AMERICAN ACADEMY *of* ACTUARIES

October 4, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4068-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Sir or Madame:

This letter presents the comments of the American Academy of Actuaries'[1] Actuarial Equivalence Work Group regarding the Centers for Medicare and Medicaid Services' (CMS) proposed regulations (CMS-4068-P) on the Medicare prescription drug benefit portion of the Medicare Modernization Act (MMA). In particular, this letter discusses actuarial equivalence issues related to prescription drug plans (PDPs), Medicare Advantage (MA) plans, Medicare supplement plans, and retiree health benefits. (We provide comments on other Medicare PDP and MA issues in separate letters.)

We provide comments, where appropriate, on issues specifically requested by CMS, and we also comment on other issues where we feel our perspective may be useful.

Determining actuarial equivalence with respect to the Medicare prescription drug benefit is a complex task and our comments only begin to address CMS's concerns regarding implementation of the MMA. The Academy would be glad to meet with CMS to elaborate on these issues and to help develop practical ways to implement the MMA. We suggest that wherever possible, CMS provide numerical examples to further clarify the various regulatory provisions.

The proposed rule requires Part D plan sponsors, Medicare Advantage plans, and employers to make a number of certifications and attestations based on prospective actuarial estimates of future prescription drug costs and utilization. As with any other actuarial projection, it is inevitable that actual experience will deviate from projected results—regardless of how carefully they are performed. Such deviations do not, of themselves, indicate that the projections were inappropriate or invalidate attestations based on the projections. The Academy strongly

[1] The Academy is the public policy organization for actuaries of all specialties within the United States. In addition to setting qualification and practice standards, a major purpose of the Academy is to act as the public information organization for the profession. The Academy is nonpartisan and assists the public policy process through the presentation of objective analysis. The Academy regularly prepares comments on proposed federal regulations, and works closely with state officials on issues related to insurance. The Academy also develops and upholds actuarial standards of conduct, qualification and practice, and the Code of Professional Conduct for all actuaries practicing in the United States.

recommends that the standard of reasonableness for prospective actuarial estimates required under the rule be based on conformance with recognized standards of actuarial practice.

The following issues are listed in order of the MMA regulations.

SUBPART B – ELIGIBILITY AND ENROLLMENT

423.56 Procedures to determine and document creditable status of prescription drug coverage

Issue: Does the CMS approach to actuarial equivalence, for the purpose of determining creditable coverage, appear practical to employers (and unions) and does it impose a minimal burden on sponsors?
Comment: CMS has determined that the calculation of actuarial equivalence for determining creditable coverage would be based on the average plan payout across the combination of all benefit packages and all plan participants and beneficiaries receiving coverage under the sponsor's group health plan. This is consistent with the definition of the one prong approach. We find this approach imposes a minimum burden on plan sponsors. In addition, care must be taken when communicating creditable coverage status to plan participants that it not be described as necessarily superior coverage to Part D.

Issue: Is it a significant administrative burden for group health plans and other sponsors to include in disclosures an indication of the value of their drug benefit, the total amount of the annual premium for their drug benefit, and the amount of the annual drug benefit premium that the beneficiary will be required to pay?
Comment: It could be a burdensome and complex requirement to provide the exact value of the coverage. Also, sponsoring organizations, for competitive reasons, may be reluctant to disclose the value of their drug benefit, the total amount of the annual premium for their drug benefit, and the amount of the annual drug benefit premium that the beneficiary will be required to pay. We recommend that disclosures be required to include information only regarding whether the plan meets creditable coverage requirements.

Issue: Timely notification to beneficiaries of creditable coverage status.
Comment: CMS proposes several approaches for notification by sponsoring organizations of their creditable coverage status to CMS and to each Part D eligible beneficiary enrolled in their plan. We believe it is reasonable to provide this information annually at the time of the plan sponsor's annual enrollment. To the extent possible, this notification should be provided before or coincident with Medicare's enrollment, which begins Nov. 15, although some employers may not use a calendar-year plan year. There will be some challenges for plans not on a calendar year basis. We also believe that, like the Health Insurance Portability and Accountability Act (HIPAA), a certificate of creditable coverage is only required when creditable coverage ends or upon request.

Issue: If the definition of Medigap is revised, then the timing of the redefinition (Jan. 1, 2006) is in conflict with notice requirements (late 2005).
Comment: Sec. 104 of MMA specifies that disclosure requirements apply only to Medigap policies. Wording in the preamble supports this position. The proposed regulation may reach

beyond current Medigap policies with prescription drugs (either as a standard or innovative benefit). If this is the intent of the regulation, additional policy types may be deemed as Medigap effective Jan. 1, 2006, but these policies will not be Medigap in 2005 when disclosure of a determination of creditable coverage is required. This group suggests that disclosure requirements be limited to those policies covered under the current definition of Medigap along with those that include innovative benefits that provide prescription drug benefits.

SUBPART C – BENEFITS AND BENEFICIARY PROTECTIONS

423.100 Definitions

Issue: Related to Sec. 423.120 (access to covered Part D drugs), should any differences between a network retail pharmacy's and a network mail-order pharmacy's negotiated price be included in the definition of incurred claims and therefore count toward meeting the out-of-pocket cost threshold?
Comment: The purpose of having the enrollee pay the difference between the negotiated prices of retail and mail-order pharmacies appears to be to "level the playing field" for the PDP sponsor or the MA organization so that they are indifferent to which the enrollee uses. However, if this difference is included in incurred claims, the use of retail versus mail order will not be cost neutral to the PDP sponsor or the MA organization. This is because individuals who use the retail rather than mail order pharmacies will generally have higher per capita claim costs and reach the out-of-pocket threshold sooner.

This definition of incurred claims could also have implications for the costs of the reinsurance the government provides to PDP sponsors and MA organizations.

423.104 Requirements Related to Qualified Prescription Drug Coverage

Issue: Beginning in 2007, various coverage limits and thresholds are to be adjusted annually. These amounts will be increased over the previous year's amounts by the annual percentage increase in average per capita aggregate expenditures for covered Part D drugs for the 12-month period ending in July of the previous year. Are there alternative data sources that CMS can use to calculate these annual percentage increases in the first several years of the program?
Comment: Determining the average per capita increase for years 2007 and 2008 will be particularly difficult due to the lack of Part D experience. Medicare has not generally covered prescription drugs before 2006. Therefore, CMS does not have extensive data on prescription drug usage and expenditures by Medicare beneficiaries. While some data are available from the Medicare Current Beneficiary Survey (MCBS), the Medicare 5 percent sample, and other sources, these data are not typically available in a timely fashion.

To the extent that the benefit provisions for the following year set a benchmark for actuarial equivalence tests for private prescription drug plans and employer-provided retiree coverage, it is important that the adjustments be known as quickly as possible. (Note that many large employers with calendar year group health coverage make their benefit decisions and annual employee enrollment many months in advance of their January 1st plan year beginning date.) Possible alternative data sources that could be used to calculate the annual percentage increases

include prescription drug trend experience under the National Health Accounts or under employer retiree health plans.

Estimates of prescription drug expenditures are measured annually in the CMS National Health Accounts. Estimates are primarily based on census data and sample surveys of private retail pharmacy sales. Trend data for employer prescription drug plans are routinely released by benefit consulting firms and Pharmacy Benefit Managers (PBMs). Either of these sources of data could be used as a starting point. However, since the trend for prescriptions used by Medicare-eligible individuals may be different from the overall prescription drug trend, an attempt should be made to separate the prescription drug usage for Medicare-eligible individuals.

The trend for the Medicare Part D program is likely to be different from the prescription drug trend determined as above for several reasons. The Medicare Part D program will be by far the largest single prescription drug program offered. The large number of enrollees could provide PDPs negotiating leverage that could help to contain the prescription drug trend for the Part D program or for prescription drugs in general. The experience of the Federal Employees Health Benefit Plan (FEHBP) in controlling prescription drug trend compared to other employer health plans may be instructive in this regard. On the other hand, the new Medicare benefit may give manufacturers some leeway to raise prices on drugs. CMS may wish to take these factors into account and adjust the prescription drug trend for employer retiree health plans to develop a proxy measure for the Medicare Part D prescription drug trend.

Also, it may be possible to use a method for the first few years in which these coverage limit adjustments are corrected in a following year for all or a portion of the overstatement or understatement of each year's trend value. CMS's Office of the Actuary uses this procedure for the development of the (now) Medicare Advantage annual increases to the various ratebooks.

Issue: How many alternative benefit designs go beyond actuarially equivalent standard coverage?
Comment: For 2006, the basic structure of the prescription drug benefit includes a deductible level ($250) for which the beneficiary is responsible, a second level ($250-$2,250) where the beneficiary is responsible for 25 percent coinsurance, a third level ($2,250-$5,100) for which the beneficiary is again fully responsible, and then a top level (above $5,100) where the beneficiary is responsible for 5 percent coinsurance. As noted above, these values will change annually. Actuarial equivalence is measured against the actuarial value of this benefit structure.

Several parameters could be changed to produce an alternative benefit design that would produce an actuarial value at least as great as the standard benefit, including:

- Reducing the deductible
- Reducing the beneficiary's coinsurance percentage between $250 and $2,250
- Extending the upper limit of the second level (e.g., to $2,500)
- Reducing the beneficiary's 100 percent responsibility between $2,250 and $5,100
- Reducing the $5,100 limit to a lower amount (e.g., to $5,000)
- Eliminate beneficiary cost sharing above the $5,100 level
- Changes in formularies or networks

Theoretically, there are an infinite number of ways to vary the benefit structure to create an alternative benefit design. It would be impossible to determine in advance whether all possible

designs are actuarially equivalent, especially those incorporating more than one of the above features, where any of the features move in the opposite direction indicated above. Note that many benefit structures may change annually at rates different from the various Part D design features.

SUBPART F – SUBMISSION OF BIDS AND MONTHLY BENEFICIARY PREMIUMS; PLAN APPROVAL

423.265 Submission of bids and related information

Issue: CMS is interested in providing information to potential bidders to help eliminate the uncertainty of drug spending and drug spending trend for Medicare beneficiaries and in delaying the submission of pricing information. What additional information would be needed to prepare bids? What methods could be used to provide for later pricing data submission?
Comment: The American Academy of Actuaries has been working with CMS as CMS develops data it plans to make available to potential prescription drug plan sponsors. CMS's goal in providing these data is to facilitate the preparation of bids. In particular, CMS has proposed to make available four sets of data. The first will be data from the MCBS, which will include micro-level information on drug utilization. The second will be distributions of total claims (i.e. continuance tables), based in part on the MCBS data. The third will be the Medicare 5 percent claims data with imputed drug utilization. The fourth will be a geographic prescription drug utilization index.

The Academy appreciates the opportunity to work with CMS as it develops these datasets and would like to confirm that each of these data sources would provide valuable information that would help potential prescription drug plans as they develop their bids. Importantly, however, the Academy would like to stress that plans should not rely solely on the data supplied by CMS. Instead, the CMS data should be considered in conjunction with other data on prescription drug utilization, including a plan's own proprietary data.

CMS requires that bids are filed no later than the first Monday in June for a plan to be offered in the subsequent calendar year. We believe this deadline is reasonable for the first several years given the time period that will be required for CMS review, negotiation with bidders, and communication with beneficiaries.

Issue: Use of waivers.
Comment: The Academy supports the use of the waiver process as an effective way of addressing certain issues associated with providing Part D coverage to employer-group retirees. The ability of PDPs and Medicare Advantage prescription drug plans (MA-PDs) to be flexible in order to meet the varying needs of these groups should support CMS’s objectives of maximizing the number of retirees with employer-provided drug coverage, maximizing the generosity of their coverage, and minimizing the administrative burden while at the same time maximizing the flexibility for employers.

It appears that waivers may be granted for many circumstances and requirements. Therefore, we suggest that CMS create safe harbors where waivers are automatically or routinely granted for certain categories or defined circumstances in order to reduce both the review time CMS requires

and the uncertainty of plan sponsors or vendors. Alternatively or additionally, we recommend that CMS create and maintain a public database of allowed waivers. We believe this would be helpful for both employers and plans in their planning processes.

Issue: In view of the newness of the PDP program and the lack of standards for review and approval, should CMS consider a simple approach to calculating the value of coverage for the first few years and a re-evaluation of the process later?
Comment: Several characteristics of the MMA and related regulations—the need for a database on prescription drug costs and utilization for Medicare eligible people, new responsibilities for actuaries to certify a plan's actuarial valuation, new responsibilities for CMS to regulate Part D, and the rigid time table for submission and analysis of bids—all suggest that the process initially be simplified as much as possible to make it manageable. The process could then be reevaluated as claims data become available and as the various parties gain experience with program administration. For example, CMS may want to focus on overall costs (claims and administration) and reinsurance subsidies, rather than evaluating bids based on utilization and costs by component areas (those with no claims, those with claims under the deductible, etc.)

Issue: Should CMS consider the use of alternative tables and methodology for special circumstances where the actuary providing the opinion can support use of these alternative methods?
Comment: One approach that could simplify the process of calculating the value of coverage for the first few years is to develop standard actuarial tables in early 2005 that could be used as a safe harbor for the actuarial valuation. This would allow for more uniformity and ease of analysis for CMS. Over time, the safe harbor actuarial tables could be re-evaluated and revised to reflect emerging experience under the program. Alternative tables and methodologies could be allowed for special circumstances where the actuary providing the opinion can support use of these alternative methods. The alternative table could allow for very regionalized or special considerations that result in characteristics different from a national, standard population. Such differences could relate to benefit utilization patterns due to benefit awareness (union plans vs. uninsured), delivery system (HMO, FFS, PPO, Medigap, etc.), formularies, generic/brand mix, drug utilization management, discounts, demographics of specific groups, etc.

423.272 Review and negotiation of bid and approval of plans submitted by potential PDP sponsors or MA organizations planning to offer MA-PD plans

Issue: With respect to evaluating the reasonableness of bids submitted by at-risk plans by means of actuarial valuation analysis, what is the most effective and least burdensome way to obtain pricing and utilization data for use in an actuarial review?
Comment: CMS could provide a sample actuarial pricing format that illustrates the type of information desired. Documentation might be similar to what is used by state insurance departments and in other actuarial rate filings.

423.279 National average monthly bid amount

Issue: Should CMS adjust the national average monthly bid amount to account for variations in unit prices for covered Part D drugs across PDP regions?
Comment: In addition to CMS's intent to make use of FEHBP Medicare beneficiary data to determine if there are significant regional unit price variations, CMS should explore obtaining

other unit price data (e.g., from PBMs or employers) to confirm whether regional variation is important. Presumably, the FEHBP data will reflect the national BlueCross/BlueShield plan. Using this single data source may misstate actual regional variation. If the data show geographic variations, the national average bid amount should be adjusted accordingly.

SUBPART G – PAYMENTS TO PDP SPONSORS AND MA ORGANIZATIONS OFFERING MA-PD PLANS FOR ALL MEDICARE BENEFICIARIES FOR QUALIFIED PRESCRIPTION DRUG COVERAGE

423.308 Definitions and terminology

Issue: In the definitions of *allowable reinsurance costs* and *allowable risk corridor costs*, the proposed regulations require the costs for any plan offering enhanced alternative coverage to exclude any basic coverage costs deemed to be attributable to *increased utilization* over the standard benefit as the result of *the insurance effect* of enhanced alternative coverage in accordance with CMS guidelines on actuarial valuation.
Comment: The amount of the allowable reinsurance costs and allowable risk corridor costs for a given set of benefits could vary significantly, depending on the prescription drug induction factor as well as the methodology used to reflect the induction factor. The American Academy of Actuaries has described the issue of induction in health care costs previously in a public policy monograph on Medical Savings Accounts,[2] which includes a detailed discussion on the development and use of induction factors. In developing the CMS guidelines on actuarial valuation, we suggest that CMS seek input from the Academy, who can draw from actuaries with proprietary data sources to ensure that induction factors are reasonable and the PDP plan sponsors apply the factors consistently.

423.322 Requirement for disclosure of information

Issue: What effect will late information about rebates and other payments have on the prospective actuarial value of alternative benefit packages?
Comment: Adjustments for discounts, chargebacks, rebates, and administrative costs could have a significant effect on costs. Discounts and administrative costs are typically negotiated in advance. Chargebacks and rebates are typically worth less than discounts, and may be a function of experience: activity, dollar volume, sales of specific drugs, etc. Experience-related items will not be known until after the close of the fiscal or negotiation year. This creates significant timing issues, since the actual values would not usually be known until after the new calendar year has begun. This timing delay may require an estimation/true-up process.

423.329 Determination of payments

Issue: Should adjustments for the insurance effect of supplemental coverage be made and what is the best way to adjust the experience of PDPs with enhanced alternative coverage or MA-PD plans that offer supplemental coverage to account for the insurance effect?

---

[2] See the May 1995 American Academy of Actuaries' monograph *Medical Savings Accounts: Cost Implications and Design Issues*, which is available on the web at http://www.actuary.org/pdf/health/msa_cost.pdf.

Comment: This is a complex issue that the Academy would be glad to discuss further with CMS.

Issue: How will risk adjustment affect incentives to enroll low-income individuals at appropriate payment levels? Will the proposed Part D risk adjustor, which for at least 2006 and 2007 makes use of only Parts A and B data, appropriately reflect the higher utilization likely with only nominal cost-sharing for low-income individuals? How will budget neutrality be determined for these low-income individuals?
Comment: In general, any newly implemented risk adjustor presents CMS, PDPs, and MA-PD contractors with many unknowns in terms of the ultimate effect on bids, incentives to enroll members, plan payments, and attractiveness of the program to bidders. CMS may want to consider how to simplify the risk adjustment process and results in 2006 and 2007, and how to reduce uncertainty for the bidding PDPs and MA-PD plans.

Issue: Should CMS reduce allowable reinsurance costs to reflect the impact of induced demand for enhanced alternative coverage?
Comment: Such an adjustment to allowable reinsurance costs would appear to be consistent with similar adjustments for induced utilization made for determining actuarial equivalence and may make reinsurance subsidies more equitable by plan. Consideration should be given to balancing perceived improvement in equity with the practicality of quantifying this adjustment, applying it for a variety of plans with alternative coverage, application to low-income cost sharing programs, etc.

Issue: CMS has proposed to have a single bid for both average income and low-income beneficiaries, then make supplemental payments for low-income cost-sharing (with an option for PDP plans to take capitated amounts instead of cost-based reimbursements). Will this kind of unified bidding structure work, or will the differences in utilization between average income and low-income members be too difficult to disaggregate for purposes of unified bidding?
Comment: In a brand-new process with a great number of unknown factors, especially for previously uninsured low-income beneficiaries, CMS should consider allowing a separate bidding process (i.e., one bid for the standard prescription drug package and a second for the low-income prescription drug package) in order to make bidding easier for PDPs and MA-PDs and review easier for CMS.

423.336 Risk-sharing arrangements

Issue: How do allowable risk corridor costs change for low-income beneficiaries?
Comment: Allowable risk corridor costs for low-income beneficiaries may be affected by the interplay of benefit options (different for various categories of beneficiaries) and by the induced demand created by the reduced cost-sharing. CMS should consider whether the allowable risk corridor costs should be different for the reduced-cost sharing options applicable to these individuals and whether the definition of actuarial equivalence may need to be changed. One possible solution may be to request separate bids for low-income beneficiaries versus regular beneficiaries with the standard benefit plan. This complex issue needs further analysis.

SUBPART J – COORDINATION UNDER PART D WITH OTHER PRESCRIPTION DRUG COVERAGE

423.458 Application of Part D rules to MA-PD plans on and after January 1, 2006

Issue (also applicable to Subpart J, 423.464): What is the likelihood that employers would use the wraparound approach?
Comment: Employers and other plan sponsors will be reviewing their options from a short-term (1-2 year) perspective first, then from a long-term (3+ year) perspective. We believe that the short-term factors that will drive employer decisions initially are somewhat different from the long-term factors, but there is a common theme that should be noted. It is unlikely that employers and other plan sponsors will increase their net spending as a result of the MMA, since they have been under enormous financial pressure due to the rapid increases of retiree prescription drug costs in past years. Their choice of methods will be based on the degree of potential savings available from the method, offset by administrative and other issues, which may limit their ability to pursue the method of optimal savings.

Initially employers and other plan sponsors may be constrained in their ability to make changes quickly. This may create a high likelihood that the direct federal subsidy is the most attractive alternative for 2006. Preliminary conversations with plan sponsors indicate that most taxable employer plans that continue to offer post-65 Medicare prescription drug coverage will take advantage of the subsidy. Non-taxable employers and plan sponsors are tending to take a wait-and-see approach. The potential greater savings of the coordination approach is being weighed against the administrative issues associated with that approach.

Several other factors will also be important. The relative value of the employer plan as determined by the test for actuarial equivalence selected by CMS in the final regulations will be important. In general, employers whose plans provide less net financial support than the Part D benefit may be inclined to use the MMA as an exit strategy. This would allow or require retirees to enroll in Part D directly, providing some degree of financial support through reimbursement of premiums. Conversely, employers with very high net value benefits will find the subsidy relatively attractive because of the effects of the true out-of-pocket cost (TROOP) requirements on the Medicare subsidy provided through the other methods. Employers with net values slightly higher than Medicare Part D may find the coordination approach or the employer-specific PDP approach to be most attractive due to the higher Medicare subsidy that will be provided. The impact of the TROOP calculation is limited by the lower value plan design.

The robustness of the PDP market and the ease of coordinating with those plans operationally (both of which are currently the subject of much speculation in the employer community) will have a substantial effect on the viability of coordination as a short-term strategy. Many employers who are interested in coordinating their current plans with Medicare (the wraparound approach) may still take the subsidy in 2006 if market and logistical issues make them unsure of their ability to execute a wraparound approach. Then, if operational issues are sufficiently clarified, the wraparound approach could be adopted in a subsequent year. Similarly, plans that currently are actuarially equivalent may start with the 28 percent subsidy and decide to wraparound if and when they are no longer actuarially equivalent.

The wraparound approach will be particularly attractive to plans that are offered by non-taxable plan sponsors or employers in a tax-loss position who won't benefit from the tax-free nature of the subsidy payment. However, since coordination is still a more complex method than providing premium support, it is not clear how attractive the approach will be in practice. A plan sponsor must balance the administrative difficulties associated with the coordination method against the additional savings.

Finally, the possibility of an employer working with a PDP or MA plan to offer an employer-specific PDP that qualifies for the higher PDP subsidies from Medicare instead of the 28 percent employer direct subsidy is an intriguing option. This PDP approach may sometimes yield a larger federal subsidy. The viability of this option depends primarily on the range of waivers that can be granted to the employer-specific PDP. For example, waivers on restricting enrollment to the employer's retirees, setting separate employer-specific premium rates, pharmacy access requirements, geographical coverage, plan design, specific state insurance regulations, and other matters will be necessary. If any of these are not allowed, the approach will be unused. CMS should consider issuing advance safe harbor waivers in as many areas as possible to make it clear that this is a viable alternative before the filing deadline for PDPs. This will allow interested employers to conduct the necessary feasibility work before CMS issues PDP approvals. In addition, employer concerns regarding state regulations would be addressed if the ERISA pre-emption were to apply to these plans.

A variant of this approach, where the employer files directly to become a PDP without the assistance of a commercial PDP, seems too difficult to be a practical alternative for most employers and plan sponsors.

In the long term, alternatives such as coordinating with Medicare Part D or offering an employer-specific PDP are more likely to be used, since any questions about the logistical and marketplace issues will be resolved. Similarly, constraints on the speed of change by an employer (such as contract requirements) must be addressed. One consequence of this is that some employers who initially take the subsidy may switch to one of the other methods after a year or two.

423.464 Coordination of benefits with other providers of prescription drug coverage

Issue: What special issues or clarifications are needed to facilitate state pharmaceutical assistance program (SPAP) coordination with new Part D plans?
Comment: Clarification should be provided on how coordination of SPAPs with the new Part D plans will impact actuarial equivalence. Will all payments from the SPAP be included in the calculation of actuarial equivalence? If so, clarification should be provided on how to evaluate the SPAP programs, which can vary dramatically by state. SPAPs, Medicaid, and low-income subsidy programs can overlap; clarification should be provided on evaluating the actuarial equivalence in these situations.

Issue: Employer coordination user fees.
Comment: Employers that sponsor Part D wraparound plans may be subject to coordination user fees to cover the cost of exchanging information necessary for the plans and PDPs to work together. Sec. 1860D-11(j) of the act requires the PDP sponsors to "…not impose fees that are unrelated to the cost of coordination." Although the PDP sponsor may benefit from such coordination (attributable to lower payments in the catastrophic coverage band), we believe it

makes sense to require some substantiation of the actual costs spent by the PDP sponsor to perform those functions. In addition, it may be useful to specify how infrastructure development costs can be recovered by specifying an amortization period. A three-year period may be appropriate given the rate of change in technology and claims systems.

Concerning the frequency at which those fees are levied, the proposed rules suggest either a monthly or quarterly payment schedule. A monthly exchange is the norm for many insurance-related matters and will aid the cash flow for companies entering this market. This payment schedule could be used even if the fees are imposed based on the volume of transactions performed rather than a fixed monthly amount.

Concerns have surfaced regarding the practicality of implementing the coordination method in the short term. If no centralized solution is available in 2006 for handling the difficult TROOP calculation, the PDPs could push for higher user fees to defray the relatively inefficient processes during the first several years. These high user fees would be an additional challenge to the attractiveness of the coordination methodology.

SUBPART R – PAYMENTS TO SPONSORS OF RETIREE PRESCRIPTION DRUG PLANS

423.882 Definitions and 423.884 requirements for qualified retiree prescription drug plans

Issue: Plan groupings for purposes of actuarial equivalence determinations.
Comment: With respect to actuarial equivalence determinations for retiree health coverage under group health plans, CMS proposes to require sponsors to apply the actuarial equivalence test to each group health plan as a whole. The standard would be met if <u>on average</u> the actuarial value of retiree drug coverage under the plan is at least equal to the value of standard prescription drug coverage under Part D.

Because the use of averages carries the potential for inequities and because the term "plan" has a history of being used in different ways by different health benefit program sponsors, a plan defined as a high-level grouping of retirees for a particular plan sponsor may blur important distinctions. Employers who have relatively simple plans for their active employees make distinctions among their retirees that may involve the retiree's date of retirement or length of service as an active employee or age at retirement, usually resulting in benefits with different actuarial values. A lower annual actuarial value might stem from higher required contributions from retirees in one group, or higher deductibles, or lower maximum payouts or other such variations.

Plans that require participant contributions may have contribution levels for dependents that are different from the levels for employees/retirees. Such differences may occur within what CMS defines as a single plan, and one can easily imagine the differences being significant in determining whether a plan qualifies for CMS subsidies.

It is quite possible that, within a retiree health program that CMS would define as a single plan, there will be benefit situations that independently differ in regards to whether they would qualify for the CMS subsidy, or whether the subsidy would be considered a windfall. If a test is applied

to the single plan based on an average across the individuals in that single plan, there will be times when subsidies are not made to sponsors that are providing actuarially equivalent coverage for a portion of their retirees. At other times, subsidies are given to sponsors that have health coverage that falls below the qualification threshold for a portion of their retirees. This will occur not only across plans but also within plans. In one year a plan may have enough of the actuarially equivalent coverage that on average it will qualify for subsides, while the following year, due to deaths or new entrants to the retiree pool, the average may no longer qualify.

Thus, one effect of plan aggregation across multiple retiree groups for testing is that the same windfall issue that CMS is concerned about on an overall plan basis could occur on an individual basis. It is worth noting that many employers now offer the same benefit plans on an access-only basis to some retirees and on a subsidized basis to other retirees. Inclusion of access-only retirees would seem to be required by the proposed regulation's aggregation approach. If this occurs, these individuals would be receiving creditable coverage from a retiree-pay-all plan that will be less attractive to them than participating in the Medicare Part D plan through a PDP or MA-PD.

In anticipating the reaction of plan sponsors to this unevenness resulting from judging a single plan, it appears unlikely that those sponsors receiving windfalls will enrich their coverage. Though they may maintain it longer than they otherwise would, those who find that their actuarially equivalent coverage is not receiving subsidies are going to make a purely financial decision: Should they enhance the non-qualifying coverage enough to get the subsides for the plan as a whole? If they have to pay much more than they are getting back from the government, they are unlikely to enhance the coverage. In other words, the additional amount added for the retirees' benefit would be less than the additional amount they would receive from CMS (i.e., the additional benefit is financed by CMS).

If CMS gives employers the flexibility to define plans and move away from a single plan definition to multiple plans, then presumably the employers will do so in a way to maximize their subsidies. Those who are not qualifying for subsidies as a single plan will disaggregate the single plan to receive subsidies for some portion of their retirees. Those who are qualifying as a single plan will not disaggregate unless they view it as a way to increase subsidies, without increasing their own contributions as much.

In summary, given that the actuarial equivalence testing yields a "Yes/No" result, if CMS chooses to combine different groupings within a single plan, there are likely to be some situations with windfalls and some with less optimal results. If CMS allows employers flexibility with groupings, there are likely to be some windfalls and some tradeoffs that benefit the employers financially without enhancing the retirees financially. If the actuarial equivalence testing resulted in some quantification of the subsidy (the second approach—one prong with limits), these problems might be avoided. But as the preamble notes, other problems arise.

423.882 Definitions and 423.886 retiree drug subsidy amounts

Issue: Calculation of allowable charge for determining retiree drug subsidy.
Comment: Allowable retiree costs are defined as gross covered retiree plan-related prescription drug costs between the cost threshold ($250 in 2006) and cost limit ($5,000 in 2006), that are

actually paid by either the qualified retiree prescription drug plan or the retiree, net of any manufacturer or pharmacy discounts, chargebacks, rebates, and similar price concessions.

In general, we have found some difficulty in understanding exactly what CMS is trying to define as gross costs to be used in the allowable retiree cost determinations. Most of this confusion may be due to terminology differences so it would be helpful to provide examples in the final regulations on what costs should be used.

The proposed regulation recognizes the difficulty in determining the actual cost of providing a pharmacy benefit due to the current pricing concessions and rebates that do not always occur at the point of sale. In general, employer plans, as negotiated through their PBM, agree to some form of a discount for the ingredient cost and a reduced dispensing fee (the charge for the pharmacist's time and service to prepare a prescription) that is paid at the pharmacy. In addition, they may receive a price concession in the form of a rebate on certain brand name drugs. These rebate credits are generally calculated as a percent of the ingredient cost, and the net effect of the rebates is an additional discount. Generic drugs and non rebate-eligible brand name drugs do not generate rebates. PBMs in turn, pay a portion of the rebates to employer plans or their at-risk insurer.

Rebates are paid after the sale and oftentimes months later. It is therefore difficult in today's reporting procedures to assign a rebate to a specific person. Since the calculation of the retiree drug subsidy is based on individual drug spending, approximate methods will need to be established. The preamble suggests several alternative ways to reflect rebates made after the sale. All suggested methods require an assignment of the rebate to an individual and recalculation of the retiree drug subsidy.

Any approach used to estimate the effect of rebates should consider the level of overall pharmacy charges on the subsidy calculation. Depending on drug utilization for individuals with spending at the cost threshold and the cost limit, the assumed reduction in charges due to rebates won't translate directly into the same percentage reduction in the subsidy. Average distributions show that if the value of rebates is 3 percent, it reduces the subsidy amount by about 2 percent. From a practical perspective however, this level of disparity may be acceptable.

423.884 Requirements for qualified retiree prescription drug plans

Issue: CMS enumerates several options for defining actuarial equivalence with respect to retiree prescription drug plans. CMS will specify further guidance in accordance with generally accepted actuarial principles. Note: In the following comment, the Academy first discusses the concept of generally accepted actuarial principles within the context of the actuarial equivalence test for the retiree drug subsidy. We then address each of CMS's potential options and evaluate them within the context of CMS's stated objectives and the concept of generally accepted actuarial principles.
Comment: The MMA directs CMS to develop processes for determining actuarial equivalence in accordance with generally accepted actuarial principles. One of the key elements of applying these principles to a given situation is understanding the purpose of the calculations and how the calculations will be applied. This leads to a determination of a point of view from which to develop the test methodology.

It is helpful to evaluate the methodology of determining actuarial equivalence for retiree prescription drug plans from the point of view of both the beneficiary as well as the plan sponsor. These perspectives are meaningful and useful in assessing how well each addresses the objectives of the MMA.

In the employer's case, the meaningful measure is the level of financial support, which can be determined as the value of the plan benefit less the value of any enrollee contributions. Thus, one test of actuarial equivalence would be a comparison of the employer's financial support for the employer plan (net of retiree contributions) compared to some threshold value of comparison. If the employer's financial support is greater than or equal to the threshold, the test would be passed.

Other aspects of actuarial analysis for plan sponsors where a relative value determination is required use a similar methodology. For example, in valuing retiree medical plans for financial statements, the standard methodology is to subtract the value of participant contributions from the cost of the benefits provided in establishing the value of the employer plans under FAS 106 accounting. Active medical plans are valued for financial statement purposes by subtracting the employee contributions from the cost of the gross plan costs. Many actuaries perform benefit comparisons between different employer plans. These comparisons establish an actuarial value of the gross benefit and then subtract the employee or retiree contributions to establish a net employer value. Merger and acquisition calculations perform similarly where the net cost of the plan to the employer is determined after subtraction of the employee or retiree contributions. Flexible benefit plan pricing looks at multiple plan options and determines the proper pricing by evaluating the net cost equal to each flexible benefit plan option's plan value less the applicable employee contribution. Therefore, there is a great deal of precedent for the use of this approach under generally accepted actuarial principles for a wide variety of employer applications. However, it is unclear whether this type of analysis will satisfy the requirements of the MMA.

From the beneficiary's point of view, the meaningful measure would be the level of out-of-pocket costs (i.e., the beneficiary premium plus the out of pocket cost sharing). However, a test of actuarial equivalence would compare the average amount of the beneficiary's expenditures (beneficiary premium plus the out-of-pocket cost sharing only) to some threshold of comparison. In this case, however, the direction of the test is reversed. Specifically, if the beneficiary's required financial support is less than or equal to the threshold, the test would be passed. In other words, a plan would be better than actuarially equivalent if the beneficiary's cost is reduced, or, said differently, if some of the savings from the Medicare subsidy result in reduced retiree costs. However, the Act does not appear to set actuarial equivalence requirements for retiree prescription drug plans from the beneficiary's perspective.

The remaining issue is to determine the appropriate threshold to use, which is essentially selecting from among the various methodologies suggested by CMS in the proposed regulations. It is possible that the same threshold definition could be used for both tests (e.g., use the value of Medicare Part D benefits less the Part D beneficiary premium for the plan sponsor threshold and use the out of pocket beneficiary costs under Medicare Part D plus the Part D beneficiary premium for the beneficiary threshold).

CMS has indicated four objectives that the selected method must try to balance. Consistency with generally accepted actuarial principles from the plan sponsor and beneficiary perspectives

introduces a fifth and sixth objective. Following is a summary of these six objectives with a focus on the direct federal subsidy:

1. Maximize retiree health coverage – Maximize the number of retirees retaining employer-based drug coverage through the drug subsidy program.
2. Avoid windfalls – Avoid creating windfalls where retirees might receive a smaller subsidy from sponsors than Medicare would pay on their behalf.
3. Minimize administrative burden – Minimize the administrative burden on beneficiaries and plan sponsors.
4. Minimize government costs – Minimize the costs to the government of providing retiree drug subsidies and not exceed the budget estimates.
5. Plan perspective – Assure that the direct subsidy methodology is consistent with generally accepted actuarial principles from the plan sponsor perspective.
6. Beneficiary perspective – Evaluate the direct subsidy methodology from the beneficiary perspective.

Option 1—Gross Benefit Test (i.e. One-Prong Approach)

The first method described by CMS is the "gross benefit test" (or one-prong approach) that would compare the plan value of the employer plan with the plan value of the Medicare Part D benefit. If the employer plan value equals or exceeds the Part D value, the test is passed. In both cases, retiree premiums would not be taken into account. We evaluate this option according to each of the stated objectives:

1. Maximize retiree health coverage – This method would result in the most favorable qualification standard for the subsidy program of any of the methods and would therefore be likely to maximize the number of employer-based plans retained.
2. Avoid windfalls – As acknowledged by CMS, there is a greater potential for employer windfalls under this methodology, so this objective is not satisfied.
3. Minimize administrative burden – This is the simplest of the proposed methods and would therefore minimize the administrative burden.
4. Minimize government costs – Because the subsidy would be provided to the widest range of employers, the number of beneficiaries transferring to enrollment in Part D would be minimized, so this objective is met.
5. Plan perspective – This method seems inconsistent with the discussion of generally accepted actuarial principles from the employer perspective, since the gross benefit value is used in the test rather than the level of the sponsor's financial support for the plan.
6. Beneficiary perspective – From the beneficiary perspective, the proposed test does not clearly address the issue of actuarial equivalence, since the only test described is from the plan sponsor perspective. Further clarification of the test would be needed to address this issue. There is at least a possibility that the test as described could allow a plan sponsor to reduce its financial support and consequently increase the beneficiary's premium and/or out of pocket cost from 2005 to 2006 and still pass the test.

Option 2 – Gross Benefit Test With a Subsidy Limit

The second method described by CMS is the use of a "gross benefit test" plus the additional constraint that the direct subsidy payment to the plan sponsor could not exceed the amount of the financial support provided by the plan sponsor. We evaluate this option according to each of the stated objectives:

1. Maximize retiree health coverage – This method would result in the second most generous subsidy program of the four methods and may result in the number of employer-based plans retained being almost as high as the first method.
2. Avoid windfalls – This method would eliminate the direct windfall where employers would receive a subsidy that is larger than their degree of financial support. However, looking at the broader financial impact on the federal government, taxable employers would still receive tax savings that would reduce federal revenues and indirectly affect the Medicare program because federal revenues must still support most of the Part D benefit costs. Thus, any employer limited by the rule comparing the direct subsidy payment to the employer's plan financial support could still be benefiting through the tax treatment.
3. Minimize administrative burden – Administratively, this method is more complex than the gross benefit test, but it is still feasible for an actuary to perform the calculations required by this method.
4. Minimize government costs – Because the subsidy would be provided to a very wide range of employers (almost as many as the gross method), the number of beneficiaries transferring to enrollment in Part D would be limited to nearly the same extent as the under the prior test, so both aspects of this objective are met.
5. Plan perspective – This method seems consistent with the discussion of generally accepted actuarial principles from the employer perspective, since the employer's financial support for the plan (the gross benefit value less offsetting retiree premiums) is used in the test.
6. Beneficiary perspective – From the beneficiary perspective, the proposed test does not clearly address the issue of actuarial equivalence, since the only test described is from the plan sponsor perspective. Further clarification of the test would be needed to address this. There is at least a possibility that the test as described could allow a plan sponsor to reduce its financial support and consequently increase the beneficiary's premium and/or out of pocket cost from 2005 to 2006 and still pass the test

Option 3 – Two-Prong Approach

The third method described by CMS is a two-prong test that involves the use first of a "gross benefit test" plus a second "net value test," under which the sponsor's financial support for the plan (the gross plan value less any amounts paid for by beneficiary premiums) must equal or exceed some threshold such as the after-tax value of the subsidy to the employer. We evaluate this option according to each of the stated objectives:

1. Maximize retiree health coverage – This method would result in a somewhat less generous subsidy program than the first two methods and would result in the number of employer-based plans retained being somewhat less than the first two methods.
2. Avoid windfalls – This method would eliminate both the overt direct windfall and the indirect tax savings windfall where employers would receive a subsidy that is larger than their degree of financial support.

3. Minimize administrative burden – Administratively, this method is more complex than the gross benefit test, but it is still feasible for an actuary to perform the calculations required by this method.
4. Minimize government costs – This method would reduce the number of beneficiaries covered by retiree health plans, due to the failure of the test by plan sponsors that provide low levels of financial support. However, beneficiaries of employers that fail the test may be able to obtain a higher level of financial support by enrolling directly in Part D plans.
5. Plan perspective – This method seems consistent with the discussion of generally accepted actuarial principles from the employer perspective, since the employer's financial support for the plan (the gross benefit value less offsetting retiree premiums) is used in the test.
6. Beneficiary perspective – From the beneficiary perspective, the proposed test does not clearly address the issue of actuarial equivalence, since the only test described is from the plan sponsor perspective. Further clarification of the test would be needed to address this issue. There is at least a possibility that the test as described could allow a plan sponsor to reduce its financial support and consequently increase the beneficiary's premium and/or out of pocket cost from 2005 to 2006 and still pass the test.

Option 3a – Alternative Two-Prong Approach

CMS describes a variant of the third method, which, unless otherwise noted below, would result in the same evaluation of objectives as option 3. This method would set the threshold for the "net value test" at the level of Medicare's support for Medicare Part D. Thus, the sponsor's financial support for the plan (the gross plan value less any amounts paid for by beneficiary premiums) must equal or exceed the Medicare support for Part D (the Medicare Part D gross plan value less the Part D beneficiary premiums). This could be calculated specifically for each plan sponsor or nationally. This method would provide the most stringent test among those under consideration by CMS. Therefore, of the options presented, it would result in the least generous subsidy program and the lowest number of employer-based plans retained. Looked at another way, however, this method would ensure that subsidies would be provided only to those retiree health plans that are at least as generous (on a net basis) as the Part D plan. Under the other potential tests, plans with less generous net coverage than Part D may still be able to qualify for the 28 percent subsidy.

In summarizing the foregoing discussion, no single test appears to optimize the results of all of the objectives. Focusing on the specific issue of actuarial equivalence, the two-prong approach seems consistent with generally accepted actuarial principles from the employer perspective and further clarification is needed under any of the proposed tests to address this concept from the beneficiary's perspective.

In performing a test of this type, generally accepted actuarial principles would suggest that the same underlying prescription drug distribution should be used for performing plan value calculations of both the employer plan and the Part D benefit. Similarly, other elements must be held constant (e.g., demographics, projection assumptions) so that the only variables in the calculation are those related to plan design differences, contribution differences, and, if appropriate, utilization differences due to the plan design or plan management. This would suggest that a national average value should not be used as a threshold, but it would be appropriate to use either the plan sponsor's actual data or a CMS standard prescription drug

distribution for performing the analysis. The same distribution should be used for all parts of the calculation.

Issue: Reasonable time frame for employer subsidy filing.
Comment: We believe that the time frame outlined in Table R-1 is reasonable and sufficient to accomplish the myriad objectives and requirements specified in the MMA. The time frame creates some relatively minor challenges for employers managing the benefit enrollment process, but we believe they are necessary to ensure that seniors are appropriately notified of the status of their retiree benefit and given enough information to understand their options.

Issue: Data and census requirements.
Comment: The data requirements for the subsidy application are appropriate. We suggest adding the requirement for a back-up or secondary point of contact at each company. CMS should allow the specific census information (i.e., names and SSNs) to be submitted after Sept. 30, 2005 but before the start of the program. It is unclear whether the demarcation, "Additionally, the following information must also be submitted for each plan—…" was intended to allow additional time beyond the Sept. 30, 2005 due date for the subsidy application. It is also not unreasonable to require employers to institute a positive enrollment process to gather the required information from all dependents covered under their retiree benefit program. This has minimal cost and is necessary for the program to work as intended.

Issue: Census file update.
Comment: Using a complete enumeration file process, including periodic updates, makes sense and will allow a complete exchange of necessary information for proper program administration.

Issue: Creditable coverage notification burden.
Comment: The credible coverage notification burden is not unreasonable as outlined in the proposed rules. In addition, we believe that the standard language is an important provision to ensure that seniors are receiving a clear message concerning their benefit options. We believe that sending separate notices to each individual eligible for coverage under a creditable benefit would reduce confusion. These procedures have a minimal cost and burden to employers and are likely to result in better outcomes for the federal program as well as for the employer.

Issue: Eliminating windfalls under the gross equivalence test and responses of employers to anti-windfall approaches.
Comment: This concept is an extension of the pattern of declining post-retirement medical coverage in general. As noted by CMS, the financial pressure on employers in recent years has been great enough to create a continual erosion in the level of retiree medical benefits and in the financial support of those benefits by employers. This same pressure will cause employers to maximize available subsidies.

Specifically with respect to the one-prong gross test, employers that meet the gross test, but who provided low financial support to the plan, would still be expected to file for a subsidy if not otherwise prohibited or limited. Consequently, a net equivalence test seems necessary for CMS to achieve their desired result of avoiding windfalls.

Issue: Treatment of disabled employees and retirees.
Comment: Sec. 423.4 of the proposed regulation defines a Part D eligible individual as someone who is entitled to Medicare Part A and B benefits. Sec. 423.882 defines a qualified retiree prescription drug plan as being an employment-based program covering eligible individuals. This section also defines a qualified covered retiree as a Part D eligible individual who is a participant under a qualified retiree plan.

Some employers cover disabled employees under their active plan and others under their retiree plan. After 24 months of Social Security disability payment, disabled employees may be eligible for Medicare Parts A and B and therefore would become an eligible Part D individual. The final regulations should clarify whether or not these individuals should be included or excluded from the retiree drug subsidy calculations.

423.886 Retiree drug subsidy amounts

Issue: Certification of actuarial equivalence.
Comment: We agree that the actuarial profession should be responsible for determining the appropriate standards for performing this important work. The American Academy of Actuaries has a Code of Professional Conduct and prescribes qualification requirements for the profession. Designation as a member of this professional organization, as well as adherence to its strict qualification standards, would help ensure that the work is being properly performed. We strongly recommend that the designation of "Member of the American Academy of Actuaries (MAAA) be required for certification of actuarial equivalence and that such certification be included in the application for the federal subsidy.

423.888 Payment methods, including provision of necessary information

Issue: Calendar year versus plan year calculation.
Comment: The preamble to the proposed regulations covering payment methods under Sec. 423.888 states the preference of CMS that the subsidy calculation will be based on a coverage year that is defined as a calendar year, not a plan year.

Although administration and regulation of a plan year alternative is more cumbersome, we believe that final regulations should allow the flexibility. For employer plans with plan year deductibles or benefit maximums, such an alternative will ease their administration and accounting of the plan allowing all annual constraints to be determined under the same definition of "year."

As the preamble discusses, this may require some latitude in the actuarial attestation of equivalence if the Medicare plan design limits are not known at the time the attestation is made. Final regulations should address reasonable methods of using projected dollar limits in the actuarial attestation. For example, the annual report to the Medicare Trustees made by the Office of the Actuary includes their assumptions regarding future cost changes to the Medicare program. The actuarial attestation should allow use of those assumptions to project the drug design dollar amounts in the actuarial attestation calculation.

Issue: The operational aspects of the payment approaches for the retiree drug subsidy and their desirability from the employer's perspective.
Comment: The preamble to the proposed regulations covering payment methods under Sec. 423.888 provides for alternative payment approaches for the retiree drug subsidy. Under the first alternative, a single payment would be made after the close of the year. The second option would make interim payments throughout the year with a settlement after the end of the calendar year. From an employer's perspective, the primary concern is the timing of the payment, which they would like to receive as soon as possible. Although some credits that employers receive today are paid much after the point of sale (primarily rebates) we suggest that CMS allow a simple allocation methodology to reflect an approximate value of rebates in the subsidy determination on a monthly or other periodic basis, with a true-up after final accounting. We would defer to others dealing with the accounting of retrospective rebates, but we have seen some payments made after the end of the plan year on dates that would make it difficult to meet a requirement of determination by the fourth month after the end of the year. We encourage further discussions with current plan administrators to determine appropriate timing of when final determinations can be made.

We encourage CMS to allow employers to use whichever method best meets their needs. Larger employers may be able to make monthly determinations as suggested, but even they may decide that an annual determination is the most cost efficient way to handle the calculations.

Under the second alternative, an estimate needs to be made in advance of the annual determination in order to receive advance monthly payments. We believe that an actuarial estimate of the subsidy amount can be made based on the plan sponsor's historical experience. When a plan sponsor indicates that it would like to use this method, part of the actuarial attestation should include an estimate of the average per capita subsidy payment expected to be received for the calendar year. The monthly payment can then be based on the average per capita payment and the number of covered persons as submitted by the plan sponsor. The preamble suggests that such estimates will become more accurate over time, and the interim payments may then increase from 70 percent to 90 percent after three years. We do not necessarily agree that estimates will become more accurate in such a timeframe. Some employers will already have adequate historical claims experience. However, estimates of the expected subsidy amount will vary based on many factors, including variance in utilization, design changes, and cost inflation. Therefore, it is difficult to determine in advance an appropriate percentage of the estimate to assure that any need to recoup overpayments is completely eliminated. One possible constraint is to pay an estimate based on current costs of the plan. For example, the basis for the 2006 estimate may be limited to claims experience for the 12-month period ending June 2005. Such a process will include an implicit margin in the calculation equal to a year-and-a-half of cost trend (utilization and inflation).

SUBPART S – SPECIAL RULES FOR STATES—ELIGIBILITY DETERMINATIONS FOR SUBSIDIES AND GENERAL PAYMENT PROVISIONS

423.902 Definitions

Issue: What special issues or clarifications are needed to deal with SPAP coordination with new Part D plans?
Comment: As discussed under Subpart J, clarification should be provided on how coordination of Medicaid with the new Part D plans will impact actuarial equivalence. Will all payments from Medicaid program be included in the calculation of actuarial equivalence? If so, clarification should be provided on how to evaluate the SPAP programs, which can vary dramatically by state. SPAPs, Medicaid, and low-income subsidy programs can overlap, so clarification should be provided on evaluating the actuarial equivalence in these situations.

SUBPART T – PART D PROVISIONS AFFECTING PHYSICIAN SELF-REFERRAL, COST-BASED HMO, PACE, AND MEDIGAP REQUIREMENTS

Medigap Policies

Issue: Process for validation/approval of a company's determination of creditable coverage.
Comment: The language of the proposed regulation specifies that Medigap issuers will be responsible for determining whether the drug coverage under their policies is creditable in accordance with the final rule implementing the Part D drug benefit. Upon determination, the regulation specifies no regulatory body that would validate/approve this assessment, which could create conflicts in the case of a beneficiary later enrolling in Part D (upon which the determination of creditable coverage would be provided to the Secretary). We suggest that this process be defined (noting that additional concerns may arise as a result).

Issue: Determination of creditable coverage versus a Part D benefit that changes.
Comment: The proposed regulation noted (and we recognize) that the process for determining creditable coverage has not been established, and additional concerns may arise upon its creation. One challenge to such a determination (and the governing guidelines) is that the Part D cost-sharing levels will be indexed according to the growth in the expenditures of the program. For benefit plans that are nearly creditable in 2006, the anticipated changes in Part D over time could make a plan become creditable coverage over time—the process of determination (and perhaps disclosure) should recognize this possibility. Another issue with plans at or near the level of creditable coverage would be the timing for the announcement for changes in the Part D cost-sharing levels. We recommend that proper advanced notice of Part D changes be scheduled to allow time for determination of creditable coverage, disclosure to beneficiaries, and decision-making time for beneficiaries.

Issue: Aggregation of data (level of scope) in the determination of creditable coverage.
Comment: In developing the process for determination of creditable coverage, the variables to be used will inevitably be considered. This group identified age (or age mix), gender, location, benefit design, and formulary design as some of the items to be included. Consistent with the regulation's stated desire not to be prescriptive, this group asks that flexibility to consider all these elements be allowed. As a matter of simplicity, this group also suggests that aggregation of

data (combining all ages, gender, locations, formularies) for a particular benefit design be allowed as reasonable in determining of creditable coverage.

Members of the Academy are available to work with you as you finalize the proposed Medicare prescription drug benefit and Medicare Advantage regulations. If you would like to discuss these issues further please contact Academy senior health fellow, Cori Uccello (Uccello@actuary.org or 202-223-8196), or senior health policy analyst (federal), Holly Kwiatkowski (Kwiatkowski@actuary.org or 202-223-8196).

Sincerely,

John M. Bertko, FSA, MAAA
Chairperson, Actuarial Equivalence Work Group
American Academy of Actuaries

Academy members who played a significant role in the development of this letter include: Michael S. Abroe, FSA, MAAA; Stephen J. Kaczmarek, FSA, MAAA; Adam J. Reese, FSA, MAAA, FIA, EA, FCA; and Margaret Wood Wear, ASA, MAAA, FCA.

Other Academy members who contributed to this letter include: Mark F. Bartorelli, ASA, MAAA; Alfred A. Bingham, Jr., FSA, MAAA, FCA; April S. Choi, FSA, MAAA; Matthew J. Hassett, ASA, MAAA; Brian J. Januzik, ASA, MAAA; Donna D. Nezames, ASA; Mark F. Olson, FSA, MAAA, FCA; Jeffrey P. Petertil, ASA, MAAA, FCA; Susan E. Pierce, FSA, MAAA; Neela K. Ranade, FSA, MAAA, EA; Wesley Allen Royse, ASA, MAAA; Thomas G. Ruehle, FSA, MAAA; Geoffrey C. Sandler, FSA, MAAA; John J. Schubert, ASA, MAAA, FCA; David A. Shea, Jr., FSA, MAAA; Thomas S. Tomczyk, ASA, MAAA, FCA; Cori E. Uccello, FSA, MAAA, FCA; David M. Walker, ASA, MAAA; Mark R. White, FSA, MAAA; Thomas F. Wildsmith, FSA, MAAA; and Dale H. Yamamoto, FSA, MAAA, EA, FCA.

We would also like to thank David Steinberg who participated in this effort.