coverage or CMS reporting
- Numerous national PDPs available
- CMS waivers allow consistent national benefit design simplifying administration and communications
- May be able to match current plan design
- Retirees get seamless Rx benefit package
- Simpler vendor management
- Greater flexibility for alternative financing and risk sharing

## Disadvantages

- Strategy more vulnerable to marketplace changes and vendor entries/exits from market
- Likely limited to PDP formulary, discounts, network and rebates
  - Higher costs likely
- May impact PBM contract terms for active employees and pre-65 retirees (non-Part D)
- Additional administrative expense from PDP

# Employer-Sponsored PDP (Contract with CMS)

## Advantages

- Employer program immunized from potential marketplace disruptions
- Employer has more flexibility on plan design, formulary, networks and pricing
- Functions similar to self-insurance

## Disadvantages

- Extensive implementation process (time and cost)
- Complex IT requirements to interface with CMS, although possible to contract to claims administrator
- Employer had to file intent to contract in January '06 for '07
- Impact on formulary, discounts, network and covered drugs
- May impact PBM contract terms for active employees and pre-65 retirees (non-Part D)
- Still emerging regulatory process with possible changes

# Factors in Deciding on Approach

- Retiree relations
- Legal constraints
- Administration
- Communication
- Financial
- Number of retirees
- Geographic dispersion

## Key Variables in Financial Modeling

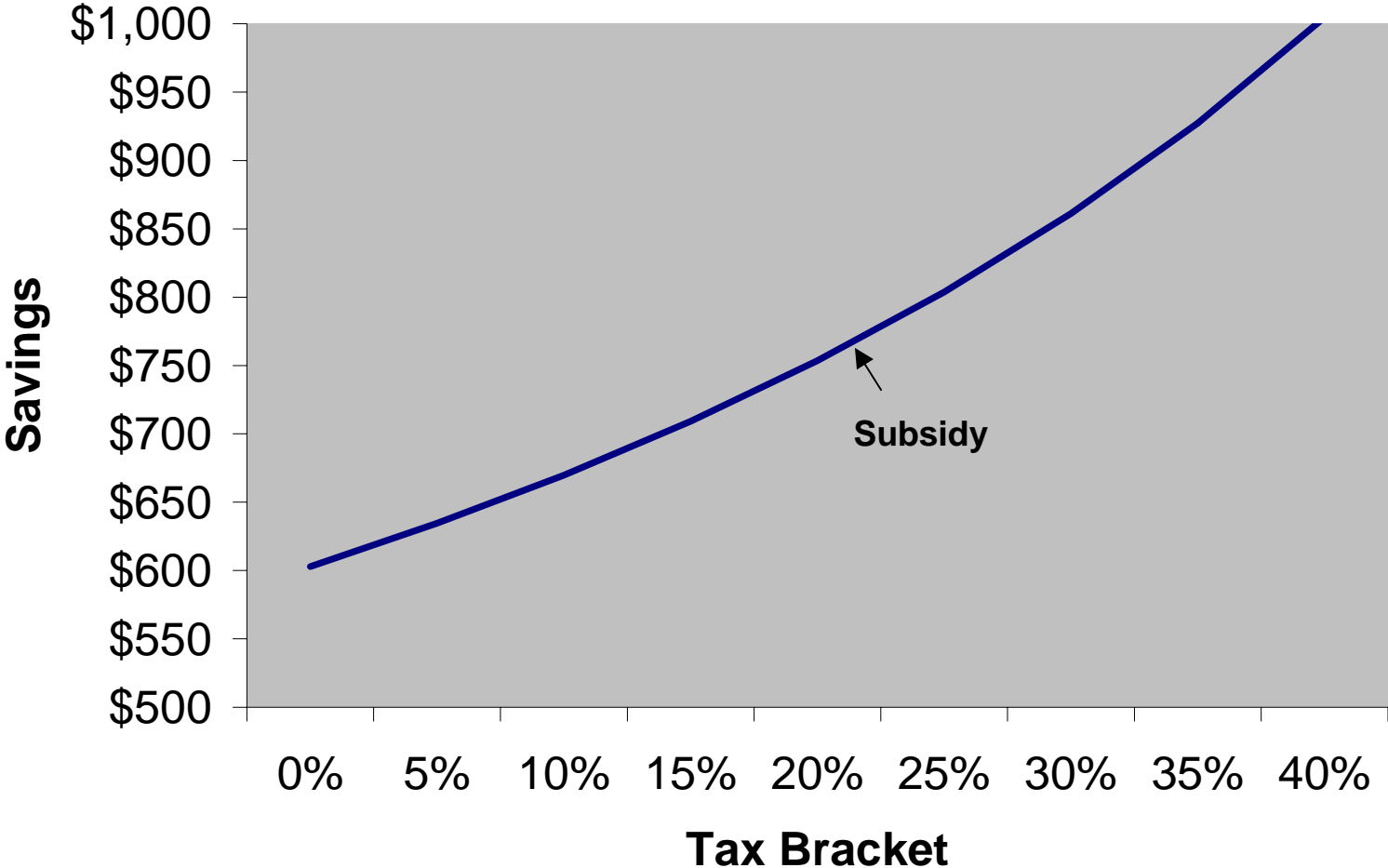
- Claims experience
- Risk adjustment (based on retiree population)
- Employer's tax bracket
- Governmental vs. private
  - GASB versus FASB accounting
- Plan design
- Cost of administration/insurance for PDP
- Formulary, discounts, Rx management changes
- Current PBM/ carrier contract

# Scenario for Decision Modeling

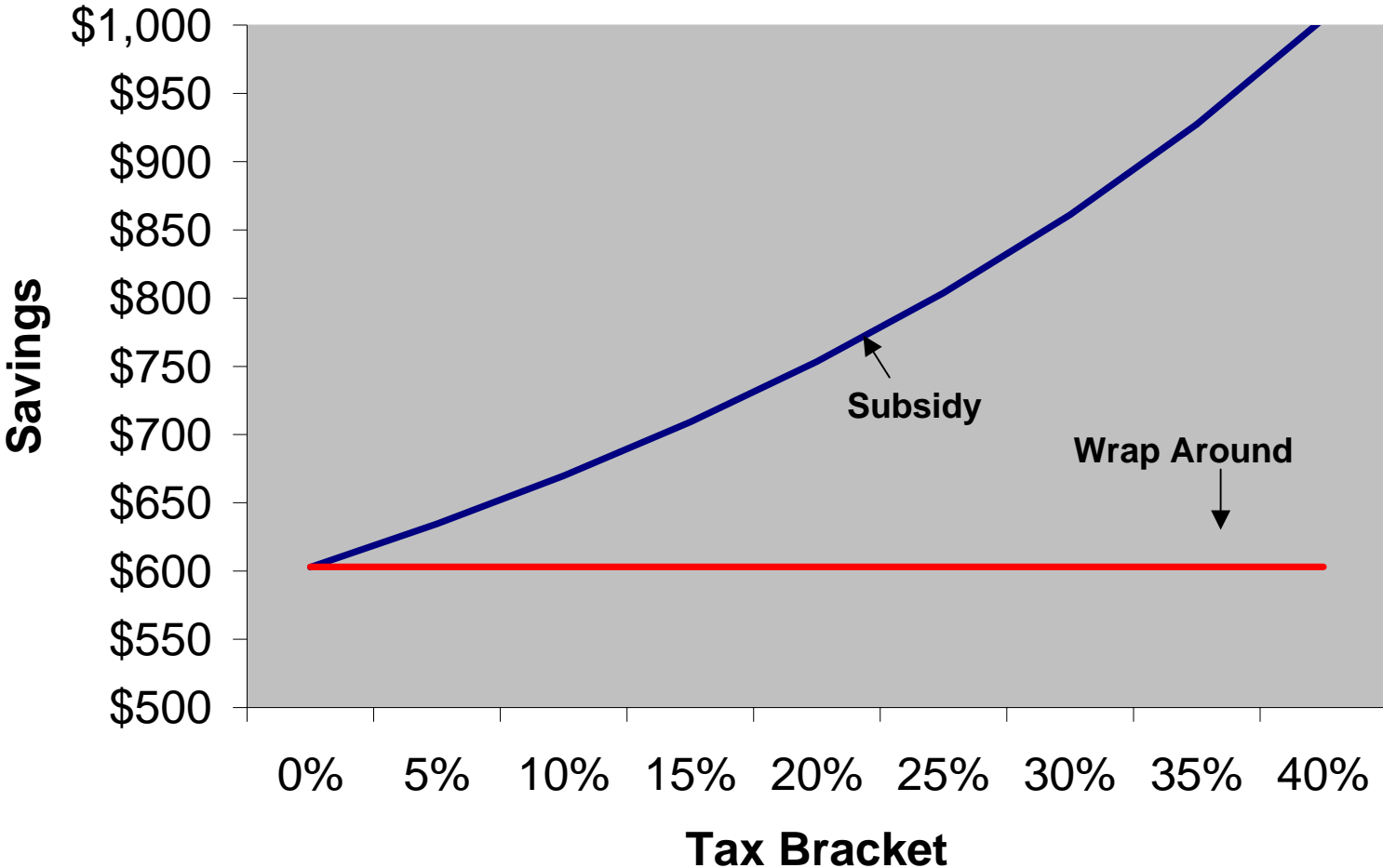
## Example: **Employer “A”**

- Private employer
- Over 30,000 Medicare retirees
  - Largely in Northeast, but spread across nation
- Rich plan designs
  - No caps on employer cost
  - Mix of formulary and no formulary
- Rx program administered by PBM
- For 2006, took the subsidy
  - For 2007, exploring other options

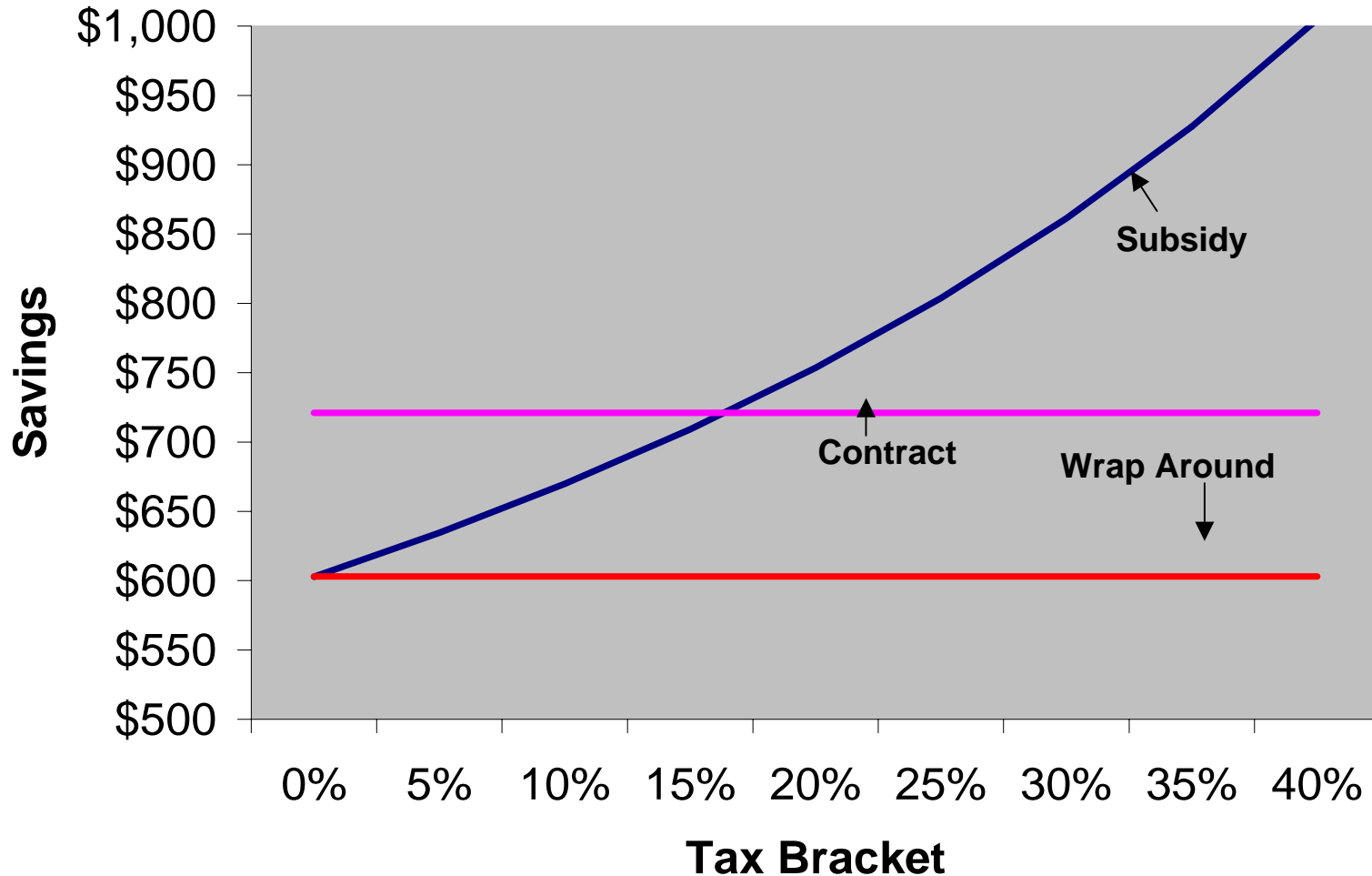
# Employer "A" Decision Model: Subsidy



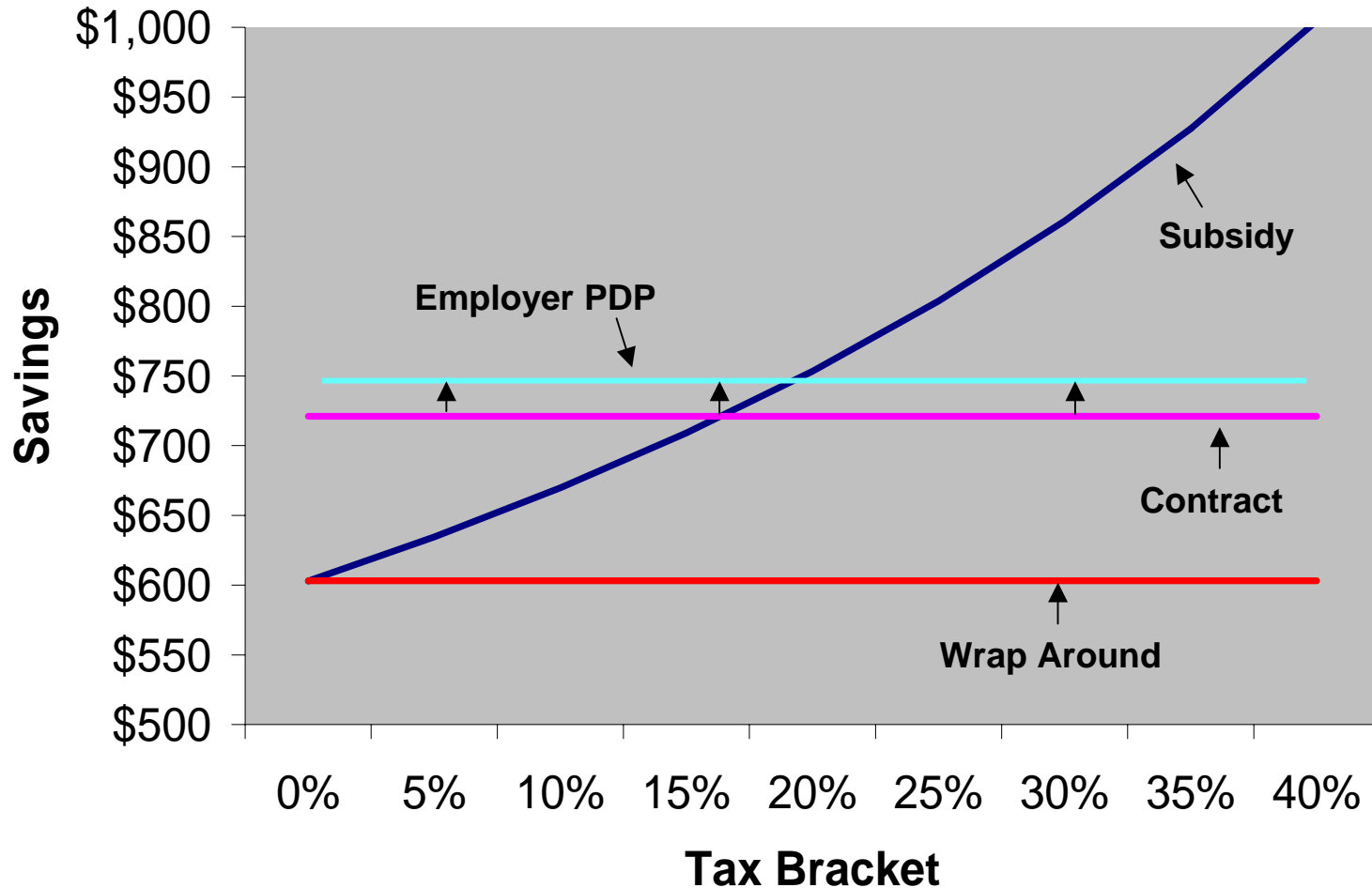
# Employer "A" Decision Model: Wrap Around



# Employer "A" Decision Model: Contract



# Employer "A" Decision Model: Employer PDP



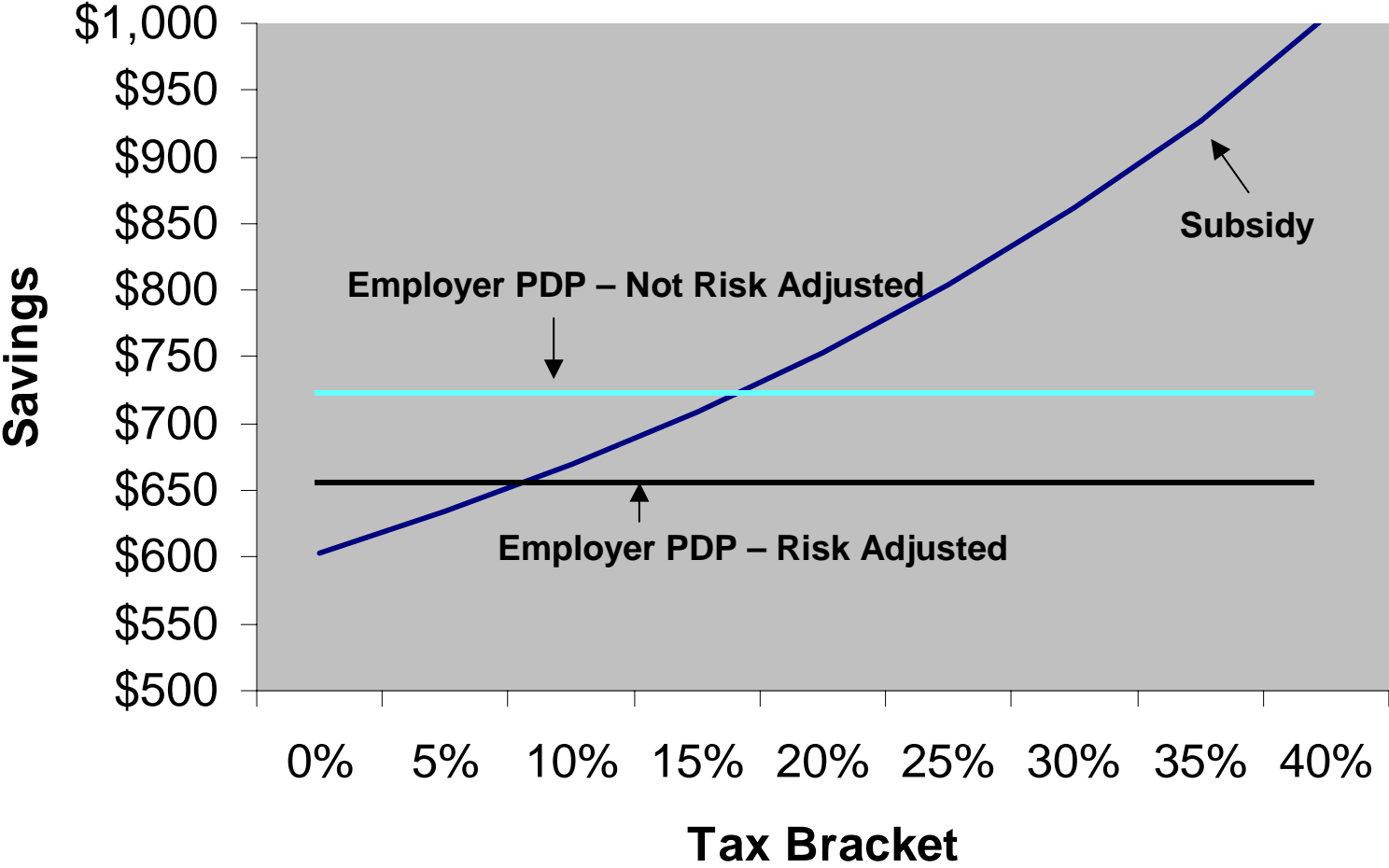
## PDP Risk Adjustments

- PDP payment adjusted to reflect relative risk status of enrollees
- Factors
  - Disease
  - Disability
  - Age
  - Sex
  - Institutionalized
  - Low income subsidy
- Can be very significant factor in CMS reimbursement

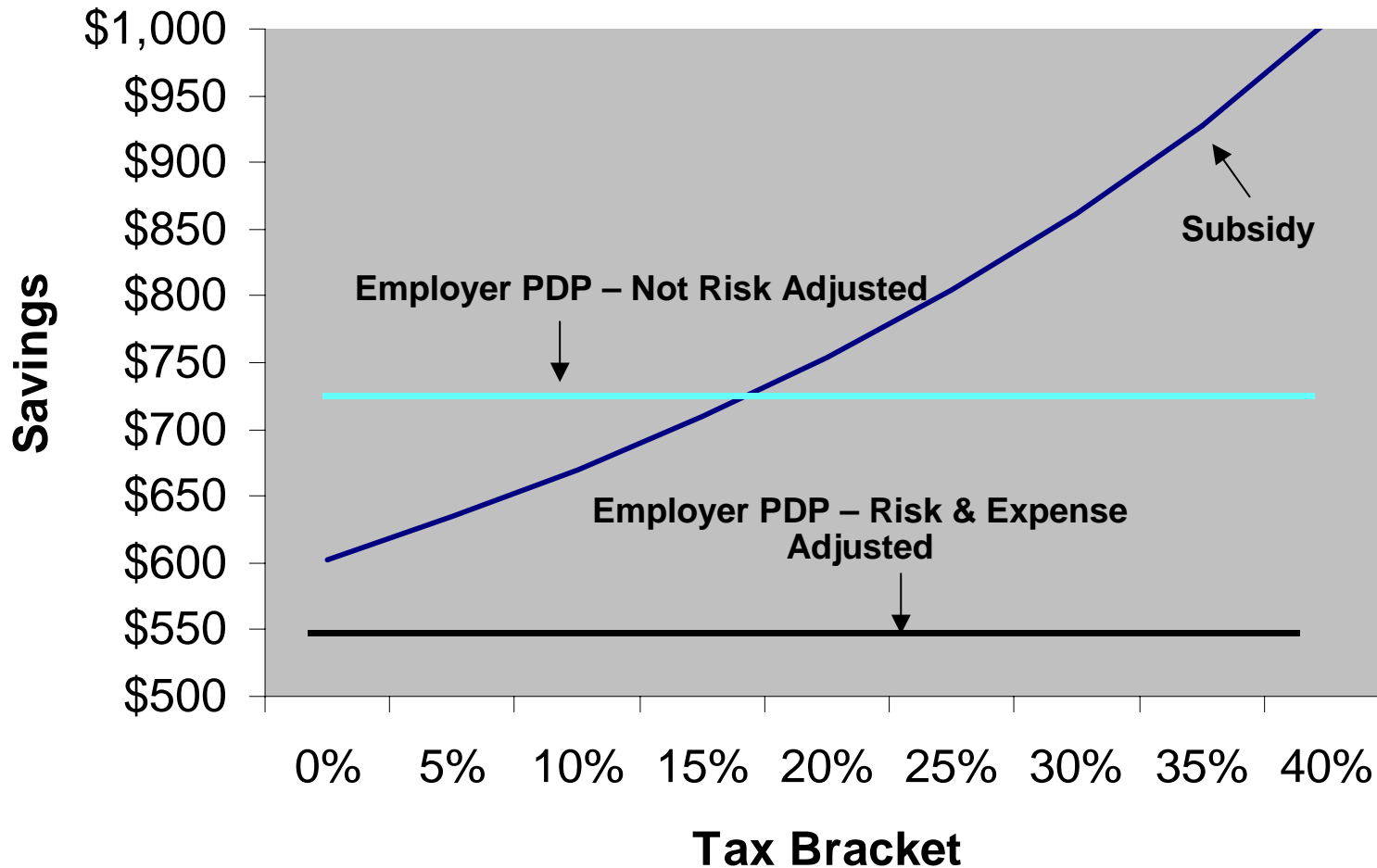
## Impact of Risk Adjustment

	Per Capita Results	
	Non-profit	Profit
2006 Subsidy	\$600	\$600
Tax Adjusted	\$600	\$923
Standard PDP Payment	\$721	\$721
Risk-Adjusted PDP Payment <ul style="list-style-type: none"> <li>▪ Risk Adjustment of 95%</li> </ul>	\$649	\$649
Risk- & Expense-Adjusted PDP Payment	\$529	\$529

# Employer "A" Decision Model: Employer PDP, Risk Adjusted



# Employer "A" Decision Model: Employer PDP, Risk & Expense Adjusted



# Accounting Treatment

- FAS 106 allows subsidy to be direct offset to obligation
- GASB may not allow direct offset
- Implications:
  - Increases GASB obligation on balance sheet
  - Uncertain revenue recognition of subsidy
  - Also impacts discount rate
    - Increases ARC
  - Increases attractiveness of other Part D approaches
- Proposed rule
  - Comments due by April 17<sup>th</sup>

# Scenario for Decision Modeling

Financial modeling is *employer-specific*

- General conclusions can be drawn from case study
- But analysis needs to be specific:
  - Claims experience
  - Demographic and risk factors
  - Tax position
  - Accounting treatment
  - Plan design
  - Current PBM financial arrangement
  - Risk and administration tolerance

## Don't Forget: Disclosure to CMS is Due by March 31<sup>st</sup>

- Initial participant notice was, of course, due November 15, 2005
- Annual notices are required thereafter *and* any time a change affects the plan's creditable status
- Next, plan sponsors must disclose to CMS by March 31, 2006 (for plan years ending in 2006)
- No need to submit a disclosure notice for groups for whom the subsidy is claimed (already provided attestation)
- However, must file notice for actives (post-65, disableds, or disabled dependents) even if in the same plan as retirees for whom you claimed a subsidy

# Final Tips: Communication Considerations

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# Communications: What Employers Should Do

- **Anticipate the May 15 Part D enrollment deadline** to proactively reduce confusion based on action steps for retirees
  - *If they should “stay put:”* The message is to “Ignore Part D”
  - *If current coverage is not creditable:* Reinforce that “May 15 is your last chance to avoid late enrollment penalties”
- **Link communication to your strategy for 2007 and/or beyond**
  - *If no changes:* Reassure retirees to stay in current offering
  - *If cleaning up after mistaken double dipping, etc.:* Offer re-education
  - *If promoting Medicare Advantage or other options:* Encourage taking a look
  - *If changing plan design or contributions:* Pave the way for understanding and buy-in
- **Remember one lesson learned:** the internet aided education and enrollment, with CMS site receiving more than 31.5 million page views
- **In the meantime, update documentation as needed**
  - Summary plan descriptions
  - Clarifications to retirees via regular newsletters, Web and other updates

# The Road Less Rocky!

- Implement and manage the process to collect subsidy
- Monitor the rapidly evolving environment
  - Drugs
  - Marketplace
  - Regulatory
- Explore additional options available in 2007 and beyond
  - Financial implications
  - Retiree relation issues
  - Very employer-specific analysis
- Manage communication needs proactively

# Questions?



Please submit questions through the "Ask a Question" button on the webcast player or by emailing Adabelle Cohen at [adabelle.cohen@buckconsultants.com](mailto:adabelle.cohen@buckconsultants.com)

# Thank You

*...and please contact us if you have further questions*

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