SEYFARTH SHAW
MANAGEMENT ALERT
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Qualifying Retiree Prescription Drug Coverage

In January of 2005, the Centers for Medicare & Medicaid Services (CMS) released final regulations addressing the new Medicare prescription drug benefit created by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Medicare Act). Beginning in 2006, Medicare beneficiaries can enroll in a prescription drug benefit under Medicare known as Medicare Part D. As detailed in a previous *Management Alert* (which can be viewed by clicking here), the Medicare Act introduced a federal subsidy for employers who provide prescription drug coverage for individuals who are entitled to Medicare benefits under Part A or who are enrolled in Part B ("Part D Eligibles") if the employer-provided benefit is at least actuarially equivalent to the benefit under Medicare Part D. The final regulations provide additional guidance for employers as to what employers need to do to obtain the subsidy.

Options for Employers

First, employers who provide retiree prescription drug coverage should review their options under the Medicare Act and determine whether applying for the subsidy is their best option. Generally, employers can choose to:

(1) Provide prescription drug coverage through an employment-based plan that is at least as valuable as the standard Medicare Part D coverage and apply for the tax-free subsidy;

(2) Purchase or maintain separate prescription drug coverage for retirees that supplements or "wraps around" Medicare Part D;

(3) Provide coverage through a prescription drug plan (PDP) or a Medicare-Advantage prescription drug plan (MA-PDP), by contracting with a PDP sponsor or MA organization or by sponsoring a PDP or MA-PDP directly; or

(4) Provide no retiree prescription drug coverage and subsidize the retirees' Medicare Part D premiums.

Applying for Subsidy

If the employer chooses to provide employer-provided prescription drug coverage and apply for the subsidy, the employer must submit an application to CMS by September 30, 2005, unless an extension request has been filed under procedures established by CMS. (Thereafter, an application must be submitted no later than 90 days before the beginning of each plan year).

Prior to submitting the application, an employer must enter into a written agreement with its insurer or group health plan. Under the agreement, the insurer or plan agrees to disclose the necessary claim information and cost data to CMS on behalf of the employer ("plan agreement"). The plan in turn may enter into an agreement with its third party administrator (TPA) or other business associate to submit the data to CMS. These agreements are in addition to the sponsor agreement described below that must be submitted with the application. The sponsor must submit the following information with each application:

- Employer tax identification number;
- Sponsor's name and address and contact information;
- Actuarial attestation (as described below) and any other supporting documentation required by CMS;
- List of qualifying covered retirees enrolled in prescription drug coverage (including their name, health insurance claim or social security number, date of birth, gender and relationship to retired employee); and
- A signed sponsor agreement. This is an agreement whereby the sponsor agrees to comply with the rules and regulations applicable to receiving the subsidy.

Actuarial Attestation

In order to collect the subsidy, a sponsor must submit an actuarial attestation to CMS annually, even if the employer provided coverage has not changed. Sponsors can submit attestations from outside actuaries or from actuaries employed by their insurance carriers, pharmacy benefit managers (PBMs) or TPAs. The actuary must attest that the actuarial gross and net values of the employer's retiree prescription drug coverage for the plan year is at least equal to the actuarial gross and net values of standard coverage under Medicare Part D. The final regulations provide further detail about determining actuarial equivalence.

Gross Value Test. Under the gross value test, the expected amount of paid claims under the employer plan and Medicare Part D must be at least equal. The expected amount of paid claims under the employer's plan must be based on actual

claims experience and demographic data for Part D Eligibles.

Net Value Test. The net value test starts with the gross value of coverage and then takes into account who pays for the retiree prescription drug coverage. The net value of coverage under the employer plan is determined by reducing the gross value of coverage by the expected amount retirees will pay for the coverage. The net value of coverage under Medicare Part D is determined by reducing the gross value of coverage by the expected amount retirees will pay for the coverage and the value of supplemental coverage.

The reduction in net value of coverage under Medicare Part D for supplemental coverage occurs for the following reason. Employees are entitled to catastrophic coverage under Part D after they have true out-of-pocket (TrOOP) costs of $3,600 (in 2006). Amounts paid by an employer-provided supplemental plan are not considered out of pocket and are not counted toward TrOOP costs. Thus, employees with employer-provided supplemental coverage will have to generate more costs than employees without supplemental coverage to become entitled to catastrophic coverage. Providing supplemental coverage theoretically makes Medicare Part D coverage less valuable. By reducing the value of Medicare Part D coverage by the value of supplemental coverage, the value of employer-provided coverage will be greater and it will be easier for employers to provide an actuarial equivalent benefit.

Plans with several benefit options. The gross value of coverage must be determined separately for each benefit option for which a sponsor requests a subsidy. The net value may be determined either separately for each benefit option or in the aggregate for all benefit options within the plan that satisfy the gross test.

Payment of Subsidy

The final regulations allow a sponsor to elect to receive subsidy payments monthly, quarterly or annually. Sponsors who elect monthly or quarterly payments must periodically submit aggregate cost data, along with an estimate of the extent expected costs will differ from the cost data submitted (based on expected rebates and other price concessions). Sponsors also will have to provide a reconciliation to CMS within 15 months after the end of the plan year that includes cost data per retiree and actual rebates, discounts or cost concessions received.

Employers can avoid the need for interim data submissions, estimates and reconciliations by electing to receive the subsidy annually. Employers receiving the subsidy annually must nevertheless submit cost data, including rebate adjustments, within 15 months after the end of the plan year.

Employer "To Do List" If Electing Subsidy

- Have actuary determine actuarial equivalency of employer plan.
- Identify who holds the relevant claim and cost data and prepare plan and sponsor agreements.
- Consider whether to enter into a voluntary data sharing agreement with CMS to identify all Part D Eligibles and those who enroll in Medicare D.
- Submit application by September 30, 2005.
- Consider renegotiating PBM agreements. Medicare Part D will eventually have a substantial effect on drug prices.

Finally, all employers who offer prescription drug coverage to active or retired Part D Eligibles will have to prepare and distribute "notices of creditable drug coverage." Watch for a *Management Alert* on this topic to be released shortly.

If you have any questions concerning retiree health coverage and Medicare Part D, please contact the Seyfarth Shaw LLP Employee Benefits Group attorney with whom you work or any Employee Benefits attorney on the website at www.seyfarth.com.

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