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Understanding Medicare Part D: Options and Strategies

California Public Employers Employees Health Care Coalition
"Health Care at a Crossroads" Conference

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Objectives

- 1 Medicare overview
- 2 Review Part D plan sponsor options
- 3 Review Part D decisions plan sponsors are making
- 4 Provide a framework for developing a Part D strategy for your organization
- 5 Summary and questions

Fast facts about Medco

- Highest rated PBM with \$42.5 B in annual revenue - a Fortune 50 Company
- More than 16,000 employees nationwide with 2,300 pharmacists, nurses, and physicians
- Provides a customer intimate servicing approach that is delivered through our four client-facing organizations
- Our vision & values are built upon the needs of our customers – to continue to deliver MORE...
 - More transparency
 - More cost management
 - More patient care without compromise

Our market position

- Single largest dispenser of generic medications in North America
- Undisputed industry leader in mail prescription dispensing
 - Process over 90 million mail prescriptions annually through our nine facilities
- Premier provider of comprehensive diabetes care and treatment / largest provider of Medicare Part B diabetic supplies, through Liberty Healthcare (PolyMedica)
- Nation's largest and broadest Specialty pharmacy practice
 - Medco's Accredo Health Group services over 42.5 million members through over 40 wholly-owned pharmacies
- No.1 ranked website – www.medco.com
- Clinical focus: programs, research, and dispensing strategy

Medco & the national labor market

- Partners for over 35 years
- Today... service over 7 million members of America's working families
- Proud employer of 6,900 employees who enjoy the right to bargain collectively



Medicare Overview

The A, B, C and D's of Medicare

The Medicare Program

What is Medicare?

Health Insurance paid by the Federal Government

- Part A: Hospital and skilled nursing care paid by the government
- Part B: Physician and outpatient hospital care paid by the gvmnt
- Part C: HMOs/Medicare Advantage (includes A, B, and D benefits)
 - Government pays Health Plans, who contract with doctors and hospitals to provide healthcare.
- **Part D: Outpatient prescription drug coverage began 1/06**
 - Government pays Health Plans, who contract with pharmacies to provide drugs
 - Member pays monthly premium

Who is affected?

- 35 million elderly, 6 million under-65 disabled
- Individuals 65+ are entitled to Medicare (Part A) if eligible to receive Social Security
 - If individuals elect to pay monthly premiums they get Part B/Part D.
 - Individuals are eligible without regard to income or medical history

What drove Part D legislation?

Seniors rely heavily on prescription drugs

- 98% of seniors nationwide take prescription drugs
- Nearly half of seniors (46%) take 5 or more prescriptions per month

Many seniors lacked prescription drug coverage

- 43% lacked drug coverage for the full year or part year

Drug coverage matters

Among seniors with heart failure, diabetes, or hypertension, those without drug coverage skip doses of medicine at twice the rate of those with drug coverage

SOURCE: Stuart and Briesacher, estimates based on 2000 MCBS Kaiser/Commonwealth/Tufts-New England Medical Center 2003 National Survey of Seniors and Prescription Drugs

What is Medicare Part D?

President Bush signed MMA into law in December 2003:
"Medicare Prescription Drug Improvement
and Modernization Act of 2003"

Phase 1: Discount Card for 2005

- Included low income assistance

Phase 2: Medicare Part D prescription benefit for 2006 and beyond

- Annual drug benefit offered by private plans
- Premiums, formularies, and cost-sharing structure vary according to plan design.

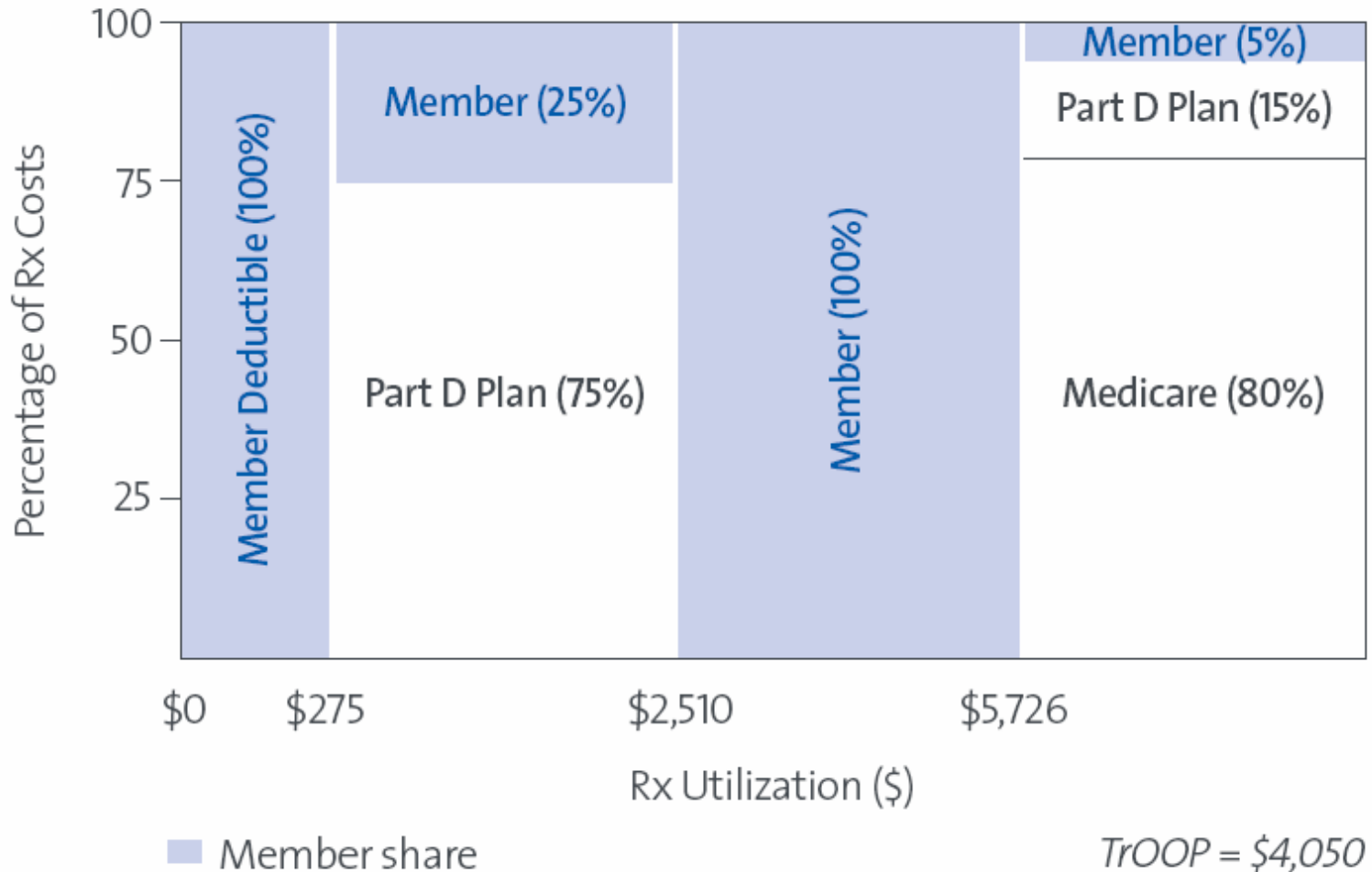
Two main types of Part D Plans:

- Medicare Advantage Prescription Drug Plans (MAPDs)
 - Health Plans provide both medical and drug coverage
- Prescription Drug Plans (PDPs)
 - Health Plans provide drug coverage only

Retiree Drug Subsidy: Employers offer a commercial benefit plan and receive a subsidy payment from the government

Standard Medicare Part D Plan

Member cost sharing will vary based on specific plan design.



The current Medicare market

Group Market

Market size:
10.0M*

Employer
Retiree Drug
Subsidy (RDS)
(~7.0M)

Group MAPD
HMO/POS
(940,000)

Employer
Enhanced
PDP
(628,000)

Employer
PDP
(134,000)

Group MA
PFFS
(242,000)

Secondary
Wrap
(approx.
500,000)

Group MA
PPO
(87,000)



PDPs
(16.3M)

MSA
(2,200)

MA PFFS
(1.5M)

MA SNP
(1.0M+)

MA HMO
(4.9M)

MA PPO
(334,000)

Individual Market

Market size:
24.0M**

* CMS numbers, July 2007 and previous CMS presentation, April 2006. Excludes the Veterans Administration, FEHBP, TRICARE, Indian Health Service and employer members without RDS support – 6.7MM. Individual market metrics do not include 800-series enrollment.

**CMS monthly contract report, September 2007

Medicare Part D 2008 landscape

Prescription Drug Plans (PDPs)

- Slight decrease in the number of PDP offerings between 2007 and 2008.
- Most states will have 50-60 PDPs
- 17 National organizations

Medicare Advantage (MA) Plans

- Local MA PPOs are coming off a two-year moratorium
- Private Fee for Service (PFFS) still strong (1.7 MM); in 2008 there will be 506 offerings, up from 343.
- 720 Special Needs Plans, an increase of 249



Plan sponsor options

Primary Payer with Federal Subsidy

- Keep or slightly improve existing retiree plan
- Manage retiree benefit and apply for the federal subsidy

Enhanced Plan (EGWP)

- Contract with a PDP (Prescription Drug Plan) sponsor for coverage equal to or greater than the standard Medicare benefit

Direct PDP

- Contract directly with Medicare to become a PDP
- Administrative burden lies with the CMS contract holder/plan sponsor

Transition to an MA-PD

- Contract with an MA-PD sponsor to combine administration of medical / pharmacy benefit
- MA-PD plan design, communications

Transition to a PDP

- Group enrollment of members into a PDP to minimize disruption
- Option to subsidize premium pymts, or pay part of member cost through secondary coordination

Retiree Drug Subsidy (RDS)

Advantages & Considerations

Advantages

- Least administrative burden
- Plan sponsor retains plan and eligibility control
- High level of flexibility in plan design, formulary, network
- Little to no member disruption
- Straightforward implementation
- Minimal member communication required
- Defined plan savings

Considerations

- Possible future changes from CMS
- Requires annual application, attestation, and reporting
- Management of enrollment and reconciliation

Suggestion: seek a partner who can effectively coordinate your Part B and D benefits!

Employer group waiver plan (EGWP)

Advantages & Considerations

Advantages

- Likelihood for more plan savings than RDS
- Ability to transfer risk
- Richer member benefits than Part D (or comparable)
- Some flexibility in plan design, formulary, network
- Less member disruption than immediate transition to an individual Part D plan

Considerations

- HICNs required for eligibility
- Control ceded to CMS requirements (eligibility, communications, etc.)
- Implementation more complex than RDS
- Challenges to enrollment reconciliation
- Timing on premium rates
- Moderate member disruption

Suggestion: seek a partner who can reduce the administrative effort!

Transition to a PDP

Advantages & Considerations

Advantages

- Plan savings– reduced drug cost and reduced risk
- Group enrollment eases the transition to a PDP will minimize the disruption for retirees and maintain retiree goodwill
- Flexibility on financial contribution and means to administer
 - Defined financial contribution eliminates risk
 - Option to provide secondary coverage, with benefits managed through a single card

Considerations

- Benefit management and oversight are ceded to the PDP, and the PDP manages financial and clinical strategies
- Member disruption

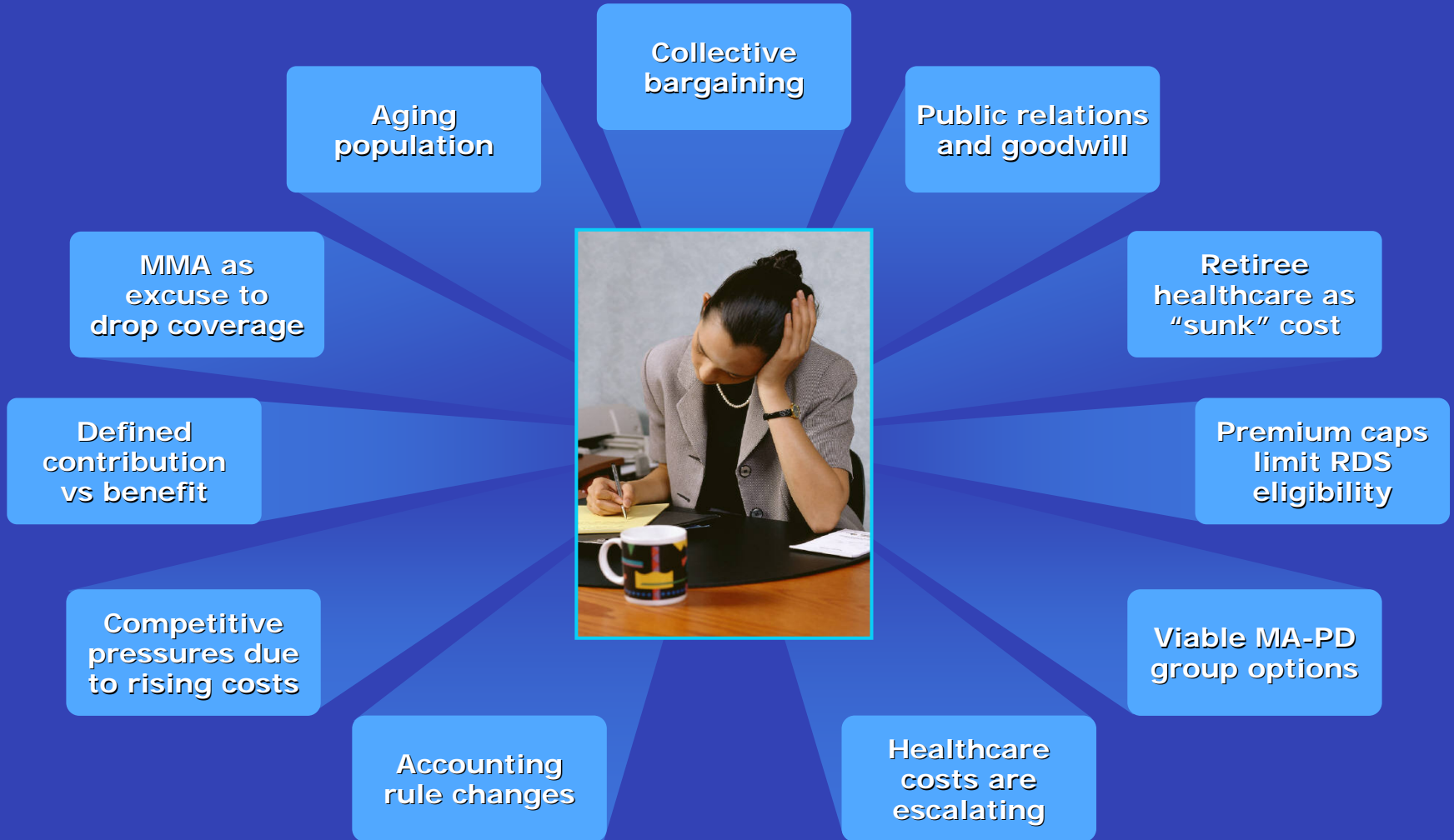
Plan sponsor choices

Options versus meeting plan sponsor expectations

	Control	Admin.	Member	↓ Spend
RDS	●	●	●	●
Enhanced (EGWP)	●	●	●	●
Direct PDP	●	●	●	●
MA-PD	●	●	●	●
Transition to a PDP	●	●	●	●
Drop	●	●	●	●

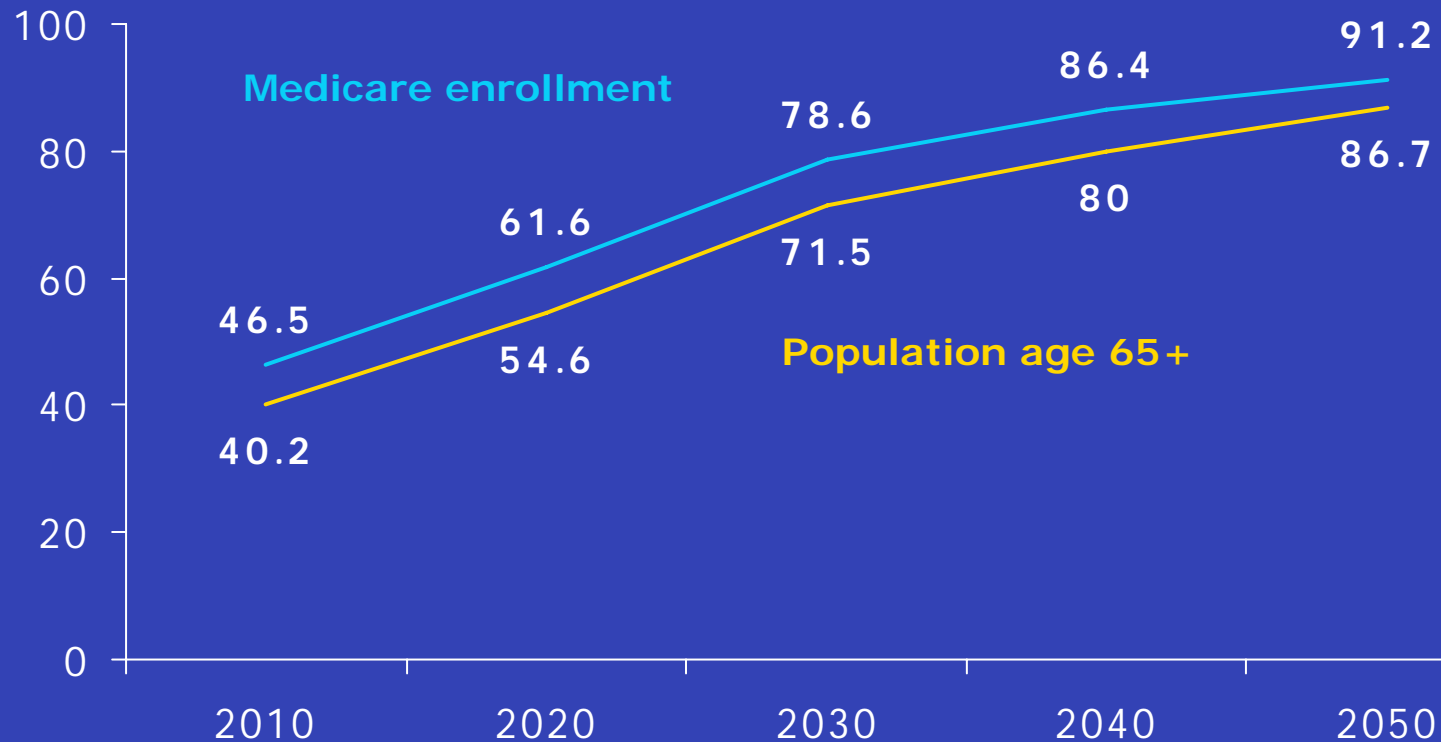
The retiree group Rx benefit market

Challenges and opportunities plan sponsors face



The "Baby Boomers" are coming...

(In millions)



Note: Projected Medicare enrollment includes disabled beneficiaries

Source: 2006 Annual Medicare Trustees Report, Table III.A3 and the U.S. Census Bureau, *U.S. Interim Projections By Age, Sex, Race, and Hispanic Origin*, Table 2a

Legislative/marketplace factors may impact your choice

Part D payment & policy reforms

Plan sponsors transferring risk

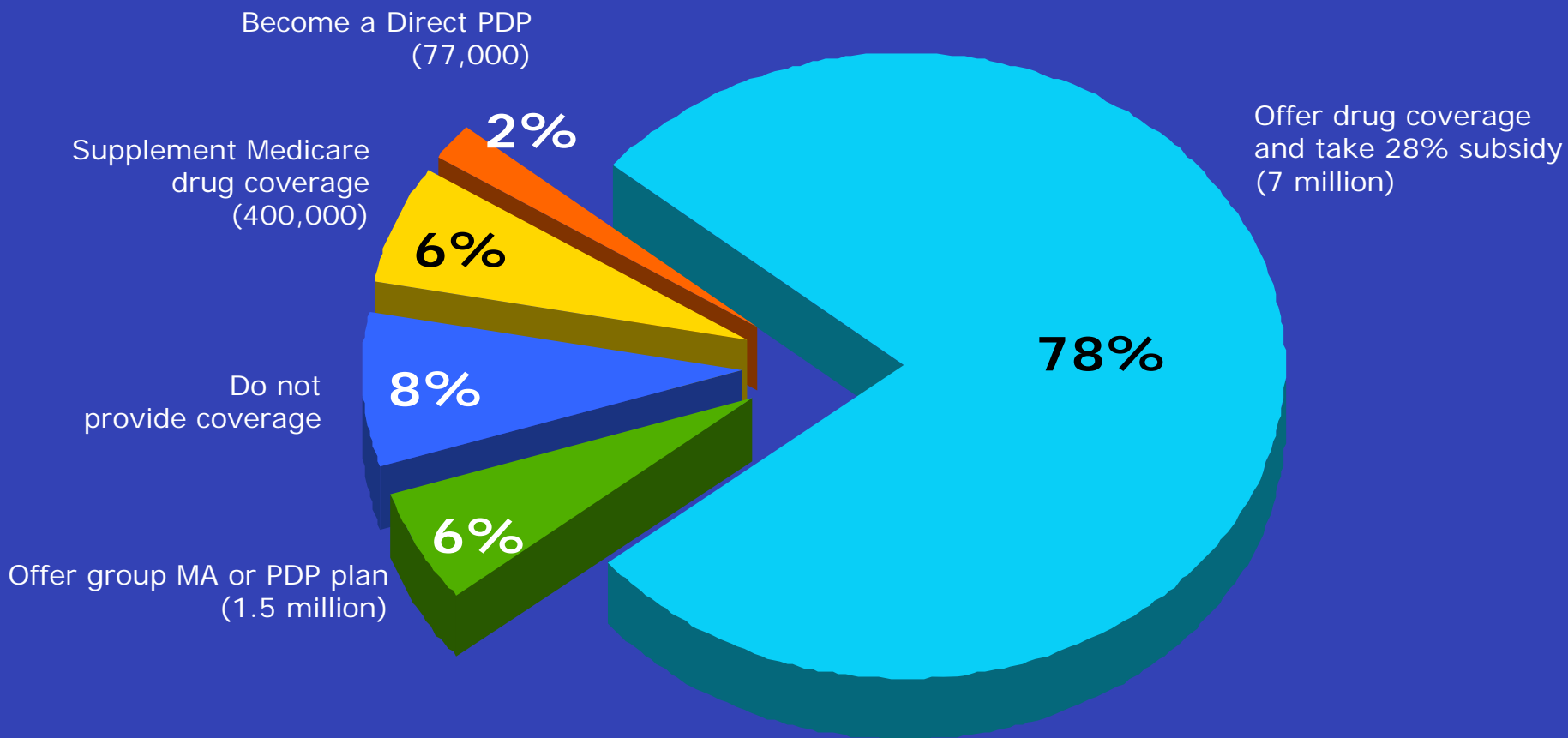
Outcome of 2008 elections

Congressional/CMS oversight

Retiree Benefits

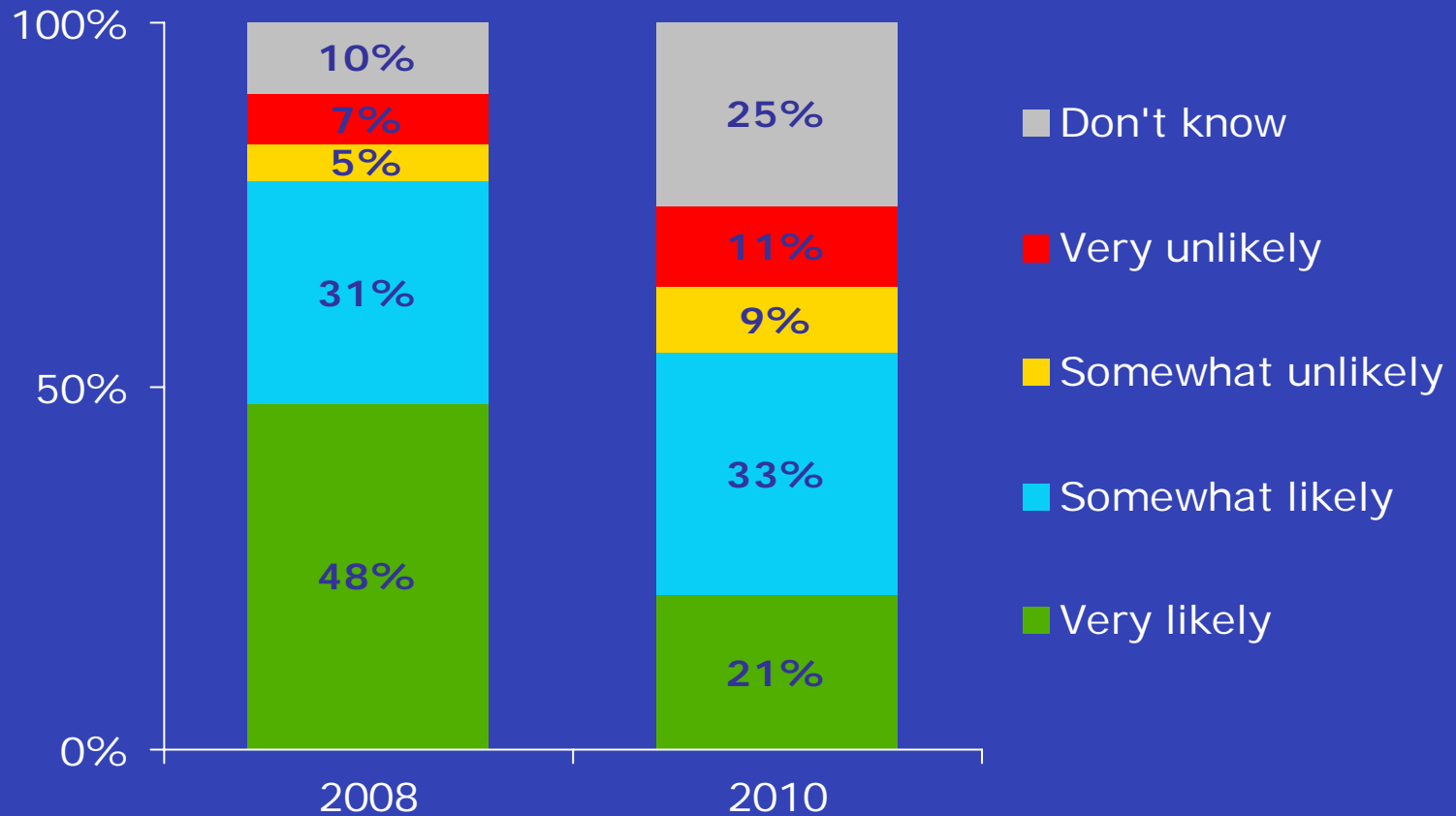


Plan sponsor decisions in 2007



Source: Kaiser/Hewitt 2006 Survey on Retiree Health Benefits, December 2006
(Informal 2006 CMS enrollment numbers)

Decisions for 2008 and beyond among plan sponsors taking the RDS in 2006



Source: Kaiser/Hewitt 2006 Survey on Retiree Health Benefits, December 2006

Current state analysis

Financial objectives

- Tax status and rate
- Baseline drug spend, cost share
- Premium caps and time horizon for RDS eligibility
- Desire for financial predictability/risk-sharing

Operational and administrative objectives

- Your existing infrastructure
- Desire to reduce administrative burdens
- Calendar year vs. non-calendar year plans
- Timing required to finalize rates

Benefit philosophy

- Flexibility in benefit plan design
- Willingness to close/modify the formulary
- Tolerance for member disruption

Choosing the best solution

Example one

Multi-employer union with following characteristics: \$500 ded / 10% generic, 20% brand cost sharing, trustees do not want member disruption or to change benefit

Recommendation: RDS

- High deductible not allowed under PDP options
- No member disruption

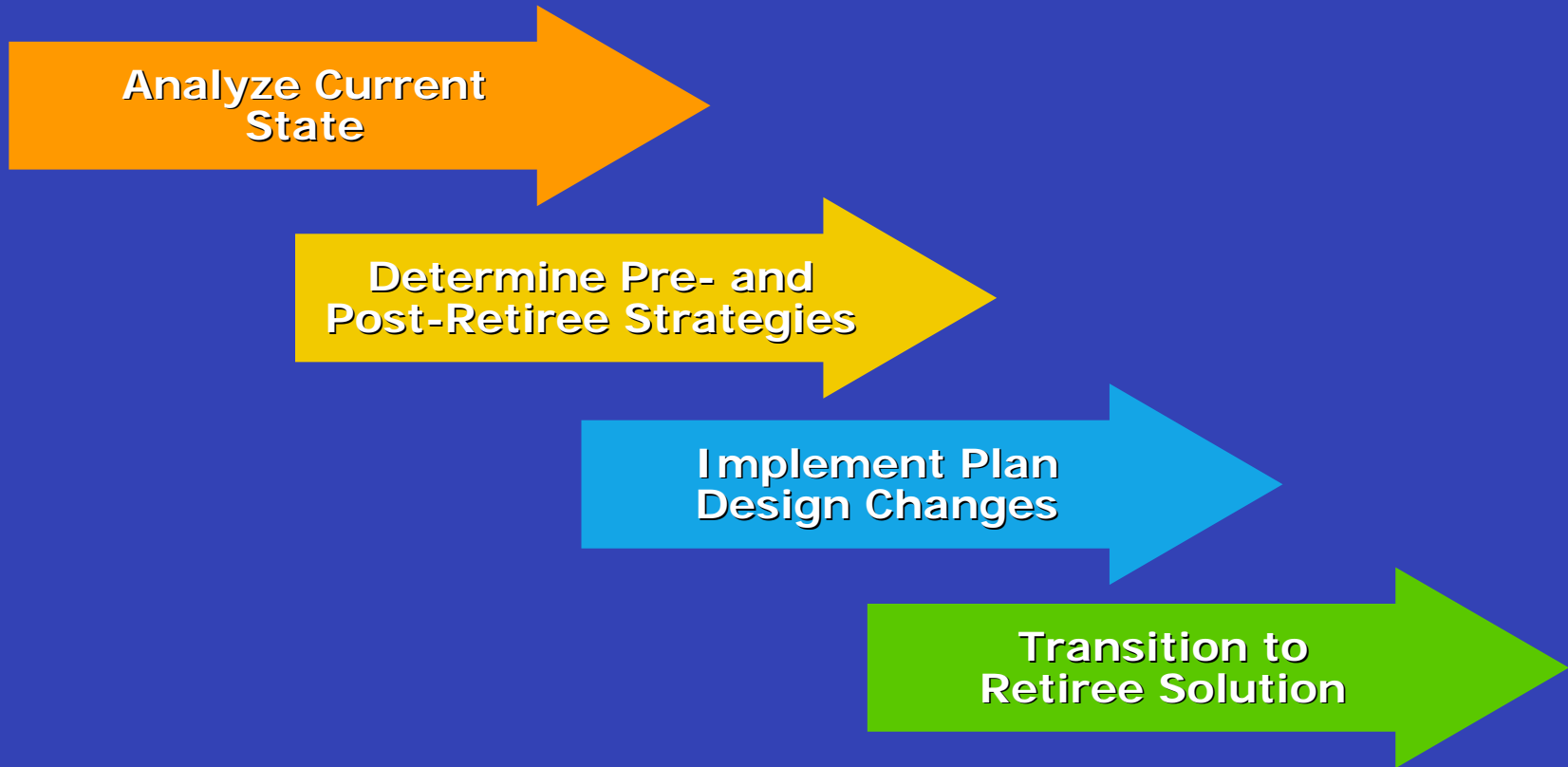
Example two

City government client with 5,000 Medicare-eligible retirees, seeking to maximize GASB relief

Recommendation: EGWP

- Non-taxable status makes EGWP option more attractive
- Limited GASB reductions further limit RDS attractiveness

Your options: A framework for future retiree planning



The model is dynamic and should be re-assessed annually

Time remains for 2009

- Understand your options
- Assess financial as well as qualitative impacts of the options
- Understand CMS, your own, and your vendor timelines
- The time to plan is now

These are complex choices



Summary

- Most employers and unions focused on RDS near-term
- All the options have trade offs
- Best decisions rely on qualitative/quantitative analysis
- It's time to plan for 2009

Questions / discussion

