Attesting to the Value of Employer Plans

THE MEDICARE MODERNIZATION ACT OF 2003 (MMA) introduced the most expansive improvement in this program since its inception. Along with the addition of prescription drug benefits to all Medicare beneficiaries (a new Part D in Medicare), the MMA provides a financial subsidy to employers who continue their own prescription drug plan for retirees. Employers can receive a tax-exempt subsidy of up to 28 percent of the prescription drug spending of each of their Medicare-eligible retirees (and their Medicare-eligible dependents) between $250 and $5,000. In order to receive the subsidy, the prescription drug benefit offered to the retirees has to be at least as good as those under the new Medicare program.

The law requires that employers submit an actuarial attestation that the employer plans are better than Medicare Part D. In essence, this is an analysis, signed by a "qualified actuary who is a member of the American Academy of Actuaries," certifying that the employer's prescription drug program provides benefits at least as good as those that the government offers to all Medicare beneficiaries.

The Rules

To qualify for the retiree drug subsidy, an employer-sponsored plan must first demonstrate that it is at least "actuarially equivalent" to the standard prescription drug coverage under Part D. The final regulation issued in January 2005 provided employers with a very flexible approach. In order for an employer's plan to be actuarially equivalent, the value of the plan must meet a two-prong test.

- **GROSS VALUE TEST:** The total plan value of the employer plan (both the employer's and retiree's share of the cost of the plan) must be at least equal to the total plan value of the standard Part D Medicare benefit.
- **NET VALUE TEST:** The net value of the employer plan (the employer's share of the cost of the plan) must be at least equal to the net value of the standard Medicare benefit (less the retiree's Part D premium), optionally reduced for the impact of TrOOP due to the employer design.

TrOOP is the "True Out-of-Pocket" design under Part D. The catastrophic portion of the benefit for a year begins when the Medicare beneficiary has paid $3,600 (indexed) of prescription drug expenses out of his or her own pocket, not counting any payment by another payer, such as another plan.

As required by the regulations, employers will need to file an annual actuarial attestation to receive a subsidy.

DALE YAMAMOTO is an actuary with Hewitt Associates, LLC, in Lincolnshire, Ill. He is a member of the Academy's Joint Committee on Retiree Health and the Retiree Health Insurance Work Group, among others.

The attestation must include several "assurances" to the government that the gross value test is met, the net value test is met, and the two tests were determined under the Centers for Medicare and Medicaid Services (CMS) rules using generally accepted actuarial principles.

In addition, the actuarial attestation must be signed by a qualified actuary, include a statement that the attestation is true and accurate, and acknowledge that the information is being used to obtain federal funds.

This acknowledgment subjects the actuary to the federal False Claims Act. Under this act, anyone knowingly making a false statement in connection with receiving government payments may be subject to a civil penalty plus a fine for damages of up to three times the payment amount. Since an actuary's work won't be audited until after potentially large sums have been paid under the program, the financial exposure is high.

Actuarial Equivalence Methodology

Both the gross value test and net value test are expected to be based on actual claims experience and demographic data for the employer's retirees who are eligible for the subsidy. For employers who don't have credible claims experience because they have a small number of retirees, the actuary can use normative databases as allowed by CMS.

The guidance released in April 2005 gives the actuary flexibility and allows the use of actuarial judgment in the analysis. It recognizes that not all employers will have credible data to determine whether the plan is better than Medicare. The actuary can decide to use normative data, such as prescription drug databases maintained by insurers, pharmacy benefit managers, and consulting firms.

Gross Value Test

This test compares the employer's overall benefit design with the standard Medicare Part D design, without regard to how the cost of the plan is shared with the retiree through retiree contributions. The comparison is made based on the benefits expected to be paid and doesn't include any administrative expenses (except for the pharmacists' cost to dispense the drugs). If an employer offers more than one plan design to Medicare-eligible retirees, each must be tested separately.

In order to use the employer's claims experience, the data needs to be projected to the year being tested.

	2004	TREND	2006
Average script cost	$ 50.00	1.166[1]	58.32
Copay	(20.00)	1.000	(20.00)
Net plan cost	30.00	1.277	38.32
Utilization	41.0	1.082[2]	44.3
Average cost per member	1,230.00	1.380	1,698.00

[1] Two year trend of 8% per year (5% price trend plus 3% change in mix)
[2] Two year trend of 4% per year

For plan designs that are copay-based, it will be important to project separately the price of drugs as well as the estimated utilization change. For example, an overall cost trend of 13 percent could be split into components of 5 percent price trend, 3 percent change in the mix of prescribed drugs, and 4 percent increase in the number of prescriptions.

The price-and-mix change affects the value of the copay in a different way from the utilization change. For example, for a plan with a $20 copay, the following type of projection is needed:

The above illustration is for the average participant. If actual data is available, a similar calculation can be done for each participant or for a carefully defined and appropriately weighted distribution of participants. Also note that with this plan design, the underlying average annual drug trend is about 13 percent, but the plan cost trend is 17.5 percent per year (annualizing the two-year 38.0 percent increase). This illustrates the "leveraging" impact of the copay on the cost trend.

Actual calculations may get more complex, too, depending on the plan design. For example, different assumptions will need to be made if the plan's cost sharing is different for generic drugs versus brand-name drugs, preferred versus non-preferred brand-name drugs, retail versus mail-order delivery of drugs, etc.

Similar calculations will need to be done on the normative data but must necessarily be based on a claim distribution instead of a single person's information. The normative data must still account for varying prices in estimates of the impact of a copay, as well as the varying overall utilization by the covered members. The actuary performing these calculations will need to be familiar with the generally accepted practices of this methodology.

Another adjustment that could be made in the evaluation is to anticipate changes in behavior under different plan designs. Several studies have shown that individuals change their pharmacy usage with different levels of benefit designs—the richer the benefit, the greater the usage. Since the Medicare design is usually less rich than the employer's, that would imply that an anticipated lower rate of utilization could be assumed in the calculations. This would help the employer meet both the gross and net value tests.

Net Value Test

The net value test compares the employer-provided value with the government-provided value of the respective plans. In addition to accounting for the contributions that the retirees must pay, the calculation may optionally account for the reduction in the value of the Medicare benefit due to the effect of the TrOOP on the Medicare design. However, an employer may use this optional credit only if the employer agrees to supplement Medicare for any retiree who joins a Medicare plan, with the TrOOP effect reflecting this supplemental coverage in the net test.

The April 2005 guidance clarifies that the actuary can either use the national average Part D premium to net out the retiree's cost, or assume that the retiree's share of the cost is 25.5 percent of the gross value.

The MMA and the regulations also allow certain aggregation of benefit options offered by the employer, as long as the options pass the gross test. The benefit options could vary according to service-based contribution schedules or have different contributions among groups of covered Medicare eligibles (e.g., retiree/spouse, salaried/union, business units). The ability to aggregate options may require a variety of initial calculations in order to determine how to proceed with the final analysis.

Qualification of the Actuary

The MMA requires that the qualified actuary be a member of the American Academy of Actuaries. No further qualification requirement is imposed by the law. This places great importance on the profession's qualification standards that require an actuary to perform work only if qualified by education and experience. Actuaries will gain the education to perform this work if they pass actuarial examinations on the topics of health care ratemaking and reserving.

Alternatively, they may gain the basic education by working with other qualified health actuaries who can verify the transmission of their experience and knowledge. The qualification standard also requires ongoing continuing education, which is most critical in this case since the practice area is new.

Summary

The regulations continually point to the use of generally accepted actuarial principles, even though many of the calculations are new to the actuarial world. True actuarial principles will evolve over time, expanding on existing health actuarial practices and developing new methods for this new requirement.

Being subject to the federal False Claims Act places a greater importance on an actuary's qualifications to perform the work than almost any other actuarial analysis.