

After three years of providing prescription drug coverage to retirees under Medicare Part D, it may be time for plan sponsors to reconsider their available options. Making a different choice may result in higher reimbursements, less administration or lower costs. This article describes the pluses and minuses of those options.

# Medicare Part D: *Optimizing the Opportunities for Employer Plans*

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**T**hree years into Medicare Part D, employers, unions and other plan sponsors are reevaluating their options for providing retirees with prescription drug coverage. The majority of plan sponsors initially opted to apply for Medicare's retiree drug subsidy (RDS). That might have been the right decision at the time. But as the program has developed, many plan sponsors have reason to revisit that decision. They want to gain higher reimbursements from the Centers for Medicare and Medicaid Services (CMS), find ways to offset accounting liabili-

ties, reduce administrative burdens, streamline administrative processes or lower the costs of providing pharmacy benefits to their Medicare-eligible retirees.

This article examines the various options through the experience of the past three years and concludes that for many larger, self-funded programs, plan sponsors may gain by switching from RDS to another option, particularly that of the direct-contract employer group waiver plan (EGWP) or contracting with an "800 series" EGWP.

## The Available Options

Prior to Medicare Part D, rising costs were eroding the availability and generosity of employment-based prescription drug benefits for retirees. Part D came along to bring the Medicare plan design up to date with current medical practices for all Medicare beneficiaries, the emphasis being on individuals covered by Medicare. The employer arrangements came along to help avoid widespread termination of group prescription drug programs for Medicare retirees now that the coverage had become available from CMS. In an effort to enable group plan sponsors to continue providing high-quality prescription drug assistance to their Medicare-eligible retirees, the new program offered a set of highly flexible options. Plan sponsors could:

- Obtain the RDS
- Offer a wraparound secondary benefit that supplements Medicare coverage
- Contract with an 800 series EGWP prescription drug plan (PDP) on a group basis
- Create a direct-contract EGWP and contract directly with CMS as a PDP.

Plan sponsors have had to decide which option will help them best meet their goals. In addition to maximizing federal subsidies, plan sponsors generally want to make sure they preserve or improve retiree drug benefits, honor collective bargaining agreements and retain as much control as possible over benefit plan design. They also may hope to limit plan cost increases and minimize out-of-pocket costs for their Medicare beneficiaries. In addition, they want to minimize their reportable liabilities by using required accounting methodologies for assessing postretirement benefit obligations, including Governmental Accounting Standards Board Statement 45 (GASB 45), Statement of Position (SOP) 92-6 and FAS 106 from the Financial Accounting Standards Board (FASB).

## The Choices: Pros and Cons

All four options listed above aim to provide employer plan sponsors with options to help the plans maximize the money available from CMS, while preserving benefits and offsetting postretirement benefit obligations. All options

help to ensure that plans can offer benefits better than the standard Medicare Part D benefits. The enhanced benefit offering includes better initial coverage and maintaining catastrophic coverage, and all are capable of filling the gap in Part D coverage known as the *donut hole*.<sup>1</sup>

**The RDS option.** The RDS option allows a plan sponsor to maintain its existing benefits (as long as they are at least as rich as the standard Part D plan) and to receive a 28% tax-free subsidy for eligible prescription drug costs. There is no impact on collective bargaining agreements, and the subsidies can be used in a variety of ways, e.g., to reduce retiree premiums or maintain the benefits.

On the negative side, RDS includes only drugs covered by Part D, which may exclude some benefits of an employer's current plan. This option is subject to federal compliance and auditing standards, including a required test of actuarial equivalence. Contrary to plan sponsors' expectations, RDS has proven to pose an administrative burden. In some cases, it has forced sponsoring organizations to increase their staffs or outsource Part D administration. Among other details, plan sponsors need to make clear to their retirees that they should not enroll in a PDP.

Because the RDS is tax-free to the plan sponsor, it is most beneficial to employers in the highest tax brackets; by the same token, it may not be the best option if the employer is tax-exempt. For this and other reasons, other options may yield higher reimbursement or allow for a significant reduction in postretirement benefit obligations. For public sector employers subject to GASB 45, RDS really does nothing to help an employer manage its other postemployment benefits (OPEB) liability. However, under an EGWP (either direct-contract or purchased from a PDP sponsor), the premium cost is reduced by the value of the CMS direct subsidy and that lower premium is used to forecast future retiree costs. As such, employers can see what might be a substantial reduction in their GASB 45 liability if they move from the RDS to an EGWP. Different requirements and accounting calculations and assumptions are used for SOP and FASB.

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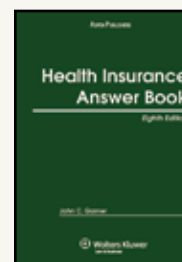
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Finally, the RDS is a retrospective payment to the plan sponsor that is tied directly to the cost for beneficiaries who incur claims. If there is no claim, there is no government subsidy. The retrospective nature of the subsidy generally means waiting six to 18 months for reimbursement from the government. Other op-

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tions, notably EGWPs, pay the subsidy up front, making the money available to the employer immediately.

**The wraparound option.** Plan sponsors that have opted for a secondary benefit to supplement their retirees' Medicare coverage have developed gap plans that maintain the retiree drug benefit with little or no impact on collective bargaining agreements and no creditable coverage or actuarial equivalence test required.

Overall, however, the wraparound approach is not a very good option; it imposes complex administrative and coordination-of-benefits (COB) processes to manage multiple PDPs with multiple benefits and possibly different formularies. There is no direct subsidy, and whether or not a plan can produce a savings depends on the benefit design and the ability of the pharmacy benefit manager (PBM) to negotiate favorable drug prices.

Nor is this option likely to be popular with members, who must enroll in a PDP individually and then put up with at least two identification cards, complicated benefit coordination, and different providers and formularies.

**The 800 series EGWP option.** Contracting for an 800 series PDP from a pri-

vate company (such as a PBM or health plan) can off-load most administrative responsibilities and possibly some insurance risks to a vendor. It can also waive some of the Part D financial and enrollment requirements. For example, an organization can group enroll its entire Medicare population into a PDP without each person having to sign individual enrollment forms.

Sponsors pay a flat premium for what is usually an off-the-shelf product (although some plans may be customized for large retiree populations). Employers may wish to join a Medicare Advantage prescription drug (MAPD) plan, which provides both insured medical and pharmacy benefits. Larger employers contracting with an MAPD may have their entire medical and pharmacy benefits experience rated or possibly self-insured. Smaller employers will receive a premium amount based on the size and demographics of their populations.

With a PDP, no actuarial equivalence test is required by the employer. There are no issues with COB, as there is with a wraparound option, because there is only one carrier, and member service issues are directed to the vendor. All of these factors suggest that an 800 series PDP may have administrative advantages for all employers, including nonprofit or government employers that do not realize the tax benefits of an RDS. The most significant advantage to public sector employers may be the value of off-setting OPEB obligations.

The downside starts in contracting with a vendor; the plan sponsor cedes control over basic benefit design. Drug coverage is determined by the vendor's formulary. Beneficiary communications and customer service are handled mainly by the vendor and may not be customizable.

What is perhaps most problematic is that plan sponsors face annual premium negotiations, often without the ability to receive claims experience. Inflation, risk and other factors can drive up premium costs significantly if the premium is not experience rated, and changing vendors can be complicated in terms of transferring records, maintaining continuous coverage and adapting to a new set of rules and conditions.

**The direct-contract EGWP option.** There are a number of advantages for a

plan sponsor that implements its own direct-contract EGWP. One notable advantage is the ability to maintain maximum control over benefit design and processes. Another is that, for both EGWP options, the creditable coverage test (i.e., whether the plan's coverage is at least equal to the standard Part D benefits available to individuals) is simpler than it is for the RDS option, and there are no COB issues as with the wraparound option. In addition, EGWPs are eligible for Part D low-income premium payments and catastrophic coverage reinsurance.

The biggest advantage, however, is that plan sponsors collect premium payments up front on a monthly basis directly from CMS. There is no waiting period or payments from another party passed on to the plan, and by receiving the money in advance, the plan sponsor can use it to help offset any pharmacy or other costs that will be occurring. Studying this option will help an employer and its senior management better understand the trends and factors within the EGWP payments versus RDS subsidies and to see what option would be the best for a defined population.

The direct-contract EGWP option is not the simple route, but it should at least be studied for a plan with 3,500 or more Medicare-eligible beneficiaries, taking note of these considerations:

- The employer continues to assume the plan cost risk.
- EGWP is a direct contract with CMS that pays generally higher payments, and therefore it requires a high level of operational and compliance oversight, as well as a great deal of reporting.
- EGWPs are more sensitive to CMS rule and regulation changes, which can occur monthly or quarterly.

The good thing is that after three years' experience involving a number of organizations, many of the compliance issues have been worked out and are much clearer than they were at first.

### Which Way to the Future?

During 2006, the first year of Medicare Part D, more than three-quarters of plan sponsors that continued to offer Medicare retiree drug benefits chose the RDS option, probably because it appeared to be the simplest approach (see Figure).

It appears, however, that plan sponsors have been trending away from RDS.<sup>2</sup> The data is not yet clear, but there is reason to believe that EGWPs are becoming more attractive to programs that want to review the value of offsetting OPEB obligations. In addition, employers are realizing that getting the payments up front provides much more flexibility in the use of the money.

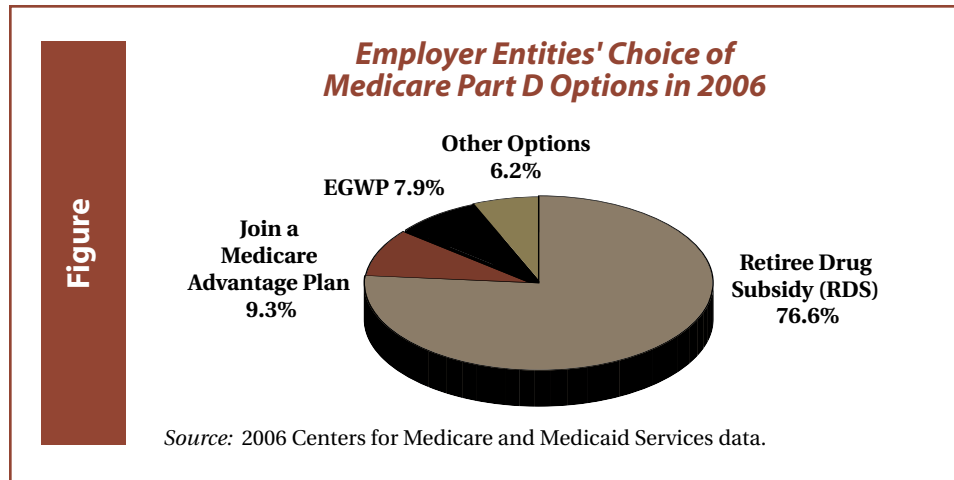
It should be said that neither EGWP option is necessarily the right option for all plan sponsors. In particular, those with smaller retiree populations might not want to take on the additional administrative and compliance work. They may also prefer to retain some control over the plan.

### Managing the Reconciliation Process

**RDS:** One of the ways in which the RDS option has proven to be difficult is in the financial reconciliation process. Plan sponsors must obtain a great deal of reportable data from their PBM or some other entity. There has been some confusion over calendar year and noncalendar year deadlines, problems getting detailed information about rebate payments from the PBM and in coordinating retrospective eligibility, and issues pertaining to claims adjustments. Navigating the CMS Web site's online submissions and responses can be tricky. Making sure a sponsor's final eligibility submission is complete and up to date is an issue requiring close attention.

**EGWP:** With an EGWP, the reconciliation process for either the contractor or the plan sponsor involves submitting eligibility data to CMS, as well as claims information as prescription drug events (PDE). There is also a requirement to report direct and indirect remuneration, i.e., rebates and any other payments received from manufacturers, pharmacies or pharmaceutical organizations. Multiple attestation forms must be signed to certify that all reporting is accurate. These steps are necessary to receive the reinsurance payments available from CMS.

No matter what options a plan is using, it is a good idea to arrange for independent complete year cost reporting. All data generated and eligibility submitted by the PBM or outside vendor should be



verified—preferably by a disinterested third party—before the plan sponsor reports the final reconciliation amounts to CMS.

**Implementation issues.** Whether a plan sponsor chooses the RDS or the EGWP options, a number of important, and often time-consuming, matters must be handled:

- **Internal approval.** Typically, a plan sponsor works with consultants and/or business partners to generate data and analysis supporting the option of choice and to present the proposal to the organization's board.
- **Resource allocation.** By the time a plan goes into effect, the employer must make sure that the staffing is complete and the right consultants and vendors are in place.
- **Existing business relationships.** In most cases, it is possible to keep existing business relationships in place as an organization moves into its chosen Part D option, but it is important to make sure vendors and consultants understand the plan and support it.
- **Waiver application.** Any choice involving a waiver of Medicare enrollment, financial solvency or communication requirements entails a complicated application process that may require the assistance of a consultant.
- **Plan development and implementation.** The plan sponsor must ensure that the plan design is fully worked out and ready to go by the time of the rollout.
- **Plan administration.** By rollout

time, all administrative staff must be in place and all procedure details worked out.

- **Communication.** The plan sponsor needs to communicate all information required by CMS to eligible Medicare beneficiaries.

**Time.** Time consideration and implementation issues with the onset of Medicare Part D are reasons many sponsors choose the RDS option over a direct-contract EGWP. RDS implementation requires only 90 days' advance setup. If a given employer's plan is to start on January 1, 2010, all arrangements must be in place by October 1, 2009, or an extension request must be filed with CMS. With direct-contract EGWP, sponsors must begin much earlier. For a plan to go live on January 1, 2010, the plan sponsor would have had to submit a notice of intent (NOI) to apply in the fourth calendar quarter of 2008. (Submitting an NOI does not bind an organization to submitting an application for the following year.) Organizations that do not complete the NOI by the deadline may experience delays in being assigned a contract number, but still will be able to complete the application process. To avoid delay, the plan sponsor must have its board approval and all data prepared more than a year in advance. Contracting with an 800 series EGWP is subject to different timing and CMS requirements and is driven by the contractor. Planning of an 800 series PDP should occur six months or more prior to the start of the plan year.

**So you want to evaluate an EGWP option. . . .** After study, some plan sponsors

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have decided that the mid- and long-term financial advantages justify the complicated processes of becoming and maintaining an EGWP. If it makes sense for your organization, here are the steps required to set up the program. The ongoing operations, reporting and compliance issues may overshadow the implementation steps as far as time and effort for the employer.

- Taking care of all the implementation issues described above
- Completing and filing with CMS the NOI to bid
- Filing your formulary
- Completing and filing your actual EGWP application
- Contracting with CMS
- Coordinating the documentation of your eligibility
- Communicating with your beneficiaries

### Uncertain? Support Is Available

If you are feeling confused by the details, you are not alone. It is good to have choices when setting up or changing an organization's benefits plan. But along with multiple options comes the need to sort through many variables to find the option that best fits your circumstances. That is where a qualified consultant can help.

A good consultant can analyze an organization's situation in depth, compare and contrast the available options as they apply to the situation, and help make the right choice. A consultant can help navigate the application process, manage the

details of eligibility and clearly interpret CMS requirements.

When the plan is up and running, consultant support can help with cost reporting, compliance planning and preparing or responding to a CMS audit. Additional support might touch on areas such as plan design and rate setting, actuarial equivalence testing, communication and financial reconciliation.

Setting up a new approach to Medicare Part D may seem overwhelming, but the opportunity to maximize government subsidies will reward organizations that choose their options correctly.

### Conclusion

In their eagerness to provide their retirees with good prescription drug benefits, many plan sponsors made their initial decision about which option to choose in a way that seemed right. Now that we have had three years' experience with Medicare Part D, it is time to reexamine that initial

decision and make sure every benefit plan is working with the most advantageous option. Just as benefit planners need to re-evaluate their overall health care plans periodically, so too is it important with the Medicare Part D option.

**B&C**

### Endnotes

1. See *Milliman Perspective* articles by Steve Kaczmarek, "Sizing up the hurdles of Medicare Part D," 5/1/2006, available online at [www.milliman.com/perspective/articles/sizing-up-hurdles-medicare-insight05-01-06.php](http://www.milliman.com/perspective/articles/sizing-up-hurdles-medicare-insight05-01-06.php), or Thomas D. Snook, "Climbing out of the 'donut hole,'" 5/1/2006, available online at [www.milliman.com/perspective/articles/climbing-out-donut-hole-insight05-01-06.php](http://www.milliman.com/perspective/articles/climbing-out-donut-hole-insight05-01-06.php).

2. A survey by the Kaiser Family Foundation and Hewitt Associates at the end of 2006 showed that only 54% of employers surveyed thought they still would be using the RDS option by 2010. See John Abell, "Life After the Retiree Drug Subsidy, What are the Other Options?" *HR Management*, July 2007.

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