

Medicare Prescription Drug Part D Compliance Conference



December 7-9, 2008 | Renaissance Baltimore Harborplace Hotel | Baltimore, MD

Medicare Managed Care Employer Group Issues

Presented by

Amy Hafey, Senior Counsel, Legal and Government Relations
Robert Raffel, Director, Group Medicare Sales and Account Management
Sheila Rankin, Vice President, National Medicare
Kaiser Permanente

Health Care Compliance Association
6500 Barrie Road, Suite 250, Minneapolis, MN 55435
888-580-8373 | www.hcca-info.org

Discussion Topics

- Employer Group Perspective on Retiree Coverage
- Requirements related to Medicare Employer Group Waiver Plans
 - Employer Group Waiver Plans
 - Approved Waivers
 - Application of Marketing Rules to Group Market
 - Creditable Coverage and Late Enrollment Penalty
 - Retiree Drug Subsidy Program
 - Employer Group Reporting
- Operational Challenges

Compliance and the Group Marketplace

Discussion Outline:

1. The Changing Group Retiree Marketplace
2. A Beneficiary Perspective
3. An Employer Perspective
4. Carrier Implications

The Changing Group Retiree Health Marketplace

- Employers are re-thinking their retiree strategies with many deciding to eliminate Group retiree health care coverage.
- Increasing costs, accounting changes (FASB & GASB), increasing administrative and compliance challenges are driving this trend.

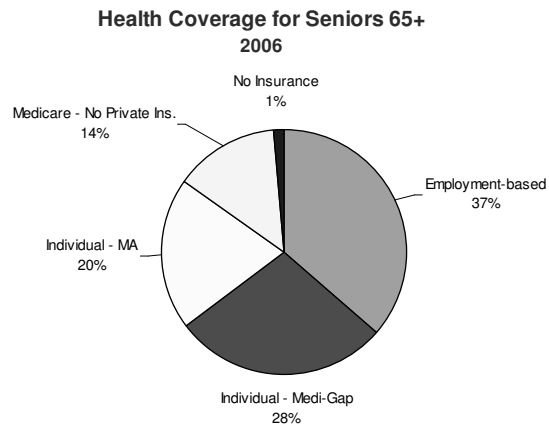
A Beneficiary Perspective

Group retiree health coverage is important to seniors:

- Provides access to benefits not available on the individual market
- Provides greater benefit stability over time
- Brings another payer to the table to share the costs
- Gives seniors an advocate who can negotiate with carriers
- Many seniors have worked hard to earn their group retiree coverage, and they have a strong emotional attachment to it.

A Beneficiary Perspective

Group retiree health coverage is important to many seniors



Sources: Employee Benefit Research Institute, Tables 36.1b, 36.2 - Updated August 2007
NAIC data for Medi-Gap, CMS for Individual MA

An Employer Perspective

Employers want the ability to:

- attract and retain talent
- compete in a global market
- compete against start-up firms

Most employers are looking for retiree strategies that:

- reduce financial liability
- ease the administrative burden

An Employer Perspective

- Financial Liability can be managed:
 - changes in cost sharing
 - changes in contributions
 - changes in eligibility
- Administrative solutions are not so easy:
 - Employers frequently lack the ability to modify administrative requirements imposed by carriers.
 - The administrative impact of recent Medicare regulations is unprecedented.
 - Carriers frequently take different approaches to implementing administrative and regulatory requirements.

An Employer Perspective

Employers are not usually happy about additional health care compliance or administrative work:

- Employers feel that health care administration and complying with health/insurance regulations is the business of the carriers. It is not their business.
- Most changes requires employers to change their systems which can be very costly.
- The challenges of implementing administrative and regulatory changes are the responsibility of the same people who make recommendations as to whether an employer should continue offering retiree health care coverage.

Carrier Implications

Carriers and regulators need to find solutions that work for employers in order to preserve group health coverage in America

- Administrative complexity is one of the top reasons employers drop retiree health coverage.
- With the MSP regulations, commercial health care coverage is impacted.
- In California, we have more small to mid-sized employers dropping commercial coverage than large employers dropping retiree health coverage.

Carrier Implications

What do carriers need to do?

Collaborate:

- Have Sales and Marketing at the table with Compliance and Legal in designing solutions.
- Work with professional associations to develop industry-wide solutions
- Get employer input on proposed solutions
- Develop options with regulators that work for employers
- Develop communications that make sense to group beneficiaries.
- Make sure solutions work for all key stakeholders: regulators, compliance, sales and marketing, employers, and beneficiaries.

Carrier Implications

The Silver Lining

There is an opportunity for exceptional business results for the carrier who collaborates with employers and finds employer friendly administrative solutions.

Medicare Prescription Drug Part D Compliance Conference



December 7–9, 2008 | Renaissance Baltimore Harborplace Hotel | Baltimore, MD

Requirements related to Medicare Employer Group Waiver Plans

Health Care Compliance Association
6500 Barrie Road, Suite 250, Minneapolis, MN 55435
888-580-8373 | www.hcca-info.org

Employer Group Waiver Plans

- CMS has statutory authority to waive or modify requirements that hinder the design of, the offering of, or the enrollment in, employer/union sponsored Medicare Advantage (MA) plans.
 - When exercising its discretion to grant these waivers or modifications, each waiver or modification will be conditioned upon the MAO meeting a set of defined circumstances and complying with a set of conditions.
- Entities that offer employer group sponsored plans must comply with CMS requirements unless those requirements have been specifically waived or modified.
- CMS' employer group waiver authority only applies to the Part D portion of the coverage provided by Cost Plans, not Parts A and B. Thus, Cost Plans may only offer Part D EGWPs as an optional supplemental benefit. Cost Plans may not offer customized MA (Parts A and B) benefits to employer/union group health plan sponsors.

HCCA
HEALTH CARE
COMPLIANCE
ASSOCIATION
888-580-8373 | www.hcca-info.org

14

Employer Group Waiver Plans

- Types of Employer Group Waiver Plans (EGWPs):
 - Plans offered by Medicare Advantage and/or Part D plans (“800 Series”)
 - Plans offered by employers/unions that directly contract with CMS (“Direct Contract” plans).
- According to CMS data:
 - There were 1,083 EGHPs in 2008 with approximately 1.7 million members

Employer Group Waiver Plans

- **Basic Rules:**
 - An MAO is permitted to modify the:
 - cost-sharing;
 - benefit level; and/or
 - premium
- offered only to employers/unions from the levels of cost-sharing, benefits and premiums offered to individual enrollees as long as:
- the minimum required Medicare coverage levels are met; and
 - the modification does not have the effect of denying or discouraging access to covered medically-necessary health care items and services.

Approved Employer/Union Sponsored Group Health Plan Waivers

- In general, MAOs have to accept all Medicare-eligible beneficiaries who reside in their service area as set forth in 42 CFR 422.60(a). EGWPs are not subject to this requirement.
 - EGWPs must restrict enrollment solely to those Medicare eligible individuals who are also eligible for the employer/union sponsor's employment-based health coverage. The employer/union sponsor's eligibility rules exclusively govern a beneficiary's enrollment entitlement in these plans.
 - MAOs offering EGWPs are eligible for extended geographic service areas for certain kinds of MA plans under service area waivers issued by CMS.
 - Minimum enrollment requirements do not apply to EGWPs.
 - MAOs can develop plans for Part B-only Medicare beneficiaries who are members of employer/union groups.
 - Employer/union group sponsored enrollments in EGWPs or individual MA plans may have different annual open enrollment periods. However, such plans must accept valid requests for disenrollment at any time.

Enrollment in MA plans and PDPs

- Subject to certain exceptions, a Medicare eligible person who is enrolled in a Medicare Advantage (MA) plan may not be simultaneously enrolled in a stand-alone Prescription Drug Plan (PDP).
 - Beginning with the 2009 contract year, all employer/union group health plan sponsors will be allowed to enroll their Medicare eligibles in both an "800 series" local coordinated care MA-Only plan (i.e., HMO, HMO/POS, Local PPO) and an "800 series" standalone PDP.
 - CMS requires the separate medical and prescription drug vendors to work closely together with the employer/union sponsor to provide coordinated care and disease management services between the MA and PD portions of the benefit.

Marketing and Disclosure

- CMS has waived the prior review and approval requirements for marketing materials and election forms
 - As of 2009, no FYI filing required
 - MAOs also will be required to retain these disclosure materials and provide access to these written materials to CMS
- Not subject to the annual restriction against communicating to Medicare eligible beneficiaries before October 1st.
- CMS has waived any rules that would otherwise prohibit EGWPs from offering customized disclosure materials to the extent those customized materials will more clearly and accurately describe the benefits available to employer/union group Medicare eligibles

Marketing and Disclosure

- EGWPs that are subject to Medicare marketing and disclosure requirements are also subject to any applicable timing requirements for issuance of these materials. CMS has waived or modified applicable timing requirements in certain circumstances.
 - Where a particular employer/union sponsor has an open enrollment period that differs from Medicare's Annual Coordinated Election Period (ACEP), the timing for issuance of any disclosure materials that are based on the ACEP should be based instead on the employer/union sponsor's open enrollment period
 - Beginning in 2009, a combined Annual Notice of Change/Evidence of Coverage (ANOC/EOC), LIS rider, and Formulary are required to be received by beneficiaries no later than 15 days before the beginning of the ACEP.
- CMS has waived the specific disclosure requirements for employer/union group health plan beneficiaries when the employer/union sponsor is subject to alternative disclosure requirements (e.g., those required by the Employee Retirement Income Security Act of 1974 ("ERISA")), and the employer/union sponsor complies with such alternative requirements.

Premiums

- The uniform premium requirement has not been waived for EGWPs; all enrollees in a particular employer/union sponsored group health plan must be charged the same premium amount for the same benefits. However, under its waiver authority, CMS will allow the employer/union sponsoring the MA plan flexibility in determining how much of a plan enrollee's Part C and Part D monthly beneficiary premium it will subsidize:
 - Employer/union sponsor can subsidize different amounts for different classes of enrollees in a plan provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried vs. hourly).
 - Different classes cannot be based on eligibility for the Part D Low-Income Subsidy.
 - The premium cannot vary for individuals within a given class of enrollees.
 - With regard to the Part D premium, an employer/union cannot charge an enrollee for prescription drug coverage provided under the MA plan more than the sum of his or her monthly beneficiary premium attributable to basic prescription drug coverage and 100% of the monthly beneficiary premium attributable to his or her non-Medicare Part D benefits (if any).
 - MAOs and PDPs must incorporate these requirements into written agreements with employer groups

Low Income Subsidy

- MAOs offering EGWPs are required to comply with the same low-income premium subsidy amount requirements that apply to MAOs offering plans to individual Medicare beneficiaries. Thus, EGWP Part D sponsors are responsible for identifying employer/union group health plan LIS Part D eligibles and passing through the low-income premium subsidy amount payments made by CMS on behalf of these Part D eligibles to reduce their premium contributions.
 - Even though premium amounts may vary among and between employer/union group health plan enrollees, the LIS premium subsidy amounts paid by CMS to all EGWPs for all enrollees of a particular “800 series” or Direct Contract plan benefit package do not vary.
 - The low-income premium subsidy must first be used to reduce any portion of the MA-PD monthly beneficiary premium paid by the Part D eligible with any remaining portion of the premium subsidy amount then applied toward the portion of any MA-PD monthly premium paid for by the employer/union.
 - Any remainder belongs to CMS

Low Income Subsidy

Refund Options:

- The Part D sponsor reduces up-front the premiums charged to reflect the low-income premium subsidy payments paid to the MAO by CMS on behalf of these individuals.
- If the MAO does not or cannot directly bill an employer/union group health plan's Part D eligibles, CMS will waive this up-front reduction requirement and permit the MAO to directly refund the amount of the low-income premium subsidy to the LIS beneficiary.
- The MAO and the employer/union may agree that the employer/union will be responsible for reducing up-front the MA-PD premium contribution required for enrollees eligible for the Low-Income Subsidy.
- If the employer/union is not able to reduce up-front the MA-PD premiums paid by the enrollee, the MAO and the employer/union may agree that the employer/union shall directly refund to the Part D eligible the amount of the low-income premium subsidy up to the MA-PD monthly premium contribution previously collected from the Part D eligible.

Low Income Subsidy

- CMS requires that all MAOs offering EGWPs retain documents and/or working papers that support their adherence to these requirements. These include:
 - Documents evidencing that low income premium subsidy amounts were properly passed through or refunded by either the MAO or the employer/union group plan sponsor
 - Documents or working papers evidencing the calculation of “illustrative premium” for each self-insured/self-funded employer/union group plan sponsor.
- CMS also requires that all MAOs offering EGWPs enter into written agreements with employers/unions which require the employer/union to comply with the LIS requirements and to retain and provide documents upon request to the MAO evidencing the employer/union group plan sponsor's adherence to such requirements.

Other Waivers

- **Non-Calendar Year EGWPs**
- **Part D Formularies**
- **Beneficiary Customer Service Call Center Requirements**
- **Private Fee For Service Plans:**
 - **Elimination of the "Nexus Test" for Non-Network PFFS and All MSA Plans (Regular and Demonstration)**
 - **Special Marketing/Disclosure Requirements For Employer Group Sponsored Private Fee-For-Service Plans**

Marketing and Disclosure

Marketing Provisions that Apply to Employer Group Plans	YES	NO
Nominal Gifts	X	
Unsolicited Contacts		X
Cross-selling		X
Scope of Appointments		X
Co-branding	X	

Marketing and Disclosure

Marketing Provisions that Apply to Employer Group Plans	YES	NO
Sales/Marketing in Health Care Settings	X	
Sales/Marketing at Educational Events	X	
Provision of Meals		X
Appointment of Agents/Brokers	X	
Reporting of Terminated Agents/Brokers	X	

Marketing and Disclosure

Marketing Provisions that Apply to Employer Group Plans	YES	NO
Agent/Broker Compensation		X
Agent/Broker Training and Testing	X Training	X Testing

All activities conducted by the employer/union or its designees to sign-up individual employees to the plan(s) selected by the employer/union are excluded from these provisions.

Creditable Coverage and Late Enrollment Penalty

- **Creditable Coverage**
 - Prescription drug coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard prescription drug coverage under Medicare Part D, as demonstrated through the use of generally accepted actuarial principles and in accordance with CMS actuarial guidelines.
- **Late Enrollment Penalty (LEP)**
 - LEP is a fee imposed by the CMS on individuals who enroll in a Part D drug plan after experiencing a lapse in creditable prescription drug coverage for any continuous period of sixty-three (63) days or longer after the end of their initial Part D enrollment period.
 - If an employer or union sponsors prescription drug coverage for its members through the Part D plan, the Part D plan sponsor shall bill the employer or union directly for any LEP if both the Part D plan sponsor and the employer or union agree. *Medicare Prescription Drug Benefit Manual, Chapter 4, 40.4 Billing the LEP to Employer or Union Sponsors*

Retiree Drug Subsidy

Overview of the Medicare Retiree Drug Subsidy:

- **Employers can choose to offer retirees prescription drug coverage that is actuarially equivalent to Medicare Part D and receive a subsidy**
- **Subsidy payments equal 28 percent of each qualifying retiree's allowable prescription drug costs attributable to gross prescription drug costs between the applicable cost threshold and cost limit (that is, in 2008, drug spending between \$275 and \$5,600). Gross costs are costs incurred for any drugs that can be covered under the Medicare Prescription Drug benefit. Allowable costs are actual incurred costs (i.e., net of discounts rebates, and similar price concessions).**

Retiree Drug Subsidy

- Employer group applies to CMS on annual basis to participate
- Employer group contracts with Health Plan
- Employer group submits information re qualifying covered retirees to RDS Website and updates the information regularly
- “Cost Reporter” submits the following interim information on monthly or quarterly basis:
 - Application ID, Unique Benefit Option Identifier
 - Vendor ID, or Plan Sponsor ID
 - Submitter Type (Plan Sponsor or Vendor)
 - Year and Month of gross retiree cost incurred and paid
 - Gross Retiree Cost, Threshold Reduction, and Cost Limit Reductions
 - Estimated Cost Adjustment

Retiree Drug Subsidy

Annual Reconciliation: Data to be submitted 15 months after the end of the Plan Year:

- Application ID, Unique Benefit Option Identifier
- Year and Month of gross retiree cost incurred
- SSN and/or HICN
- Full Name
- Date of Birth
- Gender
- Amount of Gross Retiree Cost
- Threshold Reduction: the sum of Gross Retiree Costs paid per retiree under the benefit option below the threshold per retiree (\$275 for plan years ending in 2008).
- Limit Reduction: the sum of Gross Retiree Costs paid per retiree under the benefit option in excess of the cost limit per retiree (\$5,600 for 2008)
- Actual Cost Adjustment: The actual amount of the rebate and other price concessions that was attributable to the drug cost incurred by the plan during the plan year.

Employer Group Reporting Requirement

- CMS has not historically collected information on the employer and union group plan sponsors that contract with MAOs to offer benefits using either individual or “800 series” Medicare plans, and CMS has not had information regarding which employer plans are purchasing individual plans for their employee group.
- CMS has determined that information on the employer groups purchasing EGWP coverage is needed to monitor these plans effectively and to ensure that CMS’ statutory waiver authority is being used in accordance with CMS’ statutory mandates. Has proposed reporting requirements effective in 2009.
 - Reporting will be at PBP level
 - Reporting will be twice annually:
 - 1/1/2009 to 6/30/2009 data due 8/31/2009
 - 7/1/2009 to 12/31/2009 data due 2/28/2010

Employer Group Reporting Requirement

Data Elements Requested:

- A) Employer Legal Name
- B) Employer DBA Name
- C) Employer Federal Tax ID
- D) Employer Address
- E) Type of Group Sponsor (employer, union, trustees of a fund)
- F) Organization Type
- G) Type of Contract (insured, ASO, other)
- H) Employer Plan Year Start Date
- I) Current/Anticipated enrollment

Medicare Prescription Drug Part D Compliance Conference



December 7-9, 2008 | Renaissance Baltimore Harborplace Hotel | Baltimore, MD

Operational Discussion

Health Care Compliance Association
 6500 Barrie Road, Suite 250, Minneapolis, MN 55435
 888-580-8373 | www.hcca-info.org

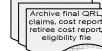
RDS Operational Flows

RDS II Input	Frequency	Source	RDS II Output (Validation)
CMS Threshold & Limit File	Annually	CMS	Interim or Annual Cost Report, Retiree Level Cost Report
CMS Application Info File	Once yearly per App ID	Employer Groups	QRL Validation or Cost Report
Employer Group Info File	Once yearly per App ID	KP Acct Mgr	QRL Validation or Inventory Reports
Employer/Fund Qualified Retiree Lists (QRLs)	1st file at start of plan year, then monthly, weekly or ad hoc	Employer Groups	QRL Validation Report
Membership Snapshots	Monthly	KP Membership Systems	Inventory Report
RX Rebate File	Quarterly	PAS Part D Rebates	
Natl Drug Code Include/Exclude Files	Ad hoc	CMS Proxy List, KP Pharmacy	
Claims Files from PDCS (Pharm Operations Data Store)	Monthly	All regional PIMS, MedImpact, Hannson	



888-580-8373 | www.hcca-info.org

Once yearly for each group after annual recon RDS II



RDS Key Operational Roles

RDS Relationship/Product Manager Functions - Accountable for ensuring KP RDS meets CMS guidelines and regulations

Pharmacy Business Subject Matter Expert (SME)

Systems Operations – Systems Operations and Ongoing Support

RDS Challenges

Incorporating RDS into Ongoing operations

Part B/D determination process

Low Income Subsidy

Low Income Subsidy (LIS)

Groups Challenges with LIS

System modifications to reimburse monies directly to group members

Groups reimbursement of monies to LIS members

Different approaches based on group size and complexity

Group Communications and Tracking

Late Enrollment Penalties

Medicare beneficiaries may incur a late enrollment penalty (LEP) if there is a continuous period of 63 days or more after the individual's Part D initial enrollment period (IEP) in which they were not enrolled in Part D or had creditable prescription drug coverage

KP is responsible for determining whether a beneficiary enrolling into our plan was previously enrolled in Part D or had other creditable coverage

KP must inform CMS of the gaps in creditable coverage and CMS will calculate the LEP

The beneficiary is then billed the LEP as part of the premium payment

If member has SSA premium withhold it will be deducted from their social security check

The LEP is assessed as 1% (subject to change) of the national base beneficiary premium coverage year times the total number of uncovered months

Group Billing for LEP

Billing the LEP to Employer or Union Sponsors

The Part D plan sponsor shall bill the employer or union directly for any LEP if both the Part D plan sponsor and the employer or union agree.

LEP for Employer Group Members

The LEP will be billed to the employer group or to the member directly

Group Challenges with LEP

System modifications to collect monies directly from group members

Different approaches based on group size and complexity

Group Communications and Tracking

MSP-MIR

Medicare Secondary Payor – Mandatory Insurance Reporting

- **Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) establishes new mandatory reporting requirements.**
- **Requirements apply to insurers that offer group health plans (GHP).**
- **While MSP-MIR is CMS driven, this project is not about Medicare groups or members – it is about commercial groups and members.**
- **All Kaiser group commercial plans are considered GHP.**
 - Exemption from requirement for small groups with fewer than 20 employees.

The following GHP members must be reported:

- **Active employees, and dependents of active employees, who are age 45 or older**
- **Members who are receiving kidney dialysis or have had a kidney transplant, of any age**
- **Active employees, and dependents of active employees, who are under 45 and entitled to Medicare**

MSP MIR CHALLENGES

- Collecting and storing of all required data from groups and members
- Collection of SSN data for dependents
- Group Engagement Plans
- Overcoming Identity theft concerns from Members