



Medicare Part D and the Plan Sponsor: What You Don't Know Can Hurt You and Your Bottom Line

By Erin Costell, Managing Partner, Global Pharmaceutical Solutions

With the enactment of the Medicare Modernization Act of 2003, Medicare Part D was born. Medicare Part D became effective January 1, 2006 and as a result anyone eligible for Medicare can now qualify for federally subsidized prescription drug benefits. The Centers for Medicare and Medicaid Services (CMS) is charged with administration and oversight of this program and in this role has published massive amounts of information aimed at informing Medicare beneficiaries of their choices within the program and how to decide which option is right for them, based upon their personal circumstances.

Knowing that prior to the inception of Medicare Part D, prescription drug benefits for a significant portion of this population were offered by Employer or Union sponsors, CMS designed the Part D benefit to allow retention of employer or union sponsored benefits and to provide subsidies to employers or unions to offset the expense of offering such benefits. CMS prescribes the manner in which this subsidization is obtained, the amount of the subsidization and the compliance requirements for qualification which are subject to change from year to year.

The most popular of the Part D subsidization options has been the Retiree Drug Subsidy (RDS) option. This option has been selected by a large number of plan sponsors for several important reasons. It is considered the easiest to comprehend, implement, and administer, and compared to other options, sponsors have fewer compliance requirements to satisfy in order to obtain the subsidy. The plan sponsor receives a tax-free subsidy of 28% of allowable prescription drug costs, between threshold and limit amounts which are set by CMS and annually adjusted for inflation. The RDS subsidization is further limited to those drugs specifically allowable under Medicare Part D.

The average value to the plan sponsor of the RDS program has been estimated by industry sources to be approximately \$670 per Medicare beneficiary per year. The assumed simplicity of the program, along with its predictable value to the plan sponsor, has driven its early popularity. After removal of drugs and expenses excluded by Part D (for being outside of the CMS limits) the RDS subsidy is estimated to be worth approximately 20% of the plan sponsor's total drug spend for Medicare beneficiaries.

Another factor that has fueled the popularity of the RDS program is the limited understanding of the value associated with other available options. Since alternative options tend to be more complex and difficult to administer, Pharmacy Benefits Managers have understandably shied away from them and supported the adoption of RDS where possible. Many benefits consultants have taken a similar path with their early advice to plan sponsors. This heavy participation in the RDS program is likely to change as the benefits of alternative options become better understood by plan sponsors.

One such alternative is the establishment by the plan sponsor of its own Medicare Prescription Drug Plan (PDP), known as a direct-contract Employer Group Waiver Plan (EGWP). With a direct-contract EGWP, the employer enters into a contract with CMS to provide plan benefits and receives payment directly from the government.

Plan sponsors with large Medicare-eligible populations may find this to be financially superior to the RDS approach. Under the direct-contract EGWP approach, the pre-tax federal subsidy is set at the national average monthly bid amount less the Part D base beneficiary premium, with the national bid being \$80.43 and beneficiary premium being \$27.35 in 2007. Unlike the RDS option, the direct subsidy available through the direct-contract EGWP plan includes subsidization for administrative costs and profit margins based on the national average of commercial plans. The direct subsidy payments are also adjusted based on the health risk status of the beneficiary. Direct subsidy payments alone are almost equivalent to the average subsidies provided under the RDS program. In addition to direct subsidy payments, direct-contract EGWPs also receive low-income subsidy payments, as well as "catastrophic" reinsurance payments that provide reimbursement for 80% of eligible drug costs that exceed a beneficiary's maximum out of pocket limit, with the out of pocket limit being \$3,850 in 2007.

The total value of the direct contract EGWP subsidies can exceed that of the RDS by as much as \$400 to \$500 (pre-tax) per year for each covered Medicare beneficiary. The subsidy is estimated to be 35% or more of the plan sponsor drug spend for Medicare beneficiaries, far exceeding the estimated 20% average subsidy yielded under RDS. For large plan sponsors, this additional savings can amount to millions of dollars per year.

Another alternative option for plan sponsors is the purchase of an Employer Group Waiver Plan from a third party Part D Sponsor, known as an "800 Series" EGWP. Under this arrangement, the employer or union does not contract directly with CMS. Instead, a third party Part D Sponsor contracts with CMS to offer this benefit to the employer or union plan sponsor on CMS's behalf. This arrangement alleviates much of the employer's or union's administrative burden because they have no direct obligations to CMS. Under an "800 Series" plan the third party Part D Sponsor receives the direct subsidies, low income subsidies and reinsurance payments for the employer's or union's approved beneficiaries, like the payments available under the direct contract EGWP. The employer or union realizes these savings through either reduced premiums or a pass-through of CMS payments from the third party Part D sponsor back to the employer or union sponsor. However, since the administrative and regulatory burdens fall on the third party Part D sponsor under this arrangement, third party sponsors typically charge additional fees to cover these expenses.

Yet another alternative option is to provide a wrap-around benefit to supplement the Medicare benefit. In this scenario, the employer or union would require the Medicare beneficiary to enroll in a commercial Part D plan and would then supplement the commercial benefit, by either providing coverage during the deductible and coverage gap phases or by providing coverage for additional drugs that are not covered under the commercial benefit's formulary. The employer or union realizes savings because it is no longer the primary pharmacy benefit provider and savings would be, depending on how the supplemental benefit is designed, roughly equal to the value of the commercial plan the Medicare beneficiary chooses. This scenario affords the employer or union sponsor the fewest compliance and regulatory burdens. However, in the current market environment, administration of this type of arrangement is extremely difficult.

Under any of these options, the plan sponsor bears some responsibility and certain steps are mandatory. However, these responsibilities and administrative burdens vary considerably under each option. The least administratively demanding is the "800 Series" EGWP, since it involves the purchase of a contract from a third party Part D Sponsor and depending on the level of services provided under the arrangement, could require little else of the employer or union plan sponsor. The RDS option carries

more administrative complexity, and for many plan sponsors this is significantly more than they initially expected. Even more complex is the direct-contract EGWP. And the most complex of all the options, while holding probably the greatest opportunity for savings for many plan sponsors, is the wrap-around benefit, since this option involves coordination of benefits between the primary and secondary plans.

In the first year of Part D, the clear favorite approach among plan sponsors was the RDS program and because of the timing requirements for Medicare program participation in 2007 the number of RDS plan sponsors did not change dramatically. Seen initially as the path of least resistance by plan sponsors, PBMs and consultants (due to its perceived ease of compliance and administration) the RDS option is now seen as including a significant burden. Since it is likely not the best financial alternative for many plan sponsors, the slate of available options is now being more carefully scrutinized. An initial industry-wide lack of knowledge of Part D and its requirements is being slowly replaced with deeper understanding, leading to closer financial assessment.

Also, given the near daily issuance of CMS guidance in 2006, many plan sponsors adopted an approach of getting through the first year as painlessly as possible, with an eye toward more detailed assessment of options later on. Even with the new closer consideration of pros and cons, plan sponsors will likely be frustrated by their vendors' inability to fully support all of the options from which a plan sponsor may benefit.

An opportunity seems to exist for the type of organization that can counsel the plan sponsor on the pros and cons of each available option, assess and quantify the financial implications of each, manage the processes required by CMS for any chosen option and provide "turnkey" administration of that option, thus relieving the plan sponsor of day-to-day involvement. Plan sponsors may well benefit from a totally integrated solution to their Medicare Part D challenge.

Erin Costell is Managing Partner of Global Pharmaceutical Solutions (GPS), a consulting firm located in St. Louis, Missouri, that specializes in the design, implementation, management and administration of pharmacy benefit programs.