Health Practice Council Practice Note

March 2006

Attestation of Actuarial Equivalence for Plan Sponsors Accepting a Retiree Drug Subsidy under the Medicare Drug Program

Developed by the Actuarial Equivalence Retiree Practice Note Work Group of the American Academy of Actuaries

American Academy *of* Actuaries

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HEALTH PRACTICE NOTE 2006-3

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Developed by the
Actuarial Equivalence Retiree Practice Note Work Group
of the American Academy of Actuaries[1]

This practice note was prepared by a work group organized by the Health Practice Council of the American Academy of Actuaries. The work group was asked to:

> Review the new Centers for Medicare & Medicaid Services (CMS) regulations that require an Academy member to attest that an employer or union's prescription drug plan, in order to receive a retiree drug subsidy (RDS), meets the actuarial equivalence standard; and
>
> Publish a practice note addressing the procedural and professional aspects of the attestation.

The purpose of this practice note is to provide advisory guidance to the actuary attesting to the actuarial equivalence of a plan sponsor's[2] retiree health plans under the requirements of 42 CFR 423.884 for payments to sponsors of retiree prescription drug plans. The actuarial comparison of plan values required by the regulation will involve methods common to health actuaries but in an entirely new circumstance. This note provides examples of possible responses to certain situations and issues, but no representation of completeness is intended. Other approaches may also be reasonable and may be used. The draft of the practice note was exposed for public comment a few

1. The American Academy of Actuaries is a national organization formed in 1965 to bring together, in a single entity, actuaries of all specializations within the United States. A major purpose of the Academy is to act as a public information organization for the profession. Academy committees, task forces and work groups regularly prepare testimony and provide information to Congress and senior federal policy-makers, comment on proposed federal and state regulations, and work closely with the National Association of Insurance Commissioners and state officials on issues related to insurance, pensions and other forms of risk financing. The Academy establishes qualification standards for the actuarial profession in the United States and supports two independent boards. The Actuarial Standards Board promulgates standards of practice for the profession, and the Actuarial Board for Counseling and Discipline helps to ensure high standards of professional conduct are met. The Academy also supports the Joint Committee for the Code of Professional Conduct, which develops standards of conduct for the U.S. actuarial profession.

2. *Plan sponsor* is used in this practice note to indicate both employer and union sponsors of prescription drug plans.

weeks before the first deadline for such attestations (August 2005). Appropriate alternatives to methods mentioned herein may develop over time and come into generally accepted use.

This practice note is based on interpretations of 42 CFR 423.884 and current CMS guidelines and requirements. The information in this practice note is not binding on any actuary and is not a definitive statement about what constitutes generally accepted practice in this area. This practice note has not been promulgated by the Actuarial Standards Board or by any other authoritative body. Regulations or other clarifying guidance promulgated subsequent to the date of publication of this practice note may make the practices described herein irrelevant or inappropriate.

The members of the work group responsible for this practice note are: Dale Yamamoto, chairperson; Al Bingham; Derek Guyton; Mark Olson; John Schubert; and Mark White. This group consists of actuaries experienced in working with employer and union groups that sponsor retiree health care plans. All members have the necessary expertise to provide technical guidance on this new actuarial certification process.

This final practice note takes into consideration the comments received during the comment period (August 2005 to Nov. 15, 2005). Additional comments are welcome as to the appropriateness of the practice note, frequency of updates, substantive disagreements, etc. Comments should be sent to the Academy's Federal Health Policy Analyst at the following address: American Academy of Actuaries, 1100 17th St. NW, 7th floor, Washington, DC 20036.

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I. Introduction

The Medicare program was established under Title XVIII of the Social Security Act of 1965. The program established hospital and medical care coverage for U.S. seniors over 65 and certain disabled individuals. The program is administered and regulated by the Centers for Medicare and Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. Medicare is administered federally and financed with dedicated payroll taxes, premiums paid by (or on behalf of) beneficiaries, and general tax revenue.

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 established a new voluntary outpatient prescription drug benefit effective as of Jan. 1, 2006. This new benefit is a substantial change to the Medicare program. The prescription drug benefit (also referred to as Medicare Part D) is provided by private plans authorized by CMS. The plans are either stand-alone prescription drug plans (PDPs) or Medicare Advantage Prescription Drug plans (MA-PDs) offering both medical and prescription drug coverage. These plans are required to offer a standard drug benefit described by the MMA but have the flexibility to vary the drug benefit as long as it is at least actuarially equivalent to the standard design. The MMA also provides for subsidized premiums and lower cost-sharing for eligible low-income beneficiaries.

In order to encourage employers and unions to maintain their retiree health care plans, the MMA provided a tax-exempt retiree drug subsidy for qualified retiree health plans that offer coverage on and after Jan. 1, 2006. Under the MMA regulations, a primary requirement for qualification to receive the subsidy is that the retiree health plan must provide a benefit design and subsidy level that is at least actuarially equivalent to the standard Medicare design and government subsidy level. The actuarial equivalence tests for subsidy qualification, which are the subject of this practice note, are different from those imposed on private PDPs.

To be eligible for the subsidy, the regulations require a plan sponsor to apply for the retiree drug subsidy each year. Included in the application is an attestation by a qualified actuary that the plan is at least actuarially equivalent to the Medicare Part D standard benefit. The MMA requires that the qualified actuary be a member of the American Academy of Actuaries, and Section VII of this practice note discusses appropriate qualifications. The actuarial attestation is required to specify that the plan meets the Gross and Net Value Tests required by the MMA under CMS rules and to acknowledge that the information is being used to obtain federal funds. The actual attestations of the Gross and Net Value Tests may be performed by one actuary for both tests or different actuaries for each test.

For Medicare beneficiaries delaying enrollment in the Part D program from their first eligibility, a late-enrollment penalty is assessed. If the beneficiary was enrolled in a prescription drug plan with benefits as good as the standard Medicare offering, however, the penalty will not apply. The regulations require plan sponsors providing such coverage to provide their retirees with a notice that their prescription drug plan is "creditable" coverage, thereby relieving the retiree from the late-enrollment penalty. Passing the "Gross Test" discussed in section III will satisfy the requirement that the benefits be at least equal to standard Medicare benefit.

This practice note offers guidance on the actuarial equivalence requirements for actuaries providing services to plan sponsors that receive the retiree drug subsidy, and does not apply to practice involving entities offering PDPs and MA-PDs.

II. Generally Accepted Actuarial Principles

In the hierarchy of generally accepted actuarial principles and practices, the Code of Professional Conduct and, by reference, the Actuarial Standards of Practice (ASOP) have the highest standing. Other items – such as practice notes, textbooks, examination study notes, and articles in professional journals – do not have the same binding authority. Since the actuarial attestation required for actuarial equivalence under the MMA is new, no ASOP has been adopted specifically and exclusively to apply to actuarial work performed to comply with CMS requirements.

The actuary may consider several existing ASOPs as valuable sources of guidance when performing the actuarial attestation, including:

No. 5: Incurred Health and Disability Claims
No. 6: Measuring Retiree Group Benefit Obligations
No. 8: Regulatory Filings for Rates and Financial Projections for Health Plans
No. 16: Actuarial Practice Concerning Health Maintenance Organizations and Other Managed-Care Health Plans
No. 23: Data Quality
No. 25: Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
No. 31: Documentation in Health Benefit Plan Ratemaking
No. 41: Actuarial Communications
No. 42: Determining Health and Disability Liabilities Other Than Liabilities for Incurred Claims

In addition, generally accepted actuarial practices have been established in the health care field that are not published in the form of ASOPs. The actuarial equivalence testing is generally expected to rely heavily on the use of prescription drug price and utilization experience. The concepts of continuation tables and claim distributions will normally be used in this type of analysis. Appropriate adjustments will usually be made to project historical medical and prescription drug claim data to the plan year of the actuarial equivalence attestation and to possibly adjust for any benefit changes. It is usually preferable for an actuary to have experience in this or comparable work before performing actuarial attestations. Guidance in such work is beyond the scope of this practice note.

III. Actuarial Equivalence Concepts

"Actuarial equivalence" has a specific meaning in the context of the MMA and the subsequent regulatory guidance, but this meaning is not explicitly defined. This meaning under MMA may be different from an actuary's preconception of the term and warrants careful attention. The MMA concept of actuarial equivalence is applied in the determination of a Gross Test and a Net Test that affect the creditable coverage determination and qualification for the direct retiree drug subsidy of an eligible prescription drug plan.

- The Gross Test is tied to the determination of creditable coverage. If the Gross Test for a plan fails, then the plan will not provide creditable coverage. When a Medicare beneficiary eventually enrolls in a Medicare Part D plan, the plan will charge a penalty premium that is based on the number of months the beneficiary was not enrolled in a plan providing creditable coverage. The primary purpose of the penalty premium is to minimize enrollment timing by late enrolling Medicare beneficiaries. If the late enrollee transfers to a Medicare Part D plan from a plan providing creditable coverage, then there would not usually be a large adverse selection effect from those late enrollees, so no penalty is warranted. Therefore, from the Medicare perspective, the determination of creditable coverage is based on the level of the plan design relative to Medicare Part D.

- The Net Test is tied to the determination of a financial subsidy for plan sponsors. The plan sponsor is providing the financial support for the benefit and will receive any financial benefits of the subsidy payment itself. As a strictly financial measure, the portion of the benefit value paid for by the plan sponsor is compared with the portion of the Medicare Part D benefit value paid for by Medicare. In addition, an alternative form of the Net Test is allowed that recognizes the lost value of the catastrophic benefit due to the "True Out of Pocket" (TrOOP) adjustment. This alternative is used only where the plan sponsor's plan includes a continued supplemental benefit for those beneficiaries who enroll in Part D. In either case, the Net Test is a relative comparison of the plan sponsor's net financial support to the retiree with Medicare's net financial support to the retiree.

For each of these tests, the actuary will make a "pass/fail" determination for the plan. There is no gradation of partial creditability under the Gross Test or partial subsidy under the Net Test. The "all or nothing" result may lead some actuaries to feel uncomfortable that the law requires them to make a definitive statement regarding "equivalence." Actuarial analysis and projection is inherently an estimation exercise and hence is somewhat imprecise. In valuing health plans and prescription drug benefits, the actuary will make choices and assumptions about data sources used, projection methodologies, and other elements. The projected plan values will be an estimate rather than a precise number. To add complexity, pharmacy costs are influenced by the introduction of new technology (e.g., new medicines) and rapid changes in prices (e.g., when brand named drugs go off patent). The resulting uncertainty affects both elements in the Gross Test and Net Test—the value calculated for the Medicare Part D standard plan, and the value of the plan sponsor's retiree prescription drug plan.

This lack of precision may become a difficulty if the plan sponsor's Gross Test or Net Test result indicates that the plan sponsor's value just slightly exceeds the Medicare value. The actuary's attestation of actuarial equivalence may imply to the non-actuary a correct and solid finding, but that finding may instead be based on underlying statistical variation or on the actuary's choice of the data set used, the methodology applied, or the specific actuarial assumptions that were applied. If slight changes in the data set, the methodology, or the assumptions would cause the test result to fail, then the actuary would usually find it prudent to be prepared to explain the choice of a particular data set, methodology, or set of assumptions against other alternatives.

This variability takes on particular importance for actuarial equivalence testing, because the test results are used by the plan sponsor to qualify for the payment of federal funds subject to the False Claims Act. Since the audit review of the test will usually be performed well after the fact, there is some risk that more than one year of testing could be affected, compounding the impact of any changes resulting from the audit process. Thus, the actuary is advised to be aware of the defensibility of the data sources, methodology, and assumptions in concluding that the results of either the Gross Test or the Net Test are favorable. Sensitivity testing is not a requirement of CMS, but the actuary would normally be better prepared to address any challenges that might occur in the audit process if those issues were addressed with analysis at the time of the initial determination. The intent of the law is clearly to encourage the maintenance of private retiree health plan coverage of prescription drugs as an alternative to Part D. The actuary and the plan sponsor have considerable flexibility in defining coverage to meet actuarial equivalence, particularly under the Net Test, and sensitivity testing may aid that process.

IV. Summary of Regulations

Subpart R of the CMS regulations contains the rules pertinent to the retiree drug subsidy and the required actuarial attestation. The regulations require this attestation to be certified by a qualified actuary who is a member of the American Academy of Actuaries, and to be based on generally accepted actuarial principles and any actuarial guidelines established by CMS in the regulations or in future guidance. To the extent CMS has not provided guidance on a specific aspect of the

actuarial equivalence standard, it seems likely that the attesting actuary may rely on any reasonable interpretation that is consistent with accepted actuarial principles in determining actuarial values.

The CMS regulations prescribe a "two prong test" to satisfy the actuarial equivalence testing. The first prong is a Gross Value Test and the second prong is a Net Value Test, taking into account the sponsor's contribution toward the financing of the coverage. CMS felt that this approach best supported the goal of maximizing the number of retirees that retain their employer or union-sponsored retiree prescription drug coverage and not creating windfalls to the sponsors. CMS also felt that this test best reflected Congressional intent.

To satisfy the Gross Test, the regulations require that the expected amount of paid claims for Part D drugs for Medicare beneficiaries under the sponsor's plan be at least equal to the expected amount of paid claims for the same beneficiaries under the defined standard prescription drug coverage, including catastrophic coverage available when an individual's out-of-pocket expenses exceed a specified threshold. Satisfying this Gross Test also satisfies the actuarial equivalence test for creditable coverage purposes.

In the final regulations, "employment-based retiree drug coverage satisfies the actuarial equivalence standard if its actuarial value (as determined after reducing the Gross Value of the benefit by expected retiree premiums) is at least equal to the Net Value of defined standard prescription drug coverage under Part D (as determined after reducing the Gross Value of the benefit by the expected monthly beneficiary premiums), with the Net Value of the defined standard prescription drug coverage reflecting the impact of employer or union-sponsored prescription drug coverage that would supplement the beneficiary's defined standard prescription drug coverage."

The Net Value of the sponsor's plan is calculated by subtracting the retiree premium/contribution from the Gross Value of the sponsor's plan. The Net Value of the defined standard prescription drug coverage is calculated by subtracting the national beneficiary premium from the Gross Value of the defined standard prescription drug coverage. The national beneficiary premium may be the national average beneficiary premium for the applicable year, or may be determined by multiplying the Gross Value of the Part D benefit by 25.5 percent.

If the sponsor provides coverage that supplements Part D for those retirees who enroll in Part D, the Net Value of the defined standard prescription drug coverage may also be adjusted to recognize the lower catastrophic coverage because of the effect of TrOOP. This "Medicare Supplemental Adjustment" (as defined in the CMS guidance issued April 7, 2005) is based on the plan design of the supplemental coverage, which is important to recognize in cases where the supplemental benefit is different from the normal benefit available to retirees that do not enroll in a Part D plan.

The regulations require that each benefit option within a group health plan (defined as a particular benefit design, category of benefits, or cost-sharing arrangement) for which attestation is made must pass the Gross Test. The plan can pass the Net Test, however, by testing each option separately or by aggregating benefit options within a group health plan.

For plans in which the sponsor charges a single, integrated retiree premium/contribution for medical and drug coverage, the sponsor may allocate any portion of the premium to the drug coverage for the purpose of the Net Test of the actuarial attestation. For practical purposes of passing the Net Test, the obvious approach is to allocate all of the retiree contribution to the other, non-drug, medical coverage and administrative expenses, which requires ascertaining the actuarial cost of the other medical coverage. If the contribution is greater than the actuarial cost of the other medical coverage and expenses, then the excess must be allocated to the drug coverage. It will usually be important for any allocation, however, to be consistent with other documentation. For example, a plan

sponsor offering separate medical and prescription drug plans, each with its own contribution structure would not be able to reallocate the retiree contributions across the two plans.

V. Claim Cost Sources

The purpose of this section is to provide guidance with respect to claim cost sources that the actuary may choose to consider in developing the support for the attestation of actuarial equivalence.

CMS has indicated that the calculations for the Gross and Net Tests should be based on the sponsor's own claims experience for participants who are Part D eligible individuals, when such data is available and credible enough to ensure that it provides a meaningful representation at all levels of claims for a given distribution. If there is not sufficient claims data at all levels to support a reasonable calculation of the actuarial values based on a sponsor's own claims data, CMS allows the use of alternative normative databases. CMS regulations state a preference, however, that normative data should only be used if the sponsor's specific data is either unavailable or is not credible. If the plan sponsor has many plans or benefit options, those with less credible data may be supplemented with the claims experience of those with more credible data to enhance the overall claims distribution.

If the actuary believes that the plan sponsor's data is insufficient for the evaluation, then the actuary may consider supplementing the plan sponsor's data with other sources that would provide additional credibility to the overall data set. Other data sources can be used, provided these additional data sources can reasonably be expected to reflect the characteristics of the plan design, demographics, and other factors. The other sources may be published claims distributions that can be adjusted to closely reflect the expected plan sponsor's retiree claim distribution. This might include claim distributions generally available for purchase in the marketplace. Other acceptable sources might include: (a) broad claim distribution data from pharmacy benefit managers or health plan administrators that may be made available to a plan sponsor, or (b) claims distribution data from a similar plan sponsor that is adjusted for differences between the two plan sponsors.

Actuaries are usually well advised to be careful when using data sources not from the plan sponsor, since these sources may require adjustments to more closely reflect the plan design, demographic, as well as utilization characteristics of the plan sponsor's retirees. Specifically, the actuary should become familiar with the data underlying any sources to determine whether they appropriately represent the plan sponsor's specific experience.

The actuary normally would disclose the data sources that have been used as well as any adjustments that may have been made.

VI. Methodology

This section provides an outline of the major steps that would usually be taken or considered in preparing the actuarial equivalence tests. The underlying data that will be used would normally be consistent with the guidance in the previous section.

There are four key steps in the testing process:

A. Preparation for Testing
B. Claim Cost Selection and Adjustment
C. Gross Value Test
D. Net Value Test

The attesting actuary is responsible for completing these four steps. These guidelines are not intended to be exhaustive or to cover every situation.

A. **Preparation for Testing.** Before testing is done, the actuary usually reviews relevant plan descriptions. The requested information might include: the plan document, SPDs, enrollment materials, and other retiree communications materials. The actuary may rely on the plan sponsor's representations of changes to be made to the prescription drug benefits for the period covered by the attestation. Consideration would normally also be given to the substantive plan (as defined under Financial Accounting Statement No. 106) and any administrative procedures that significantly affect the benefits actually paid to retirees.

   Other key preparation steps typically are:

   1. Identify separate plans and the benefit options within each plan.[3]

      a. The definition of a plan can be difficult to determine. The preamble to the proposed Part D regulations states that CMS proposed to apply the ERISA plan definition, modeling the approach adopted by the Treasury Department at 26 CFR section 54.4980B-2, in the context of a group health plan. Specifically, CMS referred sponsors to Q&A-6 of that COBRA regulation, noting that all health benefits provided by a sponsor are presumed to be under a single plan unless it is clear from the plan instruments and operation that the plans are separate arrangements. Plan sponsors must determine what is a "plan" for purposes of combining benefit options in the actuarial equivalence test. The plan sponsors must also determine the benefit options within each plan, and the actuary should take into account the defined options. If questions exist, the plan sponsor's benefits counsel usually would be consulted.

      b. A variation in plan design cost-sharing provisions for the prescription drug benefit (expected for testing year) will normally create a separate benefit option, at the discretion of the plan sponsor.

      c. Variations in retiree contributions may create separate benefit options.

         i. Many plan sponsors have situations with differences in contributions between the former employee and dependents. The plan sponsor will determine whether to treat each such contribution schedule as one benefit option or as multiple benefit options.

         ii. Many plan sponsors have situations with differences in contributions among retirees with different lengths of service. The plan sponsor will determine whether to treat each such contribution schedule as one benefit option or as multiple benefit options.

      d. The plan sponsor will determine whether it is appropriate to include disability retirees under the age of 65 in testing and whether they create another benefit option.

      e. The actuary normally confirms the plan year for each plan (and therefore for each benefit option), the benefit in force for that plan year, and the impact (if any) of the plan year on testing. Non-calendar-year plans in particular should be identified due to the special treatment specified by the MMA and regulations.

3. Note that this section states throughout that the plan sponsor will determine how to define both the plan and benefit options being offered to their retirees for purposes of the retiree drug subsidy application. This is to emphasize that the plan sponsor has the final responsibility for the definition of these two important definitions. The actuary, however, may play an important advisory role in the process because of the actuarial nature of the RDS program. The actuary should be well-versed in the rules to assist in this determination.

2. Based on a preliminary review of the design and contributions for each plan, determine whether the plan can be certified as passing both the Gross and Net Tests without detailed calculations (as exemplified by the CMS guidance for simplified calculations for creditable coverage) or whether the actuary believes that data-based testing is required for each plan. In the event a simplified testing approach is used, the actuary is usually well-advised to be prepared to provide documentation supporting his determination process. Such data might include aggregate historical claims experience, aggregate historical retiree contribution data, and similar elements. Refer to ASOP 41 "Actuarial Communications" for additional Guidance

B. **Claim Cost Selection and Adjustment.** Historical claim experience for the plan and benefit option being tested is used if available and appropriately credible. Other normative data may be appropriate for the option being tested and would usually be adjusted for differences in demographics, design, and any other factors that may affect cost levels.

A claims continuation table of allowed charges would often be employed for Gross Value testing (unless data-based testing is not indicated), whether historical claims data or normative databases are being used. Other methods may also be used, including seriatim calculations based on historical data projected to the testing year, which will have similar data requirements and issues. The data selected for testing would normally be reviewed and adjusted as follows:

1. Based on the data available, establish the credibility level of each benefit option being tested. ASOP No. 25 will likely offer useful guidance.

    a. The levels of credibility achievable include:

        i. The volume of claim data available is sufficient to produce a claim distribution that is fully credible (except perhaps in the 'tail').

        ii. The volume of claim data available is sufficient to produce a cost per member per year that is fully credible.

        iii. The volume of claim data available is sufficient to produce a cost per member per year that is only partially credible and the use of normative data would usually be considered.

        iv. The volume of claim data available is not sufficient to produce a cost per member per year that is even partially credible and normative data would, therefore, be used for actuarial equivalence testing.

    b. The actuary may choose to consider combining the experience of multiple benefit options with the same or similar plan provisions to increase credibility.

2. Where the analysis would be affected materially, adjust data used for each benefit option to:

    a. An incurred basis (if appropriate);

    b. Exclude drugs not covered under Part D, even if payable under Part B, and include drugs covered under Part D but not covered by the plan sponsor's coverage;

    c. Reflect the (estimated) savings from any rebates not reflected in point-of-sale prices.

3. Project costs to the testing year.

    a. Historical option-specific claims experience, preferably using allowed charges, will be trended appropriately. Use of separate trend rates for price and utilization would usually be considered.

    b. In most cases, the actual participant contribution rates for the testing year will be used. If not available, expected participant contributions may be used, applying the contribution policy.

    c. Costs for the sponsor's plan would be adjusted for any plan design changes.

C. **Gross Value Test.** The Gross Value Test compares the benefit value of the plan sponsor's program to the benefit value of the standard Medicare benefit using generally accepted actuarial practices. The actuary usually considers each of the following steps in preparation of this test:

1. Determine whether one of the simplified testing approaches applies or whether the full calculation will be performed. If a simplified method is used, document the basis for the simplified testing.

2. For each benefit option, identify the prescription drug plan provisions that determine each participant's level of cost sharing. The actuary will usually decide whether any plan management features might affect the Gross Value of the option.

3. For benefit options with plan provisions that apply to any covered plan expenses and are not solely applicable to prescription drug expenses, organize the combined plan provisions into separate plan provisions for prescription drugs and all other covered expenses. The organization would generally be based on historical medical and prescription drug claims experience for the plan.

    a. Special consideration would typically be given to plans with lifetime or annual benefit maximums that potentially can be reached in the testing year or that are demonstrably affecting the benefits paid from the plan.

    b. If data is available, the actuary would usually consider the amounts remaining under the plan for each member, restoration of benefits provisions, and similar items that are likely to significantly affect the amount of benefits paid in the testing year.

4. Establish the total allowed cost per member for the testing year to be used for each benefit option. This would be adjusted for factors such as non-covered drugs, expected discounts, utilization levels, or rebates, if the effects of these factors are material relative to the standard Medicare Part D coverage.

    a. If the plan design has a feature such as a low lifetime maximum benefit or pay-related deductibles that will affect individual participants uniquely, it may be necessary to perform a weighted average calculation to determine the average value of the plan design across all participants in a benefit option.

5. Apply the drug plan provisions to the selected claims continuance table or seriatim claims data to estimate the Gross Value of the sponsor's plan on a cost-per-member basis.

6. Apply the plan provisions for the standard Medicare Part D coverage to the selected claims continuance table or seriatim claims data to estimate the Gross Value of Part D for the group covered by the benefit option being tested on a cost-per-member basis.

a. If the standard Medicare Part D plan provisions are notably different from the sponsor's plan, an assumption regarding behavioral changes to utilization would normally be considered.

7. If the Gross Value of the sponsor's plan meets or exceeds the Gross Value of Part D coverage for this group, the sponsor's plan passes the Gross Value Test. Note that the results of this test also document that the option provides creditable coverage. (CMS has also specified safe harbor conditions for the purpose of determining creditable coverage, but not for this Gross Value Test.)

8. If the Gross Value of the sponsor's plan is not significantly different from the Gross Value of Part D, the actuary would usually determine the sensitivity of the results to changes in the assumptions made, to the data projection methodology, or to the normative databases used (if any). The actuary and the plan sponsor have considerable flexibility in defining coverage to meet actuarial equivalence; sensitivity testing may aid in that process.

D. **Net Value Test.** The Net Value Test uses generally accepted actuarial practices to compare the Net Value provided under the sponsor's program to the Net Value provided under the standard Medicare Part D benefit. The actuary would normally consider each of the following steps (and perhaps reconsider after seeing preliminary results) in preparing this test:

1. Decide which benefit options will be combined for Net Value testing as allowed by the regulations and guidance.

2. Determine whether one of the simplified testing methods applies or, if not, perform the full calculation. If no testing is done, document the reasons for not performing the tests. All benefit options should be able to pass the simplified Gross Test individually in order to be aggregated.

3. Determine the dollar-weighted value for those options being combined to determine the:

   a. Weighted average Gross Value of the sponsor's plans;

   b. Weighted average Gross Value of Part D for this group;

   c. Weighted average of the contributions required from plan participants.

4. Calculate the Part D contribution value by one of the following methods:

   a. National average Part D premiums; or

   b. 25.5 percent of the (weighted) Gross Value of Part D for this group.

5. Determine the Net Value as the Gross Value of the sponsor's option(s) less the projected average contributions. The Gross Value of Part D, less the Part D contribution value, equals the preliminary Net Value for Part D.

   a. If the Net Value of the sponsor's options meets or exceeds the preliminary Net Value of Part D coverage for this group, the benefit options pass the Net Value Test.

   b. If not, the plan sponsor has the option of determining whether to provide a supplemental plan to retirees electing Part D coverage and directing the actuary to apply the Medicare Supplemental Adjustment to reduce the Net Value of Part D.

i. The Medicare Supplemental Adjustment may only be applied if the plan sponsor has agreed to provide benefits exceeding the standard Part D coverage for participants electing to enroll in Part D.

ii. The Medicare Supplemental Adjustment for each benefit option is determined using the same claim continuance table or seriatim claim data (adjusted as appropriate) selected to establish the Gross Value of Part D, using the process described in the regulatory guidance.

iii. The design applied to the continuance table is required to be the design offered to those participants electing to enroll in Part D, even if this design is different from that provided to other participants.

6. The final Net Value for Part D equals the Gross Value of Part D, less the Part D contribution value, less the Medicare supplemental adjustment, if applicable.

   a. If the Net Value of the sponsor's options meets or exceeds the final Net Value of Part D coverage for this group, the benefit options pass the Net Value Test.

   b. If the Net Value of the sponsor's options is less than the final Net Value of Part D, the group does not pass the actuarial equivalence Net Value Test and the plan sponsor does not qualify for the related subsidy.

7. If the Net Value of the sponsor's plan is not significantly different from the Net Value of Part D (either before or after the supplemental benefit adjustment), the actuary would usually determine the sensitivity of the results to changes in the assumptions made, the data projection methodology, or the normative databases used (if any). The actuary and the plan sponsor have considerable flexibility in defining coverage to meet actuarial equivalence and sensitivity testing may aid that process. The results of the sensitivity tests should be discussed with the plan sponsor, highlighting circumstances under which the plan would fail testing and possible implications for future years.

CMS Guidelines

CMS has issued guidelines for some unique situations. One is on the determination of creditable coverage. The guidelines provide plan sponsors with the general concept of creditable coverage and provide some simplified test parameters. This topic is outside the scope of this practice note.

Account-based plans were addressed in another CMS guidance notification. The described accounts are more comparable to designs used for active employees but represent the only guidance available at the time of drafting this note. In brief, the guidance states:

1. Health reimbursement account (HRA) – If an HRA is offered with a high-deductible health plan (HDHP), then for creditable coverage determination, amounts contributed to an HRA in a given year should be treated as increasing the expected prescription drug claims payable from the non-account benefit for that year. Existing funds in the HRA that have been rolled over from prior years will not be factored into the value of the arrangements.

2. Flexible spending account (FSA) – An employer sponsoring an FSA shall disregard such a plan for purposes of determining whether an individual has creditable coverage.

3. Health savings accounts (HSA)/medical savings accounts (MSA) – These types of accounts cannot be taken into account in determining whether an HDHP qualifies as creditable coverage. Also, they cannot be taken into account to determine whether the HDHP can qualify for the retiree drug subsidy.

VII. Qualification

Certification of actuarial equivalence is considered a statement of actuarial opinion. Therefore, the signing actuary is subject to the Qualification Standards (Including Continuing Education Requirements) for Actuaries Issuing Statements of Actuarial Opinion in the United States. Under the Qualification Standards, the actuary should satisfy requirements for basic education, experience, and continuing education in the practice area before issuing a statement of actuarial opinion.

All actuaries, including those who work with retiree medical benefits in a valuation context, are usually prudent to recognize the importance of being careful in this area. Actuarial equivalence analysis as referenced in the law and regulations is, by its nature, a health benefit pricing analysis. While valuation experience alone may be helpful, it is, by itself, not sufficient qualification to perform this analysis or to attest to actuarial equivalence. The actuary may wish to refer to Section II for additional guidance and applicable Actuarial Standards of Practice. It is usually preferable for the actuary's work experience and continuing education to include health benefit system pricing and analysis.

VIII. Reports

This section provides an overview of suggested report documentation for the actuarial attestation of actuarial equivalence for plan sponsors receiving a retiree drug subsidy. The term "report" in this practice note refers collectively to the "reports and working documents" the plan sponsor (or their designee) is required to maintain. The actuary develops the reports in support of the actuarial work product. The plan sponsor (or their designee) is required to maintain for six years the actuarial attestation as well as the actuary's reports supporting the attestation. The actuary may choose to retain copies of the attestation and reports as well.

The reports will typically describe the relevant data, sources of data, material assumptions, methods, and process used in the actuarial equivalence comparison with enough clarity that another qualified actuary practicing in the same field could objectively evaluate the reasonableness of the work product. The actuary normally explains the reason(s) for and describes the effect of any material changes in sources of data, assumptions, or methods from the last analysis. Generally speaking, there are five key areas to be documented:

A. Documentation of actuarial equivalence
B. Participant data
C. Summary of plan provisions
D. Total rates and retiree contributions
E. Actuarial assumptions and methods

The actuary develops appropriate documentation in support of the actuarial work product. The extent of the documentation typically includes the standard information outlined in ASOP No. 41. The documentation also usually includes the source(s) of data, material assumptions, methods, and the process by which actuarial equivalence was determined. The actuary generally also explains the reason(s) for and describes the effect of any material changes in the source(s) of data, assumptions, or methods from the last attestation.

A. Documentation of actuarial equivalence. The actuary normally documents how the plan sponsor's plans and options meet the test of actuarial equivalence to the Medicare program. The following key items are usually documented:

- The Gross Value Test.
- The process for determining the average retiree contribution under the sponsor plan(s).
- The Net Value Test.

The above three elements are the key for testing actuarial equivalence. The Gross Value Test and the Net Value Test are the actuarial equivalence tests spelled out in the Act and the regulations. The average retiree contribution under the plan is a key element that will drive results and usually deserves separate analysis.

1. Document the Gross Value of the plan sponsor's program to the total value of the standard Medicare benefit:

   a. Disclose any use of the actual claims experience of the plan sponsor;

   b. Disclose use of normative databases and describe in the assumptions and methods section.

2. Document the retiree contribution rate used under each plan and benefit option. If a rate is an average or a composite of contribution rates, document the development of that average in the assumptions and methods section, along with any commentary on projected enrollment.

3. Document the Net Value of the plan sponsor's benefit to the Net Value of the standard Medicare benefit:

   a. Disclose the assumed Medicare beneficiary contribution rate used;

   b. Disclose whether a supplemental benefit adjustment (i.e., adjustment for higher catastrophic benefit limit due to TrOOP) is used. If so, describe its derivation in the assumptions and methods section.

B. Participant data. A summary of the participant data would typically be provided in enough detail to determine key plans and benefit options. At a minimum, the total number of lives used for testing purposes would normally be provided. Documentation of the number of retirees, surviving spouses, dependent spouses, and other eligible dependents may be desirable if different total cost or contribution rates apply for these members.

C. Summary of plan provisions. Key plan provisions are normally documented for each benefit option within the group health plan. Specifically:

1. Provisions of the group health plan, which will generally be the same for all benefit options. These provisions will usually include eligibility requirements (for retirees and dependents), a description of copays, coinsurance, benefit maximums, and retiree contributions; and

2. Provisions of the benefit options within the group health plan. These provisions will normally describe differences among options within a group health plan.

D. Total rates and retiree contributions. Document detailed total costs and retiree contributions by plan and benefit option. The report will usually document both prescription drug costs as well as other medical costs. This documentation will generally provide the source of cost rates (e.g., historical claims experience, exposure data, and the use of any normative data).

E. Actuarial assumptions and methods. This section typically details the methods used to value the plan sponsor's and Medicare's benefit and any assumptions used. The following documentation would usually be considered:

1. Demographic assumptions. Disclose the date of census data and any significant adjustments made.

2. Prescription drug claims cost. Disclose the experience period used to develop claim rates including: discussions of credibility and the use of normative data; the source of the claims and exposure data; and the trend rates used to project the claims to the evaluated plan year. Any plan changes made during the experience period or future changes anticipated for the projection year would also be documented. If the plan sponsor's plan design could be subject to leveraging due to fixed plan provisions, commentary would usually be included as to implicit or explicit assumptions used in the projection.

3. Medicare value. The Medicare value would normally be determined based on the underlying prescription drug costs from No. 2 (above). A description of the development of the value would normally be disclosed, including the method used. Describe any use of continuation tables, normative databases used, and use of seriatim modeling. Key assumptions used in projecting costs to the evaluated year would usually be disclosed. Note that since Medicare's plan design values are all indexed to cost trends, there is generally little or no leveraging due to plan provisions.

4. Allocation of Retiree Contributions. A description of how retiree contributions are allocated between the prescription drug and medical coverages would normally be disclosed.

The actuary's documentation would usually address the reasonableness or appropriateness of the assumptions and methodology used in the actuarial equivalence testing process. The chosen data, assumptions used, and adjustments made would usually be provided. The size and effect of any adjustments would usually be included, as well as a statement to the effect that the adjustments are mutually exclusive and are not being applied more than once. Examples of adjustments are those made because of demographics, plan design changes from historical data, and any other adjustments to actual data.

The actuarial attestation also requires affirmation that the actuary is a member of the American Academy of Actuaries and is qualified to render actuarial opinions that are contained in the report. The attestation report would usually also acknowledge that the information contained in the report is being used to obtain federal funds.

IX. Attestation Language

Sample Attestation Language[4]

XYZ, Inc.
Actuarial Equivalence Attestation of Prescription Drug Plan

This analysis has been prepared to demonstrate the actuarial equivalence of the *XYZ, Inc.* prescription drug program with the benefits provided by Medicare Part D. Such demonstration is required by the Medicare program to qualify *XYZ*'s programs for the retiree drug subsidy (RDS) provided under the Medicare Modernization Act of 2003 for plan years beginning Jan. 1, 2006. The certified, electronic attestation has been made on the CMS's Retiree Drug Subsidy Program website.

In conducting our analysis, we have relied on participant data, plan design, and prescription drug claim cost information supplied by *XYZ* and its pharmacy benefit manager. We have accepted the data without audit and have relied upon the sources for the accuracy of the data.

We have not reviewed the other information and data the plan sponsor submitted to CMS in order to qualify for the RDS. Except for the findings described in this report that certain plans are actuarially equivalent to the benefits provided by the Medicare Part D standard benefit, this report does not otherwise substantiate the basis of *XYZ*'s claim for the RDS.

The analysis was developed using generally accepted actuarial principles and practices and is considered to reflect reasonable expectations of anticipated plan experience. This analysis demonstrates actuarial equivalence in compliance with the CMS requirements under 42 CFR 423.884 and is in accordance with applicable laws and regulations. This analysis is not appropriate for any other purpose. The documentation of the methods and assumptions used in the development of the actuarial equivalence has been provided in this report. The actuarial equivalence certification that is associated with this attestation is for the plan year beginning Jan. 1, 2006.

The undersigned is a qualified actuary of *ABC*, a Member of the American Academy of Actuaries {mandatory} and an Associate / Fellow of the Society of Actuaries {if applicable}. I certify that I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established periodically by the Actuarial Standards Board. I acknowledge that the information contained in this document is being used to obtain federal funds. All of the sections of the report are considered an integral part of the actuarial opinion.

_____

John Q. Smith
Member, American Academy of Actuaries
Membership Number: xxxxx
Date

4. This sample attestation language is offered solely for educational purposes and is not intended to limit the content of individual actuaries' certifications. The actuary is encouraged to develop appropriate language for each attestation. The application process for requesting the retiree drug subsidy will include an attestation certification that the actuary will be required to sign electronically.

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