Rx Planning

By Carlton Harker

Overview

Medicare Part D was born in 2004 after a long period of gestation and labor adventures and leaps to full form in 2006. Prior to 2006, each Medicare cardholder must choose to (a) accept the new Rx benefits and pay the requisite premiums or (b) take a pass. Also, for health care covered persons who are non-working retirees, the plan sponsor may use risk management disciplines and amend its plan so that certain covered persons elect Part D and others do not. For those who do not elect Part D, a government-paid subsidy to the employer is available.

While much has already been written on the topic, the purpose of this rumination is to give the reader a good picture of what lies ahead and how to avoid most of the rocks in the water and yet gain what advantages there may be.

This writer has [illegible]

Notice of Creditable Service

Any plan-covered person prior to 2006 (and annually thereafter) must elect to accept or decline Medicare Part D. Critical to this decision, is the assurance to the covered person, that the plan's Rx benefit is no worse than that of Medicare Part D. If so, the covered person may opt out of Medicare Part D with the assurance that at a later date such person may reenter without the onerous 1% per month readmission penalty.

Usually, but not always, the plan's service will be creditable. The challenge will be administrative and not actuarial. Each plan must tag any covered person who has a Medicare card (working aged, e.g.) and send a Notice of Creditable Service to such covered person. An actuarial statement certifying such creditable service is not required.

Subsidy Considerations

The Medicare Part D benefits which are purchased with a presumed premium of $540 are as follows:

Rx Expenses	%	Medicare Maximum	%	Maximum	Beneficiary %	Total Maximum
$0 – 250	0	$0	100	$250	100	$250
250 – 2,250	75	1,500	25	500	100	2,000
2,250 – 5,100	0	0	100	2,850	100	2,850
Over 5,100	95	N/A	5	N/A	100	N/A

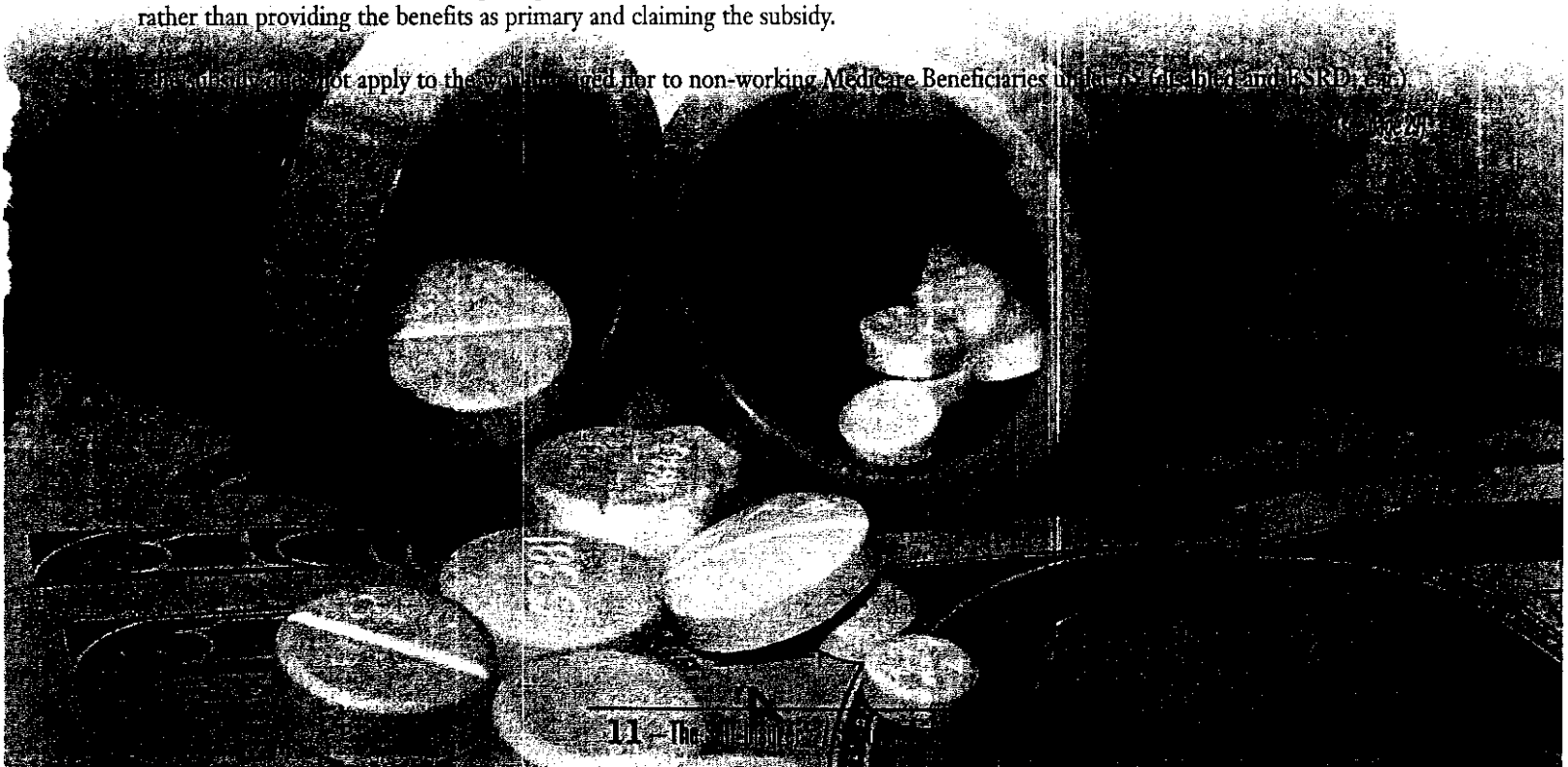
The reader will readily discern that where a covered person has $3,000 projected Rx expenses for 2006, the following two relevant risk-related indices are readily available:

	Economic Value
Medicare Part D Benefit (see above)	$960 *
Subsidy (28% of Rx expenses in $250 – 5,100 range)	770 **

* $0 + (.75)(2250 - 250) + 0 = 1500 – 540 = 960
** (3000 – 250)(.28) = 770

In the instant case, we see that the plan sponsor is best advised to have the Plan be secondary to Medicare (the so-called wraparound) rather than providing the benefits as primary and claiming the subsidy.

[illegible] not apply to the [illegible] for to non-working Medicare Beneficiaries under [illegible] and ESRD age).



Rx Planning *(continued from page 11)*

The continuum of all projected Rx expenses done in [redacted] appears as follows:

Projected Rx Expenses	Return Of Medicare Premiums	Subsidy	Economic [redacted] Being Sec[redacted]
$250	[redacted]	0	[redacted]
500	[redacted]	70	(422)
750	[redacted]	140	(305)
1000	23	210	(187)
1250	210	280	(70)
1400	322	322	0
1500	398	350	48
2000	772	490	282
2250	960	560	400
2500	960	630	330
300[redacted]	960	77[redacted]	190
3500	960	91[redacted]	50
3700	960	966	(6)
4000	960	1050	(90)
4250	960	112[redacted]	(160)
4500	960	119[redacted]	(230)
4750	960	1260	(300)
5000	960	1330	(370)
5250	1103	1358	(255)
5500	[redacted]	1358	(18)
6000	[redacted]	1358	457
7000	[redacted]	[redacted]	1407
8000	[redacted]	[redacted]	2357
9000	4665	[redacted]98	3307
10000	[redacted]	1358	3497

This d[redacted]n establishes the follo[redacted]

Pres[redacted]dicare Part D annual sele[redacted]ol of the Plan Sponsor, those covered pers[redacted] projec[redacted]e ranges of $0 – 1250 and $400 –5500 should elect the Medicare Part D option with the [redacted] um bei[redacted] Sponsor. All other covered persons should not elect Medicare Part D; i.e., such co[redacted] shou[redacted]

Sparing t[redacted]nsive details relevant to the inputted data and the computations, the needed actuarially-cert[redacted] sions are sh[redacted]ng section for a hypothetical plan of approximately 100 covered persons with a Medicare Ca[redacted] over age 65.

Conclusions (Hypothetical numbers)

A. Subsidy-Related Tests

	Plan Benefits
1. Projected gross Rx benefits	$202,303
2. Annual contribution	$ 0
3. Projected net Rx benefits (1) – (2)	$202,303 (1) - (2)

Since lines (1) and (2) for Plan Benefits exceed li[redacted]dicare Rx Benefits the Gross and Net tests are both met.

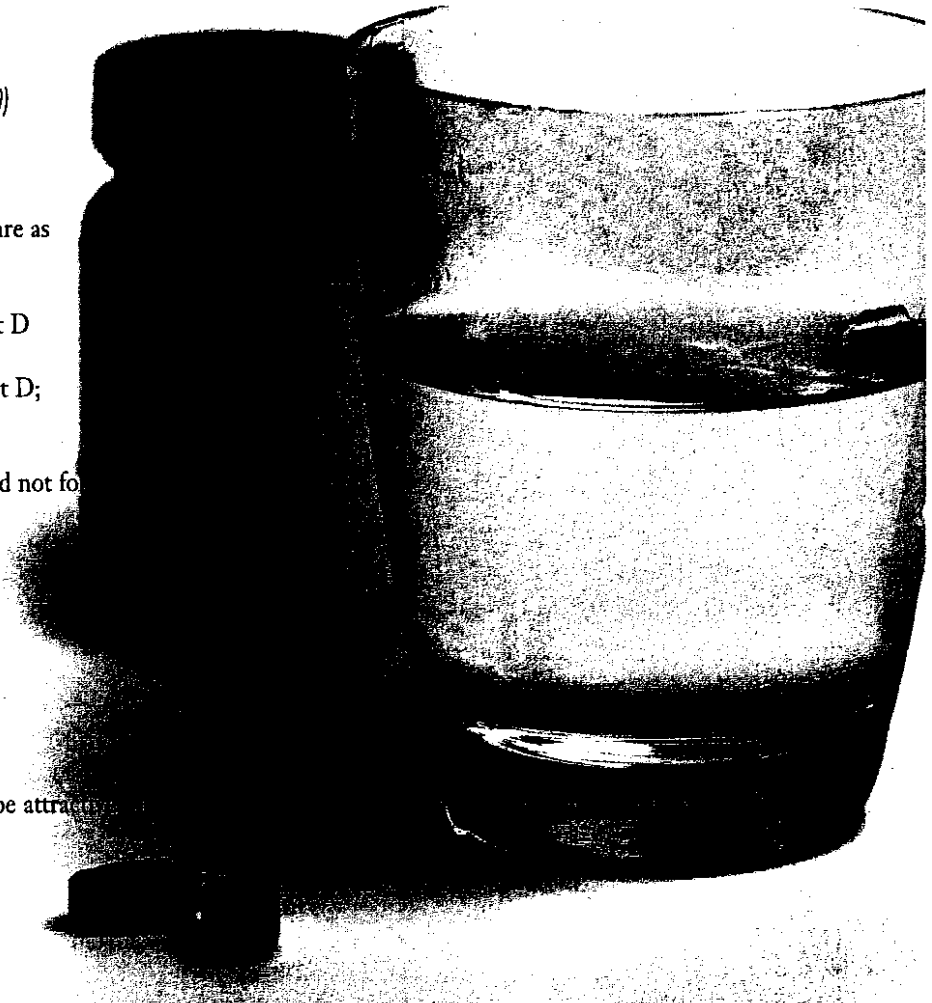
(see page 30)

■ Loss Recovery - It's Your Money *(continued from page 29)*

B. Risk Management Considerations

The net projected Rx costs for retirees over age 65 are as following based upon several assumptions:

1. All covered persons elect Medicare Part D
2. No covered person elects Medicare Part D; subsidy was maximized.
3. Medicare Part D is elected for some and not fo
   a. Low Range
   b. High Range



Medicare Part D Made Easy

Introduction

While the multiple risk management options may be attra
simpler path.

The Simple Path

The plan document should be amended as follows:

1. Every covered person who has, or could have, a Medicare Card must elect Medicare Part D as a condition of plan eligibility. It is anticipated that such Medicare Part D premiums will most often be paid by the plan sponsor, at least in part.
2. For such select covered persons, the Plan's Rx benefits shall be determined from the Medicare Worksheet provided by CMS (or the PDP is applicable) and shall be defined as follows:

Where Medicare Part D Pays at the rate of	Plan Shall Pay at the rate of
75%	___%
0%(so-called donut hole)	___%
95%	___%

3. A Notice of Creditable Services will be given to each covered person showing that the Plan's benefits are not equivalent to those of Medicare Part D and explains to such covered person what the Medicare and Plan Benefits are.

Comments

1. The fact that the purchase of Medicare Part D for the minimal-Rx user is not cost-effective is ignored.
2. The effort to gain the Rx subsidy is too great for its reward.
3. The issue of creditable services is taken totally out of the picture because no such event as opting out can occur.
4. Whether the Rx benefits for such select group of covered persons is (a) Plan Rx benefit funded in part by Medicare Part D or (b) a freestanding Medicare Rx benefit plus a freestanding Plan Rx benefit must be made clear. It appears that either (a) or (b) will be acceptable.
5. For plan sponsors wishing specially designed Rx benefits, a special plan amendment should be considered. For example: a benefit such as 50% of the Rx expenses after a $150 Calendar Year Deductible.
6. It is suggested that the plan sponsor consider a separate plan for Rx benefits at once. Also, where justifiable for reasons of size, a separate plan should be considered for all plan covered persons who have or could have a Medicare card.
7. The one option which must not be elected by the Plan Sponsor is to do nothing.

Some Dark Thoughts on the Drug Scene

Dominance of the Practice of Pharmacy

The admiration for the practice of medicine is great because of the skill, training and knowledge of physicians but even more so because of their Hippocratic Oath. The concern is that the practice of pharmacy (as the intended heir/replacement thereto) has no such oath. This sharp difference will have enormous consequences.

Political

The reality is that, at least as regards Rx issues, the Congress (and the White House to a lesser extent) work merely as much for the Rx companies as for the citizens. It is well known that drug and medical device manufacturers contribute millions in PAC and soft money contributions to federal candidates and parties to influence legislation and elections.

Practices of the Rx Companies

The Rx Card is usually a plan benefit which, when offered, establishes a nexus of such plans directly to the major Rx firms. In so doing, plan sponsors rarely realize that their ERISA plan becomes an *aide tor and abettor* of a wide range of Rx practices some of which may be anathema to such plan sponsor. Examples of such unethical practices are listed as follows:

- Wanting to exchange the practice of medicine with the practice of pharmacy
- Permitting Rx to be used for health conditions for which it was not intended
- Unfair and monopolistic marketing practices including so-called tying arrangements
- Gross violations of privacy laws
- PBM-Rx firm collusion; hospital-Rx firm collusion
- Direct advertising to private citizens
- Rebates and kickbacks to physicians
- Excessive political contributions to gain regulatory clout
- Buying off generic manufacturers
- Introducing nearly-same Rx to avoid generic price competition
- Permitting dangerous Rx to be sold
- Discriminatory allocation of Rx co-payments for marketing purposes
- Mafia-Rx Card connections
- Inadequate FDA approval disciplines
- Stampede to increase number of Rx on the market for financial gain
- Fraudulent advertising
- Rx and preventable medical errors
- Gifts to physicians, and PBMs by Rx firms
- Inordinate amount spent by Rx firms on coercive advertising
- Being party to a pricing practice that permits the U.S. - Canadian Rx price-war
- Rx companies using their supermarkets to drive out smaller retail outlets using Rx as lures to sell all non-Rx items
- Being targets of many class-action lawsuits.

Medicare Part D - Already Doomed?

It is not encouraging for those hoping for fiscal sanity to know that the CMS Chief, was willing to appear before Congress and express his opinion that the cost of the impending Medicare Part D legislation was understated but such Actuary was impeded from so doing. Some on the Congressional Committee wanted to hear his testimony (but not all). Between (a) arguments of separation of powers, (b) timing and (c) politics (i.e., many on the committee had no interest in hearing the facts), the legislation was enacted.

While this writer has no inside information, a safe guess is that the expected significant and tragic cost overruns (i.e., the Medicare Rx train wreck) will result from (a) the huge underpricing of institutional-based Rx charges and (b) the absence of any payer-provider cost controls; e.g. institutions and Rx firms may collude over costs of high-priced Rx therapy administered therein. That the Rx companies have the opportunity to control the retail pharmacies with the Rx cards and the institutions with collusive practices spells double-trouble. Institutions are long-term care facilities.

The Final Chapter?

Our employer-financed self-funded health plans have endured (albeit in much reduced strength and numbers) the onslaught of (a) COBRA, (b) HIPAA, (c) super abundance of over-zealous vendors, (d) stop-loss (which to this day - cannot, or will not agree on its true nature) and (e) the lack of a unified and coherent voice from the employer community. This writer voices concern as to how such plans will survive the federal Rx mandates. Will this new load be too much for the already-tired workhorse?

Some are already suggesting that the health care issue will be dominant in the 2008 election. Will the Rx changes help or harm employer-financed self-funded plans? The prediction of this writer is that it will harm. The political impact of (a) a high percent of health costs being funded by the U.S. Treasury (i.e., Medicare Part D), the increasing ravages of cost-shifting (resulting from the steady increase in the percent of employers who are dropping their plans) and (b) the onward march to victory by the globalists will dominate the Congress after the 2008 election.

Carlton Harker, FSA, MAAA is a well known and respected member of the self-funding community and has been an active participant in the Self-Insurance Institute of America's educational programs for many years. In addition to authoring numerous books on a diversity of subjects related to self-funded health care, Carlton has appeared as a speaker and panel member at various industry educational functions. Harker has appeared as an expert witness in many hearings and trials. Mr. Harker is the Principal of Self-Funding Actuarial Services, 8025 North Point Blvd., Suite 207 W., Winston-Salem, NC 27106. (tel) 336-759-2035, (fax) (336)892-0392, or via e-mail at harker2@earthlink.net He maintains a web site at www.self-fundhealth.com